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San Diego: Health Care Providers Expand Capacity as Competition Increases for Well-Insured Patients

Summary of Findings

Health care providers in the San Diego market generally fared well during the economic downturn, which was not as severe there as in some other areas of California. Still, some market trends, along with the advent of health care reform, have put pressure on providers since the region was last studied in 2008.

Key developments include:

- **Substantial hospital construction to meet state seismic requirements and improve competitive positions.** In a market historically considered to have inadequate inpatient capacity, current and planned hospital construction has eased concerns. Indeed, as health reform moves forward, with payment levels for inpatient services expected to decline and the shift from inpatient to ambulatory services expected to accelerate, there are some concerns that the market may now be moving toward excess capacity for some services and in some geographic submarkets.

- **Intensified provider competition in well-insured areas.** Hospitals are investing in lucrative service lines, including cardiovascular care, cancer care, and women's and children's services, particularly in more affluent submarkets in the northern region of the county. The University of California San Diego (UCSD) Health System, for example, is stepping up competitive pressure by shifting some specialty services to La Jolla from the less-affluent central city of San Diego. Physician organizations that are tightly aligned with hospitals are buying practices in competing hospitals' service areas to shift patient referrals to their aligned hospitals.

- **More limited-network insurance products.** Competition from Kaiser Permanente and pressure to offer more affordable insurance products are leading plans and providers to collaborate on an ever-increasing number of new lower-premium commercial products that feature a limited-provider network. Sharp HealthCare — the area's low-cost provider that has historically embraced capitation, or fixed per-member, per-month payments — is at the center of many collaborations, including accountable care organizations (ACOs) formed with Sharp-affiliated physician organizations.

- **Expanded safety-net capacity.** Facing increased demand for outpatient services because of the economic downturn, many safety-net providers expanded capacity. Most notably, San Diego's extensive, well-established group of federally qualified health centers (FQHCs) was able to use new federal grants to finance expansions and upgrades of existing facilities. Hospitals providing substantial safety-net care in economically struggling areas of the county, including the central city and areas to the south, such as Chula Vista, also expanded some services, particularly emergency department (ED) capacity.

However, as UCSD shifts inpatient and specialty capacity from the central city — where low-income residents are concentrated — to affluent La Jolla, the adequacy of safety-net access to these services has become a growing concern to some.

- **County government takes more active role.** Long regarded as having a weak commitment to the safety net, county officials have made health and health care a higher priority in recent years. They approved a 10-year strategic plan aimed at improving the delivery system serving low-income people, including efforts to establish patient-centered medical homes in FQHCs, integrate mental health care with primary care, and coordinate health care with other social services. Although the county has not provided additional funding, it is using implementation of the Low Income Health Program (LIHP) to promote reforms of the safety-net delivery system.

Although significant changes have occurred since 2008, many key characteristics that define the San Diego health care market remain largely unchanged:

- Large, stable, well-established hospital systems
- A substantial proportion of physicians in large medical groups exclusively tied to one of the large hospital systems
- A still-significant proportion of physicians in small, independent practices that participate in health maintenance organizations

Table 1. Demographic and Health System Characteristics: San Diego vs. California

	San Diego	California
POPULATION STATISTICS, 2010		
Total population	3,095,313	37,253,956
Population growth, 10-year	10.0%	10.0%
Population growth, 5-year	5.2%	4.1%
AGE OF POPULATION, 2009		
Persons under 5 years old	7.2%	7.3%
Persons under 18 years old	26.2%	26.3%
Persons 18 to 64 years old	63.0%	62.8%
Persons 65 years and older	10.8%	10.9%
RACE/ETHNICITY, 2009		
White non-Latino	53.1%	42.3%
Black non-Latino	5.1%	5.6%
Latino	29.6%	36.8%
Asian non-Latino	8.9%	12.1%
Other race non-Latino	3.3%	3.1%
Foreign-born	21.9%	26.3%
EDUCATION, 2009		
High school diploma or higher, adults 25 and older	89.6%	82.6%
College degree or higher, adults 25 and older	44.0%	37.7%
HEALTH STATUS, 2009		
Fair/poor health status	11.9%	15.3%
Diabetes	7.8%	8.5%
Asthma	12.3%	13.7%
Heart disease, adults	6.4%	5.9%
ECONOMIC INDICATORS		
Below 100% federal poverty level (2009)	11.9%	17.8%
Below 200% federal poverty level (2009)	29.0%	36.4%
Household income above $50,000 (2009)	56.0%	50.4%
Unemployment rate (2011)	10.5%	12.4%
Foreclosure rate* (2011)	4.0%	n/a
HEALTH INSURANCE, ALL AGES, 2009		
Private insurance	57.8%	55.3%
Medicare	9.5%	8.8%
Medi-Cal and other public programs	20.2%	21.4%
Uninsured	12.4%	14.5%
SUPPLY OF HEALTH PROFESSIONALS, PER 100,000 POPULATION, 2008		
Physicians	187	174
Primary care physicians	60	59
Dentists	70	69
HOSPITALS, 2010		
Community, acute care hospital beds per 100,000 population	133.0	178.4
Operating margin with net disproportionate share hospitals (Kaiser excluded)	2.3%	2.4%
Occupancy rate for licensed acute care beds (Kaiser included)	62.3%	57.8%
Average length of stay (in days) (Kaiser included)	4.2	4.5
Paid full-time equivalents per 1,000 adjusted patient days (Kaiser excluded)	15.8	15.8
Total operating expense per adjusted patient day (Kaiser excluded)	$2,643	$2,856

