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Sacramento Area: Large Health Systems Grow in a Pricey and Tumultuous Market

Summary of Findings

The Sacramento area — a region spanning El Dorado, Placer, Sacramento, and Yolo Counties — stands out among other inland California localities in boasting relatively high household incomes and a stable economy. Yet the region has also experienced troubling developments in recent years, including higher health costs and more people experiencing homelessness. Four large health systems — Dignity Health, Kaiser Permanente, Sutter Health, and UC Davis Health — continue to dominate the Sacramento area hospital market, a trend that likely contributes to the region's high private health insurance premiums. The region's hospitals post the highest average operating margins of the seven regional markets studied and negotiate among the highest commercial payment rates in the state. All four systems continue to expand their footprints, building new office and hospital space while affiliating with a growing number of medical groups.

The region has experienced a number of additional changes since the previous study in 2015–16 (see page 28 for more information about the Regional Markets Study). Key developments include the following:

- **The market for Medi-Cal managed care plans in Sacramento County became more crowded and chaotic, and more change is likely coming.** In 2017, the state Department of Health Care Services (DHCS) added two health plans to the Sacramento County market, which had four existing plans. One new entrant, UnitedHealthcare Community Plan, ended its contract prematurely and exited the market in 2018, causing nearly 8,000 Medi-Cal enrollees to move to other plans and networks. The state plans to recontract with health plans serving the county starting in 2021, so the field of participating plans in Sacramento may change yet again.

- **The market experienced increased consolidation between hospitals and medical groups, with hospitals' operating margins increasing substantially.** By 2019, 70% of primary care physicians and 80% of specialists belonged to practices controlled by a hospital or health system. Increases in the health systems' commercial payment rates and operating margins have coincided with this consolidation.

- **Health systems and Federally Qualified Health Centers (FQHCs) expanded capacity.** Hospitals and FQHCs alike added new facilities and expanded existing ones. Many are replacing aging infrastructure: Kaiser, Sutter Health, and Dignity Health all plan to replace hospitals to comply with the state's 2030 seismic requirements. FQHCs also expanded their scope of services, particularly for behavioral health care.

- **Providers engage in a range of value-based payment models.** Large hospital and health systems in the region are increasing capabilities to manage risk-based payments. These systems often share risk with their medical groups and affiliated independent practice associations (IPAs).
- **FQHCs are caring for more Medi-Cal patients as other providers decline to contract with Medi-Cal managed care plans.** FQHCs increasingly serve as primary care homes for Medi-Cal enrollees as small medical clinics close and large medical groups shift patients to FQHCs.
- **A complex behavioral health services system for Medi-Cal enrollees is making strides to meet service needs amid insufficient inpatient capacity and workforce shortages.** To bring care to populations in need, counties' mental health providers collaborate with criminal justice agencies and organizations providing services to people who are unsheltered. The implementation of the Drug Medi-Cal Organized Delivery System pilots across the region has expanded substance use disorder (SUD) services.
- **Health information exchange is siloed and limited.** Health systems typically exchange data internally through electronic health record (EHR) systems, with limited data sharing with FQHCs and health plans. Health systems and clinics are not prioritizing broader data exchange given other demands on time, resources, and leadership.

Market Background

The Sacramento area, which encompasses El Dorado, Placer, Sacramento, and Yolo Counties, is home to more than 2.3 million people and spans 5,200 square miles, including a robust urban core, farmland, and national parks and forest land. Sacramento County, anchored by the state capital, accounts for two-thirds of the region's population, including more than 500,000 residents in the city of Sacramento. Placer and El Dorado Counties lie to the east of Sacramento and include more affluent suburbs near their western borders. Roseville, with a population of 141,500, is the largest city in Placer County and lies roughly 20 miles northeast of the city of Sacramento. In El Dorado, the unincorporated El Dorado Hills area, with a population of 42,108, also sits on the Sacramento County border and is the largest community. At these counties' eastern edges are Lake Tahoe and the state of Nevada. Finally, Yolo County is more rural and has a higher proportion of residents with low incomes. It sits in the Sacramento Valley to the capital's west, on the other side of the Sacramento River. Yolo's largest city, Davis, with a population of 69,413, is the home of the University of California, Davis (UC Davis Medical Center, however, is in Sacramento).

Of the seven study regions, Sacramento experienced the fastest population growth between 2014 and 2018, with its population increasing by 5.8% while the state population as a whole increased by only 3.2%. Several factors may explain this trend, including the region's relatively robust economy. As of 2018, the Sacramento area's 3.9% unemployment rate was a half percentage point below the statewide average, while its median household income, levels of educational attainment, and poverty rate were all in line with statewide levels (see Table 1 on page 3). Roughly 12% of the region's workers are employed in state government, which may help explain Sacramento's relatively mild economic downturn during the COVID-19 pandemic.[1] The region's economy is also diversified among several other sectors, including finance, health care, and education.

The region's relatively affordable housing stock and proximity to job centers in the Bay Area have also contributed to economic success. The Sacramento region became a frequent destination for "Bay Area refugees" fleeing the high housing costs in San Francisco and Silicon Valley. An abundance of land in the region has kept home prices low enough that 44% of households can afford to purchase a median-priced home. (In the Bay Area and Los Angeles, just 24% and 27% of households, respectively, can afford this purchase.) The

TABLE 1. Demographic Characteristics
Sacramento Area vs. California, 2018

	Sacramento Area	California
POPULATION STATISTICS		
Total population	2,345,210	39,557,045
Five-year population growth	5.8%	3.2%
AGE OF POPULATION, IN YEARS		
Under 18	22.8%	22.7%
18 to 64	61.7%	62.9%
65 and older	15.5%	14.3%
RACE/ETHNICITY		
Latinx	21.8%	39.3%
White, non-Latinx	51.8%	36.8%
Black, non-Latinx	7.0%	5.6%
Asian, non-Latinx	13.7%	14.7%
Other, non-Latinx	5.7%	3.6%
BIRTHPLACE		
Foreign-born	15.8%	25.5%
EDUCATION		
High school diploma or higher	85.3%	83.7%
College degree or higher	41.5%	42.2%
ECONOMIC INDICATORS		
Below 100% federal poverty level (FPL)	13.3%	12.8%
100% to 199% FPL	15.7%	17.1%
Household income $100,000+	35.6%	38.0%
Median household income	$74,060	$75,277
Unemployment rate	3.7%	4.2%
Able to afford median-priced home (2019)	44.2%	31.0%
HEALTH STATUS		
Fair/poor health	16.8%	18.5%
Diagnosed with diabetes	8.2%	10.1%
Has asthma	19.3%	15.7%
Has heart disease	6.3%	6.8%

Sources: "County Population by Characteristics: 2010–2019," Education by County, FPL by County, Income by County, US Census Bureau; "AskCHIS," UCLA Center for Health Policy Research; "Employment by Industry Data: Historical Annual Average Data" (as of August 2020), Employment Development Dept., n.d.; and "Housing Affordability Index - Traditional," California Association of Realtors. All sources accessed June 1, 2020.

COVID-19 pandemic, which has made remote work more possible for many white-collar workers, may accelerate this trend, as more buyers become willing and able to live farther from San Francisco and Silicon Valley.[2]

Despite the region's strong economy and growing population, significant intraregional disparities remain. While the city of Sacramento as a whole has undergone revitalization over the past decade, these benefits have not been uniformly shared, as the city experienced a substantial increase in the number of neighborhoods where at least 40% of four-person families earn an annual net income of less than $25,100.[3] Homelessness is much more pervasive in the region than in other major California noncoastal metropolitan areas. There were 3.7 homeless individuals per 1,000 residents in the region in 2019; in the San Joaquin Valley and the Inland Empire regions, these counts were only 2.2 and 1.2, respectively.[4] Elsewhere in the Sacramento region, Yolo County is one of only two counties within the regional markets studied where the poverty rate — at 21.6%, nearly 70% higher than the rate statewide — increased between 2014 and 2018.

Finally, in at least one important respect, the Sacramento region is very different from the rest of California: the region is the least diverse of the six study markets with a large urban center. Latinx individuals account for 22% of the region's population, a level 17 percentage points below their statewide share (though in more agricultural Yolo County, they account for 31% of all residents), while Whites account for more than half of all residents.

Sacramento residents' health status remains, with few exceptions, in line with statewide trends. Estimated rates of heart disease and diabetes are below statewide rates, though asthma, which affects 15.7% of Californians statewide, has a prevalence in the region of close to 20%.

Health Coverage Sources and Trends

Health coverage and trends in the Sacramento area mirror those statewide.[5] Between 2015 and 2019, the region's uninsured rate fell slightly, from 5.9% to 5.3% (see Table 2). A significant decline of more than one-half in the uninsured rate occurred between 2013 and 2014, when the implementation of the federal Affordable Care Act significantly expanded Medi-Cal enrollment. Between 2015 and 2019, Medi-Cal enrollment declined slightly both statewide and in Sacramento. Relative to other regions, Medi-Cal covers a smaller share of people, while private insurance covers more than 50% of residents — a figure 4 percentage points higher than the statewide average.

The region's counties employ several Medi-Cal managed care models. Sacramento is one of two counties in the state — San Diego is the other — operating a Geographic Managed Care (GMC) Model, under which multiple commercial health plans offer coverage (see Table 3). Five plans participate in the Sacramento GMC Model, with Anthem Blue Cross at 41% market share, Health Net at 25%, and Kaiser at 21%. Molina and Aetna have smaller shares.

Yolo County uses a County Organized Health System model, under which one plan, Partnership HealthPlan of California, covers all Medi-Cal managed care enrollees. El Dorado and Placer Counties both participate in the Regional Model, which allows two commercial plans — California Health & Wellness, a Centene subsidiary, and Anthem Blue Cross — to compete for market share. In El Dorado County, California Health & Wellness insures 59% of Medi-Cal managed care enrollees, with Anthem Blue Cross accounting for an additional 34%. In Placer County, Anthem has 61% of the market, while California Health & Wellness accounts for 20%. In both counties, Kaiser covers the remaining Medi-Cal enrollees, most of whom were holdovers from the former Healthy Families program and their family members. New Medi-Cal members in El Dorado and Placer Counties cannot choose Kaiser as their plan except in limited circumstances.

