Two Takeaways from Health Affairs' "Improving Care for Californians" Forum

On October 15, 2018, Health Affairs hosted a forum in Sacramento called "Improving Care for Californians." Two unifying themes emerged from the three panels. First, there is a growing tension between integration and consolidation in health care. Some panelists presented data that demonstrated that integrated health delivery networks often provide better and more integrated care, but that when healthcare delivery markets become highly concentrated, prices tend to increase. Second, the panelists discussed substantial improvements in healthcare in California, but all agreed that substantial work remains to be done to improve health and healthcare in California. In particular, reforming the healthcare delivery system is going to be a long road.

[1] Growing Tension between Integration and Consolidation

In his opening remarks, Alan Weil, Health Affairs' Editor in Chief, highlighted the growing tension between integration and consolidation. He noted that clinical integration is often a "precursor or a codeword or nice way to talk about financial integration," which is a driver of cost. He urged that as California becomes more serious about clinical integration, there should also be "realistic" discussions about the potential downside.

Integration May Save Costs and Improve Quality

Clinical integration is defined as the coordination of care between physicians, hospitals, and other units of the health system including health plans.[1] As Weil mentioned, clinical integration and financial integration often go hand in hand.[2] This combination of financial and clinical integration would theoretically improve efficiency, improve quality, and help control costs[3] by eliminating waste and

duplication.[4] Additionally, clinical integration moves away from the fee for service (FFS) model toward more risk-based models.[5] Jeff Rideout, CEO of the Integrated Healthcare Association (IHA), presented evidence that integrated care is better than non-integrated care in terms of clinical measures. Using the figure seen here, he compared the total cost of care (blue squares) and clinical quality of rate (red diamonds) for four different risk models: no risk (FFS), Accountable Care Organization (ACO), professional risk only, and full risk. From the data in the figure, he concluded that when integrated organizations took on a more capitated (i.e. more risk) model, there was an increase in quality and decrease in costs. However, based on this graph, Rideout noted that one type of integrated organization, ACOs, reduced costs but did not improve quality.

Thomas Priselac, CEO of Cedar Sinai, agreed that clinically integrated systems help with overhead costs and are not "inherently inflationary." Like Rideout, he stated that the leading integrated health systems in California are doing much better than the statewide average in limiting health care cost. Priselac argued that economic integration and clinical integration are "essential requirements to 21st century healthcare."

Consolidation May Lead to High Prices

Integration, however, can result in consolidation as clinical and financial integration need horizontal and vertical integration.[6] Richard Scheffler,[7] Distinguished Chair Emeritus in Healthcare Markets and Consumer Welfare at University of California, Berkeley, agreed with Priselac that the integrated model helps with remedying administrative costs and duplication, but cautioned that consolidation typically leads to price increases.[8] Scheffler explained that today's consolidated health care market happened due to the influx of capital due to the Affordable Care Act (ACA) and a lack of state or federal challenges to consolidation following the ACA's adoption.

First, Scheffler argued that as more people gained insurance coverage from the ACA, there was an increase in spending on healthcare services, and the influx of capital caused "lots of hospitals with money" to seek out additional business opportunities including acquisitions. In addition, the ACA created shared savings

programs like ACOs in Medicare[9] to incentivize providers to provide high quality care at lower costs by allowing them to share in any savings generated by the program. Second, because these systems typically require vertical and horizontal integration to identify and eliminate duplicative care, the Federal Trade Commission (FTC) and Department of Justice (DOJ) issued a joint statement indicating that they will separate pro-competitive collaboration like ACOs from other types of collaboration that might invite strict antitrust scrutiny. This standard essentially set forth an "antitrust safety zone" for ACOs,[10] and as a result, Scheffler noted that states and the federal government made no challenge against consolidations to allow for efficiencies and integration with ACOs and other entities. He called that time "open season." Elizabeth Imholz of Consumer Union agreed that there was an "arms race of provider and plan consolidation," which led to the present reality of a consolidated market.

More importantly, this "open season" and the resulting consolidated market, Scheffler argues, is a detrimental reality to health care prices. Scheffler noted that as hospitals buy up specialists during this period, the percentage of specialists in hospital-owned practices increased from 20 percent to 54 percent between 2010-2016.[11] This increase has led to a Herfindahl–Hirschman Index (HHI), which measures market concentration, of more than 5,000.[12] For context, the U.S. DOJ and FTC consider a market highly concentrated if it has an HHI above 2,500.[13] Consolidations like hospital acquisition of specialists can affect prices, and Scheffler argued that consolidation nearly always leads to price increases. For example, he explained that the average monthly ACA premium for a forty-year old person increased by 11% when a hospital concentration doubled. This is also seen in the case of California's healthcare market, where prices and premiums in the more consolidated Northern California market are higher than the prices or premiums in the Southern California market by about 30%.

Furthermore, as Imholz noted, greater consolidation leads to greater bargaining power, which in turn leads to anticompetitive contract terms. She believes that consumers need more regulatory control like price control to stem consolidation effects. Priselac, on the other hand, pushed back stating that markets are fluid and dynamic and making policy decisions based on the data is akin to looking at the rearview mirror while driving down the highway.