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

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

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(HMOs) through independent practice associations (IPAs)

- Slowly declining but still strong HMO enrollment

The safety net in this market remains strong in some respects, and the county government is making a more concerted effort than in the past to improve quality and delivery of care by safety-net providers — particularly FQHCs. Nevertheless, county funding and public support for the safety net, as well as the level of collaboration among safety-net-providers, still lag some other California communities.

Market Background

San Diego County is a 4,500-square-mile area with well-defined geographic boundaries — the Pacific Ocean to the west, Mexico to the south, the desert to the east, and Marine Corps Base Camp Pendleton to the north. The county population of 3.1 million grew by 10% over the past decade, on par with the state's growth rate.

The region has slightly less racial and ethnic diversity than the state as a whole, with a higher proportion of White residents and lower proportions of Latinos and foreign-born residents. County residents have high average incomes and education levels, second only to the Bay Area among the six regions studied. San Diego's unemployment rate more than doubled during the economic downturn, though it remained consistently lower than the state average. In 2007, prior to the downturn, San Diego County's unemployment rate was 4.5%, while the statewide rate was 5.4%. During the downturn, unemployment in San Diego County peaked at 10.9% (versus 12.9% statewide), and in March 2012, the month that interviews were conducted, it had fallen to 9.6% (versus 11.5% statewide).

San Diego County's health insurance coverage mix is slightly more favorable than the state average. However, from 2007 to 2009, San Diego's erosion of private coverage was more pronounced than in other relatively affluent communities, such as the Bay Area and Sacramento. During this period, private insurance coverage in San Diego fell by six percentage points, from 63.9% to 57.8%. This decline was accompanied by an increase in public coverage of about the same amount, resulting in little change in the region's aggregate uninsured rate of 12.5%.

Aggregate data showing San Diego County's relative affluence mask substantial disparities within the county. Broadly speaking, areas to the north are much more affluent than the central city and the southern area. It is possible, however, to examine geographic submarkets in greater detail, using the six regions defined by the San Diego County Health and Human Services Agency. Those regions, from most to least affluent, are:

- North Central: wealthy, well insured; includes coastal community of La Jolla
- North Coastal and North Inland: affluent and well insured, though not as wealthy as La Jolla; North Inland reportedly has the fastest population growth in the county
- East: middle-of-the-road on economic indicators
- South: high rates of poverty and prevalence of uninsured residents, highest proportion of Latino residents; community of National City has highest unemployment rate in the county
- Central: includes core urban areas of the city of San Diego, highest rates of poverty and prevalence of uninsured residents, highest proportion of African Americans and second highest proportion of Latinos

Hospital Competition Focused on Affluent Submarkets

In San Diego's stable hospital sector, the two largest systems are still Sharp HealthCare, with four hospitals and 27% of inpatient discharges, and Scripps Health, with four hospitals on five campuses and 25% of discharges. Kaiser Permanente, UCSD, and Palomar Health, a district hospital system in the

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North Inland region, each command approximately 10% of the hospital market based on discharges. Smaller hospitals include Rady Children's Hospital, which dominates inpatient pediatrics; for-profit Prime HealthCare's two hospitals, Alvarado and Paradise Valley; and two district hospitals, Tri-City Medical Center and Fallbrook Hospital. The only organizational change taking place over the past few years was Prime HealthCare's 2010 purchase of Alvarado Hospital in the eastern North Central region.

Biggest Competitors: Sharp, Scripps, Kaiser

Sharp, Scripps, and Kaiser are widely considered the dominant hospital competitors in the market. Kaiser's relatively modest hospital market share understates its competitive position in the coveted market for commercially insured patients, as commercial enrollees of Kaiser Permanente Health Plan comprise a large majority of Kaiser hospitals' patient base. In addition, Kaiser — with only one hospital in the county — outsources a significant number and volume of services to other hospitals. Most hospitals — and physician organizations — identified Kaiser as their main competitor. Kaiser is poised for growth, with plans to expand to three hospitals by 2030. From 2008 to 2010, Sharp increased its market share from 22% to 27%, gaining significant volume at Sharp Memorial, while Scripps' share remained constant, and smaller hospitals lost ground.

While Sharp and Scripps compete with each other at the system level, the service areas of their individual hospitals do not overlap substantially. As a result, direct competition for patients and physicians is limited. Sharp continues to embrace capitation and to be a lower-cost provider than Scripps. In the late-2000s, Scripps moved away from capitation to fee-for-service payment in its HMO contracts. Loss of market share relative to Sharp — in part through Scripps' exclusion from products featuring limited-provider networks — recently has caused Scripps to move "incrementally" back to capitation.

