CALIFORNIA HEALTHCARE FOUNDATION

CHCF Regional Market Analyses:

Insights from Visits to Six California Markets

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Today's Program

1. Study background
2. Socioeconomic and health system background
3. Descriptions of six diverse communities
4. Cross-cutting themes

Center for Studying Health System Change (HSC)

- Analyzing local and national changes in financing and delivery of health care
  - Surveys of households, physicians
  - Site visits to 12 representative metropolitan areas
  - Additional quantitative and qualitative research
- Active dissemination program
  - Following in policy world, industry, researchers, educators
  - www.hschange.org
- Funding from foundations and government agencies

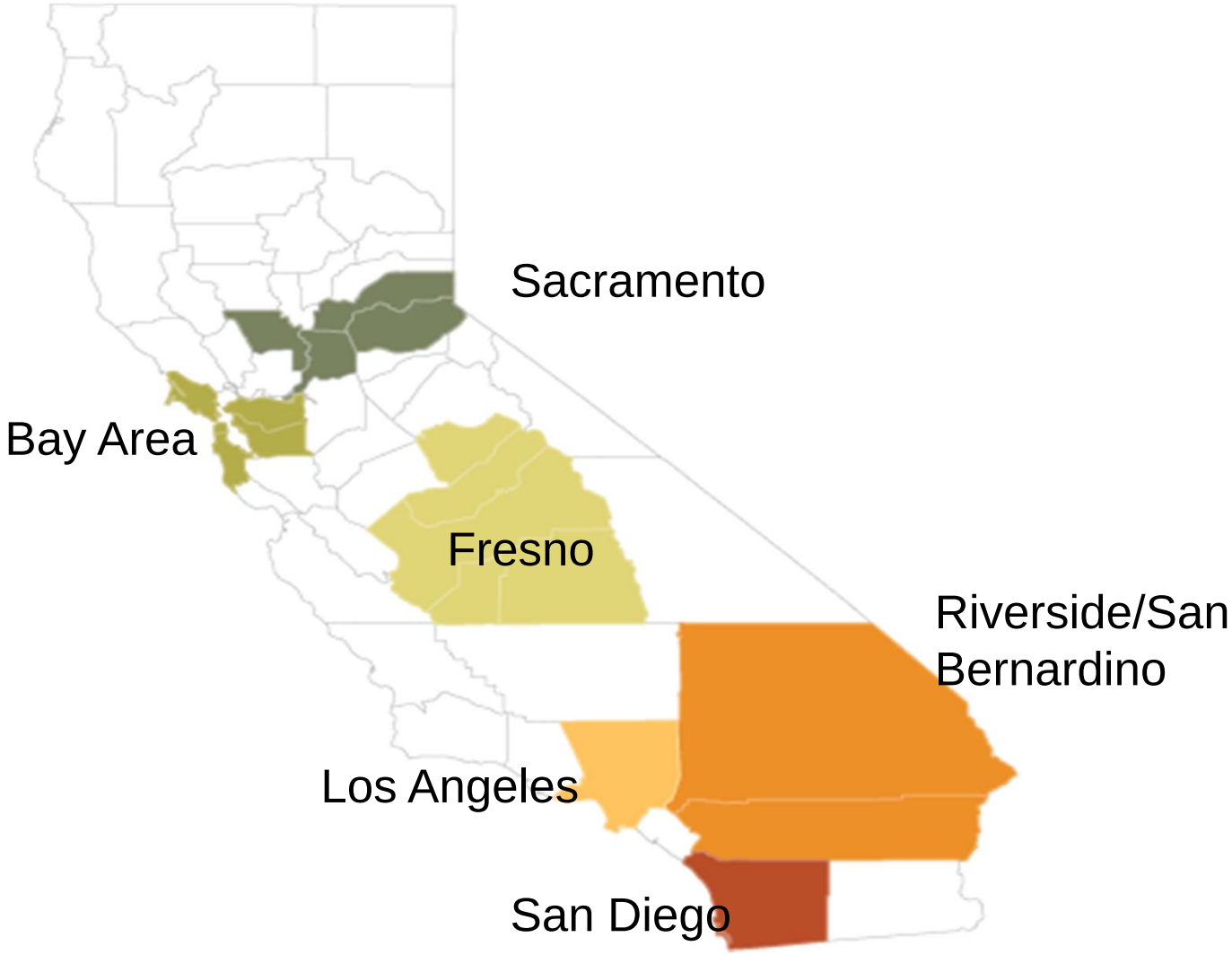
Project Objectives (1)

- Provide follow up to 2008 findings from first round of site visits to six diverse California communities
- Narrower focus on the care delivery system: hospitals, physician organizations, the safety net
  - Understand how providers are preparing for changes under health care reform — including contracting with insurers

Project Objectives (2)

- Identify implications for providers, patients, and policy
- Publications
  - Six regional market updates published by CHCF
  - Two cross-site analyses
    - Ability of safety net to meet increased demand under reform
    - New contracting and payment methods

