CALIFORNIA
HEALTH CARE ALMANAC
REGIONAL MARKETS ISSUE BRIEF DECEMBER 2012

CALIFORNIA HEALTHCARE FOUNDATION

Fresno:
Health Providers Expand Capacity, but Health Reform Preparation Lags

Summary of Findings

The Fresno region remains one of the poorest areas in California. With the economic downturn, Medi-Cal enrollment rates have been driven even higher than in prior years, and the proportion of the population with no insurance has continued to expand. The population has continued to grow, although at a slower pace than during the early 2000s. These factors have strained already inadequate provider capacity, particularly of physicians.

Key developments since the last study was conducted in 2008 include:

- **Focus on inpatient capacity.** Hospitals are expanding inpatient beds and services to ease overall capacity constraints and to compete aggressively for the shrinking base of commercially insured patients. Most hospitals weathered the economic downturn, although they continue to face financial pressures.
- **Little traction on hospital efforts to align with physicians.** Hospitals are making efforts to align more closely with physicians, including developing medical foundations to compete more effectively with other provider organizations in recruiting physicians to the area. Most physicians, however, continue to work in independent solo and very small practices and show little interest in hospital alignment efforts.
- **Expanded clinic capacity still falling short of demand in underserved communities.** Federally qualified health centers (FQHCs) and hospital-operated rural health clinics (RHCs) are expanding capacity and improving patient access, although demand still outstrips supply. As a result of these expansions, competition for Medi-Cal patients in rural areas is heating up, and competition to recruit physicians across the region is growing more intense.
- **Limited preparations for national health reform.** The region trails other areas of the state in preparing for coverage expansions under reform. Fresno County is one of only a few California counties that have not yet committed to participating in the Low Income Health Plan (LIHP), an optional county program to provide health care services to low-income, uninsured adults and to transition most enrollees to Medi-Cal once they become eligible in 2014.[1] The second-largest county in the region, Tulare, will get a late start, launching the LIHP in January 2013.

A defining characteristic of the Fresno market remains unchanged since 2008: Health maintenance organizations (HMOs) play a much more limited role in the region than elsewhere in the state. For example, Kaiser Permanente Health Plan, a large, closed-model HMO, maintains only a modest presence in the Fresno area even as it has strengthened its competitive position in many parts of the

state in recent years. As in the rest of the state, total HMO enrollment continues to decline because of competition from lower-priced preferred provider organization (PPO) products — including lower-premium, consumer-directed health plans — and the overall erosion in commercial coverage from the economic downturn. As a result of the relatively limited role of HMOs, health system features that typically develop in tandem with HMOs, such as large physician organizations operating under the delegated-capitation model, are uncommon in the market.[2]

Market Background

The Fresno region spans nearly 16,000 square miles in the center of the San Joaquin Valley of Central California, encompassing urban and rural areas of Fresno County and the surrounding counties of Tulare, Kings, Madera, and Mariposa. With a population of 1.7 million, the region continues to grow faster than California as a whole, although growth has slowed relative to the early 2000s.

The region is home to some of the poorest communities in the state and country, stemming largely from the rural region's economic reliance on agriculture and related businesses. The economic downturn worsened the already-bleak economic picture, and the region continues to lag state averages on most socioeconomic indicators (see Table 1). The proportion of the population with incomes below 200% of the federal poverty level continued to climb, reaching 53.6% in 2009 compared to 36.4% statewide. Growing unemployment contributed to worsening poverty, with the 2011 unemployment rate of 16.5% almost double

