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Sacramento:
Health Providers Collaborate and Weather Economic Downturn

Summary of Findings

Largely stable since the last study was conducted in 2008, hospitals and physicians in the Sacramento region weathered the economic downturn fairly well. Still, a number of market trends have posed challenges for the area.

Key developments include:

- **Increased pressures on hospitals to contain costs.** Hospitals reported deteriorating payer mixes because of declining commercial coverage; an uptick in public coverage; smaller commercial payment rate increases from health plans; and rising rates of uninsured patients, largely due to the economic downturn. While most hospital systems had strong financial performance despite these pressures, Dignity Health (formerly Catholic HealthCare West) was the exception with its operating margin cut by more than half.
- **Increased use of narrow-network arrangements.** The Sacramento market is on the leading edge of developing new health plan-provider collaborations — including accountable care organizations and narrow networks of providers that accept lower payment rates in exchange for exclusivity. These arrangements are aimed at competing better against Kaiser Permanente and preparing for lower payment rates under health reform.
- **Increased dominance of Kaiser.** Kaiser is viewed as an even more formidable competitor now, especially given the perception of Kaiser Permanente Health Plan as a lower-cost option. The affordability of health coverage assumed even greater importance during the economic downturn, and it will continue to be a critical issue under federal health reform.
- **Increased pressure on outpatient capacity at safety-net providers.** With the economic downturn driving up the proportion of uninsured people and reducing local resources to care for low-income residents, the fragmented safety net's outpatient capacity is insufficient to keep pace with demand, in spite of considerable growth in community health centers.
- **Growing concerns among community health centers and federally qualified health centers about remaining competitive in the Medi-Cal market.** With a shift towards capitation within Medi-Cal managed care and new populations transitioning into managed care, the number of enrollees directly assigned to federally qualified health centers (FQHCs) and other community health centers (CHCs) has been declining at a time when many of these providers expanded capacity.
- **Concern among stakeholders that the supply of physicians — especially primary care physicians — is inadequate to meet expanded demand.** In the words of one respondent, the coverage expansions under health reform will result in a "tsunami of unmet need" among both privately and publicly insured people.

In most other respects, the region's hospital and physician sectors remained largely stable. The community's well-established hospital systems — three private, nonprofit systems and one public academic medical center — experienced no significant organizational changes and had little disruption in patient volume or financial performance despite the struggling economy.

Provider consolidation increased moderately, with the large medical groups closely aligned with hospital systems continuing to grow. At the same time, many physicians remain in small private practices and participate in independent practice associations (IPAs) that provide management and other services to support contracting with health maintenance organizations (HMOs). Under this model, HMOs delegate financial risk and utilization management to large physician organizations, such as IPAs and medical groups, in return for capitated payments (fixed per-member, per-month amounts). While the number of HMO enrollees continued to decline slowly since 2008, this delegated capitation model remains an important defining feature of the Sacramento health care market.

Market Background

The Sacramento region (see map on the last page) has a population of 2.1 million people spanning four counties: El Dorado, Placer, Sacramento, and Yolo. After strong growth during the last decade, population growth has leveled off in recent years. Compared to the rest of California, the Sacramento area is less ethnically and racially diverse with a much higher proportion of white residents

Table 1. Demographic and Health System Characteristics: Sacramento Region vs. California

