

San Francisco Bay Area: Major Players Drive Regional Network Development

Summary of Findings

Since the last round of this study in 2011-2012, the San Francisco Bay Area's economy has continued to thrive overall, but stark contrasts persist—and in some cases are increasing—between have and have-not residents. In the health care sector, the web of relationships among providers became increasingly complex, as providers continued to form, or at least explore, numerous affiliations with other providers and with health plans.

Key developments include:

- ▶ **Growing regionalization of provider networks.** In a region historically characterized by many segmented, distinct submarkets, major providers are continuing recent efforts to expand their footprints throughout the region. Providers are taking very different paths to regional expansion, with one system aggressively acquiring physician groups, another system consolidating its broad but previously decentralized operations, and other systems forming strategic partnerships with providers based elsewhere in the region to jointly develop a regional care network.
- ▶ **Regional expansion expected to boost provider competition and increase consumer choices.** Underlying many—though not all—provider efforts at geographic expansion is a population health strategy of building region-wide networks that can manage care efficiently enough to compete vigorously with Kaiser Permanente for coveted commercial patients. Providers are obtaining insurance licenses, allowing them to take full financial risk for patient care. Intensifying provider competition is expected to yield lower premiums and more provider network choices for purchasers and consumers in the near future, especially in the affluent, well-insured submarkets in the East Bay. However, these benefits are likely to be sustainable only if providers succeed in lowering their cost structures significantly. There also is concern that, in the long run, growing provider consolidation will ultimately lead to less competition and higher prices, as other health care markets have experienced.
- ▶ **Number of independent hospitals shrinking as financial problems mount.** In recent years, finances for some struggling independent hospitals eroded to the point that one East Bay hospital was forced to close and others were absorbed into larger systems. Acquisition by strong, deep-pocketed systems allowed some hospitals to gain long-term stability, but hospitals acquired by a struggling county hospital system found their future prospects more clouded than before. None of the region's remaining private safety-net hospitals appear threatened by imminent closure, but several face an uncertain future, in part because they lack capital for required seismic upgrades.
- ▶ **Independent practice associations (IPAs) seeking to diversify, raise capital, and keep private practice viable.** IPAs are pursuing new revenue sources well beyond their traditional base of HMO contracting, including a range

of new payment arrangements such as commercial and Medicare accountable care organizations (ACOs). More broadly, as physician consolidation continues, IPAs are seeking ways to keep private practice viable, especially for primary care physicians (PCPs), by exploring innovative, smaller-scale models of integrated group practice. Lacking the capital to develop such models on their own, they are pursuing collaborations with a range of potential partners, including hospitals, health plans, and venture capital firms.

► **Strong safety nets challenged by increased demand.** Strong public commitment to providing health care for low-income residents has enabled San Francisco and Alameda Counties to build robust, extensive networks of safety-net providers. Recently, both counties' safety nets have faced serious capacity and access challenges trying to meet surging demand from the ACA Medi-Cal expansion. Safety-net clinic efforts to expand capacity to meet higher demand have been constrained by their limited ability to recruit and retain enough clinicians. Faced with dramatic enrollment growth, Medi-Cal managed care plans are having trouble meeting state timely access standards for both primary and specialty care. Behavioral health stands out as an area with particularly severe shortages of safety-net providers.

► **San Francisco's safety net has fared well overall, while Alameda County's safety net has been more troubled.** Disparities between the two counties reflect, in part, San Francisco's much higher level of community resources relative to safety-net

Table 1. Demographic and Health System Characteristics: San Francisco Bay Area vs. California