Table 1. Demographic and Health System Characteristics: Fresno vs. California

	Fresno	California
POPULATION STATISTICS, 2010		
Total population	1,694,727	37,253,956
Population growth, 10-year	17.9%	10.0%
Population growth, 5-year	7.8%	4.1%
AGE OF POPULATION, 2009		
Persons under 5 years old	9.5%	7.3%
Persons under 18 years old	30.0%	26.3%
Persons 18 to 64 years old	60.7%	62.8%
Persons 65 years and older	9.3%	10.9%
RACE/ETHNICITY, 2009		
White non-Latino	36.0%	42.3%
Black non-Latino	3.8%	5.6%
Latino	51.6%	36.8%
Asian non-Latino	5.4%	12.1%
Other race non-Latino	3.1%	3.1%
Foreign-born	23.6%	26.3%
EDUCATION, 2009		
High school diploma or higher, adults 25 and older	72.3%	82.6%
College degree or higher, adults 25 and older	22.6%	37.7%
HEALTH STATUS, 2009		
Fair/poor health status	19.8%	15.3%
Diabetes	8.2%	8.5%
Asthma	17.3%	13.7%
Heart disease, adults	6.0%	5.9%
ECONOMIC INDICATORS		
Below 100% federal poverty level (2009)	27.3%	17.8%
Below 200% federal poverty level (2009)	53.6%	36.4%
Household income above $50,000 (2009)	36.6%	50.4%
Unemployment rate (2011)	16.5%	12.4%
Foreclosure rate* (2011)	5.2%	n/a
HEALTH INSURANCE, ALL AGES, 2009		
Private insurance	42.0%	55.3%
Medicare	7.4%	8.8%
Medi-Cal and other public programs	33.7%	21.4%
Uninsured	16.9%	14.5%
SUPPLY OF HEALTH PROFESSIONALS, PER 100,000 POPULATION, 2008		
Physicians	118	174
Primary care physicians	45	59
Dentists	43	69
HOSPITALS, 2010		
Community, acute care hospital beds per 100,000 population	165.6	178.4
Operating margin with net disproportionate share hospitals (Kaiser excluded)	1.9%	2.4%
Occupancy rate for licensed acute care beds (Kaiser included)	64.4%	57.8%
Average length of stay (in days) (Kaiser included)	4.4	4.5
Paid full-time equivalents per 1,000 adjusted patient days (Kaiser excluded)	14.1	15.8
Total operating expense per adjusted patient day (Kaiser excluded)	$2,092	$2,856

Note: Mariposa County is not included in estimates using CHIS data for Fresno.

*Foreclosure rates in 367 metropolitan statistical areas nationally ranged from 18.2% (Miami, FL) to 1% (College Station, TX).

Sources: US Census Bureau, 2010; California Health Interview Survey, 2009; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for California Counties and Metropolitan Statistical Areas, July 2011" (preliminary data not seasonally adjusted); California HealthCare Foundation, "Fewer and More Specialized: A New Assessment of Physician Supply in California," June 2009; UCLA Center for Health Policy Research, "Distribution and Characteristics of Dentists Licensed to Practice in California, 2008," May 2009; California Office of Statewide Health Planning and Development, Healthcare Information Division, Annual Financial Data, 2010; **www.foreclosureresponse.org**, 2011.

the 2007 rate of 8.3% and well above the statewide average of 12.4%. Moreover, annual unemployment rates obscure even higher seasonal unemployment rates in the agribusiness sector, which has been under additional pressure because of water shortages. The unadjusted monthly unemployment rate peaked in March 2010 at 18.5%, compared to 12.8% statewide that month.

The downturn also eroded the already-low rates of private health coverage in the region. By 2009, the share of people with private health insurance was only 42%, down from 46.8% in 2007 and continuing to lag the state average of 55.3%. More than half of the population was on Medi-Cal or was uninsured in 2009, compared with 35.9% statewide.

The Fresno region remains an outlier on other demographic measures as well, with a much higher proportion of Latinos and much lower proportions of Whites and Asians. The population overall has lower educational attainment levels and poorer health. The concentration of agribusiness jobs attracts large numbers of undocumented and mostly uninsured immigrants to the area.

Most Hospitals Weather the Downturn

The Fresno region's health care system is segmented geographically, for the most part along county lines, although patients in more rural areas often travel to neighboring counties or even farther for specialty care. The region's major health care providers have experienced little organizational change since the last study was conducted in 2008.

Fresno County is served by three of the largest hospital providers in the region, along with some smaller hospitals in the county's more rural areas. Community Medical Centers (CMC), the dominant provider in the region, serves as a referral center for outlying counties and accounted for about a third of inpatient discharges across the five-county area in 2010 (32.3%). CMC's three facilities include its flagship hospital, Community Regional Medical Center (CRMC) in downtown Fresno, which accounts for the majority of CMC's discharges, along with a specialty heart hospital and a smaller community hospital in the more affluent area of Clovis.

Saint Agnes, the only California hospital operated by Trinity Health System of Michigan, is the second-largest provider in Fresno County, with about half as many discharges as CMC (15.7%). Kaiser, with one smaller facility, has a much lower market share at about 4.9% of discharges. However, Kaiser's share of the commercial market is higher than what is reflected by inpatient discharges, given that commercial enrollees comprise the majority of the hospital's patient base.

The demands on safety-net providers are significant in the Fresno area because of the disproportionately high rate of poverty, and CMC plays a pivotal safety-net role in Fresno County and the region. After acquiring the county's only public hospital in 1996, CMC signed a 30-year agreement with Fresno County to be the exclusive provider under the County Medically Indigent Services Program (CMISP), a county program with state funding that pays providers to care for low-income, uninsured residents. Under the program, CMC provides all primary, specialty, and inpatient care for medically indigent residents, as well as more limited care for prison inmates, primarily at the CRMC campus. (Fresno County is one of the few California counties that devote a portion of CMISP funds to pay for prison health care.) CMC is also by far the largest inpatient provider of Medi-Cal services and uncompensated care in the county and the region, even after adjusting for its larger size.

