

Regional Market Report 2026: San Francisco Bay Area



California Health Care Almanac
Regional Markets Series

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San Francisco Bay Area: Dominant Health Systems Expand as Costs Rise

Summary of Findings

As already high health care costs escalate, large dominant health systems in the San Francisco Bay Area continue to expand and compete for patients, especially those with commercial insurance. The three Bay Area counties in this study — Alameda, Contra Costa, and San Francisco — have historically been wealthier and healthier than California overall. However, in recent years, the region's ever-increasing cost of living and housing shortage have contributed to growing income disparities and a significant homelessness crisis. Moreover, the region has seen a sizable increase in drug-related emergency department visits and overdose deaths compared to other regions of the state.

The Bay Area hospital market is highly concentrated, leaving only a handful of independent hospitals without ties to the larger regional health systems. Although the large systems have faced increased financial pressures, they continue to expand capacity, particularly for outpatient care. Like the hospitals, physicians and other providers are grappling with rising input and labor costs and increased utilization. While the region has an abundance of physicians and other clinicians compared to California as a whole, the Bay Area's high cost of living makes recruiting and retaining providers difficult.

The Bay Area has experienced a number of changes since the previous study in 2020–21 (see “Background on Regional Markets Study” on page 28).¹ Key developments include the following:

- ▶ **High labor and supply costs put pressure on health system finances.** Input costs continue to grow as health plans and providers across the region experience higher-than-expected utilization and higher labor and supply costs. As providers struggle to manage risk-based payments, population health management remains a focus.
- ▶ **Regional systems continue to expand.** Large regional health systems are doubling down on expansion, particularly in the East Bay, with a focus on building outpatient capacity to compete for patients. In addition, Sutter Health and UCSF Health are both building new hospitals to meet the state's 2030 seismic deadline. Kaiser, long the region's dominant health plan and delivery system for commercially insured people and seniors enrolled in Medicare Advantage, has seen competition intensify.
- ▶ **Facing increased financial pressure, three independent safety-net hospitals were acquired by larger systems.** In 2024, UCSF Health acquired Dignity Health's two San Francisco hospitals, while Alameda Health System, the public hospital system in Alameda County, acquired St. Rose Hospital in the East Bay. As the

large health systems simultaneously expand and report increased financial pressure, some smaller independent hospitals that serve a large proportion of Medi-Cal patients are facing significant financial problems that have resulted in state loans for two hospitals.

- ▶ **Independent practice continues to erode.** Physicians continue to join hospital-affiliated medical groups and larger physician organizations as younger clinicians opt for employment rather than independent private practice. The region's only remaining large, physician-owned independent practice association continues to build capacity to take full financial risk for both professional and inpatient and outpatient hospital services.
- ▶ **Strong public safety-net hospital systems and community-based clinics eye looming Medi-Cal cutbacks with great concern.** Almost one-third of Bay Area residents are Medi-Cal enrollees, and county-run health systems and publicly owned Medi-Cal health plans provide the backbone of a strong safety net regionally. Noncounty community health centers also play an important safety-net role. Safety-net health plans and providers face significant Medi-Cal cuts in the face of state budget deficits and implementation of House Resolution 1, which will reduce federal Medicaid spending by an estimated \$911 billion nationally over 10 years.
- ▶ **State and local behavioral health initiatives bring new funding — and implementation challenges.** While many study respondents viewed new state funding for additional behavioral health care capacity as a welcome development, services remain fragmented, and implementation of the many different initiatives has been overwhelming.

Market Background

The three core Bay Area counties included in this study — San Francisco, Alameda, and Contra Costa — are home to about

3.6 million Californians. San Francisco is geographically small but dense, covering only 47 square miles but with a population of 828,000 people. It is located at the tip of the peninsula that separates the Pacific Ocean from the San Francisco Bay and stretches south to San Mateo County.

Known as the East Bay, Alameda and Contra Costa Counties are much larger geographically — 739 and 716 square miles, respectively. The Bay Bridge connects San Francisco, the only consolidated city-county jurisdiction in the state, to Alameda County's largest city, Oakland. With almost 444,000 people, Oakland accounts for slightly less than a quarter of the county's population of 1.6 million. Alameda County is bordered by Contra Costa County to the north, San Joaquin County to the east, and Santa Clara County to the south. Contra Costa County's population of almost 1.2 million spans 19 cities and many unincorporated communities, with the county's largest cities, Concord and Antioch, each having about 120,000 residents. In addition to heavily urbanized and suburbanized areas, the region, except for San Francisco, has tens of thousands of acres of productive farmland, especially in eastern Alameda County, where grapes, olives, nuts, and other crops grow.

Postpandemic, the three-county region saw a larger population decline than California as a whole — falling by 1.5% compared to 0.2% statewide between 2019 and 2024 (Table 1). San Francisco experienced the largest population decline, 5.8% between 2020 and 2024, according to the US Census Bureau (not shown). Alameda County's population also declined (-2.0%) during the same period, while Contra Costa's grew slightly (0.6%). Racially and ethnically diverse, the three core Bay Area counties have a large Asian population, with almost 3 in 10 people identifying as Asian in 2024, nearly double the statewide proportion. Almost a quarter of the area's population identifies as Latino/x, while 8.2% are Black and 33.5% are White. Almost a third of the area's population was born outside the United States.

As with other big US cities, San Francisco’s downtown, a global technology and financial hub, has struggled economically postpandemic. The city is often cited as an example of a pandemic-induced “doom loop,” where factors like increased remote work and population decline lead to decreased office occupancy, closed storefronts, reduced tax revenue, and cuts in public services.² In turn, such a spiral can drive more businesses and residents away, creating a cycle of decline.

Many others, however, argue that the doom-loop narrative is exaggerated and that San Francisco — always resilient — is showing signs of recovery, driven in part by the artificial intelligence boom.³ Well-established education, health care, and hospitality and tourism sectors also power the region’s economic engine. For instance, both Kaiser Permanente and Blue Shield of California have headquarters in Oakland, and UCSF, UC Berkeley, and many other colleges and universities call the area home.

Nonetheless, the region’s ever-increasing cost of living and housing shortage contribute to wide income disparities. Almost 1 in 10 people lived in poverty in 2023, defined as incomes below 100% of the federal poverty level of \$30,000 for a family of four.⁴ At the same time, the region’s average household income of \$180,662 was more than 30% higher than the statewide average of \$136,730 and the highest of the seven study markets. The region also has the highest rate of people with college degrees (51.6%) of the seven markets, significantly higher than the statewide rate of 36.5%. Moreover, the area’s unemployment rate is relatively low at 3.9% — almost a percentage point lower than the 4.8% statewide rate and the lowest of the seven markets. Housing affordability, however, has declined markedly since 2019, with the share of households earning enough to purchase a median-priced home in the region dropping from 24.9% to 18.1%.⁵

High housing costs, combined with pockets of concentrated poverty, contribute to an affordable housing crisis in the region, leaving both San Francisco and Oakland to grapple with significant homelessness challenges. Estimated at more than 8,300 people, with roughly half living on the streets and the other half in shelters, the homeless population

TABLE 1. Population Characteristics,
Bay Area vs. California, 2023 Unless Noted

	Bay Area	California
POPULATION STATISTICS		
Total population (2024)	3,649,193	39,431,263
Share of state population	9.3%	100%
Five-year population growth	-1.5%	-0.2%
AGE OF POPULATION, IN YEARS		
Under 18	18.9%	21.7%
18 to 64	64.0%	62.1%
65 and older	17.2%	16.2%
RACE/ETHNICITY		
Latino/x	23.2%	40.4%
White (non-Latino/x)	33.5%	34.3%
Black (non-Latino/x)	8.2%	5.6%
Asian (non-Latino/x)	29.9%	15.8%
Other (non-Latino/x)	5.1%	3.8%
BIRTHPLACE		
Outside the United States	33.1%	27.3%
EDUCATION (AMONG THOSE AGE 25 AND OLDER)		
High school diploma or higher	89.1%	84.6%
College bachelor’s degree or higher	51.6%	36.5%
ECONOMIC INDICATORS		
Income below 100% federal poverty level	9.7%	12.0%
Household income \$100,000*	60.0%	48.4%
Median household income*	\$130,118	\$96,334
Average (mean) household income	\$180,662	\$136,730
Unemployment rate	3.9%	4.8%
Households able to afford median-priced home (2024)	18.1%	13.6%

* A weighted blend of county-level median household income figures.
Sources: *Annual Estimates of the Resident Population for Counties in the United States: April 1, 2020 to July 1, 2024* (CO-EST2024-POP), *County Population by Characteristics: 2020–2023* (CC-EST2023-ALLDATA-06 and CC-EST2023-AGESEX-06), *Annual County Resident Population Estimates by Selected Age Groups and Sex: April 1, 2010 to July 1, 2019; April 1, 2020; and July 1, 2020*, “US Census, American Community Survey (ACS) 1-Year Supplemental Estimates, K200503, Place of Birth in the United States, 2019 and 2023,” “ACS 5-Year Estimates Subject Tables, S1501, 2023, Educational Attainment by County,” “US Census, ACS 5-Year Estimates Subject Tables, S1901, Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars), 2023 and (in 2019 Inflation-Adjusted Dollars), 2019,” US Census Bureau; “Current Industry Employment and Unemployment Rates for Counties,” California Employment Development Department; and “Housing Affordability Index - Traditional (Q2 2024),” California Association of Realtors.

constitutes about 1% of San Francisco’s population.⁶ An estimated 5,490 people in Oakland experienced homelessness in 2024, up 9% since 2022.⁷ On a per capita basis, Oakland has a higher homelessness rate than San Francisco, with an estimated 1,258 out of every 100,000 Oakland residents lacking a permanent roof over their heads, compared to San Francisco’s rate of 1,028 per 100,000 residents.⁸

High Overdose Rate Impacts the Region

Reflecting the regional overdose epidemic fueled by growing fentanyl use, the Bay Area has a high rate of drug-related overdose deaths — 35.6 per 100,000 population versus 29.1 statewide (Table 2). In San Francisco, the number of accidental overdose deaths reached an all-time high of 810 in 2023, before decreasing to 635 in 2024. The decline appears to be short-lived, however, as partial 2025 data indicated that accidental overdose deaths were on track to surpass the 2023 level.⁹

The share of people in the Bay Area reporting fair or poor health status has grown in recent years, reaching 15.8% in 2023, or more than 1 in 7 people, and is similar to the statewide average of 15.5%. Although the prevalence of diabetes and high blood pressure is comparable to statewide rates, the region’s infant mortality rate — 3.4 deaths per 1,000 live births — is among the lowest of the seven markets and lower than the statewide rate of 4.1 deaths per 1,000 live births.

The region has a slightly lower rate of suicides than California overall — 8.5 per 100,000 population versus 10.1 statewide. The area’s rate of drug-related emergency department visits also is slightly lower than the statewide average — 131.2 per 100,000 population versus 137.4 statewide. The prevalence of anxiety (9.5%) and depression and other mood disorders (10.2%) are similar to statewide averages.

