CALIFORNIA
HEALTH CARE ALMANAC
REGIONAL MARKETS ISSUE BRIEF JUNE 2013

CALIFORNIA HEALTHCARE FOUNDATION

Ready or Not:
Are Health Care Safety-Net Systems Prepared for Reform?

Introduction

Under the federal Patient Protection and Affordable Care Act (ACA), large numbers of people will become eligible for Medicaid (called Medi-Cal in California) in 2014. Designed to identify newly eligible California residents and to ready local safety-net providers — primarily public hospitals and community health centers — for the influx of newly insured patients, the state's federal Bridge to Reform Medicaid Section 1115 waiver program has jumpstarted preparations for this coverage expansion. Even with new federal resources to help safety-net providers prepare, however, communities with weaker safety-net systems are lagging in reform preparations. As a result, low-income people in those communities may be left without health coverage and timely access to health care services. Even well-prepared communities will need time and assistance to help people gain health care coverage.

In 2008, the Center for Studying Health System Change conducted a study of local safety-net systems in six California communities: Fresno, Los Angeles, Riverside/San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area. (See Appendix A for key safety-net organizations and programs in each community.)

In 2011–12, a second round of the study was conducted to determine how local safety-net systems have changed in the interim. In addition to capturing general changes in safety-net funding, capacity, and financial viability, the second round of the study explored safety-net system responses to changes in state policy and planning for health reform.

Almost all safety-net providers in the study reported concerns about sufficient funding and workforce to care for newly insured people and for those who remain uninsured. At the same time, these safety-net providers are bracing for potential competition for insured patients from other providers and a consequent reduction in revenue. In response to these concerns, as federal and state policymakers launch Medi-Cal expansion and the health insurance marketplace (Covered California), they may wish to improve coordination with community safety-net leaders to focus resources and assistance to those communities that are currently further behind in preparing for national reform.

The ACA and California's Bridge to Reform

Expanded Medi-Cal Coverage Under the ACA

Starting in 2014, the ACA allows states to expand Medicaid eligibility to all legal residents with incomes up to 133% of the federal poverty level (FPL), or $15,282 annually (2013 level) for an individual. About one-third of states are predicted not to expand Medicaid eligibility. But the issue has never seriously been in doubt in California, despite concerns about long-range costs and questions about when and how the expansion would occur. Governor Jerry Brown agreed to the expansion in his proposed 2013–14 budget.

Medi-Cal eligibility for children and pregnant women already matches or exceeds the 133% FPL threshold, but the ACA expansion will make Medi-Cal available to more parents (currently eligible only if income does not exceed the poverty level) and to many childless adults who are currently ineligible at any income level if not disabled. Of California's approximately 5.6 million uninsured residents, the state estimates that approximately 1.4 million will become eligible for Medi-Cal under the ACA, with between 750,000 and nearly 1 million of these individuals enrolling in the program by 2019.[1] Additionally, the state expects that more than 2 million people with incomes between 133% and 400% of FPL will purchase subsidized private coverage through the new state health insurance marketplace by the time of its full implementation in 2019.[2]

Bridge to Reform Waiver

California has been preparing for the ACA-spurred Medi-Cal expansion for several years. From 2007 to 2010, the state held a waiver from the Centers for Medicare & Medicaid Services (CMS) that provided federal matching funds to 10 counties to enroll low-income people in Medi-Cal-like coverage programs. In November 2010, the state received the more expansive Bridge to Reform waiver from CMS, which allowed all 58 counties to begin the transition of uninsured people to Medi-Cal.

The broad purpose of the waiver is to identify people expected to be eligible for Medi-Cal in 2014 and to start providing care to them in advance of full implementation of health reform. Key goals are to prepare safety-net providers to care for more people, to mitigate a massive sudden demand for care in 2014, and to help uninsured people adjust to participating in organized systems of care.

The first main component of Bridge to Reform is Delivery System Reform Incentive Payments (DSRIP) to safety-net hospitals to help improve their infrastructure and care processes so that they may better and more easily serve more people and improve health outcomes.

The second main component is funding for counties to identify uninsured people likely to be eligible for Medi-Cal in 2014 and to enroll them in Low-Income Health Programs (LIHPs) that provide them with a medical home and Medi-Cal-like benefits. (See sidebar.) Both these waiver components rely on safety-net providers: public hospitals,

Main Components of Bridge to Reform Waiver

The two cornerstones of California's Bridge to Reform section 1115 waiver are Delivery System Reform Incentive Payments (DSRIP) and Low-Income Health Programs (LIHPs). The waiver also requires the state to transition seniors and persons with disabilities who have Medi-Cal-only coverage into managed care arrangements, and to establish a pilot program to test several models of organized systems of care for children with special health care needs.

DSRIP payments are provided over five years to California public hospitals — University of California hospitals and county hospitals — to identify and meet milestones related to improved capacity, infrastructure, care delivery processes, and quality outcomes. California's DSRIP is one of the few Medicaid waiver programs in the country that pays for provider activities beyond direct patient care. Generated by a federal match to county dollars, initial payments in 2011 were based on a hospital completing a plan detailing changes it would make, with subsequent payments based on meeting the performance targets in that DSRIP plan.

