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San Francisco Bay Area:
Health Care Providers Shift Allegiances as Regional Networks Emerge

Summary of Findings

Health care providers in the San Francisco Bay Area weathered the economic downturn better than providers in most other areas of California, in large part because the downturn was less severe in the Bay Area. Still, a number of market trends and the expected effects of health reform have pressured providers, leading to significant organizational change in the provider sector since the region was last studied in 2008.

Key developments include:

- **Widened gap between have and have-not hospitals.** Large systems, along with a few independent hospitals with geographic monopolies in affluent submarkets, were able to improve already strong financial performance even during the recession. In contrast, most county hospitals and smaller independent safety-net hospitals that were struggling in 2008 continue to struggle, and some in the latter group face potential closure.
- **Substantial hospital construction to meet state seismic standards.** In a market already considered to have surplus capacity, current and planned hospital construction raises concerns about some hospitals being able to manage their debt burden and adding to excess inpatient capacity. These are particular concerns as health reform moves forward, given that payment levels for inpatient services are expected to decline, and the transfer of services from inpatient to ambulatory settings is expected to accelerate.
- **Shifting alignments among providers and growing regionalization of provider networks.** Since 2008, dramatic changes have occurred in affiliations among physician organizations — and in some cases, hospital systems. New alignments have formed among major providers as they seek both to consolidate and expand their geographic reach. The result is a growing trend toward regionalization of provider networks across the Bay Area, which historically has had many distinct geographic submarkets.
- **Increased plan-provider collaborations to form accountable care organizations (ACOs).** Under pressure to keep insurance premiums in check, health plans and providers began joining forces to form narrow-network ACOs in 2011. It remains to be seen how successful these emerging ACOs will be in managing care — particularly in reducing inpatient utilization — and keeping within their global budgets.
- **Expanded safety-net capacity.** With the economic downturn leading to increased demand for outpatient services, many safety-net providers expanded capacity. Most notably, federally qualified health centers (FQHCs) won new federal grants to finance growth. In contrast, small private clinics are struggling and some are merging with other clinics to survive.
- **Increased collaboration, particularly on care delivery improvements, across the safety net.** Bay Area safety-

net providers — such as those participating in Healthy San Francisco — are making strides in implementing the medical home model, improving care coordination across providers, and introducing other care delivery changes. Strong collaboration within the safety net means that innovations adopted by one type of provider — for example, county clinics — are readily spread and adopted by other providers, such as private clinics.

Despite the many organizational changes taking place in the provider sector, many key characteristics that define the Bay Area health care market remain constant. These include an abundant supply of hospital beds and health care practitioners compared to other California markets; a substantial proportion of physicians belonging to large medical groups exclusively affiliated with one of the large hospital systems; a still significant proportion of physicians remaining in small, independent practices that participate in health maintenance organization (HMO) contracting through independent practice associations (IPAs); and slowly declining but still strong commercial HMO enrollment. The safety net remains strong, extensive, and collaborative, and continues to benefit from widespread public support from both residents and elected officials.

Table 1. Demographic and Health System Characteristics: San Francisco Bay Area vs. California

	San Francisco Bay Area	California
POPULATION STATISTICS, 2010		
Total population	4,335,391	37,253,956
Population growth, 10-year	5.1%	10.0%
Population growth, 5-year	4.5%	4.1%
AGE OF POPULATION, 2009		
Persons under 5 years old	6.7%	7.3%
Persons under 18 years old	21.9%	26.3%
Persons 18 to 64 years old	65.9%	62.8%
Persons 65 years and older	12.2%	10.9%
RACE/ETHNICITY, 2009		
White non-Latino	45.6%	42.3%
Black non-Latino	7.8%	5.6%
Latino	21.4%	36.8%
Asian non-Latino	21.5%	12.1%
Other race non-Latino	3.7%	3.1%
Foreign-born	29.8%	26.3%
EDUCATION, 2009		
High school diploma or higher, adults 25 and older	89.6%	82.6%
College degree or higher, adults 25 and older	52.1%	37.7%
HEALTH STATUS, 2009		
Fair/poor health status	13.8%	15.3%
Diabetes	5.8%	8.5%
Asthma	14.0%	13.7%
Heart disease, adults	4.9%	5.9%
ECONOMIC INDICATORS		
Below 100% federal poverty level (2009)	11.7%	17.8%
Below 200% federal poverty level (2009)	25.3%	36.4%
Household income above $50,000 (2009)	61.9%	50.4%
Unemployment rate (2011)	10.1%	12.4%
Foreclosure rate* (2011)	3.6%	n/a
HEALTH INSURANCE, ALL AGES, 2009		
Private insurance	66.8%	55.3%
Medicare	9.5%	8.8%
Medi-Cal and other public programs	13.9%	21.4%
Uninsured	9.8%	14.5%
SUPPLY OF HEALTH PROFESSIONALS, PER 100,000 POPULATION, 2008		
Physicians	239	174
Primary care physicians	79	59
Dentists	89	69
HOSPITALS, 2010		
Community, acute care hospital beds per 100,000 population	204.7	178.4
Operating margin with net disproportionate share hospitals (Kaiser excluded)	4.1%	2.4%
Occupancy rate for licensed acute care beds (Kaiser included)	53.0%	57.8%
Average length of stay (in days) (Kaiser included)	4.7	4.5
Paid full-time equivalents per 1,000 adjusted patient days (Kaiser excluded)	15.7	15.8
Total operating expense per adjusted patient day (Kaiser excluded)	$3,490	$2,856

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

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

Market Background

The 4.3 million residents of the San Francisco Bay Area encompass a rich diversity of cultures and ethnic backgrounds. Fewer than half are white, 3 in 10 are foreign-born, and a significant proportion (21.5%) is Asian. The region has seen relatively slow population growth in the past decade (half the state growth rate), but growth has picked up over the last five years. Suburban communities in Contra Costa, Alameda, and San Mateo counties have experienced the most growth. In contrast, growth has been slow in the cities, and Oakland has even shrunk.

