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CALIFORNIA HEALTHCARE FOUNDATION

San Diego: Retreat from Capitation Raises Cost Concerns

San Diego Market Background

San Diego County had a total population of approximately 3 million in 2007, or 8 percent of the state's population (see Table 1 on page 2). Population growth over the past ten years has been steady but somewhat slower than for California as a whole (9 percent versus 14 percent statewide). The proportion of the population in San Diego that is 65 years and older (11 percent) is consistent with the state average, while the white, non-Latino population is higher than the state average (54 versus 43 percent).

The percentage of San Diego households with incomes above $50,000 is moderately higher than the state average (57 versus 51 percent), and the population lacking health insurance (13 percent) is comparable to that of the state as a whole. Residents in the northern area of the county, such as La Jolla, tend to have higher incomes and are more likely to have health insurance, while residents in the south, such as the Chula Vista and National City areas, are more likely to be uninsured and have lower incomes.

A striking feature of San Diego is the large role that public employers play in the local economy. Seven of the ten largest employers are public entities, including the U.S. Navy, federal government, state government, University of California, San Diego Unified School District, city of San Diego, and county of San Diego. The large hospital systems in San Diego, including Sharp HealthCare (Sharp), Scripps Health (Scripps), and Kaiser Permanente (Kaiser) round out the remaining ten largest employers.[1] In January 2009, San Diego's unemployment rate reached 8.6 percent — lower than the state average of 10.6 percent but markedly higher than San Diego's January 2008 rate of 5.1 percent.

Geographically, San Diego is bordered by Mexico to the south, the Pacific Ocean to the west, Marine Corps-base Camp Pendleton to the north and the desert to the east, which results in a relatively self-contained market area. These geographic boundaries have a significant influence on the configuration of the health care system and how health care providers collaborate and compete.

Hospitals Emphasize Distinctiveness

The San Diego hospital market is relatively stable after going through a tumultuous period of closure and consolidation in the 1990s. Sharp and Scripps are the largest hospital systems in San Diego. Each operates multiple hospitals and has approximately 25 percent of the inpatient market. The University of California San Diego Medical Center (UCSD) has two hospitals and Kaiser has one hospital, and each system has approximately 10 percent of the market. Together, some respondents characterized these four hospital systems as San Diego's "four, 200-pound gorillas." Other important providers of inpatient services include Palomar Pomerado Health (PPH), a government healthcare district which operates two hospitals in North County, north of the immediate San Diego metropolitan market area; and Rady Children's Hospital, the market's major provider of inpatient pediatric care.[2]

With some exceptions, San Diego's hospitals are not-for-profit entities. Tri-City Medical Center and Sharp Grossmont Hospital are government district hospitals (the Grossmont Healthcare District leases the hospital to Sharp). For-profit hospitals in San Diego generally are smaller and include Alvarado Hospital Medical Center, Fallbrook Hospital, and

Paradise Valley Hospital; all three have changed ownership in the past several years. There is no public, county-operated hospital in San Diego, but UCSD is state-owned; its Hillcrest facility was formerly a county-owned hospital and still serves as a major safety-net provider.

Hospitals in San Diego both cooperate and compete. As one hospital executive noted, "You see more collaboration than aggressive breaking of knees. We have learned to work together because we are closed in [geographically]." For instance, Sharp collaborates with UCSD by providing some specialists with admitting privileges at Sharp hospitals, and the two systems have collaborated on a bone marrow transplant program. In North County, respondents said a dearth of inpatient capacity prompts collaboration among hospitals rather than aggressive competition.

Respondents characterized hospital competition as stable overall, with hospitals trying to distinguish themselves primarily in terms of high quality and patient satisfaction. As one hospital executive said, "I think we are all working hard to differentiate in terms of [patients'] service and experience." These strategies are manifest, for example, in Sharp's "The Sharp Experience" slogan and UCSD's mission of "clinical excellence through service, innovation and education." Sharp's receipt of the prestigious national Malcolm Baldrige award for quality in 2007 has helped the system emphasize its distinctiveness, as has UCSD's designation as a National Cancer Institute center of excellence.