	San Francisco Bay Area	California
POPULATION STATISTICS, 2014		
Total population	4,594,060	38,802,500
Population growth, 10-year	10.9%	9.1%
Population growth, 5-year	6.4%	5.0%
AGE OF POPULATION, 2014		
Under 5 years old	3.9%	6.6%
Under 18 years old	20.9%	24.1%
18 to 64 years old	66.1%	63.1%
65 years and older	13.0%	12.9%
RACE/ETHNICITY, 2014		
Asian non-Latino	24.8%	13.3%
Black non-Latino	6.4%	5.5%
Latino	22.5%	38.9%
White non-Latino	41.7%	38.8%
Other race non-Latino	4.6%	3.5%
Foreign-born	30.6%	28.5%
EDUCATION, 2014		
High school diploma or higher, adults 25 and older	90.4%	83.4%
College degree or higher, adults 25 and older	54.8%	37.9%
HEALTH STATUS, 2014		
Fair/poor health	11.7%	17.1%
Diabetes	7.1%	8.9%
Asthma	13.6%	14.0%
Heart disease, adults	5.2%	6.1%
ECONOMIC INDICATORS, 2014		
Below 100% federal poverty level	11.8%	18.4%
Below 200% federal poverty level	25.5%	40.7%
Household income above \$100,000	36.4%	22.9%
Unemployment rate	5.2%	7.5%
HEALTH INSURANCE, ALL AGES, 2014		
Private insurance	62.6%	51.2%
Medicare	10.5%	10.4%
Medi-Cal and other public programs	18.5%	26.5%
Uninsured	8.4%	11.9%
PHYSICIANS PER 100,000 POPULATION, 2011		
Physicians	267	194
Primary care physicians	86	64
Specialists	181	130
HOSPITALS, 2014		
Community, acute care hospital beds per 100,000 population [†]	202.8	181.8
Operating margin, acute care hospitals*	0.2%	3.8%
Occupancy rate for licensed acute care beds [†]	44.4%	53.0%
Average length of stay, in days [†]	4.3	4.4
Paid full-time equivalents per 1,000 adjusted patient days*	15.5	16.6
Total operating expense per adjusted patient day*	\$4,219	\$3,417

*Kaiser excluded.
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Sources: US Census Bureau, 2014; California Health Interview Survey, 2014; "Monthly Labor Force Data for California Counties and Metropolitan Statistical Areas, 2014" (data not seasonally adjusted), State of California Employment Development Department; "California Physicians: Supply or Scarcity?" California HealthCare Foundation, March 2014; Annual Financial Data, California Office of Statewide Health Planning and Development, 2014.

needs, including access to more philanthropic funding and county tax revenues. However, financial struggles at Alameda County’s county-owned hospital system and public Medi-Cal plan also reportedly stemmed from missteps by former management teams, as well as issues with county oversight, at both organizations. One bright spot in Alameda County’s troubled safety net is its network of strong, stable, private Federally Qualified Health Centers (FQHCs)—which continue to collaborate well with one another.

Market Background

Home to 4.5 million residents, the San Francisco Bay Area (see map on page 17) spans five counties: San Francisco, Alameda, Contra Costa, Marin, and San Mateo. The region’s residents come from a rich diversity of cultures and ethnic backgrounds. A quarter of the population is Asian, nearly another quarter is Latino, and 3 in 10 residents are foreign-born (see Table 1).

The Bay Area continues to rank among the most affluent regions not only in California, but also across the United States. The region leads the seven study sites in income and educational attainment, and its poverty and unemployment rates consistently rank among the lowest statewide. In 2014, unemployment averaged 5.2% in the Bay Area, compared to 7.5% across California. Consistent with those patterns, the Bay Area continues to enjoy an especially favorable insurance mix: Its private insurance coverage rate ranks highest, and its Medi-Cal coverage and uninsured rate rank lowest, among the seven regions studied.

However, dramatic disparities exist within this affluent region. Among the five counties, the prevalence of poverty, residents with no insurance, and Medi-Cal coverage is highest in Alameda County and lowest in Marin County. Within each county, there also are dramatic divides between have and have-not communities and residents, with particularly stark contrasts evident in San Francisco, Alameda, and Contra Costa Counties.

Many Hospital Submarkets Within Sprawling Region

The Bay Area hospital market has long been segmented into multiple submarkets. This is largely the result of a widespread geographic area, dense population, traffic congestion, and natural barriers all combining to limit the distances and directions residents are willing or able to travel for health care. Only two health care systems have a presence throughout the region: Kaiser Permanente and Sutter Health. Across the five-county region, Kaiser has 10 hospitals, and Sutter has 8 hospitals across 11 campuses. Each system accounts for a quarter of acute inpatient discharges across the region.

Other hospitals and hospital systems historically have competed only in submarkets within the Bay Area. The most prominent include the University of California San Francisco Medical Center (UCSF) and John Muir Health; they each have relatively modest regional market shares of about 10%, but play much larger roles within their respective submarkets.

