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Fresno:
As Uninsured Rate Falls, Capacity Constraints Grow

Summary of Findings

Since the last round of this study in 2011-2012, the Fresno region's largely agricultural economy has experienced some growth, though it continues to be one of the poorest areas in California. Given the region's high poverty rate, many previously uninsured people were able to enroll in Medi-Cal when the state expanded eligibility for the program under the Affordable Care Act (ACA). The gain in the share of patients with insurance coverage has helped bring financial stability to the region's health care sector but also has compounded existing provider capacity constraints and access challenges.

Key developments include:

- **Major growth in Medi-Cal enrollment and reductions in uninsurance as a result of ACA coverage expansions.** Fresno has experienced extremely high Medi-Cal growth and very large reductions in the proportion of uninsured residents since the January 2014 ACA coverage expansions. In fact, while Fresno previously had an uninsured rate above the state average, the uninsured rate has plummeted so much that it is now below the state average.

- **Growing capacity constraints.** The growth in insurance coverage exceeded expectations of providers and Medi-Cal managed care plans alike. Despite efforts by Medi-Cal managed care plans and safety-net providers to prepare for anticipated increases in demand by boosting capacity, patients have experienced challenges accessing care. Hospitals have grappled with large increases in volumes at emergency departments, and safety-net providers struggled to address increased demand for primary and specialty care.

- **Continued growth of Rural Health Clinics (RHCs).** Some hospitals have continued to add RHCs and other outpatient facilities to help meet growing needs of low-income patients. The expansion of RHCs has exacerbated competitive tensions with some Federally Qualified Health Centers (FQHCs). While both are federally designated, FQHCs and RHCs have different structures and face different requirements.

- **Expanded coverage and government subsidies shore up hospital and clinic finances.** With the gains in Medi-Cal coverage and resulting revenues for providers, the major hospitals and community health centers have generally experienced improvements in financial status. Hospitals are also benefiting, at least temporarily, from additional Medi-Cal payments through the state's hospital fee program. FQHCs continue to receive a boost from enhanced Medi-Cal payments and federal funding to support care for the remaining uninsured.

- **Physicians begin to consolidate and align more closely with hospitals.** In past rounds of this study, Fresno had few of the market forces that pushed physicians in other California markets to consolidate into large medical groups and to align with hospitals, including very little managed care. As a result, physicians have historically

been largely independent. A noteworthy development this round is that physicians in Fresno County have started to consolidate into larger medical groups. At the same time, physicians across the region have started to align more closely with hospitals, primarily by joining medical foundations. These changes are primarily driven by physicians' apprehension about the changing landscape of provider payment arrangements and a sense that belonging to larger organizations and having closer alignments with hospitals will provide more financial security and better contracting opportunities.

- **Providers begin taking on more risk in a market that historically has been almost exclusively fee-for-service.** Unlike other California markets where large physician organizations have long assumed financial risk for physician services under the delegated capitation model, managed care arrangements never gained any significant traction in Fresno. Over the last few years, the market has seen some growth in risk contracting, as IPAs have begun to take on new risk contracts with Medicare and commercial payers. A few provider organizations have begun to participate in accountable care organizations (ACOs), with other providers reportedly planning to follow suit. Medi-Cal health plans and safety-net providers also are exploring taking on more financial risk. All of these developments are very new, and it is still too early to tell whether they will lead to major changes in care delivery or improved efficiencies.

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

	Fresno	California
POPULATION STATISTICS, 2014		
Total population	1,746,671	38,802,500
Population growth, 10-year	13.4%	9.1%
Population growth, 5-year	5.7%	5.0%
AGE OF POPULATION, 2014		
Under 5 years old	8.9%	6.6%
Under 18 years old	29.6%	24.1%
18 to 64 years old	59.1%	63.1%
65 years and older	11.3%	12.9%
RACE/ETHNICITY, 2014		
Asian non-Latino	7.0%	13.3%
Black non-Latino	5.1%	5.5%
Latino	55.2%	38.9%
White non-Latino	30.3%	38.8%
Other race non-Latino	2.5%	3.5%
Foreign-born	25.7%	28.5%
EDUCATION, 2014		
High school diploma or higher, adults 25 and older	74.6%	83.4%
College degree or higher, adults 25 and older	23.9%	37.9%
HEALTH STATUS, 2014		
Fair/poor health	22.5%	17.1%
Diabetes	10.1%	8.9%
Asthma	15.9%	14.0%
Heart disease, adults	7.0%	6.1%
ECONOMIC INDICATORS, 2014		
Below 100% federal poverty level	28.3%	18.4%
Below 200% federal poverty level	56.2%	40.7%
Household income above $100,000	13.6%	22.9%
Unemployment rate	12.0%	7.5%
HEALTH INSURANCE, ALL AGES, 2014		
Private insurance	41.7%	51.2%
Medicare	8.6%	10.4%
Medi-Cal and other public programs	40.7%	26.5%
Uninsured	8.9%	11.9%
PHYSICIANS PER 100,000 POPULATION, 2011		
Physicians	128	194
Primary care physicians	47	64
Specialists	81	130
HOSPITALS, 2014		
Community, acute care hospital beds per 100,000 population†	144.6	181.8
Operating margin, acute care hospitals*	1.3%	3.8%
Occupancy rate for licensed acute care beds†	59.7%	53.0%
Average length of stay, in days†	4.4	4.4
Paid full-time equivalents per 1,000 adjusted patient days*	15.1	16.6
Total operating expense per adjusted patient day*	$2,213	$3,417

*Kaiser excluded.
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Sources: US Census Bureau, 2014; California Health Interview Survey, 2014; "Monthly Labor Force Data for California Counties and Metropolitan Statistical Areas, 2014" (data not seasonally adjusted), State of California Employment Development Department; "California Physicians: Supply or Scarcity?" California Health Care Foundation, March 2014; Annual Financial Data, California Office of Statewide Health Planning and Development, 2014.

Market Background

The Fresno region (see map on page 16), comprises five counties in the San Joaquin Valley of central California: Fresno, Madera, Kings, Tulare, and Mariposa. The region is home to 1.8 million residents, who are largely concentrated in the urban core of the City of Fresno. Traditionally a fast-growing region, population growth has slowed since the early 2000s, though it remains slightly above the growth rate for California as a whole (see Table 1).