Although economic indicators all worsened slightly because of the recession, the Bay Area still ranks among the most affluent regions in the state, and it weathered the recession better than most other areas of California (see Table 1). The Bay Area continues to lead the six study sites in income and educational attainment and to have the lowest rates of poverty and unemployment. In February 2012, the month in which interviews were conducted, the unemployment rate was 8.7% in the Bay Area, compared to 11.4% statewide. The region continues to have a more favorable insurance mix as well: its private insurance coverage rate ranks highest, and its Medi-Cal coverage and uninsured rates rank lowest, among the six regions studied.

However, aggregate data showing overall affluence mask substantial disparities within the market. Among the five counties in the Bay Area, the prevalence of poverty, residents with no insurance, and Medi-Cal coverage is highest in Alameda County and lowest in Marin County. Within each county, stark contrasts are evident as well. In Alameda County in 2011, unemployment reached nearly 16% in Oakland but only 5% in affluent Piedmont and Pleasanton. Disparities are even larger within Contra Costa County, where unemployment in San Pablo and Richmond climbed above 20% while remaining around 4% in the suburbs of Lafayette and San Ramon.

Hospital Market Characterized by Geographical Submarkets

As the Bay Area is densely populated, divided by geographic barriers such as bodies of water and foothills, and connected by congested highways, bridges, and tunnels, the distances and directions people are willing or able to travel for health care are limited. As a result, a large proportion of health care delivery remains within local submarkets.

Kaiser Permanente and Sutter Health continue to be the dominant hospital systems in the Bay Area, each accounting for about a quarter of inpatient discharges. In the five-county area, Sutter has seven hospitals across 11 campuses, and Kaiser has 10. Kaiser's overall market share significantly understates its share of the coveted commercial market segment, since commercial enrollees of Kaiser Permanente Health Plan comprise a large majority of Kaiser hospitals' patient base.

University of California San Francisco Medical Center (UCSF), John Muir Health, and Dignity Health (formerly Catholic Healthcare West) all have significantly smaller market shares than Kaiser and Sutter, each accounting for only 5% to 8% of inpatient discharges across the five counties. However, John Muir competes in only two of the counties, and Dignity has no hospital coverage in the East Bay.

Four of the five largest hospital systems — Sutter (and its flagship, California Pacific Medical Center, or CPMC), Kaiser, UCSF, and Dignity — have a presence in San Francisco, as does the county safety-net hospital, San Francisco General Hospital. Within this submarket, UCSF's market share does not lag far behind Sutter's share.

The East Bay spans a large geographic area with several distinct, diverse submarkets. In the economically diverse northwestern portion of Alameda County surrounding Oakland, Sutter (Alta Bates Summit Medical Center) and Kaiser (Oakland Medical Center) have dominant market positions, while Alameda County Medical Center (ACMC) and Children's Hospital & Research Center Oakland serve

as major safety-net providers. In Contra Costa County, John Muir Health remains the dominant presence in the central region of the county, which is anchored by the affluent, well-insured communities of Walnut Creek, Lafayette, and Orinda. Kaiser has one hospital in Walnut Creek and another in Antioch to the northeast. The area is also served by Contra Costa Regional Medical Center, a safety-net hospital.

Both Alameda and Contra Costa Counties have other submarkets — some struggling (including the Castro Valley/Hayward and Richmond/San Pablo areas) and others more affluent (such as Fremont and the Tri-Valley region containing the communities of Dublin, Pleasanton, and Livermore). The greater Bay Area region also includes the affluent submarkets of Marin County, north of San Francisco, and San Mateo County, south of San Francisco, though the health care systems of these counties were not examined in depth in this study.

Kaiser continues to be regarded as a strong competitor by the other hospitals, although the direct competition occurs through the health plans with which the hospital systems contract. While overall commercial coverage shrank during the economic downturn, Kaiser managed to grow, thanks largely to the shift by employers and consumers to lower-priced insurance options. As a result, other hospitals lost market share.

Growing Gap Between Have and Have-Not Hospitals

The considerable gap between financially strong hospitals and those that are struggling — the haves and the have-nots — has grown in recent years. The overall operating margin for all Bay Area acute care hospitals increased from 3.4% to 6.6% between 2008 and 2010 (the most recent public data available).[1]

The hospitals ranking among the financially strongest in 2008 have improved their financial performance since then. These include the large systems, along with a few independent hospitals with geographic monopolies within submarkets, including John Muir in central Contra Costa County and Washington Hospital in Fremont in Alameda County. Except for ACMC, all the county hospitals that were struggling in 2008 continue to struggle, as do independent hospitals with a large low-income patient base. These include Children's Hospital Oakland, Doctors Medical Center in San Pablo, and St. Rose Hospital in Hayward.

Sutter continues to stand out as the market leader in the Bay Area, with operating margins growing from 7.7% in 2008 to 10.4% in 2010. However, performance varies within the Sutter system, with the East Bay region achieving weaker margins than the West Bay region in part because of a less favorable payer mix. Sutter West Bay performance remained stable in 2011, while Sutter East Bay margins eroded as a loss of patients to Kaiser coincided with an increase in uncompensated care. Within each region, financial performance varies widely across hospitals. In the West Bay region, for example, CPMC achieved a 17% margin, while the much smaller St. Luke's Hospital, which has a substantial share of low-income patients, struggled with a –22% margin.