Strategically, hospitals also are re-examining service capabilities, motivated by a belief that they can no longer afford to be "everything

Table 1. Demographic and Health System Characteristics: San Diego County vs. California

POPULATION STATISTICS	San Diego	California
Total population	2,974,859	36,553,215
Population growth, 1997–2007	9.2%	13.6%
Population growth, 2002–2007	2.3%	4.1%
AGE OF POPULATION		
Persons under 5 years old	7.4%	7.3%
Persons under 18 years old	26.7%	26.9%
Persons 18 to 64 years old	62.7%	62.5%
Persons 65 years and older	10.6%	10.6%
RACE/ETHNICITY		
White non-Latino	53.7%	43.3%
African American non-Latino	5.3%	5.8%
Latino	29.0%	36.1%
Asian non-Latino	8.7%	11.8%
Other race non-Latino	3.3%	3.1%
Foreign-born	20.3%	25.7%
Limited/no English, adults	26.1%	35.2%
EDUCATION, ADULTS 25 AND OLDER		
High school degree or higher	87.6%	82.9%
College degree or higher	40.6%	35.7%
HEALTH STATUS		
Fair/poor health status	12.3%	15.8%
Diabetes	6.3%	7.8%
Asthma	12.8%	13.6%
Heart disease, adults	6.4%	6.3%
ECONOMIC INDICATORS		
Below 100% federal poverty level	11.0%	15.7%
Below 200% federal poverty level	26.4%	33.5%
Household income above $50,000	56.7%	51.1%
Unemployment rate, January 2009	8.6%	10.6%
HEALTH INSURANCE, ALL AGES		
Private insurance	63.9%	59.1%
Medicare	8.8%	8.5%
Medi-Cal and other public programs	14.9%	19.3%
Uninsured	12.5%	13.2%
SUPPLY OF HEALTH PROFESSIONALS, 2008		
Physicians per 100,000 population	187	174
Primary care physicians per 100,000 population	60	59
Dentists per 100,000 population	70	69
HOSPITALS		
Staffed community, acute care hospital beds per 100,000 population, 2006	171	182
Hospital concentration, 2006 (Herfindahl index)	1,468	1,380
Operating margin including net Disproportionate Share Hospital payments	5.3%	1.2%
Occupancy rate for licensed beds	67.4%	59.0%
Average length of stay (days)	4.4	4.5
Paid full-time equivalents per 1000 adjusted patient days	14.9	15.7
Total operating expense per adjusted patient day	$2,182	$2,376

Notes: All estimates pertain to 2007 unless otherwise noted.

Sources: U.S. Census Bureau, Population Estimates, 2007; California Health Interview Survey, 2007; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for Counties: January 2009 — Preliminary, March 2008 Benchmark," March 5, 2009; California HealthCare Foundation, "Fewer and More Specialized: A New Assessment of Physician Supply in California," June 2009; UCLA Center for Health Policy Research, "Distribution and Characteristics of Dentists Licensed to Practice in California, 2008," May 2009; American Hospital Association Annual Survey Database, Fiscal Year 2006; California Office of Statewide Health Planning and Development, Healthcare Information Division — Annual Financial Data, 2007.

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for everyone with the latest of everything for everybody," as one respondent put it. Instead, some hospitals are trying to identify service niches on which to focus and excel. For instance, UCSD emphasizes its academic medical center niche of highly specialized tertiary and quaternary services. Scripps focuses on cardiology and cancer care systemwide, while Scripps Mercy's San Diego campus stresses trauma care. Sharp emphasizes the advantages of an integrated delivery system with a full continuum of services and views Kaiser's integrated delivery system as its main competitor.

Overall, the competition spurred by Kaiser in San Diego is somewhat nuanced. A Sharp respondent summarized Kaiser's influence by saying, "It's what drives Sharp and potentially Scripps around staying integrated. If it weren't for Kaiser, it would be one more reason why we should move to fee for service. Keeping the full-risk contract does help keep the contract [costs] lower for employers." Similar to some other California markets, Kaiser outsources certain services to other hospitals. For example, Kaiser contracts with PPH to provide services to North County members; it also uses other hospitals throughout the market to provide certain specialty services such as cardiac and orthopedic surgery.