Medicare Advantage (MA) enrollment continues to increase and remains more popular in the region than statewide, with 47.5% of beneficiaries opting for MA, compared with 43.8% statewide. Kaiser is the dominant MA plan, accounting for between 64% and 70% of MA enrollees in El Dorado, Placer, and Sacramento Counties and for 44% in Yolo County. UnitedHealthcare is typically the next largest plan, with 17% of the MA market in El Dorado and Placer Counties and 10% in Sacramento County.

Along with Kaiser, the major plans offering commercial products in the region include Health Net, Anthem Blue Cross, Blue Shield of California, Aetna, and UnitedHealthcare. In addition, regional health plans, Western Health Advantage (WHA) and Sutter Health Plus, offer coverage in the Sacramento area. Sutter Health Plus, part of Sutter Health, is an HMO with a network that includes Sutter Health hospitals, other facilities, and affiliated medical groups. WHA's

TABLE 2. Trends in Health Insurance, by Coverage Source
Sacramento Area vs. California, 2015 and 2019

	SACRAMENTO AREA		CALIFORNIA	
	2015	2019	2015	2019
Medicare*	16.3%	17.8%	14.4%	15.9%
Medi-Cal	26.9%	25.5%	29.1%	28.7%
Private insurance†	50.8%	51.4%	47.8%	47.7%
Uninsured	5.9%	5.3%	8.6%	7.7%

*Includes those dually eligible for Medicare and Medi-Cal.

† Includes any other insurance coverage (excluding Medicare and Medi-Cal).

Source: Calculations made by Blue Sky Consulting Group using data from the US Census Bureau, the Centers for Medicare & Medicaid Services, and the California Department of Health Care Services.

TABLE 3. Medi-Cal Enrollment, by Plan
Sacramento Area, October 2020

	Members	Percentage of Total Enrollment
Anthem Blue Cross	186,525	41.0%
Health Net	111,428	24.5%
Kaiser	94,558	20.8%
Molina	50,617	11.1%
Aetna	11,918	2.6%
Total Sacramento Medi-Cal enrollment	**455,046**	

Source: "Medi-Cal Managed Care Enrollment Report," California Health & Human Services Agency Open Data Portal, accessed November 18, 2020.

coverage area extends beyond the Sacramento region to Solano, Sonoma, Colusa, Marin, and Napa Counties. In 2019, WHA had about 128,000 commercial enrollees across the Sacramento and Bay Area regions. Sutter Health Plus also offers commercial products in the Sacramento region and extends into some Bay Area and Central Valley counties. Sutter Health Plus, established in 2013 as a licensed Knox-Keene health plan, has grown considerably from 8,000 lives statewide in 2014 to 94,000 in 2019.[6]

Across the Sacramento region in 2019, 70,700 people were enrolled in Covered California plans, an increase of 14.5% from 61,740 in 2015. Covered California silver plans in the Sacramento area in 2019 were roughly 17% more expensive than the average silver plan statewide (for a 40-year-old individual). Adjusting for local wages, of the seven study markets, only the Humboldt/Del Norte region has higher average premiums (see Table 4). As noted in subsequent sections, health systems in the Sacramento region obtain higher commercial payment rates for inpatient and outpatient services compared with statewide averages, and those higher payment rates likely contribute to higher commercial premiums in the Sacramento area.

TABLE 4. Covered California Premiums and Enrollment
Sacramento Area (Region 3) vs. California, 2015 and 2019

	SACRAMENTO AREA		CALIFORNIA	
	2015	2019	2015	2019
Monthly premium* (Silver Plan on the exchange for a 40-year-old individual)	$387	$532	$312	$454
Population enrolled				
▶ Percentage	2.7%	3.0%	3.0%	3.1%
▶ Number	61,740	70,700	1,190,590	1,233,360

*Rating Region 3 covers the same four counties included in the Sacramento region for this study. The price for Rating Region 3 is weighted by the number of enrollees in each of the four counties.

Sources: Blue Sky Consulting Group analysis of data files from "Active Member Profiles: March 2019 Profile" (as of May 31, 2020) and "2019 Covered California Data: 2019 Individual Product Prices for All Health Insurance Companies," Covered California.

Medi-Cal GMC Model Continues to Struggle in Sacramento

Established in 1992, the Sacramento GMC Model sparked concerns about access and quality challenges during the previous market study. In 2016, DHCS issued a proposal to add two more plans, for a total of six, with the intention of increasing enrollee options and improving access and quality through competition. Aetna and UnitedHealthcare Community Plan won contracts and began enrolling Medi-Cal members in early 2017. By November 2018, however, UnitedHealthcare Community Plan ended its contract for nearly 8,000 enrollees with DHCS and exited the Medi-Cal market in Sacramento, leaving five plans. Respondents attributed UnitedHealthcare Community Plan's departure to high costs resulting from low enrollment and adverse selection, or sicker enrollees than average. One respondent observed that adding plans and then losing a plan was disruptive for Medi-Cal patients and providers, creating new challenges for an already struggling program.

A recent study funded by the California Health Care Foundation found that the GMC Model has not resulted in the increased quality and lower costs that were expected from having multiple plans compete on cost and quality to gain market share.[7] Respondents in that study characterized the GMC Model as a confusing maze of plans, providers, benefits, and services, with significant transaction costs for both enrollees and providers. The study also found that the GMC Model, when compared with urban counties' County Organized Health System or Two-Plan Model, did not provide better access to care, and the quality of care was generally poorer.

Among the FQHC respondents interviewed for this market study, all lamented having to contract for and implement individual capitated payment and incentive programs for four different GMC Model plans (Kaiser, an integrated delivery system whose health plan has a closed provider network, does not contract with FQHCs). Noting the challenges of dealing with multiple plans, one FQHC leader remarked, "it feels like we're having the same conversation

multiple times per month." Each plan has different incentive priorities, innovation ideas, data-reporting requirements, and payment approaches. Another clinic leader referred to this muddle as the "Wild West" and noted that the financial incentives underpinning value-based payment models have become too diluted to make a meaningful difference in care delivery.

Contracting Turmoil Pushes Medi-Cal Enrollees to FQHCs for Primary Care

From the enrollee perspective, challenges related to the structure of the GMC Model have been compounded by changes to health plan networks and participating providers. Numerous respondents, including advocates, health services researchers, and providers, pointed out that health systems and medical groups — Sutter Health, Dignity Health, and UC Davis Health — have reduced or eliminated capitated primary care contracts for Medi-Cal enrollees in recent years. As a result, many Medi-Cal enrollees were shifted to FQHCs for outpatient care, giving Medi-Cal enrollees what one advocate characterized as "whiplash" as they were forced to move between health plans, medical groups, and FQHCs.

Changes to Sacramento GMC on the Horizon?

According to study respondents, the Sacramento GMC Model likely will see changes as the state plans to put contracts out to bid for commercial health plans participating in all managed care models. A request for proposals is expected in 2021, with new contracts anticipated to start in January 2024.[8] While it is unclear how the mix of plans may change through competitive selection, numerous respondents speculated that DHCS may reduce the number of plans participating in the GMC Model because of the challenges for patients and providers in working with so many plans. One respondent voiced frustration with the model but conceded that providers have adapted to myriad challenges and acknowledged that abandoning the GMC Model altogether might be "throwing the baby out with the bathwater."

Other forces may bring more substantive change. Legislation proposed in the 2019–20 legislative session, Senate Bill 1029, would have authorized Sacramento County to establish a Two-Plan Model, with a newly established health authority given the power to operate a local initiative plan or contract with a commercial health plan to operate a local initiative plan.[9] The bill also would have empowered the health authority to determine the number of commercial health plans, with a minimum of two, contracted by DHCS to participate in the GMC Model starting in 2024 until the county can establish a Two-Plan Model and local initiative plan. The proposed legislation was not passed, and several respondents said that providers remain skeptical that the county can successfully operate or contract for the local initiative plan. While proposed state legislation was not enacted, the Sacramento County Board of Supervisors passed an ordinance in mid-December 2020 creating the Sacramento County Health Authority Commission and giving it the same duties as detailed in Senate Bill 1029.[10]

Financially Healthy Systems Replace Hospitals and Expand

Along with the three large hospital systems — Dignity Health, Sutter Health, and Kaiser — the Sacramento area is home to a large academic medical center, UC Davis Medical Center, and two small independent hospitals in the Sierra foothills. The region does not have any county-operated public hospitals. Against a backdrop of robust population growth, the region has seen a slight decline in the ratio of acute care beds to residents, which fell to 157 beds per 100,000 residents in 2018 (see Table 5 on page 7). Compared with the other six areas in the regional market study, only the San Joaquin Valley region has a lower bed-to-population ratio across acute care hospitals. Overall, hospitals in the Sacramento region are financially strong, with an average operating margin more than twice the statewide rate.

TABLE 5. Hospital Performance (Acute Care)
Sacramento Area vs. California, 2018

	Sacramento Area	California
Beds per 100,000 population	157	178
Operating margin*	10.5%	4.4%
Paid FTEs per 1,000 adjusted patient days*	17.5	14.8
Total operating expenses per adjusted patient day*	$4,425	$4,488

*Excludes Kaiser.

Note: *FTE* is full-time equivalent.

Sources: "Hospital Annual Financial Data - Selected Data & Pivot Tables," California Office of Statewide Health Planning and Development; "County Population by Characteristics: 2010–2019," US Census Bureau. All sources accessed June 1, 2020.