Size Matters in Financial Performance

Overall hospital financial performance in the market has improved in recent years, with the larger hospitals and systems continuing to fare much better than smaller hospitals. Most hospitals reported that both payer mix and proportion of uncompensated care remained relatively stable at the system level, though there was great variation among individual hospitals within the systems. Over the past few years, commercial insurers ratcheted down payment rate increases, motivating hospitals to focus on reducing the total cost of care to maintain their operating margins. Hospital cost-cutting efforts also are motivated by competitive pressure from Kaiser and expectation of payment reductions from both public and private payers.

Scripps improved its already high operating margin of 9.1% in 2008 to 10.9% in 2010. UCSD's operating margin improvement was even more substantial, growing from 8.6% in 2008 to 13.5% in 2010.[1] Sharp's margin — while lower than Scripps's and UCSD's — more than doubled from 2.2% to 5.5% over the same period. For 2011, these three systems all reported stable to increasing margins, attributable in part to the hospital fee program, and in the case of UCSD, Delivery System Reform Incentive Payments (DSRIP).[2,3]

Among smaller hospitals, financial performance varied widely. Rady Children's Hospital continued to leverage its dominant position in inpatient pediatrics, doubling its operating margin to 13.0% from 2008 to 2010. Palomar Health reversed losses in 2006 to 2008 to attain a positive margin of 3.7% in 2010. Other small hospitals — Tri-City, Fallbrook, and Alvarado — saw negative and/or declining margins over the same period.

Competition in the North Heats Up

Competition among hospitals for well-insured patients in the North Central, North Coastal, and North Inland regions has accelerated over the past few years. In La Jolla (North Central) — the wealthiest part of the county —

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UCSD made progress on the long-planned expansion of its Thornton campus as it began relocating specialty services and teaching programs there from its safety-net hospital in Hillcrest. In response, Scripps upgraded facilities at Scripps Memorial La Jolla to maintain its market position. Lucrative service lines, such as cardiovascular care, cancer care, and women's and children's services, are the focus of hospital expansions throughout the San Diego market, especially in this well-insured submarket.

In the relatively affluent growth areas of the North Inland and North Coastal regions, competition is heating up among hospitals and their affiliated physician organizations. The service area of Tri-City, the struggling district hospital in Oceanside, is one submarket experiencing increased provider competition. Physician organizations aligned with Scripps and Palomar Health acquired or developed affiliations with medical practices in Tri-City's service area to draw referrals away from Tri-City and toward their nearby hospitals: Scripps Encinitas and the newly built Palomar Medical Center West.

In the economically struggling Central and South regions, hospitals are expanding capacity, but many of the services they are expanding differ from the specialty-line focus in more affluent areas of the county. Sharp Chula Vista and Scripps Mercy-Hillcrest both are investing in increased ED and critical care capacity — a reflection of this region's high and growing demand for these services.

Construction Projects Underway

Historically, San Diego County's inpatient capacity has been considered inadequate to keep pace with the needs of the county's growing population. As recent hospital construction projects have started to come online, however, most respondents believed that the market is no longer under capacity with regards to inpatient beds. One factor contributing to the change is that when hospitals first planned construction projects to comply with state seismic regulations, most intended to replace their old facilities altogether; however, a change in regulations extended the deadline for facilities to have all of their beds achieve seismic compliance until 2030. In some cases, the original facilities have been transitioned to other services, such as outpatient and rehabilitative care, but with some beds remaining licensed and available for inpatient acute care until the deadline to take these beds out of service. As a result, overall inpatient capacity has expanded.

All hospital systems have major construction projects underway except Sharp, which completed its seismic-related construction in the last few years. Some observers were concerned that with the emphasis shifting from inpatient to outpatient care and payment levels expected to decline under reform, the market will have excess capacity for inpatient services overall and for some currently lucrative service lines (e.g., cardiovascular care) in particular.

Among longer-term hospital construction plans, the most notable is Kaiser's plan to expand from a single hospital to three by 2030. Kaiser's next hospital is expected to be built in Kearny Mesa (North Central region). Kaiser currently outsources a substantial amount of care to other hospitals, both for general inpatient beds and for certain service lines, including cardiac care, bariatric surgery, and joint replacements. For example, under a 10-year contract with Scripps, Kaiser patients needing cardiac surgery receive care at Scripps La Jolla. Kaiser members account for 60% of total cardiac case volume at that facility. As its enrollment grows, Kaiser is expected eventually to bring in-house many inpatient services it currently outsources to other hospitals. The extent and pace of insourcing will depend not only on the rate and geographic location of enrollment growth, but also on Kaiser's ability to continue negotiating favorable long-term contracts with other hospitals. Kaiser's decisions on hospital construction and subsequent insourcing are expected to have significant impact on excess capacity in the market, particularly at hospitals now used extensively by Kaiser, such as Scripps La Jolla and Palomar Medical Center West.