Hospital Construction Abounds

Respondents generally agreed that San Diego is "under-bedded" because of declining capacity over the years coupled with the area's steady population growth. The number of acute care beds per 100,000 in San Diego is 171 compared with a state average of 182. Moreover, San Diego's 67 percent occupancy rate is considerably higher than the 59 percent for the state overall. As described by one hospital executive, "If someone said, 'I'll hand you 15 percent of our market share,' our response operationally would be 'Where would I put it?'"

Most hospitals are engaged in or planning new construction projects to expand capacity and meet California's seismic standards, a significant issue for San Diego hospitals. In January 2009, for example, a new $200 million patient tower opened at Sharp Memorial Hospital, replacing beds and expanding emergency department (ED) and operating room capacity. The Grossmont Healthcare District passed a $247 million bond issue to fund construction of a new patient tower and other renovations at Sharp Grossmont Hospital. Scripps plans to spend more than $1 billion on construction projects across its hospitals, including $500 million for a new cardiovascular hospital on its La Jolla campus. And construction plans for UCSD total more than $500 million for expansions and other projects at its Hillcrest and La Jolla facilities. With funding raised through a bond issue, PPH expects to spend more than $1 billion on new construction, including the development of a third hospital campus scheduled to open in 2011. Some respondents suggested that the major systems have often focused expansion efforts in areas where the population is well insured (La Jolla, for example) to generate the revenues needed to subsidize losses incurred by hospitals serving large numbers of Medi-Cal and uninsured patients.

Some hospitals — particularly smaller hospitals in the market — have found it difficult to access the capital needed to finance construction. Tri-City Medical Center, governed by the Tri-City Healthcare District, for instance, has failed three times to pass a bond issue to fund construction projects to meet state seismic requirements. In April 2009, the hospital was informed by the state that it could continue to operate one of its patient care towers until 2030 without seismic retrofitting, based on computer modeling that reclassified the building's earthquake risk; the compliance deadline for the district's other hospital facilities remains unchanged.[3] Respondents noted that hospitals' difficulty accessing funds for construction has only worsened with the economic downturn and may potentially delay some planned projects.

Generally, hospitals in San Diego are profitable, but some are poorer-performing than others. Hospitals in the southern part of the market are generally in worse financial condition because they serve more Medi-Cal and uninsured patients. All hospitals are concerned about a worsening

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financial outlook because of the economic downturn and are focusing on cost-saving measures. Some hospitals are eliminating certain services such as skilled-nursing facilities, and redirecting patients presenting at emergency departments for non-urgent care to community clinics.

Perceived Shortage of Primary Care Physicians

Among some respondents, there was a perception that physicians — particularly primary care physicians — are in short supply in San Diego, with the more rural areas of the county such as North County most affected. While the number of physicians per 100,000 persons in San Diego is slightly higher than the state average (187 versus 174), the ratio of primary care physicians per 100,000 persons is comparable to the state average (60 versus 59). A respondent characterized the physician supply issue in the market as being "over-specialized and under primary-cared."

Respondents cited the high cost of living in San Diego, coupled with low reimbursement for Medicare and Medi-Cal patients, as key obstacles to recruiting physicians to the market. Independent physicians reportedly are "lucky to get 100 percent of Medicare in their PPO contracts," and reimbursement in some PPO contracts was estimated to be well below Medicare payment rates. Physician payment rates for Medi-Cal patients also are reportedly very low. When asked if San Diego physicians provide free care, one observer responded, "That is called Medi-Cal."

The physician market is consolidated into large multi-specialty groups, with a number of single-specialty groups also present. Respondents estimated that the majority of San Diego physicians practice in relatively large groups with 20 or more physicians. In a recent reshuffling of the physician market, Scripps acquired Sharp Mission Park Medical Group, a practice with about 60 physicians in the North County area, and merged it with Scripps Mercy Medical Group to form Scripps Coastal Medical Group. The acquisition took some respondents by surprise, and some commented that they saw this as a significant step toward "dividing up" the San Diego health care market, with Scripps dominant in the north and Sharp in the south.