	Sacramento	California
POPULATION STATISTICS, 2010		
Total population	2,149,127	37,253,956
Population growth, 10-year	19.6%	10.0%
Population growth, 5-year	5.9%	4.1%
AGE OF POPULATION, 2009		
Persons under 5 years old	6.9%	7.3%
Persons under 18 years old	25.8%	26.3%
Persons 18 to 64 years old	62.6%	62.8%
Persons 65 years and older	11.5%	10.9%
RACE/ETHNICITY, 2009		
White non-Latino	58.9%	42.3%
Black non-Latino	7.1%	5.6%
Latino	19.4%	36.8%
Asian non-Latino	10.1%	12.1%
Other race non-Latino	4.5%	3.1%
Foreign-born	14.6%	26.3%
EDUCATION, 2009		
High school diploma or higher, adults 25 and older	89.4%	82.6%
College degree or higher, adults 25 and older	40.9%	37.7%
HEALTH STATUS, 2009		
Fair/poor health status	11.6%	15.3%
Diabetes	7.5%	8.5%
Asthma	16.2%	13.7%
Heart disease, adults	6.6%	5.9%
ECONOMIC INDICATORS		
Below 100% federal poverty level (2009)	13.2%	17.8%
Below 200% federal poverty level (2009)	28.1%	36.4%
Household income above $50,000 (2009)	53.8%	50.4%
Unemployment rate (2011)	12.5%	12.4%
Foreclosure rate* (2011)	5.2%	n/a
HEALTH INSURANCE, ALL AGES, 2009		
Private insurance	64.7%	55.3%
Medicare	9.9%	8.8%
Medi-Cal and other public programs	15.3%	21.4%
Uninsured	10.1%	14.5%
SUPPLY OF HEALTH PROFESSIONALS, PER 100,000 POPULATION, 2008		
Physicians	191	174
Primary care physicians	63	59
Dentists	74	69
HOSPITALS, 2010		
Community, acute care hospital beds per 100,000 population	163.3	178.4
Operating margin with net disproportionate share hospitals (Kaiser excluded)	8.0%	2.4%
Occupancy rate for licensed acute care beds (Kaiser included)	62.3%	57.8%
Average length of stay (in days) (Kaiser included)	4.2	4.5
Paid full-time equivalents per 1,000 adjusted patient days (Kaiser excluded)	16.4	15.8
Total operating expense per adjusted patient day (Kaiser excluded)	$3,276	$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.

and a much lower proportion of Latinos and foreign-born residents. Sacramento-area residents continue to have slightly higher education and income levels than state averages; they also have substantially higher rates of private health insurance, thanks largely to Sacramento's position as the seat of state government.

The Sacramento region's unemployment rate closely tracks California's average rate. In November 2011 — the month of the site study — unemployment was 11.0% versus 10.9% statewide. This represented a decline from the area's peak unemployment of 12.9%, reached in early 2010, but was still more than double the baseline unemployment rate before the 2007–09 recession (5.3% in 2007). State government continues to be the primary force in the local economy. However, state budget woes led to program cuts and staff layoffs during the downturn.

Declining county revenues and budgets also led to reductions in state and county health programs and staff, at the same time that demands on these programs increased. From 2007 to 2009, the uninsured rate rose from 8.6% to 10.1% in the metropolitan area. Still, the presence of state government as an employer — despite budget problems — helped maintain the Sacramento market's favorable payer mix: 64.7% privately insured vs. 55.3% statewide. Among the six California communities tracked in this study, the Sacramento region's proportion of residents with private insurance coverage remained second only to the Bay Area.

Within the greater Sacramento market, the affluent towns of Roseville, El Dorado Hills, and Folsom have large concentrations of well-insured residents and growing populations. Along with Elk Grove in south central Sacramento County — also growing though not as affluent — these communities represent growth areas, both current and planned, for health care providers. At the other end of the economic spectrum, parts of the city of Sacramento and rural areas of El Dorado, Placer, and Yolo counties represent some of the most financially strained communities in the market.

Cost-Containment Pressures in an Otherwise Stable Hospital Market

While the Sacramento market's hospital sector continues to be strong and stable, it has faced increasing pressures to contain costs since 2008. The region has three longstanding, private nonprofit systems: Sutter Health Sacramento Sierra Region, with five hospitals in the market; Mercy Health Care, also with five hospitals and a member of Dignity Health; and Kaiser Permanente with three hospitals. The region also has one public academic medical center, University of California Davis (UC Davis) Health System, with one hospital.

Market shares — largely unchanged in recent years — are not particularly skewed toward any single system. Sutter and Dignity each have nearly 30% of inpatient discharges, followed by Kaiser (24%) and UC Davis (15%). However, Kaiser's share of the coveted commercial market is estimated to be as much as 40%, reflecting the fact that commercial enrollees of Kaiser Permanente Health Plan comprise the majority of Kaiser hospitals' patient base.

Kaiser, regarded by the other hospital systems as their main competitor at the time of the last regional analysis, is considered to be an even more formidable competitor now, especially given the reputation of Kaiser Foundation Health Plan as a lower cost option. Affordable health coverage became a central consideration during the economic downturn and is expected to become even more critical under health reform. Sutter and Dignity regard each other as primary rivals when competing for commercial patients enrolled in non-Kaiser health plans. Despite robust competition among the hospital systems, respondents agreed that the environment remains generally cordial rather than contentious.