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Hospitals Strengthening Ties with Physicians

Many San Diego physicians continue to practice in large medical groups, each aligned exclusively with a major hospital system in the community. Kaiser's Southern California Permanente Medical Group is the largest, employing 850 physicians and operating 20 ambulatory centers throughout the county. In the UCSD Health System, physicians are employed by the university and belong to the 700-physician UCSD Medical Group. Because these physicians are medical school faculty members with research and teaching responsibilities, they provide far fewer full-time equivalents of clinical care.

Sharp and Scripps both continue to rely on the medical foundation model to align physicians with their systems.[4] Sharp Rees-Stealy Medical Group, with more than 400 physicians and 20 ambulatory centers, contracts exclusively with Sharp's medical foundation. The group's HMO enrollment has increased in recent years — counter to market trends — largely because of participation in limited-network products, which have growing enrollment. Sharp Rees-Stealy physicians refer patients primarily to other physicians within the group.

Scripps' two main exclusively contracted medical groups are Scripps Coastal Medical Group, which is composed of mainly primary care physicians (PCPs), and the multispecialty Scripps Clinic Medical Group. These two groups, which together have more than 650 physicians, typically do not refer patients to each other, in part because of limited overlap in their service areas. In contrast to Sharp Rees-Stealy, Scripps's medical groups currently accept little capitation except in Medicare Advantage.

Sharp's and Scripps's affiliated medical groups are expanding through a combination of hiring new physicians and acquiring small practices. The two systems also are increasing the number and geographic reach of their medical groups' practice sites. One smaller system — Palomar Health — set up a medical foundation in 2010 — Arch Health Partners — in an effort to align physicians more tightly. The expansion of medical groups is part of a strategy by systems not only to drive referrals but also to position themselves for new contracting arrangements.

Aligning with Other Physician Organizations

While these medical groups have grown moderately in recent years, many physicians continue to practice in small, independent, single-specialty practices — an especially common pattern in the East and South regions. These small practices have experienced little consolidation. Given the continuing use of the delegated model for HMO contracting for both commercial and Medicare Advantage business, many independent physicians participate in one or more IPAs, many of which are aligned with a hospital system. The largest is Sharp Community Medical Group, which has about 700 participating physicians and holds its own HMO contracts, although it negotiates "alongside" and receives management services from Sharp. In addition to substantial HMO enrollment (115,000 commercial; 24,000 Medicare Advantage), Sharp Community Medical Group also has preferred provider organization (PPO) enrollment of 15,000 across the ACOs in which it participates (see New Provider-Plan Collaborations). Sharp's two affiliated physician organizations regard each other as "friendly competitors." While they generally do not refer patients to each other, they collaborate on hiring and some clinical programs, as well as new contracting arrangements.

Scripps has a number of affiliated IPAs, with the most closely aligned being the two that accept risk in their HMO contracts: Mercy Physicians Medical Group (more than 500 physicians, mostly in the Central region) and Primary Care Associates Medical Group (60 physicians, mainly in the North Coastal region). These IPAs together have only a fraction of the enrollment of Sharp Community Medical Group.

As in other California markets, specialists often belong to multiple IPAs to maintain sufficient patient volume, while PCPs are more likely to be exclusive to one IPA.

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In recent years, Sharp has tightened its alignment with Sharp Community Medical Group by requiring PCPs to be exclusive. Currently, it is the only IPA in the market to impose this requirement; other IPAs offer financial incentives for PCP exclusivity.

In 2011 Scripps launched ScrippsCare, a medical management subsidiary whose objective is to "remove silos" and increase clinical care coordination across all organizations in the Scripps system. ScrippsCare is widely regarded as an attempt by Scripps to catch up with Sharp in tightening its alignment with its affiliated medical groups and IPAs. (Scripps's physician organizations are already tightly aligned with Scripps hospitals in their referral patterns, but Scripps lags Sharp in the degree of financial and clinical integration with its affiliated physician organizations.) Still nascent, ScrippsCare is not yet a contracting vehicle, but it may become one.

New Provider-Plan Collaborations

In 2008, when the region was last studied, Scripps and Sharp were pursuing divergent strategies toward contracting with commercial health plans. Scripps — known as the high-cost provider in the market — used its market leverage with health plans to move from capitation to fee-for-service payment for both its hospitals and medical groups in commercial HMO contracts, resulting in higher total payments. In response, most health plans introduced new, lower-priced narrow-network HMO products that excluded Scripps and other high-cost providers. Some of these narrow-network HMOs excluded both Scripps hospitals and physician organizations; others excluded only the latter. In contrast to Scripps, Sharp — known as the low-cost provider — embraced both institutional and professional capitation, as well as participation in narrow-network HMOs.

Respondents offered mixed views in 2008 about the extent to which employers were adopting and employees were taking up narrow-network HMOs. However, by 2010, all major commercial health plans in the market were offering narrow-network HMOs, and there was enough of an enrollment shift from Scripps to Sharp that Scripps was motivated to focus on reducing costs and returning to capitation slowly and incrementally.