The largest providers of hospital care outside of Fresno County are the Kaweah Delta Health Care District and the Adventist Health Central Valley Network. The district-owned Kaweah Delta Medical Center, similar in size to Saint Agnes with a 15% market share, is the biggest of three district hospitals in Tulare County and plays the largest safety-net role. Adventist Health Central Valley Network, part of a multistate hospital system, owns or manages four smaller acute care hospitals in Kings County and rural southern Fresno County, with 10.2% of patient discharges.

Most of the remaining hospitals are smaller rural district hospitals, with the exception of Children's Hospital Central California in Madera County, which serves as a pediatric referral center for the Fresno region and beyond.

While hospitals' financial performance continues to be mixed, most Fresno-region hospitals have maintained or even improved operating margins since 2008. Nonetheless, CMC dropped below breakeven in 2010, Saint Agnes has faced multiple years of losses, and some of the very smallest rural district hospitals are seeing substantial and mounting deficits. Hospitals continue to struggle with a poor payer mix, which has worsened somewhat during the economic downturn. Adding further pressure, commercial insurers are slowing rate increases from double to single digits. Hospitals reported mitigating the downward pressure on margins by reducing expenses. Some hospitals' bottom lines also benefited from state hospital fee program payments starting at the end of 2010, which helped reduce losses on Medi-Cal patients.[3]

CMC had operating margins of more than 5% in 2008 and 2009 but faced an operating loss of –0.9% in 2010, the most recent year of publicly available data.[4] By 2011, however, CMC's finances reportedly rebounded, even after excluding the hospital fee program payment and despite growing losses on its CMISP contract.

Under the CMISP contract, Fresno County pays CMC a fixed annual payment to provide care regardless of actual program enrollment. The payment amount increases annually only by the rise in the Consumer Price Index, and CMC's reported expenditures on indigent care have risen more substantially than payments since 1996. More recently, CMISP enrollment and related program costs increased because of the economic downturn and eligibility expansions starting in 2010. CMC publicly reported that the amount of uncompensated care provided to CMISP patients was about $62.5 million in 2011, up from about $51 million in 2010. As a result of CMC's mounting losses, tensions between CMC and the county have grown.

Saint Agnes, long viewed as a financially strong hospital, began experiencing financial pressure in 2008. Although it reported a 4.1% operating margin that year, in 2009 its margin dropped close to breakeven (0.3%) and then dipped into the negative in 2010 (–0.4%), with losses reportedly growing even larger in 2011.

Saint Agnes's weakening financial performance resulted, in part, from leadership turmoil at the hospital and increased competitive pressure from CMC. The two organizations have long had a contentious relationship. With a new CEO in place since early 2011, Saint Agnes is still working to regain its footing after repeated management turnovers that hurt relationships with physicians. In 2008, the hospital experienced highly publicized outbreaks of Legionnaires' disease and methicillin-resistant Staphylococcus aureus (MRSA) infections, with the latter leading to a three-month closure of its cardiac surgery program. Some physicians already were unhappy with Saint Agnes's earlier decision to replace community-based heart specialists with physicians from outside the market. Despite stabilizing the reopened cardiac program, the hospital still is working on broader turnaround efforts to improve physician relationships and financial performance.

In more rural parts of the region, some of the smallest hospitals are struggling to remain open in the face of mounting losses. In Fresno County, Kingsburg District Hospital shut down in 2010 while Adventist took over the long-term lease on Sierra Kings District Hospital that same year. In Kings County, a third hospital, Corcoran District Hospital, has been in discussion with Adventist about a potential partnership.

Hospitals Expand Amid Competition for Commercially Insured

Since 2008, the number of inpatient beds in the region has increased by almost 15% — more than 300 beds — and hospital emergency departments (EDs) have expanded. Hospitals are undertaking these construction projects primarily to ease capacity constraints and to better compete for the limited number of commercially insured patients. Some of the largest hospitals also are competing for insured patients by expanding capacity to support lucrative service lines, including cardiovascular services, neurosurgery, and orthopedics. Together, CMC, Saint Agnes, and Kaweah Delta (along with Kaiser) provide the bulk of the facility-based specialty care in the market, although they compete to some extent with local physician-owned surgical facilities and providers outside the region.