Hospitals have faced escalating pressures to contain costs since 2008, largely as a result of the economic downturn. Hospitals reported deteriorating payer mixes because of declining commercial coverage, an uptick in public coverage, and rising rates of uninsured patients. Health plans also are

ratcheting down commercial payment rate increases under pressure from purchasers to slow premium increases. Before the recession, hospitals and commercial health plans largely operated in a "pass-through" environment, where high — often double-digit — payment rate increases typically were passed on to employers in premium increases of similar magnitude. More recently, hospitals have accepted lower commercial rate increases.

Yet, even with increased revenue pressures, hospital financial performance remained strong. In 2010 — the most recent year public data are available — the aggregate operating margin across Sacramento-area hospitals was a robust 8.0%.[1] Given the persistently low payment rates from public payers and the pushback against commercial rate increases, hospitals all reported undertaking aggressive cost-cutting measures to help protect their bottom lines. In addition, Sutter, Dignity, and UC Davis all benefited from the state hospital fee program, which helped hospitals offset losses on Medi-Cal patients.[2]

Sutter maintained especially strong operating margins: 13.3% in 2010, up slightly from 12.6% in 2008. Respondents indicated that this reflects its negotiating leverage with health plans, which stems from being seen as an essential provider. UC Davis, while not achieving margins of the same magnitude as Sutter, managed to increase its operating margin from 2.8% in 2008 to 4.8% in 2010. Discontinuing Medi-Cal managed care and commercial capitation, as well as revenues from the hospital fee program and the Delivery System Reform Incentive Payments (DSRIP) from the California's Bridge to Reform Medi-Cal waiver, were key contributors to its improved financial performance in 2011.[3]

Dignity proved the exception to strong and improving financial performance in the market, with its operating margin more than halved (to 4.2%) between 2008 and 2010. According to respondents, Dignity continues to lose financial ground. Among Dignity hospitals, Methodist Hospital of Sacramento, which serves a low-income area, reportedly faces the most severe financial strain. To a lesser extent, the system's two largest hospitals in the market, Mercy General Hospital and Mercy San Juan Medical Center, are struggling with eroding margins as well. Only Mercy Hospital of Folsom, which serves an affluent, well-insured submarket, maintains strong margins.

Hospitals continue to invest in lucrative service lines and expand capacity in growth areas to increase their share of commercial patients and revenues. In recent years, all four hospital systems constructed new inpatient and ambulatory facilities, not only to meet state seismic requirements but also to strengthen service lines. Prominent examples of expansions in growth areas with well-insured populations include Sutter, Dignity, and Kaiser all expanding ambulatory facilities in Elk Grove; and Sutter and Kaiser both expanding inpatient services in Roseville, including maternity, neonatal intensive care, and pediatric intensive care services.

Moderate Increase in Physician Consolidation

The Sacramento market's relatively consolidated physician sector — which focuses on commercially insured and Medicare patients — continues to be dominated by four large medical groups and two large IPAs, each affiliated exclusively with a hospital system. Kaiser and UC Davis each continue to contract directly with a single large medical group, while Sutter and Dignity both rely on the medical foundation model to align physicians.[4]

Kaiser's physician arm, The Permanente Medical Group, employs about 1,400 physicians in greater Sacramento. In the UC Davis Health System, physicians are employed by the university and belong to the UC Davis Medical Group, which numbers approximately 700 physicians — but only about 400 full-time equivalents, since physician faculty members also are engaged in research and teaching.

The Sutter Medical Foundation includes Sutter Medical Group with approximately 500 physicians. The foundation also contracts with Sutter Independent Physicians — an IPA with about 600 physicians — for capitated contracts. Within

the Sacramento region, both organizations are under the umbrella of Sutter Physician Alliance, which acts as a single network, allowing patient referrals between the medical group and the IPA for capitated contracts. Admissions to Sutter hospitals are reportedly split evenly between the medical group and the IPA.