Substantial Hospital Construction

Most hospitals in the region have substantial construction projects underway or planned, largely driven by the need to meet state seismic requirements. Overall, the Bay Area is considered to have excess capacity, with the most acute beds per capita and the lowest hospital occupancy rates among the six regions studied. However, capacity utilization varies significantly, with Kaiser, John Muir, and several safety-net hospitals coping with relatively tight capacity, in contrast to Sutter and Dignity hospitals, most of which run at 50% to 60% capacity.

As hospital systems work to bring their facilities up to seismic code, many of them are using the opportunity to adjust capacity to meet expected future inpatient needs. John Muir, UCSF, and Kaiser are increasing inpatient capacity, while CPMC may downsize bed capacity by 30%. Hospitals are also strategically using construction to continue investing in lucrative service lines. For example, the new medical

center being built at UCSF's Mission Bay campus focuses on three lines targeted by UCSF: women's, children's, and cancer services, with each considered a separate hospital.

The financial burdens of construction are of serious concern to have and have-not hospitals alike. For hospitals with projects underway, much of the new inpatient capacity will come online at the same time that payment levels for inpatient care are expected to come under greater pressure, and the shift from inpatient to ambulatory services is expected to intensify under health reform.

For have-not hospitals unable to reverse operating losses, compliance with seismic regulations may not be possible because the hospitals lack the capital for major construction. Though the seismic deadlines have shifted to provide more time for compliance, the threat of closure for some hospitals remains. Closure would adversely affect access for low-income patients in those communities and put pressure on neighboring hospitals. One such hospital is Doctors Medical Center in San Pablo, which has remained open in part thanks to funding from other hospitals, including Kaiser and John Muir. Another is St. Rose Hospital in Hayward, which has received funding from Alameda County and a loan from Kaiser, and is pursuing a potential merger to stay afloat.

Major Shifts in Physician Alignments

Many Bay Area physicians continue to practice in the large medical groups aligned with Kaiser, Sutter, UCSF, and John Muir. The largest in the market is Kaiser's, The Permanente Medical Group, with more than 2,600 physicians. Sutter maintains separate medical foundations in San Francisco, the East Bay, and the South Bay, each with its own exclusively contracted medical groups.[2] To some extent, physicians are also joining medical groups affiliated with other hospitals' fledgling foundations. Some of these foundations are sponsored by smaller hospitals in the market, such as ValleyCare Health System in the Tri-Valley area of the East Bay. However, Stanford Hospitals and Clinics based in Palo Alto is a major player aggressively moving into the East Bay through its relatively new foundation, University HealthCare Alliance.

While large medical groups have grown in recent years, many physicians maintain their autonomy in small, independent, single-specialty practices. The Bay Area lacks large, integrated multispecialty practices, except for Kaiser and the Sutter-affiliated Palo Alto Foundation Medical Group (the largest medical group within the Palo Alto Medical Foundation), which is headquartered outside the market but has about 20% of its physicians practicing in Alameda and San Mateo Counties.

Little consolidation of smaller physician-owned practices has taken place over the past few years. Given the continued use of the delegated model for HMO contracting, many of these physicians belong to one or more IPAs, which provide both risk contracting and practice support. Specialists often belong to multiple IPAs to maintain sufficient patient volumes, but primary care physicians (PCPs) are more likely to belong exclusively to one IPA. The major IPAs either require or give incentives for PCP exclusivity, such as larger bonuses and electronic health record connectivity.

Two large IPAs span multiple Bay Area submarkets: Brown and Toland (B&T), which is aligned with Sutter, and Hill Physicians, which is aligned with UCSF, as well as other hospitals. Among the handful of smaller IPAs in the market, most are affiliated with medical foundations sponsored by other hospitals, John Muir and Stanford being the most prominent. For most Bay Area hospitals, the approach of aligning with IPAs for HMO contracting remains a key part of a multipronged strategy to attract referrals. The hospitals' own physician organizations have not grown fast enough to allow hospitals to rely only on these organizations for referrals, especially of HMO enrollees.

Cascading Effects of B&T and UCSF Medical Group Split

In a dramatic shift from the organizational stability that characterized the market in 2008, a surge of new affiliations and alignments for key physician organizations has taken

place over the past few years. The catalyst for these shifting alignments was the dissolution of the long-time affiliation between B&T and UCSF Medical Group, the faculty practice for UCSF.

To put the relationship in historical perspective, B&T was created in the late 1990s by combining the medical staffs at UCSF and the Sutter-owned CPMC to form an open-access network for patients across the two systems. By all accounts, tensions between the two partners had been rising for several years, although the major causes remain in dispute. According to some, B&T physicians' preferential referrals to UCSF for specialty and hospital care were putting pressure on B&T's relationship with CPMC. According to others, the strategic interests of the two partners had diverged over time as UCSF became more specialty-focused while B&T, already primary care–focused, became more so.

By 2010, the partnership between B&T and UCSF — already unraveling — was officially dissolved, leading to a series of cascading events and realignments. B&T underwent a major contraction in San Francisco, its area of historic dominance, as it lost 600 physicians and more than 30,000 commercial HMO patients. UCSF Medical Group, having lost both a referral source and an IPA for HMO contracting when it split with B&T, formed a new affiliation with Hill Physicians, whose presence in San Francisco until then had been minimal (limited to an affiliation with Dignity).

