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Sacramento: Pressures to Control Costs Persist Alongside Growing Capacity and Access Challenges

Summary of Findings

Since the last round of this study in 2011-2012, the Sacramento economy has largely rallied from its long post-recession slump. While the health care sector has remained mostly stable overall, it has grappled with capacity constraints and access challenges stemming largely from the Affordable Care Act (ACA) insurance coverage expansions. In addition, the competitive standing among the four major hospital systems in this region — Dignity Health; Kaiser Permanente; Sutter Health; and University of California, Davis — has shifted somewhat over the past few years.

Key developments include:

- **Shifting market positions among hospital systems.** Despite relatively stable inpatient market shares among Sacramento's four well-established systems over the past few years, Kaiser Permanente was perceived to be gaining strength, while Dignity Health appeared to be losing ground. Kaiser, already widely recognized as the lowest cost of the four systems, has increased health plan enrollment while continuing to reduce inpatient utilization and costs. Dignity has faced far more challenges than the region's other systems in meeting state seismic requirements, and is seen as disadvantaged in competing on major service lines, such as cardiology, that appear headed toward excess capacity.

- **Continuing pressure on hospitals to contain costs.** Although the region's economy has largely recovered from the protracted economic downturn, there is pressure on hospital bottom lines from employer insistence on lower premium hikes than in the pre-recession era, and increasing penetration of high-deductible health plans (HDHPs). Some hospitals also viewed the ACA's Medicaid expansion as an added cost pressure; however, others saw it as a net benefit, despite California's low payment rates. Overall, hospital systems have fared well financially by continuing to cut costs. Sutter Health — one of the market's premier brands but also its high-cost provider — has been emphasizing cost reduction as a major organizational strategy, as it aims to step up competition with Kaiser and position itself to take on more value-based payment in the future.

- **Plan-provider collaborations not gaining traction as many had expected.** The narrow-network collaborations first pioneered in the market several years ago have faced challenges aligning incentives among the partners and finding new sources of savings in care delivery to keep the low-premium trend sustainable. Plans and providers are cautiously discussing and experimenting with new collaborations, but Sutter also has rolled out its own health plan targeted initially at mid-sized employers, for whom Sutter is offering HMO products price-competitive with Kaiser.

- **Private practice increasingly challenging for physicians.** Consolidation continued in the physician sector, as young physicians — especially primary care physicians (PCPs) — increasingly chose higher reimbursement

and more controllable lifestyles in the large, system-affiliated medical groups over the autonomy of independent practice. Even single-specialty groups that had long exercised market clout began finding independent practice increasingly unsustainable, and several sold out to hospital medical foundations over the past few years.

- **Capacity constraints tied to ACA coverage expansions.** Both mainstream and safety-net providers faced challenges in expanding primary care capacity to meet surging demand from newly insured patients, especially new enrollees in Medi-Cal (California's Medicaid program). Primary care capacity constraints appeared least acute for Kaiser and most severe for safety-net clinics—reflecting, in large part, the wide disparity in their ability to recruit and retain PCPs and other clinicians. Problems accessing primary and urgent care led many patients to seek treatment in hospital emergency departments (EDs), causing overcrowding. EDs also were overwhelmed by an influx of patients with mental health needs because of county funding cuts for mental health services.

- **Fragmented safety net gains some cohesion and coordination.** The government of Sacramento County recently demonstrated greater commitment to the health care safety net than in the past, though the level of support still lags significantly behind those of some other California counties. Hospital systems and Federally Qualified Health Centers (FQHCs)—along with other stakeholders, including a clinic consortium—have stepped up collaborations

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

	Sacramento	California
POPULATION STATISTICS, 2014		
Total population	2,244,397	38,802,500
Population growth, 10-year	12.1%	9.1%
Population growth, 5-year	5.6%	5.0%
AGE OF POPULATION, 2014		
Under 5 years old	7.3%	6.6%
Under 18 years old	23.8%	24.1%
18 to 64 years old	62.5%	63.1%
65 years and older	13.7%	12.9%
RACE/ETHNICITY, 2014		
Asian non-Latino	12.7%	13.3%
Black non-Latino	7.0%	5.5%
Latino	21.7%	38.9%
White non-Latino	53.0%	38.8%
Other race non-Latino	5.5%	3.5%
Foreign-born	20.1%	28.5%
EDUCATION, 2014		
High school diploma or higher, adults 25 and older	89.6%	83.4%
College degree or higher, adults 25 and older	42.9%	37.9%
HEALTH STATUS, 2014		
Fair/poor health	16.6%	17.1%
Diabetes	10.1%	8.9%
Asthma	15.0%	14.0%
Heart disease, adults	7.2%	6.1%
ECONOMIC INDICATORS, 2014		
Below 100% federal poverty level	12.1%	18.4%
Below 200% federal poverty level	37.4%	40.7%
Household income above $100,000	22.9%	22.9%
Unemployment rate	7.2%	7.5%
HEALTH INSURANCE, ALL AGES, 2014		
Private insurance	56.8%	51.2%
Medicare	12.2%	10.4%
Medi-Cal and other public programs	20.8%	26.5%
Uninsured	10.1%	11.9%
PHYSICIANS PER 100,000 POPULATION, 2011		
Physicians	205	194
Primary care physicians	69	64
Specialists	136	130
HOSPITALS, 2014		
Community, acute care hospital beds per 100,000 population†	165.4	181.8
Operating margin, acute care hospitals*	10.2%	3.8%
Occupancy rate for licensed acute care beds†	58.6%	53.0%
Average length of stay, in days†	4.1	4.4
Paid full-time equivalents per 1,000 adjusted patient days*	18.5	16.6
Total operating expense per adjusted patient day*	$4,126	$3,417

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

to increase capacity and coordination of primary care for low-income residents.

- **Despite more support, the safety net has been strained by increased capacity and access challenges.** Medi-Cal managed care plans, hospital EDs, and safety-net providers have struggled to cope with the health needs of people who gained coverage through the ACA Medi-Cal expansion. This group has been sicker, with more complex needs—including behavioral health—than the traditional Medi-Cal population. Problems caring for the expansion population are compounded by longstanding access and quality problems in three of Sacramento County's four private Medi-Cal managed care plans.