The region's largely agricultural economy is marked by high rates of unemployment and very high rates of poverty. Tulare and Fresno were the first and third largest agricultural counties in the US, and taking the five counties together they had $19.9 billion in agricultural production.[1] The region's chronically high unemployment rate is in large part reflective of this agricultural economy, which has recently been affected by the statewide drought, in addition to a longer-term trend toward mechanization and seasonal swings in the demand for labor.

While unemployment in the Fresno region decreased from 17% of the population in 2011 to 12% by 2014, it remains much higher than the state average of 7.5%. Related to high unemployment, Fresno is by the far the poorest community of the study sites, with more than half (56%) of its residents living below 200% of the federal poverty level (FPL), compared to 41% statewide. The region is also an outlier along other demographic indicators, as it has a much higher proportion of Latino residents, and lower proportions of White, Black, Asian, and foreign-born residents relative to the California average. In addition, Fresno-area residents continue to be less educated and have higher rates of chronic disease than state averages.

Over the last few years, Fresno has seen a sharp decline in the proportion of its uninsured residents. In fact, the region's uninsured rate, which was historically above the California average (12%), has dropped below the state's average and is now around 9%. The biggest driver of Fresno's drop in uninsurance rate was the Medi-Cal expansion, which had a substantially larger impact in Fresno than in many other California communities. With a high proportion of residents poor enough to meet the Medi-Cal income eligibility requirements under the expansion (up to 138% FPL), the percentage of Fresno residents enrolled in Medi-Cal now stands at 41%, much higher than the state average (27%), and a full 10 percentage points higher than the study site with the next highest percentage (Riverside/San Bernardino, with 31%).

Also, while Fresno has consistently had low rates of private coverage relative to the state average (42% vs. 51% statewide), the region's rate of private coverage held steady over the last few years, while the state as a whole saw a slight decrease. This occurred despite relatively few Fresno residents enrolling in Covered California (only 3% vs. 5% statewide).[2]

Stable Hospital Sector

The Fresno hospital market remains geographically segmented, largely along county lines, although people in the region's remote areas often travel across county lines for specialty care. Across counties, the market shares of the major systems have remained mostly consistent since the last round of the study.

Located in Fresno County are three of the largest hospital systems in the region, along with a few smaller hospitals in the county's rural outskirts. Community Medical Centers (CMC) remains the dominant system, not only for Fresno County, but for the entire region. The system has three acute care hospitals, all of which are located in the urban center of the county, and which together accounted for 40% of the market's acute discharges in 2014, up from 34% in 2011.[3] CMC's flagship hospital, Community Regional Medical Center (CRMC) in downtown Fresno, is the major referral center for more specialized needs for the whole region. The system's other hospitals include a specialty heart hospital and a smaller community hospital located in the more affluent northern part of the county.

Saint Agnes Medical Center, the only California hospital operated by the Michigan-based Trinity Health System and the second-largest hospital provider in Fresno County, has one

facility on the north side of Fresno. Saint Agnes comprised 16% of the market's discharges in 2014. Kaiser Permanente is the third-largest hospital provider in the county, with fewer inpatient beds and a much lower market share — about 5% of discharges.[4]

Outside of Fresno, each of the outlying counties is primarily served by a single hospital or system. The district-owned Kaweah Delta Medical Center (Kaweah) is the anchor for Tulare County and the bordering regions of Kings and Fresno Counties. Kaweah's market share is comparable to that of Saint Agnes in Fresno, with 15% of acute discharges. Kings County is primarily served by the Adventist Health Central Valley Network (Adventist), operated by the West Coast-based Adventist Health system. The system includes four acute care hospitals that together comprised 11% of acute discharges in 2014. Madera County is served by a community hospital and Valley Children's Hospital, the pediatric referral center for the entire region. Mariposa County is served by a small district hospital.

Many Hospitals Play Safety-Net Role, but Safety Net Remains Weak

Due to the very high prevalence of Medi-Cal and other low-income patients in the region, most of the hospitals in Fresno play a safety-net role, but the resources and services extended to low-income people's health care needs have been low relative to many other California communities. This is partly due to the rural nature of the region in that it is difficult to offer an adequate footprint of services that enables timely access to all people, especially those in the most remote areas.

Within the region, there are no large county safety-net hospitals dedicated to serving low-income people, or University of California hospitals, which typically care for a large share of low-income patients in other communities. Instead, many of the hospitals in the region serve a large share of Medi-Cal and uninsured patients, along with more affluent patients within their geographic areas.

As Fresno County's major safety-net hospital and the region's referral center for more specialized care, CRMC continues to be the largest hospital provider of safety-net care for the Fresno region. As a whole, the CMC system provided almost half (48%) of discharges for the low-income (Medi-Cal and uninsured) population in the market in 2014.[5] Other hospitals serving a high share of low-income patients include Kaweah, Adventist, and several smaller district hospitals. Kaweah is the primary safety-net hospital in Tulare County for both routine and some advanced care needs, while Adventist plays a key role in the safety net for Kings County and beyond, particularly for outpatient services because of its large and growing network of RHCs. The community and district hospitals serve as safety-net providers in Madera and Mariposa Counties.

In contrast to CRMC and the major systems serving the neighboring counties, Saint Agnes and Kaiser — which are both located in the more affluent north side of Fresno — serve a relatively small share of low-income patients. For example, in 2014, St. Agnes' low-income population accounted for 15% of its revenue, a much lower share than the majority of hospitals in the region. As in many other California markets, Kaiser also serves a very limited number of Medi-Cal patients, and commercial enrollees make up the majority of the system's patient base.[6]

Within the region, there has been limited government focus on and funding for safety-net services, little collaboration among local government and safety-net providers, and inadequate provider capacity to serve low-income people. There have been some improvements over the last few years, including Medi-Cal health plans growing their provider networks, rural hospitals adding RHCs, FQHCs adding sites of care, and new collaborations among local government officials and safety-net providers to better serve this population. Nonetheless, access to primary, specialty, and behavioral health care remains insufficient and may have become more difficult in some areas over the past several years.