LIHPs identify low-income uninsured people likely to be eligible for Medi-Cal as of 2014 and provide services through temporary county programs with Medi-Cal-like benefits. Counties can include people with incomes up to 200% of FPL, although people between 133% and 200% of FPL receive fewer benefits — for example, no mental health, podiatry, or nonemergency medical transportation services.[3] Resources to create these county-level programs come from federal dollars matching counties' existing funds for caring for low-income populations. As of February 2013, 51 of the state's 58 counties had implemented a LIHP, and as of March 2013, approximately 575,000 people statewide were enrolled in a LIHP, meeting the state's initial goal.[4]

county governments, community health clinics, and other local providers that focus on care for low-income people.

Role of Counties in ACA Medi-Cal Expansion

County governments in California play a prominent role under health care reform. Local communities are a natural place to focus reform efforts, particularly in a state as large, populous, and diverse as California. State law makes counties responsible for providing health care to "medically indigent" residents who are ineligible for Medi-Cal. Also, managed care for Medi-Cal enrollees is arranged by county.[5] (See sidebar.)

County-Based Medi-Cal Managed Care Models

Of California's 58 counties, 30 have implemented Medi-Cal managed care using one of three models. The model chosen by each county dictates the type and number of health plans with which the California Department of Health Care Services contracts to serve that county's Medi-Cal enrollees. The most common models are the County Organized Health System (COHS) and the Two-Plan Model. In a COHS, the county runs a single health plan that covers all managed care enrollees. In the Two-Plan Model, enrollees can chose between a county-operated plan (known as a "local initiative") and a private health plan. There is also a little-used third model, Geographic Managed Care (GMC), in which there is no local public plan, but several private health plans compete for Medi-Cal enrollees. GMC is used in just two counties: Sacramento and San Diego.

Many counties already have a relatively extensive set of safety-net providers — which typically include public hospitals, certain private hospitals, and community health centers (CHCs), including federally qualified health centers (FQHCs) — dedicated to serving low-income people. Traditionally, the state and counties have financially supported safety-net providers, but in recent years, strained state and local budgets have prompted cuts. At the same time, however, the federal government's support for safety-net providers has grown through federal matching dollars to a state hospital fee program and through increases in federal grants to FQHCs.[6]

Local Strategies to Serve Low-Income People

The safety-net systems studied were generally trying to expand capacity to address a growing demand for care as more people lost private coverage, particularly as a result of the 2007–09 recession and the anemic recovery, and so became uninsured or obtained Medi-Cal coverage.[7] Safety-net providers were already benefiting from the Bridge to Reform waiver's increased funding to improve capacity and processes. The waiver also gave safety-net providers the opportunity to develop relationships with patients before they gained Medi-Cal coverage so that these patients and the new Medi-Cal reimbursement would remain with the safety-net provider. Often with help from the waiver, local safety-net providers implemented several common strategies to help enroll people into Medi-Cal or other coverage in the near future and to provide health care services to this growing group, including:

- Strengthening local leadership to help provide needed services and to set a broad plan for the safety net to prepare for reform
- Expanding outpatient care capacity, both in hospitals and in CHCs, to treat people early and thereby prevent more serious health problems
- Implementing LIHP to identify and establish relationships with uninsured people and to provide them with care in an appropriate, organized manner
- Enhancing collaboration among county officials, safety-net providers, and others to improve integration in hopes of providing more people with comprehensive and cost-effective care

Based on the degree to which each of the six communities is implementing these strategies, findings suggest that the

San Francisco Bay Area and Los Angeles are relatively well prepared for health reform, San Diego and Riverside/San Bernardino are moderately prepared, and Sacramento and Fresno lag in preparation. (See Appendix B.) In many cases, a community's implementation pace reflects its general safety-net capacity. That is, communities with relatively strong safety-net systems have advanced further while already-struggling communities have fallen further behind.

A community safety net's level of preparedness for health reform does not necessarily correlate with the amount of need in that community. (See Appendix C.) For example, the relatively well-prepared Bay Area has less need than Fresno in terms of proportion of residents who are in poverty, uninsured, or on Medi-Cal, and in poor health. Indeed, high need can be a barrier for counties to commit resources to make a significant difference in preparation for reform. Of the six sites, Riverside/San Bernardino has the highest percentage of uninsured residents, and the region appears well positioned to make a good dent in the uninsured rate.

Some aspects of a community's demographics, however, may reduce the effectiveness of good preparation. For example, communities with large undocumented immigrant populations, such as Los Angeles, the Bay Area, and the Central Valley (Fresno area), may be left with relatively high numbers of people who are ineligible for Medi-Cal coverage and thus remain uninsured.[8]

Strengthening Leadership

Strong local public leadership is key to preparing the safety net for reform. As found in the 2008 study, markets where county government plays a larger, direct leadership role in care provision typically are better able to ensure financial stability for safety-net providers and access to care for low-income county residents. In particular, counties that own hospitals and clinics have more control over how dollars are spent than counties that do not, but they also have more financial responsibility for rising capital and operational costs as needs increase. In contrast, counties that do not own hospitals have a greater ability to allocate money to help other providers.[9] Communities with a historically strong county-based safety net include the Bay Area counties of San Francisco and Alameda, the Riverside/San Bernardino region, and Los Angeles: Each has a county-run hospital and a network of public outpatient clinics. They also each operate a local Medi-Cal health plan. The recent round of this study found that local leadership for the safety net remains strong in these communities today.

