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Los Angeles:
Fragmented Health Care Market Shows Signs of Coalescing

Summary of Findings

Illustrating the fragmented nature of the Los Angeles (LA) health care market, scores of hospitals and numerous physician practices are scattered across a vast and congested area that is home to 10 million people. With the exception of Kaiser Permanente, hospital systems and physician organizations tend to operate in isolated silos without an extensive footprint across the county. Emerging market trends and expected changes under national health reform are prompting many providers to pursue new strategies to ensure their viability.

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

- **Intense competition for physicians.** Physician organizations, hospitals, and others are seeking new, tighter affiliations with physicians to gain patients, compete with Kaiser Permanente, and prepare for health reform. The two largest physician organizations, HealthCare Partners and Heritage Provider Network, are growing both their medical groups and independent practice associations (IPAs). In November 2012, national dialysis provider DaVita purchased HealthCare Partners, which also operates in other states.
- **Growing interest in affiliations among hospitals.** Although the market is generally considered to have excess inpatient beds, some hospitals face capacity constraints. Hospitals are starting to consider affiliating or even merging with each other, in part to help adjust capacity, expand referral bases, organize service-line strategies, and improve care coordination. The more prestigious and financially healthier hospitals (including UCLA) have been at the forefront of these activities.
- **Physician organizations leading integration efforts.** Given their experience in accepting financial risk for patient care, LA physician organizations are spearheading efforts to develop accountable care organizations (ACOs). For example, HealthCare Partners and Heritage Provider Network are participating in Medicare ACOs, while HealthCare Partners is also working with Anthem Blue Cross in a commercial ACO.
- **Fresh leadership for the county's safety net.** New health department leadership is redesigning the extensive county-operated delivery system, which includes hospitals, outpatient centers, and primary care clinics, and collaborating with private hospitals and community health centers. These changes are intended to help both public and private safety-net providers remain financially viable, use existing capacity efficiently to serve more patients, and improve patient care, especially as the county prepares to enroll many uninsured residents into Medi-Cal under reform.
- **Safety-net interest in ACOs.** Unlike other markets studied, there has been substantial ACO activity for the Medi-Cal population, with two such entities under

development that include safety-net hospitals, community health centers, and Medi-Cal health plans.

Market Background

Los Angeles County's diverse economy helped insulate the community from significant job losses and declining rates of private health insurance that afflicted many other California communities during the economic recession. With approximately 10 million residents, Los Angeles County is the most populous county in the United States and home to more than a quarter of California's residents. After rapid growth between 2000 and 2005, the county's population has stabilized in recent years. Still, the greater LA region is the most densely populated urban area in the country, and significant traffic congestion leads many to seek medical care close to home, contributing to the fragmented nature of the health care market.[1]

Los Angeles also is known for its racial and ethnic diversity. Compared to California overall, the county has a lower percentage of White residents and higher proportions of Black, Latino, and Asian residents. The county attracts many foreign-born residents and people with limited to no English language skills, creating serious challenges for providers to serve them effectively. Notably, the rest of California is catching up with LA in population diversity, as immigrant populations grew faster in other parts of the state between 2007 and 2009.

The socioeconomic status of LA residents is somewhat lower than in the rest of the state. In 2009, the percentage of LA residents living in poverty was higher than the state average

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

	Los Angeles	California
POPULATION STATISTICS, 2010		
Total population	9,818,605	37,253,956
Population growth, 10-year	3.1%	10.0%
Population growth, 5-year	0.1%	4.1%
AGE OF POPULATION, 2009		
Persons under 5 years old	7.2%	7.3%
Persons under 18 years old	26.7%	26.3%
Persons 18 to 64 years old	62.7%	62.8%
Persons 65 years and older	10.6%	10.9%
RACE/ETHNICITY, 2009		
White non-Latino	27.9%	42.3%
Black non-Latino	8.4%	5.6%
Latino	48.3%	36.8%
Asian non-Latino	13.1%	12.1%
Other race non-Latino	2.4%	3.1%
Foreign-born	33.0%	26.3%
EDUCATION, 2009		
High school diploma or higher, adults 25 and older	77.6%	82.6%
College degree or higher, adults 25 and older	35.2%	37.7%
HEALTH STATUS, 2009		
Fair/poor health status	18.0%	15.3%
Diabetes	10.9%	8.5%
Asthma	12.5%	13.7%
Heart disease, adults	5.8%	5.9%
ECONOMIC INDICATORS		
Below 100% federal poverty level (2009)	22.7%	17.8%
Below 200% federal poverty level (2009)	42.9%	36.4%
Household income above $50,000 (2009)	43.7%	50.4%
Unemployment rate (2011)	13.3%	12.4%
Foreclosure rate* (2011)	4.7%	n/a
HEALTH INSURANCE, ALL AGES, 2009		
Private insurance	50.8%	55.3%
Medicare	7.7%	8.8%
Medi-Cal and other public programs	24.6%	21.4%
Uninsured	17.0%	14.5%
SUPPLY OF HEALTH PROFESSIONALS, PER 100,000 POPULATION, 2008		
Physicians	176	174
Primary care physicians	58	59
Dentists	64	69
HOSPITALS, 2010		
Community, acute care hospital beds per 100,000 population	204.6	178.4
Operating margin with net disproportionate share hospitals (Kaiser excluded)	–1.2%	2.4%
Occupancy rate for licensed acute care beds (Kaiser included)	60.3%	57.8%
Average length of stay (in days) (Kaiser included)	4.8	4.5
Paid full-time equivalents per 1,000 adjusted patient days (Kaiser excluded)	15.8	15.8
Total operating expense per adjusted patient day (Kaiser excluded)	$2,677	$2,856

