CALIFORNIA
HEALTH CARE ALMANAC
REGIONAL MARKETS ISSUE BRIEF JULY 2009
CALIFORNIA HEALTHCARE FOUNDATION

Los Angeles: Haves and Have-Nots Lead to a Divided System

Los Angeles Market Background

Los Angeles (L.A.) County's population of 9.9 million comprises more than a quarter of all state residents (see Table 1 on page 2). The market's population growth rate has been below the state average (8 percent in the past decade compared with the state average of 14 percent), but it represents a significant number of new residents given the large population base. Besides population size, the L.A. region is remarkable for its diversity. It has a lower proportion of whites, and a higher proportion of African Americans, Latinos, Asians, foreign-born residents, and adults with limited or no English language skills compared with California as a whole.

Los Angelinos face considerable educational, economic, and health challenges. Educational attainment among L.A. residents is somewhat lower than for California as a whole. The proportion of households with annual incomes above $50,000 is lower than the state average, and the proportion of the population living in poverty is significantly higher than for California overall. Unemployment in L.A. reached 10.8 percent in January 2009, nearly two-thirds higher than a year ago and slightly higher than the state average of 10.6 percent. Los Angeles residents are more likely to be uninsured or covered by Medi-Cal than residents of the state as a whole, and they are more likely to report fair or poor health than Californians generally.

Many large employers have left Los Angeles, leaving a market of largely mid- to small-sized firms, although several large firms with headquarters elsewhere do have significant operations in the area. Labor unions are strong in L.A., especially those in the entertainment, health care, and public sectors. Health care unions exercise strong influence over policy decisions such as proposed closures of hospitals and county clinics.

A Fragmented Hospital Market of Haves and Have-Nots

In contrast to hospital markets in northern California, the fragmented L.A. hospital market is not dominated by any one health system, and has not moved toward greater consolidation. In addition to a large safety-net hospital (Los Angeles County + USC Medical Center), the market includes several large and successful institutions that have a corner on the tertiary and quaternary care markets (including three of the market's teaching hospitals: Cedars-Sinai Medical Center, Ronald Reagan UCLA Medical Center, and USC University Hospital), and many small- to mid-sized independent community hospitals that fairly evenly divide the remainder of the market.

On average, hospitals in L.A. are not doing well financially. However, financial well-being is not distributed equally among L.A. hospitals, as they break down into two distinct financial performance categories: the haves and the have-nots. Much of the divergence in fortune is related to geography. Hospitals on the west side of the county tend to serve a predominantly affluent population, and hospitals in other areas of the county serve predominantly low-income people. Of the nearly dozen hospitals that have closed since 2003, most have been in the southern part of the county, where there are higher rates of poverty and fewer health care resources. Financially weak hospitals outnumber financially strong hospitals in the market, and the gap between the two groups is widening. As a hospital respondent explained,

"There are hospitals in L.A. that are doing quite well, and then 40 percent are operating in the red…We have a crisis on our hands."

The geographic variance in hospital performance overlaps with differences in payer mix, leverage with payers, and payment rates. For the financially stronger hospitals, the top two payer sources are commercial insurance and Medicare, which together can account for as much as 80 to 90 percent of their patient volume. For these hospitals, Medi-Cal patients often comprise the third largest patient group, mostly arriving through emergency departments (EDs) or by referral for tertiary and quaternary care, including pediatric specialty care. Other factors also play into these hospitals' success, such as philanthropic support and a substantial volume of Medicare Advantage patients, which boosts profits because the program's private plans offer higher payment rates than fee-for-service Medicare. These hospitals tend to offer more lucrative specialty-service lines and capture related referrals for insured patients. Additionally, the stronger hospitals have developed leverage over health plans, because they are perceived as "must-have" hospitals for plan networks based on their community reputation. Some of these hospitals also benefit from being part of larger systems that can negotiate effectively with plans, which often translates into commercial rates well in excess of what Medicare pays.

The payer mix among the financially weaker hospitals varies considerably but is heavily weighted toward programs for low-income people, with limited revenues from commercial sources and Medicare. These hospitals lack leverage with plans and receive considerably

Table 1. Demographic and Health System Characteristics: Los Angeles County vs. California

