ALAMEDA HEALTH SYSTEM: CONTRACTS, COMPENSATION, AND CARE

EXECUTIVE SUMMARY

Over the past century the Alameda Health System (AHS) has evolved into an essential part of the health care fabric of Alameda County. Beginning as Highland Hospital, the effort initially was to become one of the principle providers of specialty care in the East Bay. Currently, Highland and the other facilities within the AHS umbrella provide a full range of medical services to county residents. AHS came to the attention of the Grand Jury in past years and was the subject of a Grand Jury report in 2014-2015 regarding governance and finances. This year's Grand Jury recognizes that efforts have been made to make improvements and that progress has been achieved.

The current Grand Jury received a citizen complaint regarding the management of physician contracts by AHS. The jury investigated this complaint and found that the old contract ending in 2016 did have significant problems, but that important changes have been made in the processes leading to the current contract. Nonetheless, some issues remain as to how AHS is structured and performs in its role of overseeing physician contracts, the levels of compensation for these services, the use of public resources for direct support of the medical group, and the governance and management of federal, state and private foundation contracts and grants.

BACKGROUND

The Alameda Health System was created in March of 2013 and is an organizational outgrowth of the Alameda County Medical Center. It is an integrated public-health delivery system, operating over 800 beds across nine major facilities in the county of Alameda, and providing a variety of service from ambulatory primary care, specialty care, and behavioral health care. Institutions in the system range from community health centers to Highland Hospital.

While AHS maintains its independence as a public organizational entity of the public hospital authority, it is linked to Alameda County in three important ways. First, the Alameda County Board of Supervisors appoints the eleven trustees of the AHS board. There are corresponding

reporting obligations from AHS back to the board of supervisors. Second, while the county no longer directly subsidizes AHS in its financial operation, it indirectly provides financial support by giving AHS a line of credit from the county treasury to back up its operations against periodic and at times significant cash flow issues. Finally, AHS is the service provider to residents of the county who have no other means to pay for care. The county pays for these services through HealthPAC.

AHS and its relationship to the county were the subjects of a Grand Jury investigation in 2014-2015, and were part of its final report. Many of the report's findings and recommendations are relevant to the investigation conducted this term and merit review here. The 2014-2015 Grand Jury found a general failure in the governance and communications relationship between the county and AHS. It also found that management systems for financial and operational oversight within AHS were inadequate. These two factors combined to create failures by AHS in the acquisition and management of San Leandro and Alameda Hospitals, both now part of the system. The Grand Jury made recommendations for more transparency, improved communication between the board of supervisors and AHS, and attention to performance metrics from Alameda County Health Care Services Agency.

A general complaint was filed with the current Grand Jury, claiming that the governance and management structure and operations of AHS physician contracts lacked transparency and were inadequate, leading to significant waste, fraud and abuse. We decided that several of the issues in the citizen complaint had merit and decided to pursue an investigation.

INVESTIGATION

The citizen complaint focused on five issues related to how Alameda Health System provides oversight for the contracted relationships it maintains with medical groups and individual physicians. The services provided include: clinical care of patients, medical governance, general medical administration, and medical education, particularly related to the graduate medical education provided for the residency training programs that are sponsored by the hospital. These contracts represent an annual expenditure in excess of $40 million dollars, and these physician services are fundamental to the overall quality of care received within AHS.

The general questions investigated were:

- Does AHS provide adequate governance and clinical, operational and financial oversight for contracted groups and physicians that provide care at AHS?
- Does AHS pay an excessive amount for the volume and quality of physician services it purchases from medical groups and individual physicians when compared to other systems?
- Has AHS inappropriately compensated groups or physicians for making diagnostic or treatment referrals to AHS?
- Has AHS inappropriately provided support, equipment, material or other services of value to contracted groups or physicians?
- Has AHS adequately managed contracts and grants that have been received by independent groups and physicians, but that are officially received and managed by AHS?