A new competitive dynamic resulted, with Hill gaining substantial market share from B&T, and care networks being redrawn and becoming more distinct: B&T strengthened its alignment with CPMC/Sutter, and Hill aligned with UCSF and Dignity. The emerging ACO activity in the market (discussed below) reflects these new relationships. The realigned care networks led to disruptions for some patients — most notably those already seeing both a B&T primary care physician and a UCSF specialist. These patients either had to switch to a smaller panel of Hill PCPs to maintain access to their UCSF specialists, or they had to switch to a CPMC-affiliated specialist to remain with their B&T PCPs.

In a further break with UCSF, CPMC shifted its partnership for pediatric specialty care from UCSF to the Lucile Packard Children's Hospital at Stanford. With Packard specialists now seeing patients at CPMC's California Campus (its women's and children's center), the head-to-head competition between Packard and UCSF's new Benioff Children's Hospital in San Francisco has ramped up.

Meanwhile, UCSF and Dignity — already aligned in the same HMO network — signaled intentions of creating a much tighter relationship. In August 2012, the two systems signed an agreement to integrate UCSF's academic medical center with Dignity's two San Francisco community hospitals. The nature and extent of the integration have not been made public, but the systems did announce that the new relationship would not take the form of a merger or acquisition.

Emergence of New Regional Affiliations

Other regional affiliations have already formed or are being considered, with the most activity in the East Bay. Although B&T lost its dominant market position in San Francisco, it expanded its presence in the East Bay, which has long been Hill's main turf. In mid-2011, B&T merged with Alta Bates Medical Group, the largest IPA in the northwest Alameda County market centered on Oakland. The IPA admits primarily to Sutter hospitals, most notably Alta Bates Summit. The merger allowed B&T to gain as many physicians and HMO enrollees in the East Bay as it had lost in San Francisco. Meanwhile, the affiliation between UCSF and Hill has the potential to expand beyond San Francisco into the East Bay, providing UCSF an opportunity to leverage Hill's strong presence there to gain more regional referrals.

Hospitals in the East Bay have been exploring potential partnerships with other hospitals. John Muir and Stanford reportedly have considered an affiliation, reflecting a strategy of building a regional network and preparing to bear financial risk for patient care under expected new contracting

arrangements with health plans. At the same time, John Muir also has discussed potential affiliations with smaller East Bay hospitals ValleyCare Health System and Washington Hospital Healthcare System — a partnership that aims to replicate some of the benefits of a larger hospital system (e.g., full array of services, larger geographic service area, volume purchasing discounts) without an outright merger or acquisition.

In addition, two major players headquartered in Palo Alto, just south of the market, are increasingly making their presence felt in the region. The Palo Alto Medical Foundation and its affiliated medical group, the Palo Alto Foundation Medical Group, are expanding in the East Bay — particularly in Fremont and Dublin. The group has a strong reputation and is regarded as a potential competitive threat. Although the group is exclusively aligned with Sutter, most of its physicians do not practice near Sutter hospitals; as a result, they admit patients primarily to non-Sutter hospitals. As noted earlier, Stanford's medical foundation is expanding in the East Bay. Within the past year, it has signed professional service agreements with two previously independent multispecialty groups and a large cardiology group formerly aligned with John Muir.

The changing relationships all reflect an ongoing and increasing trend toward regionalization of provider networks across the Bay Area. In positioning themselves for health reform, providers are seeking to expand their geographic reach beyond their historical niches as the first step toward building regional networks and preparing to take on new contracting arrangements.

Nascent Provider-Plan ACO Collaborations

Motivated by expectations of lower payment under reform and the continuing need to compete with a strong Kaiser system, Bay Area providers are focusing on reducing the total cost of patient care. Hospitals are investing on multiple fronts to curb inpatient utilization, reduce variation in care, and improve care coordination across inpatient and outpatient settings. To some extent, hospitals are collaborating with affiliated physician organizations on these efforts. In particular, Sutter — historically a high-cost provider — acknowledged the need to cut costs.

Cost-containment pressures are also leading providers to explore collaborations with health plans to form ACOs based on commercial narrow-network HMO products. However, these ACO collaborations are just beginning to emerge as Bay Area hospitals and physician organizations begin tighter alignment with one another. Creation of narrow-network products has been relatively slow, as the region lacks lower-cost, full-service, region-wide providers around which health plans can build comprehensive products. For example, while Dignity's two community hospitals in San Francisco are reportedly less costly than CPMC and UCSF, they lack the full array of services necessary to qualify as sole providers in a narrow network.

The commercial ACO activity in the Bay Area has been concentrated in San Francisco, which has a higher degree of provider competition and clearer alignment among hospitals and physician organizations than the East Bay. Much of the interest in ACO collaborations has been driven by Hill and B&T, both of which — as IPAs set up for the purpose of HMO contracting — are motivated to expand the commercial HMO market, which has been slowly shrinking in recent years.

The first ACOs developed in San Francisco were introduced by Blue Shield of California for the San Francisco Health Service System (SFHSS), the purchaser of health benefits for employees of the city and county of San Francisco. Blue Shield modeled these ACOs on the narrow-network ACO it implemented for CalPERS (California Public Employees' Retirement System) in Sacramento, in collaboration with Dignity and Hill. Both San Francisco ACOs were launched in mid-2011. The smaller ACO network (5,000 enrollees) consists of UCSF, Dignity, and

Hill; the larger (21,000 enrollees) includes CPMC/Sutter and B&T. The initial enrollment in each ACO reflects the existing HMO membership of the two IPAs.