Sharp Taking the Lead in ACO Contracting

Recently, health plans and providers have moved beyond the first-generation narrow-network products introduced in the late 2000s, which tended to focus on reducing premium growth by limiting participation to providers with lower unit prices. Plans and providers are now collaborating on a variety of new ACO-like contracting arrangements aimed at reducing the total cost of care. The lower-premium products resulting from these collaborations span both narrow- and tiered-network product offerings. In contrast to narrow-network products, which exclude non-preferred providers from the network altogether, tiered-network products place these providers in tiers requiring higher patient cost sharing at the point of service. Narrow-network products typically are built on an HMO platform, and tiered-network products on a PPO platform, though exceptions exist.

San Diego is ahead of other California markets in making limited-network products based on ACO collaborations available in the commercial market — the result of favorable market conditions, including strong competition from Kaiser, close alignment between hospitals and physician organizations, experience with and enthusiasm for professional capitation (and, to some degree, hospital capitation), and the presence of a single full-service, low-cost provider — Sharp — with sufficient geographic reach to serve as the core of limited-network products. One driver that San Diego lacks is a single large purchaser pushing for lower-cost, narrow-network products, as the California Public Employees' Retirement System (CalPERS) has done in Sacramento. Respondents suggested, however, that indirect pressure from smaller, acutely cost-conscious employers has acted as a catalyst for limited-network collaborations.

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In addition to participating in a number of narrow-network HMOs, Sharp and its affiliated providers are participating to varying degrees in commercial ACOs with Anthem Blue Cross of California and Aetna, as well as the Medicare Pioneer ACO program. The Anthem Blue Cross ACO, introduced as a pilot in 2011, launched full-fledged commercial products in 2012. Sharp Rees-Stealy, the medical group, and Sharp Community Medical Group, the IPA, are both collaborating with Anthem in the ACO. Currently, Sharp hospitals are not participating.

Anthem Blue Cross offers two commercial PPO products based on the ACO. Both products aim to return a portion of savings achieved by the ACO to purchasers and consumers in the form of lower premium trends. The first, ACO Flex, aimed at large groups, features a three-tiered network, with the ACO providers forming the first (preferred) tier, other PPO network providers forming the middle tier, and non-network providers making up the last tier. Patients have cost-sharing incentives to use the providers in the preferred tier. The other product, ACO Core, aimed at small groups, limits its provider network to the Sharp ACO providers. Together, ACO Flex and ACO Core have enrollment totaling about 15,000 in San Diego. Currently available only on a fully insured basis, the products will be extended to the self-insured market if there is evidence of cost savings.

Like other ACO collaborations, the Anthem Blue Cross ACO emphasizes the exchange of data between the health plan and providers as critical to managing patients. The current method of physician payment is still fee-for-service, with the addition of a per-member, per-month care management fee and a shared-savings pool. The ACO plans to transition to capitation for professional services and ultimately to global capitation if participation expands to Sharp hospitals. A global capitation arrangement would require state Department of Managed Health Care approval and a limited Knox-Keene license. The Aetna ACO collaboration with Sharp is similar to that of Anthem Blue Cross but involves a partnership only with Sharp Community Medical Group, not Sharp Rees-Stealy. With these collaborations just beginning, respondents noted that it is too early to assess the impact on enrollment, use, and costs.

In addition to participating in commercial ACO collaborations, Sharp is participating in the Medicare Pioneer ACO program — the only San Diego provider to do so. The system is participating via the Sharp HealthCare ACO, whose governing board includes representatives from the system (including Sharp hospitals and both affiliated physician organizations: Sharp Rees-Stealy and Sharp Community Medical Group). About 32,000 fee-for-service Medicare beneficiaries are attributed to Sharp under the ACO. Sharp's strategy is to reach out to these patients to engage them and manage their care in the same manner as a patient-centered medical home.

Safety Net Weathers Economic Downturn and Increased Demand

Between 2007 and 2009, while private insurance coverage declined and public coverage increased in the aggregate by the same amount, the overall uninsured rate in San Diego County remained steady at 12.5%. Despite no overall change in the uninsured rate, many safety-net providers reported increases in demand, both overall and from uninsured patients. This apparent discrepancy may reflect the concentration of the uninsured in certain low-income communities that safety-net providers serve. Regionally, uninsured rates were twice as high in the Central and South regions compared to the North Central region. The variation was even greater when looking at particular communities and neighborhoods within those regions. Another possible explanation for the discrepancy is that San Diego has a large immigrant population — including undocumented immigrants — who are likely to be underrepresented in population estimates of uninsured residents.

San Diego is one of the few large counties in California to have no county-operated hospital. Instead, the bulk of safety-net inpatient care is shared by a number of hospitals

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in the community. The primary facilities serving low-income residents are UCSD's Hillcrest campus in the central city, Scripps Mercy's campuses in Hillcrest (central city) and in Chula Vista (South region), Sharp Grossmont in El Cajon (East region), and Sharp Chula Vista. Rady Children's Hospital continues to be an important provider of inpatient (especially tertiary) and outpatient care for children enrolled in Medi-Cal. All of these hospitals receive disproportionate share hospital (DSH) payments. These hospitals belong to systems that are faring well financially overall, but they tend to have lower margins than other hospitals in their systems and, in some cases, need cross-subsidization.