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

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

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(22.7% vs. 17.8%), and the proportions of uninsured residents (17.0%) and those with Medi-Cal or other public coverage for low-income people (24.6%) were higher than the state averages of 14.5% and 21.4%, respectively. The proportion of LA residents with commercial insurance fell slightly between 2007 and 2009, from 52.8% to 50.8%, slightly less than the statewide decline. The county unemployment rate has tracked the state's, peaking at about 13% in July 2010 and declining to 11.8% in March 2012 (the month of the site study).

Socioeconomic status varies significantly across the county, however. The more affluent areas include the San Fernando Valley, West LA, San Gabriel, and South Bay, while South LA and the Metro areas have the lowest incomes. West LA and South LA display some of the starkest differences in socioeconomic status. For example, in 2009, the percentage of uninsured residents in West LA was significantly lower than in South LA (11.6% vs. 26.4%), and 8.1% of residents in West LA lacked a usual source of health care, compared to 22.3% of South LA residents.[2]

Efforts to Align Physicians

While hospital-physician alignment has been historically weak in this region, hospitals and physician organizations are seeking more and closer relationships with physicians for a variety of reasons. As people lose private insurance, hospitals are redoubling efforts to shore up admissions and patient referrals. Hospitals and physician organizations interviewed also view physician alignment as an important component of participating in ACOs and other new payment arrangements. Strengthening physician alignment is also a way for non-Kaiser providers to compete with Kaiser Permanente's integrated delivery system, which includes the Southern California Permanente Medical Group with almost 2,000 physicians.

Other than Kaiser, no private physician organization has a footprint over the entire Los Angeles market. Most physicians practice in small or midsized groups and participate in IPAs that negotiate health maintenance organization (HMO) contracts. Independent primary care physicians (PCPs) tend to belong to one or two IPAs; specialists tend to participate in multiple IPAs to gain sufficient patient volume. Physicians — primarily PCPs — increasingly are moving to exclusive relationships with IPAs as physicians become comfortable with a given IPA's payment rates, information technology, and volume of patient referrals. To provide nearby options for patients needing hospital care, physician organizations typically contract with multiple hospitals across geographic areas rather than aligning with particular hospitals.

The largest physician organizations in the market focusing on Medicare and commercially insured patients — HealthCare Partners and Heritage Provider Network — are both primarily IPAs but also own medical groups and have a presence beyond Los Angeles. In LA, HealthCare Partners contracts with about 3,900 physicians through an IPA and employs 700 physicians in a medical group. Heritage has approximately 1,800 physicians in an IPA and employs another 700 physicians in a medical group. Since 2008, both physician organizations have expanded their physician networks significantly.

As part of a plan to expand nationally, HealthCare Partners was acquired by DaVita, a publicly traded national dialysis provider based in Denver. According to market observers and media reports, DaVita was interested in diversifying and was seeking a partner with experience in coordinating patient care. Also, HealthCare Partners needed capital to finance growth but reportedly was not interested in merging with a health plan or hospital. Both DaVita and HealthCare Partners may also be motivated by preparations for new payment arrangements under health reform.[3]

Los Angeles hospitals also are pursuing physicians by expanding medical foundations, affiliated physician organizations, and faculty practices, and by aligning with IPAs.[4] The largest hospital-affiliated physician organizations include the faculty practices of UCLA Medical Group (1,500 physicians), Cedars-Sinai Medical Delivery Network

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with about 900 physicians aligned through a medical foundation, and USC Medical Group (500 physicians). Providence Health & Services (a large system with five hospitals) sponsors a foundation called Providence Medical Institute, which has grown to approximately 200 physicians. The health system also operates a joint venture with 650 independent physicians, called Providence Partners for Health, to promote clinical integration and data sharing.