An example of local leadership growing even stronger since 2008 is that of Los Angeles. While Los Angeles has a long tradition of a county-run safety-net system, the significant challenge of addressing the vast needs of this large, diverse, and congested county was heightened by the 2007 closure of inpatient and emergency services at the county-owned Martin Luther King Jr.-Harbor Hospital in South Los Angeles. During this time, the county recruited new leadership for the county health department, which brought new energy and approaches to improving the Los Angeles safety net, including redesigning the management structure for county clinics, increasing collaboration with private providers, and adopting new technology to improve access to specialty care.

While county leadership in San Diego had been lacking in 2008, it has improved in recent years. The University of California, San Diego's (UCSD) 2005 decision to close a campus in a low-income area appears to have prompted the county to take a more active role in the area's safety-net system, even though community outcry led to UCSD rescinding plans for full closure. The county commissioned a report to examine the status of the safety net, which led to the county implementing safety-net improvement strategies, such as helping people with chronic conditions transition from hospital to home and to outpatient providers, and integrating behavioral health with acute care services. A 10-year strategic plan — called Live Well, San Diego! — was also launched, with a broad goal of improving access to care through increased integration of the delivery system.

While Live Well, San Diego! is still a nascent effort, study respondents were optimistic about the new local focus and effort to improve health and health care.

Expanding Outpatient Care

Hospital Outpatient Care

To varying degrees, all six communities in the study are focusing on primary and other outpatient care over inpatient capacity to treat people in a timely manner before medical issues present or worsen. Although capacity is tight for many safety-net hospitals, hospital leaders generally expect inpatient capacity to be sufficient when coverage expands under reform in 2014 and do not plan to increase beds.

Although the 2008 study findings indicated that counties that own a hospital and clinics (compared to those that contract with providers) might be less nimble in preparing for reform, recent findings show that these counties are making considerable changes in care delivery. In part to expand capacity and prepare for payment changes — for example, assuming risk for the costs of care — counties are emphasizing increased outpatient care and expect a resulting gradual decline in inpatient hospital use. At the same time, county hospitals must juggle near-term demand for beds, particularly in the face of decreased inpatient capacity as they retool or build facilities to meet seismic requirements, as is the case at Los Angeles County + University of Southern California Medical Center, Arrowhead Regional Medical Center in San Bernardino, and Riverside County Regional Medical Center.

Many major safety-net hospital systems have expanded outpatient capacity. DSRIP funds are targeted, in part, to help hospitals expand outpatient infrastructure and to emphasize primary and specialty care access, medical homes, and care coordination. Public hospitals across all six markets in this study are undertaking these activities. One hospital executive explained, "We're using a lot of our DSRIP funds to expand our ambulatory [outpatient] network to be more competitive . . . to add more people [and] to provide more services to the community. . . . It's putting us in a better position so we're prepared for reform." For example, Alameda County Medical Center's complete renovation of its Highland Hospital campus will not increase inpatient capacity, but will expand primary and specialty care on the campus and throughout the county.

Not all efforts to increase outpatient capacity include facility expansions. Some involve changing patient scheduling practices and deploying team-based care principles to increase productivity and the number of patients seen. For example, Los Angeles County is redesigning its existing clinic sites to implement a patient-centered medical home model. To allow for greater focus on outpatient capacity, the county has also separated management and oversight of county clinics from the county hospital.

Community Health Center Care

Even the largest, most-established county health systems cannot address demand for primary and other outpatient care by themselves. Private community health centers — especially FQHCs — are expanding in the six communities to address both current and future needs. (See sidebar on page 6.) Largely because of greater capacity, the volume of CHC patient visits increased from 2008 to 2010, ranging from 6% growth in Fresno to 30% growth in Sacramento.[10] The large jump in Sacramento is likely attributable to a relatively recent surge in CHCs gaining FQHC status in a community with historically few FQHCs.

Many CHCs in California have benefited from recent increased federal funding — first through the 2009 American Reinvestment and Recovery Act (ARRA) and then through the ACA. This funding has improved FQHCs' financial performance and helped support facility renovations, information technology development, and expansion of physical space and operational capacity. For instance, as of June 2012, Family Health Centers of San Diego had received the largest ARRA and ACA grants among FQHCs in the

FQHC and Look-Alike Designations

Community health centers that meet a host of federal requirements under Section 330 of the Public Health Service Act are deemed federally qualified health centers (FQHCs). FQHCs primarily treat Medicaid and low-income uninsured people. FQHC designation provides benefits, including federal grants to subsidize capital and operational costs, cost-based payments per Medicaid patient visit (Prospective Payment System — PPS — 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 pays the health center and the full payment rate to which the health center is entitled.

six studied communities, totaling more than $22 million. This health center, the largest of the many FQHCs in the county, used these funds to add several care sites, for a total of 16 across the county, and to expand access at existing sites through walk-in appointment availability and weekend hours.