TABLE 2. Health Status,
Bay Area vs. California, 2023 Unless Noted

	Bay Area	California
PHYSICAL HEALTH		
Fair/poor	15.8%	15.5%
Adults with an independent living difficulty*	5.5%	5.8%
Diabetes prevalence†	10.3%	11.3%
High blood pressure prevalence†	20.5%	21.9%
Infant mortality rate (deaths per 1,000 live births), 2019–21	3.4	4.1
BEHAVIORAL HEALTH		
Anxiety prevalence†	9.5%	10.3%
Depression, bipolar, or other depressive mood disorders, prevalence†	10.2%	10.5%
Opioid or other drug-related emergency department visits (per 100,000 population)	131.2	137.4
All drug-related overdose deaths (per 100,000 population)	35.6	29.1
Suicide deaths (per 100,000 population), 2020–22, age-adjusted	8.5	10.1

* An independent living difficulty refers to, for example, difficulty doing errands alone, visiting a doctor’s office, or shopping because of a physical, mental, or emotional condition.
† Prevalence reported from the Healthcare Payments Data (HPD) source reflects data from claims and encounter records, which capture instances of a condition treated during the specified time. Results may differ from prevalence rates obtained by other methods — for example, surveys or record sampling. HPD reporting of measures data suppresses counts from any group (age, sex, payer, and county-specific) with fewer than 30 people; caution is advised when interpreting results for geographic areas with fewer than 30,000 residents.
Sources: “AskCHIS,” UCLA Center for Health Policy Research; “American Community Survey, 2023 5-Year Estimates, S1810, Disability Characteristics,” US Census Bureau; *HPD Measures Data (2018–2023)*, California Department of Health Care Access and Information, last updated July 8, 2025; “Infant Mortality,” California Department of Public Health (CDPH); *County Health Status Profiles 2024: Tables 1–29*, CDPH, last updated August 8, 2024; “California Overdose Surveillance Dashboard,” CDPH, last updated May 19, 2025.

Health Coverage Sources and Trends

Bay Area residents are much more likely to have commercial health insurance compared to Californians overall — 65.0% versus 50.8% — and less likely to have Medi-Cal coverage than the statewide population — 26.3% versus 35.6%; also, 4.5% of both Bay Area residents and Californians statewide are dually eligible for Medicare and Medi-Cal (Table 3). The share of regional residents enrolled in Medicare increased slightly from 12.1% in 2019 to 13.0% in 2023, mirroring the statewide rate (12.8%). The proportion of residents without health insurance remained largely stable at 4.1% and lower than the statewide rate of 6.4% in 2023.

Within the commercial insurance market, several market observers commented on the ongoing but gradual migration

from health maintenance organization (HMO) products to preferred provider organization (PPO) products. While HMO products often are viewed as more cost-effective and offering better quality, employers are choosing PPO products because workers prefer the broader choice of providers. PPOs typically have lower premiums but higher patient cost sharing, both attractive features for employers.

Like California overall, Medi-Cal enrollment in the region has increased since 2019, growing from a fifth to more than a quarter of the population by 2023. Two significant policy changes helped drive growth: the pandemic-era freeze on Medi-Cal eligibility redeterminations, which ended March 31, 2023, and the state’s coverage expansion to eligible undocumented adults.

Coverage options for people dually eligible for Medicare and Medicaid in the Bay Area are expected to shift in the coming years. In response to a California Department of Health Care Services (DHCS) mandate, all Medi-Cal health plans must offer a Medicare Advantage (MA) Exclusively Aligned Enrollment Dual Eligible Special Needs Plan (D-SNP) product, known as a “Medi-Medi Plan” in California (see “Local Medi-Cal Plans to Launch D-SNP Products” on page 24).

TABLE 3. Sources of Health Insurance,
Bay Area vs. California, 2019 and 2023

Coverages as Share of Population (Totals > 100%)	2019		2023	
	Bay Area	California	Bay Area	California
Uninsured	4.3%	7.7%	4.1%	6.4%
Medi-Cal and Medicare dually eligible enrollees	3.7%	3.7%	4.5%	4.5%
Medi-Cal (non-dually eligible enrollees)	19.9%	28.6%	26.3%	35.6%
Medicare (non-dually eligible enrollees)	12.1%	12.1%	13.0%	12.8%
Commercial	63.4%	50.6%	65.0%	50.8%

Note: Percentages may sum to more than 100% due to people being included in more than one category.
Sources: *MA State/County Penetration* (July 2019 and July 2023), US Centers for Medicare & Medicaid Services; “Selected Characteristics of Health Insurance Coverage in the United States, American Community Survey, 1-Year and 5 Year Estimates,” US Census Bureau; “By Medicare Dual Status, Certified Eligibles,” California Department of Health Care Services; and Katherine Wilson, *California Health Insurers, Enrollment Almanac — 2025 Edition*, California Health Care Foundation, February 2025.

Kaiser Remains Dominant Commercial, MA Insurer

Kaiser Permanente (Kaiser) remains the dominant insurer for both commercial and MA coverage in the three Bay Area study counties. Historically one of the lower-cost options in the region, Kaiser premiums are now more in line with other health plans, according to market observers, as Kaiser struggles with rising costs and inflation. Along with Kaiser, major commercial health insurers in the region include Aetna, a subsidiary of CVS Health; Anthem Blue Cross; Blue Shield of California; Cigna; and UnitedHealthcare. Additionally, several smaller, regional health plans offer coverage. For example, Chinese Community Health Plan, owned by Chinese Hospital and headquartered in San Francisco, offers commercial, MA, and Covered California products in San Francisco and San Mateo Counties, although the plan’s enrollment fell from more than 18,000 enrollees in 2019 to about 12,000 in 2024.¹⁰

Medicare Enrollment Grows Slightly

Between 2019 and 2024, Medicare enrollment increased as a percentage of the total population in the region, growing from 15.8% in 2019 to 17.5% in 2024 (Table 4). Over the same time, enrollment in MA health plans increased to more than one-half of the region’s Medicare enrollees, mirroring state-wide trends.

Kaiser remains the dominant MA plan in the region, covering 66% of MA enrollees, despite the plan’s MA market share falling by five percentage points since 2019 (Table 5). Kaiser’s market share ranges from 45% of enrollees in San Francisco County to 72% of enrollees in both Alameda and Contra Costa Counties. No other MA plan in the region has more than an 8% market share.

While the MA market historically has been considered lucrative, the regional MA market has “lost favor” among health plans in recent years, with respondents citing higher overall medical costs and unexpected utilization as well as changes by the federal Centers for Medicare & Medicaid Services (CMS)

to the Medicare star ratings methodology, which ties plan bonus payments to higher quality scores, among other factors.

TABLE 4. Medicare Enrollment Overview,
Bay Area vs. California, 2019 and 2024

	BAY AREA		CALIFORNIA	
	2019	2024	2019	2024
Total Medicare enrollment	586,475	639,921	6,239,477	6,899,496
Medicare as share of population	15.8%	17.5%	15.8%	17.5%
SHARE OF TOTAL MEDICARE				
Medicare Advantage	44.8%	52.0%	44.1%	51.2%
Original Medicare	55.2%	48.0%	55.9%	48.8%

Source: *MA State/County Penetration* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

TABLE 5. Largest Medicare Advantage Health Plans and Market Share,
Bay Area, 2019 and 2024

Health Plan	2019	2024
Kaiser Foundation Health Plan	71%	66%
Sierra Health and Life Insurance Company	6%	8%
United Health Care of California	6%	4%
Arcadian Health Plan	3%	3%
Blue Cross of California Partnership Plan	0%	2%

Source: *Monthly MA Enrollment by State/County/Contract* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

Covered California Premiums Still Higher Than Statewide Average

Covered California, the state’s Affordable Care Act marketplace, plays a small but growing role as a coverage source in Alameda, Contra Costa, and San Francisco Counties. In 2023, Covered California accounted for 4.5 and 4.3 percentage points of commercial enrollment in the three counties and the state, respectively. This is a slight increase from 2019, when Covered California accounted for 3.7 percentage points of commercial enrollment in the Bay Area and 3.4 percentage points statewide.¹¹

Reflecting the higher cost of living and health care costs, Covered California premiums regionally remain significantly higher than the statewide average and grew at a faster rate

between 2020 and 2025 (Table 6). Similarly, the hourly wage needed to pay the monthly premium for a Covered California silver plan for a 40-year-old is higher in the Bay Area than in California at large. In 2025, monthly premiums in the region consumed \$3.54 of an hourly wage and 21.4% of a full-time minimum-wage salary — higher than the statewide figures of \$2.72 per hour and 16.5% of minimum-wage income.

Most Covered California enrollees receive a premium subsidy that reduces the monthly cost of coverage, with those receiving subsidies paying a \$140 average net monthly premium in the Bay Area compared to \$134 statewide. Enhanced federal premium subsidies enacted during the COVID-19 pandemic expired on January 1, 2026, making premiums less affordable for approximately 162,000 Bay Area residents who received premium subsidies in 2025.¹² In 2024, Kaiser enrolled almost three-quarters (73%) of Covered California members in the region, followed by Blue Shield with 18%, and Anthem Blue Cross with 6%. Chinese Community Health Plan held 2%, and Aetna held 1% of market share.¹³

TABLE 6. Covered California Monthly Premiums,
Bay Area vs. California, 2020 and 2025

Covered California Premiums*	2020		2025	
	Bay Area	California	Bay Area	California
Lowest-cost silver monthly premium, 40-year-old	\$484	\$398	\$613	\$472
Percentage higher/lower than California average	21.7%		30.0%	
Average annual premium increase, 2020–25			4.9%	3.5%
Per hour wage amount needed to pay monthly premium†	\$2.79	\$2.29	\$3.54	\$2.72
Monthly premium as share of state minimum wage, full-time†	21.5%	17.6%	21.4%	16.5%
Percentage of members who receive premium subsidy			90.3%	89.4%
Average net monthly premium paid by those receiving subsidy			\$140	\$134
Median net premium paid by those receiving subsidy			\$43	\$57

* California premiums are weighted averages across all Covered California rating regions. Similarly, regional premiums are weighted averages for the counties that make up the region. Weighting is by enrollment.

† Assumes person pays the entire premium (i.e., no subsidy to offset cost).

Sources: *2025 Individual Product Prices*, Covered California; *2020 Individual Product Prices for All Health Insurance Companies*, Covered California; and *Active Member Profiles, June Profile* (2020 and 2025), Covered California.

Across the region, the prevalence of medical debt has increased slightly, growing from 8.2% in 2018–19 to 8.9% in 2022–23, but remains lower than the statewide figure (Table 7). Among those with medical debt, 40% owe less than \$2,000, while 60% owe more than \$2,000.

TABLE 7. Medical Debt,
Bay Area vs. California, 2018–19 and 2022–23

Medical Debt	2018–19 POOLED*		2022–23 POOLED*	
	Bay Area	California	Bay Area	California
Prevalence (% of adults with medical debt)†	8.2%	10.8%	8.9%	10.2%
AMOUNT OF MEDICAL DEBT THEY ARE HAVING TROUBLE PAYING‡				
Less than \$2,000	37.9%	45.1%	40.0%	43.7%
More than \$2,000	62.1%	54.9%	60.0%	56.3%

* Data are pooled across two years to increase data stability; confidence intervals on the amount of debt are broad in multiple regions.
† Prevalence figure is the percentage of people who answered yes to the question “Ever had problems paying for self or household family’s medical bills in past 12 months?”
‡ The amount of medical debt reflects the responses of those who said they had experienced problems paying medical bills in the past 12 months.
Source: “AskCHIS,” UCLA Center for Health Policy Research.