Much smaller than Sutter's medical foundation is the Dignity Health Medical Foundation. The foundation's presence in the Sacramento area is represented primarily by Mercy Medical Group, which has grown to about 250 physicians. Despite being aligned through the medical foundation, Dignity hospitals and Mercy Medical Group are not as integrated as the Sutter hospitals and Sutter Medical Group.

The physician sector experienced substantial consolidation prior to 2008; consolidation has been moderate since then. The large groups aligned with Kaiser, Sutter, and Dignity all continued to grow, using diverse strategies to draw new hires from within and outside the market. Kaiser is still perceived as holding a competitive edge in recruiting physicians — particularly primary care physicians — reportedly by offering higher compensation as well as a work-life balance that many recruits find attractive.

Still, many physicians remain in smaller, independent single-specialty practices and belong to IPAs for HMO contracting. Two IPAs dominate the market: Sutter Independent Physicians and Hill Physicians. Hill admits patients exclusively to Dignity hospitals in Sacramento but does not participate in Dignity's medical foundation, instead negotiating directly with health plans for HMO contracts. Hill and Mercy Medical Group regard each other as competitors and generally do not engage in mutual referrals, in contrast to Sutter's medical group and IPA.

While some primary care physicians are exclusively aligned with one IPA, specialists typically belong to multiple IPAs, motivated by the need to maintain sufficient patient volume. Overall, there is substantial overlap in the membership of Sutter Independent Physicians and Hill Physicians.

Since 2008, there has been no movement toward specialists choosing to exclusively contract with a single IPA. In fact, the development of narrow-network insurance products (discussed below) may have slowed consolidation activity for fear it may close off opportunities for physicians to participate in a rival system's exclusive contract with a health plan for a narrow-network product.

Providers, Plans Experiment with Narrow-Network Contracts

Providers in the Sacramento region viewed the current market environment as a transition from the status quo to a less secure future under health reform. As pressures to compete on affordability increase and are expected to intensify under health reform, providers are further focusing on improving efficiency. All systems reported not only continuing efforts to reduce input costs but also a new — or heightened — focus on streamlining care delivery across inpatient and ambulatory settings with the goal of reducing per-patient spending while maintaining or improving quality.

A notable recent development is the collaboration between providers and health plans to develop narrow-network arrangements, with providers accepting lower payment in exchange for exclusivity. Non-Kaiser providers hope to use narrow networks to better compete with Kaiser and to work toward more efficient care delivery in preparation for health reform.

Stakeholders and observers see Sacramento as having the right market conditions for new payment and contracting models: large hospital systems that, together with aligned physician organizations, can serve as exclusive networks; physician experience with and enthusiasm for capitation; and the need for providers to compete with a strong Kaiser system.

Like other historic strongholds of capitation in California, the Sacramento region has seen an enrollment decline in

recent years in network-model HMOs associated with the delegated capitation model. This decline stems not only from the economic downturn, but also from competition from Kaiser's closed-panel HMO model, and from preferred provider organization (PPO) products, including lower-premium, consumer-directed health plans. As a result, providers have been motivated to seek opportunities to revive capitation.

All these factors have combined to make Sacramento the first California market to become "a giant Petri dish" and "a laboratory to test out new models and relationships," according to respondents. Hospital executives acknowledged the need to get these efforts well under way while their systems still have some financial cushion to invest in infrastructure and absorb potential losses.

CalPERS ACO

The first and most prominent new narrow-network contracting arrangement was the accountable care organization (ACO) developed for the California Public Employees' Retirement System (CalPERS) by Blue Shield of California, Dignity, and Hill Physicians. It was built within an existing Blue Shield product, NetValue HMO, which already excluded Sutter and other higher-priced providers, including Mercy Medical Group. Blue Shield and its provider partners viewed this collaboration as a way to retain and perhaps increase their CalPERS business — for which Kaiser and Anthem Blue Cross compete vigorously on the health plan side — by improving efficiency of care and slowing premium trends.

The CalPERS ACO began as a one-year pilot in 2010 and performed well enough to gain a contract extension through 2012. Under the arrangement, the partners agreed to a global budget that required total provider payments to be lowered to reflect reduced premium trends negotiated with CalPERS: zero for 2010 and, according to one respondent, "positive but significantly lower than other HMO premiums" in 2011. Payment methods remained unchanged — fee-for-service payment for Dignity's hospital services, capitation for Hill's professional services — but a three-way risk-sharing pool, with both upside and downside risk, was added. In 2010, the partners targeted $15.5 million as the amount of cost savings needed to break even, given the zero premium trend.