Hospitals and Physicians Tightly Aligned

San Diego physicians are tightly aligned with hospitals through the medical foundation model or professional services arrangements.[4] Scripps and Sharp use the foundation model to recruit physicians, offering a salaried practice platform and lower practice overhead costs. Sharp Rees-Stealy Medical Group, one of the oldest practices in San Diego with more than 400 physicians, is aligned with Sharp through a foundation model. Scripps has a foundation model with Scripps Clinic, a multi-specialty group with 400 physicians, and Scripps Coastal Medical Group, a primary care group with 100 physicians. Kaiser also uses a foundation model to align with its approximately 1,000 San Diego-based physicians, the same model that it employs throughout the state. UCSD contracts for the services of the UCSD Medical Group, which includes physicians on the UCSD School of Medicine faculty.

Physicians who already have strong affiliations with independent practice associations (IPAs) or who are members of independent medical groups may be less attracted to foundation participation. But even these physicians often align with and practice at a single hospital. As one hospital respondent said, "The doctors tend to affiliate with one main system. They are a Sharp or a Scripps doctor. They tend to bring patients to one facility, not three or four, because it's hard to manage." For instance, Sharp Community Medical Group, a multi-specialty IPA with 700 to 800 physicians, is affiliated with Sharp through contract; Mercy Physicians Medical Group and Scripps Mercy Physician Partners are IPAs that serve Scripps hospitals. Some hospitals that do not use foundation models are considering developing them.

Relationships between San Diego hospitals and physicians reportedly are relatively good. Given the consolidated nature of the physician and hospital markets, one respondent observed, "Both sides try to figure out ways to work with

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each other." For example, emergency call coverage historically has been a source of tension, but hospitals and physicians have developed physician compensation arrangements that have helped alleviate the problem. The use of hospitalists, which cover the vast majority of admissions in many hospitals, has also helped smooth over call coverage issues. Additionally, San Diego hospitals often pursue joint ventures with physicians to enhance particular service lines—ambulatory surgery centers, diagnostic facilities, and oncology centers—and strengthen physician relations.

Health Plans Face Escalating Cost Pressures

As of 2006, commercial HMO penetration in San Diego was 45.9 percent and overall HMO penetration was 47.4 percent (compared to commercial HMO penetration of 46 percent and overall HMO penetration of 47 percent for California as a whole).[5] Kaiser, UnitedHealthcare, and Anthem Blue Cross have the largest health plan enrollments, followed by Blue Shield of California, Health Net, Aetna, CIGNA, and Sharp Health Plan. Kaiser's market penetration varies; close to downtown and near Kaiser patient care facilities, market penetration is higher, while it is lower in the more distant North County area where Kaiser provides hospital services through an agreement with PPH.

UnitedHealthcare has assumed a more prominent role in San Diego through its acquisition of PacifiCare, a health plan that had virtually all its enrollment in HMO products. However, one respondent noted that "The UnitedHealthcare acquisition of PacifiCare has not gone well…PacifiCare was the darling of San Diego managed care," an opinion echoed by others. As a result, UnitedHealthcare reportedly lost a significant number of PacifiCare enrollees, with some migrating to PPO products.

The presence of Aetna and CIGNA in the San Diego market is mainly to meet the needs of national self-insured employers for PPO products. Recently, however, both plans reportedly have gained membership through mid-sized, self-insured employers.

Respondents reported that large San Diego employers' health care costs increased about 6 percent last year, with slightly smaller increases expected for 2009. While these increases are lower than in recent years, the economic downturn has intensified employer pressure on health plans to control costs. At the same time, health plans are facing demands from some providers to switch from capitated payment (fixed per-patient, per-month payments) to a fee-for-service basis; given providers' consolidation and capacity limitations, plans believe they have little leverage to resist. This is a significant change in the market; respondents characterized San Diego as "the last bastion of capitation," and some believe that the incentive for providers to manage resources efficiently under capitation is an important reason that health care costs in San Diego have historically been at or below costs of other metropolitan areas in California.

Scripps has been the most aggressive in jettisoning capitation contracts and reportedly is in the final stages of converting from full-capitation payments to fee-for-service payment for inpatient care. Scripps' affiliated medical groups no longer accept financial risk for commercial patients, although they continue to accept Medicare risk, which is viewed as relatively more lucrative. UCSD has not had capitation payments for hospital services for several years, and its physicians are currently reimbursed on a capitated basis for only about a quarter of their commercial patients. Currently, the two largest capitated care providers in San Diego are Kaiser and Sharp with approximately 500,000 and 150,000 capitated enrollees, respectively.