Markets Studied



Methods

- Interview 185 health care leaders from:
  - Hospitals
  - Physician organizations
  - Health centers and clinics
  - State and local policymakers
  - Insurers (on hospital contracting)
  - Other key stakeholder organizations
- Conducted Nov. 2011 – May 2012

Variation of Local Markets' Socioeconomic Profiles

Market	Lower Socioeconomic Profile	Higher Socioeconomic Profile
Fresno	54% < 200% poverty	
Los Angeles	43% < 200% poverty	
Riverside/San Bernardino	39% < 200% poverty	
California	*36% < 200% poverty*	
San Diego		29% < 200% poverty
Sacramento		28% < 200% poverty
San Francisco Bay Area		25% < 200% poverty

Fresno Round 1

Fresno, Kings, Madera, Mariposa, and Tulare Counties

- Economic downturn intensifying already severe poverty, unemployment, and lack of health insurance
- Rapid population growth
- Geographically segmented hospital market
  - Fragmented safety net
- Historically low penetration by Kaiser and other HMOs
- Inadequate provider capacity contributes to serious access problems for low-income people

Fresno Update

- Continued weak economy
- No major organizational changes
- Most hospitals weather downturn; little progress in physician-alignment strategy
- Expansion in hospital and clinic capacity
  - But access to care problems for low-income people persist
  - Trails other areas in preparing for coverage expansions
    - Low income health plan (LIHP) participation minimal
    - Little collaboration among providers re: physician shortages

Los Angeles Round 1

Los Angeles County

- Fragmented hospital market; no dominant system
  - Growing gap between “have” and “have-not” hospitals
- Highly competitive physician market
- Large market share for HMO products
- Well-developed, strong safety net
  - But some gaps remain

Los Angeles Update

- Gap between “have” and “have-not” hospitals persists
  - Increased payer pushback on “haves”
- Hospitals actively pursuing physician integration
- Physician organizations lead the way on accountable care organization (ACO) contracting
- County safety net energized by new leadership
  - Undergoing significant care delivery redesign
  - Leader in preparing for reform

Riverside/San Bernardino Round 1

Riverside and San Bernardino Counties

- Vast geographic area leads to fragmented health care market
- Rapid population growth; housing crash
- Providers concerned about patient migration to Los Angeles
- Strong political support for local safety net
  - Led by county hospitals

Riverside/San Bernardino Update

- Continued economic decline
  - Worst foreclosure rates across all markets
  - Nearly 1 in 5 uninsured
- Kaiser growth threatens other providers
- Growing concerns about physician supply, especially outlying areas
- Safety net faces financial and capacity pressures
  - Slower FQHC growth than in other markets studied

Sacramento Round 1

El Dorado, Placer, Sacramento, and Yolo Counties

- Rapid population growth in high-income, well-educated areas
- Four powerful not-for-profit hospital systems — each with aligned physician groups
- Strong presence by Kaiser and other HMOs
  - Large impact of CalPERS
- Small, fragmented safety net; limited community health center capacity

Sacramento Update

- Increasing dominance of Kaiser
- "Petri dish" for new contracting and payment arrangements
  - Narrow-network products, global payment
- Competing pressures on outpatient safety net providers
  - Capacity still inadequate despite growth over past three years
  - Concern among FQHCs about losing Medi-Cal patients to for-profit clinics because of growing use of managed care contracts

San Diego Round 1

San Diego County

- High-income, well-insured population
- Four large hospital systems with close physician group affiliations
  - Tight inpatient capacity
- Plans have weak leverage with providers
  - Turning to narrow-network products
  - Scripps shift to FFS; Sharp retains commitment to capitation
- No county-owned hospitals or clinics
  - Extensive network of private, nonprofit community health clinics (CHCs)

San Diego Updates

- New inpatient capacity has come online
  - No longer under-bedded
- Competition accelerating in affluent geographic submarkets
  - Emphasis on lucrative service lines
  - Continuing concerns on specialty access for low-income
- Increased use of narrow-network HMO products and innovative contracting including PPO ACOs
  - Scripps' incremental moves to return to risk sharing

Bay Area Round 1

Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties

- Stable, highly educated, and diverse population
- Kaiser and Sutter systems dominate
  - Very competitive
- Tradition of small physician practices
  - But low payment rates lead to growing interest in medical groups/hospital foundations
- Strong county support for well-developed safety net

Bay Area Update

- Substantial organizational change in provider sector
  - Split between Brown & Toland and UCSF in 2010
  - Resulting “regionalization” trend of provider networks across the Bay Area
- Independent practice associations (IPAs) challenged by continued declines in HMO enrollment
  - New life from payment reform pilots
- Smaller private safety net hospitals continue to struggle financially
  - Concerns about closure and resulting impact on access
- Strong, collaborative safety net relatively well-prepared for reform

Cross-Cutting Market Themes

Continued Hospital Themes from Round 1 (1)

- Aggressive Kaiser growth
  - Continues to gain market share
  - Attractive practice model for new physicians
  - Substantial capital investment over past several years
    - Focus on ambulatory care
    - Fully implemented IT system
    - New hospital construction allows for more in-sourcing of care