POPULATION STATISTICS	Los Angeles	California
Total population	9,878,554	36,553,215
Population growth, 1997–2007	8.4%	13.6%
Population growth, 2002–2007	0.7%	4.1%
AGE OF POPULATION		
Persons under 5 years old	7.4%	7.3%
Persons under 18 years old	27.8%	26.9%
Persons 18 to 64 years old	62.0%	62.5%
Persons 65 years and older	10.2%	10.6%
RACE/ETHNICITY		
White non-Latino	28.7%	43.3%
African American non-Latino	8.4%	5.8%
Latino	47.6%	36.1%
Asian non-Latino	13.1%	11.8%
Other race non-Latino	1.8%	3.1%
Foreign-born	33.8%	25.7%
Limited/no English, adults	38.7%	35.2%
EDUCATION, ADULTS 25 AND OLDER		
High school degree or higher	78.2%	82.9%
College degree or higher	32.8%	35.7%
HEALTH STATUS		
Fair/poor health status	18.4%	15.8%
Diabetes	8.8%	7.8%
Asthma	11.8%	13.6%
Heart disease, adults	6.2%	6.3%
ECONOMIC INDICATORS		
Below 100% federal poverty level	20.8%	15.7%
Below 200% federal poverty level	41.2%	33.5%
Household income above $50,000	44.3%	51.1%
Unemployment rate, January 2009	10.8%	10.6%
HEALTH INSURANCE, ALL AGES		
Private insurance	52.8%	59.1%
Medicare	7.2%	8.5%
Medi-Cal and other public programs	23.8%	19.3%
Uninsured	16.1%	13.2%
SUPPLY OF HEALTH PROFESSIONALS, 2008		
Physicians per 100,000 population	176	174
Primary care physicians per 100,000 population	58	59
Dentists per 100,000 population	64	69
HOSPITALS		
Staffed community, acute care hospital beds per 100,000 population, 2006	214	182
Hospital concentration, 2006 (Herfindahl index)	310	1,380
Operating margin including net Disproportionate Share Hospital payments	–5.3%	1.2%
Occupancy rate for licensed beds	58.5%	59.0%
Average length of stay (days)	4.8	4.5
Paid full-time equivalents per 1000 adjusted patient days	16.0	15.7
Total operating expense per adjusted patient day	$2,245	$2,376

Notes: All estimates pertain to 2007 unless otherwise noted.

Sources: U.S. Census Bureau, Population Estimates, 2007; California Health Interview Survey, 2007; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for Counties: January 2009 — Preliminary, March 2008 Benchmark," March 5, 2009; 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; American Hospital Association Annual Survey Database, Fiscal Year 2006; California Office of Statewide Health Planning and Development, Healthcare Information Division — Annual Financial Data, 2007.

lower payment rates; one respondent cited a lower-end medical-surgical commercial rate of 55 to 60 percent of what Medicare pays. Financially weaker hospitals actively compete for Medi-Cal patients, even though Medi-Cal reportedly pays only 60 to 70 percent of costs, as it may be their only major third-party payer. In addition, serving Medi-Cal patients is a strategy for have-not hospitals to receive Medi-Cal disproportionate share hospital (DSH) funds, which can mean the difference between being profitable or not.

Small community hospitals (many of them have-nots) are reportedly undercapitalized and consequently face difficulty funding construction to comply with the state's seismic requirements, a significant issue for L.A. hospitals. In contrast, some of the larger teaching hospitals either do not need retrofitting or have already completed any necessary renovations or new construction, in part supported by philanthropy.

Prime Healthcare Services has a particularly controversial strategy in L.A. (and elsewhere in California). The firm buys financially ailing hospitals—including three in L.A. County in the past three years—cancels existing commercial contracts, encourages admissions of patients through the ED, and then bills health plans full charges. Prime Healthcare's strategy also included billing patients if the hospital was not paid in full, but a January 2009 state Supreme Court ruling now precludes hospitals from billing ED patients for charges their plans do not pay. While Prime Healthcare's approach has been contentious, it appears to have been successful. For example, it was viewed by some respondents as responsible for the rapid financial turnaround of Centinela Hospital Medical Center. One respondent explained that the root of Prime Healthcare's business model is in the haves/have-nots dichotomy: "If these hospitals had been getting rates from plans and Medi-Cal that [were] the same as those with the clout, this wouldn't have been necessary. The haves and have-nots are causing this."

Overall hospital capacity in the Los Angeles market has shrunk, a trend viewed with concern by respondents amid predictions that the local population will continue to grow substantially. Still, L.A. has a comparatively higher acute care bed ratio per 100,000 residents than the state overall (214 versus 182). The fact that two major teaching hospitals—Ronald Reagan UCLA Medical Center and Los Angeles County + USC Medical Center (LAC+USC)—recently were rebuilt with fewer beds has contributed to concerns about inadequate bed supply. LAC+USC, for instance, was downsized by about 100 beds.

Among the region's hospital closures, the 2007 closure of the county's Martin Luther King Jr.-Harbor Hospital particularly stressed the health care system in L.A. and was widely viewed as poorly planned. The closure was criticized both for having large negative effects on access to care for residents in South L.A. and for burdening neighboring hospitals that these patients turned to for services. Although the county contracted with a number of community hospitals to provide services for the former hospital's patients, respondents suggested that these hospitals may not have had sufficient bed capacity to cope with the increased demand.

At some capacity-strapped hospitals, emergency department wait times are increasing as patients awaiting hospital beds remain in the ED. At these hospitals, walk-in patients experience long wait times and paramedics face long "wall times" as they must "stand at the wall," sometimes for hours, unable to relinquish care until the hospital can admit their patient.

Some respondents suggested that in addition to a shortage of beds, a lack of staff also contributes to hospitals' capacity constraints. As in other areas of the state, L.A. hospitals struggle to maintain a sufficient and affordable supply of nurses. The state-mandated nurse staffing ratios and high levels of unionized workers reportedly create additional staffing pressures for hospitals.

Fiscal Pressures Prompt Physicians to Seek New Opportunities

The supply of physicians in the Los Angeles market is comparable to that of the state on average. There are 58 primary care physicians per 100,000 residents, compared with 59 statewide, and 176 physicians overall per 100,000 residents, compared with 174 statewide. Solo and small-group practice is the dominant physician practice arrangement in Los Angeles. Some specialists have consolidated into single-specialty groups to be better able to support specialized cancer services, such as transfusion centers and radiation therapy. However, such consolidation is often not successful; as one physician respondent explained, "Every time you get five to seven doctors [together], they split apart the next year. There was a cardiology group…of 12 and they fragmented. It seems to be a cultural thing. We don't trust anyone in Los Angeles."