Market Background

The Sacramento region (see map on last page) has a population of 2.2 million people spanning four counties: El Dorado, Placer, Sacramento, and Yolo. The region's population, which has grown at a modest pace in recent years, continues to be less ethnically and racially diverse than the rest of California, with a much higher proportion of white residents and a much lower proportion of Latino and foreign-born residents. Sacramento-area residents continue to have moderately higher education and income levels than state averages; they also have a higher rate of private insurance coverage, thanks largely to the roles played by state government and the four large health systems as major employers in the community.

The region's unemployment rate closely tracks state unemployment trends but is consistently a little below the state average. In 2014, regional unemployment was 7.2%, compared to 7.5% statewide. Besides state government and the major health systems, the local economy does not have many large employers. In recent years, health care has overtaken government as the region's top employment sector.[1]

Within the greater Sacramento market, areas east and northeast of the city of Sacramento—centered around towns such as Roseville and Folsom—are among the region's most affluent, well-insured, and fastest-growing communities. Not surprisingly, these communities represent expansion areas for health care providers, along with Elk Grove in south central Sacramento County—also a high-growth (though not as affluent) population center. Some areas of downtown Sacramento are experiencing a wave of economic revitalization—most notably, the area around the new sports arena being built for the Sacramento Kings professional basketball team. Near the new arena, Kaiser Permanente will be opening a medical office building, the system's first presence in downtown Sacramento. Several blocks north of this site, Kaiser is spearheading development in an area known as the Railyards by building a campus to house new ambulatory facilities and a hospital (see below). However, many parts of the city of Sacramento remain untouched by the current wave of economic development and continue to rank among the most financially strained communities in the region. The incomes of many residents of rural El Dorado, Placer, and Yolo Counties remain low.

Largely Stable Hospital Market Faces Cost-Containment and Capacity Pressures

Sacramento's largely stable hospital sector continues to be characterized by robust competition among its four well-established systems, in an environment widely described as cordial rather than contentious. Three of the systems are private nonprofits: Sutter Health, with four acute care hospitals in the market; Dignity Health, with five hospitals; and Kaiser Permanente, with three hospitals. The fourth system is an academic medical center, UC Davis Health System, which operates one hospital.

No single system has a dominant inpatient market share. In 2014, Dignity's 31% share of inpatient discharges edged Sutter's 27%, followed by Kaiser (21%) and UC Davis (17%). While the hospital sector experienced no major shifts in market shares, these estimates represent a slight increase for Dignity, and a slight decrease for Sutter, over the past few years.

Kaiser's inpatient market share substantially understates Kaiser Permanente Health Plan's dominant and still-growing presence in the insurance market, especially the coveted commercial sector, where it commands about 40% of the market. In contrast to conventional systems that rely on inpatient facilities to serve as profit centers, Kaiser's hospitals are cost centers in its unique business model, where it is both an integrated delivery system and a health plan taking full financial risk. Kaiser's ability to improve on an already efficient model by reducing hospital utilization, while it continues to expand health plan enrollment, is a central reason why other providers view it as an even more formidable competitor now than in the past. As one market observer noted, "With the ACA and all the other market forces creating pressures and incentives to move to . . . value-based payment and population management, the emphasis is on moving to a Kaiser-like model. . . . Kaiser's the only [system] that doesn't have to remake itself, realign incentives, and move out of the fee-for-service world and that 'heads in beds' mentality."

Since the first round of this study in 2008, hospitals have faced strong pressures to contain costs, but some of the key underlying factors have changed. Until three or four years ago, cost pressures stemmed largely from the 2008 recession and the economy's slow recovery. During this period, hospital payer mix deteriorated as commercial coverage fell while low-paying public insurance and lack of insurance both became more prevalent. Even on commercial contracts, many hospitals were forced to accept lower payment rate increases from health plans, which were under pressure from purchasers to slow premium increases.

By 2015, the economy had largely recovered from its extended downturn, but hospitals still felt strong pressure to contain costs. In the commercial market, the pressure to keep insurance premiums in check and competitive with Kaiser is "unrelenting," according to one hospital executive. The pressure comes not only from the California Public Employees' Retirement System (CalPERS), the largest purchaser in the region and the state, but also the region's many small employers, who are acutely price-conscious. A health plan executive noted that, despite Sacramento's generally high rate of private insurance coverage, the market "doesn't have the kinds of high-margin companies you see in San Francisco or Silicon Valley . . . who can afford a pass-through environment" in which payment rate increases to providers are passed on to employers in the form of premium increases of similar magnitude.

Many Sacramento-area employers have been shifting to high-deductible health plans (HDHPs) over time to keep premiums in check. HDHP penetration, in turn, has put pressure on hospital bottom lines; one market observer estimated that "hospitals manage to collect only 18 to 34 cents on every dollar of out-of-pocket" amounts owed by patients with HDHP coverage. This bad-debt issue looms larger for Sutter, Dignity, and UC Davis than for Kaiser, since Kaiser hospitals primarily serve Kaiser's own health plan members, who have lower rates of HDHP coverage than the rest of the insured population.

ACA insurance coverage expansions were viewed by some hospital executives as adding to hospital cost pressures, as these expansions increased the number of insured people, but at low payment rates—especially for the Medi-Cal expansion, which was substantially larger than the growth in Covered California, the state's ACA insurance marketplace. Nearly all hospital respondents noted that California's Medicaid payment rates ranked near the bottom among all states. However, not all hospital systems regarded the coverage expansions as contributors to cost pressures; in fact, several hospitals acknowledged that many newly insured patients had been previously uninsured, and that hospitals had received much less—if anything at all—for treating them as self-pay, charity care, or patients in the counties' medically indigent programs. In addition, Sutter, Dignity, and UC Davis were all net recipients of supplemental funding from the state hospital fee program, which helped hospitals offset losses on Medi-Cal patients.[2]

Despite the cost pressures they faced, hospitals achieved solid to strong financial results in 2014, thanks in part to ongoing administrative and clinical cost-containment efforts. Among the three systems that report hospital-level financial performance,[3] Sutter and UC Davis both posted very strong operating margins of nearly 13%. Sutter's performance was consistent with its historically high margins, while UC Davis' margin represented a substantial increase over previous years. Dignity's smaller but solid margin of 4.8% was in line with its performance in recent years.