These hospitals and systems have particularly strong reputations and resources, making them attractive to physicians. In addition, the hospitals strive to be physician friendly and take multiple approaches to alignment. For example, Cedars-Sinai has a half-dozen options for physicians under its foundation, including a medical group, an IPA, an exclusive contract with a hospitalist group, and three specialized physician organizations focused on particular conditions (heart transplants, hematology/oncology, and patients with workers' compensation claims).

Fragmented and Overbedded Hospital Market

Of the more than 80 hospitals in Los Angeles, many are standalone facilities, while some belong to one of 14 systems with two or more hospitals. No hospital or system dominates the overall market. In 2010 (the most recent year for which public data is available), Kaiser, with seven hospitals, had the largest market share with 11.8% of total discharges, followed by the county-operated Los Angeles County - University of Southern California (LAC+USC) Healthcare Network (four hospitals) with 7.7% of discharges; Providence Health & Services with 7.3% of discharges; and Dignity Health (four hospitals) with 6.0% of discharges.[5] No hospital system beyond Kaiser has extensive enough geographic coverage to claim a market-wide presence or to gain efficiencies by, for example, consolidating services among its own hospitals.

The financial picture for non-Kaiser hospitals varies and is closely related to their payer mixes: the proportions of privately insured, Medicare, Medi-Cal, and uninsured patients served. In 2008, hospitals fell into two distinct financial categories: the haves and have-nots. Following the closure of nearly a dozen hospitals in the last decade and improved financial performance for some hospitals, this distinction has broadened to include a middle category of hospitals that are performing moderately well financially.

Hospitals in the market tend to be one of three types:

- **Academic medical centers (AMCs)** and other teaching hospitals that have strong leverage with health plans, a good payer mix, and solid financial performance, due in part to their reputations, teaching, and tertiary/quaternary services. Cedars-Sinai Medical Center, UCLA Health System (two hospitals), Keck Hospital of USC, and Providence Health & Services are all examples of this type.
- **Smaller and midsized community hospitals** with a balance of privately insured and lower-income patients, and average financial performance. Many are independent, such as Good Samaritan Hospital and Hollywood Presbyterian Medical Center. Several hospitals are owned by Prime Healthcare or other for-profit systems. Tenet Healthcare sold several struggling hospitals to other nonprofit or for-profit systems in 2008–09.
- **Safety-net hospitals** that primarily serve Medi-Cal and uninsured patients, and are struggling with financial performance. These include the county system, Daughters of Charity (two hospitals), Adventist Health Systems (two hospitals), and California Hospital Medical Center (part of Dignity; other Dignity hospitals fall into other categories).

Although Los Angeles hospitals as a group are faring better financially since 2008, many are still operating in the red. Most hospitals face downward pressure on patient care revenues because of relatively high and slightly rising shares of Medi-Cal and uninsured patients and a declining

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proportion of privately insured patients. The average operating margin of hospitals across the county was −1.5% in 2010, compared to −5.4% in 2008. But the financially strong hospitals continued to fare better given their more profitable payer mixes and ability to negotiate higher payment rates from insurers. In 2010, Cedars-Sinai reported a 7.6% operating margin, and UCLA's margin improved considerably to 14.3%.[6] In contrast, the county hospital system continued to face significant operating losses in 2010.

The financial picture of the LA market may be related to the number of hospital beds in the region. While licensed inpatient beds in the county declined 4.5% between 2008 and 2010, market observers continued to believe that LA overall has too much inpatient capacity. LA had 205 acute care hospital beds per 100,000 people in 2010, compared to a state average of 181. Additionally, inpatient discharges for the overall market fell 1.5% between 2008 and 2010. The volume decline was generally attributed to a drop in elective procedures during the recession, which put additional pressure on some already struggling hospitals.

However, some hospitals face strained inpatient capacity because of growing demand for or reductions in available beds. Kaiser, Providence Health & Services, Cedars-Sinai, and UCLA are operating at or above capacity. Generally, LA hospitals are ahead of other California markets in terms of retrofitting or rebuilding facilities to comply with seismic requirements. In the course of upgrading or building new facilities over the last few years, some hospitals reduced inpatient capacity. For example, UCLA's Ronald Reagan and Santa Monica hospitals now have fewer licensed beds.