[2] Reforming Delivery System is Going to be a Long Road

Many of the panelists acknowledged the difficulty in implementing systematic changes due to the current complexity of the California healthcare system.

First, Weil noted that California is a local-based system, where counties tackle health care. While the state administers the Medi-Cal program, each county's welfare department is responsible for the local administration of the Medi-Cal program with direction from the state's Department of Health and Human Services.[14] Such local administration has led to six different models of Medi-Cal managed plans.[15] For example, much of the Central California coast from Mendocino to Orange (excluding Los Angeles and San Francisco) operates under a "County Organized Health System" (COHS) model, where a single plan serves all Medi-Cal beneficiaries in that county, while both San Benito County and Imperial County have their own individual model.[16] Weil observed that the county-based system gave an excuse for the state not to lead. Additionally, "robust" and diverse local health systems complicate delivery system reform, because reform will require discussions of realignment and resource allocation at both the state and local levels. Nonetheless, Weil believed that the large scale of Medi-Cal and Covered California programs has turned the attention to the overall delivery system.

To further complicate the landscape, Jennifer Kent, the Director of Department of Health Care Services (DHCS), broke down the six different delivery systems DHCS runs to cover 13 million Californians: fee for service (FFS), managed care, California Children's Services (a stand-alone, specialized FFS), a mental health system operated through county-level health plans, substance abuse and disorder services, and dental (both FFS and managed care). She noted that these are delivery systems that are long standing and "historic" with specific funding attached. For example, she mentioned that California's Children Services has been maintained since 1927.

Weil noted another challenge was California's weak primary care system. Because California's reimbursement rates for Medicaid services are one of the lowest in the country, the focus of many of the state's academic medical centers is on specialty care. As a result, California's health system lacks a necessary primary care

infrastructure, which could help lessen costs.

Finally, Weil questioned whether California can deliver on coverage and delivery system reform with the current formula. He pointed out that California has the "highest level of income inequality, fairly high poverty rates, … [and] pretty high median income." Despite these obstacles, he claimed that Californians could afford to share values because they have the resources to fund health reform effort. Weil questioned, however, whether shared values could be sustained given an economic downturn.

At the end of the discussion, Priselac insightfully summed up the difficulty in systemic reform: "[i]t is imperative to recognize that we are still in the midst of revising a delivery and payment system built over 50 years . . . we should have an appreciation for what it means to reconfigure 20% of the American economy while flying the plane." Questions remain about the best route forward to providing better quality care to all Californians while containing costs. But, with California's dedication to improving care and a commitment to analyzing data to assess and refine reforms that are working (see the Health Affairs September theme issue), California can lead the way to better health care for all of its residents. The Health Affairs forum was just one important discussion among many as California continues to move to a cost-efficient, quality health care system.

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[1] *See* Robin Gilles, et. al., *Conceptualizing and measuring integration: Findings from the health systems integration study*, 38 Hospital & Health Services Administration 467 (1993); Alain C. Enthoven and Laurence C. Baker, *With Roots In California, Managed Competition Still Aims To Reform Health Care*, 37 Health Affairs 1425, 1426 (Sept. 2018). *See also 12 things clinical integration is — and is not*, Becker's Hosp. Rev. (July 29, 2014).

[2] *See* Douglas Hastings, *Medicare ACOs: The Integration Of Financial And Clinical*

Integration, Health Affairs Blog (Apr. 11, 2012) (explaining "Financial integration among providers involves: shared financial data and shared financial risk and reward; mutual dependency on financial outcomes; and aligned financial incentives. Clinical integration among providers involves: shared clinical data and shared patient relationships; mutual dependency on clinical outcomes; and aligned clinical incentives").

[3] Center for Studying Health System Change, Rising Hospital Employment of Physicians: Better Quality, Higher Costs?, Issue Brief. No. 136 at pg. 3 (Aug. 2011).

[4] *See* American Hospital Association, Clinical Integration – The Key to Real Reform (2010).

[5] *See* Dixon Hughes Goodman Healthcare, Clinical Integration (July 2013) (noting that clinical integration embraces risk).

[6] *See* Gillies, *supra* note 1.

[7] Dr. Scheffler also serves on the Advisory Board for the Source on Health Care Price and Competition.

[8] However, Scheffler noted that not all integration should lead to consolidation, as integration can happen through contracts.

[9] Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010).

[10] Fed. Trade Comm'n & Antitrust Div. of U.S. Dep't of Justice, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, — Fed. Reg. — (2011). Available from: https://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf.

[11] *See also* Richard M. Scheffler, et. al., *Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices*, 37 Health Affairs 1409, 1411 (Sept. 2018).

[12] *Id.*

[13] *See* U.S. Department of Justice & Federal Trade Commission, Horizontal Merger Guidelines (Aug. 2010).

[14] 22 CCR § 50004.

[15] *See* Map of Medi-Cal Managed Care Models, https://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf.

[16] *See id.*