Major hospitals and systems in the region include the following:

Sutter Health. Based in Sacramento, the nonprofit Sutter Health system operates 24 hospitals across Northern California, including four hospitals in the Sacramento area. The largest is Sutter Medical Center, Sacramento, with 523 staffed beds; this hospital accounts for about one-fifth of the county's inpatient discharges. In Placer County, Sutter Health's two hospitals — Sutter Roseville Medical Center and the smaller Sutter Auburn Faith Hospital — have a combined 392 staffed beds and account for just over half of the county's discharges. In Yolo County, 48-bed Sutter Davis Hospital accounts for nearly half of the county's discharges. Sutter Health plans to make $5.63 billion in capital investments systemwide through 2024, covering seismic retrofits and expansions.[11] In 2020, Roseville Medical Center added 24 intensive care unit beds and 34 beds in its emergency department (ED).[12]

Kaiser Permanente. Kaiser's model — a health plan taking full financial risk for all patients, coupled with an integrated delivery system of Kaiser-owned hospitals and affiliated physicians — relies on population health strategies that stress prevention and care coordination to avoid costly hospital stays. Kaiser serves mostly commercially insured and Medicare patients and operates three hospitals in the Sacramento area. Kaiser's Roseville facility in Placer County is the largest of the three hospitals, with nearly half of the county's discharges and 340 staffed beds. In Sacramento County, Kaiser's two hospitals together provide roughly one-fifth of all county discharges. All Kaiser's hospitals are staffed by physicians employed by the affiliated Permanente Medical Group, which has more than 9,000 primary care and specialty physicians across Northern California, including about 1,900 in Sacramento and Placer Counties. At Kaiser's South Sacramento Medical Center, plans have been filed to more than double the hospital's ED capacity, from 41 to 88 beds.[13] Kaiser is also doubling ambulatory care capacity in Roseville with the opening of a new medical office building.[14] In downtown Sacramento, as part of the Railyards redevelopment project, Kaiser plans to build a medical campus that includes a 420-bed hospital and medical office building.[15] This new hospital will replace the aging Sacramento Medical Center on Morse Avenue.

Dignity Health. Part of a large multistate system, Dignity Health operates 29 hospitals (28 acute care and one psychiatric facility) in California, including five in the Sacramento area. In Sacramento County, Dignity Health's four facilities — Mercy General Hospital, Mercy Hospital of Folsom, Mercy San Juan Medical Center, and Methodist Hospital of Sacramento — collectively have 1,224 beds and account for roughly 38% of discharges in the county. In Yolo County, Dignity Health's Woodland Memorial Hospital, with 108 beds, accounts for 57% of all county discharges. In early 2019, Dignity Health merged with Catholic Health Initiatives (CHI) to form CommonSpirit Health, creating a network of more than 137 hospitals across 21 states. CHI was based in Denver, and Dignity Health was based in San Francisco. The two companies jointly formed a new company, CommonSpirit Health, which is based in Chicago. Dignity Health is building a new hospital in Elk Grove and will close Methodist Hospital once the new hospital is complete.[16] The new 200,000-square-foot facility will have 100 staffed beds, fewer than the 169 currently at Methodist. At Dignity Health's Mercy San Juan Hospital, plans are underway to significantly expand the neonatal intensive care unit.[17]

UC Davis Medical Center (UCDMC). The only academic medical center in the region, UCDMC is the largest hospital in Sacramento County by beds and discharges, with 605 beds and nearly a quarter of discharges in the county. Along with the region's only Level I trauma center and burn center, the medical center's Sacramento campus is home to the 129-bed UC Davis Children's Hospital. UCDMC is staffed by physicians in the UC Davis Medical Group, which employs more than 1,100 physicians who split their time among clinical service, teaching, research, and often clinical work outside of UC Davis Health. The group collaborates with and supports staffing at Shriners Hospitals for Children–Northern California, which is located near UCDMC. Additionally, UC Davis Medical Group physicians, mostly primary care, staff the Sacramento County FQHC, which also serves as a physician residency teaching site.

Independent hospitals. Other hospitals play a relatively small role in the Sacramento region. Two nonprofit hospitals, 125-bed Marshall Medical Center and 111-bed Barton Memorial Hospital, operate in El Dorado County, with Marshall accounting for nearly 70% of discharges in the county and Barton the remainder. A new independent academic medical center is slated to come to the region in the next few years. In 2018, California Northstate University, a private for-profit institution, announced plans to construct a new 400-bed teaching hospital in Elk Grove, a suburb of the city of Sacramento. The university's filing is currently under city review.[18]

Only Two Independent Hospitals Remain in the Region

The Sacramento hospital market is relatively consolidated into three large health systems — Kaiser, Sutter Health, and Dignity Health. Respondents voiced different opinions about the local impact of Dignity Health's interstate merger. One hospital leader observed that Dignity Health will reap financial and administrative economies of scale from CommonSpirit Health's vast 21-state system and draw clinical expertise and resources for community-focused initiatives such as addressing homelessness. In contrast, another respondent remarked that Dignity Health's mission and focus in California will be diluted by other organizational priorities and leadership from afar. It remains to be seen how CommonSpirit Health's $550 million operating revenue loss in fiscal year 2020 will impact Dignity Health's Sacramento region operations.[19]

Several respondents observed that Marshall Medical Center and Barton Memorial Hospital in El Dorado County remain "fiercely independent." Barton Memorial is more financially sound than Marshall, which in 2018 had a negative operating margin. Barton Memorial benefits from a more robust tourism-driven economy in the South Lake Tahoe area. However, with increasing regulatory requirements, staffing challenges, care delivery in rural areas, and financial strain from the COVID-19 pandemic, these independent hospitals may find it more and more challenging to go it alone.

Dignity Health Serves Large Number of Medi-Cal Enrollees

With no county-operated public hospitals in the region, all hospitals provide inpatient care to Medi-Cal enrollees and the uninsured. Dignity Health serves the largest number of Medi-Cal patients, covering 39% of the region's Medi-Cal discharges (see Table 6 on page 9), with Sutter Health accounting for 24% of Medi-Cal discharges. UC Davis Medical Center accounts for 22% of Medi-Cal discharges across the region. Kaiser plays a relatively small role, with only 11.3% of the region's Medi-Cal discharges. El Dorado's independent hospitals — Barton Memorial and Marshall Medical Center — provide care to Medi-Cal patients roughly in proportion to their share of all-payer discharges.

TABLE 6. Hospital Medi-Cal Discharges, Sacramento Area, 2018

	Medi-Cal as a Share of System's or Facility's Discharges	Share of Region's Medi-Cal Discharges
Dignity Health	**36.7%**	**39.1%**
Mercy General Hospital	30.3%	8.2%
Mercy Hospital of Folsom	17.0%	2.1%
Mercy San Juan Hospital	41.7%	16.0%
Methodist Hospital of Sacramento	49.3%	9.5%
Woodland Memorial Hospital	34.6%	3.2%
Sutter Health	**24.0%**	**23.6%**
Sutter Auburn Faith Hospital	14.0%	0.8%
Sutter Davis Hospital	27.3%	1.9%
Sutter Medical Center, Sacramento	30.2%	14.5%
Sutter Roseville Medical Center	16.9%	6.4%
Kaiser Foundation Hospitals	**12.4%**	**11.3%**
Roseville	10.1%	4.3%
Sacramento	12.7%	2.8%
South Sacramento	15.6%	4.3%
UC Davis Medical Center	**36.4%**	**22.2%**
Independents	**25.7%**	**3.8%**
Barton Memorial Hospital	23.1%	1.0%
Marshall Medical Center	26.9%	2.8%

Source: "Hospital Annual Financial Data — Selected Data & Pivot Tables," California Office of Statewide Health Planning and Development, accessed June 1, 2020.

TABLE 7. Acute Care Hospitals, Sacramento Area, 2018

	Staffed Beds	Share of Region's Discharges
Dignity Health	**1,332**	**28.6%**
Mercy General Hospital	419	7.3%
Mercy Hospital of Folsom	106	3.3%
Mercy San Juan Hospital	370	10.3%
Methodist Hospital of Sacramento	329	5.2%
Woodland Memorial Hospital	108	2.5%
Sutter Health	**963**	**26.4%**
Sutter Auburn Faith Hospital	64	1.6%
Sutter Davis Hospital	48	1.9%
Sutter Medical Center, Sacramento	523	12.9%
Sutter Roseville Medical Center	328	10.1%
Kaiser Foundation Hospitals	**844**	**24.7%**
Roseville	340	11.4%
Sacramento	287	5.9%
South Sacramento	217	7.4%
UC Davis Medical Center	**605**	**16.4%**
Independents	**286**	**4.0%**
Barton Memorial Hospital	111	1.2%
Marshall Medical Center	125	2.8%

Source: "Hospital Annual Financial Data — Selected Data & Pivot Tables," California Office of Statewide Health Planning and Development, accessed June 1, 2020.

Hospital Market Concentration

Across the Sacramento region, hospital markets remain relatively fragmented according to a commonly used measure called the Herfindahl-Hirschman Index.[20], [21] Across the region (see Table 7), Dignity Health captures the largest share of the market, though accounting for only 28.6% of all discharges; Kaiser and Sutter Health are each responsible for about one-quarter of the region's discharges, and UCDMC provides 16.4%. Kaiser's market share across the region has grown by more than 4 percentage points since 2014, from 20.4% to 24.7% of all discharges, while market shares for Sutter Health and Dignity Health have declined by 1 percentage point and 2.8 percentage points, respectively. Over the same time, market shares for UCDMC and El Dorado's two independent hospitals remained unchanged.

However, within individual counties in the region, hospital market concentration is high (data not shown). The four Dignity Health facilities account for nearly 38% of Sacramento County discharges, followed by UCDMC (23.6%), Kaiser (19.2%), and Sutter Health (18.6%). Hospital market concentration is higher in less densely populated El Dorado, Placer, and Yolo Counties. In El Dorado County, Marshall Medical Center is responsible for nearly 70% of all discharges and Barton Memorial for the remaining 30%. In neighboring Placer County, Kaiser splits the market equally with two Sutter Health hospitals. Within Yolo County, Dignity Health accounts for roughly 57% of all county discharges and Sutter Health for the remainder.