The region's per capita inpatient capacity — already lower than the state average — has been trending downward. Most hospital respondents and market observers are not concerned about the contraction in inpatient capacity overall, given the many market forces shifting care away from inpatient facilities toward ambulatory settings; these include technological innovations, the shift toward population health management, and changing payment incentives. Indeed, consistent with this trend, the systems are all expanding a wide array of ambulatory facilities both on hospital campuses and throughout the community, particularly in high-growth areas with large concentrations of well-insured populations.

Although future inpatient capacity did not appear to be a significant concern overall, some respondents did raise concerns about how well the types of new inpatient beds coming online would be matched to future patient needs. As one hospital executive observed, "The absolute number of beds might be sufficient, but the distribution of beds might not be right." Many of the new beds are slated for specific service lines, and converting them to alternative uses will be challenging. Another hospital executive explained: "You can't just convert part of the maternity unit if you need to expand, say, an oncology unit. The challenge isn't so much one of licensure as it is about . . . disrupting the culture, environment, and patient experience."

In August 2015, Sutter became the first system in the region to achieve full compliance with state seismic standards when it closed Sutter Memorial Hospital and opened a new women's and children's hospital on the same campus as a completely renovated, seismically compliant Sutter General Hospital. The expanded campus is now known as Sutter Medical Center. To varying degrees, the three other systems need new hospital construction to meet seismic compliance by 2030. Kaiser and UC Davis are expected to meet seismic standards many years before the deadline.

Kaiser, which needs to replace one of its three hospitals (Sacramento Medical Center), has set capital aside for construction and has chosen a site in the Railyards area just north of downtown. UC Davis also has capital set aside for its smaller project, a replacement of one wing of its single hospital. Dignity faces the toughest challenge among all four systems: Only one of its five hospitals is compliant beyond 2030. The system does not appear to have set aside the multibillion-dollar capital commitment required for these major construction projects, and it is likely to need a reprieve from the state. This looming issue may explain, in part, the view widely held by hospital competitors and market observers of Dignity as a struggling organization, despite its still-positive financial margins.

Potential Excess Capacity Looming for Some Services

The three non-Kaiser systems (Sutter, Dignity, and UC Davis) continue to pursue fee-for-service strategies vigorously — including the development of lucrative service lines such as oncology and cardiology — even as providers all acknowledge the need to prepare themselves for value-based payment. Several respondents raised questions about whether capacity in certain service lines has reached the point of market saturation. For instance, all three non-Kaiser systems have new cancer centers providing mostly outpatient services. In cardiology, the market used to have two major programs — Dignity and Sutter — with Kaiser outsourcing its cardiac care to Dignity's Mercy General Hospital, where Kaiser members accounted for 40% of the volume. In recent years, Kaiser has been building its in-house cardiology capacity; its exclusively affiliated physician organization, The

Permanente Medical Group, now employs all the cardiologists treating Kaiser members. Kaiser also has begun hiring cardiac surgeons—a process that is likely to be completed over the next 5 to 10 years.

With hospital systems having expanded capacity in key service lines in recent years, most respondents believed that demand within the regional market would not be sizable enough to support all the competing programs. The systems all appeared to be looking to smaller markets beyond the immediate Sacramento region to serve as patient feeders for their service lines. This approach includes the development of formal clinical affiliations with hospitals in outlying areas and less formal referral relationships with providers farther afield, in some cases as far as the Oregon border and into Nevada. Sutter appeared to have advanced the furthest in developing strong referral networks from outside the region. Many respondents perceived Dignity to be facing key disadvantages, including management turnover, a late start in developing referral networks, and what some competitors and observers viewed as the lack of a clear organizational strategy to support key service lines.

Systems Facing ED and Primary Care Capacity Constraints

Hospitals in all four systems reported facing serious problems with ED overcrowding—problems they attributed, at least in part, to funding cuts Sacramento County had made to mental health services. In 2009, during a budget crisis at the height of the economic downturn, the county slashed funding for both inpatient and outpatient mental health care for its medically indigent population. As a result, uninsured people experiencing mental health crises had no place to seek care but the ED—a situation that resulted not just in overcrowding, but also a difficult and disruptive environment for EDs throughout the county. In mid-2015, Sacramento County voted to restore much of the funding it had cut in 2009 (see Safety Net section below), which should help alleviate some of the ED capacity constraints.

The other key driver of ED overcrowding was the insurance coverage expansions mandated by the ACA, which led to surging demand for many services, including primary and urgent care. When these services were not readily available in other care settings, newly insured people—mostly Medi-Cal enrollees—sought care in the ED. The systems have responded by expanding their partnerships with safety-net clinics in initiatives to make primary and urgent care more accessible in ambulatory settings (see Safety Net section below).

Historically, the Sacramento region has had modestly higher primary care capacity than California as a whole. While the strains on that capacity brought on by the ACA insurance expansions created challenges for all four systems, Kaiser's issues were less pressing than those faced by others. In part, this stemmed from the significant edge Kaiser holds in recruiting primary care physicians (PCPs). It also can be attributed to Kaiser's greater use of technologies such as telemedicine and secure messaging to supplement and substitute for office visits. Despite an increase in health plan enrollment, Kaiser has been able to maintain a commitment to same-day PCP access for its members. Sutter's medical group has been increasing capacity with the aim of providing same-day primary care access, but in a reflection of PCP scarcity outside the Kaiser system, Sutter's commitment is likely to be for same-day access to a PCP team member (who might be another clinician such as a nurse practitioner or physician assistant) rather than a patient's personal PCP. Sutter also has rolled out My Health Online, which allows patients to schedule medical appointments, view their medical records, and communicate with physicians online—all features that Kaiser introduced years ago. While Sutter is playing catch-up to Kaiser in using technology to improve primary care access, it is widely viewed as ahead of the other hospital systems in these areas.

Consolidation Continues in Physician Sector

The Sacramento market's relatively consolidated physician sector continues to be dominated by four large medical groups and two large independent practice associations (IPAs), each affiliated exclusively with a hospital system. Kaiser and UC Davis each continue to contract directly and exclusively 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 (TPMG), is by far the largest physician organization in the region. It employs about 1,500 physicians in greater Sacramento. At UC Davis, physicians are employed by the university and belong to the UC Davis Medical Group, which is about half the size of TPMG—but with far fewer full-time equivalents because UC Davis faculty physicians also engage in research and teaching.