Medi-Cal Changes Shift Enrollment

For many years, Alameda, Contra Costa, and San Francisco Counties were part of the Medi-Cal Two-Plan model where enrollees can choose between a publicly run local initiative plan and a private commercial plan. Alameda Alliance for Health (Alameda Alliance), Contra Costa Health Plan, and San Francisco Health Plan served as the local initiative plans, with Anthem serving as the longtime commercial plan in each county. Also, beginning in 2013, the local initiative plans subcontracted with Kaiser as part of the consolidation of California’s Children’s Health Insurance Program into Medi-Cal.

In 2024, however, Alameda and Contra Costa both switched to the Medi-Cal Single Plan model. As originally conceived, this would have meant Alameda Alliance and Contra Costa Health Plan were the sole Medi-Cal health plan in each county. However, on a parallel track, DHCS awarded Kaiser a no-bid statewide contract, enabling Kaiser to bypass subcontracting with the local plans. As a result, Kaiser now offers coverage directly to Medi-Cal enrollees. Notably,

unlike the other Medi-Cal health plans, Kaiser limits Medi-Cal enrollment to those who were Kaiser members within the preceding 12 months or who are immediate family members of a current Kaiser member.¹⁴ Even with these limitations, Kaiser reportedly has been surprised by the number of “new” members — those who were not previously enrolled in Kaiser under the local health plan subcontracts — who have enrolled with the health plan since 2024.

Kaiser has been among the highest-performing Medi-Cal plans statewide in terms of quality for many years. As a subcontractor to the local health plans, Kaiser’s quality scores were combined with each contracted plan for reporting purposes, and one market observer noted the local health plans have had to “level up” now that they can no longer count Kaiser’s performance as part of their quality scores.

Local Plans Cover Most Medi-Cal Enrollees

Across the region, Medi-Cal managed care enrollment as a share of total Medi-Cal enrollment has grown significantly, increasing from 76% of enrollees in managed care in 2019 to 94% in 2024, reflecting the state’s push to enroll most Medi-Cal enrollees into managed care (Table 8).

TABLE 8. Medi-Cal Enrollment Overview,
Bay Area vs. California, 2019 and 2024

	BAY AREA		CALIFORNIA	
	2019	2024	2019	2024
Total Medi-Cal enrollment	880,964	1,077,336	12,778,575	14,796,389
Medi-Cal as share of population	24%	30%	32%	38%
Share of Medi-Cal in managed care	76%	94%	82%	94%

Source: “Certified Eligibles by Delivery System and Plan” (August 9, 2024), California Department of Health Care Services.

As a result of Kaiser’s direct contract and changes to the Medi-Cal managed care models, two health plans are available in Alameda and Contra Costa (the local initiative and Kaiser), and three plans are available in San Francisco (the

local initiative, Anthem, and Kaiser). Together, Alameda Alliance, Contra Costa Health Plan, and San Francisco Health Plan cover more than 850,000 (82%) of the region’s Medi-Cal enrollees. Kaiser has 14.8% (Alameda County) and 17.6% (Contra Costa County) of Medi-Cal managed care enrollment (Table 9). In San Francisco County, Anthem enrolls 14.8% of managed care enrollees, while Kaiser enrolls 9.0%.

TABLE 9. Medi-Cal Managed Care Plans by County, Bay Area, 2019 and 2024

County	Plan	MARKET SHARE BY COUNTY	
		2019	2024
Alameda	Alameda Alliance for Health	80.8%	84.9%
	Kaiser Permanente	0.0%	14.8%
	Anthem Blue Cross Partnership Plan	18.9%	0.0%
Contra Costa	Contra Costa Health Plan	86.9%	82.3%
	Kaiser Permanente	0.0%	17.6%
	Anthem Blue Cross Partnership Plan	13.1%	0.0%
San Francisco	San Francisco Health Plan	87.3%	75.7%
	Anthem Blue Cross	12.0%	14.8%
	Kaiser Permanente	0.0%	9.0%

Note: Plan-level Medi-Cal managed care market share is as of December 2019 and December 2024. Source: “Medi-Cal Managed Care Enrollment Report” (data through January 2025), California Department of Health Care Services.

Alameda Alliance covers more than 400,000 Medi-Cal enrollees, as well as about 5,800 In-Home Supportive Services (IHSS) workers who provide in-home assistance to eligible Medi-Cal patients so they can remain safely in their own homes. With Anthem’s exit from the county, Alameda Alliance added 81,000 Anthem Medi-Cal members but lost 51,000 members to Kaiser. Also in 2024, Alameda Alliance enrolled 37,000 undocumented county residents between the ages of 26 and 49 newly eligible for Medi-Cal. The health plan contracts with providers on both a fee-for-service (FFS) and risk basis.

Contra Costa Health Plan covers more than 262,000 Medi-Cal enrollees. The health plan also offers two other products: a commercial product available to Contra Costa County

employees, including health plan employees, and one for IHSS workers. When the county launched the Single Plan model in 2024, Anthem’s 34,000 members transferred to Contra Costa Health Plan, about the same number of members who transferred to Kaiser under the direct contract. The health plan is part of the Contra Costa County health department (Contra Costa Health), which operates a county hospital and extensive network of Federally Qualified Health Centers, which form the core of the health plan’s provider network. The health plan also contracts with noncounty providers, including hospitals and medical groups in the region. Although Contra Costa Health Plan contracts with providers primarily on an FFS basis, the plan is working with a subset of contracted primary care providers (PCPs) to implement a pay-for-performance program tying incentive payments to performance on quality measures.

San Francisco Health Plan covers more than 180,000 Medi-Cal enrollees. With the advent of Kaiser’s direct contract, approximately 16,000 members transitioned out of San Francisco Health Plan at the beginning of 2024. The plan operates two additional lines of business: one for county workers and one for IHSS workers. The plan also is the longtime third-party administrator of the county’s Healthy San Francisco program, which provides care for uninsured residents ineligible for other coverage. The plan contracts with 10 networks made up of medical groups and affiliated hospitals. Along with the local public hospital (Zuckerberg San Francisco General Hospital), the health plan contracts for hospital services with Chinese Hospital, Sutter California Pacific Medical Center, and UCSF Health. The health plan’s network medical groups include community health centers (CHCs) and the county-owned San Francisco Health Network, as well as private medical groups. In the past, San Francisco Health Plan primarily contracted with providers on a capitated basis but has moved away from this strategy, resulting in contracts now being evenly split between risk-based and FFS approaches.

Health Systems Double Down on Expansion

The Bay Area hospital market is highly concentrated, leaving only a handful of independent hospitals without ties to the larger regional health systems. Kaiser and Sutter Health are the dominant systems in the region, followed by UCSF Health, which continues to expand in Alameda and Contra Costa Counties. The major systems all have new leadership since the previous study was completed in 2020–21 and reportedly all have growth aspirations, particularly in the East Bay. As one market observer said, “Competition is more intense now” than it has ever been.

The payer mix for hospitals in the region has shifted in recent years, with more revenue from government payers and less from commercial payers, reflecting Medi-Cal coverage expansions and aging of the regional population. Some respondents noted that Medi-Cal can pay better than Medicare if the hospital qualifies for any of the supplemental payments (e.g., disproportionate share hospital funding, directed payment programs) intended to help bridge the gap between Medi-Cal base rates paid by the health plans and the costs of providing care.

As shown in Table 10, the region has slightly more available beds per 100,000 people than California as a whole. Hospital net income margins (-2.3%) are much lower than the California average (4.5%), while operating expenses per adjusted patient day are about 40% higher.

Region Divided into Hospital Submarkets

Even as the major health systems — Kaiser, Sutter, and UCSF Health — expand regionally, the Bay Area continues to have hospital submarkets reflecting the region’s size, sprawling geography, and traffic congestion, which has largely reverted to prepandemic gridlock. In each submarket, along with hospitals operated by each major health system, there are smaller independent providers and county-run safety-net systems.

TABLE 10. Acute Care Hospitals, Overview, Bay Area vs. California, 2023

	Bay Area	California
Number of facilities	28	334
Beds (available) per 100,000 population	203	198
Number of discharges	284,760	3,148,191
Net income margin	-2.3%	4.5%
Operating expenses per adjusted patient day	\$7,186	\$5,117

Notes: *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Operating expenses per adjusted patient day* equal total gross patient revenue divided by gross inpatient revenue times the number of inpatient days.
Source: 2023 *Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

The **Inner East Bay** includes the portions of Alameda and Contra Costa Counties bordering San Francisco Bay, including the cities of Berkeley, Oakland, and Richmond. Kaiser and Sutter are the dominant providers in this submarket, which also includes UCSF Benioff Children’s Hospital Oakland; Washington Health, which operates a district hospital in Fremont; and the public Alameda Health System, which includes several safety-net hospitals.

In the **Eastern Alameda and Contra Costa Counties** submarket, John Muir Health, Kaiser, Tenet Health, and Sutter serve Contra Costa County residents. John Muir operates two hospitals and owns a minority interest in a third with Tenet Health, Kaiser operates two hospitals, and Sutter operates a hospital in Antioch in east Contra Costa County. In southeastern Alameda County, Stanford Health Care operates a hospital in Pleasanton, in the Tri-Valley area.

In the **San Francisco** submarket, Kaiser, Sutter, and UCSF Health all operate hospitals, some with multiple campuses. Chinese Hospital is also in San Francisco, and San Francisco County operates Zuckerberg San Francisco General Hospital.

Kaiser Remains Market Leader

Kaiser is widely viewed as the Bay Area market leader, accounting for 25% of all hospital inpatient discharges in the region (Table 11). Medicare patients account for 46% of

Kaiser's inpatient discharges, while Medi-Cal accounts for only 9%, reflecting Kaiser's well-established practice of limiting Medi-Cal enrollment. Headquartered in Oakland, Kaiser is a closed-model HMO with a vertically integrated delivery and financing system, which includes a health plan, Kaiser-owned hospitals, and a large medical group, The Permanente Medical Group. In the Bay Area, Kaiser operates six hospitals across seven campuses: one in San Francisco, one that straddles Alameda and Contra Costa Counties with campuses in Oakland and Richmond, and two additional hospitals each in Alameda County and Contra Costa County.

In 2021, Kaiser opened a new 66,000-square-foot outpatient building in Berkeley, with approximately 70 exam rooms, providing adult and family medicine, obstetrics and gynecology, and pediatrics.¹⁵ Kaiser also opened a new 4,000-square-foot clinic in the Salesforce Transit Center in San Francisco, at the western end of the Bay Bridge, in 2022. The clinic offers same-day and walk-in doctor's visits as well as laboratory services.¹⁶ Although Kaiser has been focused on expanding outpatient capacity in the Bay Area, a respondent noted that Kaiser also may eventually expand the system's Richmond hospital campus, which has just 50 licensed beds.

Sutter Looks to Expand

Sutter is the second-largest Bay Area health system, accounting for 22% of discharges across the three counties. Medicare patients account for 43% of Sutter's inpatient discharges, and Medi-Cal accounts for an additional 29%. Sutter operates six hospitals across the region — three in Alameda County, two in San Francisco, and one in Contra Costa County.