Hospitals Continue to Align with Medical Groups

Over the past decade, Sutter Health and Dignity Health have continued to align with physicians, both by employing physicians through medical foundations and through affiliations with independent physicians. This trend intensified between 2016 and 2018, with the number of physicians affiliated with Dignity Health increasing nearly fourfold and the number of Sutter Health–affiliated physicians nearly doubling.[22] By 2019, 70% of primary care physicians in the region belonged to practices controlled by a hospital or health system — a figure that is 27 percentage points higher than the statewide average (see Table 8). The specialist market (which in the assessment included cardiology, hematology/oncology, orthopedics, and radiology) is similarly concentrated within hospitals and health systems.

TABLE 8. Physicians in Practice Owned by a Hospital or Health System
Sacramento Area vs. California, 2019

	Primary Care Physicians	Specialists
Sacramento Area	70%	80%
California	43%	53%

Note: Specialty care physicians include physicians practicing cardiology, hematology/oncology, orthopedics, and radiology.

Source: Blue Sky Consulting Group calculation of population-weighted regional and state averages from Richard M. Scheffler, Daniel R. Arnold, and Brent D. Fulton, *The Sky's the Limit: Health Care Prices and Market Consolidation in California*, California Health Care Foundation, October 2019.

Dignity Health works with affiliated physicians through a variety of models. These include an exclusively contracted medical group (Dignity Health Medical Foundation), affiliated medical groups such as Mercy Medical Group, clinically integrated networks, and IPAs.[23] Dignity Health has been purchasing affiliated independent physician practices and incorporating them into its medical group. These independent practices were already referring patients to Dignity Health facilities. Dignity Health Medical Foundation oversees some 950 physicians and another 800 affiliated providers throughout California.[24] Mercy Medical Group in the Sacramento region directly employs nearly 500 physicians across specialties.

Sutter Medical Foundation includes a network of Sutter Health–affiliated physicians extending beyond the immediate Sacramento area into Yuba, Sutter, Amador, and Solano Counties.[25] The network includes the Sutter Medical Group, which employs more than 800 physicians, and Sutter Independent Physicians (SIP), an IPA with nearly 600 physicians who remain independent and retain their group names. SIP serves Sacramento, Placer, Amador, Solano, and Yolo Counties, and the Sutter North Medical Group serves Yuba and Sutter Counties. With SIP, Sutter Health has expanded its outpatient network and referral pathways to inpatient care. The affiliated physicians and practices benefit from discounted management services, including billing, data management, and EHR support. Moreover, these affiliates also benefit from Sutter Health's considerable negotiating power with health plans. Like Dignity Health Medical Foundation, Sutter Medical Foundation has been expanding by purchasing small practices in the region.

Some Independent Physicians Remain

While the vast majority of physicians are affiliated with health systems, as discussed previously, several large IPAs remain in the region, including the following:

River City Medical Group is the second-largest IPA in the region and one of the largest IPAs in Northern California. The IPA's Sacramento regional network serves some 280,000 members and includes more than 1,900 physicians, 1,000 midlevel providers, and 600 locations.[26] Some River City physicians are also members of other IPAs, notably Hill Physicians Medical Group. River City serves mostly Medi-Cal managed care patients through delegated risk contracts with health plans in both GMC Model and Regional Model counties. Of the more than 330,000 Medi-Cal enrollees delegated by four plans to IPAs in Sacramento in early 2019, River City had 71%.[27] River City also is expanding into the MA market through Health Net.

Nivano Physicians is an IPA with more than 1,400 physicians, including 500 primary care clinicians. Nivano has

delegated risk contracts for Medi-Cal and commercially insured enrollees and some MA enrollees. A direct competitor to River City IPA for Medi-Cal enrollees, Nivano had responsibility for less than 10% of health plans' delegated Medi-Cal enrollees in early 2019. In recent years, Nivano faced financial compliance challenges that resulted in corrective action plans required by the state Department of Managed Health Care.[28] These financial issues resulted in the loss of contracts with UnitedHealthcare, Blue Shield, and Anthem Blue Cross and the transfer of nearly 50,000 enrollees to other medical groups.[29]

Hill Physicians Medical Group, an IPA serving 11 counties in the Sacramento, Bay Area, and San Joaquin Valley markets, is the largest IPA in Northern California.[30] In the Sacramento region, Hill has 700 physicians, including 250 primary care physicians. The group's broader Northern California network includes some 4,000 independent physicians and serves more than 350,000 patients enrolled in Medi-Cal, MA, and commercial health plans. Hill has a close alliance with Dignity Health and, by extension, Dignity Health Medical Foundation and the Mercy Medical Group. Mercy provides hospitalists and specialists for Hill's patients.

Health Systems, Physician Groups, and Risk-Based Payment Arrangements

Large hospital and health systems in the region are increasing capabilities for risk-based payment as payers move in this direction. Kaiser, with its integrated health plan and hospital system managing global risk for all enrollees, is seen by study respondents as the model to emulate and the target of competition.

At Dignity Health, more than half of commercial patients are in some form of value-based contract. Dignity Health works with its medical group partners to share risk and manage the total cost of care. Dignity Health is clinically integrated with the Mercy Medical Group, and in the HMO contract with Western Health Advantage, capitated payments are split between the hospital and medical group. Specifically, physicians are incentivized to manage inpatient admissions carefully; to do so, physicians receive data on inpatient length of stay, infection rates, and other quality-of-care metrics. This approach has incentivized a movement of care to outpatient settings. Dignity Health has a similar contractual arrangement with Hill Physicians. A respondent involved in these models observed that care coordination between the hospitals and physicians is still developing and has yet to reach maturity.

Dignity Health recently created an internal group, Value Based Operations, tasked with managing care for enrollees associated with risk-based contract arrangements, including MA and Medi-Cal managed care. Four interdisciplinary committees — operations, financing, clinical, and strategy — will work with the team to monitor service metrics and support operational decisions.

Sutter Health is growing its value-based payment contracting and enrollments with commercial plans and is increasing MA enrollment. Within Sutter Health Plus, capitation for professional services is delegated to the Sutter Valley Medical Foundation and can cascade further out to IPAs and physicians participating with SIP. Sutter Health also has a joint venture with Aetna offering a commercial PPO product to self-insured employers. While not a risk-bearing product, it includes targets for total cost of care and pay-for-performance incentives for providers.

Hill Physicians has been moving toward accepting full-risk capitation and recently received a limited Knox-Keene license in June 2020 from the state Department of Managed Health Care, a designation that allows Hill to take full risk and contract with hospitals and other providers. Hill Physicians now has a global risk contract with Health Net for a small number of MA enrollees. The contract creates a provider-specific plan, an HMO model with a restricted provider network; Dignity Health is Hill's hospital partner but does not share financial risk. As an IPA, Hill Physicians offers an integrated clinical network to health plans and self-insured employers through PriMed, its management services organization.

PriMed offers all member physicians care and quality management, discharge planning, pharmacy services, EHR and population health tools, and claims processing.

Currently, UC Davis Health engages in "total cost of care" contracting with several commercial health plans, accepting risk-based payments for physician professional services and fee-for-service (FFS) payments for hospital services. Under these arrangements, UC Davis Health and the plan negotiate an annual budget and reconcile the total cost of care at the end of the year. Savings are typically shared between UC Davis Health and the plan, but UC Davis Health must reimburse the plan for any losses. For HMO contracts, UC Davis Health accepts risk only for professional services, while PPO contracts are exclusively FFS. UC Davis Health also operates an accountable care organization (ACO) responsible for about 25,000 Medicare beneficiaries. Currently, the ACO assumes no financial risk for losses but is eligible to share savings with Medicare and plans to transition to sharing both losses and savings in 2022.[31]

The two small independent hospitals, Barton Memorial Hospital and Marshall Medical Center, participate in Medicare ACOs through the Medicare Shared Savings Program with no downside financial risk. As noted for UC Davis Health previously, the Medicare ACO risk-sharing arrangements will change in 2022 to include both upside and downside risk. Barton is a member of Caravan Health, a nationwide firm specializing in managing ACOs. Both independent hospitals report plans to grow their risk-based contracting and relationships.

Sutter Health's Competitive Tactics Lead to Legal Trouble

Sutter Health has been building market share and negotiating leverage in the region and Northern California for well over a decade.[32] One market observer noted that Sutter Health had profited handsomely from commercially insured patients from 2009 to 2018.[33] In December 2019, Sutter Health settled class-action antitrust charges with the state Office of the Attorney General and agreed to repay $575 million of overcharges due to anticompetitive behavior.[34] The lawsuit alleged that Sutter Health engaged in unlawful practices such as conditioning the participation of a must-have Sutter Health provider on the participation of other Sutter Health providers that might otherwise be excluded; antitiering provisions that prohibited plans from putting Sutter Health providers in any tier other than most favored; and confidentiality restrictions on price and quality data that restricted effective provider comparisons. As part of the settlement, Sutter Health will end these and other anticompetitive practices; a court-appointed monitor is charged with ensuring Sutter Health adheres to the terms of the settlement for at least 10 years.

High Inpatient and Outpatient Payment Rates

As research into provider consolidation has demonstrated, horizontal consolidation among hospitals, as well as vertical integration between hospitals and physician groups, has in recent years driven increases in health care payment rates across the country.[35] Both horizontal consolidation and vertical integration offer the hospital (or the hospital-physician pairing) greater negotiating leverage with commercial health plans.

Respondents' understanding of the region's market dynamics supports the broader findings of researchers. One respondent observed that the loss of independent physicians to system-affiliated groups resulted in reduced utilization of lower-cost independent diagnostic and ancillary services and increased use of hospital-based services. Numerous respondents noted that the large hospital systems in the region were "very expensive" and cited the vertical integration with physician groups as a major factor. Another respondent went as far as to describe the hospital systems in the region as oligopolies with significant leverage over payment rates.