Sutter Medical Foundation includes Sutter Medical Group (more than 650 physicians) and is affiliated with Sutter Independent Physicians, an IPA exclusive to Sutter (about 600 physicians). Together, the medical group and IPA form a single referral network for capitated contracts. Dignity's medical foundation continues to be much smaller than Sutter's. In the Sacramento region, the foundation's presence is represented primarily by Mercy Medical Group, which has grown to about 300 physicians. Despite being aligned through the medical foundation, Mercy Medical Group is widely perceived to be less integrated with Dignity hospitals than Sutter Medical Group is with Sutter hospitals.

Hill Physicians, an independent IPA active in many Northern California markets, is roughly equivalent in size to Sutter Independent Physicians in the Sacramento region. Although Hill admits patients exclusively to Dignity hospitals, it does not engage in mutual referrals with Mercy Medical Group. Instead, it maintains its reputation for being highly independent and entrepreneurial, and negotiates directly with health plans for HMO contracts.

The region's large medical groups continued to grow at a moderate pace over the past few years, using diverse strategies to draw new hires from within and outside the market. As noted above, TPMG retained a competitive edge in its ability to attract PCPs—an edge that some attributed to a richer compensation package, and others to factors such as more favorable working conditions (e.g., lighter call-coverage duties) resulting from the group's large size. The latter is considered a particularly important advantage in attracting younger physicians, who tend to value lifestyle considerations more highly.

With young physicians—especially PCPs—increasingly choosing to join large groups for higher reimbursement rates as well as more controllable lifestyles, the composition of IPAs has been gradually changing over time. IPA members have become older on average and increasingly tilted toward specialists, reflecting broader changes in independent practice not only in the Sacramento region, but across many markets.

Over the past few years, the environment has become increasingly challenging for independent single-specialty groups—even for those groups that had long exercised leverage in the market by virtue of their ability to control a large share of physicians in their specialty. Some of these groups became embroiled in contract disputes with major systems—particularly Sutter—which caused their volumes and market positions to erode, leading the groups to become acquisition targets by the large system-affiliated groups.

The most prominent example was Radiological Associates of Sacramento (RAS), which long enjoyed an undisputed reputation as the premier radiology practice in the region. For decades, RAS served as Sutter's exclusive radiology provider, but after a protracted contract dispute, Sutter terminated contracts with RAS in 2010. In the aftermath, Sutter had to hire its own radiologists—a move resulting in some care disruptions and quality issues, according to multiple observers. The contract termination, however, had a far more devastating impact on RAS, where a collapse in patient volume led to major staff layoffs. In 2014, RAS agreed to join Sutter Medical Group. Respondents cited other similar examples,

including a hematology-oncology group that disbanded, also following a contract dispute with Sutter.

For other practices that have given up their independent status to join larger, system-affiliated groups, the catalyst was not a contract dispute but more generally, the increasingly untenable demands of private practice. Recently, several groups announced plans to sell their assets to Dignity's medical foundation and become part of Mercy Medical Group.

Plans and Providers Continue to Experiment with New Narrow Networks

Several years ago, Sacramento became one of the first California markets to develop experimental narrow-network collaborations between providers and health plans in which providers accepted lower payment in exchange for exclusivity. Unlike previous versions of narrow networks formed by health plans based solely on providers' unit prices, these new initiatives involved providers and plans working together—including exchanging data—to improve overall care efficiency by reducing unnecessary utilization and better managing care for a defined population.

In the last round of the study, one market observer described Sacramento as "a giant petri dish" for these new value-based payment and care delivery models, because the region featured a number of promising market conditions: large hospital systems that, together with aligned physician organizations, could serve as exclusive networks; physician experience with and enthusiasm for capitation; the need for providers to compete with a strong Kaiser system; and the presence of purchasers pressuring health plans for innovations to slow premium growth.

Given these favorable conditions, two narrow-network partnerships were introduced to the market. The first, and by far the state's most prominent, was the CalPERS ACO, a partnership among Blue Shield of California, Dignity, and Hill Physicians. First piloted in 2010, the accountable care organization (ACO) was initially successful in generating savings—with a substantial portion going to CalPERS in the form of prospective premium trend reductions—and gaining market share by undercutting Kaiser premiums.

Over time, however, these gains proved difficult to sustain for several reasons. First, it became more challenging for the ACO partners to identify new shared savings opportunities for the same enrolled population. Also, in 2013, CalPERS began allowing other health plans to enter the previously restricted CalPERS market and offer HMOs to its members, thus creating more competition for the ACO. Finally, Kaiser responded to the new competition by cutting its own premiums, thus regaining many enrollees. The CalPERS ACO still exists—in fact, the partners have expanded their arrangement to include more covered lives from other purchasers—but it struggles to maintain competitive pricing.

Sacramento's other narrow-network offering was the Health Net PremierCare Network, an HMO collaboration between Health Net and the Sutter system, including Sutter's hospitals, affiliated medical group, and IPA. Like the CalPERS ACO, the PremierCare HMO aimed to gain HMO members by undercutting Kaiser premiums. The product was targeted toward the mid-sized employer segment, and after its 2011 rollout, it had some initial success in signing up local public employers. However, it failed to gain traction in building enrollment. Respondents offered mixed views about the underlying reasons. Some suggested that Health Net did not promote the product as aggressively or effectively as it could have, while others pointed out how challenging it was for such collaborations to achieve enough efficiency to continue undercutting Kaiser, especially when Kaiser could respond to new competition by cutting its own premiums. Some respondents also cited the "stickiness" of the Kaiser system, referring to the ability of Kaiser to win back members who leave the system for lower-premium products. These competing products are typically narrow networks, and many enrollees reportedly return to Kaiser after finding less seamlessness, convenience, and access—especially to PCPs—in other provider networks.

The transition from volume-based to value-based payment in the Sacramento market has progressed far more slowly than most respondents had expected. One hospital system executive observed, "In 2012 we hypothesized that by 2015, 50% of our patient population would be in an ACO model or total-cost-of-care contracts. In reality, the penetration has been minimal. But we think it is still headed in that direction."