CMC has expanded the most. The system added a large number of specialty beds at CRMC as part of an effort to improve the downtown safety-net facility's payer mix. The system is doubling the size of the smaller Clovis Hospital to 205 beds to compete more aggressively with nearby Saint Agnes in the most affluent and growing part of Fresno County. Saint Agnes added a relatively modest 35 beds, while Kaweah Delta and Adventist each added 75 or more beds.

Physicians Slow to Align with Hospitals

Both primary care physicians (PCPs) and specialists in the region tend to work in independent solo and very small practices. Exceptions include Kaiser's Permanente Medical Group, with about 225 physicians, and a few other large, mostly physician-owned medical groups ranging from 50 to 100 or more physicians. Most of these groups, located in Fresno County, are aligned with CMC. The aligned groups have a close referral relationship with the system and may receive administrative support through a management services organization (MSO) jointly owned by CMC and the community physicians who own the largest independent practice association (IPA) in the area, Santé Community Physicians.

With limited risk sharing, little competitive pressure for patients from Kaiser, and tight physician supply, Fresno-area physicians do not have the same incentives as physicians in other California markets to consolidate into large physician-owned medical groups or to tightly align with hospitals. Two IPAs continue to support limited professional risk contracting under commercial HMOs and Medicare Advantage. Santé Community Physicians, the larger of the two, operates in Fresno, Madera, and Kings Counties. This physician-owned IPA is aligned with CMC and is supported by the jointly owned MSO. Santé admits primarily to CMC, excluding Saint Agnes from its commercial HMO networks. The smaller Key Medical Group operates in Tulare and Kings Counties.

Chronic Physician Shortages

The Fresno region continues to have chronic shortages of PCPs and specialists, with a physician supply of 118 per 100,000 population, well below the state average of 174. Most communities in the region are designated as shortage areas under government programs. Provider organizations — including hospitals, medical groups, Kaiser, FQHCs, and RHCs — continue to face many challenges in recruiting physicians to the market, including low payment rates, a poor payer mix, and such quality-of-life considerations as poor air quality and lack of employment opportunities for spouses. In addition, there is resistance from established physicians who see new physicians as competition for an ever-shrinking pool of commercially insured patients. Finally, with the exception of Kaiser, the market has few options to attract young physicians looking for salaried employment in large medical groups.

The Fresno area's physician shortages create access barriers for both insured and uninsured patients, including long wait times for appointments. Reflecting the PCP shortages in the commercially insured population, the IPA Santé,

pays member PCPs a 10% bonus on monthly capitation rates to accept new HMO patients. Access to physicians is an even greater challenge for low-income patients and those in the more remote areas, particularly for specialty care. As few private practice physicians accept Medi-Cal or medically indigent patients, most specialty care for these patients is provided at CMC in Fresno, and to a lesser extent, at Kaweah Delta, the other three Tulare County district hospitals, and Adventist. Because of limited capacity at these facilities, wait times for specialty care often exceed a year, prompting some patients to travel outside the area — for example, to the Bay Area.

Despite the persistent and acute physician shortages in the region, community-wide recruiting efforts have been limited. Local providers have collaborated to some extent on graduate medical education programs, which may help increase local physician supply, since physicians often settle where they do their training. For example, CMC has expanded its longtime program with the University of California, San Francisco, which also includes partnerships with other hospitals and clinics in the region. However, because of competitive tensions, in part, other providers are now establishing separate programs with different medical schools. For example, Kaweah Delta is starting its own program with University of California, Irvine. Similarly, safety-net primary care organizations serving the Central Valley have other training programs in place — for example, to support medical students from the valley who promise to return to the area to practice — and are working to expand partnerships to place primary care residents in FQHCs.

Fierce Competition Among Providers for Physicians

Overall, the region's provider organizations compete intensely for physicians with each other and with providers from other markets. Kaiser is viewed as a stiff competitor on physician recruitment and is reportedly able to offer more attractive compensation packages, including higher salaries and loan forgiveness programs. Since 2008, the Permanente Medical Group has expanded from around 200 to 225 physicians, adding both PCPs and specialists. Local hospitals reported being at a competitive disadvantage in physician recruiting relative to Kaiser and large systems in other California markets. Even local RHCs and FQHCs are rivals in the recruiting competition because they potentially can offer higher compensation than private practices since they receive cost-based Medi-Cal and Medicare rates (see sidebars "FQHC and Look-Alike Designations" and "Rural Health Clinics Compared to FQHCs").

To compete more effectively with other provider organizations on physician recruitment, Fresno-area hospitals are ramping up efforts to develop medical foundations which are already in place in many large systems across the state.[5] The foundation model provides a vehicle to offer more-competitive packages to recruit and retain physicians than what hospitals would otherwise legally be allowed to offer. Moreover, foundations can strengthen hospital-physician relationships by aligning financial incentives, exerting greater leverage with health plans through joint contracting, and implementing quality improvement programs. Risk contracting has not been a focus of foundation development in the Fresno area, in contrast to some other California markets.

