A Large Community Health Center Adapts to a Changing Insurance Market

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The ACA era provides both opportunities and challenges for AltaMed and other community health centers. The expansion of Medi-Cal in California promises more stable revenue as the uninsured obtain coverage, but it has also attracted new competitors.

INTRODUCTION

The Affordable Care Act (ACA) has transformed the landscape of California's health care delivery system, unleashing changes with far-reaching implications that include:

- a large-scale expansion of Medi-Cal managed care, California's Medicaid program
- creation of Covered California, the state's health benefit exchange, and
- expansion of care management initiatives from HMO to PPO and Medicare fee-for-service through accountable care organizations.

Of particular significance has been growth in Medi-Cal. Enrollment reached 11.9 million in December 2014—nearly one-third of the state's population—with two million members becoming eligible since the ACA took effect in January 2014. Growth in coverage brings new opportunities and revenue potential for the providers that have traditionally cared for the uninsured, but also new challenges as those patients gain coverage and choices. This Issue Brief provides an on-the-ground view of California's shifting environment through the lens of a major community health center: AltaMed Health Services.

OVERVIEW OF ALTAMED HEALTH SERVICES

AltaMed was founded more than 40 years ago as a grant-funded free clinic serving the Latino population in Los Angeles. It is the largest independent Federally Qualified Health Center (FQHC) in the U.S., with more than 930,000 annual visits for 180,000 patients through 43 sites in Los Angeles and Orange Counties. AltaMed provides care through staff-model clinics with a wraparound IPA that supplements the clinic staff with community physicians. AltaMed offers primary medical care, dental care and senior long-term care services, and in May 2011 was the first organization in the nation to become accredited by the Joint Commission's Primary Care Medical Home designation.

ABOUT THIS ISSUE BRIEF

This Issue Brief provides an on-the-ground view of California's shifting environment through the lens of a major community health center: AltaMed Health Services. Related Issue Briefs address other aspects of ACOs emerging in the state, including:

- *ACO Contractual Arrangements in California's Commercial PPO Market,* by Thomas R. Williams, Dr.PH
- *Accountable Care in California: Imperatives and Challenges of Physician-Hospital Alignment,* by James C. Robinson, Ph.D, and
- *Referral Management and Disease Management in California's Accountable Care Organizations,* by James C. Robinson, Ph.D.

Background on the underlying case study and descriptions of the physician organizations included are in the Appendix.

AltaMed has experienced tremendous growth. Twenty years ago, it reported revenue of $15 million, which skyrocketed to $400 million by 2014. AltaMed primarily serves managed care enrollees, with some fee-for-service and self-pay patients as well. Among managed care enrollees, approximately:

- 70 percent have Medi-Cal coverage
- 23 percent have commercial insurance, including Covered California, and
- 3 percent are seniors with Medicare Advantage.

Twenty years ago, AltaMed reported revenue of $15 million, which skyrocketed to $400 million by 2014.

Recent growth has been focused in Medi-Cal, AltaMed's core patient population, based on California's expansion of Medicaid eligibility.

AltaMed has operated a Program for All-Inclusive Care for the Elderly (PACE) since 1996, and had nearly 1,600 enrollees in 2014—the third largest of 110 PACE programs operating in 32 states across the country, according to the National PACE Association.[1] PACE is available to individuals age 55 and older who are nursing home-eligible but able to live in the community if well-supported; all acute and long-term care services covered by Medicare and Medicaid are provided through the program. AltaMed takes global risk for PACE members, including adult day care, inpatient services, prescription drugs, home health and nursing home care.

MANAGING RISK FOR DUAL ELIGIBLES

AltaMed attempted to form an accountable care network in 2012, pulling together medical groups, community health centers and hospitals to create a common entity that would facilitate risk contracting. The diverse interests of the provider organizations outweighed the benefits of collaborating, and the network stalled. More recently, AltaMed re-engaged those efforts, partnering with several hospitals to provide services to enrollees in Cal MediConnect, a federal-state demonstration program intended to improve care coordination for beneficiaries eligible for both Medicare and Medicaid, or "dual eligibles."