Hospitals Consider New Relationships

After a raft of hospital closures, caused in part by cash-strapped hospitals' inability to meet new seismic standards, no additional hospitals have closed since 2008 — but a number of hospitals have changed ownership or have affiliated with larger systems. In 2008, Providence acquired Tarzana Regional Medical Center from Tenet, while St. Francis and St. Vincent Medical Centers, both part of the Daughters of Charity Health System, were recently acquired by Ascension Health, a Catholic organization and the country's largest nonprofit health care system. As some smaller hospitals continue to struggle financially, market observers reported that more acquisition and affiliation activity is likely if smaller, independent hospitals are to keep up with needed capital improvements.

To help adjust overall inpatient capacity to better meet current needs while preparing for changes under reform that may require less bed capacity, some hospitals are starting to explore tighter affiliations and even mergers. Generally, financially stronger hospitals are considering partnerships with other well-located hospitals with good payer mixes. The financially stronger, larger hospitals are interested in working with smaller hospitals to grow capacity, while the smaller, struggling hospitals need financial support to invest in capital improvements, particularly if they have not yet met seismic requirements. The partnerships also are geared toward serving patients in the most efficient setting to contain costs — for example, by referring more-routine admissions to less expensive community hospitals and more-specialized cases to higher-cost teaching facilities. Hospitals believe these changes will help them compete for newly insured patients and prepare for new payment arrangements under health reform.

For example, Cedars-Sinai is focusing on expanding lucrative service lines, such as organ transplants and neurosurgery, while UCLA is seeking to increase its geographic reach beyond West LA into South Bay, the San Fernando Valley, and Downtown LA. UCLA's flagship facility, Ronald Reagan UCLA Medical Center, is expected to transition into a predominantly tertiary/quaternary care facility, while more-routine admissions would go to UCLA Medical Center, Santa Monica, and to new partners in areas where UCLA now lacks a presence. Market observers expected additional alignments among hospitals. An executive at a smaller hospital described the situation this way: "All of a sudden I am getting asked to the prom."

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Health plans have had difficulty using the market's overall excess inpatient capacity to hold down payment rate increases because of the need to cover distinct submarkets. The result is that health plan leverage varies based on available capacity in a given region. A market observer noted, "It's totally a case of mini-market by mini-market. Health plans will say in certain areas that hospitals have the advantage, but in other areas hospitals have less leverage."

Still, hospitals — even those with considerable leverage — are feeling downward pressure from health plans on payment rates. Health plans reportedly are moderating payment rate increases and indicating willingness to sever ties with providers that command high payment rates. Notably, Anthem Blue Cross is now offering an HMO product with a more limited network of providers (it excludes Cedars-Sinai and UCLA) to city of Los Angeles employees.[7]

Physicians at Forefront of ACO Development

Los Angeles has had an early start establishing several ACOs: groups of providers that take responsibility for a defined patient population and work to improve the quality and efficiency of patient care. Typically, ACO arrangements include providers assuming some financial risk for patient care, or mechanisms for providers and payers to share any savings. Some LA providers — many already experienced in assuming financial risk for patient care — and payers view ACOs as a way to compete with Kaiser's integrated delivery system.

The area's largest physician organizations, HealthCare Partners and Heritage Provider Network, are in the vanguard of developing ACOs in the LA market, unlike in other regions, where hospitals tend to lead the way. This may be due in part to LA lacking hospitals with broad geographic reach, the absence of tight alignment between hospitals and physicians, and the absence of other conditions favorable to ACO development found in some other markets, particularly Sacramento. Both HealthCare Partners and Heritage Provider Network are participating in Medicare Pioneer ACOs for fee-for-service beneficiaries, capitalizing on their experience and expertise in managing care for their Medicare Advantage patients.[8] HealthCare Partners is working with Providence Health & Services in its Medicare Pioneer ACO.

HealthCare Partners also is participating in the Anthem Blue Cross ACO in LA. After completing a pilot phase in 2011, Anthem implemented two new fully insured products in January 2012: The ACO Core is a narrow-network preferred provider organization (PPO) aimed at small groups and consists of a network of ACO providers only; the ACO Flex is a PPO aimed at large groups and has three tiers of providers. The first (preferred) tier consists of the ACO providers, the second tier consists of the other PPO providers, and the third consists of non-network providers. Patients have lower cost-sharing when using providers in the preferred tier. Anthem currently pays ACO providers fee-for-service rates plus monthly incentive payments for managing care. It intends eventually to implement partial capitated payments and ultimately adopt global payments. The Anthem Blue Cross ACO — the umbrella ACO and the Core and Flex products within it — has a shared-savings pool; participating providers that meet quality targets share any savings and currently do not face downside risk. The health plan returns any savings it accrues in the form of lower premiums.