Some plans are converting to fee for service to further their own strategic interests. For instance, UnitedHealthcare is renegotiating capitated contracts that providers had signed with PacifiCare for commercial enrollees to bring these contracts into line with the plan's fee-for-service contracts nationally.

While the full impact of the shift away from capitation will take some time to fully assess, respondents were concerned the move will lead to significant cost increases.

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One benefits consultant suggested that the conversion from capitation to fee-for-service payment ultimately could increase costs in the market by 15 to 20 percent, depending in part on the number of providers in addition to Scripps that follow suit.

Plans Offer Options for Employers to Buy Down Costs

As plans with diminished negotiating leverage acquiesce to provider demands for fee-for-service payment, options to control employer costs have become more limited. All plans offer disease management and wellness programs as part of their insured products or as add-ons in contracts with self-insured employers. The larger plans use their data-mining capabilities to identify enrollees who might benefit from more intense care management, and some target specific services such as imaging for more aggressive utilization management. However, where capitation contracts remain in place, physician groups continue to assume the major responsibility for controlling utilization.

Given these realities, health plans are turning to benefit redesign as a major strategy for controlling employer health care costs. Until recently, large employers have tended to offer Kaiser as one HMO option, and then offer an additional HMO and PPO administered by a competing health plan. In the past several years, there has been a steady reduction in benefit levels in PPO products, as well as an expansion in the number of different products available to employers. Respondents reported that plans often offer a menu of products to employers, who then select a subset of products to offer their employees, making a fixed-dollar contribution toward whichever option an employee chooses.

Several plans have new product designs under development or in the early experimental stages. For instance, UnitedHealthcare is contemplating offering its Edge product in California. Under this product, PPO enrollees pay lower coinsurance rates when they choose providers designated by the plan as delivering higher-quality care more efficiently. Likewise, Aetna offers a product based on a high-performance specialty physician network called Aexcel. Kaiser has attempted to increase its attractiveness to national employers by partnering with UnitedHealthcare to create a dual offering in California called Sweet Spot. Under this approach, the employer can offer Kaiser and UnitedHealthcare side-by-side with the two plans addressing any risk selection issues in a way that is seamless to employers. Additionally, Kaiser, long committed to HMOs, has recently introduced plan designs with high deductibles and is preparing to offer administrative services and other products to self-insured employers.

Health plans also are introducing "narrow-network" products throughout California — products that exclude a provider system with rates that are viewed as too high — and San Diego is no exception. In San Diego, these products often exclude Scripps providers from the plan network and are offered by employers alongside other plan products. By excluding Scripps providers, plans hope to avoid higher payments to Scripps because of its conversion to fee-for-service payments. While most plans have developed narrow networks along these lines, these products are relatively new in San Diego, and therefore it is difficult to assess their market significance. Respondents' views varied as to what influence, if any, these products might ultimately have on the market, including their impact on health care costs.

In response to employer demands, health plans in San Diego (as in California more generally) have added consumer-directed health plans (CDHPs) — high-deductible plans with (or eligible for) a health savings account (HSA) or health reimbursement arrangement (HRA) — to their product portfolios.[6] Like narrow-network products, the market significance of CDHPs is difficult to determine at this point. Some respondents saw them as "the coming thing," and there are reports that these products are of particular interest to small employers because of the potential cost savings. However, other respondents believed that CDHPs will have difficulty making headway in San Diego with its history of strong HMOs; HMO enrollees are not used to the

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high deductibles or coinsurance that CDHPs impose. Some respondents suggested that if PPO enrollment continues to grow in the market, exposing more consumers to deductibles and coinsurance, this may lead to enrollment growth in CDHPs.