A study by the Rand Corporation explored negotiated rates between hospitals, self-insured employer plans, employer-sponsored commercial plans, and individual

market plans in selected states.[36] The study identified negotiated payment rates as a percentage of what Medicare would have paid for the same services and found that employers and commercial plan payers often pay triple and sometimes four times as much as Medicare. Negotiated rates between Sacramento-area hospitals and commercial health plans are particularly high. Compared with the average rates of all 279 California hospitals included in the study, the Sacramento region's hospital payment rates are higher across the board (see Figure 1).

Health Systems Achieve Healthy Operating Margins

The region's hospitals in recent years have further strengthened their already solid balance sheets. Across the 12 acute care hospitals in the Sacramento area in 2018, the average operating margin (10.5%) exceeded the statewide average by more than 5 percentage points (see Table 9). Nearly all systems' operating margins improved between 2014 and 2018, with the largest increases occurring at Dignity Health (5.2% to 8.3%) and UC Davis Health (12.7% to 15.0%). UC Davis Medical Center's performance has been particularly strong; in 2018, the hospital posted a 15.0% operating margin. Only Marshall Medical Center's operating margin, at –0.9%, was below the regional and state averages in 2018.

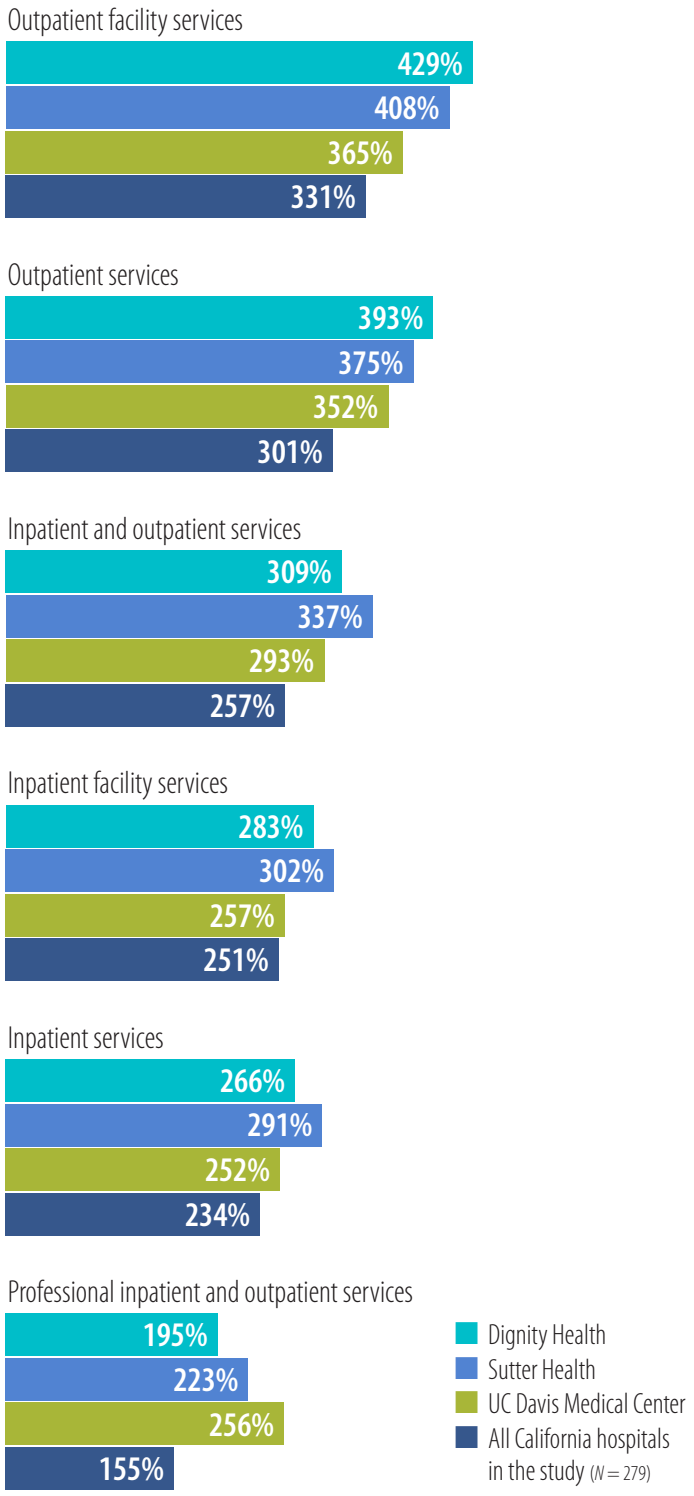
TABLE 9. Operating Margins at Hospitals and Health Systems
Sacramento Area vs. California, 2014 and 2018

	2014	2018
Sutter Health (all facilities)	11.9%	8.2%
Dignity Health (all facilities)	5.2%	8.3%
UC Davis Medical Center	12.7%	15.0%
Marshall Medical Center	–1.7%	–0.9%
Barton Memorial Hospital	20.4%	23.9%
All Sacramento hospitals*	**9.9%**	**10.5%**
Statewide average	**2.9%**	**4.4%**

*Excludes Kaiser.

Source: "Hospital Annual Financial Data — Selected Data & Pivot Tables," California Office of Statewide Health Planning and Development, accessed June 1, 2020.

FIGURE 1. Payment Relative to Medicare, by Commercial Plans
Selected Sacramento Region Hospitals, 2016–18



Notes: Payment rates are calculated based on allowed amounts, including amounts paid by the health plan and the patient. Kaiser is not included.

Source: "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans," RAND Corporation, accessed November 6, 2020.

FQHC Growth Continues

The region is home to numerous FQHCs, all with large footprints in the Sacramento metropolitan area and several extending into adjacent counties. FQHCs continued to expand across the region between 2014 and 2018. According to the Office of Statewide Health Planning and Development, between 2014 and 2018 seven new FQHC sites were added in the region. The main FQHCs in the region include the following:[37]

- **WellSpace Health**, the largest FQHC in the region, operates 22 service sites across Sacramento County and served more than 83,000 patients in 2018. WellSpace Health also has a site in Folsom, in El Dorado County.
- **Sacramento Community Clinics**, including nine sites in the city of Sacramento and one in North Highlands, served nearly 40,000 patients in 2018.
- **CommuniCare Health Centers**, with six sites in the cities of Sacramento, Davis, and Woodland, served nearly 20,000 patients in 2018.
- **Elica Health Centers**, operating 11 service sites in and around the city of Sacramento and in Yolo County, served more than 27,000 patients in 2018.
- **One Community Health**, with two locations in the city of Sacramento, served nearly 10,000 patients in 2018.
- **Sacramento Native American Health Center**, a clinic in Sacramento's midtown, served nearly 9,000 patients in 2018.
- **Sacramento County** has one location that is largely staffed by UC Davis physicians, including residents. The county clinic served nearly 9,000 patients in 2018.

While the number of FQHC encounters, or patient visits, per capita in the Sacramento area increased by more than 50% from 2014 to 2018, FQHCs' utilization remained lower than the statewide average in 2018 (see Table 10). The Sacramento region's relatively strong economy, in part, explains the lower FQHC utilization. Only a quarter of the region's population is covered by Medi-Cal, the largest source of FQHC patients. By contrast, in the San Joaquin Valley, 44% of the population is covered by Medi-Cal, and FQHCs there are responsible for 1.1 patient visits per capita.

TABLE 10. Federally Qualified Health Centers
Sacramento Area vs. California, 2014 to 2018

	SACRAMENTO AREA		CALIFORNIA	
	2018	Increase from 2014*	2018	Increase from 2014*
Patients per capita	0.1	56%	0.2	28%
Encounters per capita	0.3	55%	0.5	35%
Operating margin	0.4%	–92%	2.1%	–32%

*Reflects the percentage change in patients/encounters per capita, and the absolute change in margins.

Notes: Includes FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources & Services Administration Health Center Program but do not receive Health Center Program funding. Patients may be double counted if the same person visits more than one health center.

Sources: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development; "County Population by Characteristics: 2010–2019," US Census Bureau. All sources accessed June 1, 2020.

FQHCs' Growing Responsibility for Medi-Cal Enrollees

FQHCs have taken on a growing role in the region, particularly in Sacramento County, for providing care to Medi-Cal patients and uninsured people. As discussed previously, the major health systems have worked to limit capitated Medi-Cal enrollees. In addition, FQHCs have assumed care of Medi-Cal enrollees from financially struggling private practices. In some cases, the FQHCs have taken over these practices' physical clinic spaces as well.

The changes and disruptions within the Medi-Cal GMC Model in Sacramento pushed many Medi-Cal enrollees to FQHCs. In 2017, Anthem Blue Cross shifted 10,000 Medi-Cal enrollees from Sutter Health to Sacramento Native American Health Center and other FQHCs for primary care.[38] In late 2018, UCDMC was entangled in UnitedHealthcare Community Plan's terminated participation in GMC, and some 4,000 Medi-Cal enrollees lost UC Davis as their primary care provider, with many enrollees shifting to FQHCs.[39] UC Davis Health did, however, begin a new primary care contract with Health Net

for 5,000 capitated Medi-Cal enrollees in late 2018, serving most through the Sacramento County FQHC. In early 2019, Anthem Blue Cross ended its contracts with Sutter Health for Medi-Cal and MA over payment issues, forcing some 12,000 enrollees to find new primary care providers, with many landing with FQHCs as their medical homes.[40]

WellSpace took responsibility for about 30,000 Medi-Cal enrollees from private medical groups in early 2019 as three Golden Shore Medical Group clinics closed their doors. Later in 2019, WellSpace took more Medi-Cal patients from five Sacramento Family Medical Clinics that were also struggling financially.[41] An FQHC leader observed that private medical clinics serving Medi-Cal patients without the benefit of cost-based prospective payment system (PPS) rates can face financial challenges. Moreover, another respondent remarked that most providers do not have the benefit of such cost-based reimbursement for Medi-Cal enrollees, creating a disincentive to serve them.