At the end of the pilot year, Blue Shield reported that total savings exceeded $20 million, so the $5 million difference between actual and targeted savings constituted the shared savings pool for that year. Much of the savings stemmed from reductions in readmissions and lengths of stay. Inpatient revenue losses to Dignity reportedly were offset in part by the ACO driving more referrals to Dignity's outpatient facilities. The Blue Shield NetValue plan is offered at a lower premium than the Kaiser CalPERS product.

Health Net PremierCare Network

The other, newer narrow-network offering in Sacramento is the Health Net PremierCare Network, an HMO collaboration between Health Net and the Sutter system, including Sutter's hospitals, affiliated medical group, and IPA. Sutter, long regarded as the market's high-cost provider, is reportedly using this arrangement as a way of "testing the waters" and taking "prudent, contained risks" to work on reducing system costs through care management. Under this new contractual arrangement — built on an existing HMO contract — payment methods remained unchanged, but rates were lowered.

Unlike the CalPERS ACO, the PremierCare collaboration does not include any shared risk or savings pool. Like the CalPERS ACO, this product also tracks Kaiser HMO pricing, with premiums aimed at undercutting Kaiser by about 5%. Targeted to a broad swath of mid-size employers from as few as 50 lives to as many as a few thousand, the product was rolled out in 2011 and is still building enrollment, with some school districts already signed up. The product is considered too new to measure its impact on costs.

Fragmented Safety Net Faces More Demand

Over the past few years, the rising number of uninsured people has increased demands on a safety net already considered insufficient to meet the needs of uninsured and low-income residents. Sacramento County's safety net is characterized by a county government and county-run health clinic struggling with budget cutbacks; a collection of historically small, private community health centers (CHCs) only loosely affiliated with one another; and several hospitals providing some level of care to low-income people. Of the CHCs, some are FQHCs: organizations eligible to receive both federal grants and enhanced, cost-based Medi-Cal payments. Repeated attempts over the years to bring safety-net providers together to create a more coordinated system of care for low-income people have largely fallen flat. The neighboring counties — El Dorado, Placer, and Yolo — have more safety-net capacity and infrastructure relative to the size of their low-income populations.

Changing Safety-Net Roles of Hospitals

The safety-net roles of hospitals in the Sacramento region have shifted in recent years. Perhaps the most notable development is that UC Davis is no longer perceived as the main safety-net hospital, with Sutter and Dignity both assuming greater roles. While the three systems provided relatively similar levels of services to low-income people in 2008, by 2010, Sutter and Dignity's volume had risen while volume at UC Davis had declined. The payer mix at UC Davis — which has improved slightly over the past few years — is still more heavily weighted toward Medi-Cal and uninsured patients compared to Sutter and Dignity. However, the two larger systems — each with multiple hospitals and twice the bed capacity of UC Davis — both provide more inpatient and outpatient services to the total population of low-income people in the market.

Low-income groups include enrollees in public insurance including Medi-Cal and Healthy Families (Children's Health Insurance Program or CHIP); enrollees in the County Medically Indigent Services Program (CMISP, a Sacramento County program with state funding support that pays providers to care for low-income uninsured residents); and other low-income uninsured people, including undocumented immigrants.

The scaled-back safety-net role of UC Davis can be traced to two key developments. The first is the 2008 termination of its contract with Sacramento County to provide emergency department (ED), inpatient, and specialty care to CMISP enrollees. Through a third-party administrator, the county started contracting with a broader set of hospitals at lower payment rates. As a result, many enrollees instead seek services at Sutter and Dignity, which still contract with the county. While no longer under contract, UC Davis provides some services to medically indigent patients, primarily through the ED. UC Davis sued the county for unpaid services provided after the contract termination; a state court judge found the county liable for nonpayment of ED care, but the amount of the award is yet to be determined.

The second development is the withdrawal of UC Davis from all but one Medi-Cal managed care contract, a move that reportedly helped its bottom line. UC Davis continues to participate in fee-for-service Medi-Cal.