To pursue these questions the Grand Jury reviewed a number of sources of information, including over 800 documents related to the operational relationship between AHS and contracted groups and physicians, a past Grand Jury report related to AHS, and a comprehensive report on physician contracts at AHS conducted by an outside consulting firm. The jury also received testimony from individuals with direct knowledge of the governance and oversight process, both as managers and leaders.

During the review of the material and interviews with witnesses, it became apparent that past contracting problems and issues existed across many, if not most, of the relationships between AHS and groups and individual physicians; however, the dominant issue in terms of its overall size as a part of the entire physician practice at AHS was with one medical group: OakCare Medical Group, Inc. (OakCare). OakCare employs more than 50% of the physicians who provide medical care at AHS. Given the size and centrality of OakCare's role at AHS, the Grand Jury decided to limit its investigation to the contracting process and oversight associated with OakCare.

OakCare Medical Group employs more than 50% of the physicians who provide medical care at Alameda Health System.

OakCare is a private professional group owned by an independent physician board. The group was created in 1995 with a stated mission to provide medical services to Alameda County's public hospital system. The group provides physician coverage for general internal medicine, specialty

medicine in cardiology, critical care (Intensive Care Unit), diabetes, geriatrics, hematology-oncology, obstetrics and gynecology services, emergency medicine and neonatology. The group also provides the medical administration and leadership for the units represented by these services, as well as more general medical leadership services to AHS. In addition, OakCare provides academic services for the educational programs associated with these clinical service lines. The contract ending in 2016 was in excess of $34 million annually. OakCare is deeply identified and affiliated with AHS, and a member of OakCare's board sits on the AHS board.

The OakCare contract with Alameda Health System ending in 2016 was in excess of $34 million annually.

Other medical groups and individual physicians also contract to provide clinical services to AHS. In reviewing extensive documentation regarding these contracts, the Grand Jury found that the same problems regarding lack of transparency, communication, accountability, and responsiveness that were characteristic of AHS's relationship with OakCare also were evident in the other relationships.

Does AHS provide adequate governance, clinical, operational and financial oversight for contracted groups and physicians that provide care at AHS?

During its investigation, the Grand Jury found that there has often been a contentious, and, at times, uneasy relationship between AHS and OakCare. In previous contracts OakCare failed to:

- Provide a description of services provided by their physicians in support of AHS's service lines, after it was requested by AHS.
- Provide adequate justification for the volume of service actually provided on each service line, after it was requested by AHS.
- Provide adequate itemization for invoices for services after it was requested by AHS.
- Keep AHS informed about changes in staffing.
- Keep its own roster of physicians updated for AHS.

Many of these issues have been partially addressed in the current contract, but key problems still exist. The relationship between OakCare and AHS seems to be "one-way," with OakCare's power derived from its role of providing the majority of physician services and virtually all of the medical leadership at AHS. This dynamic is made even more difficult as OakCare is organized as

a private for-profit medical group. Most county hospitals and academic medical centers in California directly employ their medical staff and medical leadership.

Moreover, in the past, AHS has not had adequate systems for effective tracking and monitoring physician activity at the unit level and this has made it impossible for AHS to monitor whether or not contracted services were being provided appropriately.

In its investigation, the Grand Jury found that the latest contract between AHS and OakCare has much more detailed descriptions of the services to be provided, specifies accountabilities, and has enhanced the overall transparency. Also, the operational capacity within AHS for tracking and monitoring physician activity has been improved considerably. While this remains a work in progress, seemingly headed in the right direction, there is additional work that needs to be done in order for this obligation of good management to be met by AHS. This ongoing work must focus on governance and management oversight of the contract, the implementation of an integrated information system that can effectively monitor the provision of care called for in the contract, and more authority by AHS to enforce the contract.

The relationship between OakCare and Alameda Health System seems to be "one-way," with OakCare's power derived from its role of providing the majority of physician services and virtually all of the medical leadership at Alameda Health System.

Does AHS pay an excessive amount for the volume and quality of physician services it purchases from medical groups and individual physicians, when compared to other systems?