Sutter is particularly dominant in Alameda County, where the health system operates the 354-bed Summit Hawthorne campus in Oakland and the 393-bed Alta Bates campus in Berkeley. The Alta Bates campus, which does not meet state seismic standards, has the sole non-Kaiser emergency department (ED) between Berkeley and Vallejo, to the north in Solano County. Rather than rebuild the hospital, Sutter plans to build a new 200-bed hospital in neighboring Emeryville, which will include an ED and outpatient facility. Alta Bates will remain open until the new hospital is completed and then be converted into an ambulatory surgical center and urgent care clinic. A skilled nursing facility may also be part of the Alta Bates facility.¹⁷

TABLE 11. Systems of Hospitals,
Bay Area, 2023

Hospital System	Hospitals in System	Available Beds	Occupancy (Available Beds)	Share of Discharges in Region	DISTRIBUTION OF DISCHARGES BY PAYER TYPE			Net Income Margin	Current Ratio	Operating Expenses per Adjusted Patient Day
					Medicare	Medi-Cal	Commercial			
Sutter Health	6	1,593	60%	22%	43%	29%	26%	-7%	4.5	\$6,741
Kaiser Foundation Hospitals	6	1,319	65%	25%	46%	9%	44%	2%	n/a	\$6,500
University of California, San Francisco	2	977	88%	15%	31%	37%	31%	-4%	2.1	\$11,061
John Muir Health	2	634	74%	11%	46%	22%	32%	2%	1.7	\$6,939
Bay Area	28	7,283	65%	100%	42%	28%	29%	-2%	1.9	\$7,186
California	334	77,339	64%	n/a	42%	31%	25%	4%	1.6	\$5,117

Notes: *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Current ratio* is current assets divided by current liabilities. This ratio shows the dollar amount of current assets per dollar of current liabilities. It is a gross indicator of the facility's liquidity. Usually, a ratio of 2.0 or more indicates a healthy liquidity position. *Adjusted patient day* equals total gross patient revenue divided by gross inpatient revenue times the number of inpatient days. The Bay Area row includes all hospitals in the region, including those not affiliated with a system. *Distribution of Discharges by Payer Type* may not add to 100% because *Other Indigent* and *Other Payers* are excluded.

Source: 2023 Pivot Table - Hospital Annual Selected File, California Department of Health Care Access and Information.

In eastern Contra Costa County, 141-bed Sutter Delta Medical Center serves Antioch and nearby communities, including Brentwood, Discovery Bay, Oakley, and Pittsburg. Within the last decade, Sutter has opened two new hospitals in San Francisco — the 120-bed California Pacific Medical Center (CPMC) Mission Bernal campus and 274-bed Sutter CPMC Van Ness campus.

Reflecting larger industry trends, Sutter is expanding outpatient facilities across the region, including plans for 27 ambulatory care centers by 2027.¹⁸ In 2021, Sutter and Stanford Health announced plans to partner on a new cancer center in Oakland, adjacent to Sutter's Summit Hawthorne campus. The 167,000-square-foot facility is scheduled to open in late 2026. Sutter also is expanding in the Tri-Valley area, opening an outpatient facility in Livermore in 2025 and two outpatient facilities in Pleasanton.¹⁹ In 2024, Sutter purchased property in Hercules, a city in Contra Costa County north of Richmond, to open an ambulatory care center along the busy I-80 corridor.²⁰ In San Francisco, Sutter is building a new neurological outpatient facility adjacent to the CPMC Mission Bernal campus on the site of the former St. Luke's Hospital. The 121,000-square-foot complex is slated to open to patients in 2028. Sutter is also building a 124,000-square-foot cancer center on CPMC's Pacific campus.²¹

The Sutter Bay Medical Foundation represents the consolidation of various Bay Area medical groups into a single organization. The foundation, which has more than 2,000 physicians across the larger Bay Area, includes three medical groups serving Alameda, Contra Costa, and San Francisco Counties — Palo Alto Foundation Medical Group, Sutter East Bay Medical Foundation, and West Bay Medical Group.

In 2025, Sutter settled an antitrust lawsuit that alleged the health system used its market power to require health plans to contract only with Sutter hospitals, preventing health plans from directing members to lower-cost, non-Sutter

hospitals. While a jury initially ruled in Sutter's favor in 2022, the Ninth US Circuit Court of Appeals reversed this decision and remanded the case for a new trial. Sutter and the plaintiffs reached a \$228.5 million settlement shortly before the trial was scheduled to begin.²² As described in the 2020–21 Regional Markets Study, Sutter also settled an antitrust lawsuit with California's attorney general in 2019.

UCSF Looks to Solidify Market Position

UCSF Health is one of two academic medical centers in the greater Bay Area — the other is Stanford Health Care based in Palo Alto in Santa Clara County. UCSF Health has three hospital campuses in San Francisco: Parnassus Heights, Mission Bay, and Mount Zion. Along with a children's hospital on the Mission Bay campus, UCSF Health operates the 155-bed Benioff Children's Hospital Oakland, a partnership that began in 2014. In 2024, UCSF Health broke ground on a new San Francisco hospital that will replace the 600-bed Moffitt/Long Hospital on the Parnassus campus. Slated to open in 2030, the 15-story, 880,000-square-foot facility will expand the system's capacity, adding 22 new operating rooms and expanding the ED from 39 to 71 beds. The new 324-bed hospital will be known as the UCSF Health Helen Diller Hospital.²³

UCSF Health also is expanding Benioff Children's Hospital Oakland, where a new seven-story, 277,500-square-foot hospital will replace two older buildings that no longer meet state seismic standards. The new facility will include a larger ED, a neonatal intensive care unit, and a 20-bed inpatient behavioral health unit.²⁴

UCSF Medical Group is UCSF Health's faculty practice with more than 2,000 physicians who teach and who also see patients at UCSF Health hospitals as well as county-owned Zuckerberg San Francisco General Hospital. UCSF Health also is affiliated with independent physician groups throughout the region, including Hill Physicians. In addition, UCSF Benioff

Children's Physicians is a medical foundation affiliated with the children's hospitals that both employs physicians directly and offers a partner model for physicians who want to maintain practice ownership. UCSF reportedly plans to hire 200 PCPs to expand primary care services across the region.

In a deal finalized in 2024, UCSF Health purchased 294-bed St. Francis Memorial Hospital and 159-bed St. Mary's Medical Center from Dignity Health. Both hospitals historically have served as key Medi-Cal hospitals in San Francisco and have struggled financially in recent years. In 2023, St. Mary's had a net income margin of -31%, while St. Francis had a net income margin of -22%. UCSF Health also acquired a Dignity medical group affiliated with the hospitals and Dignity's GoHealth urgent care clinics as part of the transaction.

While UCSF Health usually requires all providers to be UCSF faculty members, the former Dignity physicians are not subject to this requirement, enabling non-UCSF faculty physicians to continue seeing patients at both hospitals. As part of the purchase, the California attorney general required UCSF Health to continue participating in Medicare and Medi-Cal and to operate and maintain both hospitals at existing service levels. Neither St. Francis nor St. Mary's meets state seismic requirements, and UCSF Health will need to determine whether to rebuild them by the 2030 deadline.

Over the past decade, UCSF Health has implemented a strategy to expand regionally to address capacity issues at the health system's San Francisco campuses. UCSF Health reportedly turns away hundreds of patients referred for specialty care from other hospitals and health systems. Partnering with community hospitals across the region enables UCSF Health to ensure capacity for tertiary services like transplants and other highly specialized care at the health system's hospitals. These partnerships include Washington Health in Fremont and John Muir Health in Contra Costa County. UCSF Health also has partnered with Chinese Hospital in recent

years, which has helped Chinese Hospital address financial challenges.

Hospital respondents reported that UCSF Health's 2023 negative net income margin (-5%) was driven in part by a relatively high and increasing percentage of Medicare and Medi-Cal patients. In 2023, Medicare accounted for 37% of discharges, Medi-Cal accounted for 29%, and commercial patients accounted for 32% of UCSF Health's discharges. Respondents noted rising input costs also contributed to the health system's relatively challenging financial performance, including higher salaries to recruit physicians to practice in the Bay Area and rising pharmacy and supply costs.

UCSF Health is largely paid FFS rates under accountable care organization (ACO) performance improvement contracts with the major regional commercial health insurers. According to one respondent, to succeed going forward, UCSF Health will have to be able to accept and manage risk, adding that UCLA Health has obtained a Knox-Keene license and plans to launch an MA plan. UCLA Health will be the first UC health system to take this step, and the other UC health systems are watching to see whether UCLA Health can manage risk well enough to make MA financially feasible.

John Muir Expands Amid Financial Challenges

John Muir Health is an independent nonprofit health system that plays an important role in providing access to hospital and physician services for Contra Costa County residents, operating a 396-bed hospital in Walnut Creek and a 238-bed hospital and 73-bed psychiatric hospital in Concord. In partnership with Stanford Medicine Children's Health, the Walnut Creek campus operates the only pediatric intensive care unit as well as the only Level II trauma center in the county. As one market observer said, "They are the only game in town in Walnut Creek and Concord."

John Muir Health has a 49% ownership share in San Ramon Regional Medical Center in southeastern Contra Costa County, with investor-owned Tenet Health, headquartered in Texas, owning the other 51%. In 2023, John Muir Health planned to acquire Tenet's portion, but the Federal Trade Commission and the California attorney general blocked the sale, citing concerns the deal would eliminate John Muir Health's main competition along the I-680 corridor and increase health care costs for patients.²⁵ For now, the hospital will continue to be jointly owned, since Tenet cannot sell to another health system without John Muir Health's approval.

Over the last 15 years, John Muir Health has experienced a significant change in payer mix. Commercial insurance accounted for 50% of the health system's revenue in 2009, according to a respondent, while Medicare and Medi-Cal accounted for about 42% and 8%, respectively. By 2023, the hospital's payer mix had shifted significantly, with Medicare accounting for 46% of discharges, Medi-Cal accounting for 22%, and commercial coverage accounting for 32%. Essentially, John Muir Health has become more reliant on government payers, contributing to financial challenges, and respondents noted that growth in Medi-Cal patients has put financial pressure on the health system. John Muir Health also embraced MA enrollment growth, taking full risk for MA contracts, but struggled to manage facility risk for MA patients, losing an estimated \$40 million to \$50 million and ultimately exiting risk-based facility MA contracts. John Muir Health continues to accept risk for professional services from MA health plans.

To address financial issues, John Muir Health has worked to reduce costs and improve clinical efficiency across inpatient and outpatient settings. For example, in 2019, the system contracted with Optum to manage the delivery of a range of administrative functions, including information technology, revenue cycle management, and analytics. John Muir Health also is diversifying revenue sources by growing its

ambulatory care footprint in Contra Costa. The health system reports that these efforts are paying off, with operating cash flow moving from negative in 2022 to positive by 2023. Even so, several respondents commented on the health system's financial challenges and speculated whether one of the region's larger health systems ultimately will acquire John Muir Health.

John Muir Health has expanded outpatient services in southern Contra Costa County, opening a 52,000-square-foot outpatient facility in San Ramon in 2025 and consolidating primary and specialty care and lab, imaging, and urgent care services at the new facility. John Muir Health also plans a second expansion of the San Ramon facility, scheduled to open in early 2027, that will nearly double its footprint. Since 2018, John Muir Health and UCSF Health have operated an outpatient center offering primary and specialty care services as well as lab, imaging, and urgent care services in Berkeley in Alameda County. The two systems opened a cancer center at this location in 2020 and, in 2024, opened the 155,000 square-foot UCSF-John Muir Health Jean and Ken Hofmann Cancer Center on John Muir Health's Walnut Creek campus.

The John Muir Physician Network is a nonprofit medical foundation that includes 400 physicians associated with John Muir Medical Group, John Muir Health Specialty Medical Group, John Muir Health Cancer Medical Group, and John Muir Health Cardiovascular Medical Group, as well as approximately 800 independent physicians. The John Muir Medical Group also provides hospitalist coverage for both John Muir Health hospitals.