San Francisco is the most competitive of the Bay Area’s submarkets, with four of the five largest hospital systems—Sutter, Kaiser, UCSF, and Dignity Health (two community hospitals)—competing there, along with San Francisco General Hospital, the county-owned safety-net hospital and the county’s only trauma center. Within San Francisco, UCSF’s presence is at least as prominent as that of Sutter’s flagship, California Pacific Medical Center (CPMC).

The East Bay spans a large geographic area consisting of several distinct, diverse submarkets across two counties, Alameda and Contra Costa. In the economically diverse northwestern portion of Alameda County surrounding Oakland, Sutter (Alta Bates Summit Medical Center) and Kaiser (Oakland Medical Center) continue to hold dominant positions—largely splitting the lucrative commercial market between them—while Alameda Health System (AHS) and UCSF Benioff Children’s Hospital Oakland serve as major safety-net hospitals for adults and children, respectively.

In Contra Costa County, John Muir Health (with two hospitals) remains the dominant presence—especially in the affluent central region, where its flagship hospital is located in

Walnut Creek. Kaiser, also with two hospitals in the county, represents Muir's main competition in this submarket. Contra Costa's other acute-care hospitals include county-owned Contra Costa Regional Medical Center, which serves primarily a safety-net role, and San Ramon Regional Medical Center, which has been operated as a joint venture between Muir and for-profit Tenet Healthcare since 2013, when Muir purchased a 49% stake in the hospital.

The two East Bay counties have other submarkets—some flourishing (such as Fremont and the Tri-Valley region anchored by the communities of Dublin, Pleasanton, and Livermore), and others struggling (including the Castro Valley/Hayward and Richmond/San Pablo areas).

The greater Bay Area also includes the affluent submarkets of Marin County (north of San Francisco) and San Mateo County (south of San Francisco), but the health care systems of these counties were not examined in-depth in this study.

Independent Hospitals Dwindling in Number

The Bay Area's hospital sector has long been characterized by a divide between have and have-not hospitals, with the gap between financially strong and struggling hospitals growing over the past decade. In the three years since the last study was conducted, the overall operating margin for all acute care hospitals in the region deteriorated from 3.5% to 0.2% between 2011 and 2014 (the most recent public data available).¹

Most hospitals that had been financially strong in 2011 continued to show solid financial performance since then, though margins tended to be smaller than before. Muir and UCSF both posted operating margins of 4.4% in 2014 (compared to margins of 5.1% and 7.5%, respectively, in 2011). Sutter—historically one of the region's highest-margin systems—posted a relatively modest margin of 2.5% across its Bay Area hospitals. Performance varied widely across Sutter's hospitals, with St. Luke's Hospital, which serves many low-income patients, struggling with a large operating deficit, while the rest of CPMC achieved an 11% margin. Among the systems that serve primarily a mainstream rather than

safety-net patient base, only Dignity Health posted a deficit overall (–2.8%). Its two community hospitals in San Francisco reportedly struggle to compete against hospitals with stronger brands and more robust physician referral networks.

The financial performance of many safety-net hospitals has deteriorated recently (see also Safety Net section below). Most observers noted these struggles occurred despite the boost that Medi-Cal expansion gave to hospital bottom lines. As one hospital executive noted, “Medi-Cal may be a poor payer...but it still pays considerably more cents on the dollar than self-pay or uncompensated care.” For hospitals with high Medi-Cal volumes, California's hospital fee program also provided an additional funding boost by redistributing revenues from hospitals, such as Kaiser, with low Medi-Cal volumes.²

Among the hospitals that were struggling in the last round of this study, one hospital was forced to close: Doctors Medical Center in San Pablo (western Contra Costa County), which ceased operations in May 2015. Other struggling hospitals remain open but face uncertain futures, including Seton Medical Center (in Daly City, just south of San Francisco) and St. Rose Hospital (in Hayward, central Alameda County). Three struggling East Bay hospitals were acquired: Children's Hospital Oakland by UCSF in 2014; and Alameda and San Leandro Hospitals by Alameda Health System, the county-owned safety-net system. These acquisitions had very different outcomes: Children's Oakland achieved financial stability and access to major philanthropic funding, while the hospitals acquired by AHS experienced worsening performance. (These developments are discussed in more detail below.)