Medi-Cal Expansion and Hospital Fee Program Drive Improved Financial Outlook for Major Hospitals

In the last round of this study, the longstanding weak payer mix and delicate financial position of many hospitals in the region had deteriorated further in the wake of the economic recession. That trend has shifted in a more positive direction over the last few years, with the major hospitals reportedly having a better financial outlook and positive operating margins in 2015. According to respondents, the key drivers of this change have been the Medi-Cal expansion and corresponding reductions in uncompensated care, along with financial boosts from the state hospital fee program, through which revenues from hospitals with stronger payer mixes are redistributed to hospitals serving a larger share of Medi-Cal patients.[7]

While respondents almost universally reported improvements in hospital finances across the region, the latest available public data do not entirely reflect this. For example, from 2011 to 2014, operating margins varied considerably across the major hospitals and also fluctuated a great deal at individual hospitals from year to year.[8] CMC, Saint Agnes, and Kaweah all experienced years with positive margins and other years of losses, with CMC experiencing the most dramatic shifts. In 2014, the most recent year for which data are publicly available, CMC had an operating margin of 3.6%, while Saint Agnes's was –2.3%, and Kaweah's was just below breaking even. In contrast, Adventist had consistently strong, though declining, margins during this period. The system's overall financial strength could be due to its geographic monopoly in Kings County and its significant expansion of RHCs, which are typically profitable because of their enhanced payment rates (see "RHCs and FQHCs" sidebar).

In contrast to the major hospitals' recent financial improvements, small rural hospitals continue to struggle. In the last few years, small community hospitals are facing what they describe as the increasing difficulty of remaining independent. For example, because they are located in areas with lower population density, they have less patient volume to cover their fixed operating costs.

In the face of these pressures, Corcoran District Hospital in Kings County closed its doors in October 2013 after several years of financial strain. Madera Community Hospital has been losing patients to other hospitals and the expansion of an FQHC in its service area, reportedly related to real and perceived quality issues. Its margin fell dramatically, from 8.3% in 2011 to –9.1% in 2014. Although the hospital fee and more disproportionate share hospital (DSH)

RHCs and FQHCs

A growing number of both Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) serve the Fresno safety net. While both are federally designated, these organizations have different structures and face different requirements.

FQHC status provides a health center with federal grants, enhanced Medi-Cal payment rates to cover a range of medical and social services (based on historical allowable costs and updates for medical inflation), and student loan forgiveness for providers, among other benefits. FQHCs with "look-alike" status receive most of the same support, except federal grants. FQHCs focus on primary care and supportive services (e.g., language interpretation, transportation), must serve all patients who present for care, and can charge only minimal copayments for low-income uninsured patients (on a sliding scale based on income). The FQHCs in Fresno are typically independent, private organizations.

RHCs also receive enhanced Medi-Cal payments, but they face fewer governance and reporting requirements and regulations on the types of services they provide, relative to FQHCs. Another key difference is that RHCs do not receive federal grants to support care for the uninsured and are not required to treat uninsured patients for free or at discounted rates, although some RHCs reportedly do extend discounts to uninsured patients. Most of the RHCs in the Fresno market are hospital-owned.

funds are helping in the short term, the hospital may face more challenges in the longer term. Tulare Regional Medical Center also struggled over the last several years. The hospital's financial status reportedly has improved since 2014, when it entered into a management services contract with a hospital turnaround firm.

Amid Coverage Expansions, Hospitals Focus on Increasing Outpatient Capacity

From about 2005 to 2012, the major hospitals in the Fresno market undertook substantial inpatient and emergency department (ED) expansion projects. Over this timeframe, hospitals collectively added hundreds of beds to the market, both to ease capacity constraints and to compete for the market's small number of commercially insured patients. Since this period of significant growth, the pace of inpatient expansions has slowed dramatically, and some critical gaps in inpatient capacity remain. In particular, respondents universally emphasized the market's dire need for more inpatient psychiatric beds, but the major hospitals do not have plans to add any, reportedly because of low return on investment.

With the completion of the inpatient capacity expansions and construction projects in the last round of the study, some of the market's hospitals have addressed California's 2030 seismic compliance requirements. Kaiser's facilities meet all of the requirements for 2030. In contrast, other major hospitals will need to replace or retrofit some or all of their buildings. For example, some of CMC's and Adventist's buildings are fully compliant with 2030 requirements, but both systems will need to retrofit or replace other buildings. Kaweah will need to replace its main acute care facility, and Saint Agnes has a substantial number of beds that are not in compliance. Given that these hospitals reportedly lack the funding to cover the major costs associated with seismic upgrades, and that major funding strategies are still in development, they may need a reprieve from the state. Smaller rural hospitals, whose facilities are generally not in compliance and who lack capital resources, also may need a reprieve to avoid closure.

Hospitals reported substantial growth in ED visits over the past few years, which has strained their capacity. Respondents generally attributed the growth to the drastic expansion of Medi-Cal coverage and the related increase in demand for services, along with insufficient availability of primary, specialty, and mental health services in the community. For example, much of the growth in ED visits stems from patients with less intensive needs, who could be treated in alternative, lower-cost settings, such as community clinics or urgent care centers, if these settings were convenient and accessible.

To varying degrees, hospitals are investing in RHCs and other outpatient facilities to ease capacity constraints for EDs; improve access, particularly in rural areas; and draw patients from broader geographic areas. Adventist is the most active. The system continues to expand its RHCs and other outpatient clinics throughout the market, both by building new facilities in some locations, and acquiring and converting private physician practices in others (see "RHCs and FQHCs" sidebar on page 5). Kaweah also has expanded its RHCs and urgent care centers and recently opened two ambulatory clinics that provide a wide range of services, including physical, occupational, and speech therapy. Similarly, Saint Agnes is planning to open two urgent care facilities over the next year and is currently building a 50,000-square-foot outpatient facility in northwest Fresno, which will offer urgent care, internal medicine, and full imaging and lab services. Taking a different approach, CMC is developing affiliations with existing FQHCs and RHCs rather than acquiring or opening new facilities.