A respondent remarked that health systems' and medical groups' movement away from Medi-Cal has caused a "different kind of consolidation," with FQHCs now shouldering responsibility for most outpatient care for Medi-Cal enrollees. This movement has accelerated FQHCs' capacity and service expansion, especially for behavioral health and SUD treatment services.

FQHCs Moving Toward Collaboration

Numerous respondents remarked that FQHCs, which have historically been more competitive, are slowly working toward more collaborative relationships. Some are participating in the Central Valley Health Network (CVHN), an FQHC membership organization that provides technical assistance and learning networks. The CVHN convenes regular calls for FQHC chief operating officers, chief medical officers, and human resource directors to share best practices and discuss common issues.

Two particular issues in the Sacramento metropolitan area have fostered increased collaboration. First, FQHCs are working together with the county and hospitals on initiatives targeting mental health and homelessness. As primary care homes offering integrated behavioral health and other services for patients with complex needs, FQHCs play an instrumental role in addressing the myriad needs of people experiencing homelessness. Second, the upcoming recontracting of managed care plans for the GMC Model has rallied FQHCs to coalesce around influencing how the model evolves. A respondent observed that FQHCs have relationships with each of the participating plans and their provider networks and therefore have a stake in how plans prepare for the recontracting. FQHCs also have a collective stake in the newly created Sacramento County Health Authority Commission, which will play a role in Sacramento County's Medi-Cal managed care future. The county ordinance requires that three of the 20 commissioners represent nonprofit community health centers serving Medi-Cal enrollees.

One respondent observed that in the future, FQHCs will face the challenge of successfully balancing two distinct and sometimes contrary organizational objectives: to remain community-based systems, in which patients feel "known," while also being sophisticated organizations that work across multiple sites with multiple lines of service. The same respondent proposed that FQHCs might consider mergers or shared administrative infrastructures to reap economies of scale and scope but, in the same breath, lamented the prospect of losing organizational identity and personality that allows for a personal touch with patients.

FQHCs Expand Their Behavioral Health Services

In addition to physical site expansion, FQHCs have also expanded their scope of services. Many formerly focused largely on primary care or narrow specialties such as HIV care but have added dental services, mental health and SUD services, and even optometry. In expanding behavioral health services, some FQHCs have contracted as providers with Medi-Cal managed care plans' provider networks for less severe mental health conditions (also referred to as

"mild-to-moderate" conditions). Some FQHCs are also contracting with counties as specialty mental health and SUD service providers.[42] Many of the larger FQHCs focus on providing integrated physical and behavioral health care and have invested in care management staff, quality improvement, and information technology infrastructure to improve care coordination. One FQHC leader said that 70% of the FQHC's more than 40,000 patients need some type of behavioral health service.

El Dorado Community Health Center (EDCHC) has 10.5 full-time equivalent (FTE) employees dedicated to medication-assisted treatment (MAT), which combines medication with counseling to treat SUDs; EDCHC has another seven FTEs for counseling services and offers psychiatry services 30 hours per week. It also has a relationship with Marshall Medical Center, which has a CA Bridge program, and collaborates with Barton Memorial for MAT. EDCHC provides these behavioral health services without managed care or county contracts and instead relies on PPS-funded encounters and grants. EDCHC coordinates with the county for patients needing specialty mental health services.

A few FQHCs in the region have contracts with county mental health plans to provide specialty mental health services (to adults with serious mental illness or children and youth with serious emotional disturbances) and SUD services. For example, WellSpace Health is one of the largest SUD and MAT contractors for Sacramento County. CommuniCare contracts with Yolo County to provide both specialty mental health and SUD services. In Placer County, Chapa-De Indian Health has a contract with the county to provide specialty mental health services.

While FQHCs have stepped in to provide behavioral health services, several statewide billing constraints can make such service delivery challenging. First, FQHCs cannot bill for a physical health and mental health visit on the same day. Second, only certain types of clinicians can bill the clinic's PPS rate (e.g., physicians, psychiatrists, licensed clinical social workers [LCSWs], and clinical psychologists); others (e.g., marriage and family therapists) cannot. Finally, FQHCs contracting with county mental health plans or drug and alcohol programs to provide SUD and specialty mental health services must maintain a separate billing infrastructure from their physical health PPS billing infrastructure. While a clinic may use its own EHR system for clinical documentation and share some data with the county Avatar system, billing may still be done on paper. An independent review of Yolo County described this approach as an "inefficient and error-prone process which would benefit from automation."[43]

Behavioral Health System Stretches to Meet Service Needs

The share of the region's residents reporting frequent mental distress (11.8%) is slightly higher that the statewide percentage (11.0%).[44] The region's suicide rate, however, is more than 30% higher than the state average (Table 11). While opioid-related ED visits were higher than statewide rates, the rate of opioid-related deaths — 3.3 per 100,000 residents in 2018 — was below the statewide average of 5.8 per 100,000. Several area hospitals — Marshall Medical Center, Mercy San Juan, and UCDMC — participate in the CA Bridge program. The program addresses care for persons with opioid use disorder (OUD) in the acute care setting by prescribing buprenorphine and connecting patients to community treatment services. Buprenorphine to address OUDs is prescribed twice as often in the Sacramento region (30.3 prescriptions per 1,000 people) than statewide (14.5 prescriptions per 1,000 people).[45]

TABLE 11. Behavioral Health Measures (age adjusted per 100,000 people)
Sacramento Area vs. California, 2018

	Sacramento Area	California
Suicide	13.3	10.4
Opioid deaths	3.3	5.8
Opioid emergency department visits	23.5	21.4
Amphetamine-related overdose hospitalizations	5.5	5.6

Sources: "California Opioid Overdose Surveillance Dashboard," California Department of Public Health; Centers for Disease Control and Prevention; "Vital Records Data and Statistics," California Department of Public Health. All sources accessed June 1, 2020.

As in other counties, behavioral health services for Medi-Cal enrollees in the Sacramento region are provided through a complex system of organizations and provider networks. Medi-Cal managed care plans contract with providers to deliver services for less severe mental health conditions (also referred to as "mild-to-moderate" conditions). County behavioral health departments are responsible for services to those with more serious mental health needs (generally, serious mental illness for adults and serious emotional disturbances for children and youth), as well as those with SUD. Medi-Cal enrollees needing services often have to navigate a complex array of systems and providers.

County Mental Health Plans Wrestle with Capacity but Make Improvements

External quality reviews of the region's mental health plans (MHPs) identify strengths as well as opportunities for improvement.[46] Each of the four MHPs (Placer and Sierra have a joint MHP) in the region reports a penetration rate — the percentage of Medi-Cal enrollees receiving specialty mental health services — below the statewide average (Table 12). These rates suggest that there are Medi-Cal enrollees with unmet needs in the region. El Dorado County's penetration rate is lower than the average for other small counties and is particularly low for Latinx populations.[47] The independent reviews also noted shortcomings with meeting standards for timely access to care in Sacramento, El Dorado, Placer, and Sierra Counties.

TABLE 12. Penetration of Medi-Cal Enrollees Using Specialty Mental Health Services, Sacramento Area vs. California, 2016–2018

	2016	2017	2018
Sacramento Area	**3.8%**	**3.6%**	**3.7%**
► Sacramento County	4.2%	4.1%	4.4%
► Placer-Sierra Counties	3.7%	3.5%	3.6%
► El Dorado County	3.7%	3.4%	3.7%
► Yolo County	3.4%	3.3%	3.3%
Statewide	**4.5%**	**4.5%**	**4.7%**

Source: Fiscal Year 2019–20 Reports, Behavioral Health Concepts, California External Quality Review Organization for Medi-Cal Specialty Mental Health services, accessed January 21, 2021.

These shortcomings result, in part, from the capacity challenges county MHPs have, notably with psychiatric services. For example, in Sacramento County, about a third of Medi-Cal enrollees authorized for services were discharged from the MHP without receiving any services.[48] The independent review recommended that the El Dorado County MHP improve follow-up appointments after hospital discharges. In Yolo County, challenges with transportation for patients were identified for improvement.[49] One respondent observed that the increasing demand for behavioral health services as a result of the COVID-19 pandemic, an economic downturn, and growing homelessness will outpace available funding and capacity expansions.

Despite these challenges, the region's MHPs have made progress monitoring care capacity for patients and connecting them with available providers and resources. All of the region's MHPs use standardized assessment tools for adults and children to inform treatment and monitor progress. In addition, the MHPs have increased efforts to add and fill psychiatry positions and add other staff to address capacity challenges. In 2019, Yolo County doubled the size of its program providing mental health and SUD services to those involved with the criminal justice system, increasing available slots from 15 to 30. Sacramento County has increased outreach and engagement through community care teams to help patients navigate to their first appointments once referred for services. In addition, Sacramento has six mobile crisis units working throughout the county.

The independent review praised Yolo County as a "model of collaboration" between criminal justice agencies and mental health and homeless services to support those needing mental health and other community services. Sacramento County was noted for its robust continuum of care — from prevention and early intervention, to outpatient services, crisis intervention and stabilization, and inpatient psychiatric services — as well as the county's coordination with law enforcement. The El Dorado and Placer-Sierra MHPs work closely with, or are colocated with, other county

agencies, community partners, or both. In addition, the Placer-Sierra MHP coordinates care transitions with the Medi-Cal managed care plans in this MHP's counties.