Not all struggling hospitals that were acquired by larger systems were safety-net hospitals. ValleyCare Medical Center (in Pleasanton, in the East Bay's prosperous Tri-Valley area) became part of Stanford Health Care in a deal finalized in May 2015 (see Regionalization section below). An aging patient base reportedly played a key role in ValleyCare's eroding financial performance in recent years, as the hospital found itself serving progressively more Medicare beneficiaries

relative to commercial patients, for whom payment rates are much higher.

The aging population—and the resulting deterioration in payer mix—has put pressure on hospitals serving affluent East Bay submarkets, including the much stronger, larger Muir system as well as Washington Hospital in Fremont. Washington Hospital has remained independent, though it formed a clinical affiliation with UCSF in 2013 and reportedly is exploring other partnerships. Some market observers expressed surprise that Washington Hospital has not already been absorbed into a larger system, and questioned how long it can remain viable as an independent entity.

Capacity in Flux as Hospitals Replace Aging Facilities

Largely driven by the need to meet state seismic requirements, most major systems either have completed or are currently undertaking major hospital construction. Muir was first among the region's systems to fulfill seismic compliance, including a replacement of its Walnut Creek flagship hospital. Kaiser replaced 3 of its 10 hospitals in the region, including a major replacement of its Oakland flagship; most other Kaiser hospitals have been made fully compliant through retrofitting. In 2015, UCSF opened new hospitals on its Mission Bay campus to support three key service lines—women's, children's, and cancer services—and is retrofitting older facilities on multiple campuses. Sutter's new CPMC campus, long delayed by disputes with state and local regulators, is currently under construction; when complete, it will consolidate and replace services that until now have been provided on multiple CPMC campuses. Among hospital systems serving primarily a commercial and Medicare patient base rather than a safety-net population, only Dignity Health—with two community hospitals in San Francisco—appears to lack the capital to achieve full seismic compliance by 2030.

In contrast to most mainstream systems, several independent and safety-net hospitals lack the capital to achieve full seismic compliance, and face potential closure by 2030

or earlier unless the state grants them reprieves from current seismic requirements. As one observer noted, “[The need] to set aside, at a conservative estimate, hundreds of millions [of dollars] per facility to achieve full compliance makes potential buyers very leery, to put it mildly. It's hard to see how [hospitals like] St. Rose or Seton can have long-term futures as inpatient facilities.”

With some of the major systems yet to make final decisions about how much old capacity to phase out as new hospitals come online, plus uncertainty about the viability of financially struggling hospitals, respondents reported that the overall net change to inpatient capacity over the next several years will remain uncertain for some time. One facility that many observers expect to close eventually is the Berkeley campus of Sutter's Alta Bates Summit Medical Center. While Sutter has made no public announcements regarding the fate of the Berkeley campus, observers noted that the system has not filed plans to either rebuild or retrofit the facility, which is seismically compliant only until 2030.³

Overall, nearly all respondents expected beds per capita to be reduced in the region once all the new hospitals have come online and old facilities have been phased out. Given the historically overbedded nature of the market, and the broader trend of services moving from inpatient to outpatient settings over time as a result of advances in technology and changes in payment incentives, most respondents did not view inpatient capacity reductions as a problem overall. However, in some submarkets—especially low-income communities most likely to experience hospital closures—reduced inpatient and emergency department (ED) capacity may become a significant access issue.

Physician Consolidation Increases

In recent years, an increasing number of Bay Area physicians have been joining the large medical groups aligned with Kaiser, Sutter, UCSF, and John Muir. Kaiser's physician arm, The Permanente Medical Group (TPMG), is the largest in

the region, with more than 2,600 physicians. TPMG is widely viewed as holding a recruiting edge over other physician organizations, especially for primary care physicians (PCPs).

Sutter has long maintained separate medical foundations to support its three Bay Area regions: West Bay (San Francisco), East Bay, and Peninsula Coastal. The Palo Alto Medical Foundation (PAMF)—the Peninsula Coastal region’s foundation—has been by far the largest and most successful of Sutter’s foundations. PAMF’s elite brand and reputation (independent of the Sutter brand) has long translated into strong leverage with health plans. Along with TPMG, PAMF’s largest medical group, the Palo Alto Foundation Medical Group, is among the only large, integrated multispecialty practices in the region. As part of its system-wide reorganization (see Sutter section below), Sutter plans to merge its three Bay Area foundations into one, using PAMF as the model for the merged entity. However, no definite timeline has been set for the foundation merger.