Enrollment in Cal MediConnect began in June 2014 in seven California counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara. To meet health plan interest in providers able to take financial risk for the dual eligible population, AltaMed negotiated three-way contracts—aligning incentives among the health plan, AltaMed and several hospitals. Under the arrangement, the health plan pays capitation to AltaMed for professional services and to the hospital for inpatient services; in addition, the hospital and AltaMed share savings from a risk pool if inpatient utilization falls below a targeted level. AltaMed currently contracts with health plans on shared risk and dual risk bases, and will consider full risk with health plan partners as the demonstration project evolves.

Enrollment of dual eligibles was strong in the initial period. AltaMed budgeted and staffed for 1,000 dual eligibles, and 1,300 enrolled during the first month. In the early days of the program in the summer of 2014, continued growth was anticipated: AltaMed projected enrolling more than 7,000 dual eligibles by the end of 2015. However, higher-than-expected opt-out rates for the Cal MediConnect program across all the pilot counties—attributed both to complicated enrollment procedures and providers unwilling to give up patients requiring lucrative care and treatment—have resulted in a more modest projection of 3,500 enrollees by the end of 2016.

Still, AltaMed is well positioned to serve Cal MediConnect beneficiaries due to its experience managing risk and coordinating care for PACE, which serves the relatively small but complex population of frail older people—a subset of the broader dual eligible population. In addition to qualifying for both Medicare and Medicaid, PACE participants must be certified as needing nursing home level of care, at least 55 years of age and living near a PACE care site. The objective is to enable individuals to live as independently as possible for as long as possible, outside of a care facility. Because the population is so frail, the payment for each beneficiary's care is substantial; the program generates more than one-quarter of AltaMed's revenue.

The PACE model depends on team-based care, utilizing case managers, therapists and nurses alongside physicians and other care providers to meet the array of needs—including help with daily living, socialization, transportation, mental health and nutrition. In addition to having hospitalists on staff, AltaMed has arrangements with alternative sites of care for the PACE population to help reduce emergency room visits and inpatient hospitalizations. A contract with HealthCare Partners (a large physician organization based in Southern California) provides urgent care to PACE enrollees at two sites; AltaMed diverts an estimated 10 to 12 cases per month from the

emergency room to urgent care, potentially preventing several inpatient admissions each month.

RAISING THE BAR ON QUALITY AND PATIENT EXPERIENCE

AltaMed recognizes its core customers have a greater choice of providers and is making a major push to improve patient experience. That focus has included development of a wraparound Independent Practice Association (IPA) of private physicians. AltaMed employs 100 staff physicians and 40 mid-level nurse practitioners in its FQHC clinic sites; the IPA expands AltaMed's network to an additional 370 community physicians. The IPA network consists of primary care, family practice and internal medicine physicians, with some specialists as well. Overall, 85 percent of AltaMed's patients are served by clinic staff. There is some variation by product line, with IPA physicians serving a greater proportion of commercial and Covered California patients and fewer Medi-Cal enrollees.

> *To simplify the array of measures across programs, AltaMed has created a single set of tracking metrics for clinic physicians.*

Historically, AltaMed was a provider of last resort, and long wait times at clinics were common. To raise the bar on service, AltaMed improved scheduling, reduced cycle time and expanded hours. It also launched a patient portal in June 2014, offering online appointment services, secure provider communication, prescription refill services and bill-paying capabilities. AltaMed has expanded data collection efforts to include a survey of patients served by IPA physicians and clinic staff. The survey is costly to administer, and there is an added expense for reporting the results back to providers and patients. However, AltaMed believes it is a core component of improving patient experience, and that satisfied patients will remain loyal.