The L.A. market's largest multi-specialty groups are those affiliated with HMOs and include the Kaiser Permanente Medical Group and Healthcare Partners Medical Group. Somewhat smaller, but still large, are the multi-specialty groups affiliated with Cedars-Sinai Medical Center and the UCLA Health System. Most of Cedars-Sinai Medical Center's approximately 2,000 affiliated physicians are part of either the Cedars-Sinai Medical Group or a foundation-model independent practice association (IPA). The UCLA Medical Group serves as the contracting entity for physicians within the UCLA Health System.

How groups and IPAs compensate affiliated physicians varies greatly and no clear "best" way has emerged. IPAs variously use both delegated capitation and fee for service to pay primary care physicians, while several large medical groups typically pay their primary care physicians a salary and a bonus. Common forms of specialist payment include capitation or some form of fee for service.

The delegated capitation model—where a medical group receives fixed per-patient, per-month payments for a specified set of services from health plans and assumes financial risk for delivering care to those enrollees—persists in the market, although its sustainability is unclear as enrollment shifts from HMO to PPO products. Nationally, Healthcare Partners is one of the largest groups outside of Kaiser that continues to engage in delegated capitation. This model is considered a viable strategy for many IPAs in the market and is viewed positively by many physicians who believe it gives them more leverage with plans and more control over patient care.

The L.A. market has numerous IPAs, many of which are relatively small. Physicians tend to align with multiple IPAs, which in turn pressures IPAs to sign up as many physicians as possible to capture sufficient patient volume to ensure financial viability. The larger IPAs divide the market into niches based in part on geography and hospital affiliation, but most strikingly on the insurance status of patients. For example, Physicians' Healthways represents physicians who treat Medi-Cal and Healthy Families patients and is aligned with Cedars-Sinai and Ronald Reagan UCLA medical centers for tertiary care. This does not conflict with the medical centers' affiliated physician organizations, whose interests are predominantly in the commercial market.

Like the hospital market, the physician market in Los Angeles is divided by the financial status of the haves and the have-nots. The have-nots typically include solo practitioners and small groups that lack the efficiencies available to large group practices and the leverage to negotiate good rates with health plans. The haves, mainly the large multi-specialty groups, typically have greater leverage with health plans and enjoy higher reimbursement rates.

LA physicians face a number of pressures that are largely financial: reimbursement not keeping pace with costs, a declining economy, and difficulties with Medicare and Medi-Cal payments (the former, the result of a change in Medicare carriers; the latter, the result of the recent state budget impasse, which delayed payments). To cope with the financial pressures, physicians reportedly have taken out lines of credit, laid off employees, or dropped Medicare and Medi-Cal patients. Specialists are reportedly seeking new

business or compensation opportunities, including accepting capitated payment arrangements that they may have refused several years ago.

Physicians are also looking to hospitals for opportunities to generate additional income. Although alignment between hospitals and physicians has historically been weak in L.A., physicians increasingly are looking to work more closely with hospitals to preserve or bolster their incomes. Los Angeles has had a long tradition of physician-owned ambulatory surgery centers (ASCs), and it is not a new trend for physicians to draw routine ancillary services away from hospitals by doing their own laboratory and imaging services. While hospital-physician joint ventures around ASCs and ancillary services have not been prevalent, interest in partnerships appears to be increasing as changes in federal reimbursement make these enterprises less profitable for physicians and hospitals seek to curtail the loss of patient volume.

Health Plans Face Increasing Costs and Growing Employer Expectations

The health plan market in Los Angeles is not highly concentrated, but mergers and acquisitions have given plans leverage with employers. Anthem's acquisition of WellPoint (Blue Cross of California's parent company), UnitedHealthcare's acquisition of PacifiCare, Health Net's purchase of Universal Care, and Cigna's purchase of Great-West Healthcare have reduced the number of competing plans in the market. These changes have left few plans in the L.A. market with local knowledge and local decision-making authority—only Kaiser, Health Net, and Blue Shield of California.

Kaiser has a significant presence in L.A., reflecting the continued popularity of HMOs in southern California. The general perception in the market is that Kaiser has improved its quality of care and data management capabilities based on a heavy investment in new information technology, including full implementation of an electronic health record (EHR) system. On the other hand, Kaiser's unique, integrated delivery system model creates challenges. Kaiser has faced considerable competition for the business of large national employers that want more product options and prefer to self-fund. In response, Kaiser has devoted substantial effort to developing and offering third-party administrative services to self-insured employers. Kaiser also reportedly faces very high costs for members treated in non-Kaiser facilities, a particular issue for members served in Prime Healthcare Services' hospitals.