The SFHSS ACOs use the same basic payment rates and payment methods used in the providers' conventional HMO contracts with Blue Shield: capitation for physician services and fee-for-service payment for hospital services. Like the CalPERS ACO, these ACOs diverge from conventional payment by the partners' commitment to a global budget and the addition of a risk pool, with the partners sharing both upside and downside risk. Providers across both ACO networks collectively committed to achieving $10 million in savings for the first year of the program — a minimum target for the program to break even, given the commitment made to SFHSS for zero premium increases in the first year.

While the ACOs are still too new for their performance to be measured definitively, the smaller Dignity-Hill-UCSF ACO was reported by respondents to be working collaboratively, integrating care management, and meeting cost targets better than the larger B&T-CPMC ACO. As a result, the employer — the city and county of San Francisco — is said to be considering various approaches to steering enrollees to the Dignity-Hill-UCSF ACO.

Commercial ACO development in the East Bay has lagged behind San Francisco. One explanation offered by market observers is that a strong Kaiser East Bay presence leaves insufficient non-Kaiser HMO enrollment to support a commercial ACO for any single health plan. (One health plan executive estimated 15,000 to be the minimum enrollment for ACO viability.) Observers also suggested that the dominant position held by Sutter's Alta Bates Summit in a large portion of Alameda County means it has little incentive to participate in collaborations whose key aim is curbing inpatient utilization.

The first commercial ACO in the East Bay, announced in May 2012, is a collaboration between Blue Shield and John Muir for 16,000 HMO enrollees in Contra Costa County. About 40% are CalPERS members. Like Blue Shield ACOs in other California communities, this ACO is committed to zero premium increases in the first year and single-digit premium increases in subsequent years. While this particular ACO is limited to Contra Costa County, some see John Muir serving as the key hospital anchor for other narrow-network ACO collaborations more broadly in the East Bay, including Alameda County. Historically, traffic congestion has hindered patient travel to Walnut Creek from much of Alameda County, but improved transportation infrastructure (an expanded Caldecott Tunnel) by 2014 is expected to ease travel, perhaps making John Muir a more viable alternative to Alta Bates Summit.

Strong Safety Net Weathers Downturn

Compared to most other California communities, the safety nets in San Francisco and Alameda Counties remain extensive and strong, continuing to benefit from longstanding, deep-seated support from elected officials and community residents to provide care for vulnerable populations.[3] Collaboration among safety-net providers, and between these providers and local governments, has historically been robust and continues to grow.

County Hospitals Anchor Safety Net

The mainstay of the San Francisco safety net is San Francisco General Hospital (SFGH), owned and operated by the San Francisco Department of Public Health. Since 2008, its inpatient and surgical volumes have declined, while outpatient visits have risen and emergency department (ED) volumes have remained high, sometimes resulting in bottlenecks. SFGH's payer mix has worsened since 2008, with both uninsured and Medi-Cal shares increasing. It consistently runs large operating deficits — nearly –20% in 2008 and 2010 — but the 2010 Medi-Cal waiver has helped the hospital's finances. In addition, the city and county of San Francisco help make up SFGH's budget shortfalls. In 2008, voters approved a bond measure to rebuild SFGH's 400-plus-bed facility to meet seismic requirements. Expected

to open in 2015, the new facility will boost inpatient capacity modestly overall, but ED capacity will double.

Private hospitals play a small role in the San Francisco safety net, accepting some Medi-Cal and uninsured patients. Among these are the two Dignity hospitals, UCSF, Chinese Hospital, Kaiser, and Sutter/CPMC's St. Luke's Hospital. Located in a low-income neighborhood with a poor payer mix, St. Luke's fate has been in question for several years. Future plans for St. Luke's have been the topic of several rounds of negotiations between Sutter/CPMC and the city of San Francisco. By late 2012, no resolution had been reached.

In Alameda County, the safety net is anchored by Alameda County Medical Center (ACMC), which is owned by the county but independently operated as a public health authority. Like SFGH, ACMC has seen a considerable increase in outpatient visits in recent years. However, unlike SFGH, its inpatient volume has increased slightly. ACMC's financial performance has improved dramatically in recent years: The hospital has been able to reverse substantial losses (–17% operating margin in 2004) to achieve strong operating margins (almost 4% in 2010 and 11% in 2011), even in the wake of the economic downturn. The main factors in its recovery include a continued turnaround plan started by new management in 2005, several internal strategies to boost revenues, and in particular, help from the Delivery System Reform Incentive Payments in the Medi-Cal waiver, and from the hospital fee program.[4,5]

ACMC's revenues from a local dedicated sales tax, though helpful in getting the hospital financially stable after first being passed in 2004, have shrunk with the recession. Its payer mix has not changed significantly in recent years, although there has been a slight shift from Medi-Cal to uninsured patients. With funding from a bond measure, ACMC is undergoing a $700-million rebuild of much of its acute care facility on the Highland Hospital campus to meet seismic requirements. The rebuilt facility will include a new inpatient tower and renovated ED facilities, though inpatient capacity will not increase overall. ACMC plans to expand primary and specialty care capacity both on campus and in the community.

ACMC is pursuing a strategy of expanding its footprint by creating a "north-south safety-net hospital network" in Alameda County. To that end, it made a bid to acquire a struggling hospital, the independent St. Rose in Hayward, in partnership with Washington Hospital, a district hospital in Fremont. (However, St. Rose's board voted to accept an alternative offer from private investor Lex Reddy, an offer that still must be approved by the state attorney general.) ACMC is taking steps to acquire another financially ailing facility, San Leandro Hospital, currently part of Sutter's Eden Medical Center, and keeping it running as an acute care facility with ED capacity for at least three years, with funding from Alameda County and the Eden Health Care District, among others.