Chronic Physician Shortages Increase

Despite recent recruiting efforts, the Fresno market continues to experience a severe shortage of physicians, with a supply of 128 physicians per 100,000 residents, drastically lower than the state average of 194. The shortage is more extreme in the rural regions of the market, as Fresno (city and county) is somewhat better able to recruit — though it too faces considerable challenges. Over the last few years, the shortage has reportedly grown more acute due to the large Medi-Cal

coverage expansion and because the market's relatively older physician population continues to age and retire.

As in the last two rounds of the study, recruiting new physicians to the market is reportedly challenging because of the region's generally poor payer mix, call-coverage obligations, and quality-of-life factors (including poorer air quality and less desirable weather relative to coastal regions of the state). Another contributing factor is that Fresno has historically lacked large medical groups offering salaried employment arrangements, which especially appeal to younger doctors — though, as discussed below, this is starting to change. The key exception is The Permanente Medical Group (TPMG), which is reportedly somewhat better able to recruit because of its employment model and relatively generous compensation package.

The physician shortage contributes to bifurcation of the physician market, with most private practice physicians almost exclusively serving Medicare and commercially insured patients, and other physicians primarily serving Medi-Cal and uninsured patients in RHCs or FQHCs, or in small private practices in outlying rural areas. Despite the very large percentage of Medi-Cal enrollees in the market, most private practices do not have excess capacity, so they have no need to — and generally do not choose to — serve Medi-Cal patients. Most private practice physicians are also reportedly unwilling to accept payment rates offered by Covered California products, which are lower than rates from other commercial contracts. Some respondents reported that health plans had to raise their Covered California payment rates for physician services in order to attract a sufficient number of physicians to their provider networks.

Several hospitals are expanding residency and fellowship programs in an effort to bring more physicians to the market. CMC has partnered with University of California, San Francisco (UCSF) since the 1970s but, in the last 10 years, has increased the size of its primary care and emergency medicine residencies and added fellowships in pulmonology, cardiology, trauma, critical care, and other specialties. CMC currently has approximately 300 residents in 25 specialties. As part of its pediatric residency program with UCSF, CMC is also planning to expand the range of pediatric services it will provide at the downtown CRMC campus. This development follows Valley Children's decision to break away from its partnership with UCSF Fresno and establish its own pediatric residency and fellowship program in partnership with Kaiser and Stanford University School of Medicine.[9]

Kaiser also partners with UCSF Fresno for residency programs in emergency and geriatric medicine and offers an elective for UCSF Fresno psychiatric residents. Kaweah has established a residency program with UC Irvine (in Orange County) in family medicine, psychiatry, emergency medicine, general surgery, and transitional year (which provides broad experience across clinical areas).

Physicians Consolidate, Align with Hospitals

Physicians in the market have historically practiced medicine with much more independence relative to physicians in other California communities. Fresno-area physicians continue to generally practice in independent solo or very small group practices. Key exceptions include Kaiser's physician arm, TPMG, with about 300 physicians, and a few other large medical groups ranging in size from 50 to 200 physicians.

Physicians in the market are also independent in the sense that they historically have had limited alignments with hospitals, with no medical foundations in the market until very recently and limited physician membership in Independent Practice Associations (IPAs). Two IPAs continue to support limited professional risk contracting under commercial and Medicare Advantage HMOs. Santé Community Physicians, the larger of the two, operates in Fresno, Madera, and Kings Counties. The IPA is aligned with CMC, and physician members primarily admit patients to CMC. The smaller Key Medical Group operates in Tulare and Kings Counties.

A number of factors drive the independent nature of physicians in this market. In general, physicians have not faced pressures to consolidate into large medical groups or to align

with hospitals because the market has relatively little managed care penetration, from either Kaiser or other HMOs. The presence of Kaiser's health plan, a large closed-model HMO, is relatively small in Fresno, especially in comparison to its dominant position in many other California markets. With the very modest managed care presence in the market, aspects of the delivery system that tend to develop alongside managed care — including physician organizations operating under the delegated-capitation model and close alignments between hospitals and physicians — have not gained traction in Fresno. The key underlying factors driving all of these trends is that much of the region is both rural and poor. The low population density in rural areas of the market makes the operation of HMOs much less feasible and efficient, particularly Kaiser's integrated delivery system model. In addition, the poverty of the area and the low number of commercial enrollees make it less attractive for commercial health plans, including Kaiser.

In the last few years, several market forces have contributed to both the consolidation of physicians into larger medical groups and tighter alignment of physicians with hospitals through the development of medical foundations.[10] Key drivers of physicians' recent change of heart include apprehension about the changing landscape of provider payment arrangements toward those that reward value over volume, and a sense that being in larger organizations and more closely aligned with hospitals will provide stability and better contracting opportunities, including the ability to take on financial risk. Also, many physicians in the Fresno market lag behind in terms of electronic health record (EHR) adoption, and some view joining a larger medical group with an established EHR system as preferable to taking on the administrative and financial burden of establishing an EHR system individually.

Physician Consolidation in Fresno County

Over the last few years, the size of medical groups in Fresno County has grown due to consolidation of existing small practices and to some degree, the recruitment of new physicians. The largest market's largest medical group, The Permanente Medical Group, has grown over the last three years, from around 225 physicians to just under 300. The next largest medical groups — which belong to Santé Community Physicians, the market's largest IPA — are the newly formed Santé Health Foundation, which is estimated to have more than 200 physicians, and the Central California Faculty Medical Group (CCFMG), a multispecialty medical group affiliated with the UCSF training program located at CMC, that now includes 200 physicians, up from about 100 in the last round of the study.

In contrast to Fresno County, physician consolidation has not occurred in the market's outlying counties. The major physician organization outside of Fresno County is the Key Medical Group, an IPA with approximately 400 to 450 physicians located primarily in Tulare County, which admit patients primarily to Kaweah. While the size of the IPA has grown from about 300 physicians in the last round of this study, physician members reportedly continue to operate in small practices. The lack of consolidation in the outlying counties is partly due to the fact that they are rural areas, where the drivers behind and opportunities for consolidation are not present. For example, in many parts of these counties, there is generally not a high enough concentration of patients to support the development of medium and large physician practices. Also, the natural physician-hospital alignment — due to the presence of only one major hospital or system within geographic submarkets — allows many physicians to fare well in small practices.