Anthem Blue Cross remains strong in Los Angeles, although observers noted some challenges in the process of rebranding itself from Blue Cross of California and moving its headquarters outside of California, particularly staff turnover and a resulting loss of local knowledge. UnitedHealthcare gained a larger footprint in southern California through the acquisition of PacifiCare and is reportedly beginning to rebound from earlier problems with converting provider contracts and claims administration that negatively impacted its reputation and market share. Aetna and Cigna are fairly strong players with national accounts in L.A. because of their well-developed provider networks. Blue Shield of California has a more limited presence in the L.A. market, particularly among national employers. However, Blue Shield has been increasing its presence among small employers by competing more aggressively on price and improving its infrastructure and service. Health Net is respected for its local market knowledge, but reports of its financial fragility led some respondents to question whether it would survive.

With the exception of Kaiser, health plans' provider networks in Los Angeles generally are inclusive and broad. Plans often offer a narrow-network product, which includes a subset of the full network's providers—those providers deemed by the plan to be higher quality and/or lower cost. Anthem offers a narrow-network HMO called Power Select, and Aetna has a "high- performance" specialty network called Aexcel. Health Net offers Salud, a product that targets Latinos and includes a limited network of providers in

L.A., as well as about 200 physicians in Mexico. According to some respondents, these narrow-network products can reduce premiums by about 10 percent.

The main pressures on health plans are to manage costs effectively, compete on price, and maintain or expand enrollment. Plan respondents noted that soaring rates of obesity and multiple chronic diseases pose challenges to managing costs and moderating premium increases. Some employers are demanding wellness programs to address rising costs and want health plans to demonstrate that the financial return on these programs justifies the investment. Plans — particularly for-profit plans faced with shareholders' expectations — also face pressure to increase enrollment, which is a challenge when, for example, employers are reducing dependent coverage.

Health plans use similar strategies to respond to these challenges, and observers noted a distinct lack of differentiation across plans. As one benefits consultant stated, "I would love to say that innovation is a differentiator, but it's not." Plans are reportedly focused on doing a better job of managing the total health care needs of employees through a combination of identifying those who might benefit from more intensive care management, and integrating wellness and disease management programs.

For example, Aetna offers a program — MedQuery — that compares patient claims and other data to evidence-based clinical guidelines to identify omission/commission gaps in care; Aetna guarantees certain rates of return on the fees it charges employers to participate in the program. Anthem purchased Resolution Health, a vendor that mines data to identify inconsistencies in care compared to established clinical guidelines; for example, identifying a member who is not using a clinically recommended drug for the treatment of a chronic disease. Kaiser is emphasizing wellness and prevention, which are cornerstones of its Thrive marketing campaign. Views on the effectiveness of plans' disease management and wellness programs are mixed, and methodologies for measuring return on investment vary significantly.

Employee Benefits Emphasize HMOs, But Other Options Make Headway

Employers continue to use health care benefits as an important recruitment and retention strategy, but the recession has given employers more leverage to make benefit changes with minimal employee pushback. Unions are seen as fostering more robust health benefits and are very influential in the public sector in Los Angeles. In the private sector, unions maintain some influence in the entertainment industry (TV/film), aerospace, and health care.

The popularity of HMOs continues in the L.A. market, as in much of southern California. As of 2006, HMO commercial penetration was 45 percent, comparable to the commercial HMO penetration of 46 percent for California as a whole.[1] Respondents, however, have noted a gradual shift in enrollment from HMOs to PPOs as the premium differential between the two has narrowed. As one health plan executive noted, "We are primarily selling only on a PPO platform. Some are still on HMO, but it's dwindling, primarily because of costs." The difference in cost, according to observers, is in part a result of the higher levels of patient cost sharing in PPOs compared with HMOs.

Another factor behind the erosion of the HMO price advantage has been more stringent interpretation of benefit mandates and broader regulatory scope by the Department of Managed Health Care (DMHC), which oversees HMOs, than by the California Department of Insurance (CDI), which oversees most fully insured PPOs.[2,3] HMOs are at an even greater disadvantage compared with self-insured PPOs, which are not subject to benefit mandates and are minimally regulated by the U.S. Department of Labor. Upcoming implementation of additional mandates, such as those concerning timely access to care and autism treatment, is expected to further affect the costs and competitive position of HMOs. In response, health plans have moved to

create insured PPO products outside the regulatory reach of DMHC. One approach is to buy a life insurance company and create health insurance products under that subsidiary, under much less stringent CDI oversight.

Most large employers offer what has been characterized as the standard dual option: a fixed copayment option in an HMO product, and a PPO option with a deductible of $300 to $500 and 80 percent coinsurance for use of in-network providers. Large employers have increasingly consolidated these offerings to one carrier with the exception that a Kaiser HMO product is also frequently offered. Employers are increasingly moving to products with higher deductibles and reduced benefits to mitigate cost increases. This is particularly true of smaller firms, many of which are struggling to maintain coverage at all. Traditionally, smaller firms have offered HMOs, but these products are becoming less popular with employees because of the increasing cost. As small employers struggle to maintain benefits, they are looking to plans to offer a variety of product and benefit options so they can make changes — increasing patient cost-sharing amounts, for example — without switching plans. Small companies are more willing now than in the past to drop or decrease coverage for spouses or dependents.

Public employee health benefits differ from those in the private sector. Public-sector decisions are largely driven by labor negotiations, so the benefits are generally much richer than for private firms. Los Angeles County, the area's largest public employer, has 100,000 employees with nearly 90 percent represented by unions. The county offers a variety of HMO and PPO options, but most county employees are enrolled in HMOs with fixed-dollar copayments.