In Alameda County, other key providers of inpatient safety-net care include independent Children's Hospital & Research Center Oakland for pediatric services and Sutter-owned Alta Bates Summit for obstetric services, especially for Medi-Cal patients. Children's Hospital Oakland reportedly has long considered relocating to the suburbs to improve its payer mix and, in late 2012, signed a letter of intent to merge with UCSF — a move that still requires approval from both hospitals' boards.

FQHCs Expand Capacity

Since 2008, the economic downturn has increased demand for safety-net outpatient services, posing challenges to a historically strong and extensive network of community health centers (CHCs) and clinics. Some CHCs are FQHCs: CHCs that are eligible to receive both federal grants and cost-based Medi-Cal payments (see sidebar on page 10). The larger, more well-established FQHCs have been able to expand capacity to meet increased demand, often with the help of federal grants. In contrast, smaller clinics have

FQHC Designation

Community health centers that meet a host of federal requirements under Section 330 of the Public Health Service Act are deemed federally qualified health centers (FQHCs). FQHCs primarily treat Medicaid and low-income uninsured people. FQHC designation provides benefits including federal grants to subsidize capital and operational costs, cost-based payments per Medicaid patient visit (Prospective Payment System payments based on previous average costs that are updated annually for medical inflation), discounted pharmaceuticals, access to National Health Service Corps clinicians, and medical malpractice liability coverage. A smaller number of health centers have FQHC look-alike status, which provides most of the benefits that FQHCs receive but not federal grants. In managed care arrangements, FQHCs and look-alikes receive "wraparound" payments from the state to account for the difference between what the health plan or intermediary (such as an IPA) pays the health center and the full payment rate to which the health center is entitled.

struggled, and some have merged with other health centers or are considering merging with others and applying for FQHC status.

In San Francisco, the extensive and stable network of safety-net clinics providing primary care includes SFGH's on-campus general medicine and internal medicine clinics; a dozen primary care clinics throughout the community operated by the Department of Public Health; nine FQHCs; two free clinics; and a health center affiliated with Dignity-owned St. Mary's Medical Center. Also, Bay Area Addiction Research and Treatment — primarily a substance abuse center — has become a comprehensive primary care provider.

With demand rising from low-income patients, many San Francisco CHCs have increased capacity without expanding their physical facilities, such as by extending hours and increasing their nurse-practitioner workforce. A few of the most well-established FQHCs have added clinic sites; for example, the region's largest FQHC, North East Medical Services, expanded to a total of five clinics in San Francisco and added satellite clinics in other counties.

Like San Francisco, Alameda County has an extensive network of safety-net clinics providing primary care, including three county clinic sites operated by ACMC, eight private FQHCs, and several free clinics. With demand rising during the downturn, FQHCs in Alameda have undertaken more extensive brick-and-mortar expansions since 2008 than have those in San Francisco. The largest FQHC in Alameda County, La Clínica de la Raza — with a predominantly Latino patient base and operating numerous sites offering primary care, dental care, and other services — added two primary care sites in Contra Costa County. LifeLong Medical Care, an FQHC with an older patient base and a focus on homeless patients and psychiatric services, grew dramatically through mergers and partnerships, adding four clinics and two school-based health centers for a total of nine sites. It also gained a presence in Contra Costa County through its merger with Brookside Community Health Center.

While financial performance has varied across clinics and CHCs in this region, FQHCs generally have been able to support expansions through federal grants from the 2009 stimulus package and, more recently, the federal health reform law. Also, in Alameda County, FQHCs have received significant funding increases through the Low Income Health Program (LIHP), as they must be reimbursed at their FQHC payment rate.[6] In contrast, San Francisco FQHCs are not included in the LIHP network and do not receive those revenues.

Healthy San Francisco Grows

Since its inception in 2007, Healthy San Francisco (HSF), a program for the city and county of San Francisco to provide primary care to low-income, uninsured adults, has taken a broader, more comprehensive approach than medically indigent programs offered by other California counties. In 2008, HSF expanded eligibility to people with incomes up

to 500% of federal poverty, in contrast to the 200% or even lower eligibility thresholds seen in other California counties. The program remains open to adult residents, including undocumented immigrants. HSF continues to cover a broad set of services, including primary, specialty, hospital, ED, and mental health services, as well as prescription drugs, but excludes dental and vision care.

Both enrollment and provider participation in HSF have grown over the past few years. By early 2011, enrollment in HSF had reached 54,000 (compared to 43,000 in 2008), representing almost two-thirds of the eligible uninsured adult population at that time. (Some enrollees have since transitioned from HSF to the LIHP.) The provider network has expanded beyond the traditional safety net to include mainstream providers such as B&T, CPMC, Dignity, and Kaiser, though these providers account for a relatively small proportion of HSF services.

Funding for HSF continues through a combination of general funds from the Department of Public Health, participant fees, and the employer spending requirement (ESR), which requires employers with at least 20 employees to contribute to health insurance, HSF, or for employees ineligible for HSF, a Medical Reimbursement Account. In 2010, the US Supreme Court rejected a challenge to the ESR by the Golden Gate Restaurant Association.

Over the past few years, HSF providers — with help from the San Francisco Health Plan, the local public Medi-Cal plan that serves as the third-party administrator for HSF — have focused on moving care delivery toward the medical home model and improving clinical outcomes. Among the changes they have introduced are same-day scheduling, assigning patients to a provider's panel ("empanelment"), using a team-based care delivery model (e.g., creating larger roles for medical assistants), and implementing disease registries. These innovations — which apply to the providers' entire patient populations, not just HSF participants — were first implemented by public clinics, and now private clinics are following suit. These changes demonstrate that the San Francisco safety net has evolved to the point where providers can focus on changing and improving care delivery, in contrast to many other communities where safety-net providers are still focused on more basic access issues.