The concern about the level of compensation for physicians at AHS is driven by two things: the Affordable Care Act, and the county's half-cent sales tax that supports AHS. The Grand Jury heard testimony confirming that the Affordable Care Act had provided a more favorable financial environment for AHS and that the system was moving toward more financial "independence" from the county.

As the provider of care for the uninsured and medically indigent of the county, AHS continues to receive public funds directly and indirectly for this service. A half-cent of the county sales tax is dedicated to AHS and provides approximately $100 million annually to support AHS. Good stewardship of these funds is essential for AHS to be an accountable public institution. In addition, well over half of the insurance coverage for patients at AHS comes from Medicare or

MediCal. These programs require that provider organizations receive compensation for providing care at or near the fiftieth percentile when compared to similar compensation practices in the area.

The previous contract between OakCare and AHS was far too general to allow any conclusion about the compensation levels paid to OakCare physicians for their work. This is possible because OakCare is a private for-profit entity. The new contract has been evaluated by an outside physician compensation consulting firm, which concluded that "the contract is within the limits required by federal payers." While the Grand Jury welcomes this assurance, it does observe that while the level of work remains the same, the total amount of compensation in the contract went up by 5% over the last contract. A reasonable conclusion would be that the contract remains more generous than either good management or federal guidelines might allow.

To address this issue, witnesses indicated that it would be desirable to explore the possibility of purchasing physician services from alternative medical groups or providers. Included in these suggestions were the ideas to expand the existing in-house medical group, Alameda Health Partners; acquire OakCare and other independent medical groups and practices; or affiliate with other systems in the area.

Has AHS inappropriately compensated groups or physicians for making diagnostic or treatment referrals to AHS?

The relationship between health-providing organizations, such as hospitals, and physicians who make referrals to them for diagnostic and therapeutic services, is carefully controlled by federal and state law and regulation. One of the principal concerns of these laws is to prohibit organizations that provide care services from inappropriately incentivizing physicians and other professionals to order unnecessary and inappropriate services. The federal anti-kickback and Stark laws address these issues.

In its current investigation, the Grand Jury found no evidence indicating that financial arrangements between AHS and its affiliated physicians have violated the principles of inappropriate financial incentives to effect prescribing behaviors.

Has AHS inappropriately provided support, equipment, material or other services of value to contracted groups or physicians?

This issue concerns itself with the appropriate stewardship by AHS of public resources entrusted to its management. The leadership of AHS supervises an extensive staff of professionals and support personnel. They also manage many physical facilities and equipment. All of these are public resources and are intended to be used to support public purposes pursued by AHS. It is inappropriate for AHS to barter these resources for private gain or to align them in ways that contribute to private gain. The Grand Jury heard testimony that resource misuse occurred, such as giving office equipment to OakCare, providing free office space to OakCare to conduct business that benefits OakCare exclusively, and providing staff resources to carry out work that is the responsibility of OakCare.

Alameda Health System has not been as judicious as required in insuring that AHS resources do not inure to the benefit of OakCare.

The line between what benefits AHS and OakCare separately is difficult to draw and recognize. The Grand Jury concludes from its review of documents and interviews with witnesses that AHS has not been as judicious as required in insuring that AHS resources do not inure to the benefit of OakCare. There seems to be little recognition by staff and leaders that this is a real issue, few safeguards in policy or practice, and enough examples of questionable or clearly wrong practice to conclude that this is an issue to be addressed.

Has AHS adequately managed contracts and grants that have been received by independent groups and physician, but that are officially received and held by AHS?

An important part of professional practice and development for many physicians, particularly when they are affiliated with an academic or public health oriented institution such as AHS and its mission to serve the public and to advance education, is the pursuit of contracts and grants that advance this academic or public health work.