Safety Net Stretched

With approximately 4 million Los Angeles residents covered by Medi-Cal or uninsured, the community relies on an extensive safety net. Since 2008, the number of people on Medi-Cal or without insurance has increased only slightly, and payer mixes for safety-net providers have been relatively stable.

The county-operated hospital and clinic system remains LA's major safety-net provider. LAC+USC is the county system's flagship hospital; the system also includes Harbor-UCLA, Olive View-UCLA, and a rehabilitation hospital, Rancho Los Amigos. The county system provides almost

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all inpatient care for low-income uninsured people deemed medically indigent (for whom the county provides health care with funding from state vehicle license fees and sales tax revenue), although Medi-Cal admissions are spread more broadly across county-operated and private hospitals. Other hospitals serving a notable safety-net role include White Memorial Medical Center and California Hospital Medical Center (CHMC).

The county system has faced capacity constraints since 2008, when a rebuilt LAC+USC downsized from approximately 900 beds to 665. This downsizing exceeded the hospital's subsequent drop in demand for inpatient care; discharges decreased 10% between 2008 and 2010. The hospital has tried to decrease lengths-of-stay to improve efficiency but has met with mixed success. To address rising emergency department (ED) use, LAC+USC plans to implement electronic ED triaging software and add an urgent care facility. One safety-net respondent lamented LAC+USC's capacity constraints: "I know there are hospitals out there with empty beds, but as far as taking the uninsured, there are not that many hospitals that have that interest or obligation."

Further, the county system has struggled to meet demand for outpatient care. The county operates two multiservice ambulatory care centers that provide primary and specialty care and some ambulatory surgery services, six comprehensive health centers that provide primary care plus limited specialty care, a dozen primary care centers, and one school clinic. Lacking the ability to expand — budget shortfalls led to hiring freezes, for example — these facilities have provided a relatively stable number of patient visits since 2008.

Large Role for Private Clinics, CHCs, and FQHCs

In addition to its county facilities, Los Angeles has an extensive array of private, independent clinics and community health centers (CHCs) that serve low-income people. More than 200 sites — excluding school-based clinics — serve low-income patients across the county. More than half of these facilities have federally qualified health center (FQHC) or look-alike status (see sidebar). The largest FQHCs, which have multiple sites, include Northeast Valley Health Corporation in the San Fernando Valley, AltaMed in Southeast and Central LA, Northeast Community Clinic and QueensCare in Downtown LA, and St. John's Well Child and Family Center in South LA. Health centers collaborate under both a countywide association — the 47-member Community Clinic Association of Los Angeles County — as well as through smaller, regional clinic associations within the county.

FQHCs in Los Angeles are serving more patients than when the last study was conducted, with overall visits increasing 17% between 2008 and 2010. Federal and county funding helped existing clinics to expand and new facilities to open. Federal grants allowed 18 new FQHCs or look-alike sites to open between 2008 and 2010. At the county level, the Community Clinic Expansion Project

FQHC and Look-Alike Designations

Community health centers that meet a host of federal requirements under Section 330 of the Public Health Service Act are deemed federally qualified health centers (FQHCs). FQHCs primarily treat Medicaid and low-income uninsured people. FQHC designation provides benefits including federal grants to subsidize capital and operational costs, cost-based payments per Medicaid patient visit (Prospective Payment System payments based on previous average costs for an individual health center that are updated annually for medical inflation), discounted pharmaceuticals, access to National Health Service Corps clinicians, and medical malpractice liability coverage.

A smaller number of health centers have FQHC look-alike status, which provides most of the benefits that FQHCs receive but not federal grants. In managed care arrangements, FQHCs and look-alikes receive "wraparound" payments from the state to account for the difference between what the health plan or intermediary (such as an IPA) pays the health center and the cost-based rate to which the health center is entitled.

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awarded $47 million from state tobacco settlement funds to community clinics for capital and operational expenses in 2010–12, allowing the clinics to serve more residents deemed medically indigent.

For example, the main FQHC in South LA, St. John's, has added sites and other capacity to serve additional patients. With the help of local and federal grants, patient visits grew from approximately 70,000 in 2008 to 120,000 by 2011. To address the high need in South LA, the Community Clinic Expansion Project allocated a relatively large proportion of available county funds to health centers in the area, including St. John's.