Fragmented Providers

Primary care safety-net providers in the Sacramento market remain fragmented, each focusing on a certain low-income subgroup — Medi-Cal, medically indigent, other uninsured — or an ethnic population. Overall, capacity for Medi-Cal enrollees is growing, while capacity for medically indigent enrollees is contracting.

Two of the four hospital systems in the region continue to operate primary care clinics focused on low-income patients. Dignity runs four clinics that serve as key sources of care for low-income, primarily uninsured people, including undocumented immigrants. With the economic downturn, the loss of eligibility for CMISP by undocumented immigrants, and patient visits doubling since 2008, these

clinics are operating at capacity. UC Davis continues to operate medical resident teaching clinics that focus on Medicare and Medi-Cal patients, and UC Davis medical students run seven weekend clinics focusing on certain uninsured ethnic groups.

Clinics operated by Sacramento County serve as the sole designated source of primary care and prescription drugs for CMISP enrollees. Budget woes led to dramatic downsizing of these clinics — from six, including three full time, in 2008, to only one staffed at 50%. As a result, CMISP enrollees reportedly wait longer for care and/or end up in hospital EDs. One respondent characterized the county's budget and program cuts as "an ongoing dismantling of the public health system."

Historically, the development of FQHCs in the Sacramento region has lagged many other California communities, but since 2008, several clinics gained full FQHC status or look-alike status, which allow cost-based Medi-Cal payments and other benefits (see sidebar). Of eight FQHC organizations in the area — five full FQHCs and three look-alikes — half gained their federal status since 2008, and many are in expansion mode. In particular, The Effort, a full FQHC, has experienced a significant increase in patient visits (to 45,000 annually) since 2008. Likewise, Health and Life Organization (HALO), a look-alike, saw visits nearly triple (to 50,000 annually) over the same period.

For most clinics, gaining FQHC status has helped to boost financial performance; however, The Effort has struggled financially, reportedly as a result of too-rapid expansion and a payer mix with too high a proportion of uninsured patients relative to Medi-Cal. After posting a negative 15% operating margin in 2010, the health center laid off staff and installed new management, which is addressing provider-productivity issues and improving the clinic's financial performance. The Effort will further extend its capacity and geographic scope by collaborating with Dignity to take over most of the system's clinics for low-income patients, as well as build new health centers.

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.

Challenges with Medi-Cal Managed Care

Sacramento County continues to organize Medi-Cal managed care through a Geographic Managed Care (GMC) model, in which the state contracts with multiple managed care plans and pays each plan on a capitated basis.[5] In contrast, Yolo County has a single, county-owned Medi-Cal plan, referred to as a County Organized Health System, while El Dorado and Placer counties continue to operate fee-for-service Medi-Cal. Currently, four health plans — Anthem Blue Cross, Health Net, Molina, and Kaiser — participate in the GMC market in Sacramento County. Western Health Advantage, a local provider-sponsored plan, withdrew from Medi-Cal in early 2010. In using a GMC model, Sacramento County does not have a public, or so-called "local initiative" plan; in other California counties, such plans place a particular emphasis on including CHCs and other safety-net providers in their networks. (See Medi-Cal Managed Care Models on page 9.)

Medi-Cal Managed Care Models

In California, Medicaid managed care is organized at the county level. Thirty of the state's 58 counties have implemented managed care using one of three models, which dictate 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. In Geographic Managed Care (GMC) there is no local public plan, but rather several private health plans compete for Medi-Cal enrollees. GMC is used in just two counties: Sacramento and San Diego.

About four years ago, Sacramento County's Medi-Cal plans (excluding Kaiser) began moving from fee-for-service payment to capitation for physician services, bringing payment methods for their Medi-Cal HMO contracts in line with methods used on the commercial side. In moving to capitation, the plans began contracting exclusively with IPAs — most notably, River City Medical Group and Employer Health Services (EHS), both longstanding participants in Medi-Cal under fee for service.[6]

CHCs have struggled financially with this change. EHS has an exclusive arrangement with the Sacramento Family Medical Center, a large for-profit Medi-Cal provider with 11 clinics. River City is willing to contract with CHCs in the region, but CHCs reported challenges getting enrollees assigned to them and consequently serve fewer Medi-Cal managed care patients than they had anticipated as they expanded capacity. Some CHCs also noted being more likely to receive sicker enrollees. Further, CHCs reportedly face problems with low, slow, or no payment for the patients they do treat, which affects their financial health and ability to care for uninsured patients.