Another large system based just outside the market—Stanford Health Care, headquartered in Palo Alto—has been aggressively establishing a presence in the East Bay. Stanford has used its relatively new foundation, University HealthCare Alliance, to acquire numerous East Bay physician practices. This development—first reported in the last round of the study—has continued unabated since then (see Stanford section below).

Efforts to Keep Private Practice Viable

While large system-affiliated groups continue to grow, many physicians—particularly specialists—have continued to maintain their autonomy in small, independent, single-specialty practices. Many belong to IPAs, which provide risk contracting and practice support. Two large IPAs span multiple Bay Area submarkets: Brown and Toland (B&T), historically dominant in San Francisco, and Hill Physicians, historically an important presence in the East Bay (and other Northern California markets).

In the last round of this study in 2011-2012, the market had just experienced major shifts in physician alignments. By 2010, B&T and UCSF had severed longstanding ties, leading UCSF to form an affiliation with Hill, which gave Hill a presence in the San Francisco market for the first time. B&T merged with a major East Bay IPA, Alta Bates Medical Group, thus making itself a key East Bay player. These shifting affiliations led to increasing regionalization of provider networks across the Bay Area.

Over the past three years, the Bay Area has seen no repetition of such major realignments, but the web of relationships among providers has become more complex. For example, B&T and UCSF, whose split five years ago set off a cascading series of shifting affiliations, reportedly have been considering partnering with each other again. Market observers viewed that development as part of a larger pattern of providers exploring a range of partnerships and affiliations with other providers (and with health plans). One market expert described providers as taking a “more pluralistic approach to collaborations [and] avoiding getting locked into exclusive arrangements that might cause them...to miss out on the volume...and the opportunities...that other collaborations can bring.”

Recently, IPAs have been diversifying their revenue streams beyond their traditional core business of commercial HMO contracting. The push to diversify is motivated largely by the continuing slow erosion of the commercial network-model HMO. As IPAs’ commercial HMO lives have declined, their Medicare Advantage lives have grown significantly, as has their participation in a spectrum of new payment arrangements. B&T has been especially active in diversifying. Unlike most IPAs, it has long been able to negotiate fee-for-service PPO contracts on behalf of its physician members, having satisfied the Federal Trade Commission’s requirement to demonstrate clinical integration. B&T also participates in numerous commercial ACOs with most major health plans, and has been the only provider in Northern California to participate in Medicare’s Pioneer ACO program.⁴

Beyond pursuing diverse revenue streams, IPAs more broadly have been seeking ways to keep private practice viable—especially for young PCPs, who overwhelmingly have been choosing large system-affiliated groups over private practice. IPAs are seeking to develop viable new models of smaller-scale, integrated group practices that can accommodate physicians looking to practice part-time, keep practice overhead costs manageable and predictable, and provide physicians with clinical support without subjecting them to the bureaucracy of large groups. Without the successful emergence of such new models, IPA physician membership and patient volumes are likely to shrink over time, and membership will become more skewed toward older physicians and specialists.

Because IPAs need capital to pursue the development of these new models, they are forming or exploring partnerships with other organizations to gain access to capital.⁵ In 2014, Hill Physicians began partnering with two health plans, Anthem Blue Cross and Blue Shield of California, which provided Hill with capital by purchasing ownership stakes in PriMed, Hill's management services organization (MSO). B&T reportedly has been exploring joint ventures and other affiliations with a range of partners, but as of late 2015, had not finalized any plans.

As IPAs and other physician organizations seek ways to keep independent practice sustainable, one new model of primary care practice that several respondents pointed to as a successful, innovative, and growing model was One Medical Group, headquartered in San Francisco. With substantial venture capital backing, the organization has grown to include 20 Bay Area practice sites with nearly 100 PCPs; it also has opened practice sites in numerous cities around the country. One Medical combines aspects somewhat similar to the Kaiser model (the use of information technology and e-medicine, convenience and access features such as same-day appointments) with the concierge care model (longer visits, fewer patients) and retail-clinic model (storefront locations, transparent prices). The group also draws on approaches from

other industries, including the hospitality sector, to improve the consumer experience and reduce overhead costs.