In the wake of its failed collaboration with Health Net, Sutter has turned to other strategies for increasing volume. Since 2014, for example, it has partnered with United Healthcare on a narrow-network HMO for CalPERS members. But by far the biggest strategic move by Sutter was the introduction of its own health plan, Sutter Health Plus. Launched in 2014 in the Sacramento region, the new health plan offers HMO products centered around Sutter's own providers, and—like the PremierCare HMO before it—is aimed squarely at competing with Kaiser for mid-sized employers. A central objective in sponsoring its own health plan is to keep the savings from Sutter's cost-reduction efforts within the Sutter system, rather than having to share them with external health plans.

With Sutter Health Plus HMO products priced lower than those of Kaiser, the new health plan has shown promising early signs of being able to build enrollment. Several observers, however, questioned whether Sutter Health Plus can keep undercutting Kaiser premiums without continuing substantial subsidies from the Sutter system, given that Sutter's cost structure is widely viewed as significantly higher than Kaiser's. Some respondents also noted that many attempts in the past by providers—including Sutter—to sponsor their own health plans ended unsuccessfully.

Sutter Aims to Transform into a Value Provider

Launching its own health plan is part of a broader, more ambitious effort by Sutter—long regarded as the market's premier provider brand but also its high-cost provider—to reduce costs and remake itself into a value provider. As one market observer noted, "It's a huge paradigm shift for Sutter." On the administrative side, Sutter consolidated its many back-office services throughout Northern California into a single Sacramento location in 2013. On the clinical side, the system implemented multiple initiatives to reduce inpatient costs and reportedly was able to lower those costs significantly; more recently, it has been working on cutting ambulatory costs. Sutter has made recent progress in integrating its delivery system—most notably implementing a common electronic health record across inpatient and ambulatory settings in 2015. While lagging behind Kaiser in the use of clinical IT, Sutter is generally viewed as ahead of the other two systems in the market.

Sutter also has made major organizational changes with the aim of centralizing and streamlining decisionmaking. The system undertook two rounds of consolidation to rein in a previously sprawling, decentralized, unwieldy governance structure. The first round, in 2010, consolidated more than 40 separate hospital regions into five. The second round, completed in spring 2015, further consolidated the five regions into just two. One of these new regions is the Valley Region, formed by merging the Sacramento Sierra Region—which includes the Sacramento market—with the Central Valley Region.[5]

As Sutter seeks to improve its competitive position by reducing its cost structure, one of the key challenges it faces is that Kaiser is focused on reducing its own, already lower cost structure. A health plan executive referred to Kaiser as "a moving target . . . continuously working on becoming more efficient [in areas where] they're already known for their efficiency, like inpatient [utilization]." Respondents cited examples such as Kaiser's Early Recovery After Surgery (ERAS) initiative, which has not only reduced lengths of stay but also improved clinical outcomes and satisfaction for joint-replacement patients.

More broadly, Sutter's effort to transform itself into a value provider is a major shift in emphasis for the organization, one that requires a major realignment of incentives

and culture throughout the system. One market observer described Sutter as a "classic case of a tremendously successful . . . fee-for-service provider trying to straddle [the] twin worlds" of conventional fee-for-service and new value-based payment. Several respondents suggested that Sutter inevitably will face many conflicting incentives about how much, and how fast, to transition away from a longstanding approach of leveraging its consolidated market power to command high payment rates. Indeed, some observers pointed to Sutter's recent, highly contentious contract dispute with Blue Shield (resolved in early 2015) as evidence that the system has not moved away from the conventional fee-for-service strategy of using must-have status to extract high rates.

Fragmented Safety Net Gains Some Cohesion but Faces More Demand

Historically, the Sacramento County safety net has been weak and fragmented, characterized by a county government providing limited funding and support; a collection of small, poorly funded, private community health centers only loosely affiliated with one another; and no dedicated county safety-net hospital. The neighboring counties—El Dorado, Placer, and Yolo—have had more safety-net capacity and infrastructure relative to the size of their low-income populations.

Recently, Sacramento County's safety net has grown somewhat stronger and less fragmented, with the Board of Supervisors demonstrating a greater commitment to safety-net funding than it has shown in several years. In addition, there have been increasing efforts by several players—including philanthropic organizations, the hospital systems, and a clinic consortium—to expand safety-net provider capacity and to coordinate efforts among the safety-net providers. Despite these promising signs, the safety net has continued to face challenges over the past couple of years, and is under stress due to high demand and insufficient capacity, in large part as a result of surging demand from the large Medi-Cal expansion.

Three Systems Share Hospital Safety-Net Responsibility

In a community without a dedicated, county-operated safety-net hospital, UC Davis had long been perceived as the primary inpatient and specialty outpatient facility for low-income patients. That perception began changing approximately five years ago, as Sutter and Dignity both began assuming larger safety-net roles.[6]

UC Davis' somewhat scaled-back role stems in part from the termination of its contract with Sacramento County to provide care to residents the county deems medically indigent.[7] The two parties are still in litigation over unpaid fees for indigent care that UC Davis has provided since that termination. In recent years, UC Davis also has stopped participating in all but one Medi-Cal managed care contract. Multiple observers noted that these developments are consistent with a broader trend of UC health systems statewide stepping back from their roles as the primary safety-net hospitals in their communities, in an effort to maintain financial viability in the face of diminished funding from the state.

Kaiser's safety-net hospital role is largely limited to the care it provides to its 74,000 Medi-Cal enrollees (approximately 18% of Medi-Cal managed care enrollees in Sacramento County as of April 2015; see Medi-Cal Managed Care section below). Overall, Medi-Cal accounts for a smaller proportion of Kaiser's patient mix compared to the other three systems.

As described earlier, all four systems faced serious ED overcrowding in recent years, in large part stemming from Sacramento County mental health funding reductions. In June 2015, the County Board of Supervisors restored many of the mental health services it had cut in the 2009 budget crisis, with an emphasis on expanding the number of outpatient beds.[8] The nearly $14 million in new funding includes about $6 million in state grants for which the county expects to receive state approval soon. The restoration of mental health funding was a high priority for a community coalition composed of the four systems, safety-net providers, community organizations, and other stakeholders that worked with the county to address the ED crisis. Several observers cited the

coalition's work as an example of the collaborative environment in the community. The board's unanimous approval of new funding also reflected Sacramento's improved economy and a changing, less politically conservative board, according to several observers. When the new mental health services come online, they are expected to alleviate not only overcrowding but also the chaotic environment created by people undergoing mental health crises in the county's EDs.