Safety Net Continues to Collaborate and Innovate

The safety-net systems in San Francisco and Alameda Counties, long characterized by partnerships among providers and county government, have become even more collaborative over the past few years. In part this increased collaboration has arisen from necessity, as demand has grown and resources have been stretched. Both counties continue to have active clinic consortiums in which the community health centers work together on a number of issues such as quality improvement.

In a key Alameda County collaborative effort, the county health department clinics, CHCs, and ACMC have worked together to select a common practice management system and electronic health record (EHR), NextGen. Respondents believed that implementation of this common system will greatly improve communication among providers about patient care and will establish a more integrated care delivery network. In a similar but more modest effort, several CHCs in San Francisco are coordinating EHR implementation among themselves.

Integrating behavioral health care with primary care is a focus of considerable and increased collaboration among county health departments, safety-net hospitals, CHCs and clinics, and county-operated Medi-Cal plans in both San Francisco and Alameda Counties. In San Francisco, these integration efforts were sparked in part by local budget cuts for mental and behavioral health services. SFGH reduced inpatient psychiatric service capacity, and San Francisco's public mental health clinics started focusing more on patients with serious mental illness and substance abuse problems. To help fill the gaps in more routine behavioral health issues, the public and private primary care clinics began adding new staff and services. Also, some clinics focusing on mental

health and/or substance abuse services are merging with FQHCs to ameliorate their financial strain and improve access to both primary care and behavioral health care. Indeed, given the high prevalence of behavioral health needs in the low-income population, the integration of primary and behavioral health is a key component of HSF and the LIHPs, and both provide some funding to support these efforts.

Improving access to specialty care is another focus of significant safety-net collaboration. In San Francisco, the eReferral system — a web-based referral tool embedded in SFGH's EHR system that facilitates communication between PCPs and specialists — continues to be a key collaborative effort between SFGH and county and community clinics. eReferral has been adopted by nearly all the specialties at SFGH and by most of the CHCs in San Francisco. In Alameda County, providers have adopted different approaches to addressing gaps in specialty care, in part because of the longer distances low-income people must travel for care. Alameda's CHCs continue to collaborate on managed care contracting through their consortium; this includes establishing their own network of community-based specialists willing to accept CHC patients. Also, private hospitals are helping to develop specialty care at CHCs — for example, through direct funding and through Kaiser's placement of volunteer specialists at CHCs.

Most safety-net collaborations to date have taken place within counties, not across counties. In one exception, SFGH and ACMC established a shared bank of interpreters to provide translation services during patient visits. On a larger scale, the fledgling HealthShare Bay Area health information exchange is a collaboration with an ambitious goal of syncing all Bay Area providers' health records. Safety-net respondents expressed enthusiasm for HealthShare Bay Area, but several mainstream providers have yet to commit to the initiative.

Preparing for Health Reform

In addressing questions about preparations for health reform, most mainstream providers in the Bay Area focused on the expected financial effects of reform and, in general, did not raise concerns about whether provider capacity will be adequate to handle insurance expansions. With a greater supply of health professionals in the Bay Area than in other California markets (e.g., 79 primary care physicians per 100,000 residents vs. 59 for the state), primary care access under reform is not as pressing a concern. Providers expressed mixed views about inpatient capacity: Some hospitals are concerned that all the current construction may result in an excess of beds, especially given the incentives to shift to ambulatory care under reform. However, a bed shortage could emerge in some submarkets if struggling hospitals were to close.

Safety-net providers expressed some concern about the adequacy of outpatient capacity — especially primary care — under reform, even though the network of CHCs and clinics in the Bay Area is stronger and more extensive than those in most other communities. San Francisco is considered particularly well-prepared for reform, in large part because of the HSF program. By 2014, HSF will have been in operation for seven years, and respondents believed the program has prepared providers to better manage uninsured patients and to transition them to Medi-Cal relatively smoothly. In preparation for insurance expansions, SFGH intends to expand primary clinics, but San Francisco CHCs do not expect to add new sites of care, though some may add capacity to existing facilities. In contrast, capacity-squeezed Alameda County CHCs expect to add sites, and ACMC has plans to build new capacity, including developing a stronger presence in the central part of the county.

Both San Francisco and Alameda Counties are implementing the LIHP but taking different approaches. San Francisco Provides Access to Healthcare (SF PATH) started in July 2011 through a transfer of 10,000 people with incomes below 133% of federal poverty from HSF into

the new program, which receives federal matching funds. However, with the federal change in Ryan White policy for patients with HIV, program cost estimates soared (primarily because of the cost of HIV medications), and the program had to reduce income eligibility to only 25% of federal poverty in November 2011.[7] Enrollment has since grown modestly. The medical home network for SF PATH enrollees is limited to Department of Public Health primary care clinics.

Alameda County's LIHP is an expansion of its existing medically indigent program, Health Program of Alameda County, or HealthPAC. The transition to the LIHP reportedly has been seamless to enrollees. People with incomes up to 200% of federal poverty are eligible, with undocumented immigrants remaining in the part of the program funded only by county sales tax revenues. With more than 35,000 people already enrolled in HealthPAC, the county is targeting 45,000 for enrollment by 2014. Provider reaction to HealthPAC has been positive; as mentioned earlier, CHCs benefit from the cost-based payments they receive for LIHP enrollees.