Many safety-net respondents noted that FQHC status is increasingly important to clinics' and health centers' ability to prepare for health reform. For free clinics, the change to FQHC status means both broadening the mission beyond serving only uninsured patients without charge and having to adjust to the administrative burdens that accompany insurance contracting and billing. However, respondents reported that federal support for FQHCs is uneven across communities, with state data showing a particular dearth of FQHC development per capita in Riverside/San Bernardino. For example, as of June 2012, ARRA and ACA FQHC grants totaled approximately $10 million in this region, compared to almost $100 million in Los Angeles, a 10-fold difference even though Los Angeles has just three times the number of low-income residents that Riverside/San Bernardino has.

Many clinics and health centers without FQHC status have turned to other strategies to stay afloat, particularly in light of state funding cuts.[11] Many are pursuing traditional cost-cutting strategies, such as reducing staff hours or closing sites, and some are considering merging with larger FQHCs. Several Bay Area free clinics and other smaller health centers are taking these approaches.

Another factor related to expanding primary care capacity is the rapid development of rural health clinics (RHCs) in Fresno, the most rural of the study sites. The five counties composing the broader Fresno region are home to 40% of all RHCs in the state. RHCs are similar to FQHCs in that they are intended to improve health care access in underserved areas and are paid similarly for Medicaid and Medicare patients. Unlike FQHCs, however, RHCs are not required to treat all patients regardless of their ability to pay (mostly uninsured patients), and they can readily add specialty and other services without going through complex federal and state application processes. Many of the Fresno RHCs were developed by private hospitals — either built as new facilities or converted from existing physician practices — and present some competition to existing FQHCs in the area.[12]

Developing a Low-Income Health Program

Local study respondents typically viewed the LIHP as a key way to identify more uninsured people, address their health care needs early, and provide a transition for them to Medi-Cal or other insurance coverage. The LIHP has been readily embraced and implemented in most, though not all, California counties. (See Appendix A.) These new programs typically are built on existing medically indigent programs, with many medically indigent enrollees transferred to the LIHP. With funding now gaining federal matching funds, the programs are able to provide more services and reach more people. (See sidebar on page 7.)

Traditional County Health Care Programs for the Medically Indigent

California has given counties great latitude to define the scope of their responsibility to care for medically indigent residents. While smaller and/or more rural counties typically contract with the state-run County Medical Services Program, larger counties establish and run their own indigent care programs, which vary significantly in reach.[13] For example, counties can decide at what income level to provide services to uninsured people and whether to serve people regardless of their immigration status. (San Francisco, Alameda, and San Diego Counties received federal matching funds under the state's previous Medi-Cal waiver to assist people with incomes up to 200% of FPL.)

While programs typically provide comprehensive inpatient and outpatient services, some limit those services only to an immediate medical need rather than also focusing on prevention. The size of a county's program is also related to how the state distributes so-called realignment funds (state vehicle licensing fees and sales tax revenues) to support these programs, with some counties contending that allocations are inequitable and do not accurately reflect county needs.[14] Also, in recent years funding for medically indigent programs has been relatively flat while costs have grown, causing some counties to reduce the scope of their programs.

The LIHP, however, mirrors Medi-Cal more closely than it does the medically indigent programs. In exchange for federal matching dollars, county LIHPs must provide more standardized, comprehensive benefits; conduct stricter income documentation; require legal immigration status; and focus on establishing a broader network of medical homes. To pay for these services, LIHP providers typically receive more funding than they would under the medically indigent program. In particular, the state's Medi-Cal Bridge to Reform waiver requires each LIHP to include at least one FQHC in its provider network, and all participating FQHCs must receive the Medi-Cal PPS rate, which in many cases is considerably more than what they received from medically indigent programs.

County decisions about implementing a LIHP and how many people to enroll are largely governed by available funding and how a county calculates the trade-off between additional federal dollars and added responsibilities. Currently, LIHPs reach a relatively small percentage of the uninsured population in most communities. Alameda County's program appears to have the broadest reach, with income eligibility to 200% of FPL and about a quarter of uninsured county residents enrolled.[15]

A recent change in federal Ryan White program funding for low-income people with HIV/AIDS has created challenges for some communities. With the Bridge to Reform waiver, LIHPs were required to assume payment responsibility for this population. Some counties lowered income-eligibility levels after estimating that costs would be greater than initially expected. For example, in San Francisco, estimates of high drug costs to care for a large number of residents with HIV/AIDS led the county to reduce income eligibility for LIHP from 133% of FPL to 25% of FPL for new enrollees.

Counties with less-developed safety-net systems tended to take longer than expected to set up LIHP enrollment processes and provider networks, particularly where, as in Sacramento, there was insufficient infrastructure to build on. Sacramento finally implemented a LIHP at the end of 2012, in partnership with a Medi-Cal managed care plan and two private hospital systems, Sutter and Dignity Health.[16]

Fresno, on the other hand, has opted out of the LIHP altogether. The county's main hospital, Community Medical Centers, has a 30-year agreement with the county to serve the medically indigent population. Funding to the hospital is fixed, while the costs of caring for indigent people have grown. Even with new federal funding available through LIHP, the combined costs for the medically indigent program, which serves undocumented immigrants, plus costs of a LIHP, were expected to widen the gap between available funds and the costs of care for the enrolled population.