Also as noted earlier, ED capacity constraints have been driven more broadly by increased demand from newly insured Medi-Cal enrollees, with many in this group seeking ED treatment for primary and urgent care when alternative care settings were unavailable or hard to access. Recognizing this issue, all four systems have been collaborating, to varying degrees, with Federally Qualified Health Centers (FQHCs) to improve primary care access for Medi-Cal patients, with the primary aim of reducing inappropriate ED use. The effectiveness of these efforts has varied overall and has been limited by the capacity and expertise of the FQHCs—which are less developed in Sacramento than in some other communities—and by overall primary care capacity constraints in the community.

Primary Care Safety-Net Providers Expand and Face Growing Pains

The ACA coverage expansion resulted in a significant expansion of the FQHCs that primarily serve the Medi-Cal population (and receive federal grants and enhanced payments for doing so). As FQHCs have grown, there has been a corresponding contraction in safety-net clinics focusing on the low-income uninsured population, which has declined with the ACA eligibility expansion.

UC Davis and Dignity, the two systems that had long operated clinics focused on low-income patients, have been transferring operations of those clinics to FQHC organizations, to varying degrees. The public FQHC, county-operated Sacramento County Health Center, now serves as one of UC Davis's primary medical resident training sites for adult medicine. WellSpace Health, one of the region's largest FQHCs, now operates the clinic site serving as UC Davis's part-time training site for pediatrics. Within the past couple of years, Dignity transferred operation of its four clinics to FQHCs: Three were transferred to WellSpace and one to Peach Tree Health, an FQHC from nearby Sutter and Yuba Counties. Dignity still owns the clinics but signed agreements allowing the FQHCs to operate the clinics at their discretion at no charge. These transfers of clinics from hospital systems to FQHCs appeared to be primarily a response to payment incentives, as FQHCs receive federal grants and generally receive higher payment rates than other clinics for treating Medi-Cal patients. Also, as FQHCs began growing in the community in recent years, the mainstream systems began to view the FQHCs as potential partners, especially in providing care for Medi-Cal patients.

Sacramento's FQHCs, whose development has lagged behind that of many California communities, grew substantially over the past few years. In 2011, Sacramento County had 8 FQHC organizations: 5 full FQHCs and 3 look-alikes (which receive the enhanced payment rates but are not eligible for federal grants). By 2015, there were 11 full FQHCs operating in the county. In addition, several existing FQHCs were able to expand capacity by opening new clinic sites. Grants from the region's hospital systems and philanthropic organizations have helped these health centers provide the services and meet the requirements needed to gain federal status.

After recent expansion, WellSpace (formerly known as The Effort) has more clinic sites than any other FQHC in the region, with nine full clinic sites and five satellite sites. Measured by patient visits, however, Health and Life Organization (HALO)—with four full clinic sites and one dental clinic—has a slightly larger presence, with over 113,000 visits compared to WellSpace's 103,000 visits in 2014.

Tensions reportedly exist between WellSpace and other FQHCs, spurred by WellSpace's aggressive expansion and the perception that it receives a disproportionate share

of attention from hospital systems as a partner in collaborations. These tensions reflect continuing fragmentation within the safety-net provider community. Some safety-net advocates—most notably, the regional clinic consortium, Capitol Health Network—have been working on improving collaboration and cohesion among the FQHCs. One major challenge they face is that FQHCs in the region are relatively new and less developed than in many in other California regions. As one respondent observed, the region's clinics are still sorting out what it means to be part of an "FQHC community," and cohesion has been slow to develop. It was only recently that two of the region's largest FQHCs, WellSpace and Sacramento Native American Health Center, joined the Capitol Health Network clinic consortium.

FQHC expansions have been accompanied by growing pains, most notably staffing constraints. From 2011 to 2014, total patient visits to FQHCs in Sacramento County increased by 95%, but full-time equivalents (FTEs) grew by only 57%. The number of visits per clinician went up by 25% over the same period, placing substantial stress on clinic staff. Clinic respondents also noted that patients find it very difficult to get timely appointments.

Each of the four hospital systems is collaborating, to varying degrees, with FQHCs to help clinics expand primary care (and, in some cases, specialty care) for low-income people. Sutter—the system most active in collaborations—has been partnering with FQHCs in Sacramento, Placer, and Yolo Counties to establish clinics on or near Sutter campuses. As noted above, the systems are motivated in large part by the need to relieve overcrowding and inappropriate use of their emergency departments.

By most accounts, the partnerships between hospital systems and FQHCs have faced many challenges, with some of the most serious reportedly stemming from FQHC capacity constraints and relative lack of experience in managing care. One hospital executive described an FQHC partner as having "overpromised and underdelivered" on its ability to provide a medical home for the new Medi-Cal enrollees seeking primary and urgent care in that hospital system's EDs. Many Medi-Cal patients continued seeking care in the ED when the "overwhelmed" FQHC could not meet their needs in outpatient clinic settings, according to this respondent.

Safety-net clinics reported facing major staff recruitment and retention challenges, which have hampered not only their expansion efforts, but in some cases also their ability to maintain current capacity. As noted above, the number of patient visits per clinician FTE has soared, reflecting the very challenging working conditions resulting from the Medi-Cal expansion. In addition, safety-net clinics find it difficult to compete with the mainstream systems—especially Kaiser—which offer higher compensation, as well as more favorable working conditions, for physicians or other clinical staff. With trouble filling many vacancies, some FQHCs, including WellSpace, have been plugging staffing gaps by using temporary physicians.

County Expands Safety-Net Commitment

Sacramento County's Board of Supervisors has long had a reputation for being more focused on law-and-order issues than public health. Its commitment to safety-net care historically has been limited, and in economic downturns, county funding for low-income care often was subject to severe cuts. Some respondents suggested that recently, the board has begun to show greater commitment to the safety net, as board composition has been slowly evolving to reflect changing demographics and politics in the county, caused in part by an influx of residents from the Bay Area.

As an example of the board's increasing focus on health care for low-income people, respondents cited the county's 2012 implementation of the Low Income Health Program (LIHP), a county option under California's "Bridge to Reform" Medicaid waiver to transition low-income people to a Medicaid-like program in preparation for the Medi-Cal expansion. Sacramento County's decision to implement the LIHP reportedly created some goodwill between the county and the safety-net community. However, other safety-net

advocates pointed out that Sacramento did not commit to the LIHP as fully as some other counties; it was slow to get the program off the ground and set a relatively low income-eligibility threshold (67% of federal poverty). Ultimately, the LIHP provided a care network for 18,000 uninsured adults and transitioned them to Medi-Cal in January 2014, where they accounted for about 12% of the new Medi-Cal population.