Medical Foundations Take Root

For several years, hospitals in the Fresno market have attempted to create medical foundations. The foundation model allows hospitals to align with physicians as closely as possible through an employment-like model while complying with California's corporate practice of medicine law, which prohibits hospitals from directly employing physicians. Through foundations, hospitals generally provide clinical and

administrative support so that physicians' compensation is higher than it would be in private practice. Physicians that belong to foundations give up some clinical autonomy in exchange for this higher compensation.

In recent years, physicians have reportedly become more receptive to the foundation model because of new financial pressures and the increasing administrative burdens associated with being independent. However, the development of foundations has been slow and somewhat different than what is typical in other parts of California, reflecting some remaining physician reluctance. For example, in Fresno County, Santé Health Foundation has a very unusual structure in that it is not directly sponsored by the hospital partner, CMC. Rather, leadership at Santé (IPA) formed the foundation in 2010 in order to maintain control and independence while creating a vehicle to receive funding from CMC to support physician recruitment.

Saint Agnes's approach also reflects physician reluctance to align closely with hospitals. For example, the hospital established two physician organizations in 2013: Saint Agnes Medical Group, an IPA, which allows physicians an option for a looser alignment, and Saint Agnes Medical Providers (SAMP), a "friendly PC" model — in this case, reportedly an interim step toward creating a foundation — with approximately 30 physicians.[11] Saint Agnes's goal is reportedly to transform SAMP and some of the physicians in the IPA into a medical foundation in 2016. In Tulare County, Kaweah's efforts to develop a foundation were rejected by physicians last round, but Kaweah is now working to form a foundation with Visalia Medical Clinic (VMC), the only multispecialty group in the county. Finally, in Kings County, Adventist Health started a medical foundation with about 30 physicians, plus additional physicians working in RHCs. Since these alignments are still developing or very new, it is too early to assess whether they are leading to clinical integration or other major changes in care delivery.

Providers Dip Their Toes into Risk-Contracting Arrangements

As noted above, in past rounds of this study, a key defining characteristic of the Fresno market has been its very limited managed care activity relative to that of California as a whole. While Fresno is still nowhere near other California markets in penetration of managed care and other related payment arrangements, more providers have reportedly begun to participate in managed care contracts. In particular, a few Fresno-area physician organizations have taken on new risk-based contracts with Medicare Advantage and commercial health plans. The Key Medical Group, which was already taking risk through commercial contracts, started accepting Medicare Advantage risk in 2013. Saint Agnes Medical Group also recently started accepting risk with both commercial and Medicare Advantage HMO products. In addition, Santé — an early adopter of risk contracting in the market — continues to accept professional risk in its commercial and Medicare Advantage contracts.

Providers in Fresno County are also participating in the market's first accountable care organization (ACO) and bundled payment initiatives. Santé is one year into a three-year commercial ACO contract with Anthem Blue Cross for 40,000 covered lives, while Saint Agnes reportedly will be participating in a systemwide commercial ACO through the Trinity system in 2016, and is currently participating in the Center for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvements Initiative.[12] Other hospitals report interest in participating in ACOs but note that they need to first focus on preliminary steps to prepare, including developing the requisite IT infrastructure and analytic capabilities.

The trend of more providers assuming financial risk is occurring in Medi-Cal managed care as well. CalViva and Anthem reportedly are increasingly contracting with their network physicians through an IPA structure, with many of them paid capitation for professional services. In a significant movement toward hospitals assuming risk for

Medi-Cal patients, in December 2015 Adventist Health and Community Medical Centers announced a collaboration to form a new Medi-Cal health plan and provider network to share risk for a subset of Medi-Cal patients in Kings, Fresno, Madera, and Tulare Counties. The two systems bring complementary services to this arrangement, as Adventist has an extensive outpatient (primary and specialty) rural health care presence, while CMC brings its highly specialized inpatient services. Pending approval from the state, the new Adventist Health Plan will subcontract with the established plans in the region to administer benefits. It will start with approximately 13,000 Medi-Cal enrollees in Kings County in early 2016 and plans to ultimately include up to 200,000 Medi-Cal enrollees across the four-county area.[13]

Given providers' limited experience with risk contracting, and that the market lacks some of the features required for it to be successful — such as more sophisticated approaches to coordinating care across settings and a unified or at least interoperable EHR infrastructure — it remains an open question whether new payment arrangements will gain momentum. Another challenge may be encouraging physicians who are used to operating in a largely fee-for-service environment to buy into and adopt new models of care delivery based on managing patients' total cost of care. Still, the development of tighter hospital-physician alignment through medical foundations may support the growth of risk contracting, and at the same time, growing interest in risk contracting may encourage medical foundation growth.

Medi-Cal Enrollment Growth Drives Down Uninsurance Rate

Medi-Cal has historically had a large presence in the Fresno region and, with the increase in Medi-Cal enrollment under the ACA, its presence is even greater, particularly in comparison to the other markets included in this study. Fresno's Medi-Cal enrollment grew by about a third between December 2013 and October 2015, from 620,000 to 860,000 people. Key to outreach and enrollment efforts has been Fresno Healthy Community Access Partners (FHCAP), the main safety-net advocacy organization in the community.

Medi-Cal enrollment was further boosted as Fresno County began using the Permanent Residence Under Color of Law (PRUCOL) screening, which allows individuals who are not legal immigrants under federal law, but fall within one of several immigration classes, to claim public benefits. The state of California has made this option available for several years, but the other study sites did not report using PRUCOL in such a widespread way and with the same impact on Medi-Cal enrollment as in Fresno County.

Fresno County did not have an early leg up on Medi-Cal enrollment as did most other counties in the state through the Low-Income Health Program (LIHP), a county option under California's "Bridge to Reform" Medicaid waiver to transition low-income people to a Medicaid-like program in preparation for the Medi-Cal expansion. In the last round of this study, the county and safety-net stakeholders (convened by FHCAP) could not agree on a reasonable way to implement the LIHP due to concerns about insufficient funding, while other counties in the region did implement the program. Respondents indicated that, without LIHP, uninsured people were slower to gain Medi-Cal coverage than in neighboring counties, and Medi-Cal health plans and safety-net providers lacked adequate time to transition individuals to coverage, link them to primary care medical homes, and help them navigate the health care system.