The principles for good practice of such activity should include:

- alignment of the work of the contract or grant with the mission of the host institution (in this case AHS),
- avoidance of conflict of interest between the lead professional's (in this case typically a member of OakCare) ethical obligations and the work carried out by the contract or grant,

- appropriate and publicly transparent compensation for the lead professional supervising the grant that does not conflict with his or her pre-existing duties and compensation,
- adequate and appropriate oversight by the host institution, such as AHS, of the contract or grant and the lead professional, even if that individual is not a direct employee of the host institution.

The Grand Jury received evidence that individual members of OakCare have secured private and public contracts and grants that are administered by and through AHS. The Grand Jury also received testimony from executive officers at AHS that this process has not been formal, transparent, or carried out in an intentional, consistent, and professional manner in accordance with the principles listed above.

CONCLUSION

The complaint brought to the Grand Jury the issue of the appropriateness of the contracts and the adequacy of oversight by AHS of its financial relationships through contract with medical groups and individual physicians. The Grand Jury focused its investigation on the largest of these contracts, the one with the OakCare Medical Group.

For the contract ending in 2016, the Grand Jury concluded that the contract was inadequate as to its specifications of performance standards, compensation, oversight, remedies, and evaluation elements. Moreover, it found that the nature of the relationship between AHS and OakCare was not characterized by open communication, responsiveness, or collaboration, all of which would be necessary to ensure the best level of patient care and the judicious use of resources. There is evidence that OakCare did not operate in a manner that ensured full compliance with the clinical service obligations set forth in the contract.

The Grand Jury found evidence that many of these issues have been partially addressed in the current contract; however, some of the concerns regarding lack of transparency and alignment remain. The Grand Jury concludes that the major contributor to this flawed dynamic is the outsized power that OakCare has in its relationship with AHS. OakCare provides the majority of physician services and virtually all of the physician leadership at AHS's Highland Hospital.

The Grand Jury also found evidence that contracts and grants were received by AHS for individuals who were members of OakCare, and that policies and practices for proper oversight and management of these grants were not in place or not followed in order to ensure proper

operation. Similarly, the Grand Jury found evidence that a proper understanding of the organizational boundary between AHS and OakCare is not well understood throughout AHS, nor is there a proper set of policies and practices in place and followed for ensuring that public resources are not used to benefit OakCare.

FINDINGS

Finding 18-27: The relationship between Alameda Health System and OakCare Medical Group has been characterized, in the past, as contentious and lacking in transparency. In large measure, this is a function of the outsized role that OakCare plays in the medical leadership and medical staff at Alameda Health System. While the contract and management processes have improved under the current contract, the ability to build a sustainable health system to serve the county is hampered by lack of alignment between the medical leadership and staff and the strategic directions of Alameda Health System.

Finding 18-28: Policies and procedures related to the use of public resources by management and leadership OakCare have been inadequately developed and followed. This includes use of public space, public equipment, and direct public budgetary expenditures for activity that supports the private medical group.

Finding 18-29: Policies and procedures related to the acquisition and management of contracts and grants received from federal and state agencies and private foundations by affiliated physicians who are members of OakCare Medical Group have been inadequately developed and followed.

RECOMMENDATIONS

Recommendation 18-21: Alameda Health System must continue to improve its contracting process with medical groups and independent physicians making sure that staffing requirements and performance standards are clearly established, complied with by the medical groups and individual physicians, and are transparent.

Recommendation 18-22: Alameda Health System must continue to improve its internal monitoring capacity to assess compliance and performance by all groups and physicians providing care in the system.

Recommendation 18-23: Alameda Health System must establish and enforce policies and procedures related to the use of public resources by private contractors.

Recommendation 18-24: Alameda Health System must establish and enforce policies and procedures related to the acquisition and management of private and public contracts and grants by affiliated physicians.

Recommendation 18-25: Alameda Health System should aggressively pursue the expansion of its medical staff and leadership along the employed medical staff model. This is the most effective way to fully align physician services, service lines and the public mission of Alameda Health System.

RESPONSES REQUIRED

Board of Trustees, Alameda Health System
Findings 18-27 through 18-29
Recommendations 18-21 through 18-25