UCSD Downsizing in Low-Income Hillcrest Neighborhood

The safety-net roles played by UCSD and Scripps have shifted in recent years. The changes began in the mid-2000s, when UCSD announced plans to shut its Hillcrest inpatient facility as part of its La Jolla expansion. In response to public outcry, UCSD modified these plans in 2008 and pledged to maintain an inpatient presence — though a reduced one — at Hillcrest. The system is moving ahead, however, with a planned relocation of its women's and infants' services to La Jolla — a move that many observers expected would create significant access issues for Medi-Cal patients. Also, with the transfer of some inpatient capacity to La Jolla, along with implementation of new federal guidelines restricting work hours for medical residents, the ongoing availability of UCSD residents for safety-net care at Hillcrest may be restricted. UCSD residents have been an important source of care — particularly specialty care — for low-income and uninsured residents in this community.

Scripps Mercy — whose main Hillcrest campus is within a few blocks of the UCSD campus — is the hospital most directly affected by UCSD's move. Although Scripps Mercy's total discharges have remained stable, its ED visits increased significantly since 2008 — a change that some attributed to UCSD's downsizing at Hillcrest. In 2012, Scripps Mercy opened a new ED facility at Hillcrest that doubled its previous capacity. Going forward, it is expected that Scripps Mercy will provide more specialty and tertiary care in Hillcrest as a result of UCSD's downsizing.

Large and Expanding Group of FQHCs

For outpatient care, San Diego County has an extensive, well-established group of health centers, many of which have expanded in the past three years. The county has a total of 12 FQHCs and one FQHC look-alike (see sidebar). While the number of FQHCs and look-alikes has remained stable, the total number of clinic sites across the county has grown to more than 100. The growth is primarily the result of expanded federal funding and increased demand. To date, FQHCs in the county have received $45 million in grants from the 2009 federal stimulus package and nearly $40 million in grants from the federal health reform law.

San Diego County's largest FQHC is Family Health Centers, which has 16 sites, including three mobile medical clinics. Other large FQHCs include San Ysidro Health

FQHC and Look-Alike Designations

Community health centers that meet a host of federal requirements under Section 330 of the Public Health Service Act are deemed federally qualified health centers (FQHCs). FQHCs primarily treat Medicaid and low-income uninsured people. FQHC designation provides benefits including federal grants to subsidize capital and operational costs, cost-based payments per Medicaid patient visit (Prospective Payment System payments based on previous average costs for an individual health center that are updated annually for medical inflation), discounted pharmaceuticals, access to National Health Service Corps clinicians, and medical malpractice liability coverage.

A smaller number of health centers have FQHC look-alike status, which provides most of the benefits that FQHCs receive but not federal grants. In managed care arrangements, FQHCs and look-alikes receive "wraparound" payments from the state to account for the difference between what the health plan or intermediary (such as an IPA) pays the health center and the cost-based rate to which the health center is entitled.

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Center, North County Health Services, Neighborhood Healthcare, and La Maestra Community Health Centers — each with 6 to 11 sites. Overall FQHC volume increased 20% from 2007 to 2009, leveling off in 2010. The health centers' proportion of uninsured patients increased from 21% to 31% between 2007 and 2010. With help from federal grants, FQHCs are managing financially despite state budget cuts — most notably to the Expanded Access to Primary Care program and Medi-Cal reimbursement for adult dental care — and delays in state Medi-Cal reimbursement.

Competition and lack of collaboration among FQHCs continue to be regarded as problems in San Diego County. Most of the collaboration that does take place is centered on the San Diego Council of Community Clinics, which provides coordination and support for such activities as funding, outreach, specialty referral, and implementation of health information technology. However, the reach and impact of this organization is limited because the largest FQHC, Family Health Centers, is not a member.

County Takes on More Active Safety-Net Role

While respondents' characterizations of a fragmented San Diego safety net stem in part from lack of FQHC collaboration, they also reflect widely held perceptions that the county government has a weak commitment to low-income and uninsured residents' health care. Historically, the County Board of Supervisors' priorities included keeping county health care spending low and preventing undocumented immigrants from receiving locally subsidized services. The county's role in direct care provision has been limited to public health and preventive services, as well as outpatient and inpatient mental health services; the county does not operate its own primary care clinics.

In recent years, however, the safety net has become a higher priority for county government. Respondents believed that an initial catalyst for greater county involvement was UCSD's 2005 announcement — since rescinded — that its Hillcrest facility would close. This spurred the county to act to ensure that all of its low-income residents have access to at least a minimum level of care. In addition, a new leadership team that joined the county Health and Human Services Agency (HHSA) since 2008 has been credited by many with taking a more proactive role in health care issues.