In addition to patient experience metrics, performance measures include bed days, emergency room visits, readmissions and specialty referrals. AltaMed's data warehouse can integrate claims and clinical data, and several contracting health plans send claims data to AltaMed each month. AltaMed has pulled analytic staff from various departments to create an "enterprise analytics" team charged with producing a dashboard on quality and medical management performance that is reviewed and

discussed at regular meetings. For example, the Clinical Quality Improvement Committee meets monthly and relies on a dashboard of metrics displaying data across AltaMed's product lines, including Medi-Cal, commercial, Medicare Advantage and PACE.

AltaMed participates in a variety of performance measurement efforts and takes an organization-wide approach to managing the complexity on behalf of its staff and contracted physicians. Three of AltaMed's product lines feature some form of pay for performance (P4P):

- The Centers for Medicare and Medicaid Services (CMS) operates the Five Star program for Medicare Advantage.
- Commercial HMOs in California generally rely on the Integrated Healthcare Association's P4P program.
- Medi-Cal managed care plans operate their own independent P4P programs. AltaMed has contracts with LA Care and Health Net for Los Angeles and with CalOptima for Orange County, and each of the three plans has a different incentive program.

To simplify the array of measures across programs, AltaMed created a single set of tracking metrics for clinic physicians, choosing a subset from the broader set of measures used by any of the incentive programs. As membership in the IPA grows, the same process will apply to those physicians.

DIVERSE REVENUE STREAMS CHALLENGE
A PAYER AGNOSTIC IDENTITY

AltaMed sees itself as "payer agnostic"—treating all patients the same regardless of payer. Yet, its product lines are each associated with a distinct revenue stream, as noted in Table 1. AltaMed receives cost-based reimbursement for Medi-Cal managed care enrollees, the bulk of its patient population; professional capitation with no supplemental payment for commercial business and for Medicare Advantage enrollees; capitation with risk-sharing for dual eligibles; and global risk for PACE enrollees.

Perhaps the most significant challenge to AltaMed's payer agnostic identity is the federal Prospective Payment System (PPS), through which AltaMed and other FQHCs receive cost-based reimbursement for Medi-Cal enrollees. The intent of PPS is to ensure that community health centers caring for low-income patients with multiple social service and medical needs have the resources to provide services not

Table 1. AltaMed's Product Lines and Payment Arrangements

PRODUCT LINE	PAYMENT ARRANGEMENT
Medi-Cal Managed Care	Capitation for professional services with Prospective Payment System reconciliation for clinic visits (cost-based reimbursement)
Commercial	Capitation for professional services; some fee-for-service
Covered California	Capitation for professional services; some fee-for-service
Medicare Advantage	Capitation for professional services
Cal MediConnect (dual eligibles)	Capitation for professional services plus institutional gain-sharing (shared savings with hospitals)
PACE	Global risk

typically covered, such as transportation to appointments. An unintended consequence of PPS is its powerful fee-for-service incentive, since AltaMed receives a per-visit payment for each qualifying visit to one of its clinic sites. See the sidebar (below).

At the same time, AltaMed has expanded its network of affiliated physicians by growing its IPA. As a result, the organization has two distinct cost structures:

- The FQHC is based on a staff model of employed clinicians and a relatively high cost structure due to the broad array of services and licensing requirements.
- The IPA is based on a contract model that draws on physicians in the community and has a lower cost structure.

Prospective Payment in Medi-Cal

Capitation of care for Medi-Cal managed care enrollees occurs through a rather tortuous set of transactions: California's Department of Health Care Services (DHCS) capitates a health plan, such as L.A. Care in Los Angeles, for Medi-Cal beneficiaries; L.A. Care pays AltaMed capitation for professional services for its Medi-Cal patients; and the difference between capitation payments received by AltaMed and the cost-based reimbursement AltaMed would have received if it had billed DHCS directly for services provided is reconciled annually.