In recruiting PCPs, One Medical reportedly has had success competing against the large system-affiliated groups, in part because its model has been more flexible in accommodating part-time physicians and also because physicians have found its relative lack of bureaucracy and longer visits with patients appealing. On the consumer side, the model appeals especially to millennials, leading observers to suggest that One Medical benefits from favorable selection in its risk contracts. Many of its practice sites are retail storefronts in very affluent locations, so the group tends to get a favorable payer mix as well.⁶

Several respondents pointed to One Medical's innovations as a potential blueprint for a viable alternative to large system-affiliated groups. However, it is unclear how replicable or scalable the model is. Some observers suggested that One Medical's continued growth and success may depend on ongoing infusions of venture capital. Also, as the group grows, keeping the flexibility and lack of bureaucracy that has attracted physicians may become more of a challenge.

Provider Networks Increasingly Regionalized

The regionalization of provider networks, first reported in the last round of this study in 2012, has continued and evolved since then. Providers are not following a single blueprint for regional expansion, but instead are pursuing a diverse array of strategies to expand their clinical footprints across the region. These strategies include Sutter consolidating its sprawling, decentralized Bay Area operations into a single corporate region and Stanford acquiring numerous physician practices and a hospital in the East Bay. In addition, UCSF and Muir formed a partnership, the Bay Area Accountable Care Network (BAACN),⁷ aimed at expanding the geographic reach of these two systems to encompass the entire Bay Area region.

As noted above, on the pediatric side, UCSF acquired Children's Hospital Oakland and rebranded it as UCSF

Benioff Children's Hospital. Marin General Hospital's pediatric department also gained the UCSF Benioff brand after a clinical partnership was formed between UCSF and Marin General. Meanwhile, Stanford's Lucile Packard Children's Hospital formed clinical partnerships with Sutter's CPMC (reported in the 2012 study) and Muir, making Packard specialists accessible to pediatric patients in San Francisco and Walnut Creek.

Stanford's East Bay Expansion

The motivation for Stanford Health Care's acquisition of numerous physician practices and a hospital in the East Bay has been the subject of much speculation among Bay Area providers and market observers. Many assumed the acquisitions were driven primarily by Stanford's desire to gain more quaternary (e.g., transplant) referrals for its hospital in Palo Alto. However, other observers cast doubt on the view that referrals were driving Stanford's geographic expansion. As one respondent pointed out, acquiring practices—reportedly at premium prices—and an inpatient facility (ValleyCare) was “a very expensive way to obtain referrals, even lucrative transplants”; another respondent noted that because Stanford Hospital already was operating at or near capacity, an aggressive strategy to steer more referrals to the hospital did not make sense.

Instead, these observers suggested, Stanford has been building a regional provider network to support an expansion of its health plan. Stanford reportedly saw a lucrative opportunity to offer high-end insurance products targeted toward high-margin technology employers who are much less price-sensitive than the average employer, and who value strong provider brands and a seamless consumer experience for their high-wage workers, both as a recruiting and retention tool, and as a way to minimize productivity disruptions.

To capture this high-end market segment, Stanford reportedly has been pursuing a multipronged strategy: (1) expanding its own provider network into affluent parts of the Bay Area where many tech workers live and/or work, to attract

tech employers with a regional presence, and (2) renting a provider network from a major health plan in other parts of the state, to attract tech employers with a statewide presence. According to respondents from multiple health plans, Stanford executives had sought to rent a statewide provider network, and in the process, had discussed their strategies for both the region and the state. To date, it does not appear that any major health plan made its provider network available for Stanford to rent.

The future course of Stanford's Bay Area expansion, and of the system's strategies more broadly, recently became more uncertain when it was announced that Stanford's CEO would be leaving the organization by the end of 2015.⁸ With a new leadership team yet to be announced, it is unclear the extent to which geographic expansion in the Bay Area will continue to be a strategic priority for Stanford.