Physicians, who historically have been fiercely independent and distrustful of hospitals in this market, are showing little interest in hospitals' overtures. For example, Kaweah Delta's proposal to develop a medical foundation was rejected outright by affiliated physicians before it got off the ground. CMC is taking a different approach. Rather than having the system directly sponsor the foundation, Santé, CMC's affiliated IPA, is working to establish an independent medical foundation that would be allowed to accept grants from CMC to support physician recruitment. However, no medical groups had agreed to participate at the time of the site study. Physician reluctance to participate in medical foundations reportedly reflects, in part, concern about competition from new recruits and the possibility that

hospitals will use medical foundations to constrain physician autonomy or redirect revenues from physicians.

FQHC Capacity Expanding but Still Inadequate

The Fresno region's safety net remains fragmented. Each of the five counties operates its own medically indigent programs, and a geographically distinct set of providers serves the uninsured and low-income populations. These providers include hospitals and FQHCs: organizations eligible to receive both federal grants and cost-based Medi-Cal payments. The exception to distinct county safety-net systems is CMC in Fresno County, which serves as the safety-net hospital for patients in surrounding areas when inpatient procedures and services are unavailable locally. Even within counties, there is little coordination or collaboration among safety-net providers.

In Fresno County, CMC maintains an ambulatory care center — which it recently moved to a new facility with 104 exam rooms — as a source of primary care and some specialty care to CMISP and other patients. Because the ambulatory care center is at full capacity, and CMC is contractually obligated to serve CMISP patients, other patients — particularly Medi-Cal — are often referred to Clinica Sierra Vista, the major FQHC serving the city of Fresno, with eight sites. The more rural parts of Fresno County are served by Valley Health Team on the west side, with three sites, and United Health Centers of the San Joaquin Valley to the southwest, with six sites in Fresno County and one each in Tulare and Kings Counties.

In Tulare County, Family HealthCare Network (FHCN) is the largest FQHC; it has 10 sites in that county and one in Kings County. Tulare Community Health Clinic is an FQHC with three sites. The Tulare County government also operates three FQHC look-alike clinics, the only county government in the region to provide direct patient care. Madera County has just one FQHC, Camerena Health, with four sites serving the county's western half. The primarily rural Kings County has two FQHCs, while Mariposa County has only a single, non-FQHC health center.

Several FQHCs in the region, including Clinica Sierra Vista, United Health Centers, and Camerena Health, have each added one or two new clinic sites and have increased capacity at existing clinics, either through construction or by extending operating hours. More construction is underway or planned by these clinics as well as others, including FHCN. The FQHC expansions were funded by a combination of tax-exempt bonds and federal grants from the 2009 stimulus package and the 2010 Patient Protection and Affordable Care Act.

Although most FQHCs have expanded capacity, Tulare County closed some clinic sites in 2009 because the clinics were operating at a loss and the county faced budget shortfalls. The county's remaining clinics continue to struggle because they are contractually obligated to serve CMISP patients and are less able to compete for Medi-Cal patients with the growing number of FQHC sites in the county.

Despite expansions, FQHCs in the region struggle to provide adequate access to the large and growing number of uninsured and Medi-Cal patients. Some clinics reported

FQHC and Look-Alike Designations

In the Fresno region, FQHCs are the main providers of primary and preventive health services to Medi-Cal and low-income, uninsured patients, with the exception of CMC's ambulatory care center. FQHCs must meet a host of federal requirements under Section 330 of the Public Health Service Act. FQHC designation provides benefits including federal grants to subsidize capital and operational costs, cost-based payments per Medicaid and Medicare patient visit (for Medicaid, Prospective Payment System payments based on previous average costs for an individual health center that are updated annually for medical inflation), discounted pharmaceuticals, access to National Health Service Corps clinicians, and medical malpractice liability coverage. The Tulare County government operates clinics that have FQHC look-alike status; this status provides most of the benefits that FQHCs receive but not federal grants.

that patients filled added capacity almost immediately. Most respondents agreed that a substantial amount of unmet need remains, particularly in the more remote eastern areas of Madera and Mariposa Counties in the foothills of the Sierra Nevada Mountains.

Although some FQHCs have experienced negative margins in recent years because of such factors as expansion activity and some loss of direct state funding, no FQHCs were considered financially troubled at the time of the site study. The loss of state funding was more serious for Fresno County FQHCs, which do not receive significant CMISP funds. Although some clinics are struggling to finance expansions and electronic health record implementation, they view such investments as necessary for long-term viability.