Stanford Maintains East Bay Presence

Based in Palo Alto, in the heart of Silicon Valley, Stanford Health has been expanding into the East Bay since 2015 when the system acquired 167-bed ValleyCare Medical Center in Pleasanton. To solidify the relationship, Stanford renamed the hospital in 2022 to Stanford Health Care Tri-Valley. The

hospital includes the only ED in Pleasanton and one of two EDs in the fast-growing Tri-Valley area. Stanford Tri-Valley estimates that approximately 2,000 ED patients leave without ever being seen each year, and Stanford intends to expand the hospital's ED, announcing plans in 2025 to construct a new 66,000-square-foot wing. Also in 2022, Stanford purchased a Pleasanton office park and opened an ambulatory center to serve Tri-Valley patients.²⁶

Washington Health Expands

In southern Alameda County, 402-bed Washington Health is owned and operated by the Washington Township Health Care District, a public entity. Washington Health includes the multispecialty Washington Hospital Medical Group with more than 500 physicians and other providers. The system's hospital was designated a provisional Level II trauma center in 2024. Washington Health also plans to complete a new 200,000-square-foot hospital tower by January 1, 2030, when state seismic standards take effect. The addition will house a birthing center, special care nursery, and medical-surgical units. Additionally, Washington Health and UCSF Health have operated the UCSF-Washington Health Cancer Center since 2016, embarking on a 15,000-square-foot expansion in 2024, with completion expected in early 2026. Washington Health and UCSF Health also are scheduled to open a new outpatient facility in 2027, including imaging services and an ambulatory surgical center, in Fremont's growing Warm Springs neighborhood.²⁷

Chinese Hospital Receives State Distressed Hospital Loan

Chinese Hospital, in the heart of San Francisco's Chinatown, serves a predominantly Chinese patient population with 81 beds. Medi-Cal accounts for 9% of discharges, Medicare accounts for 56%, and commercial coverage accounts for 30%. The hospital also operates five outpatient clinics in San Francisco and neighboring San Mateo County to the south. The hospital's 2024 net income margin was -15.5%. In 2023, Chinese Hospital was one of two hospitals in the

region to receive a loan from the state's Distressed Hospital Loan Program (DHLP), which offered \$300 million statewide in interest-free, working capital loans to nonprofit and publicly operated financially distressed hospitals. As part of the \$10.35 million loan's required turnaround plan, the hospital is working to negotiate better payment rates from commercial and public payers.²⁸ The hospital also is working with the San Francisco Department of Public Health to obtain licensure and certification for a 23-bed skilled nursing facility and sub-acute care unit.

St. Rose Hospital Affiliates with Alameda Health System

In Hayward, 171-bed St. Rose Hospital, an independent nonprofit hospital now affiliated with Alameda Health System, plays an important role serving the Medi-Cal and Medicare populations in central and southern Alameda County. The hospital operates the only ED in Hayward, which has about 28,000 visits a year. In 2023, Medicare accounted for 56% of the hospital's discharges, and Medi-Cal accounted for 36%.

The hospital has struggled financially in recent years, which is reflected in a 2023 net income margin of -8.8%, and applied for DHLP assistance in 2023. In the application to justify the loan, St. Rose cited changes in service volume, declining inpatient and outpatient volumes, difficulties placing patients ready for discharge into lower-acuity settings, and reimbursement that did not keep pace with increasing costs. St. Rose was awarded a \$17.65 million DHLP loan in August 2023.

On a parallel track, the St. Rose board of directors commissioned a study, in conjunction with Alameda County and the Eden Health District, on St. Rose's long-term sustainability. Even with the DHLP loan, the study concluded that St. Rose would require significant additional public funding to regain financial viability and recommended that the hospital seek to affiliate with a larger system.²⁹ As a result, St. Rose and the Eden Health District issued a request for proposals to identify a suitable hospital partner and selected Alameda Health

System, the county's public hospital system. The state attorney general approved the affiliation in late 2024.

Hospitals Surpass State Spending Control Targets

In 2024, the California Office of Health Care Affordability (OHCA) established an annual statewide spending growth cap based on the average growth rate of median household income between 2002 and 2022. The growth cap will be phased in, with a 3.5% growth target in 2025 and 2026 that drops to 3.2% in 2027 and 2028 before settling at 3.0% in 2029 and beyond. The growth target applies to health plans, hospitals, and all provider organizations with at least 25 physicians. Moreover, in 2025, OHCA established an additional, separate spending cap for the hospital sector that equals the statewide cap. The state also identified seven "high-cost" hospitals, including Washington Health, that are subject to tighter growth caps: In 2026, the growth target is 1.8%, decreasing to 1.6% in 2029.

A number of respondents expressed concern about the ability of hospitals to meet the OHCA growth targets. As one market observer noted, "How can you tell hospitals they are capped at 3.5% when labor costs are rising by 5%, and labor is 60% of our costs?" Other cost drivers cited by respondents include pharmacy costs reportedly rising by "double-digit percentages," energy costs, and medical supplies. Hospitals also are concerned about the potential impact of new federal tariffs on supplies as well as pharmaceuticals, many of which are manufactured in Europe, India, or China. Further, several respondents noted the high costs for hospitals of mandatory seismic work to meet the state's 2030 compliance deadline, with one commenting that seismic requirements are "a very profound piece of the cost puzzle for hospitals."

In response to the growth targets, hospital respondents reported closely analyzing cost data to identify cost reductions, including shifting patients to lower-cost outpatient settings, which were noted as important to meeting the

OHCA targets. Reviewing care models and implementing stronger utilization management for pharmaceuticals also reportedly were under consideration as hospitals consider how to respond to the targets. Even so, health plan respondents reported that hospital systems asked for rate increases higher than the 3.5% target for 2025 and 2026.

Physician Sector Continues Consolidation

While the Bay Area's physician supply is the highest in the state, the number of independent practice associations (IPAs) and medical groups in the region has continued to decline in recent years. Market observers commented that "the economics don't work for private practice" because smaller practices and groups do not have the scale and resources to participate in risk-based payment arrangements and lack the bargaining power of the large health systems with insurers. One respondent noted that commercial payment rates for physicians affiliated with a large health system can be as much as 300% of the Medicare rate, while independent physician rates can be as low as 90% of Medicare. The payment disparity puts independent physicians and medical groups at a disadvantage when recruiting new physicians as well as when trying to retain clinicians over time.

Although the large health systems and their medical foundations continue to affiliate with or employ more physicians, local medical groups also have been acquired by publicly traded entities. For example, publicly traded Astrana Health, with more than 10,000 physicians and other clinicians across three states, entered the market by acquiring several medical groups, including Bay Area Care Partners in Alameda and Contra Costa; All American Medical Group in San Francisco; and Jade Health Care Group in San Francisco. Headquartered in Walnut Creek, BASS Medical Group, one of the region's last large primary care and multispecialty groups, with more than 300 physicians, sought capital to support its management services organization (MSO), and in 2021, publicly traded Privia Health invested in the MSO. Even Brown & Toland, a

long-standing IPA in the region, was acquired in 2020 by Altai, a sister company of Blue Shield of California, adding to the shift of physicians to larger organizations.

Changes in payer mix toward less lucrative public payers — as noted by hospital respondents in the region — also apply to physicians, contributing to challenging finances. In addition, changing physician demographics add to the ongoing shift away from independent practice. As happened nationally, the Bay Area saw a spike in physician retirements during the pandemic, which continued postpandemic. As physicians reach retirement, they close or sell their practices. New, younger physicians are less interested in buying or opening practices, preferring employment with larger organizations that offer more stability and a better work-life balance than private practice.

Hill Physicians Seeks to Keep Private Practice Viable

Hill Physicians, among the largest physician-owned IPAs in Northern California, has more than 6,000 primary care and specialist physicians serving almost 400,000 patients across 14 counties in the Bay Area, Sacramento, and the Central Valley. Since the last study, Hill has grown significantly, with more than 3,500 physicians in Alameda, Contra Costa, and San Francisco Counties.³⁰ The IPA also owns PriMed Management Consulting Services with several partners, including Blue Shield and Anthem; PriMed is an MSO that supports Hill providers.

As many Hill physicians near retirement age, the IPA is working to recruit and retain physicians to offset this trend. Hill sees promise in AI-based technologies that can help providers improve workflows, including a scribe function embedded in the IPA's epic electronic health record that creates a first draft of visit notes that the clinician edits and finalizes, enabling physicians to see more patients in a day and to manage their workload more efficiently, reducing the

likelihood of burnout. Hill also offers their providers support for recruitment activities as well as forgivable loans that can be used to pay costs such as signing bonuses. In 2023, Hill provided support for 28 searches, resulting in the hiring of 18 physicians and advanced practice providers.³¹ In 2024, Hill provided \$1.8 million for loans and recruiting fees for their providers.³²

Hill takes professional risk across all products in the region, including commercial HMO, PPO, MA, and Medi-Cal. The IPA also holds a restricted Knox-Keene license, enabling Hill to take full risk in the MA market in Sacramento and, more recently, in San Joaquin County in the Central Valley. MA health plans increasingly want contracted providers that can take full risk, and Hill has experienced an increase in full-risk business as a result. Hill currently has 15,000 full-risk MA enrollees.

Although Hill participates in multiple commercial ACOs, participation has become more challenging, as health plans expect providers to continuously improve quality and lower costs to achieve shared savings. This structure does not reward organizations like Hill that have significant experience managing costs and risk and hence have less room for improvement. At least one health plan in the region reportedly has started to require providers to take downside financial risk, which Hill also has found challenging. Typically, the health plan pays Hill a case management fee and pays the providers directly for services. If the expected cost and quality targets are not met, Hill must absorb any losses, as there is no way to recoup reimbursement from its affiliated providers.

While most Hill physicians remain in private practice, Hill created an employed group practice model in 2016. Known as Hill Health, the model was intended to give independent providers an alternative to joining Sutter or Kaiser in the East Bay. However, Hill has struggled with the economics of its

employed physician group practice model, which remains small with just 12 physicians and other clinicians in Oakland.

Altais Looks to Expand

Launched by Blue Shield in 2019 with a goal of enabling physicians to remain in private practice, Altais, now a subsidiary of Ascendium and sister company of Blue Shield, is an MSO that supports a provider network of more than 10,000 physicians — about 6,000 independent and 4,000 affiliated with medical groups or IPAs — across the state, mostly in the greater Bay Area. Altais supports care for more than 500,000 patients in California. In 2020, shortly after launching, Altais acquired Brown & Toland, which then had about 2,700 physicians, including Brown & Toland's employed model, formerly known as BT Health and now known as Altais Medical Group. Given interest among younger physicians for employment, Altais anticipates the medical group will grow as older physicians retire.

In recent years, Altais has expanded beyond the Bay Area. In 2021, Altais acquired Los Angeles-based Family Care Specialists Medical Group, including more than 20 providers, and opened a multispecialty medical group in Riverside County in 2022. Altais seeks to become a multistate provider organization, and one respondent noted that the national Blue Cross Blue Shield Association is pushing member health plans to “become a provider,” following the United/Optum model, to remain competitive.

Altais pays providers under both FFS and capitated arrangements based on provider preference and ties incentive payments to performance. Altais takes risk for commercial contracts across HMO and PPO products and has seen commercial growth recently. Altais also participates in MA contracts and takes full risk, although MA health plan changes regionally have been disruptive and challenging to manage. In addition, Altais supports provider participation in

value-based payment arrangements, including the Medicare Shared Savings Program, through data analytics, workflow improvements, and practice transformation.