Some employers in the Los Angeles market are offering consumer-directed health plans (CDHPs) alongside HMO and PPO options. CDHPs are high-deductible plans with (or eligible for) a health savings account (HSA) or a health reimbursement arrangement (HRA).[4] However, take up of these products is quite low, which is not surprising given the popularity and, at least until recently, relative affordability of HMOs. CDHPs are also less attractive in California than in other states because California does not offer the same favorable tax treatment for HSA contributions as offered by the federal government.

County Anchors Local Safety Net

The Los Angeles County Department of Health Services is the single largest actor in the safety net, operating LAC+USC, the main safety-net hospital, as well as Olive View-UCLA Medical Center, Harbor-UCLA Medical Center, one rehabilitation hospital, two multi-service ambulatory care centers, six comprehensive health centers (offering specialty care and some outpatient surgery), and 11 primary care clinics. A few other private, nonprofit hospitals also provide a fair amount of charity care, especially those located near the former Martin Luther King Jr.-Harbor Hospital. A network of independent community health centers (CHCs) has gained strength over the last ten years, as most of the 42 members of the Community Clinic Association of Los Angeles County have now attained federally qualified health center (FQHC) status and contract with the county for the provision of indigent care.

As in all of California, the county is required to be the provider of last resort for low-income uninsured people who are not eligible for coverage through public programs. In addition, a legal settlement in the 1970s and a more recent lawsuit concerning the downsizing of LAC+USC further established the county's obligations to provide care for low-income residents. The county fulfills this mandate by operating its own health care system and managing several financial access programs for medically indigent people — those with incomes below 133 percent of the federal poverty level and who are not eligible for full Medi-Cal benefits. Of these, a key program is the Public-Private Partnership (PPP), which was developed under a Medicaid waiver that provided federal funding and required the county to create stronger connections between county hospitals and private community health centers. Through the PPP, the

county pays participating clinics to provide primary care for medically indigent individuals.

Local health care is a high priority among county supervisors. Unlike some California counties, L.A. did not divest its county hospitals, which both demonstrates an inherent support of health care and compels local policy makers to be involved in local health care issues as the administrators of a large delivery system.

Moreover, Los Angeles County's somewhat unusual form of government heightens the importance of health care services for local policy makers. Historically, the five county supervisors have had both legislative and executive powers, not only representing their respective districts but also directly overseeing county departments. In this combined role, each supervisor has sought to influence county services (of which health care is among the largest) to the benefit of her/his constituency. Two years ago, the supervisors transformed the county administrator position into a chief executive officer (CEO) position, responsible to the Board of Supervisors for managing all county departments. County departments now report to deputy CEOs (who report to the county CEO); the Health Services, Mental Health, and Public Health agencies report to a single deputy CEO. Respondents suggested that this new model is still a work in progress, as supervisors continue at times to involve themselves in administrative matters.

As a result of lower than expected revenues from state realignment funds (from vehicle license fees and sales taxes) as well as rising costs, the county Department of Health Services faces a projected cumulative deficit of $344 million through fiscal year 2009–10 out of a total budget of $3.5 billion.[5,6] Although the county is reportedly committed to providing care, one respondent said, "They find themselves in such a deficit with aging facilities that they can't keep going, and three hospitals that have to be brought up to seismic standards by 2013."

The county supervisors have considered expanding the PPP program by transferring more primary care from county-owned clinics to contracted CHCs. The experiences with the Martin Luther King Jr.-Harbor Hospital closure and a previous closure of some county clinics, however, have made many wary of this proposal, because of fears—heightened by the budget crisis—that services will just disappear. In addition, the unions that represent public employees are reportedly resistant to closing county clinics. So the county is starting slowly, issuing a request for a statement of interest for an organization to provide services in one area, Glendale, north of downtown L.A., instead of the existing county clinic.

In addition, the supervisors decided to make a one-time allocation of approximately $45 million from tobacco settlement funds to the PPP program to rectify inequities in county safety-net funding. Much of this money is to be used for physical plant and information technology improvements and expanded services in "under-equity" areas: districts of the county, notably South L.A., that have historically received proportionately less funding. To be used over three years, this allocation represents the largest single infusion of county funds into the PPP program since its inception in 1997.

Efforts to Strengthen Safety Net Amid Rising Demand

By most accounts, the safety net in Los Angeles is well developed and stronger than it was ten years ago. Overall demand for care by low-income people, however, has been increasing in Los Angeles County. Given the economic downturn, demand is expected to increase across populations, including the newly unemployed and lower-middle-income workers whose employers have dropped insurance or who are unable to pay for the coverage offered. Increased demand is stretching safety-net resources, which already are strained, to provide access to such services as mental health care, dental care, and urgent and emergency care. Specialty medical care for low-income and uninsured residents is particularly difficult to access, with appointment wait times for some services reportedly averaging six to nine months. As one respondent explained, "Once people get into

the system it works for them. It is getting into the system [in the first place that is difficult]."

The Los Angeles Healthy Kids program is one of more than 20 similar initiatives across California that uses government and charitable grants to provide coverage for uninsured children. The program targets all uninsured children through age 18 who are ineligible for public programs such as Medi-Cal. About 30,000 children in L.A. reportedly have coverage through the program, but enrollment is currently closed for children ages 6 to 18 because of limited funding.