Mental health service capacity in Fresno County, already inadequate, has shrunk over the past three years. The psychiatric crisis center closed in 2009, and the county's mental health budget was cut further in 2010. Mental health–related visits to FQHCs and EDs reportedly have increased as a result, and ED capacity at CMC has been particularly strained. To help alleviate the problem, Fresno County provided funding to United Health Centers to start a behavioral health program that includes onsite case workers and social workers.

Hospital-Owned Rural Health Clinics: Filling a Need or Competing with FQHCs?

Rural health clinics play a large role in providing care in the Fresno region's rural areas, alongside FQHCs (see sidebar). About 40% of California's 300 RHCs are located in the five-county Fresno area. While the majority of these RHCs are independent clinics, including physician-owned practices, many rural hospitals also operate RHCs. Adventist is the largest hospital owner by far, with 23 RHCs in the Fresno region plus more elsewhere in California and in other states.

Since 2008, Adventist and other large rural hospitals, including Kaweah Delta and Tulare Regional Medical Center, have expanded the number of RHCs they operate, often in the same communities where other RHCs and FQHCs are located. Hospitals are acquiring existing RHCs or converting private practices in some locations, while in others, they are adding net capacity by building new clinics. Since 2008, Adventist grew the most, primarily through acquisitions, expanding from 16 to 23 RHCs. It has plans to operate about 30 clinics by 2014. Kaweah Delta, which had one RHC in 2008, added two more with plans for a fourth. Tulare Regional Medical Center opened at least four RHCs, some of which were acquisitions.

Hospitals in the Fresno region are investing in RHCs not only to improve ambulatory care access in rural areas — now

Rural Health Clinics Compared to FQHCs

RHCs, certified by the federal government, are located in rural areas that face shortages of physicians to serve Medicare and Medicaid patients. Like FQHCs, they receive cost-based payments for these patients at rates that are generally significantly higher than what private practice physicians are paid for the same patients. While similar, RHCs and FQHCs are overseen by different divisions of the US Department of Health and Human Services: RHCs by the Centers for Medicare and Medicaid, and FQHCs by the Health Resources and Services Administration.

Unlike FQHCs, RHCs are not required to treat uninsured patients, and they are ineligible for federal grants to help pay for such care. Although many California RHCs post sliding-scale fees for the uninsured, RHCs typically serve a higher proportion of insured patients (Medi-Cal, Medicare, and commercially insured) than FQHCs.

While RHCs were originally intended to promote primary care access, they can expand their scope of services to provide specialty care. This is another way that RHCs differ from FQHCs: Unlike RHCs, FQHCs must obtain state and federal permission to expand services, which FQHCs report is a time-consuming and frustrating process in California. FQHCs also face stricter federal governance requirements and other more intensive certification and reporting requirements.

and as demand grows with coverage expansion under health reform — but also to draw patients to their facilities from a broader geographic area. Hospitals also are leveraging RHC patient volumes and cost-based payments to help recruit and retain physicians, especially specialists.[6] Having more local specialists improves access for all of the hospital's patients, not just those visiting the hospital's RHCs, and helps support hospital specialty-service lines. Hospitals reported that their RHCs are profitable, with cost-based payments helping to offset any losses from Medi-Cal patients being referred to their hospitals. However, other respondents disputed this claim.

The growth in hospital-operated RHCs has sparked competitive tension with rural FQHCs over Medi-Cal patients and has further accelerated competition for physicians across the region. These FQHCs are concerned that they will have difficulty cross-subsidizing care for the uninsured if hospitals aggressively expand RHCs and are able to compete effectively for Medi-Cal patients while taking fewer uninsured patients than FQHCs. FQHCs are particularly concerned about the financial burden of serving high numbers of undocumented immigrants who are not currently eligible for CMISP (outside of Fresno County) and will be ineligible for coverage expansions in 2014.

While there is tension between Tulare County's largest FQHC — FHCN — and Kaweah Delta over the hospital's RHC expansions, FHCN and Adventist Health are exploring collaborations that may include integrating some aspects of care. For example, rather than compete for primary care patients, Adventist RHCs would serve as specialty care referral sites for primary care patients treated at FHCN clinics, as well their own.

Preparing for Reform: Limited Collaborations

County governments and providers were doing little coordinated community-wide planning for health reform despite the importance of coverage expansions for this region and the large number of undocumented immigrants who will be ineligible to transition into Medi-Cal in 2014. Fresno County did collaborate with Kings and Madera Counties to create a local Medi-Cal managed care plan in 2009 (CalViva Health), motivated in part by the potential for CalViva Health to help facilitate implementation of the LIHP and federal health reform. However, counties in the region have ended up pursuing different strategies with regard to the LIHP. While most California counties have committed to participating in the LIHP, Fresno County withdrew its initial application. Tulare County was one of several counties with applications on hold, although the county now plans to implement the LIHP in January 2013 for the remaining year of the program.