Limited Coverage Options for Low-Income Residents

San Diego County operates the County Medical Services program (CMSP) as part of its state-mandated responsibilities to provide indigent care. However, respondents described CMSP as a very limited program. As a result of lawsuits alleging the county was not fulfilling state-mandated requirements to care for the medically indigent, the county recently increased income eligibility from 135 percent to 165 percent of the federal poverty level. Individuals with incomes of up to 350 percent also can enroll but are required to share in the costs of their care and eventually reimburse the county for the cost of any services they use. For CMSP enrollees with incomes above 165 percent of the federal poverty level, the county places a lien on their homes to ensure repayment. Undocumented immigrants are ineligible for the program, and documentation requirements to enroll in the program are strict. In addition, there are a limited number of locations that accept applications. As one respondent noted, "There are barriers set up constantly so you'll just walk away in frustration or you'll end up not having the right documentation." CMSP participants also reportedly have difficulty accessing needed specialty care; the county has tried to alleviate this situation by raising specialist reimbursement to 140 percent of Medi-Cal payments.

Given the limited enrollment in CMSP, the state's Medi-Cal and Healthy Families programs remain the primary sources of health care coverage for low-income San Diegans. Healthy Families is California's State Children's Health Insurance Program and provides health insurance to low-income children who do not qualify for Medi-Cal.

San Diego has a geographic Medi-Cal managed care model in which multiple plans participate.[7] The dominant plan — for both Medi-Cal and Healthy Families — is Community Health Group (CHG), a local, non-profit HMO with 83,000 Medi-Cal enrollees and 25,000 Healthy Families enrollees. The plan with the second highest enrollment is Molina Healthcare, a for-profit national plan with 50,000 local enrollees. Other participating plans include Health Net, Kaiser, and CareFirst.

Plans regard low reimbursement from the state as a significant threat to their ability to serve Medi-Cal and Healthy Families enrollees. According to one respondent, "The state's philosophy is to pay the plans actuarially sound rates, minus what fits into the budget. So the theory of actuarial rates has never been the reality here in California." And while the plans have relatively broad provider networks, there are concerns regarding enrollee access to specialists, especially orthopedists, neurologists, neurosurgeons, and urologists. Limited access to specialists is attributed in part to low plan payment rates.

An aspect of Medi-Cal managed care that makes San Diego distinct is the involvement of the Healthy San Diego collaborative, which brings together the Medi-Cal plans, major providers, the county, and consumer advocates to discuss access and quality of care. Currently, Healthy San Diego is pursuing several initiatives, including a workgroup aimed at increasing the use of preventive care and a quality improvement task force.

Through California's Health Coverage Initiative, a Medicaid waiver demonstration program, San Diego County was awarded a total of about $40 million for fiscal years 2007–08 through 2009–10 to test innovative ways of providing care to the uninsured. The San Diego initiative, which is called the Safety Net Access Program, enrolls uninsured diabetic or hypertensive people with incomes below 200 percent of poverty to more closely manage their care and avoid emergency department visits. Program

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enrollment is limited to 3,200 individuals to study its impact on public expenditures.

Weak Safety Net Commitment of Local Government

Consistent with the controversy around San Diego County's participation in the CMSP, the county is widely perceived as having a weak commitment to health care for low-income and uninsured residents. San Diego County ranks fifth from the bottom of California counties on spending per uninsured resident.[8] Respondents attributed this lack of commitment to a fiscally conservative County Board of Supervisors and to a perception that expansions in county funding for health care would simply provide more services to undocumented immigrants. There are no county-owned hospitals or primary care clinics in San Diego, an unusual situation for a large metropolitan area in California. As one respondent explained, "Our safety net, while we have vibrant, well-intentioned people, the connections are very fragmented. It exists because of the good will of individuals, rather than being thought-out and formalized."

As a result, private health care providers carry much of the financial burden of providing care to uninsured residents and Medi-Cal patients. Respondents often described a "delicate" balance among hospitals providing safety-net services, citing concerns that if one hospital were to reduce the amount of services provided, it would disrupt this balance and jeopardize the financial well-being of the other hospitals.

While UCSD's Hillcrest Hospital is a major provider of inpatient care for the uninsured, Scripps Mercy Hospital (downtown San Diego and Chula Vista campuses) and Sharp Grossmont and Chula Vista hospitals also were acknowledged as critically important safety-net providers. Other hospitals also mentioned as important safety-net providers in the market include Sharp Mary Birch Hospital for Women, PPH, Rady Children's Hospital, and Tri-City Medical Center.