Community health centers are increasingly seeking FQHC status as a survival strategy. As state support for CHCs declines due to cuts in Medi-Cal benefits and in state grants to help pay for primary care for uninsured people, CHCs are more reliant on federal grants and their cost-based Medi-Cal payments from the FQHC program. Approximately 10 CHCs have converted to full FQHC or look-alike status in recent years. For example, Saban Free Clinic, described by a respondent as a "stalwart of the free-clinic movement" because of its focus on serving the uninsured without expecting payment, gained look-alike status in 2011.

Challenges in Underserved Areas

South LA remains a particularly high-need and underserved region of Los Angeles County. Since the temporary closure of Martin Luther King Jr.-Harbor Hospital (MLK) in 2007, the MLK facility has operated as a multiservice ambulatory care center, primarily providing urgent and specialty care with no inpatient or ED services. Because the remaining county hospitals are mostly outside of the area previously served by MLK, several private hospitals in South LA have been affected by MLK's closure. These include St. Francis Medical Center of Lynwood, CHMC, and Centinela Hospital Medical Center (affiliated with Prime Healthcare Services). At St. Francis, ED volumes jumped following MLK's closure, and inpatient and outpatient visits increased to a lesser extent.

With funds from the state Medi-Cal waiver, LA County provides some financial compensation to the private hospitals providing inpatient and ED care to uninsured patients. MLK is expected to reopen in 2014 as a full-service community hospital, but it will have half the beds of the previous facility, operate under private nonprofit status, and be affiliated with UCLA for physician services.

County Safety Net Under Redesign

Los Angeles County is redesigning its safety net to add needed capacity, adapt to growing Medi-Cal managed care enrollment, and remain financially viable — both now and under national health reform.

New county health department leadership has energized public and private safety-net providers alike, as the county's changes have implications for the latter group as well. Mitch Katz, former director of the San Francisco Health Department, became the director of the Los Angeles County Department of Health Services in January 2011, bringing in several colleagues from the Bay Area and working with local leaders. Market observers and safety-net providers anticipate that the new leadership team, with its expertise and record of successful strategies, will help improve the overall safety-net system in LA. The challenges are significant, however, in no small part because Los Angeles's population is more than 10 times as large as San Francisco County's. In addition, LA has a significantly larger proportion of residents with Medi-Cal or no coverage.

The county is expanding and enhancing ambulatory care, with a focus on implementing a patient-centered medical home model. The county's first step in formalizing this new focus was to create the Ambulatory Care Network, which took over oversight and management of the county clinics from the county hospital system, with a focus on redesigning clinic organization and operations to increase patient capacity in existing facilities. As part of this effort,

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clinics are adopting standards for productivity and patient panel sizes and developing clinical teams. The Ambulatory Care Network is also working to improve coordination and capacity for specialty care. The main strategy is to replicate San Francisco's eReferral system, a web-based technology to facilitate communication and consultations between primary care physicians and specialists to prevent inappropriate or premature referrals. The Ambulatory Care Network also works closely with the private FQHCs and community health centers to improve patient care and services within the context of health care reform.

As part of the redesign, the Ambulatory Care Network is helping county clinics and private health centers prepare for an expansion of Medi-Cal managed care enrollment under state policy changes and national health reform. Administrative and billing functions will be refined and clinical processes revised to adapt to more capitated revenues.

Los Angeles has a two-plan Medi-Cal managed care model (see sidebar), giving enrollees a choice of a private plan (Health Net) or the county's LA Care, an umbrella Medi-Cal managed care organization. LA Care includes a county-owned plan (LA Care Health Plan) and subcontracts with private health plans (Anthem Blue Cross, Care1st Health Plan, and Kaiser Permanente) to ensure adequate provider networks throughout the county. LA Care is the dominant Medi-Cal entity in the county, with 1 million enrollees as of September 2012, more than double the enrollees of Health Net. LA's Community Health Plan, which served Medi-Cal and Healthy Families (CHIP) enrollees, was terminated by the county in 2012 so the county could dedicate more capital and leadership attention to improving care delivery.

Medi-Cal Managed Care Models

In California, Medicaid managed care (Medi-Cal) is organized at the county level. Thirty of the state's 58 counties have implemented managed care using one of three models, which dictates the type and number of health plans with which the California Department of Health Care Services contracts to serve Medi-Cal enrollees. The most common models are the County Organized Health System (COHS) and the Two-Plan Model. In a COHS, the county runs a single health plan that covers all managed care enrollees. In the Two-Plan Model, enrollees can chose between a county-operated plan (known as a "local initiative") and a private health plan. There is also a little-used third model, Geographic Managed Care (GMC), in which there is no local public plan, but rather several private health plans that compete for Medi-Cal enrollees. GMC is used in just two counties: Sacramento and San Diego.