Behavioral Health Workforce Shortages

While the region has slightly more psychiatrists per 100,000 people (12.3) than the statewide average (11.8), many respondents noted that the region has severe shortages of behavioral health professionals, particularly psychiatrists, to serve the Medi-Cal population.[50] One respondent remarked that recruiting a psychiatrist to El Dorado County can take up to 18 months. Other professionals in short supply, as reported by respondents, include LCSWs, marriage and family therapists, and SUD counselors. One respondent said, "Mental health need is so desperate; if we had the opportunity to hire one LCSW for each physician, we could keep them busy." Another respondent highlighted not just the overall shortage of behavioral health professionals but also the dearth of such professionals who are able to provide culturally competent care.

Concerns over Access to Inpatient Psychiatric Care

As is the case statewide, inpatient psychiatric care beds, which in the Sacramento region are in short supply, are one component in a complex, interconnected system for behavioral health care.[51] When access at one or more of these points is constrained, the effects may be felt throughout the system. According to respondents in the regional market study, access to inpatient psychiatric care is constrained in part by Medicaid's exclusion of payment for "institutions for mental diseases" (IMD), which means that no federal funds are available for services in settings with 16 or more beds.[52] Of the eight inpatient psychiatric facilities in the region, four are large enough to fall into the IMD exclusion. The lack of federal funding constrains the counties' ability to find appropriate care settings and drains resources that could be used for more outpatient services and prevention. A respondent observed the need for more inpatient psychiatric facilities with 16 or fewer beds. A consortium of providers, the city of Sacramento mayor's office, and the governor's office have been working to address inpatient bed capacity.

In Placer County, respondents note that the mental health continuum of care has gaps, as there are no inpatient crisis stabilization beds. Universal Health Services, an investor-owned company that specializes in psychiatric care, attempted to build an inpatient psychiatric facility in Rocklin, but community resistance scuttled the project. Respondents in El Dorado County also noted the lack of inpatient crisis stabilization capacity, adding that this shortage sometimes "strands patients in the ED for days or weeks." Counties use Full Service Partnership resources from the Mental Health Services Act to deliver supplemental wraparound care and fill in gaps (i.e., those created by IMD exclusion) for patients with the most complex needs. These services can include intensive day treatment and rehabilitation.

Integrating Levels of Care in the GMC Model Maze

As noted earlier, the GMC Model presents a challenging labyrinth of providers and services for Medi-Cal enrollees to navigate in Sacramento County. The integration and coordination of behavioral health services is particularly challenging with five Medi-Cal managed care plans having to coordinate with the Sacramento County MHP and SUD services. Moreover, Medi-Cal managed care plans that delegate to private behavioral health plans, such as Beacon Health Options, add another layer of complexity.

Sacramento County and Medi-Cal managed care plans, however, have developed a tool to coordinate care and navigate provider networks and to clarify steps for filling prescriptions for medications. While the collaboration has worked administratively for the plans and county, consumers still find the system confusing, according to several respondents. An advocate observed that despite these efforts, there is "no fluidity" in the system, and Medi-Cal enrollees do not know where and when to get services. Moreover, there is sometimes a disconnect between the time that someone is

willing to enter treatment and the availability of SUD treatment appointments. Finally, a respondent commented that neither DHCS nor the Department of Managed Health Care oversees the system well, and Medi-Cal enrollees' needs may go unaddressed as a result.

Tiptoeing to Risk-Based Payments in Medi-Cal Specialty Mental Health

For Medi-Cal specialty mental health services, payment innovation is difficult. However, Sacramento County, which contracts out 90% of its behavioral health services, has been slowly moving to a "per-member per-month" model that may lay the foundation for value-based payments in the future. The county is contracting with community-based private providers and making monthly payments for specialty mental health services for a minimum volume in each "modality" (e.g., case management, medication support) based on historical utilization. This model is not the same as capitation, because the providers do not incur downside financial risk. A year-end cost reconciliation squares up total expenditures with the minimum payments made initially; if a provider's volumes and costs were higher, the provider will receive additional reimbursement. If expenditures were lower, however, the county can recover some of the original minimum payments.

Providers paid in this manner have some flexibility with how to staff and meet service objectives. The model also promotes the use of financial, administrative, and clinical management tools necessary to accept traditional risk-based payments in the future. Providers have requested technical assistance to adapt to this new payment approach. County MHP leaders expressed their interest in the California Advancing and Innovating Medi-Cal (CalAIM) behavioral health payment reform proposals, particularly the reduction of documentation requirements that would accompany these reforms. These leaders cautioned, however, that value-based payments are "tricky" with a patient population in which a few high-cost enrollees can drain available resources.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Aims to Transform Care Delivery

All four counties in the region participate in the DMC-ODS pilot program with Yolo and Placer Counties launching in 2018 and Sacramento and El Dorado Counties launching in 2019. In contrast to the FFS DMC program, the DMC-ODS brings a more focused clinical approach with more individualized treatment. Providers are better able to place individuals at appropriate levels of care. The DMC-ODS pilot allows the use of providers designated as licensed practitioners of the healing arts to provide SUD services.[53] One behavioral health leader observed that the transformation in the approach to care "will take time for the county and providers to really understand the implications of the changes."

The Placer County DMC-ODS program provides case management for high-need clients with individualized case plans. The county has contracts with providers in adjacent counties to increase capacity for patients. Placer County has a network of 23 sober living recovery residences with a total of 125 beds. Despite capacity and staff improvements, an independent review found that Placer County still struggles to meet standards for timely access to care, particularly for urgent and post-discharge appointments.[54]

Sacramento County implemented the DMC-ODS pilot in July 2019 and has seen a 90% increase in patients served, according to a behavioral health leader. The county increased payment rates for providers, resulting in less provider turnover and more retention of high-quality staff. There has also been an increase in available treatment beds.

Addressing the Needs of a Growing Homeless Population

Hospital and other respondents reported that managing the health and well-being of people without permanent housing presents a significant and growing challenge in the Sacramento region. A 2019 point-in-time study found that more than 5,500 people experience homelessness in Sacramento County on any given night, an increase of 19 percent since 2017.[55] This number represents 36 residents per

10,000 residents in the county — lower than San Francisco's 91 per 10,000 but higher than San Diego's 24 per 10,000. The same study also found that 26% of those experiencing homelessness have a debilitating cognitive or physical impairment, and 21% have a severe psychiatric condition, such as depression or schizophrenia.

The city of Sacramento has established several initiatives to resolve the array of challenges facing people without permanent shelter. The city is building new rehousing shelters that will offer hundreds of additional temporary beds, as well connections to health care and social services.[56] In addition, Sacramento County has expanded behavioral health spending and capacity with the addition of more crisis residential beds, increasing capacity from 12 to 72 beds. The county also opened a mental health urgent care clinic in November 2017.[57]

The city of Sacramento is also the only city in California running its own Medi-Cal Whole Person Care (WPC) pilot, Pathways, which targets more than 3,000 high-need people for the coordinated delivery of physical and behavioral health care, housing support, and food assistance.[58] Pathways represents a joint effort of various government agencies, health plans, and medical and social service providers. The pilot enrolled its first members in November 2017 and had 1,900 members by early 2020. Placer County's WPC pilot had served more than 444 enrollees by March 2020.

The state has also invested in the region's homelessness response through its No Place Like Home program, which awards grants to local governments to support construction of permanent supportive housing. Thus far, across the region, the state has awarded more than $39 million, including more than $24 million in Sacramento County, nearly $10 million in Yolo County, $1.9 million in Placer County, and $3.4 million in El Dorado County.[59]

Fragmented Exchange of Health Information

Health information exchange (HIE) in the Sacramento region largely relies on providers using the same EHR system or EHR systems that are interoperable. Three of the four major health systems in Sacramento County use the Epic EHR system — Sutter Health, Kaiser, and UC Davis. Providers using Epic can access a patient's health records at organizations sharing the system. For example, UC Davis uses Epic across inpatient and outpatient clinic settings, along with Healthy Planet, an Epic module designed for population health management to track quality metrics and assess system performance.

There is also limited data sharing between FQHCs and hospitals. The major exception is the Sacramento County FQHC, which uses a version of Epic that enables UC Davis, Sutter Health, and Kaiser providers to pull FQHC clinical data into the hospital EHR. Respondents observed that sharing data improves care management and makes it much easier for shared patients. Several other FQHCs have limited access to hospital inpatient data. FQHCs using Care Everywhere, an Epic module, automatically receive notifications of their patients' inpatient admissions or ED visits and can then retrieve related patient care summaries.

By contrast, Dignity Health uses the Cerner EHR system, so other hospital systems and providers have limited access to Dignity Health patient medical record information. One health plan respondent anticipates that data exchange will improve as providers comply with the forthcoming federal Interoperability and Patient Access regulations for 2021.[60] These regulations introduce standards-based data-exchange and information-blocking rules intended to reduce data-exchange barriers and improve patient access to clinical data and provider directories, improve the care experiences of people dually eligible for Medicare and Medicaid, and improve information sharing among health plans for care coordination.

Data exchange will likely remain fragmented given the various EHR systems used in the region. One FQHC leader observed that Carequality, an EHR interoperability vendor

used by some FQHCs and hospitals, had "created an explosion of interaction between health records" and showed some promise. Nevertheless, one FQHC executive remarked that HIE with hospitals or other FQHCs is "not the rallying cry like other priorities."

Using Data and Analytics to Improve Quality of Care

FQHC respondents reported that capabilities to collect, manage, and send encounter data for Healthcare Effectiveness Data and Information Set (HEDIS) performance measures varies but is continuously developing. Some FQHCs have established information technology (IT) positions to manage requirements for reporting encounter data to health plans. The GMC Model, with five plans and several IPAs requiring encounter data reports, increases the IT burden for FQHCs. FQHCs not only submit encounter data to plans but also calculate the FQHCs' own HEDIS quality performance measures to validate what plans report to the FQHCs for care improvement and incentive payments. Other FQHCs have invested significantly in IT departments and use analytics platforms to target quality improvement efforts for specific populations. These investments may include a chief quality officer or population health coordinator.