Among local efforts to strengthen the safety net is a plan by county officials to renovate and reopen Martin Luther King Jr.-Harbor Hospital by 2012 to include inpatient and emergency department services. The University of California has tentatively agreed to form a new nonprofit corporation with the county to operate the hospital. If approved by the UC Board of Regents, UCLA would provide physician services and medical oversight but no financial support. In April 2009, the Los Angeles Healthcare Options Task Force published its proposal for "achieving a high-quality, integrated safety net healthcare delivery system in L.A. County," which included a recommendation that a reopened Martin Luther King Jr.-Harbor Hospital be part of an integrated safety-net system.[7]

Safety-net providers are engaged in several initiatives that aim to increase the efficiency and capacity of the overall system. Notable among these efforts are increased collaborations among organizations. For example, the Southside Coalition of Community Health Centers, a group of seven CHCs with a total of 15 to 20 sites and a member of the countywide CHC association, has developed a model to strengthen specialty referrals. The coalition coordinates which organization will be the focus of specific specialty services—podiatry, speech therapy, cardiology, ophthalmology, and perinatology—and then coordinates referrals accordingly, providing transportation between CHCs as needed. Camino de Salud, a partnership between LAC+USC hospital and 10 clinics in the surrounding area, is working to increase access to primary and specialty care through a medical-home pilot. The pilot includes a dedicated case manager to connect patients needing frequent hospital visits to a CHC and to ensure these patients are treated more effectively by training clinic family practitioners through "mini-fellowships." To facilitate the pilot, the California HealthCare Foundation funded COPE Health Solutions, a local consulting firm.

LA Health Action, initiated about five years ago by the California Endowment, also has several efforts aimed at strengthening the safety net, including the LA Health Collaborative. Involving about 80 organizations, the collaborative is focused on improving working relationships between the public and private sectors of the safety net; as one respondent put it, "The county doesn't have a strong history of that." In the midst of the state budget crisis, the collaborative reportedly was developing a plan to prepare L.A. for health care reform. "In some ways, when you have crises, that's when you have your moments and people come together," observed one respondent.

Medi-Cal Managed Care Garners Support

Managed care for Medi-Cal beneficiaries is mandatory for families and voluntary for the aged, blind, and disabled population. About half of L.A. residents covered by Medi-Cal are in managed care, which is provided through a two-plan model. In the two-plan model, Medi-Cal enrollees have a choice of a public health plan or a private one. In Los Angeles, L.A. Care, the public plan, has about two-thirds of the Medi-Cal managed care enrollees, and Health Net, the commercial plan, has the remainder. This enrollment split reportedly has been stable over recent years. L.A. Care is an umbrella organization that subcontracts with several private health plans: Anthem Blue Cross (the largest with 346,000 Medi-Cal members), Care First (a privately held plan that was created to participate in L.A. Care), Community Health

Plan, and Kaiser. In 2006, L.A. Care also began offering its own product, L.A. Care Health Plan, under the umbrella.

The intent of the two-plan model is to provide enrollees with a choice of plans and promote competition, while also supporting safety-net providers. Safety-net providers in L.A. largely support the two-plan model for a variety of reasons; for example, representatives of FQHCs sit on the board of L.A. Care, and safety-net providers can benefit from the competition, playing one plan against another. In addition, L.A. Care is viewed as a strong partner with safety-net providers, giving grants for infrastructure and service-delivery innovations; steering Medi-Cal patients to safety-net providers; and supporting community public health programs. This positive view of L.A. Care, however, is not universal; some observers pointed to the plan's umbrella structure — in which L.A. Care coordinates but also competes with the other plans — as being a conflict of interest.

The state's low Medi-Cal provider payment rates are a major concern in Los Angeles, adversely affecting the willingness of providers to serve Medi-Cal patients. The state reduced Medi-Cal fee-for-service rates for many providers and services (excluding some inpatient acute care service providers and FQHCs) by 10 percent in July 2008. A court injunction stalled the cuts until March 2009, and a federal judge has since blocked them from taking effect. But worsening budget problems may result in further cuts, including services such as dental care, that have been spared so far. Any payment cuts are expected to reduce already inadequate provider participation in Medi-Cal.