Enhancing Collaboration

Enhanced collaboration among local policymakers, public and private providers, and other safety-net organizations is important to carrying out coverage expansions and introducing strategies to integrate the safety net to serve more people in efficient, appropriate, and comprehensive ways.

The Bay Area stands out for advancing its safety-net focus from access to care to a broader improvement of care delivery in collaborative ways across public and private organizations. Although its LIHP is small, since 2007 San Francisco has operated Healthy San Francisco, a large program available to most uninsured residents, which provides broader access than a typical program for the medically indigent. Funded through a combination of local general revenue, an employer fee, and participant fees, the program's enrollment has grown to about 55,000 people with incomes up to 500% of FPL. As the third-party administrator for the program, the public San Francisco Health Plan has fostered adoption of patient-centered medical homes to improve access to services and comprehensive, coordinated care. A number of improvements are in process within both county clinics and private CHCs in San Francisco, including use of same-day scheduling so patients can see a provider as soon as they feel they need to, establishment of formal patient panels so providers can more easily know whether the patients they are responsible for get needed preventive services, and a team-based care delivery model that gives medical assistants greater roles in improving provider efficiency and capacity.

Moreover, LIHPs have encouraged, and in some ways required, stronger collaboration among safety-net providers. For example, the LIHP encourages integration of primary care and behavioral health services. San Francisco and Alameda Counties, in particular, have made gains in this area. San Diego and Riverside/San Bernardino offer additional examples of how LIHPs have improved collaboration, with public-private partnerships emerging as counties contract with private CHCs and other providers to expand the LIHP provider networks and to coordinate services across providers.

Another key development in collaboration is fledgling work to develop accountable care organizations (ACOs) for low-income people. Two ACOs are under development in Los Angeles — one focused on the high-need area of South Los Angeles (HealthCare First South LA) and the other more broadly across the county (Regional Accountable Care Network). The ACOs involve establishing integrated delivery systems among hospitals, health centers, private physicians, the county, and the county Medi-Cal health plan. Starting with processes to share patient information and to improve care coordination, the intent is to move toward risk-based global payments that give providers more responsibility and financial risk for patient care, with the ultimate goal of improving patient outcomes and lowering costs.

Ongoing Challenges and Concerns

Despite early efforts to prepare for health care reform, local safety-net providers have concerns about adequately serving low-income people, insured or not. These concerns center on changes in funding and other resources, competition from other providers, and sustaining an adequate workforce.

Adequate Funding

Despite specific funding to care for LIHP enrollees, many safety-net providers reported feeling the strain of helping uninsured patients understand and enroll in the program, without adequate resources to perform this function. These providers have similar concerns about the Medi-Cal expansion. Providers in Los Angeles particularly have struggled with this issue because the LIHP enrollment process is more stringent there than the previous process for its medically indigent program. In contrast, the San Diego Health Department has integrated the application process for LIHP and Medi-Cal and increased application locations to 10 county-operated social service and family resource centers, which may take pressure off providers.

Also, safety-net providers are concerned that financial support to shore up capacity to care for low-income people is insufficient and will evaporate before the ACA transition to insurance coverage is completed. LIHP funds are slated to expire at the end of 2013, and DSRIP payments will expire in 2015.

Further, local safety-net providers expect to have many patients remain uninsured in the near term or indefinitely (for example, undocumented immigrants). And although counties typically plan to keep medically indigent programs in place to care for remaining low-income, uninsured residents, especially counties now covering new and undocumented immigrants, respondents feared state funding for these programs will dry up.

Even as people gain coverage, providers expressed concern that subsidies to help cover the costs of caring for low-income, uninsured people and current Medi-Cal enrollees could decline more than the increase in Medi-Cal revenues from newly covered patients. California hospitals, like hospitals across the country, face reductions in Medicaid and Medicare disproportionate share hospital payments that help offset the cost of caring for low-income and uninsured patients. Also, it remains to be seen how new state mechanisms to take into account changes in counties' revenues and costs of caring for low-income people will affect resources and health care services at the local level.[17]

Competition from Non-Safety-Net Providers

While safety-net providers expect significant increases in demand for services arising from ACA-generated coverage beginning in 2014, they also are concerned about losing some uninsured patients to other providers once those uninsured patients gain coverage. To the extent that newly insured patients do move to other providers, some safety-net providers would be left with a greater proportion of uninsured patients and fewer resources. From the Medi-Cal enrollees' perspective, however, this increase in competition among providers may be beneficial if it results in more choices and timely access to care. To respond to the expected increase in demand and growing competition for insured patients, some providers are making capital expenditures to rebuild and renovate facilities, and adding operational expenses to expand the array of social and other support services — for example, transportation and language interpretation — they offer low-income people.