A stalemate between Fresno County and CMC about modifying the contract designating CMC the exclusive provider for CMISP patients has stymied LIHP development. While the county proposed that CMC remain the primary provider under the LIHP and the restructured CMISP program, CMC proposed establishing a larger provider network. The parties also have not agreed on how to pay for the LIHP: Even with the new federal matching dollars, the combined costs for CMISP and LIHP are expected to exceed the county's current spending. Both the county and CMC were particularly concerned about the potential for increased costs of treating the large undocumented immigrant population that would be ineligible for the LIHP but would remain eligible for CMISP. Despite efforts to facilitate additional discussions by the Fresno Healthy Communities Access Partners, a nonprofit stakeholder organization working to improve health care access, most respondents were skeptical that the county would submit a revised LIHP application.

Some respondents were concerned that failure to participate in the LIHP will preclude transitioning eligible uninsured people to Medi-Cal coverage in a timely fashion in 2014. For example, FQHCs in Fresno County now are largely excluded from the CMISP program and will miss out on a new funding source under the LIHP that could

be used to expand and upgrade facilities. More generally, some respondents believed that forgoing participation in the LIHP is a lost opportunity to begin the process of moving away from a fragmented and inefficient system focused on hospital-based care at CMC to a more integrated system that incorporates primary care–focused FQHCs and other providers.

The county's CMISP program will continue to be important under health reform, given the many undocumented immigrants who will be ineligible for Medi-Cal, but its future remains unclear. Some respondents worried that health reform implementation could trigger a prolonged renegotiation of the CMISP agreement between the county and CMC, and that neither entity will take responsibility for the medically indigent until the matter is resolved.

Despite the lack of community-wide collaboration, individual provider organizations are preparing for reform. FQHCs and hospital-owned RHCs are expanding capacity to improve access for the newly insured. Recruitment and retention of physicians continues to be the greatest concern in terms of needed capacity for these organizations and the market as a whole. Kaiser has hired more physicians and plans to expand ambulatory centers in anticipation of expanded enrollment.

Despite cost-cutting efforts, safety-net hospitals fear health reform will negatively impact finances, with expected Medicare and Medi-Cal funding cuts unlikely to be offset by increased revenues from coverage expansions. Although two of the largest hospitals and affiliated IPAs — CMC/Santé and Kaweah Delta/Key Medical Group — are exploring new contracting arrangements with commercial health plans, Fresno lags other markets in these efforts. One provider respondent noted, "Fresno is not typically a test market." Another said, "We're going to let bigger markets do that first."

Issues to Track

- How will hospitals fare financially under health reform? Will Saint Agnes regain its financial footing?
- How will Fresno County restructure its CMISP program after the 2014 Medi-Cal expansions to provide care to those who remain uninsured, including undocumented immigrants?
- How will CMC's safety-net role, and that of other hospitals and FQHCs, evolve with health reform?
- Will community clinic expansions meet patient demand under health reform? Will rural FQHCs and hospital-owned RHCs continue to compete for insured patients or begin to collaborate?
- Will the already short supply of physicians grow enough to meet expanded demand under health reform as more people gain health coverage?
- Will physicians begin to aggregate into larger physician-owned organizations or become increasingly affiliated with FQHCs and RHCs? Will hospitals be successful in aligning physicians to support recruiting and, ultimately, more clinical integration?
- Will Kaiser become a more substantial competitor for commercially insured people in this market? Will new contracting and payment arrangements between other health insurers and providers gain traction?

ENDNOTES

1. The LIHP is part of the Bridge to Reform, California's Medicaid waiver program. The LIHP does not provide health insurance but requires participating counties to provide benefits similar to Medi-Cal, which may require expanding services beyond what is currently provided under CMISP. Counties receive federal matching funds to help support the cost of the LIHP.