Earlier in the decade, San Diego avoided a potential crisis in the availability of inpatient care for low-income residents when UCSD cancelled plans to transfer inpatient services from its Hillcrest campus to its La Jolla campus. La Jolla is a relatively affluent area and is much less accessible to low-income uninsured and Medi-Cal patients. The planned move generated an outcry both from the community and from other hospitals, the latter of which feared a dramatic increase in low-income patients. The planned move also motivated the county government to fund, in conjunction with The California Endowment, a 20-year assessment of the county's health care safety net. Commonly referred to as the Abaris report for the organization that conducted the study, the 2006 report is widely recognized by both health care providers and local government as having focused new attention on the safety net. Ironically, while the Abaris report concluded that the impact of the UCSD move from Hillcrest would not be as great as had been feared, the plan to close all inpatient care facilities at UCSD Hillcrest has not moved forward, although some services have shifted to the La Jolla campus.

While there are no county-owned clinics in San Diego, there is a robust network of 20 community health centers (CHCs) in the region. These CHCs operate close to 100 sites, the majority of which are federally qualified health centers (FQHCs). Family Health Centers of San Diego is the largest CHC, with 18 sites, but it does not belong to the Council of Community Health Clinics, a local organization that provides coordination and support for such activities as funding, outreach, specialty referral, and installation of health care information technology. Complementing the CHCs, some hospitals, such as UCSD's Hillcrest facility and Rady Children's Hospital, have outpatient clinics that serve low-income patients.

Respondents generally reported that San Diego has adequate primary care capacity in the safety net, but that some CHCs struggle to recruit primary care physicians. Access to specialty care for low-income residents, however, is

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difficult. A recent San Diego Medical Society survey suggests that specialists are increasingly unwilling to take Medi-Cal and uninsured patients. As one physician noted, “I think, by and large, there is not a shortage of actual specialists. I think there is a shortage of specialists that are willing to treat all kinds of patients.” Typically, CHCs refer patients to UCSD or Rady Children’s Hospital for specialty care. However, the hospital specialty clinics are becoming overwhelmed with patients and are concerned about accepting more uninsured patients. As a result, low-income residents in San Diego frequently seek care from emergency departments, where they can be assured of receiving a specialty consult. Emergency departments have experienced steady increases in utilization and have problems providing necessary emergency specialist call coverage.

In response to the Abaris report recommendations, several steps have been taken to stem the increase in ED use, including expanding access to urgent care and increasing coordination between hospital emergency departments and CHCs. For instance, the county has funded an expansion of a program developed at UCSD, called Safety Net Connect, that electronically links UCSD emergency departments with CHCs and allows ED physicians to schedule follow-up appointments for patients at local health centers. The expansion will eventually allow CHCs to view hospitals’ electronic health records and, ultimately, allow hospitals and clinics to exchange health information on shared patients. The county also encourages CHCs to expand evening and weekend hours to better serve patients who might otherwise seek care at an ED.

The Community Health Improvement Partners (CHIP), a nonprofit community collaborative that includes representatives from health care providers, health plans, universities, community organizations, and the county, serves as a catalyst for safety-net activities in the community. CHIP conducts community-needs assessments, operates the Immunize San Diego program, and is involved in health literacy and care coordination projects and the expansion of the Safety Net Connect program.

Issues to Track

While San Diego has been called the “last bastion of capitation,” this appears to be changing. The strong market positions of some hospital systems and affiliated physicians have enabled them to move from capitated to fee-for-service contracts with health plans. The desire of some national health plans to move away from capitated payment arrangements has contributed to this change. But there is concern among some purchasers that health care costs in San Diego are likely to increase significantly as a result. Health plans are expanding their product portfolios to offer plans with limited benefits in response to employer demands for lower costs, and are experimenting with narrow-network products that exclude higher-cost providers from their networks.

San Diego’s somewhat unique system for providing health care for the uninsured relies heavily on private providers but is being challenged by low Medi-Cal payment rates. Safety-net providers are also being challenged by increasing demand for their services and limitations on access to specialty services, which stand to worsen with the economic decline. The following are among the key issues to track:

- How will the shift from capitation to fee for service evolve in San Diego? Moving forward, what will be the impact on care delivery, costs, and quality?
- Will large hospital systems seek to divide the health care market in San Diego along geographic lines? Will consolidation of providers continue? If so, how will this affect costs and access?
- Will narrow-network and consumer-directed health plan products gain employer and employee acceptance and, if so, will they be effective in injecting new cost discipline into the San Diego market?