Workforce Shortages

Respondents across the communities studied thought that the supply of primary care physicians (PCPs) and other clinicians was insufficient to care for the large numbers of people who will gain public and private coverage under health care reform. Among the six communities, the supply of PCPs per capita is particularly low in Riverside/San Bernardino and Fresno. Respondents in these two regions reported few comprehensive strategies to build physician supply, with the exception of a long-term plan by UC Riverside to establish a four-year medical school. Beginning in summer 2013, however, California PCPs will receive a two-year temporary boost in Medi-Cal payments up to Medicare levels, which is significant considering that Medi-Cal rates are among the lowest Medicaid rates in the nation.[18] Increases will be retroactive to January 1, 2013, and may encourage greater provider participation in Medi-Cal.

While many safety-net providers reported that recruiting and retaining physicians have not yet been particularly difficult, they did note a need for more staff as they expand capacity. Many are adding nonphysician staff or "midlevels," such as nurse practitioners and physician assistants, and using them to the fullest extent of their training and licensure. Yet the effectiveness of this strategy to increase capacity is contingent upon the extent to which midlevels are used as PCPs, either with their own patient panels or in a delegated-work role with physicians.[19] This strategy seems to have gained more traction in some markets than in others. In Sacramento, for example, two large FQHCs have added midlevel practitioners to the point of having three per PCP.

In Riverside/San Bernardino, however, providers seemed more hesitant about extensively expanding use of midlevels in new ways.

Implications for Health Reform

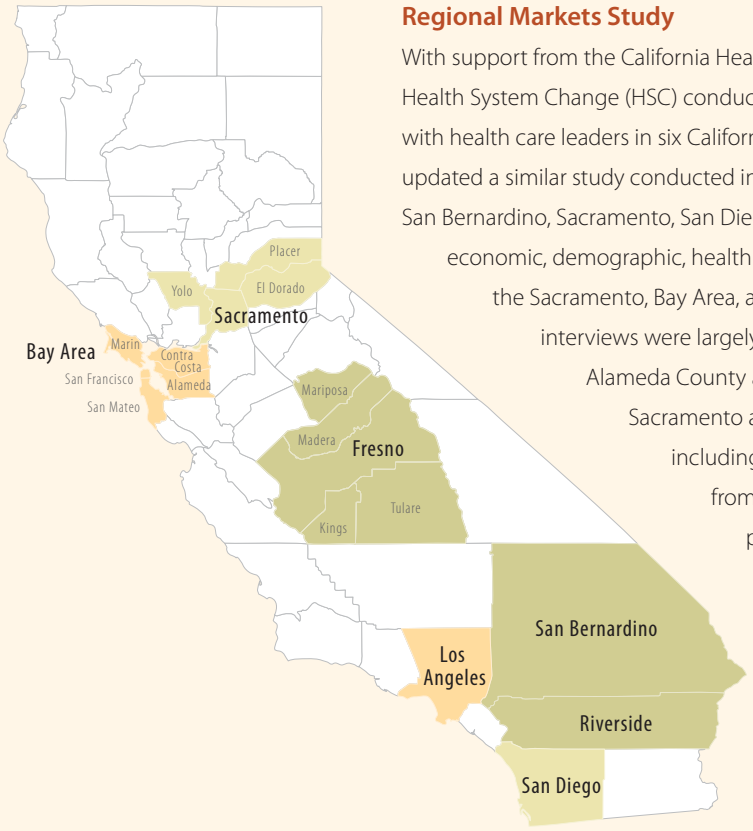
California's significant delegation of responsibility to counties has considerable benefits in providing flexibility to meet local health care needs. The findings from six California regions indicate that community activities to prepare for health care reform can help mitigate the stress on the health care system to enroll and care for people come 2014. At the same time, considerable community variation in these efforts suggests that some counties are struggling to overcome long-standing weaknesses in their safety-net systems. Also, counties have traditionally operated on their own in caring for low-income people. There appears to be little structure for cross-county collaboration, which may preclude the sharing of useful strategies and resources.

To help ensure a minimum level of progress toward health reform across the state, policymakers may wish to take into account specific ways that communities are preparing for reform and how the reach of these efforts varies from community to community. For example, while the LIHPs appear to be successful in many communities, they are not an across-the-board solution to the problem of transitioning low-income people to health insurance coverage, medical homes, and other appropriate health care services. Also, while most of the county-based Medi-Cal managed care programs have been relatively stable in recent years, Sacramento County has set up an advisory board to consider changes in its program following tensions between the health plans on the one hand, and the hospitals and FQHCs on the other.[20]

Even in counties that appear relatively well prepared for the effects of health reform, many local strategies are still nascent and require more time to develop. It's unknown how readily uninsured people will gain coverage and access to care. In that regard, how well the LIHPs are able to reach the remaining eligible individuals before 2014 is uncertain. San Francisco provides an example of the time and effort needed: Although approximately half of this county's uninsured residents are enrolled in the Healthy San Francisco program, the program has been in place for six years and continues to work on changes in care delivery. Similarly, many uninsured Californians are already eligible for Medi-Cal but are not enrolled, indicating that local efforts to reach people — screenings for Medi-Cal through medically indigent programs — could be improved.[21]

Outreach and enrollment strategies conducted by the state, local governments, and private organizations — which were outside the scope of this study — will also play a part in the rollout of health care reform. New "navigators" will be deployed by the state to help people enroll in coverage, and it may be efficient for the state to coordinate these activities with existing local safety-net structures to supplement, and to avoid duplication or conflict with, existing strategies. Communities lagging in enrollment will need more assistance in this regard.