In June 2015, the Sacramento County Board of Supervisors approved new spending for two key safety-net programs that had been slashed during the 2009 economic crisis. As noted above, county mental health spending will be boosted by nearly $14 million. In addition, the board voted unanimously to restore health services to a portion of the medically indigent, undocumented-immigrant population. The board's approved budget of more than $5 million would cover 3,000 adults—just a small segment of the estimated tens of thousands of undocumented immigrants[9]—and the program would focus mostly on primary care, plus some services not provided by emergency Medi-Cal. Still, despite the program's limited scope and funding, the board's unanimous vote was viewed by providers and safety-net advocates as a promising sign of renewed county support for services to undocumented immigrants.

Until the 2009 funding cutbacks, undocumented immigrants had been eligible for care under the county's medically indigent program, so the new funding can be regarded as a return to pre-recession priorities—a move made possible by an improved economy. The board decision to approve funding came after the county had studied other counties' indigent care programs and convened stakeholder meetings. The board reportedly was influenced by Fresno County's recent decision to retain limited services for its undocumented population after its broader medically indigent program ended.

Although the county recently has been stepping up its funding of care for low-income people, budget challenges have led the board to move slowly and cautiously in approving new funding. Most notably, state Assembly Bill 85 reduced the county health budget by almost $30 million.[10] In addition, the county's general revenues have been slow to recover from the economic downturn.

Medi-Cal Geographic Managed Care Model Still Under Fire

Sacramento County continues to organize Medi-Cal managed care through the Geographic Managed Care (GMC) model, with the state contracting with multiple managed care plans and paying each on a capitated basis. Under the GMC model, there is no public, county-run plan (called a "local initiative") that many other California counties operate. Four private health plans—Anthem Blue Cross (39% market share), Health Net (30%), Kaiser (18%), and Molina (14%)—compete for Sacramento County's total Medi-Cal managed care population of nearly 420,000 in 2015. The Medi-Cal expansion resulted in an increase of about 153,000 enrollees—or about 57% growth—in Medi-Cal managed care in Sacramento County from December 2013 to October 2015, with the growth distributed fairly evenly across the four plans.

Critics have long pointed to access and quality problems under the GMC model. In the last round of the study, the county had convened a stakeholder advisory committee to meet regularly to assess the model, as mandated by the state legislature.[11] Since then, this committee reportedly has struggled to gain traction because of lack of funding and limited staffing.

According to the Department of Health Care Services' Medi-Cal Managed Care Performance Dashboard, the three non-Kaiser plans—Anthem, Health Net, and Molina—performed well below the state average on a composite measure of quality and satisfaction. Their scores ranged from 40 to 45 out of 100, compared to a state average score of 58.[12] It is the performance of these three plans that has raised questions about access and quality in Medi-Cal managed care plans in Sacramento County. In contrast, Kaiser—whose Medi-Cal members have access to exactly the same care network as its

commercial members—outperformed all Medi-Cal plans in California, with a composite score of 98.

As noted above, however, only about 18% of the Medi-Cal managed care population in Sacramento has Kaiser coverage. In large part, this relatively modest enrollment stems from Kaiser's longstanding policy of limiting its Medi-Cal enrollment to people who meet its own strict eligibility criteria: either having been Kaiser members themselves within the last 12 months or having an immediate family member who has been a Kaiser member during that period. As part of the ACA insurance expansion, Kaiser did hold a 90-day open-enrollment period for the Sacramento region in late 2013, during which all residents eligible for Medi-Cal could sign up for Kaiser Medi-Cal coverage. This open enrollment boosted Kaiser's Medi-Cal enrollment significantly.

The Medi-Cal expansion has brought more challenges for Sacramento's Medi-Cal managed care plans, particularly the three non-Kaiser plans already dealing with capacity and access issues. Numerous respondents noted that besides the large numbers of newly insured residents straining capacity, Medi-Cal plans also faced challenges of providing care for an expansion population that had far more complex, multiple health needs—particularly behavioral health issues—than the traditional "mothers and kids" Medi-Cal population. Providing appropriate and timely behavioral health care—already in scarce supply in the community—has been especially challenging. Under the expanded Medi-Cal behavioral health benefit, Medi-Cal managed care plans are responsible for mild-to-moderate mental health issues, while county specialty mental health providers have responsibility for severe mental health issues. Communication and coordination between the plans and the specialty providers have been fraught with problems, according to several respondents.

Despite widespread dissatisfaction with the performance of most health plans under the GMC model, the stakeholder advisory committee has not discussed moving Sacramento County to an alternative model of Medi-Cal managed care. As in the past, some in the safety-net community are advocating a shift to a County Organized Health System, in which the county runs a single health plan, or a Two-Plan Model, in which a county-run plan competes against a private plan. However, given that some of the access and quality issues experienced by the three non-Kaiser plans appear to stem, at least in part, from the relative weakness and fragmentation of safety-net providers in the Sacramento community, it is not clear that an alternative Medi-Cal managed care model would resolve the issues, since a county-run plan presumably would have to use much the same infrastructure currently employed by the three non-Kaiser plans.

Among other counties in the region, Yolo County continues to have a single, county-run health plan under the County Organized Health System. In late 2013, El Dorado and Placer Counties transitioned from fee-for-service Medi-Cal to a new "Regional Model" of managed care for rural counties, with two private plans—Anthem Blue Cross and California Health and Wellness—competing for enrollees.[13]

Issues to Track

- Will hospitals be able to continue containing costs and improving efficiency to maintain their relatively strong financial performance? How will the changing payer mix under the ACA coverage expansions ultimately affect hospitals' bottom lines? Will cost pressures continue, increase, or decrease for hospitals in the future?

- How well will hospital capacity align with overall patient demand in the community? Are some service lines headed toward excess capacity, and if so, what will be the ultimate fallout?

- To what extent will contracts between providers and health plans continue to evolve from volume-based to value-based arrangements? How much traction will Sutter's new health plan gain? How effective will these initiatives be in improving efficiency, expanding enrollment, and competing with Kaiser?