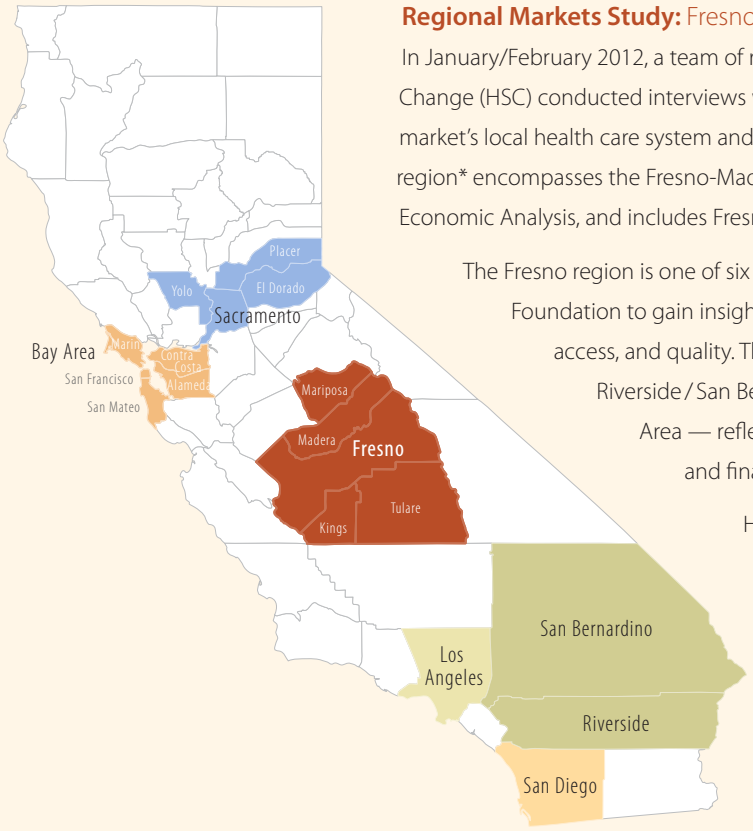
2. HMOs in California typically operate under the delegated-capitation model, passing on financial risk and utilization management responsibilities to large physician organizations such as independent practice associations and medical groups, in return for capitated payments (fixed per-member, per-month amounts).

3. Passed by the California legislature in 2009, the Hospital Quality Assurance Fee Program (commonly known as the hospital fee program) generates additional funding for hospitals serving relatively large numbers of Medi-Cal patients. Hospitals pay a fee based on their overall volume of inpatient days; after the addition of federal matching dollars, the funds are redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. Approximately 20% of hospitals are net contributors to the program. While the program originally only covered the period from April 2009 through December 2010, it has been renewed twice to 2013. Payments were first made to hospitals at the end of 2010.

4. California Office of Statewide Health Planning and Development, Healthcare Information Division, Annual Financial Data, 2010. Data reflect each hospital system's fiscal year.

5. Because California's corporate practice of medicine law prohibits hospitals from directly employing physicians, some hospitals sponsor medical foundations as a way to align with physicians. Under a medical foundation model, physicians either contract with the foundation through an affiliated IPA or are part of a medical group that contracts exclusively with the foundation through a professional services arrangement. University of California hospitals, county hospitals, and some nonprofit organizations such as community clinics are among the entities allowed to employ physicians directly, through exceptions to the corporate practice of medicine prohibition.

6. Because of California's corporate practice of medicine law, hospitals cannot employ physicians in RHCs directly in the same way FQHCs can, instead contracting with physicians in private practice through a professional services agreement.



Regional Markets Study: Fresno

In January/February 2012, a team of researchers from the Center for Studying Health System Change (HSC) conducted interviews with health care leaders in the Fresno region to study that market's local health care system and update a similar study conducted in November 2008. The region* encompasses the Fresno-Madera California Economic Area, as defined by the Bureau of Economic Analysis, and includes Fresno, Tulare, Kings, Madera, and Mariposa counties.

The Fresno region is one of six markets being studied on behalf of the California HealthCare Foundation to gain insights into regional characteristics in health care affordability, access, and quality. The six markets included in the project — Fresno, Los Angeles, Riverside / San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area — reflect a range of economic, demographic, health care delivery, and financing conditions in California.

HSC researchers interviewed 26 respondents specific to the Fresno market, including executives from hospitals, physician organizations, community clinics, and programs for low-income people. Interviews with 18 health plan executives and other respondents at the state level also informed this report.

▶ FOR THE ENTIRE REGIONAL MARKETS SERIES, VISIT WWW.CHCF.ORG/ALMANAC/REGIONAL-MARKETS.

*Expanding the study site from Fresno County, or the Fresno Metropolitan Statistical Area, to the five-county region allowed for greater exploration of rural health care issues in this community.

ABOUT THE AUTHORS

Joy Grossman, Peter Cunningham, and Lucy Stark of the **Center for Studying Health System Change (HSC)**. HSC is a nonpartisan policy research organization that designs and conducts studies focused on the U.S. health care system to inform the thinking and decisions of policymakers in government and private industry. More information is available at **www.hschange.org**.

ABOUT THE FOUNDATION

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at **www.chcf.org**.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to **www.chcf.org/almanac**.