Many communities likely will also need more provider capacity to meet the increased demand for care as more people become insured. But while the sudden availability of coverage to so many people may release a huge, long-standing, pent-up demand for care, the full scope of the resulting jump in demand for services may be only temporary. Communities will need to be careful to find ways to expand capacity to meet large but potentially short-term needs without overextending themselves financially through brick-and-mortar or other expansions that are expensive and difficult to downsize if demand subsides. Focused leadership and collaboration will be important to address this balancing task, to create the best mix of inpatient and outpatient care, to develop an adequate workforce, to control the costs of serving the expanded Medi-Cal population, and to provide care for people who remain uninsured.



Regional Markets Study

With support from the California HealthCare Foundation, researchers from the Center for Studying Health System Change (HSC) conducted interviews between November 2011 and April 2012 with health care leaders in six California regions to study these local health care systems. The work updated a similar study conducted in 2008. The six regions — 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. Although the Sacramento, Bay Area, and Fresno regions each encompassed several counties, the interviews were largely concentrated in the largest, urban cores of these regions: Alameda County and the city and county of San Francisco for the Bay Area, and Sacramento and Fresno Counties. HSC researchers interviewed 185 people, including 167 community-level provider respondents (executives from hospitals, physician organizations, community clinics, and programs for low-income people), as well as 18 health plan executives and other state-level respondents. Researchers supplemented the qualitative interview information with quantitative data on demographics, provider characteristics, and other background information.

▶ FOR THE ENTIRE REGIONAL MARKETS SERIES, VISIT WWW.CHCF.ORG/ALMANAC/REGIONAL-MARKETS.

AUTHORS

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.

ABOUT THE FOUNDATION

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at 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/almanac.

ENDNOTES

1. Marjorie Swartz, "Bill Analysis: Medi-Cal Eligibility," *Analysis of California Assembly Committee on Health Bill AB 1 X1,* www.leginfo.ca.gov.

2. "Covered California," *Annual Report to the Governor and Legislature* (Sacramento, CA: California Health Benefit Exchange, January 2013).

3. Peter Harbage and Meredith Ledford King, *A Bridge to Reform: California's Medicaid Section 1115 Waiver* (Oakland, CA: California HealthCare Foundation, October 2012), www.chcf.org.

4. "Low Income Health Program Update," Stakeholders Advisory Committee Meeting (February 22, 2013), www.dhcs.ca.gov; *LIHP March 2013 Monthly Enrollment* (Sacramento, CA: Department of Health Care Services, May 23, 2013), www.dhcs.ca.gov.

5. Deborah Reidy Kelch, *The Role of Counties in the Health of Californians: An Overview,* (Oakland, CA: California HealthCare Foundation, October 2011), www.chcf.org.

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

7. Statewide between 2007 and 2009, the portion of the population on Medi-Cal increased from about 19% to 21%, the portion lacking any coverage increased from 13% to almost 15%, while the portion covered by commercial insurance declined from 59% to 55%. Source: California Health Interview Survey, 2009.

8. Laura Hill and Joseph Hayes, "Undocumented Immigrants" (San Francisco: Public Policy Institute of California, February 2013), www.ppic.org.

9. Laurie E. Felland, Aaron B. Katz, and Johanna R. Lauer, *California's Safety Net: The Role of Counties in Overseeing Care* (Oakland, CA: California HealthCare Foundation, December 2009), www.chcf.org.

10. California Office of Statewide Health Planning and Development, *Annual Financial Data,* (Sacramento, CA: Healthcare Information Division, December 2012).

11. Two key funding changes have affected safety-net clinics and CHCs across the board. Funding ended in 2010 for the Expanded Access to Primary Care program, through which the state had used general revenues to help CHCs cover some of their costs of delivering services to uninsured people. Also, state cuts in optional Medi-Cal benefits (including adult dental care, podiatry, and optometry) had financial impacts because CHCs continued providing these benefits to the extent possible, though availability of these services declined for some people.

12. Joy Grossman, Peter Cunningham, and Lucy Stark, *Fresno: Health Providers Expand Capacity, but Health Reform Preparation Lags* (Oakland, CA: California HealthCare Foundation, December 2012), www.chcf.org.

13. O'Neill, "Governor Brown Commits."

14. Felland, Katz, and Lauer, *California's Safety Net.*

15. This assessment is based on estimates of the total uninsured population in the county; study researchers were unable to obtain estimates for the subset of the uninsured population likely to be eligible for LIHP.

16. "Sacramento County Announces November Launch of LIHP," *California Healthline* (October 18, 2012), www.californiahealthline.org.

17. Edmund G. Brown Jr. Governor, State of California, Governor's Budget May Revision 2013-14, (Sacramento, CA: State of California, May 2013). Please note: The full budget is set to be in place by June 30, 2013.