UCSF Health Expands Ownership of Canopy Health

Canopy Health was founded in 2015 by UCSF Health, John Muir Health, and Hill Physicians to develop a regional provider network to compete with Kaiser and Sutter, especially for commercial patients. Under the closed-network model, Canopy patients must receive care from network providers except for emergency care. Canopy also offers enrollees the ability to access specialty care and ancillary services across the network through referrals to network providers who may belong to different medical groups than the enrollee's PCP. Although Canopy has expanded its provider network over the last several years, the venture still lacks an aligned hospital in the Oakland-Berkeley area of the East Bay, since Kaiser and Sutter are the only options outside the county health system in Alameda.

Canopy holds a restricted Knox-Keene license to contract with health plans and take full risk on behalf of the providers in its network. Canopy partners with Health Net to participate in the UC Blue and Gold HMO plan for UC employees in the Bay Area. Canopy takes full risk for these members, with Health Net retaining responsibility for pharmacy, transplants, and certain high-cost injectables. In addition, until recently, Canopy's products included a commercial HMO through both Health Net and United, an exclusive provider organization product with United, and an MA product also with United.

Canopy has not been immune to challenges in the regional MA market and, like other provider organizations, has struggled to manage full risk for both hospital and professional services. Together, these factors reportedly led to a \$100 million loss on Canopy's MA line of business, requiring the partners to step in and meet Knox-Keene financial

solvency requirements. These capital calls to address financial solvency, low enrollment growth, and John Muir Health's adverse experience with full risk for MA ultimately led John Muir Health to sell its Canopy stake to UCSF Health in the first half of 2025. Although the deal was still awaiting approval by the California Department of Managed Health Care at the time of this writing, if finalized, it would result in UCSF Health owning 94.5% of Canopy, and Hill Physicians owning the remainder. John Muir Health's hospitals and providers will continue to participate in the Canopy network.

Market observers noted that Canopy, with 40,000 enrollees, has not yet gained the scale needed to succeed, which would require 75,000 to 100,000 enrollees. As a result of financial issues and inability to scale enrollment, Canopy exited the MA market at the end of 2024 and, by the end of 2025, planned to exit the commercial market except for the Health Net UC Blue and Gold plan. A market observer commented that UCSF Health may be interested in taking full risk, and Canopy's existing restricted Knox-Keene license could provide a contracting vehicle to do so.

Counties Operate Robust Safety Net

Known across California for a strong health care safety net, all three Bay Area counties operate a public hospital or health system as well as outpatient clinics. In addition, noncounty CHCs also serve safety-net patients across the region.

County Safety Nets Centered on Public Hospitals and Health Systems

Alameda Health System is the public health system serving Alameda County residents. The system's flagship hospital is Wilma Chan Highland Hospital in Oakland, the only East Bay Level I trauma center. The system also includes John George Psychiatric Hospital in San Leandro; San Leandro Hospital; the Fairmont Rehabilitation and Wellness Center in Castro Valley, which includes a hospital-based skilled nursing facility; and a Federally Qualified Health Center (FQHC) with four

sites. In addition, the system operates the 247-bed Alameda Hospital on behalf of the City of Alameda Health Care District. Similarly, Alameda Health System operates St. Rose Hospital in Hayward, which had struggled financially for many years.

In 2023, Medi-Cal accounted for 58% of discharges across Alameda Health System, and Medicare accounted for 33% of discharges.³³ The system is exploring how to appeal to commercial patients to ease reliance on public payers, as well as working to increase primary care capacity.

In contrast to San Francisco and Contra Costa Counties, Alameda Health System operates as a public hospital authority. Though the Alameda County Board of Supervisors appoints the system's board of trustees, the board operates independently from the county. Reflecting strong public support for the safety net, the system receives about \$100 million annually from a dedicated county sales tax, accounting for about 10% of the system's budget.

As part of affiliating with St. Rose, Alameda Health System intends to expand and upgrade the hospital, with plans to add a skilled nursing facility and a kidney dialysis center. The system also plans to base its prenatal care programs for low-to medium-risk births at St. Rose. In addition to plans for St. Rose, Alameda Health System has continued to upgrade and expand facilities over the past several years. Alameda Hospital is currently undergoing seismic retrofitting to meet state standards. This project also includes the addition of an 18-bed skilled nursing facility. Scheduled for completion by 2028, the work is being financed by the system and the city of Alameda using funds generated from a local parcel tax.

Owned by the San Francisco Department of Public Health (SFPDH), Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) is part of the San Francisco Health Network. The 397-bed hospital has the only Level I trauma center for San Francisco and northern San Mateo County and

operates the only county psychiatric emergency service unit, which is licensed for 18 patients. As a safety-net provider, the hospital relies heavily on public payers, with Medi-Cal accounting for 51% of discharges and Medicare accounting for 37% in 2023. Commercial discharges account for 11% of ZSFG's discharges, mostly due to the hospital's trauma center. The hospital reportedly operates at capacity. ZSFG and UCSF's School of Medicine have a long-standing history, and all the hospital's physicians are on the UCSF faculty. Reflecting this relationship, UCSF opened a new research and academic building on the ZSFG campus in 2023.

In addition to ZSFG, the San Francisco Health Network includes Laguna Honda Hospital and Rehabilitation Center, which offers short-term rehabilitation and long-term skilled nursing care. The facility lost federal Medicare and Medi-Cal certification in 2022 when inspectors found numerous deficiencies and safety violations at the 769-bed facility. Since Laguna Honda rarely accepts patients with commercial insurance, the hospital almost closed following the loss of its Medicare and Medi-Cal certifications. SFDPH worked with CMS to complete a two-year recertification process, instituting hundreds of changes to improve patient safety and comply with federal requirements, with the facility receiving full certification in 2024. Within the first year of receiving full recertification, the hospital achieved a five-star quality rating from CMS. While the hospital is licensed for 769 beds, it has operated with 649 beds since the sanctions. SFDPH sought a 120-bed expansion from CMS with a proposal to return to having three patients per room. CMS denied the request — only hospitals certified before 2016 are allowed to have “triple rooms.” Because Laguna Honda lost its certification and then was recertified in 2024, the hospital no longer met this criterion. To help address the region's housing shortage, the county intends to build 215 housing units for low-income seniors on the hospital campus. The complex also will include an adult day health care center and childcare

center for Laguna Honda staff, with construction scheduled to begin no sooner than spring 2027.³⁴

Operated by Contra Costa Health, the 167-bed Contra Costa Regional Medical Center in Martinez is the public hospital in Contra Costa County. The hospital operates a Level II neonatal intensive care unit and includes a 24-bed secure adult psychiatric unit. In 2023, Medi-Cal accounted for 74% of the hospital's discharges and Medicare accounted for 16%. In addition to the hospital, Contra Costa Health operates 11 FQHC clinics, including two on the hospital campus, reflecting the county's preference to “build rather than buy” outpatient services.

Community Health Centers Play Important Safety-Net Role

With 46 organizations operating more than 95 sites across the three counties, CHCs — including many designated as FQHCs — play a critical role in delivering safety-net services in the Bay Area (Table 12). The CHCs and FQHCs include a combination of county-run clinics, hospital-based clinics, and community-based clinics. As one market observer said, the CHCs “keep the safety net tethered together.” Among the community-based CHCs, Medi-Cal accounts for two-thirds of net CHC patient revenue in the region (compared to more than three-quarters statewide), and almost three-quarters of patients have incomes at or below the federal poverty level.

TABLE 12. Community Health Centers, Overview,
Bay Area vs. California, 2023

	Bay Area	California
Number of sites	95	1,139
Patients with incomes under 100% poverty level	74%	70%
Patients per capita	0.15	0.21
Encounters per capita	0.54	0.69
Medi-Cal as share of net patient revenue	66%	78%

Notes: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region, as this information is not reported to the California Department of Health Care Access and Information. Source: 2023 Primary Care Clinic Annual Utilization Data (November 2024), California Department of Health Care Access and Information, last updated October 31, 2024.

TABLE 13. Largest Community Health Center Systems, Bay Area, 2023

Community Health Center System	Encounters	Patients with Incomes Under 100% Federal Poverty Level	Medi-Cal as Share of Net Patient Revenue
Bay Area Community Health	290,346	88%	90%
La Clínica De La Raza	285,056	61%	92%
North East Medical Services	281,115	61%	49%
Lifelong Medical Care	233,154	85%	72%
Asian Health Services	136,510	61%	53%
Bay Area	1,920,418	74%	66%
California	26,871,453	70%	78%

Notes: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region, as this information is not reported to the California Department of Health Care Access and Information.

Source: 2023 *Primary Care Clinic Annual Utilization Data (November 2024)*, California Department of Health Care Access and Information, last updated October 31, 2024.

Along with CHCs operated by Alameda Health System and UCSF Health Benioff Children's Hospital Oakland, multiple community-based CHCs serve Alameda County, including three of the largest CHC systems in the region: Bay Area Community Health, La Clínica de la Raza, and Lifelong Medical Services (Table 13). Eight of the community-based CHCs belong to the Alameda Health Consortium, which has operated an IPA — Community Health Center Network (CHCN) — for many years. With Anthem's exit from Medi-Cal in the county, CHCN now contracts only with Alameda Alliance on behalf of member CHCs for 180,000 Medi-Cal members. CHCN takes financial risk for professional services and participates in the Alameda Alliance pay-for-performance program. CHCN also operates an internal pay-for-performance program and, in 2024, added a shared savings component for reductions in inpatient utilization with the goal of helping member CHCs prepare to take more risk-based payments. With the impending implementation of the Medi-Cal health plan D-SNP requirement, CHCN is interested in expanding into the MA market to retain patients as they age into Medicare. There is also concern that Kaiser will seek to expand its D-SNP enrollment by competing for Alameda Alliance's CHC dually eligible enrollees.

Contra Costa Health operates an extensive county-operated CHC network that includes 11 sites along the northern edge of the county, from Richmond in the west to Brentwood in the east. A handful of community-based CHCs, including La Clínica de la Raza and Lifelong Medical Care, also operate in the county. Each serves about 10,000 patients, with the county-run CHCs reportedly serving the majority of the Medi-Cal population. Further, with the change to the Single Plan model for Medi-Cal and Kaiser's entrance into Contra Costa as a direct Medi-Cal plan, the community-based CHCs lost Anthem members who moved to Contra Costa Health Plan or qualified for Kaiser coverage.

In San Francisco, 12 CHCs belong to the San Francisco Community Clinic Consortium (SFCCC), operating 30 sites and serving more than 120,000 people annually. The SFDPH also operates a CHC with 13 sites, including four on the ZSFG hospital campus. SFCCC CHCs reportedly provide about 55% of safety-net primary care services, with the county-run CHC providing a larger share of specialty care. In 2022, Lyon-Martin Community Health Center split off from HealthRIGHT 360, reversing a 2015 merger. Lyon-Martin received federal approval as an FQHC Look-Alike in 2024, enabling the CHC to receive enhanced cost-based Medicare and Medicaid rates but not federal grant funding available to FQHCs.

Founded in San Francisco's Chinatown neighborhood, North East Medical Services (NEMS) is the largest community-based CHC in San Francisco. NEMS operates 31 clinic sites across three counties, including 12 sites in San Francisco (the other sites are in San Mateo and Santa Clara Counties south of San Francisco), and one health center in Las Vegas, Nevada. Medi-Cal accounts for 49% of NEMS net patient revenue, while Medicare provides 37%. NEMS also has operated an MSO for many years.