The business imperative requires at least some attention to matching reimbursement with provider cost structure. For example, AltaMed receives cost-based reimbursement for Medi-Cal beneficiaries attended by clinic providers, but not physicians in the affiliated IPA network. Likewise, commercial capitation rates do not cover the cost of services provided through the higher-cost clinic structure, but they do generally cover the cost of services provided through the IPA network. In spite of the challenges and complexities of diversifying product lines and expanding beyond its core FQHC staff model, AltaMed is looking beyond PPS cost-based reimbursement and positioning itself as a provider organization capable of managing population risk under capitation.

NEW COMPETITION FOR MEDI-CAL BENEFICIARIES

As Medi-Cal enrollment nears one-third of California's population, providers and plans are taking note. UnitedHealthcare and Blue Shield of California are both entering the Medi-Cal managed care market for the first time. UnitedHealthcare plans to begin offering coverage in San Diego and Sacramento, and Blue Shield recently acquired the Care1st health plan, with significant membership in Los Angeles and San Diego. Providers, including some that have historically avoided Medi-Cal due to low rates compared to the commercial market, are assessing the opportunity. As shown in Table 2, four of the five physician organizations included in the study (see the Appendix) experienced significant growth in Medi-Cal managed care enrollment between 2012 and 2014.

In recent years, AltaMed's perspective on market competitors for Medi-Cal managed care enrollees in Los Angeles and Orange Counties has broadened beyond other community health centers to include providers that have traditionally served the commercial market, such as HealthCare Partners and Monarch HealthCare. In addition to Medi-Cal managed care, providers are looking closely at the dual eligible population. Given the higher payments per beneficiary, there is significant market opportunity for physician organizations experienced in taking risk and managing complex patients to add value through coordinated care. HealthCare Partners, St. Joseph Heritage and Monarch HealthCare all have plans to launch or expand enrollment of dual eligibles.

Table 2. Medi–Cal Managed Care Enrollment Among Select Physician Organizations in California

PHYSICIAN ORGANIZATION	MEDI–CAL MANAGED CARE ENROLLMENT	
	2012	2014
AltaMed (Los Angeles and Orange Counties)	56,000	85,000
Brown & Toland (Bay Area)	2,150	2,700
HealthCare Partners (Los Angeles and Orange Counties)	26,000	112,000
Monarch HealthCare (Orange County)	40,000	61,500
St. Joseph Heritage (Orange County)	5,000	3,500

LOOKING AHEAD

The ACA era provides both opportunities and challenges for AltaMed and other community health centers. The expansion of Medi-Cal in California promises more stable revenue as the uninsured obtain coverage, but it has also attracted new competitors. California's demonstration program for dual eligibles, Cal MediConnect, creates an opportunity for AltaMed to leverage risk management and care coordination capabilities built through experience with the nursing home-eligible seniors enrolled in the PACE program. However, large medical groups and IPAs in Southern California also have that expertise—and the capitation payments from Medicare and Medicaid for the dual eligible population are a bright spot as the commercial market shifts away from HMO coverage.[2]

At the same time, the state of California is developing a number of initiatives targeting the Medi-Cal population, including health homes for complex patients, behavioral health integration and payment for community health centers that would move away from PPS. For example, Senate Bill 147, introduced in January 2015, would authorize a three-year alternative payment methodology pilot project for California FQHCs in which capitated monthly payments would replace the wraparound per-visit payments currently made by DHCS.

Other states across the nation are also considering alternatives to PPS, exploring greater flexibility and accountability for FQHCs in this changing health care environment.[3] For example, Oregon's pilot shifts payment from a per-visit rate to a per-member-per-month payment based on historic costs, allowing community health centers more freedom to meet patient needs. The National Association of Medicaid Directors has requested that the Department of Health and Human Services address the apparent disconnect between the national shift from volume to value in payment for medical care and the legacy of PPS rate-setting: rates for individual FQHCs were set over a decade ago and have trended forward since then without regard to performance.[4]

AltaMed's long history of caring for low-income individuals, particularly the Latino population, and growing experience managing risk are assets that will serve it well as changes spurred by the ACA continue to unfold; how it will fare against commercial market competitors interested in its core business remains to be seen.