The focal point of the county's health initiatives is a 10-year strategic plan approved by the Board of Supervisors in mid-2010. Called "Live Well, San Diego," the plan has the broad aim of improving the health and health care of county residents. One of its core goals is to "build a better delivery system" by creating "a seamless system that integrates all aspects of a client's needs, including physical health, mental health, and self-sufficiency services."

New Initiatives to Reform the Delivery of Safety-Net Services

The county did not appropriate any new funds to meet the strategic plan's objectives, but it is using its strategic plan as a tool to apply for federal grants and as a guide in designing the LIHP and other initiatives.[5] For care delivery in LIHP, the county has created a network of patient-centered medical homes, concentrated on FQHCs. The county reportedly is contracting with almost all of the FQHCs in the community to provide primary care for LIHP enrollees. FQHCs are paid the same cost-based rate for LIHP as for Medi-Cal — considerably higher than the rates they were receiving under the previous county indigent care program, the County Medical Services (CMS) program. To monitor the impact of the LIHP's medical-home and care-coordination activities, the county is requiring participating FQHCs to report performance and quality measures as part of a pay-for-performance program.

The county has been active in initiatives linking health care with social services such as housing. An example is Project 25, a program that initially targeted serving 25 homeless people who are intensive users of health care and other public resources and is now serving approximately 35. Co-funded by the city, the county, and the United Way, the

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program provides these "frequent users" with housing and mental health services in addition to a medical home.

Integrating mental health care with primary care is another key component of the county's efforts to change the delivery system. One county initiative involves placing primary care providers in county mental health clinics, a practice which is seen as key to improving health outcomes and reducing costs. In addition, the county is encouraging FQHCs to employ physicians with board certifications in both family medicine and psychiatry, although it is unclear whether there is a significant pool of physicians with such credentials from which to recruit. The county is undertaking these efforts largely in response to the shortage of mental health providers, which continues to be an acute problem in the safety net. On the inpatient side, only three general acute care hospitals (UCSD, Scripps Mercy, and Sharp Mesa Vista) and the San Diego County Psychiatric Hospital currently provide inpatient mental health care for the general population. UCSD services are limited to geriatric patients, and Scripps may cut back inpatient services. On the ambulatory side, the county has stepped up provision of mental health care by contracting with six mental health clinics to supplement the three county-run clinics.

Overall, most safety-net respondents regarded the county's initiatives favorably, recognizing these efforts as a net improvement over the county's past lack of involvement. However, San Diego's level of commitment to the safety net — in funding, direct provision of services, and coordination with safety-net providers — still lags far behind that of some other large California counties.

The county's increasingly active role in health care extends beyond the safety net. The county is partnering with Scripps, Sharp, Palomar, and UCSD to pursue a grant from the Center for Medicare & Medicaid Innovation's Community-Based Care Transition Program, aimed at reducing hospital readmissions for high-risk Medicare fee-for-service patients discharged from hospitals.

More Providers Exploring Partnerships and Collaboration

Along with community-wide initiatives, collaborations among specific safety-net providers also have increased. Several have focused on connecting FQHCs with hospital EDs, with the goal of reducing ED use — especially among intensive users — and linking people to medical homes. The most prominent of these programs, Safety Net Connect, electronically linked EDs with FQHCs to facilitate follow-up appointment scheduling and patient-record sharing. Initiated by the county and first implemented by UCSD, it has yielded mixed results: Scripps scaled back the program after reimbursement cuts, while UCSD maintains the program and views it as a success. New partnerships seeking to coordinate ED and ambulatory care have emerged, including a collaboration between Sharp Chula Vista Hospital and Family Health Centers.

Hospitals and FQHCs are exploring closer partnerships, including potential ACOs. However, the extent to which most hospitals would regard FQHCs as desirable ACO partners remains far from certain. Hospital systems that already have their own tightly aligned medical groups and IPAs are much more likely to develop ACOs with those organizations first before turning to FQHCs, where their connections are neither as broad nor as deep.

Preparing for Reform

San Diego County's LIHP has two components: the Medicaid Coverage Expansion (MCE), which covers adult citizens and legal residents below 133% of the federal poverty level, and the Health Care Coverage Initiative (HCCI), which was implemented as part of the state's previous Medicaid waiver initiative and covers adults with chronic diseases at 133% to 200% of the federal poverty level. By November 2012, LIHP enrollment reached nearly 32,000 — exceeding county expectations by about 10,000 — with enrollment leveling off since that time. The vast majority of LIHP enrollees are part of the MCE program. HCCI

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enrollment consists entirely of people grandfathered into the LIHP when it was implemented: There is no new enrollment in the HCCI part of the LIHP.

Some LIHP enrollees had been covered previously under CMS, the county's indigent care program. However, CMS eligibility had been restricted to people with immediate or chronic conditions. CMS enrollment also had been limited by strict documentation requirements and a small number of application sites — barriers that many believed were intentionally erected by the county to make application and enrollment difficult for eligible residents. In comparison, the LIHP application process is easier and more accessible; the San Diego HHSA integrated the LIHP and Medi-Cal application processes and increased the number of enrollment sites.