In early 2021, NEMS launched a Program of All-Inclusive Care for the Elderly (PACE) in San Francisco. PACE helps

people — typically seniors eligible for both Medicare and Medicaid — meet their health care needs in the community instead of entering a nursing home or other care facility. NEMS also plans to open a new residential care facility for the elderly in 2026 to provide a supervised, nonmedical living environment with meals, housekeeping, personal care assistance for daily activities like bathing and dressing, and medication support for seniors who cannot live independently but do not require 24-hour nursing care.

NEMS holds a restricted Knox-Keene license and partnered with Health Net to launch an MA product, Golden Bay Health Plan, in 2022. NEMS also participated in the Medicare Accountable Care Organization Realizing Equity, Access, and Community Health Model, or ACO REACH, which was created to support Medicare providers in moving from FFS payments toward value-based payments. NEMS exited the model in 2025, reportedly due to profitability concerns. Building on its experience serving Medicare enrollees, NEMS reportedly will be the exclusive partner for San Francisco Health Plan’s D-SNP network for its first year of operation.

Robust Workforce Supply Overall, but Specific Shortages Remain

The concentration of large health systems, academic medical centers, and several medical schools across the greater Bay Area likely explains, in part, the robust local supply of health care professionals. Compared to California overall, the three-county Bay Area has significantly more physicians per 100,000 residents — 514 physicians regionally per 100,000 population versus 358 statewide (Table 14). Similarly, the region has more advanced practice providers — nurse practitioners (NPs) and physician assistants (PAs) — and behavioral health providers per 100,000 residents than California as a whole. The region also has more primary care and specialty physicians, including psychiatrists, than statewide.

TABLE 14. Health Care Workforce Supply,
Bay Area vs. California, 2024

	Bay Area (Percentage of Statewide Average)	California
LICENSED PROVIDERS PER 100,000 POPULATION*		
License Group†		
Physicians	514 (143%)	358
Advanced practice providers	145 (113%)	128
Nurses	1,331 (98%)	1,353
Behavioral health providers	488 (127%)	384
PHYSICIAN DETAIL BY SPECIALTY AND HOURS WORKED*		
Physicians per 100,000 population†		
Physicians working 20+ hours/week	401 (136%)	294
Primary care	164 (139%)	118
Specialty	236 (135%)	176
Psychiatry	26 (143%)	18

* License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). Physicians are MDs and DOs; advance practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.
† Allocation of physicians into specialties and hours of practice used the HCAI Physicians by Specialty and Patient Care Hours, as of April 3, 2024.
Source: “2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024,” custom data request, HCAI, received April 14, 2025.

Physicians in the three counties are less diverse in terms of race and ethnicity than the overall population (Table 15). Nearly half of physicians (46.8%) are White compared to a third of Bay Area residents (33.5%), while 37.8% of physicians are Asian compared to 29.9% of the regional population. Both Latino/x and Black people are significantly under-represented in the physician workforce regionally. Among advanced practice providers, nurses, and behavioral health providers, there is greater representation of racial and ethnic diversity compared to the overall population, with the exception of Latinos/x, who are underrepresented in all provider categories.

Even though the Bay Area, relative to elsewhere in California, has an abundance of providers, respondents noted that specialty care access challenges exist, especially for neurologists and behavioral health providers, including psychiatrists.

More generally, there are shortages of bilingual and multilingual providers. Some public sector respondents also noted that PCPs are in short supply. Several market observers commented that physician shortages may worsen as the workforce continues to age and retire — a trend that started during the pandemic and is projected to continue.

The Bay Area’s high cost of living adds to recruitment challenges, since physicians may have large educational loans. Public sector providers also noted the challenge of competing with the large private health systems for physicians. As one CHC respondent noted, “The CHCs train physicians, and then they leave for Sutter or Kaiser where they can make 40% more.”

TABLE 15. Physician and Health Workforce Characteristics,
Bay Area, 2024

	Physicians	Advanced Practice Providers	Nurses	Behavioral Health Providers	Population
RACE/ETHNICITY OF PROVIDERS*					
Latino/x, any race	6.9%	10.5%	11.7%	11.7%	23.2%
White, non-Latino/x	46.8%	48.1%	30.9%	30.9%	33.5%
Asian, non-Latino/x	37.8%	28.1%	42.8%	42.8%	29.9%
Black, non-Latino/x	4.2%	6.3%	7.9%	7.9%	8.2%
LANGUAGES SPOKEN†					
English only	58%	61%	55%	75%	—
Spanish	13%	16%	9%	12%	—

Notes: License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). Physicians are MDs and DOs; advance practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.

* Not shown: Other, non-Latino/x.

† Spoken fluently/well enough to provide direct services to clients. Some providers speak multiple non-English languages (e.g., 8% of physicians statewide); these languages are not captured here.

Sources: “2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024,” custom data request, HCAI, received April 14, 2025; and *Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023* (CC-EST2023-ALLDATA), US Census Bureau.

Safety Net Supports Training and Recruitment

All safety-net respondents commented on the need to improve patient access to care, and many safety-net health

plans and providers offer programs and incentives to recruit and retain physicians and other providers. For example, Alameda Alliance has budgeted \$2 million in FY 2025 and FY 2026 for a provider recruitment initiative to help safety-net providers recruit physicians, medical assistants, registered nurses, community health workers, behavioral health providers, and others. The health plan also offers stipends to bilingual providers through the initiative.

Safety-net providers in the region also directly support a variety of workforce-related efforts. For example, ZSFG is working with San Francisco City College to develop a training program for psychiatric technicians. Bay Area CHCs also support and participate in a range of workforce initiatives, including Tiburcio Vasquez Health Center (TVHC), NEMS, and HealthRIGHT 360.

Located in southern Alameda County, TVHC offers a training program for NPs, and NPs completing the training are offered a full-time position. Over the last seven years, 30 to 45 NPs have stayed to practice with the clinic. In 2024, TVHC implemented a program that offers loans to providers that can be used to help offset tuition and training costs as well as other costs like housing and childcare. TVHC forgives the loan over time as long as the provider remains employed at the clinic.

With seed funding from San Francisco Health Plan, NEMS has developed an internal medicine residency program in recent years, and the third cohort started in July 2025. The FQHC reportedly received 1,300 applicants for five slots. NEMS sends the residents to Seton Medical Center in Daly City, just south of San Francisco, and Garfield Medical Center in Southern California for inpatient rotations, and the residents complete ED rotations at ZSFG. To help with housing in San Francisco, NEMS purchased 10 condominiums for residents to use.

HealthRIGHT 360, an FQHC headquartered in San Francisco, has several pipeline programs to help address workforce

challenges, including a postgraduate advanced practice provider primary care residency that supports two residents at a time at HealthRIGHT’s Integrated Care Center in San Francisco. The program provides two additional years of training to NPs and PAs in clinical care and behavioral health. HealthRIGHT also offers a five-month apprenticeship program for people with lived experience in recovery who want to become counselors and is planning to start a doctorate-level psychology fellowship program to expand access to these services. Finally, HealthRIGHT receives funding from the California Department of Health Care Access and Information to support the practicum component of the training for master’s-level mental health clinicians who then become HealthRIGHT employees once they complete their training.

Medi-Cal in Midst of Significant Changes

The state’s DHCS began the rollout of CalAIM (California Advancing and Innovating Medi-Cal) in 2022, with major changes to Medi-Cal planned for phased implementation over several years. Two foundational aspects of CalAIM are Enhanced Care Management (ECM) and Community Supports (CS) services. A new Medi-Cal benefit, ECM provides resources for care coordination and complex care management for patients with complex needs. CS services, which are optional for the health plans to offer, expand Medi-Cal beyond traditional health care services, adding services for health-related social needs such as housing supports, including transitional rent payments, housing transition navigation, and short-term posthospitalization housing; medically tailored meals; sobering centers; home modifications to improve accessibility; and in-home inspections for asthma remediation. These CalAIM programs have prompted more social service organizations to contract with the Medi-Cal health plans and more health care organizations, especially CHCs, to offer social services directly or through partnerships. In the Bay Area, about 1.8% of Medi-Cal members were enrolled in ECM, a slightly higher share than statewide, while

about 1.4% of members received any CS service in 2024, a slightly lower share than statewide (Table 16). In the Bay Area, during the fourth quarter of 2024, the most-used CS service was medically tailored meals (4,194 members), followed by housing transition navigation (4,071 members), and housing tenancy and sustaining services (1,027 members).³⁵

TABLE 16. Medi-Cal and CalAIM, Bay Area vs. California, 2024

	Bay Area	California
ENHANCED CARE MANAGEMENT (ECM) ENROLLMENT*		
ECM enrollment	18,230	206,501
Share of Medi-Cal managed care enrollees receiving ECM	1.8%	1.5%
COMMUNITY SUPPORTS (CS) ENROLLMENT†		
CS enrollment	14,129	258,141
Share of Medi-Cal managed care enrollees receiving CS	1.4%	1.9%

* ECM enrollment is the number of unique members who received ECM in the last 12 months of the reporting period ending September 30, 2024.
† CS enrollment is the number of members receiving services in the 12 months of the reporting period ending September 2024.
Source: *ECM and Community Supports Quarterly Implementation Report* (data through September 30, 2024), California Department of Health Care Services, last updated March 2025, data tables for charts 1.7.1 and 3.9.1.

Across the region, health plans and providers expressed support for ECM and CS services while noting that the CalAIM rollout has been challenging. As one market observer said, “The state has been way too aspirational about how it would work operationally.” Many CHCs appreciated the new revenue source for services they were already providing to their patients. However, providers, particularly smaller community-based organizations, have struggled with learning how to contract with health plans as well as managing new billing and coding requirements. In addition, the uncertain federal policy environment has created sustainability questions for providers, making it difficult to plan long term. To support organizations with implementation, state funding is available through the Providing Access and Transforming Health initiative and from the Medi-Cal health plans through the Incentive Payment Program.

Recognizing the challenges facing smaller, local providers in partnering with Medi-Cal health plans, the state has begun to encourage the use of hub models where a single organization holds the health plan contract on behalf of service providers and supports administrative functions such as billing for service providers. Kaiser already uses a hub model to manage ECM and CS services, with two organizations serving as hubs in Kaiser's Bay Area service area. Some local providers, however, have reported challenges with connecting with the Kaiser hub organizations. In Alameda, Alameda Alliance contracts with Alameda County Health to serve as the hub for 21 organizations for the three housing-related CS services, known as the "housing trio."

Local Medi-Cal Plans to Launch D-SNP Products

Another major CalAIM initiative requires Medi-Cal health plans to offer a D-SNP beginning in 2026 for people dually eligible for Medicare and Medicaid. Only health plans that contract with the state for Medi-Cal will be allowed to offer D-SNPs in California. Existing D-SNPs can continue serving current members but will not be allowed to enroll new ones.

While Anthem and Kaiser already offer MA products, implementing D-SNPs has been a "heavy lift" for local Medi-Cal health plans that have not previously participated in MA. As part of developing their D-SNPs, the local health plans are using different strategies to build out their provider networks. For Alameda Alliance, most current Medi-Cal providers will be part of the D-SNP network, and as noted previously, San Francisco Health Plan has contracted with NEMS as the health plan's only D-SNP provider for the first year. Given higher MA capitation rates, at least compared to Medi-Cal rates, health plans have reported some "friction" in provider negotiations as they construct D-SNP provider networks. Providers reportedly are using the higher MA rates as leverage to try to secure higher Medi-Cal rates as well. As discussed earlier, a health plan's Medicare star quality rating is a key factor in determining MA payments — which differs from

the Medi-Cal rate-setting system local Medi-Cal health plans are familiar with. As new D-SNPs, the Medi-Cal health plans automatically will be granted 3½ stars for the first two years, after which actual performance will drive their star ratings. San Francisco Health Plan reportedly aims to achieve 4-star status from the beginning, recognizing the importance of MA star ratings to payment rates.