Along with the rest of California, LA County is transitioning its seniors and persons with disabilities (SPD) population, known as "aged, blind, and disabled" in other states, into managed care. In addition, LA was selected as one of four counties statewide to move people covered by both Medi-Cal and Medicare — known as dual eligibles — into managed care.

Medi-Cal ACO Activity

The LA market displays more activity than other California markets in forming ACOs for the Medi-Cal population. One contributing factor may be that safety-net providers are more accustomed to providing services within a capitated Medi-Cal payment structure than providers in other markets. Safety-net hospitals and community health centers are partnering to form two main integrated delivery systems for Medi-Cal patients, with a goal of incorporating all payers eventually.

First, the Regional Accountable Care Network (ACN) includes providers that have not collaborated much in the past. Owners of the ACN include Hollywood Presbyterian, White Memorial and Citrus Valley hospitals, and AltaMed, one of the country's largest FQHCs. In addition to employing physicians, AltaMed operates an IPA to contract with private practice physicians to care for patients. The county hospital system is a partner but not one of the ACN owners.

The ACN service area covers a large part of the county: mainly the Downtown, East LA, and San Gabriel areas, but also a small part of South LA. Grants and owner fees have

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enabled the ACN to develop a patient-centered medical home model, including hiring care managers for high-risk patients and creating a health information technology exchange to share patient information. The ACN also is working to strengthen palliative care services for dual eligibles, which is the first population to be assigned to the ACN. The ACN is expected to take on financial risk for patient care from LA Care by 2013. How individual providers will be paid in the new model is yet to be determined.

A second Medi-Cal ACO is forming to serve South LA exclusively. Called HealthCare First South LA, participating organizations include LA Care, St. John's FQHC and nine others that serve South LA, St. Francis Hospital, MLK (when it reopens), 40 private physicians (mostly specialists), the LA County Department of Health Services, and the Service Employees International Union, which represents many health care workers. Enrollees under SPD and Healthy Way LA will be the first groups assigned to HealthCare First South LA. Providers have agreed to new payment arrangements — a mix of fee-for-service and capitation — and to the sharing of any savings, although details of the arrangement are not public.

Preparing for Reform

Anticipating health reform's Medicaid expansion in 2014, Los Angeles is well along in implementing a Low Income Health Program (LIHP): a county option under the state's Medi-Cal waiver to transition low-income uninsured people into Medi-Cal-like arrangements.[9] In July 2011, the county modified and merged two existing programs serving medically indigent individuals — the Public-Private Partnership and Healthy Way LA — into a single LIHP, also called Healthy Way LA.

As in the previous programs, income eligibility remains at 133% of federal poverty, but the new program includes all citizens and legal residents — not just the chronically ill — and provides more services. Enrollment has surpassed 200,000 people despite a more stringent enrollment process than the former program for medically indigent individuals. There is considerable onus on providers to screen patients for eligibility and to help them enroll, which has been time-consuming and challenging for providers. Also, even with county funding to help private community health centers perform this role and expand capacity, market observers remained concerned about having sufficient capacity to care for additional people as health reform is implemented.

Issues to Track

- Will physician organizations continue to take the lead in aligning with physicians and participating in ACOs, or will hospitals catch up? How will alignment activity affect providers' leverage with payers and care delivery?
- Will there be more consolidation and/or tighter affiliations among hospitals, and if so, how will that affect hospital capacity and geographic reach?
- What impact will new health department leadership and strategies have on the safety net? Will the reopening of MLK Hospital relieve safety-net providers in South LA and significantly improve access to care for residents in that community?
- What will be the impact of Medi-Cal ACOs on patient care and costs? To what degree will Medi-Cal ACOs reshape the delivery of care for low-income people?
- To what extent will LA County's active transition of uninsured people into the Low Income Health Program pave the way for significant numbers of uninsured people to quickly gain coverage when Medi-Cal eligibility expands in 2014? Will providers be able to meet demand as more people become insured and seek care?