The LIHP primary care network includes almost all FQHCs, which also serve the CMS population and are designated as medical homes, and pays these FQHCs the same cost-based rates as Medi-Cal. For specialty care, LIHP is further expanding the specialist network the county began building for HCCI. The county has indicated it now has an extensive network of more than 115 access points for specialty care other than UCSD, including many private practices.

In terms of provider capacity, San Diego's overall physician supply per capita is moderately higher than the California average, while its supply of primary care physicians per capita is about the same as the state average. The high cost of living poses an ongoing challenge in physician recruiting, but this is offset by the area's attractive location and climate, as well as the presence of multiple large medical groups — a practice setting that new physicians tend to find appealing.

Despite characterizing San Diego as an "over-specialized and under-primary-cared" market, respondents provided little evidence of residents having problems accessing primary care from either mainstream or safety-net providers. In the safety net, the extensive network of FQHCs helps provide reasonably good access to primary care. Some are concerned, however, that growing demand — which will only increase with health reform — will tax primary care capacity in the safety net. Geographic areas of particular concern include the Central and South regions and some pockets of the North Coastal and North Inland regions, including Escondido, Oceanside, and San Marcos.

Issues to Track

- Will the hospital construction boom lead to excess capacity, particularly on the inpatient side? What will be the impact on hospitals' financial health and their leverage with health plans?
- Will independent physicians practicing in the market continue to move toward more exclusive alignment with a single hospital system?
- How much will new contracting arrangements between providers and plans continue to grow? How tied in will the contracting arrangements be with narrow- or tiered-network products? How effective will they be in improving efficiency and competing with Kaiser?
- How will safety-net access in the central city be affected by UCSD's shift of inpatient and specialty capacity to La Jolla, the wealthiest part of the county?
- To what extent will safety-net capacity expand to meet the needs of a growing Medi-Cal population under reform?
- Will the county government continue to play an increasingly active role in the safety net? What impact will the county's efforts to create medical homes and otherwise coordinate care have on quality, cost, and access for low-income people?

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ENDNOTES

1. Most hospital financial performance data are from California Office of Statewide Health Planning and Development (OSHPD), Healthcare Information Division, Annual Financial Data, 2010. However, UCSD's data are from UCSD audited financial data. OSHPD reported negative operating margins for UCSD for this period, which is inconsistent with the positive trend in the audited financials.

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

3. Starting in 2011, Delivery System Reform Incentive Payments are provided to California public hospitals for identifying and meeting numerous milestones around improving their infrastructure, care delivery processes, and quality outcomes over a five-year period.

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

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

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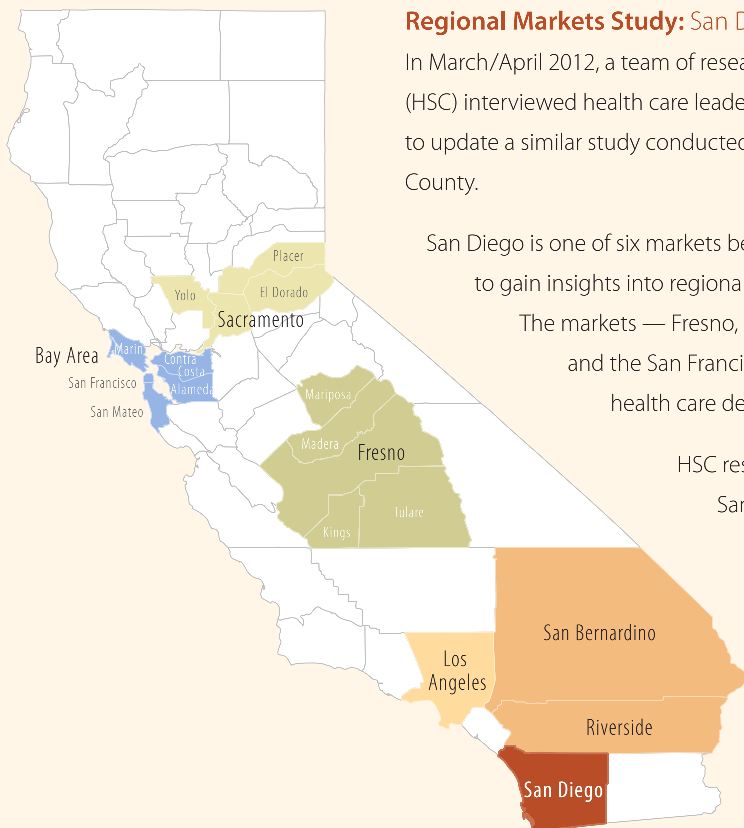

Regional Markets Study: San Diego

In March/April 2012, a team of researchers from the Center for Studying Health System Change (HSC) interviewed health care leaders in San Diego to study that market's health care system and to update a similar study conducted in November 2008. The market encompasses San Diego County.

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

HSC researchers interviewed 27 respondents specific to the San Diego market, including executives from hospitals, physician organizations, community clinics, and programs for low-income people. Interviews with 18 health plan executives and other respondents at the state level also informed this report.

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ABOUT THE AUTHORS

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

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