Medi-Cal Behavioral Health Transformation Underway

Over the last several years, California has implemented a series of investments aimed at transforming the public behavioral health system. Policy initiatives to strengthen the behavioral health care continuum include CalAIM Behavioral Health Payment Reform; BH-CONNECT (Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment); the Children and Youth Behavioral Health Initiative; and investments in infrastructure and housing through Behavioral Health Continuum Infrastructure Program (BHCIP) grants. In addition, Proposition 1, which voters approved in March 2024, included significant changes to the Mental Health Services Act of 2004 and authorized a \$6.4 billion general obligation bond to build additional behavioral treatment facilities and supportive housing. In many cases, county behavioral health agencies are tasked with implementation of these new initiatives. One respondent commented on the "overwhelming number of policy changes" counties are working to implement, while another said, "There is so much coming at us, we can't be strategic about what to prioritize."

Region Grapples with Homelessness Crisis

Like other regions in California, addressing homelessness is a key concern for the Bay Area. Even though Alameda and Contra Costa both experienced a decrease in the number of people experiencing homelessness between 2022 and 2024 (3% and 8% declines, respectively), the homeless population in San Francisco grew by 7% over the same period. In 2024,

an estimated 20,616 people experiencing homelessness resided in the three counties.³⁶

In Alameda County, voters narrowly passed Measure W in 2020, implementing a 10-year half-cent sales tax to fund housing and services for people experiencing homelessness. Initially, the county collected the tax but was unable to use the funds until a legal challenge was resolved in the first half of 2025. Roughly \$810 million had accrued since 2021, and the board of supervisors, along with establishing a \$170 million reserve fund, allocated 80% of the remaining funds to address homelessness and 20% to other “essential services” like food security and behavioral health.

In 2019, San Francisco launched Mental Health SF to improve access to behavioral health services for people experiencing both homelessness and serious mental illness or substance use disorder (SUD). Managed by the SFDPH, the initiative has four components: create a street crisis response team, create the Office of Coordinated Care, launch a mental health service center, and expand new beds and facilities. These components have largely been accomplished, including the addition of 400 residential care treatment beds (most located within San Francisco, although some are outside the county). Mental Health SF is funded by 25% of the revenue from Proposition C, which San Francisco voters passed in 2019 and imposed a tax on people and businesses earning more than \$50 million in gross receipts annually. In 2025, San Francisco’s new mayor signaled support for addressing homelessness and behavioral health through the “Breaking the Cycle” initiative, funded through a public-private partnership, that will support increased bed capacity as well as reforms to San Francisco’s behavioral health and homelessness response system.

Behavioral Health Delivery System Remains Fragmented

Medi-Cal divides responsibility for behavioral health care between Medi-Cal health plans responsible for non-specialty

mental health services, typically for people with lower-acuity illness, and county behavioral health plans responsible for specialty mental health and SUD services. While stakeholders agree this system is confusing for patients and providers to navigate, behavioral health integration is complicated to implement, and respondents agreed that it has yet to be realized. One bright spot that was highlighted in Alameda County is the work the Medi-Cal health plans and the county have undertaken to implement CalAIM’s “No Wrong Door for Mental Health Services” policy that enables Medi-Cal enrollees to receive mental health services immediately regardless of the delivery system where they seek care.

State Funds to Develop Behavioral Health Infrastructure

Enacted by the California legislature in 2021, BHCIP provides grant funding to expand the behavioral health infrastructure across the state. Although these funds were welcomed by stakeholders and providers, one respondent noted that the grants do not provide ongoing operating funds, which is challenging, particularly for county providers.

Over the first five BHCIP rounds, the region’s county agencies, hospitals, CHCs, and other providers have received millions of dollars in grants. The early rounds included grants to Alameda, Contra Costa, and San Francisco providers to support county and tribal planning; grants to build out the crisis and behavioral health continuum and crisis care mobile units; and funding to build or expand facilities to serve children and youth. The organizations receiving BHCIP funds in the region include Seneca Family of Agencies, Native American Health Center, SFDPH, Contra Costa County, and Alameda County Behavioral Health. In San Francisco, SFDPH received a \$34 million BHCIP grant in 2022 to increase access to inpatient and outpatient psychiatric services for youth at ZSFG. When completed, the new facilities will include 12 inpatient psychiatric beds as well as an intensive behavioral health outpatient program with 12 slots. In 2023, Contra Costa Health was awarded an \$18.6 million grant to build a

44-bed locked facility to provide 24-hour subacute care to patients with serious mental illness. The new facility, which will be the first of its kind in Contra Costa County, will serve as a step-down facility for patients once they are discharged from the inpatient setting.

In 2025, the state awarded additional funding of over \$285 million in Proposition 1 bond funds, which are being administered through the existing BHCIP structure, to support new facilities across the region. Grants included a \$98 million award to Contra Costa Health to build three new behavioral health facilities, including a facility that will house a 16-bed adult residential treatment center and a 16-bed mental health rehabilitation center; a facility that will include a sobering center as well as a crisis triage center, a withdrawal management program, and outpatient behavioral health services; and a 16-bed adult treatment and transitional residential facility. SFDPH also received a \$21 million grant to almost double the number of secure psychiatric beds at ZSFG. In addition, Alameda Health System received more than \$77 million for two projects: a 10-bed inpatient medical detox and psychiatric care unit at San Leandro Hospital and two 20-bed units to treat geriatric psychiatric patients at St. Rose Hospital — the first dedicated geriatric psychiatric beds in the East Bay.

Proposition 1 Implementation

A major focus of the Behavioral Health Services Act, a part of Proposition 1, is on people with serious mental illness who are homeless and, as such, requires a different allocation of funding by the counties. The counties are developing their Behavioral Health Services Act plans, which are due to the state in early 2026 and take effect in July 2026. Many respondents were concerned about the likelihood of cuts to critical prevention and early intervention services to allocate funding to those experiencing homelessness who need specialty mental health or SUD services.

Large Funding Cuts Expected at Federal and State Levels

Interviews with regional leaders were conducted after the Trump administration took office in January 2025 and completed just as House Resolution 1 was signed into federal law in July 2025. While respondents were aware of the potential changes in the funding environment, they did not yet have sufficient information to adjust course.

Under Section 17000 of the California Welfare and Institutions Code, counties are considered the provider of last resort and, as such, are required to provide health care to low-income, uninsured residents. Most medically indigent programs were significantly scaled back as a result of the Medi-Cal expansions in the 2010 federal Affordable Care Act with a few programs closing completely. With the potential for eligibility and coverage changes at the state and federal level, Bay Area counties in early 2025 already were beginning to revisit their medically indigent programs, with the expectation of needing to restart or expand them as residents lose coverage due to federal and state policy changes.

Health plans and providers voiced concerns about the “ripple effect” of higher rates of uninsured people across the entire health care delivery system. As more uninsured people seek treatment at hospital EDs or FQHCs, which are required to treat all patients regardless of ability to pay, financial pressures from increased uncompensated care will increase. The potential for changes in federal Medicaid financing for safety-net hospitals, including Medicaid supplemental payments, also was cited as a major concern by safety-net providers, given their heavy reliance on Medi-Cal.

Additionally, as a large academic medical center, UCSF Health receives significant federal funding to support research projects and was analyzing the risks to current and planned work. As one market observer said, “UCSF is one of the largest recipients of federal funding from the National

Institutes of Health, and they have had scores of grants canceled.” Counties in the region face similar funding threats because of heavy reliance on federal dollars to support a wide range of activities and have been working to understand impacts on programs and staff.

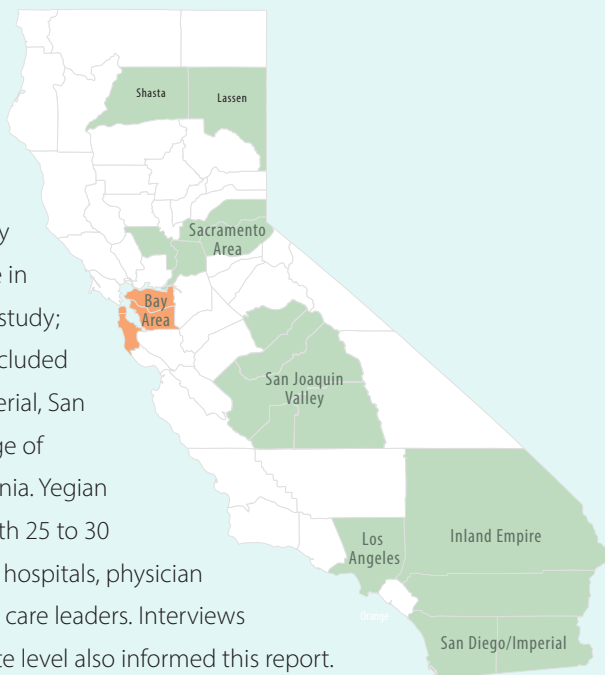
Finally, California will need to renew the Medi-Cal waivers underpinning CalAIM as well as the many Medi-Cal behavioral health changes underway. The two CalAIM waivers expire at the end of 2026, and the behavioral health waiver expires at the end of 2029. Respondents noted uncertainties surrounding how California would approach CalAIM renewal and CMS willingness to renew CalAIM provisions.

Issues to Track

- ▶ How will Kaiser adjust to increased competition across the health plan’s commercial and MA lines of business?
- ▶ Will the remaining independent hospitals be able to remain independent or be acquired by one of the large hospital systems in the region? What will be the impact of the consolidation that has already occurred?
- ▶ How will hospitals and other providers respond to the OHCA spending growth targets? How will hospitals attempt to reduce costs, and what might be the impact on hospitals’ workforce and patients? What will be the impact of the outpatient expansions undertaken by the hospitals on access and cost? What will happen to hospitals that fail to meet the growth targets?
- ▶ How will the region’s remaining IPAs and other physician organizations keep private practice viable? Will the remaining small medical groups be acquired?
- ▶ How will the public health systems and CHCs respond to looming changes in federal and state health care policy? How will the large health systems that serve a large proportion of Medi-Cal and Medicare patients absorb the federal cuts, given their high-cost structures?
- ▶ How will counties reformulate their indigent care programs, which were largely unwound following implementation of the Affordable Care Act and the Medi-Cal expansion, to cover undocumented people and others with unsatisfactory immigration status?

Background on Regional Markets Study

Between March and June 2025, researchers from Yegian Health Insights, LLC, conducted interviews with health care leaders in the San Francisco Bay Area to study the market's local health care system. The San Francisco Bay 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 fifth round of the study; the first set of regional reports was released in 2009. The seven markets included in the project — Inland Empire, Los Angeles, Sacramento, San Diego/Imperial, San Francisco Bay Area, San Joaquin Valley, and Shasta/Lassen — reflect a range of economic, demographic, care delivery, and financing conditions in California. Yegian Health Insights interviewed over 200 respondents for the overall study, with 25 to 30 interviews specific to each region. Respondents included executives from hospitals, physician organizations, CHCs, 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.



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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.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system.

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