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ENDNOTES

1. "Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports," US Census Bureau (Press release), March 26, 2012, **www.census.gov**.
2. 2009 California Health Insurance Survey.
3. "HealthCare Partners to Be Bought by DaVita in $4.42 Billion Deal," *Los Angeles Times,* May 22, 2012.
4. Because California's corporate practice of medicine law prohibits hospitals from directly employing physicians, some hospitals sponsor medical foundations as a way to align with physicians. Under a medical foundation model, physicians either contract with the foundation through an affiliated IPA or are part of a medical group that contracts exclusively with the foundation through a professional services arrangement. University of California hospitals, county hospitals, and some nonprofit organizations such as community clinics are among the entities allowed to employ physicians directly, through exceptions to the corporate practice of medicine prohibition.
5. California Office of Statewide Health Planning and Development, Healthcare Information Division, Annual Financial Data, 2010. Data reflect each hospital system's fiscal year.
6. UCLA's financial improvement is attributed in part to additional revenues from payment rate increases from commercial insurers; Delivery System Reform Incentive Payments (DSRIPs) for public hospitals through the California Medi-Cal waiver (for identifying and meeting numerous milestones toward improving its infrastructure, care delivery processes, and quality outcomes over a five-year period starting in 2011); and the state hospital fee program. Passed by the California legislature in 2009, the Hospital Quality Assurance Fee Program (commonly known as the hospital fee program) generates additional funding for hospitals serving relatively large numbers of Medi-Cal patients. Hospitals pay a fee based on their overall volume of inpatient days; after the addition of federal matching dollars, the funds are redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. Approximately 20% of hospitals are net contributors to the program. While the program originally only covered the period from April 2009 through December 2010, it has been renewed twice to 2013. Payments were first made to hospitals at the end of 2010.
7. "Los Angeles Selects Anthem Blue Cross sans UCLA, Cedars-Sinai," *Health Plan Week,* October 1, 2012.
8. The Centers for Medicare and Medicaid Services Innovation Center created the Medicare Pioneer ACO model for providers already working to coordinate services across care settings to achieve greater care coordination and cost savings with a traditional Medicare (fee-for-service) beneficiary population. Participating organizations share in both savings and losses for a defined population and have the opportunity to move to a prospective capitated payment method in year three. There are 32 ACOs participating in this model nationwide for the period 2012–15.
9. The Low Income Health Program does not technically provide health insurance but requires counties to provide a benefit similar to Medi-Cal, which is typically more comprehensive than the traditional medically indigent programs. Counties receive federal matching funds to help support the cost of the LIHP.

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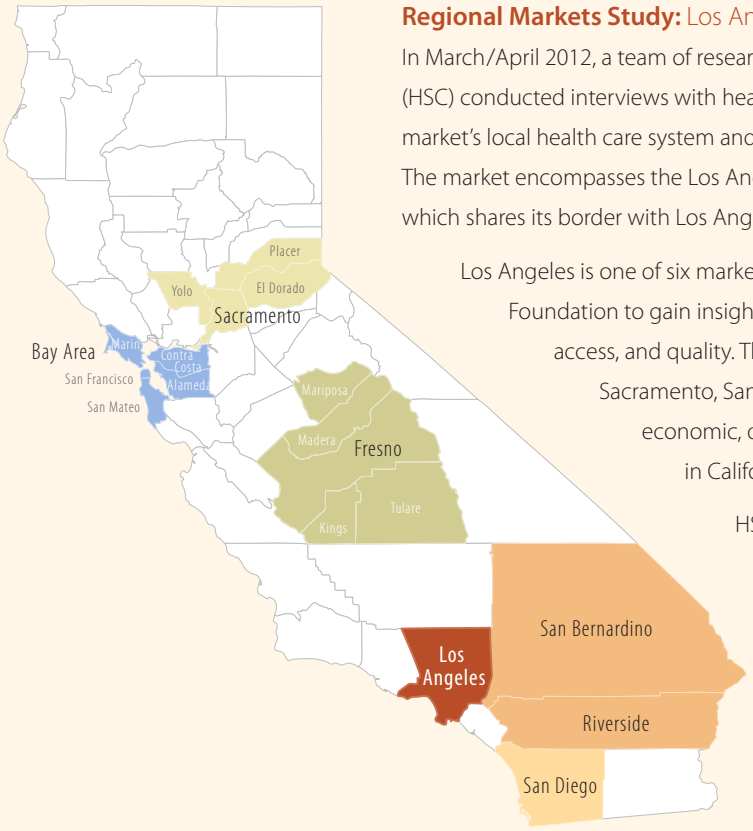

Regional Markets Study: Los Angeles

In March/April 2012, a team of researchers from the Center for Studying Health System Change (HSC) conducted interviews with health care leaders in the Los Angeles region to study that market's local health care system and to update a similar study conducted in December 2008. The market encompasses the Los Angeles-Long Beach-Glendale, California, Metropolitan Division, which shares its border with Los Angeles County.

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

HSC researchers interviewed 32 respondents specific to the Los Angeles market, including executives from hospitals, physician organizations, community clinics, and programs for low-income people. Interviews with 18 health plan executives and other respondents at the state level also informed this report.

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ABOUT THE AUTHORS

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

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