Continued Hospital Themes from Round 1 (2)

- Physician alignment strategy key for hospitals
  - Continued focus on strengthening relationships for referrals and continuum of care under expectation of future payment methods
  - Continued growth in hospital medical foundations
  - More exclusivity in IPA relationships — both physicians and hospitals

Provider Themes: Then and Now (1)

2008	2011-2012
Economy	
-Increasing economic pressures for all providers -Drop in demand, more uninsured patients	-Recession impact less severe but continuing; impacting hospital payer mix and volumes; private coverage rates; strain on the safety net -Fee Program has stemmed hospital losses
Hospital Construction	
-Pressure to meet 2013 seismic deadline -Constrained by damaged financing capacity from the recession and shortage of specialized builders	-Original 2013 deadline relaxed -Still extensive construction efforts statewide -- Investment in new/key service lines and more affluent submarkets may drive overcapacity -- Also opportunities to right size; for example, conversion to ambulatory capacity

Provider Themes: Then and Now (2)

2008	2011-2012
Provider-Plan Leverage	
-Capacity constraints, provider consolidation and consumer preference for choice all contribute to growing provider leverage -Growing differences between "must-have" hospitals/systems and others	-Unsustainable cost increases and growing competition from Kaiser lead to hospital willingness to accept lower rate increases and collaborate with health plans and large employers on new contract approaches; growth in narrow-network products -Disparity in leverage continues between haves and have-nots
The Delegated Model	
-HMO penetration and delegated model remains strong in California markets	-Erosion of non-Kaiser HMO enrollment; potential for payment reform increases reach of IPAs; initially focused on HMO products

New Contracting Arrangements

- Medicare ACO and bundled payment contracting
- Public employers initiating commercial contracting innovations
  - Three-way sharing of global risk on top of existing payment methods
  - Often coupled with narrow-network product
  - Data sharing a critical element

New Benefit Designs

- Products that exclude or provide disincentive to use high-cost providers in networks
  - San Diego: Scripps excluded from certain products by most major health plans
    - Shift in market share toward Sharp
- Product that limits network to one full-service provider in exchange for lower rates
  - HealthNet/Sutter in Sacramento
- Reference pricing
  - Anthem CalPERS design for hip/knee joint replacement

Continued Safety Net Themes from Round 1

- Demand for services continues to grow
  - Greater number of uninsured and Medi-Cal
  - Safety net capacity has not kept pace with utilization trends, particularly in terms of workforce
- Challenge in availability of specialty, dental, and mental health services
- Role of the county government varies in terms of providing services and programs for low-income people
  - Larger county role: San Francisco, Riverside/SB, Los Angeles
  - Smaller county role: San Diego, Fresno, Sacramento

New Safety Net Themes (1)

- Infusion of federal money to expand access, stabilize providers
  - Newly designated FQHCs and capacity expansion for existing FQHCs under ARRA and ACA
  - California Hospital Fee program
    - Enhanced Medicaid match to bolster hospital reimbursement
- Medi-Cal Bridge to Reform Waiver
  - Incentive payments to public hospitals to support infrastructure development
    - Future payment tied to outcomes
  - LIHP

New Safety Net Themes (2)

- Care delivery reform
  - Increased emphasis on the medical-home model
    - Aimed at shifting locus of care to ambulatory setting
  - Increased integration of behavioral/mental health services with primary care
- Providers exploring collaboration opportunities
  - ACO-like shared savings
  - Shared resource arrangements like health information exchange
    - Expectation of improved collaboration in anticipation of health care reform

Low Income Health Plan (1)

- Intended to expand access, transition future Medi-Cal eligibles to program
- Most counties set eligibility at 133% FPL (federal Medicaid eligibility in 2014)
  - Counties can set more stringent income limits
    - Sacramento: Expects 67% FPL
- Counties also can set enrollment caps based on available funding and capacity
  - Riverside and San Bernardino each limiting enrollment to approx. 20,000; minority of those eligible

Low Income Health Plan (2)

- Smaller counties able to enroll in statewide Path2Health program
  - Adults up to 100% FPL
  - County and Medi-Cal funding
- Notable variation in program reach
  - Some counties have yet to implement
  - Eligibility varies considerably
  - Concern in some markets whether payment levels sufficient to induce provider participation

Concluding Thoughts (1)

- State health care system distinctive
  - Large Kaiser Permanente presence
    - Impact on rest of delivery system
  - Independent practice associations
  - Continued resilience of HMO products
  - County leadership of safety net in some areas
  - State regulations:
    - Seismic standards for hospitals
    - Corporate practice of medicine prohibitions
    - Nurse-staff ratios

Concluding Thoughts (2)

- Important variations by community
  - Physician practice settings — large versus small practice and degree of alignment with hospitals
    - But uniform concern about physician shortages
  - Support for HMO model: Kaiser and delegated model
  - County role and support of safety net
- Active payment innovation
  - Builds on distinct health system features
  - Collaborations focused on lowering premiums to compete with Kaiser
  - Challenges to overcoming barriers to integration among physicians and between physicians and hospitals