The majority of the Fresno region continues to operate under Medi-Cal managed care's Two-Plan Model, in which a county-owned public plan (called a "local initiative") competes against a private health plan. CalViva, which began operations in 2011, is the public plan for Fresno, Kings, and Madera Counties. Anthem is the second, smaller plan in the three-county area. Between December 2013 and January 2016, CalViva's managed care enrollment grew 56%, and Anthem's grew 49% in these three counties. CalViva holds about 70% market share. Although both plans perform below the state average for Medi-Cal plans on a composite

score of quality and satisfaction, CalViva performs better than Anthem.[14] This, along with other factors in which the state preferentially assigns enrollees (if they do not select one themselves) to county-owned health plans, are likely driving enrollment into CalViva.[15]

Tulare County also operates under the Two-Plan Model but, lacking a local initiative, Anthem and Health Net largely split the Medi-Cal market. New to managed care, Mariposa County recently entered the state's new regional model for rural counties, where Anthem splits enrollment with Centene. Additionally, Anthem participates in the Covered California marketplace for residents of all five counties, reportedly in part to help manage individuals who move between subsidized coverage and Medi-Cal due to income fluctuations — a common phenomenon in the agricultural workforce.

The state's transition of the Seniors and Persons with Disabilities (SPD) Medi-Cal population to managed care several years before the 2014 Medi-Cal expansion helped Medi-Cal health plans establish more expertise and infrastructure necessary to address an adult population that also characterizes the Medi-Cal expansion population. These needs, which involve chronic, complex, and multiple health issues, differ from the needs of the traditional Medi-Cal managed care population that consisted of primarily mothers and children.

Still, Medi-Cal health plans have been ramping up provider networks to accommodate additional demand for care from the large Medi-Cal expansion under the ACA, particularly adding behavioral health providers to address new requirements on Medi-Cal plans for these services. As noted, the health plans are largely reliant on FQHCs and RHCs, so provider growth at those clinics has helped health plan network expansion. Also, payments to Medi-Cal plans for the expansion population reportedly are higher relative to costs than they were for the SPD population, which reportedly has helped establish more financial incentives to gain provider participation. However, the plans continue to face challenges adding community-based physicians — especially specialists — given the general physician supply shortages and private practice physicians' lack of interest in serving Medi-Cal patients.

Medi-Cal health plans experienced relatively high use of services among new enrollees, related both to pent-up demand (seeking services for conditions that previously went untreated) and a disproportionate increase in enrollees with complex medical, behavioral, and social needs. While pent-up demand should plateau over time as enrollees' conditions are either resolved or better managed, Medi-Cal plans also are implementing strategies to respond to the social needs with which they have less experience, especially to help control rising ED use (discussed earlier). For example, Anthem's case managers gather daily reports on ED use from area hospitals and work closely with the IPA medical directors to understand individuals' reasons for using the ED, and to identify and address any contributing social issues. CalViva's main new initiative is to provide temporary housing to homeless patients being discharged from the hospital so they have a safe and supportive environment in which to recover, which also could reduce hospital readmissions and reduce overall costs of care.

Initiatives for the Remaining Uninsured

Like other California counties, Fresno County traditionally provided health care to low-income uninsured individuals through its Medically Indigent Services Program (MISP).[16] Compared to similar programs in other California counties, Fresno's MISP was more limited in some ways and more expansive in others. The program started with relatively low income eligibility (to those earning below 63% FPL), but following a lawsuit several years ago, the county increased the maximum income to 224% FPL. Fresno also allowed undocumented immigrants to enroll. However, the scope of the program was limited: It supported individuals for only short periods during acute medical episodes, rather than providing ongoing preventive care and care management.

Fresno contracted exclusively with CMC to provide outpatient and inpatient services to program enrollees. However,

CMC's reported costs of serving the MISP population vastly exceeded the approximately $22 million the county paid them annually (via state realignment funds to the local health department).[17]

Fresno County ended its medically indigent program at the end of 2014 for two main reasons. First, the majority of individuals in the program (about 16,000 of the 20,000 enrollees) gained Medi-Cal coverage. Second, the county's realignment funds from the state that supported the entire public health department were halved, to approximately $30 million annually. With fewer resources, the health department is focusing more on public health activities and data analysis and less on direct service provision.

However, following significant community concern about access to care for people who remain uninsured, the Fresno County health department, under new leadership, collaborated with safety-net providers and other community leaders to establish two initiatives for the uninsured. First, the county dedicated some of its remaining realignment funds to a modified medically indigent program for people earning 138% to 224% FPL if they meet hardship criteria (i.e., if they need medical services but did not enroll in Covered California during open enrollment, or cannot afford Covered California). Undocumented immigrants are not eligible for this program.

Second, the county set up a structure to reimburse CMC for providing specialty care (inpatient, outpatient, and emergency services) to uninsured individuals with incomes under 138% FPL, including the undocumented. The initiative is funded through $5.5 million in unused funds from the state that had been originally allocated for another purpose. Some respondents were doubtful that these funds would be sufficient relative to the need and wondered whether additional funds will be made available if necessary. FQHCs use their existing resources to serve as the primary care medical homes for these individuals.[18]

To limit demand, the county does not advertise these initiatives because they are an extension of services provided by the FQHCs and are not a county entitlement program. As of February 2016, the modified medically indigent program helped all applicants enroll in Medi-Cal or Covered California coverage instead, and no applicants have met the hardship criteria. The new specialty care initiative has served about 80 people at an estimated cost of $300,000. The county and the FQHCs are working together to provide more education to undocumented individuals about the medical services available to them.

The other counties in the region have either ended their medically indigent programs or significantly downsized them, also reflecting growth in coverage and reduced realignment funds.

Community Clinics Expand in Attempt to Address Growing Demand

In anticipation of the Medi-Cal expansion and increased demand for health care services, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) expanded their facilities and significantly increased outpatient service capacity in the market over the past several years. However, demand has outpaced new overall community clinic capacity, as capacity was insufficient even before the Medi-Cal expansion, and new Medi-Cal enrollment exceeded expectations.