In shifting to capitation, the Medi-Cal plans appeared to be motivated by the need to reduce their cost trends to better reflect trends in the capitated payments that they receive from the state. Because of budget pressures, state payment rates to Medi-Cal health plans have been flat or increased only slightly for many years. The plans' unwillingness to contract directly with FQHCs/CHCs on a capitated basis apparently reflected doubts about those clinics' ability to bear financial risk, manage utilization, and ensure adequate access to specialty care for Medi-Cal patients — especially since FQHCs in the Sacramento area are relatively new and small, with no track record of being able to manage risk.

CHC concerns about remaining competitive in the Medi-Cal market are escalating as the state moves the Seniors and Persons with Disabilities (SPD) population, known as Aged, Blind, and Disabled in other states, into managed care. The transition began in mid-2011 and was completed in May 2012. Prior to this transition many SPD enrollees received care at CHCs, which could lose substantial Medi-Cal patients and revenues once these enrollees transition into managed care and are assigned primarily to IPA members.

Hospitals have joined community clinics in raising questions about the adequacy and appropriateness of care provided to Medi-Cal enrollees under the GMC model. The hospitals' main concern is that many Medi-Cal managed care patients reportedly come to EDs for non-emergency services. Hospitals suggested that these patients resort to seeking care in inappropriate, costly settings because their care is not well-managed and they are often unaware of their assigned primary care physician. Largely in response to these concerns, Sacramento County convened a stakeholder advisory committee to meet regularly to assess the GMC model.

Preparing for Reform

Most stakeholders in the Sacramento region believed that hospital inpatient capacity is sufficient to handle the increase in insured patients resulting from coverage expansions under national health reform. In support of those views, respondents noted that uninsured patients now generally receive the inpatient care they need, and care is expected to shift from inpatient to ambulatory settings under reform.

However, there was an even greater consensus among stakeholders that the physician supply — especially primary care physicians — is inadequate to meet expanded demand. In the words of one respondent, the coverage expansions will result in a "tsunami of unmet need." Some FQHCs are planning additional primary care expansions but are constrained in part by their inability to recruit physicians — a particular challenge in a market where they must compete against Kaiser and other system-affiliated large groups that offer compensation packages that safety-net providers have difficulty matching. The number of specialist physicians per capita is generally considered adequate, but there is concern that specialists may not accept newly insured patients covered under Medi-Cal or the California Health Benefit Exchange if the payment rates are as low as many expect.[7]

The Sacramento region is not implementing any mainstream community-wide initiatives to prepare for reform, and the safety-net activities that are underway lag behind some other California communities. As part of the Bridge to Reform — California's Medicaid waiver program — the Low Income Health Program (LIHP) is being implemented at the county level to transition uninsured people to insurance when Medi-Cal eligibility expands in 2014.[8] Sacramento County set a low-income threshold for LIHP eligibility (67% of federal poverty, compared to 200% of federal poverty for CMISP and 133% for the Medi-Cal expansion under reform) and has not yet begun enrolling people.

Issues to Track

Recent developments in the Sacramento health care market generate a number of outstanding questions to track over the next several years:

- To what extent will new contracting arrangements such as ACO-like programs between providers and health plans continue to grow? How effective will these collaborations be in improving efficiency, expanding enrollment and competing with Kaiser?
- How will hospitals fare financially under health reform? Can costs be contained and efficiency improved to maintain their relatively strong financial performance?
- Will the construction boom lead to overcapacity, particularly on the inpatient side as care moves to ambulatory settings, resulting in increased financial pressures for hospital systems?
- Will the independent physicians currently practicing in both the Sutter and Dignity systems move toward exclusive alignment with a single system?
- How will provider participation in Medi-Cal change under health reform? In particular, how will Medi-Cal participation of UC Davis and its broader safety-net role evolve?
- To what extent will the community be able to expand primary care capacity to keep pace with demand as more people gain health insurance?
- Will the GMC Medi-Cal model survive in Sacramento County? What will be the impact on FQHCs' Medi-Cal patient bases and financial viability?