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- Can San Diego's safety net be sustained in the face of increased demands for services in a deteriorating economy? Will the county government increase financial support for the safety net?

ENDNOTES

1. San Diego SourceBook, "San Diego County's Largest Employers," **sourcebook.sddt.com** (accessed April 15, 2009).

2. Government health care districts are governed by an elected body separate from the local government and have the authority to impose property taxes to pay for the operation of the hospital. Because the district board is responsible to the community, the hospital often provides services for the underserved.

3. Sherman, Lola, "Hospital Tower Gets Break on Quake Retrofit," *The San Diego Union-Tribune* (April 3, 2009).

4. Under a medical foundation model, the foundation is sponsored by a hospital or hospital system, and physicians either contract with the foundation's IPA or are employed by the foundation through a professional services arrangement with the medical group.

5. Cattaneo & Stroud, Inc., *2006 California Statewide HMO & Special Programs Enrollment Study,* Burlingame, CA (2008).

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

7. Under the geographic managed care model, the state contracts with multiple private managed care plans and pays each plan on a capitated (fixed per-enrollee, per-month payment) basis.

8. Abaris Group, *San Diego County Healthcare Safety Net Study,* Walnut Creek, CA (September 18, 2006).

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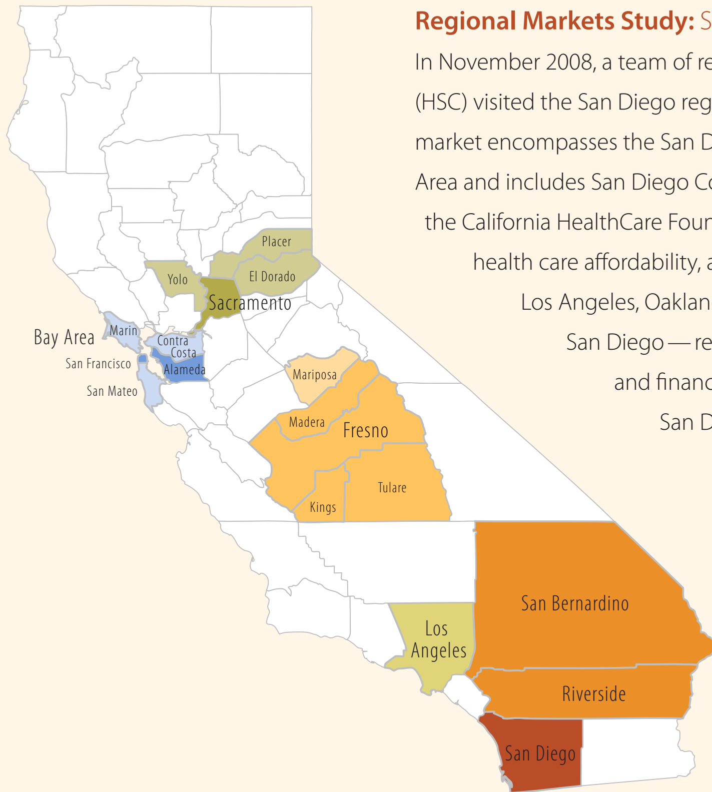

Regional Markets Study: San Diego

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

▸ ACCESS THE ENTIRE REGIONAL MARKETS SERIES HERE.

ABOUT THE AUTHORS

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ABOUT THE FOUNDATION

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

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to **www.chcf.org/topics/almanac**.

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

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

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

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

Sources: U.S. Census Bureau, Population Estimates, 2007; California Health Interview Survey, 2007; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for Counties: January 2009 — Preliminary, March 2008 Benchmark," March 5, 2009; California HealthCare Foundation, "Fewer and More Specialized: A New Assessment of Physician Supply in California," June 2009; UCLA Center for Health Policy Research, "Distribution and Characteristics of Dentists Licensed to Practice in California, 2008," May 2009; American Hospital Association Annual Survey Database, Fiscal Year 2006; California Office of Statewide Health Planning and Development, Healthcare Information Division — Annual Financial Data, 2007.

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