FQHC leaders, however, identified several challenges to using data to drive performance improvement initiatives. First, data provided by health plans to FQHCs about care gaps and target populations are often out of date and inaccurate. For example, health plans may hold FQHCs responsible for patients who are not assigned to an FQHC's patient panel, or the reverse may occur, with plans unaware of patients who are on an FQHC's panel. Second, payments received for meeting quality performance targets may come months after the goal has been met. Finally, one FQHC leader observed that the HEDIS performance measures selected by DHCS are "not an accurate reflection of what's happening on the ground" and do not include a population-health perspective.

Limited Participation in SacValley MedShare

Participation in SacValley MedShare, a regional health information organization (RHIO), has been slow among metropolitan Sacramento providers. The RHIO serves a 19-county area mostly north and east of Sacramento. Several Yolo County providers participate.

Experts interviewed observed that health systems and providers using Epic and Cerner EHR systems participate in national health information exchange platforms such as eHealth Exchange or Carequality but are less likely to participate in RHIOs. Furthermore, RHIO participation has to compete with many other health system IT and organizational priorities.

Despite the reluctance of systems to make large investments in RHIOs, SacValley MedShare recently added member access to continuity of care data that Sutter Health shares via eHealth Exchange. Using California Health Information Exchange Onboarding Program grant funding from DHCS, SacValley MedShare will add Medi-Cal providers in Placer, Nevada, and Sierra Counties to the RHIO, as well as expanding current member data contributions.

Aspirational Behavioral Health Information Exchange

Several respondents commented on the difficulties of accessing and exchanging behavioral health data. For example, clinicians at UCDMC can access patient information from the UC Davis psychiatric clinic but nothing from the county MHP, human services, or the county jail. According to those interviewed, numerous impediments exist, but two are most prominent. First, the county MHP EHR and billing system, Avatar, has only limited connectivity capability. Second, federal regulations regarding the privacy of SUD treatment restrict what data can be shared without explicit patient consent. Another respondent said that behavioral health data exchange, at this point, is aspirational but slowly emerging with several promising undertakings.

UCDMC is working to design and implement an HIE protocol with other providers, including county MHPs and social services providers. This protocol would employ HIE when UCDMC providers prescribe medications to assess comorbidities and facilitate the transfer of patients from mild-to-moderate to specialty mental health services.

Among the county MHPs, their contracted providers, and other providers in their counties, electronic HIE is only recently beginning to emerge. In El Dorado County, the MHP implemented the CareConnect Inbox in the Avatar system, which will facilitate HIE with contracted community-based providers. And Placer County launched an emergency department (ED) information exchange that alerts county behavioral health clinicians when one of their patients uses a hospital ED and provides information about the nature of the visit.

COVID-19 Impact in the Sacramento Region

Similar to other California regions, the COVID-19 pandemic has led to both significant health impacts and a significant economic downturn in the Sacramento area, with particularly large impacts on the health care industry. Likely because state government accounts for a high share of regional employment, however, the pandemic's broader economic impact in the region was less severe than elsewhere in the state. While the unemployment rate increased 7.1 percentage points statewide between February and August 2020, the increase in the Sacramento region was just 5.6 percentage points over the same period (see Table 13).

Within health care, the virus's spread strained providers' balance sheets, medical supply inventories, and staff capacity. Especially in the pandemic's early months, hospitals lacked sufficient personal protective equipment (PPE), testing kits, and respirators, leading to concerns over staff safety and patient health. Moreover, effective responses to the virus were hampered by a mismatch between the staff on hand and the personnel needed, such as frontline nurses. For behavioral health providers, COVID-19 created challenges for the crisis care continuum, with psychiatric hospitals, crisis stabilization centers, skilled nursing facilities, and mental health urgent care sometimes failing to meet staffing ratio requirements.

The COVID-19 pandemic has put tremendous pressure on and demand for clinical laboratory scientists. A hospital leader reported that many workers in the field are in their 60s with retirements looming. In addition, the state does not have enough training programs to respond to coming retirements and increased demand.

Providers suffered significant revenue shortfalls, with many clinic sites closing as a result of the sharp decline of in-person visits and hospitals temporarily pausing elective surgeries. While loans offered to physician practices through the CARES Act's Paycheck Protection Program helped sustain operations, providers reported that assistance was inadequate. Providers that rely on capitation were better positioned to weather reduced service utilization because of closures. For specialist practices and hospitals, which rely predominantly on FFS payment, the financial impact was more dire.

TABLE 13. COVID-19 Impacts
Sacramento Area vs. California, October 2020

	Sacramento Area	California
UNEMPLOYMENT RATE		
► Pre-pandemic (FEBRUARY 2020)	3.8%	4.3%
► Mid-pandemic (OCTOBER 2020)	7.3%	11.4%
MEDI-CAL ENROLLMENT		
► Percentage change (FEBRUARY TO OCTOBER 2020)	4.3%	1.0%
CARES ACT, PER CAPITA (AUGUST 2020)		
► Provider Relief Funds	$227	$148
► High Impact Funds	$0	$16

Sources: "Employment by Industry Data," State of California Employment Development Department; "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," California Health and Human Services, Open Data; and "HHS Provider Relief Fund," Centers for Disease Control and Prevention. CARES Act data accessed August 31, 2020; all other data accessed January 15, 2021.

Mitigation Efforts

Sacramento County received $181 million from the federal government under the CARES Act's state and local government assistance provisions, while the city of Sacramento received an additional $90 million. Since El Dorado, Placer, and Yolo Counties are home to fewer than 500,000 residents, the city and county of Sacramento were the only local governments in the region to receive funding directly.[61] Controversially, rather than using the emergency funds to address the pandemic directly, the county used its allocation primarily to offset general fund expenses by covering payroll for the sheriff's office and other county employees working in public health and social services. According to officials, this approach was necessary given the loss of tax revenue expected to result from the pandemic.[62], [63] The remaining funding was later approved to fund public health initiatives, such as expanding COVID-19 testing and employing contact tracers. The city of Sacramento, however, dedicated its CARES relief to a range of economic and public health efforts, including assistance to small businesses, youth workforce training, and rehousing the city's homeless residents.[64]

Also available to hospitals and other providers through the CARES Act was the Provider Relief Fund, which allocated $175 billion to providers nationwide to help cover increased costs and lost revenues from the pandemic. The Sacramento region's hospitals and clinics received nearly $180 million in aid. Even while the pandemic's impact was greater in other regions, on a per capita basis, Sacramento providers received roughly $227 per resident — an amount significantly above the statewide per capita payment of $128. This disparity is likely a result of the Provider Relief Fund's allocation formula, which set each provider's award roughly proportional to its share of Medicare and Medicaid revenues.

Growth of Telehealth

One silver lining of the pandemic has been the rapid adoption of telehealth to connect providers and patients, with changes in federal requirements for conducting and billing for telehealth easing the transition. As in other regions, the move to telehealth generally proceeded more smoothly than providers had expected, with many patients able to access videoconferencing services such as Zoom and Google Hangouts and providers reporting lower no-show rates. UC Davis, for instance, converted 50% of visits to telehealth within just one week. For smaller practices, however, the transition was more protracted; for some, several weeks were required to establish systems with telehealth vendors.

For some patient populations, access to the internet and proficiency with technology also proved challenging. Particularly in the behavioral health context — where telehealth would, in theory, be most promising — providers worried that patients (especially youth) are not as forthcoming with pertinent information in telehealth visits. Moreover, one administrator noted that the pandemic's onset was followed by a reduction in youth referrals to behavioral health services, perhaps because of parents' lack of awareness of the availability of telehealth.

Issues to Track

- Will Sacramento County's GMC Model evolve in ways that ease provider reporting burdens and simplify and improve access to quality services for Medi-Cal enrollees? Will the upcoming recontracting result in fewer participating plans? Will the new Sacramento Health Authority Commission successfully move to a Two-Plan Model of managed care?
- Will the remaining independent physicians and two smaller independent hospitals join the region's large health systems? What countervailing forces will remain to keep health system payment rate increases in check?
- How will value-based payment and care delivery arrangements evolve? Will employers use their negotiating leverage to get better value at lower costs?
- Will medical groups and IPAs affiliated with health systems continue dropping contracts for Medi-Cal primary care and fuel a further migration of enrollees to FQHCs?
- What are the next organizational developments for FQHCs as they assume more responsibility for Medi-Cal enrollees? Will FQHCs increase collaboration? Can they retain their community-based roots and close connections with patients as they grow and develop more sophisticated capabilities?
- What imperatives will drive improved health information exchange and participation in a regional health information organization?
- How will pilots and other innovations in behavioral health improve access to care for Medi-Cal enrollees? Can any improvements be institutionalized through CalAIM?

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Background on Regional Markets Study: Sacramento Area

Between March and October 2020, researchers from Blue Sky Consulting Group conducted interviews with health care leaders in El Dorado, Placer, Sacramento, and Yolo Counties in the Sacramento area of California to study the market's local health care system. The market encompasses the Metropolitan Statistical Area of Sacramento-Roseville-Folsom.

The Sacramento area is one of seven markets included in the Regional Markets Study funded by the California Health Care Foundation. The purpose of the study is to gain key insights into the organization, financing, and delivery of care in communities across California and over time. This is the fourth round of the study; the first set of regional reports was released in 2009. The seven markets included in the project — Humboldt/Del Norte, Inland Empire, Los Angeles, Sacramento Area, San Diego, San Francisco Bay Area, and San Joaquin Valley — reflect a range of economic, demographic, care delivery, and financing conditions in California.

Blue Sky Consulting Group interviewed nearly 200 respondents for this study, with 24 specific to the Sacramento area. Respondents included executives from hospitals, physician organizations, community health centers, Medi-Cal managed care plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report. The onset of the COVID-19 pandemic occurred as the research and data collection for the regional market study reports were already underway. While the authors sought to incorporate information about the early stages of the pandemic into the findings, the focus of the reports remains the structure and characteristics of the health care landscape in each of the studied regions.

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ABOUT THE FOUNDATION

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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