ENDNOTES

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

2. 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.

3. Since its inception in 2011, the Delivery System Reform Incentive Program (DSRIP) has provided payments to California public hospitals for identifying and meeting numerous milestones around improving their infrastructure, care delivery processes, and quality outcomes over a five-year period.

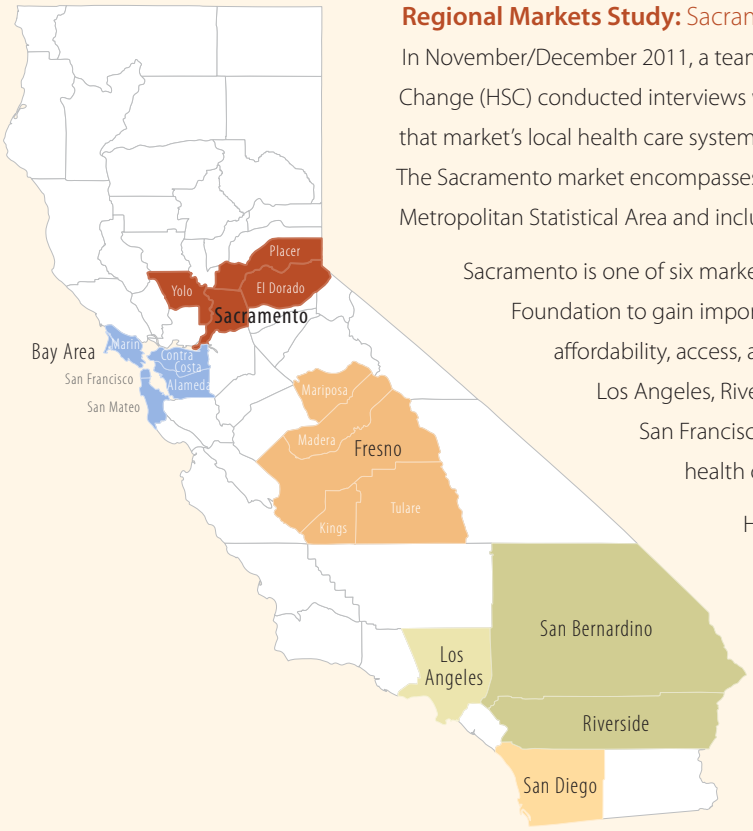
4. Because California's corporate practice of medicine law prohibits hospitals from directly employing physicians, some hospitals sponsor medical foundations as a way to align with physicians. Under a medical foundation model, physicians either contract with the foundation through an affiliated IPA or 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. Sacramento's pilot dental managed care program for children came under fire following a series of stories in February 2012 in the *Sacramento Bee.* Issues are being closely monitored by the Department of Health Care Services (DHCS). In addition, legislation was introduced to make Sacramento's managed care dental program voluntary rather than mandatory.

6. One CHC holds a grandfathered arrangement with a plan: Midtown Medical Center with Anthem Blue Cross.

7. California was the first state to create a health benefit exchange following the passage of federal health care reform. The California Health Benefit Exchange is an independent public entity that will provide a mechanism for individuals and small businesses to shop for and buy health insurance beginning in 2014. The Exchange will be the sole means by which eligible individuals and small businesses can access federal subsidies and credits to help pay for insurance coverage.

8. The Low Income Health Program does not itself provide health insurance but requires counties to provide a benefit similar to Medi-Cal. In Sacramento County, this represents an expansion of services beyond what the currently provides in its CMISP; for example, the expansion includes a mental health benefit, transportation services, and a requirement to meet the Department of Managed Health Care's timely access to care law.



Regional Markets Study: Sacramento

In November/December 2011, a team of researchers from the Center for Studying Health System Change (HSC) conducted interviews with health care leaders in the Sacramento region to study that market's local health care system and update a similar study conducted in October, 2008. The Sacramento market encompasses the Sacramento–Arden-Arcade–Roseville, California, Metropolitan Statistical Area and includes El Dorado, Placer, Sacramento, and Yolo counties.

Sacramento 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 project — Fresno, Los Angeles, Riverside / San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area — reflect a range of economic, demographic, health care delivery, and financing conditions in California.

HSC researchers interviewed 25 respondents specific to the Sacramento 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 FOUNDATION

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