Issues to Track

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

- Will the regionalization trend among providers continue? What impact will increasing regionalization have on provider competition and on patients?
- Will hospitals be successful in aligning more closely with physicians and integrating care? Will growth in hospital foundation–affiliated medical groups accelerate?
- Will the nascent provider-plan commercial ACO collaborations gain traction? Will Medicare ACOs develop in this community?
- To what extent will hospital construction projects lead to serious financial burdens for hospitals and excess inpatient capacity in the market? How will prices and competition be affected?
- Will the region's struggling hospitals remain viable independent entities, or will they face closure or acquisition? What will be the impact on low-income patients and on neighboring hospitals?
- Will this region prove to be ahead of the game in covering people under reform and being able to handle increased demand for care?
- What impact will collaborations among safety-net providers, especially related to specialty care and behavioral health services, have on access to care and patient outcomes?

ENDNOTES

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

2. Because California's corporate practice of medicine law prohibits hospitals from directly employing physicians, some hospitals sponsor medical foundations as a way to align with physicians. Under a medical foundation model, physicians either contract with the foundation through an affiliated IPA or are part of a medical group that contracts exclusively with the foundation through a professional services arrangement. University of California hospitals, county hospitals, and some nonprofit organizations such as community clinics are among the entities allowed to employ physicians directly, through exceptions to the corporate practice of medicine prohibition.

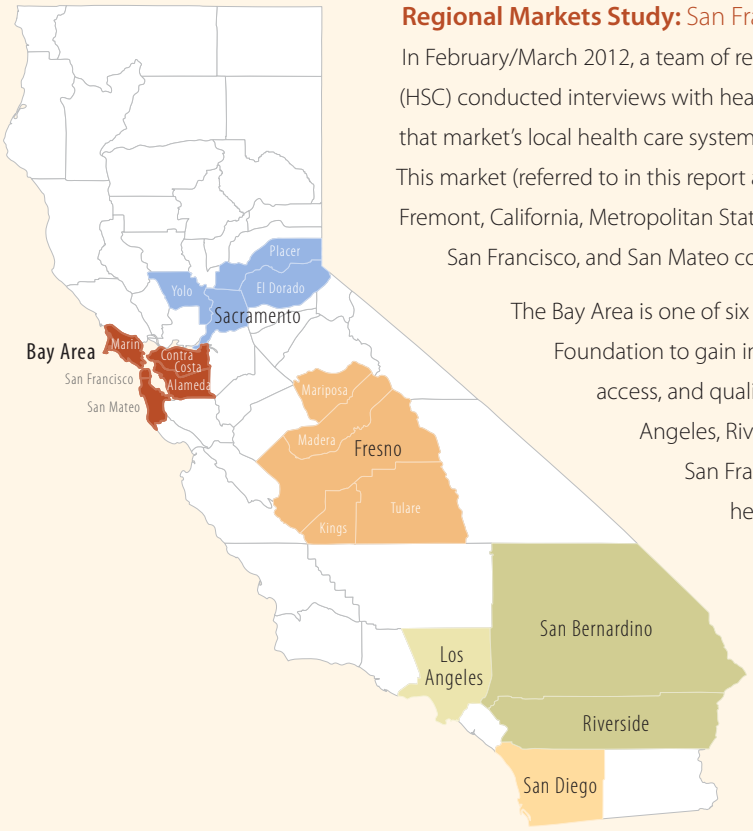
3. While Contra Costa, San Mateo, and Marin counties are also part of the study, most interviews were conducted in San Francisco and Alameda, and therefore the discussion focuses on these two counties.

4. Starting in 2011, the Delivery System Reform Incentive Payments (DSRIP) provides payments to California public hospitals for identifying and meeting numerous milestones around improving their infrastructure, care delivery processes, and quality outcomes over a five-year period.

5. Passed by the California legislature in 2009, the Hospital Quality Assurance Fee Program (commonly known as the hospital fee program) generates additional funding for hospitals serving relatively large numbers of Medi-Cal patients. Hospitals pay a fee based on their overall volume of inpatient days; after the addition of federal matching dollars, the funds are redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. Approximately 20% of hospitals are net contributors to the program. While the program originally only covered the period from April 2009 through December 2010, it has been renewed twice to 2013. Payments were first made to hospitals at the end of 2010.

6. The Low Income Health Program does not technically provide health insurance but requires counties to provide a benefit similar to Medi-Cal, which is typically more comprehensive than the traditional medically indigent programs. Counties receive federal matching funds to help support the cost of the LIHP.

7. A change in federal Ryan White policy, which requires the LIHP to be the primary payer of services to HIV/AIDS patients for whom Ryan White was previously the primary payer, has driven up expected costs of the programs.



Regional Markets Study: San Francisco Bay Area

In February/March 2012, a team of researchers from the Center for Studying Health System Change (HSC) conducted interviews with health care leaders in the Oakland/San Francisco region to study that market's local health care system and update a similar study conducted in December 2008. This market (referred to in this report as the Bay Area) encompasses the San Francisco-Oakland-Fremont, California, Metropolitan Statistical Area and includes Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties.

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

HSC researchers interviewed 34 respondents specific to this market, including executives from hospitals, physician organizations, community clinics, and programs for low-income people. Interviews with 18 health plan executives and other respondents at the state level also informed this report.

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ABOUT THE AUTHORS

Ha Tu, Joy Grossman, Laurie Felland, and Dori Cross of the **Center for Studying Health System Change (HSC)**. HSC is a nonpartisan policy research organization that designs and conducts studies focused on the U.S. health care system to inform the thinking and decisions of policymakers in government and private industry. More information is available at **www.hschange.org**.

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