About a dozen FQHC organizations continue to serve the market in rather distinct but somewhat overlapping service areas, largely along county lines. Aided by additional federal funds available through the ACA, the total number of FQHC sites of care grew from approximately 40 to over 60 between 2011 and 2014, with each of the larger FQHCs in the market opening one or two additional facilities, and several opening additional sites in 2015.

The largest FQHCs, by service area, are:

- Fresno County: Serving the Fresno core area, with a total of 10 sites, Clinica Sierra Vista is the largest FQHC in the county and the market. Valley Health Team operates in

western, rural Fresno County with 5 main sites, with three additional sites opening in 2016.

- United Health Centers has 11 sites across three counties: the rural areas of southwest Fresno County, and Tulare and Kings Counties.
- Tulare County is also served by Family HealthCare Network (11 sites), Tulare Community Health Clinic (4 sites), and the county's three FQHC Look-Alikes.
- Kings County is also served by Avenal Community Health Clinic, with 6 sites.
- Madera County has one FQHC, Camarena Health, which has grown significantly over the past 3 years, adding 2 sites for a total of 5 sites.

Additionally, a new strategy among FQHCs in the region is to expand through school-based satellite clinics, which requires little capital and removes transportation barriers for patients. The market is also served by about a dozen comprehensive primary care community clinics that do not have federal status; they expanded very modestly during this period.

Like hospitals, FQHCs are benefiting from the improved payer mix as a result of increased Medi-Cal enrollment. FQHCs report that many of their uninsured patients are now covered by Medi-Cal and that they are seeing new Medi-Cal patients as well. The region's FQHCs provided approximately 20% more visits in 2014 (approximately 1.3 million) than in 2011.[19]

As noted, hospitals' RHCs, which were relatively new to the market in the last round of this study, have grown rapidly over the last few years. Adventist, serving rural areas in Kings, Tulare, and south Fresno Counties, has almost doubled its RHC sites over the last few years; it currently has 40 sites (providing over 500,000 annual visits) and plans to add half a dozen more over the next few years. Kaweah, serving Tulare County, now has five sites, up from three. These clinics also are faring well financially under the Medi-Cal expansion.

Growing Tension Between RHCs and FQHCs

While the FQHC and RHC expansions have added much-needed capacity, the growth in RHCs has fueled growing competitive tensions with FQHCs serving the same general areas, which stem from the differences in their structures and requirements (see "RHCs and FQHCs" sidebar on page 5). RHCs' Medi-Cal payments reportedly are higher than FQHCs' because the cost structure of their hospital owners, which is considered in establishing the payment rates, is higher than the FQHC cost structure that is based on primary care and support services.

This payment difference reportedly aids RHCs in paying physicians higher rates to attract them, leaving FQHCs with less ability to recruit and retain already scarce primary care providers (PCPs) to support their expansions and continued growth. FQHCs are relying more on mid-level providers, but the lack of PCPs still has contributed to increased patient wait times for appointments at some FQHCs. One FQHC director expected the number of visits they can provide to actually decrease soon because the health center is unable to retain an adequate number of physicians.

At the same time, however, with higher payment rates and fewer federal restrictions on adding services than FQHCs, many RHCs also have added specialists. This has reportedly improved access to specialty services — which are typically more difficult for low-income patients to obtain than primary care — not only for RHCs' patients, but for FQHCs' patients as well.

Some respondents report that, without the mandate to serve patients regardless of their ability to pay, RHCs disproportionately focus on treating Medi-Cal patients. As one market observer noted, "[RHCs] are helping with access, but they select the patient population they want to serve." To the extent this is the case and RHCs continue to grow and take in more Medi-Cal patients, FQHCs could be left with a growing proportion of uninsured patients and related financial strain.

Impacts on Access to Care

The relatively limited attention extended to — and resources available to — the safety net in this community compared to other California communities means that many low-income people's needs remain overlooked and unaddressed. While many low-income people in the Fresno community have gained Medi-Cal coverage since 2014, the associated increase in demand for services has further strained the region's already tight capacity of safety-net providers. While these providers are treating many of the same patients as before — the previously uninsured who now have Medi-Cal coverage — many of these patients are now seeking more services, and providers are seeing new patients as well. In the words of one respondent, "The previously uninsured are accessing care more freely and frequently than before."

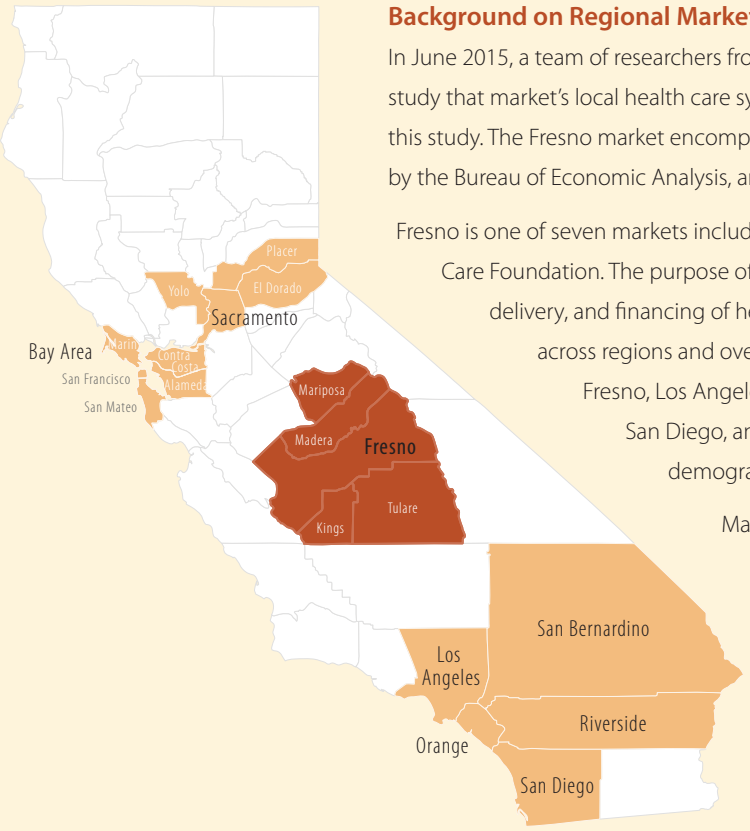
With this growth in demand outpacing provider capacity, many patients are unlikely to be able to obtain timely access to primary, specialty, and behavioral health care in appropriate outpatient settings. The concerted efforts to add primary care through FQHCs and RHCs have incrementally helped improve primary care capacity, and to a lesser extent specialty and behavioral health care, but it remains to be seen how much more this capacity will grow, especially if these facilities cannot recruit needed providers. Also, the ultimate reach and impact of nascent strategies to better coordinate care — namely, through the new collaboration between Adventist and CMC — are unknown. Further, with many resources and efforts focused on the Medi-Cal population, access to care for those who remain uninsured could further decline.