- How successful will the Sacramento region be in expanding primary care capacity overall? Which providers and patient populations will most feel the impact of primary care capacity constraints?

- Will FQHCs be able to achieve financial and organizational stability as they expand and mature? How effective will they be in providing medical homes for their Medi-Cal and other low-income patients, and helping reduce patients' use of EDs?

- Will Sacramento County continue to increase its commitment to safety-net funding and support? Will recent efforts to bring safety-net providers together to create a more coordinated system of care prove productive?

- What does the future hold for the Medi-Cal GMC model in Sacramento? Will county or state authorities take concrete steps to address access and quality issues for plans with subpar performance? Will Medi-Cal managed care's new Regional Model improve access and coordination of care for beneficiaries in El Dorado and Placer Counties?

ENDNOTES

1. Dale Kasler, "Sacramento's Economy Rebounds, but Many Workers Struggle," *Sacramento Bee,* April 18, 2015, **www.sacbee.com**.

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, to which federal matching dollars are added; these funds are then redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. Payments began in 2010. The program has been renewed three times and is currently set to expire at the end of 2016. However, California voters could approve a ballot initiative in November 2016 that would eliminate the program's end date and require voter approval of further changes to the program.

3. As an acknowledgment of Kaiser's unique business model, the state of California does not require Kaiser to report financial performance at the individual hospital level.

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 belong to a medical group that contracts exclusively with the foundation through a professional services arrangement. University of California hospitals, county hospitals, and some nonprofit organizations such as community clinics are among the entities allowed to employ physicians directly, through exceptions to the corporate practice of medicine prohibition.

5. The other new region is the Bay Area Region, formed by merging three Sutter regions: West Bay, East Bay, and Peninsula Coastal.

6. In 2014, UC Davis accounted for far fewer discharges for low-income patients than either of the larger systems; however, UC Davis had by far the most total revenues from low-income programs. The difference between the two sets of numbers likely reflects differences in the mix of services provided by the three systems, with UC Davis providing the most high-end tertiary and subspecialty services.

7. Under California Welfare and Institutions Code Section 17000, all California counties are responsible for providing health care services to their neediest residents, although counties have considerable discretion in setting eligibility criteria (e.g., income and immigration status) and the level of services they provide.

8. Kathy Robertson, "Sacramento County Boosts Mental Health-Care Funding to Relieve Crowded ERs," *Sacramento Business Journal,* June 18, 2015, **www.bizjournals.com**.

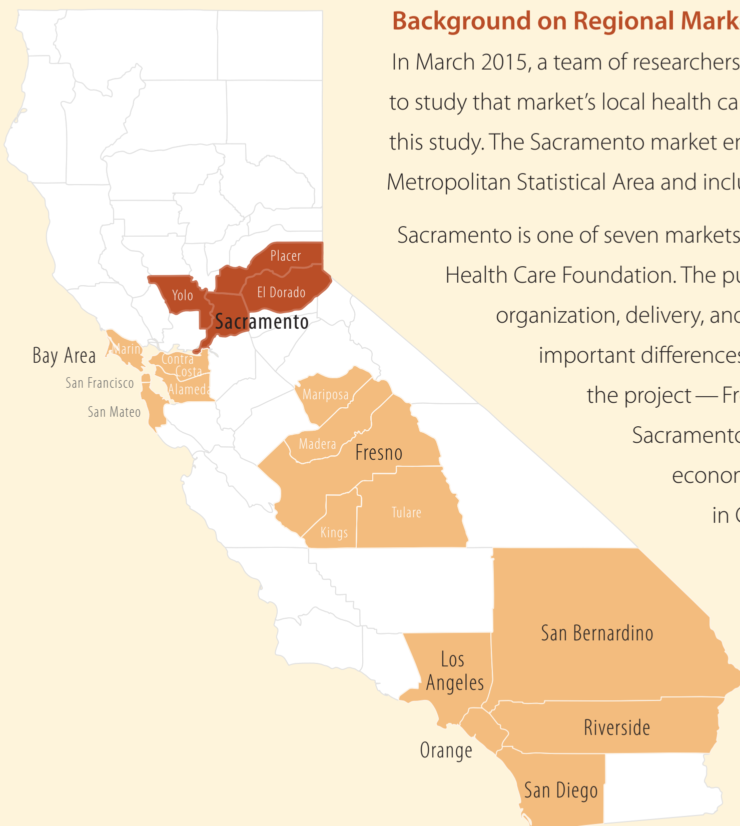
9. David Gorn, "Sacramento County Votes to Provide Health Care for Undocumented Adults," *California Healthline,* June 18, 2015, **www.californiahealthline.org**.

10. In an arrangement known as 1991 realignment, California counties receive funds from state vehicle license fees and sales tax revenues to support county health, mental health, and social services programs. With the expectation that many uninsured residents would gain Medi-Cal or other coverage under the ACA and the need for county medically indigent programs would decline, Assembly Bill 85 transfers either 60% or a formula-based percentage of each county's health fund to social services. Sacramento is one of the counties to have 60% of its county health funds redirected.

11. The legislature also mandated a committee to address dental managed care plans and poor access for Medi-Cal beneficiaries; this committee has also had limited impact due in large part to staff turnover at Denti-Cal.

12. *Medi-Cal Managed Care Performance Dashboard,* California Department of Health Care Services, June 16, 2015, **www.dhcs.ca.gov** (PDF).

13. Kaiser also has a small number of enrollees — a result of Healthy Families enrollees transitioning into Medi-Cal.



Background on Regional Markets Study: Sacramento

In March 2015, a team of researchers from Mathematica Policy Research visited the Sacramento region to study that market's local health care system and capture changes since 2011-2012, the last round of this study. 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 seven markets included in the Regional Market Study funded by the California Health Care Foundation. The purpose of the study is to gain important insights into the organization, delivery, and financing of health care in California and to understand important differences across regions and over time. The seven markets included in the project — Fresno, Los Angeles, Orange County,* Riverside/San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area — reflect a range of economic, demographic, health care delivery, and financing conditions in California.

Mathematica researchers interviewed more than 200 respondents for this study, with 19 specific to the Sacramento market. Respondents included executives from hospitals, physician organizations, community clinics, Medi-Cal health plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.

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

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