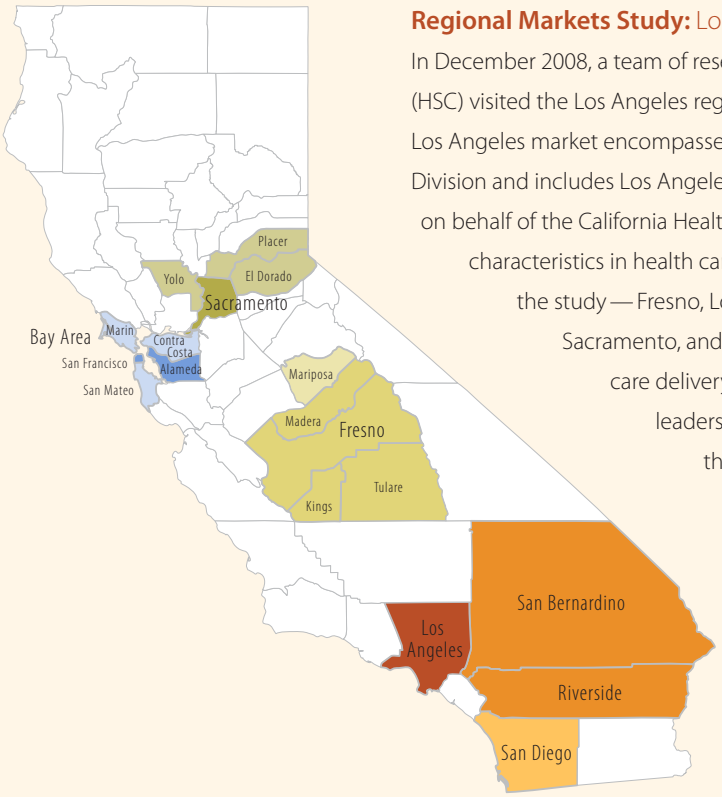
Issues to Track

The hospital and physician markets in L.A. are highly fragmented, with no single dominant organization. Hospitals and physicians do compete, but the competition has not been aggressive and numerous examples of collaboration exist, including a new trend toward hospital-physician joint ventures. HMOs remain dominant in L.A., but PPOs are gradually gaining ground as purchasers seek lower premiums and health plans seek the less stringent regulatory oversight that PPOs enjoy in California. The safety net is stronger than it was a decade ago, largely because of the efforts of local leadership, but financial and other challenges persist. The following are among the key issues to track:

- Will the gap continue to widen between have and have-not providers? Will there be more hospital consolidation in response to increasing financial and other pressures, including the hospitals' need to secure capital to fund construction to meet state seismic requirements?
- Will the recession result in tighter alignment between hospitals and physicians? What influence will the recession have on hospital-physician relationships?
- Will the shift from HMO to PPO products continue? What impact will it have on hospital-physician relationships? On costs?
- As the Los Angeles safety net evolves, what will be the impact on access by residents and demand on other area providers? Will Martin Luther King Jr.-Harbor Hospital reopen? To what degree will there be a shift of primary care from county clinics to FQHCs via the PPP program?

ENDNOTES

1. Cattaneo & Stroud, Inc., 2006 California Statewide HMO & Special Programs Enrollment Study, Burlingame, CA (2008).
2. While most PPOs are regulated by CDI, most Blue Cross and Blue Shield PPO products operate under Knox-Keene licensure, putting them under DMHC regulatory control. See Roth, Debra L. and Kelch, Deborah Reidy, Making Sense of Managed Care Regulation in California, California HealthCare Foundation Report, The California HealthCare Foundation (CHCF), Oakland, CA (November 2001).
3. For example, DMHC's regulatory scope includes quality of care while CDI's does not. Also, products under DMHC jurisdiction are required to provide all "medically necessary basic health care services," including services such as maternity; products under CDI jurisdiction have no equivalent requirement.



Regional Markets Study: Los Angeles

In December 2008, a team of researchers from the Center for Studying Health System Change (HSC) visited the Los Angeles region to study that market's local health care system. The Los Angeles market encompasses the Los Angeles-Long Beach-Glendale, California, Metropolitan Division and includes Los Angeles County. Los Angeles is one of six markets being studied on behalf of the California HealthCare Foundation to gain important insights into regional characteristics in health care affordability, access, and quality. The six markets included in the study — Fresno, Los Angeles, Oakland/San Francisco, Riverside/San Bernardino, Sacramento, and San Diego — reflect a range of economic, demographic, health care delivery, and financing conditions in California. Fifty-two interviews of leaders in the Los Angeles health care market were conducted to inform this report.

▶ ACCESS THE ENTIRE REGIONAL MARKETS SERIES HERE.

4. HSAs are tax-favored accounts that must be linked to health plans with minimum deductibles of $1,100 for self-only coverage and $2,200 for family coverage in 2008; HRAs are accounts funded and owned by the employer; no companion health plan is required. HRA contributions are not subject to business income tax, and unused funds revert to the employer when the employee retires or leaves the company.

5. Realignment funds, derived from sales tax and vehicle license fees, were allocated to the counties when the state shifted responsibility for health and social services to the county governments. The formula for distribution of the funds was based on historical spending levels and is not updated each year based on population and population in poverty.

6. On April 2, 2009, the supervisors received an updated budget outlook memorandum that estimated the total deficit for this fiscal year and next at $344 million.

7. Los Angeles Healthcare Options Task Force, *Achieving the Vision: Healthcare Options for Los Angeles County* (April 2009), www.calendow.org (accessed May 29, 2009).

ABOUT THE AUTHORS

Aaron B. Katz, Allison Liebhaber, Robert A. Berenson, Elizabeth A. November, and Johanna R. Lauer, **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 policy makers in government and private industry. More information is available at www.hschange.org.

ABOUT THE FOUNDATION

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit 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/topics/almanac.