18. Kaiser Family Foundation, "Medicaid-Medicare Fee Index" (2012), www.kff.org.

19. Tracy Yee et al. "Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies," *NIHCR Research Brief No. 13* (Washington, DC: National Institute for Healthcare Reform, February 2013), www.nihcr.org.

20. Ha Tu et al., *Sacramento: Health Providers Collaborate and Weather Economic Downturn* (Oakland, CA: California HealthCare Foundation, September 2012), www.chcf.org.

21. Research models predict 10% to 20% of the "eligible but not enrolled" to enroll by 2019 through the "woodwork effect," which refers to people becoming aware of their eligibility through increased attention surrounding the ACA generally, the availability of health insurance exchanges, and the enrollment of family members. See Swartz, "Bill Analysis."

Appendix A. Safety-Net Structure, by Community

	Fresno	Los Angeles	Riverside/San Bernardino	Sacramento	San Diego	San Francisco Bay Area
Main Safety-Net Hospitals	Community Medical Centers (private)	County hospital: LAC+USC Medical Center (plus two other acute care county hospitals)	County hospitals: Arrowhead Regional Medical Center, Riverside County Regional Medical Center	UC Davis, plus (private) Dignity Health and Sutter	UC San Diego, plus (private) Children's, Scripps, and Sharp	County hospitals: San Francisco General Hospital, Alameda County Medical Center
Clinics and CHCs	Community Medical Centers outpatient care center, several FQHCs throughout region	County clinics plus an extensive set of FQHCs and private clinics	County hospital-operated outpatient care clinics plus other county facilities, several FQHCs plus some RHCs and non-federally qualified clinics	UC Davis and Dignity safety-net clinics, one county clinic, several newly designated FQHCs	Many FQHCs	San Francisco and Alameda Counties have several county clinics, large FQHCs, and free clinics
Medically Indigent Program Eligibility*	Eligibility increased from 56% to 200% of FPL (following lawsuit)	Chronically ill under 133% of FPL, some coverage for undocumented immigrants	200% of FPL (both counties), undocumented immigrants covered in Riverside but not in San Bernardino	200% of FPL, no longer covers undocumented immigrants	Chronically ill under 165% of FPL	**San Francisco:** 500% of FPL **Alameda:** 200% of FPL
LIHP Eligibility and Enrollment (as of May 2013)	Not implementing	Implemented July 2011 **Healthy Way LA:** • 133% of FPL • 250,000 enrolled	Implemented January 2012 (both counties) **Riverside (Riverside County HealthCare):** • 133% of FPL • 22,000 enrolled **San Bernardino (ArrowCare):** • 100% of FPL • 30,000 enrolled	Implemented November 2012 **Sacramento County:** • 67% of FPL • 10,000 enrolled	Implemented July 2011 **San Diego County LIHP:** • 133% of FPL (plus some grandfathered in at up to 200% of FPL) • 36,000 enrolled	Implemented July 2011 (both counties) **San Francisco (SF PATH):** • 25% of FPL (dropped from 100%) • 10,500 enrolled **Alameda (HealthPAC):** • 200% of FPL • 48,000 enrolled
Medi-Cal Managed Care Model	Two-Plan Model; Anthem Blue Cross and CalViva	Two-Plan Model; LA Care (public) plus Anthem Blue Cross, Care1st, and Kaiser	Two-Plan Model; Inland Empire Health Plan (public) plus Molina	Geographic Managed Care; Anthem BC, Health Net, Kaiser, and Molina participating	Geographic Managed Care; Care 1st, Community Health Group Partnership, Health Net, Kaiser, and Molina	Two-Plan Model; San Francisco and Alameda each have county health plan, plus Anthem Blue Cross

*Upper income limit noted at which enrollees may encounter cost sharing; enrollees at lower incomes do not.

Source: Respondent interviews; LIHP March 2013 Monthly Enrollment (Sacramento, CA: California Department of Health Care Services, May 23, 2013), www.dhcs.ca.gov.

Appendix B. Preparedness for Reform, by Community

	Fresno	Los Angeles	Riverside/San Bernardino	Sacramento	San Diego	San Francisco Bay Area
Local Leadership	Low	High	Medium	Low	Medium	High
Outpatient Care Emphasis	Medium	High	Medium	High	Medium	High
LIHP Development	Low	High	Medium	Low	Medium	Medium
Advanced Collaboration	Low	Medium	Medium	Low	Medium	High

Source: Authors' assessment based on analysis of interview data.

Appendix C. Baseline Need for Safety Net, by Community

	Fresno	Los Angeles	Riverside/San Bernardino	Sacramento	San Diego	San Francisco Bay Area
% Uninsured	16.9%	17.0%	19.5%	10.1%	12.4%	9.8%
% Medi-Cal	33.7%	24.6%	21.2%	15.3%	20.2%	21.4%
% Fair/Poor Health	19.8%	18.0%	16.1%	11.6%	11.9%	13.8%
% Below Poverty (FPL)	27.3%	22.7%	17.0%	13.2%	11.9%	11.7%

Source: UCLA Center for Health Policy Research, California Health Interview Survey, 2009.