Issues to Track

- What longer-term impact will the Medi-Cal expansion have on access to care for low-income people? How much will community clinic expansions help bridge the gap between the number of people needing services and available provider capacity to treat them?
- How will access to care for the remaining uninsured change? Will RHCs and FQHCs adequately serve this population as they expand? To what extent will the replacement of the medically indigent program in Fresno County with new initiatives impact access to care for uninsured individuals?
- To what extent will current recruiting efforts affect the physician shortage? How will physician shortages impact the various efforts in the market to expand outpatient services and access to care for the many new Medi-Cal enrollees and others?
- Will physician consolidation continue in Fresno County and spread to outlying areas?
- Will new hospital-physician alignments through the development of medical foundations continue to grow? If so, will they foster clinical integration and create meaningful changes in care delivery?
- Will providers be able to develop and demonstrate the ability to manage risk successfully?

ENDNOTES

1. See respective counties' Agricultural Crop and Livestock Reports for 2014.
2. Authors' calculation based on 2014 population estimates from the US Census Bureau.
3. California Office of Statewide Planning and Development (OSHPD), Healthcare Information Division, 2014. Data reflect each hospital system's fiscal year. Number of licensed acute beds and market percentages of licensed acute beds and patient discharges for all hospitals/hospitals systems reflect 2014 OSHPD data. Percentages are based on total discharges in the market.
4. Estimates of discharges generally understate Kaiser's market position because Kaiser generally focuses on reducing admissions and providing care in less intensive settings.
5. OSHPD 2014 data.
6. Kaiser also covers Medi-Cal enrollees in both counties through subcontracts with the local initiatives. Kaiser's Medi-Cal population consists largely of people who either had Kaiser coverage themselves, or who have an immediate family member who has had Kaiser coverage, within the past 12 months.
7. 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 to which federal matching dollars are added; these funds are then redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. With payments beginning in 2010, the program has been renewed three times and currently is set to expire at the end of 2016. However, California voters could approve a ballot initiative in November 2016 that would eliminate the program's end date and require voter approval of further changes to the program.
8. OSHPD 2014 data.
9. Barbara Anderson, "Community Medical Centers to Partner with UCSF Benioff Children's Hospitals," *The Fresno Bee*, September 16, 2015, **www.fresnobee.com**.
10. 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 belong to 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.
11. Through a "friendly PC" model, physicians form a professional corporation (PC), that provides staff for a hospital (or other facility). The PC receives a fee from the hospital to provide management services, such as administering billing and collection for services and paying physicians.
12. Through the Bundled Payments for Care Improvement (BPCI) Initiative, the Center for Medicare and Medicaid Innovations is testing different bundled payment models. The models link payments for all services provided to patients for specific episodes of care with the goal of encouraging providers to deliver higher quality and more efficient care. For more information see "Bundled Payments for Care Improvement (BPCI) Initiative: General Information," Centers for Medicare & Medicaid Services, August 20, 2015, **innovation.cms.gov**.
13. Cassandra Sandoval, "Adventist Health Collaborates with Community Medical Centers to Form New Health Plan," *Hanford Sentinel,* December 23, 2015, **www.hanfordsentinel.com**. Kathy Robertson, "Adventist Health to Launch Medi-Cal HMO Next Year," *Sacramento Business Journal,* December 18, 2015, **www.bizjournals.com**. See respective counties' Agricultural Crop and Livestock Reports for 2014.
14. "Medi-Cal Managed Care Performance Dashboard," California Department of Health Care Services, December 15, 2015, **www.dhcs.ca.gov** (PDF).
15. In part, CalViva's disproportionate growth stems from auto-assignment rules used to assign new beneficiaries who do not choose a plan. The auto-assignment algorithms include assigning new beneficiaries into plans with (1) higher quality scores, (2) higher discharges at disproportionate share hospital (DSH) program hospitals, and (3) PCPs within the county public hospital system.
16. Under California Welfare and Institutions Code Section 17000, all California counties are responsible for providing health care services to their neediest residents, although counties have considerable discretion in setting eligibility criteria (e.g., income and immigration status) and the level of services they provide.
17. In an arrangement known as 1991 realignment, California counties receive funds from state vehicle license fees and sales tax revenues to support county health, mental health, and social services programs. With the expectation that many uninsured residents would gain Medi-Cal or other coverage under the ACA and the need for county medically indigent programs would decline, Assembly Bill 85 transfers either 60% or a formula-based percentage of each county's health fund to social services. Fresno is one of the counties to use the formula, and had to return 44% of its funds to the state.
18. For both initiatives, behavioral health continues to be provided separately, through the separate county behavioral health department.
19. OSHPD community clinic data, 2011 and 2014.



Background on Regional Markets Study: Fresno

In June 2015, a team of researchers from Mathematica Policy Research visited the Fresno region to study that market's local health care system and capture changes since 2011/2012, the last round of this study. The Fresno market encompasses the Fresno-Madera, California, Economic Area, as defined by the Bureau of Economic Analysis, and includes Fresno, Tulare, Kings, Madera, and Mariposa Counties.

Fresno is one of seven markets included in the Regional Market Study funded by the California Health Care Foundation. The purpose of the study is to gain important insights into the organization, delivery, and financing of health care in California and to understand important differences across regions and over time. The seven markets included in the project — Fresno, Los Angeles, Orange County,* 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.

Mathematica researchers interviewed over 200 respondents for this study, with 30 specific to the Fresno market. Respondents included executives from hospitals, physician organizations, community clinics, Medi-Cal health plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.

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*Orange County was added to this study in 2015; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

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