Notes
1. National PACE Association, "Pace in the States," http://www.npaonline.org/website/download.asp?id=1741&title=PACE_in_the_States.
2. Jill M. Yegian and Thomas R. Williams, "Status, Challenges, and Opportunities of the Delegated Model in California," *Cal. J. Pol. & Pol'y*, Vol. 6, Issue 2 (April 2014). http://escholarship.org/uc/item/3gn7q6x9#.
3. "2014 Update on Implementation of the FQHC Prospective Payment System (PPS) in the States," National Association of Community Health Centers, State Policy Report #52, December 2014: http://www.nachc.com/client/2014%20pps%20report%201%2029%2015.pdf.
4. "Medicaid and the Federally Qualified Health Center and Rural Health Clinic Programs: Alignment and Modernization Opportunities," National Association of Medicaid Directors, February 24, 2014: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_fqhc_letter_to_

ABOUT THIS STUDY

This Issue Brief and three others draw upon information from a case study conducted by the Integrated Healthcare Association (IHA) and researchers from the University of California at Berkeley, School of Public Health. Support for the two-year study, which was launched in April 2013, was provided by a grant from the Robert Wood Johnson Foundation® and focused exclusively on the California market. The research team conducted two rounds of structured interviews in 2013 and 2014 with five prominent Accountable Care Organizations (ACOs). It also undertook two rounds of interviews with health plan executives responsible for ACO strategy and contracting at five health plans in California: Aetna, Anthem, Blue Shield of California, CIGNA and UnitedHealthcare.

PHYSICIAN ORGANIZATIONS INCLUDED

This study focused on five physician organizations—each distinct in scale, geography, structure and ownership ties to hospitals. All are deeply engaged in ACO initiatives, defined broadly as including payment methods linked to the total cost of patient care. Some have new ACO contracts with Medicare and private insurers, while others are focused on capitation payment from Medicare Advantage, commercial HMO and managed Medicaid plans.

- **AltaMed Health Services** was founded more than 40 years ago as a grant-funded free clinic serving the Latino population in Los Angeles. It is the largest independent Federally Qualified Health Center in the U.S., delivering more than 930,000 annual patient visits to 180,000 patients through 43 sites in Los Angeles and Orange Counties. The majority of AltaMed's patients—85,000—are Managed Medi-Cal enrollees, but it serves an additional 11,500 through Medi-Cal fee-for-service contracts. In addition, 26,000 patients are covered through commercial HMO and PPO contracts, and 5,000 are Medicare patients. AltaMed provides care through staff-model clinics with an IPA that supplements the clinic staff with community physicians. It offers primary medical care, dental care and senior long-term care services.

- **Brown & Toland Physicians** is an Independent Practice Association (IPA) founded in 1992 in San Francisco, with a recent expansion into the East Bay market. Its 1,500 physicians care for more than 34,000 Medicare patients—including 16,000 through Medicare Advantage and 18,000 through its Pioneer ACO contract. It also serves 100,000 commercial HMO patients through capitation contracts; 175,000 commercial PPO patients; and 2,700 Medicaid managed care enrollees. Brown & Toland partners with several hospitals in the area, including Sutter, where many admits come from California Pacific Medical Center and Alta Bates Summit Medical Center. It also partners with other area hospitals—including Dignity Health, the University of California, San Francisco and the Alameda Health System.