Table A. Demographic and Health System Characteristics: Six Selected Regions vs. California (SUPPLEMENT TO THE *CALIFORNIA HEALTH CARE ALMANAC REGIONAL MARKETS* ISSUE BRIEF SERIES)

POPULATION STATISTICS	Fresno	Los Angeles	Riverside/ San Bernardino	Sacramento	San Diego	San Francisco Bay Area	California
Total population	1,634,325	9,878,554	4,081,371	2,091,120	2,974,859	4,203,898	36,553,215
Population growth, 1997–2007	21.6%	8.4%	33.9%	26.3%	9.2%	6.6%	13.6%
Population growth, 2002–2007	9.0%	0.7%	16.1%	8.3%	2.3%	0.6%	4.1%
AGE OF POPULATION							
Persons under 5 years old	8.7%*	7.4%	7.6%	6.8%	7.4%	6.4%	7.3%
Persons under 18 years old	30.6%*	27.8%	29.7%	26.4%	26.7%	22.2%	26.9%
Persons 18 to 64 years old	60.3%*	62.0%	60.9%	62.4%	62.7%	65.9%	62.5%
Persons 65 years and older	9.1%*	10.2%	9.4%	11.1%	10.6%	11.9%	10.6%
RACE/ETHNICITY							
White non-Latino	37.4%*	28.7%	42.0%	59.7%	53.7%	46.2%	43.3%
African American non-Latino	4.0%*	8.4%	7.1%	6.4%	5.3%	8.3%	5.8%
Latino	50.8%*	47.6%	42.9%	18.9%	29.0%	20.8%	36.1%
Asian non-Latino	5.3%*	13.1%	5.3%	10.4%	8.7%	20.4%	11.8%
Other race non-Latino	2.6%*	1.8%	2.7%	4.6%	3.3%	4.2%	3.1%
Foreign-born	20.4%*	33.8%	20.9%	15.1%	20.3%	27.5%	25.7%
Limited/no English, adults	41.3%*	38.7%	30.5%	28.5%	26.1%	27.6%	35.2%
EDUCATION, ADULTS 25 AND OLDER							
High school degree or higher	71.9%*	78.2%	81.5%	89.9%	87.6%	89.7%	82.9%
College degree or higher	22.2%*	32.8%	24.5%	38.3%	40.6%	49.4%	35.7%
HEALTH STATUS							
Fair/poor health status	19.8%*	18.4%	15.0%	12.3%	12.3%	12.5%	15.8%
Diabetes	10.5%*	8.8%	8.5%	6.5%	6.3%	7.0%	7.8%
Asthma	16.7%*	11.8%	13.0%	18.5%	12.8%	14.6%	13.6%
Heart disease, adults	6.4%*	6.2%	6.3%	6.5%	6.4%	5.5%	6.3%
ECONOMIC INDICATORS							
Below 100% federal poverty level	24.0%*	20.8%	14.8%	11.6%	11.0%	11.0%	15.7%
Below 200% federal poverty level	45.1%*	41.2%	35.2%	25.7%	26.4%	22.4%	33.5%
Household income above $50,000	39.7%*	44.3%	50.9%	54.9%	56.7%	61.6%	51.1%
Unemployment rate, January 2009	15.5%	10.8%	11.8%	10.4%	8.6%	8.4%	10.6%
HEALTH INSURANCE, ALL AGES							
Private insurance	46.8%*	52.8%	58.7%	66.8%	63.9%	69.3%	59.1%
Medicare	7.0%*	7.2%	7.7%	9.4%	8.8%	9.6%	8.5%
Medi-Cal and other public programs	30.5%*	23.8%	18.5%	15.1%	14.9%	13.4%	19.3%
Uninsured	15.7%*	16.1%	15.1%	8.6%	12.5%	7.8%	13.2%
SUPPLY OF HEALTH PROFESSIONALS, 2008							
Physicians per 100,000 population	118	176	110	191	187	239	174
Primary care physicians per 100,000 population	45	58	40	63	60	79	59
Dentists per 100,000 population	43	64	47	74	70	89	69
HOSPITALS							
Staffed community, acute care hospital beds per 100,000 population, 2006	173	214	142	146	171	211	182
Hospital concentration, 2006 (Herfindahl index)	702	310	542	2,178	1,468	1,176	1,380
Operating margin including net Disproportionate Share Hospital payments	3.0%	–5.3%	1.3%	7.1%	5.3%	3.4%	1.2%
Occupancy rate for licensed beds	67.9%	58.5%	64.0%	70.7%	67.4%	56.4%	59.0%
Average length of stay (days)	4.4	4.8	4.3	4.3	4.4	4.9	4.5
Paid full-time equivalents per 1000 adjusted patient days	15.0	16.0	15.0	17.3	14.9	15.9	15.7
Total operating expense per adjusted patient day	$1,883	$2,245	$2,110	$2,731	$2,182	$2,934	$2,376

Notes: All estimates pertain to 2007 unless otherwise noted. Fresno region includes Fresno, Kings, Madera, Mariposa and Tulare counties. Sacramento region includes El Dorado, Placer, Sacramento, and Yolo counties. San Francisco Bay region includes Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties.

*Estimate does not include Mariposa County because the California Health Interview Survey public-use dataset does not report separate estimates for very small counties such as Mariposa.

Sources: U.S. Census Bureau, Population Estimates, 2007; California Health Interview Survey, 2007; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for Counties: January 2009 — Preliminary, March 2008 Benchmark," March 5, 2009; 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; American Hospital Association Annual Survey Database, Fiscal Year 2006; California Office of Statewide Health Planning and Development, Healthcare Information Division — Annual Financial Data, 2007.