- **HealthCare Partners,** a division of DaVita HealthCare Partners, manages and operates HealthCare Partners Medical Group in California along with organizations in Arizona, Colorado, Florida, Nevada and New Mexico. In California, HealthCare Partners serves 175,000 Medicare patients, including 125,000 through Medicare Advantage, and the remainder through its Medicare Shared Savings Program (MSSP) ACO and the Medicare fee-for-service program. It also serves 100,000 commercial PPO patients, 400,000 commercially insured HMO patients and 117,000 Medi-Cal managed care and fee-for-service patients. For HMO and Medicare Advantage patients, HealthCare Partners is paid capitation for the full range of physician and hospital services. HealthCare Partners contracts with nearly 50 hospitals in Southern California.

- **Monarch HealthCare** is an IPA that includes 640 primary care physicians throughout Orange County. It serves 61,000 Medicare patients, of which 38,000 come through Medicare Advantage plans and 23,000 through its Pioneer ACO contract, plus 61,500 Medi-Cal patients through the CalOptima managed care program and 92,000 commercially insured HMO and PPO patients, combined. It is owned by Optum, Inc., a subsidiary of the UnitedHealth Group that also has an affiliation with the UnitedHealthcare insurance plan. Monarch does not have an ownership association with any hospital system, but admits patients to all the major facilities in Orange County and Los Angeles. Through Optum, it is also involved with payment and organizational initiatives for a larger set of medical groups across the nation.

Patient Enrollment at a Glance

PHYSICIAN ORGANIZATION	COMMERCIAL		MEDICARE		MEDICAID	
	HMO	PPO	Medicare Advantage	Medicare FFS	Managed Medi-Cal	Medi-Cal FFS
AltaMed Health Services	23,000	3,000	2,500	2,500	85,000	11,500
Brown & Toland	100,000	175,000	16,000	18,000	2,700	0
HealthCare Partners	400,000	100,000	125,000	50,000	112,000	5,000
Monarch HealthCare	89,500	2,500	38,100	22,800	61,500	0
St. Joseph Heritage	151,500	111,000	33,000	38,000	3,500	5,500

*Enrollment as of August 2014

- **St. Joseph Heritage Medical Group** is the physician organization affiliated with the St. Joseph Hoag Health alliance in Orange County. It contains both integrated medical groups and IPAs around the four major St. Joseph Hoag facilities in the county, as well as smaller initiatives at hospitals it owns in northern California. It serves 33,000 Medicare Advantage enrollees; 151,500 commercial HMO enrollees; 3,500 Medi-Cal managed care enrollees; and 5,500 Medi-Cal fee-for-service patients. In addition, it serves 38,000 Medicare fee-for-service and 111,000 commercial PPO enrollees; these are not covered by ACO contracts and their care continues to be reimbursed on a fee-for-service basis. Together, St. Joseph Hoag hospitals and the Heritage physician groups represent the vertically integrated physician-hospital organization, contracting as a single unit with health insurers.

RESEARCH TEAM MEMBERS

The research team was comprised of:

- **Thomas R. Williams**, Dr.PH—Vice President and General Manager of Accountable Care at Stanford Health Care; Former President and CEO at the Integrated Healthcare Association

- **James C. Robinson,** Ph.D Leonard D. Schaeffer Professor of Health Economics at the University of California at Berkeley School of Public Health and Director of the Berkeley Center for Health Technology

- **Jill Yegian,** Ph.D—Senior Vice President, Programs and Policy at the Integrated Healthcare Association

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- **Kelly Miller**—Project Manager at the Integrated Healthcare Association.

ISSUE BRIEFS PRODUCED

This Issue Brief focuses on findings related to AltaMed, which, as a community clinic, faces unique opportunities and challenges in the health care insurance market. Additional Issue Briefs stemming from this study address other aspects of ACOs emerging in the state, including:

- *ACO Contractual Arrangements in California's Commercial PPO Market,* by Thomas R. Williams, Dr.PH

- *Accountable Care in California: Imperatives and Challenges of Physician-Hospital Alignment,* by James C. Robinson, Ph.D, and

- *Referral Management and Disease Management in California's Accountable Care Organizations,* by James C. Robinson, Ph.D.