UCSF-Muir Partnership

In 2014, UCSF and Muir formed the BAACN partnership, aimed at building a regional care network large enough to compete with systems like Kaiser and Sutter throughout the entire region. Numerous other Bay Area providers, including both physician organizations and community hospitals, currently are in negotiations to join BAACN to round out the regional provider network. The new entity is applying for a limited Knox-Keene license, allowing it to assume full financial risk for health care services from health plans.⁹ BAACN is expected to compete in the employer-sponsored market, first targeting the Muir and UC workforces by mid to late 2016, then expanding to the broader employer-sponsored market in 2017 (with the exact timetable to be determined, in part, by the timing of state approval of the limited insurance license). The East Bay is home to a large population of UC employees, which is considered a particularly attractive initial target for BAACN.

In accepting full risk for patient care, the onus will be on the collaborating providers to manage population health efficiently enough to keep BAACN's insurance products priced

competitively against the likes of Kaiser over time. Indeed, competing with Kaiser on value appears to be a primary goal of the collaboration. If BAACN can meet that objective—a major challenge—it has the opportunity to become a force in submarkets where both principal partners have had only limited presence to date. One prominent example is the Oakland/Berkeley submarket, which has a large concentration of well-insured commercial lives, currently split largely between Kaiser and Sutter. It is among the first submarkets that BAACN is expected to pursue vigorously.

UCSF brings to the partnership an already substantial regional footprint, forged in part through clinical relationships with numerous community providers and in part through its ability to draw patients from outside San Francisco, who view UCSF as a premier destination for high-end services. Muir brings to the collaboration a strong track record of building physician networks and managing care, making it a valuable strategic partner for UCSF. Those capabilities—central to a successful population health strategy—have been areas of relative weakness for UCSF, in common with many academic medical centers focused on teaching, research, and tertiary care. For the BAACN partnership to manage care and compete head-to-head with Kaiser effectively, it will need to develop clinical integration—including a common IT infrastructure—between the principal partners; this represents a key priority and a significant challenge for the fledgling collaboration.

Muir's partnership with UCSF in BAACN will take place alongside the ongoing collaboration Muir has with Stanford's Lucile Packard Children's Hospital in pediatrics. That partnership, formed in 2012, makes a wide range of Packard's pediatric specialty services available at Muir's Walnut Creek hospital. In 2015, Muir and Packard jointly launched a pediatric intensive care unit at that facility. Market observers pointed to Muir's simultaneous, separate strategic partnerships with UCSF and Packard as an example of how the web of provider linkages in the Bay Area has grown, and become more complex, in recent years.

Sutter Consolidates Operations, Introduces Health Plan

In recent years, the Sutter system has made several major changes to its operations aimed at reducing clinical and administrative costs, integrating care delivery, and unifying and streamlining corporate decisionmaking. According to market observers, the fee-for-service powerhouse undertook these changes largely to position itself for a transition to value-based payment and population health management, which many view as inevitable.

To reduce administrative costs, Sutter consolidated the many back-office functions throughout its Northern California operations into a single Sacramento location in 2013. On the clinical side, the system implemented multiple initiatives to reduce inpatient costs. These efforts included consolidation of services previously duplicated among multiple facilities; for example, Alta Bates Medical Center's cardiac services were discontinued in Berkeley and consolidated on the Oakland campus. Sutter also has made strides in integrating its care delivery, including implementing a common electronic health record across inpatient and ambulatory settings in 2015.

To gain control over a previously decentralized, unwieldy governance structure, Sutter has undertaken multiple rounds of corporate reorganization. In 2010, it consolidated more than 40 hospital regions into five. And, as noted above, a second round of consolidation in 2015 saw Sutter's three Bay Area regions combined into one—a move that should further centralize and streamline decisionmaking and implementation. As part of this consolidation, Sutter's three Bay Area medical foundations will eventually be merged into one, with the aim of spreading the highly successful PAMF model throughout Sutter's Bay Area operations.

Market observers viewed the pending foundation merger as a necessary move for Sutter, given that its other foundations—especially the East Bay foundation—have not approached PAMF's success in recruiting physicians, building an integrated group culture, forging a strong brand, or generating profits. However, the foundation merger is widely

expected to present a major challenge for Sutter, as the three foundations have very different histories and physician cultures. Another key challenge for the merged foundation is that, according to multiple observers, much of PAMF's success has been based on a model of owning its own ancillary facilities and driving high patient volumes to those facilities at high unit prices. Going forward, that model is likely to become progressively less of a blueprint for success if value-based payment gains traction, as most observers expect.

One of Sutter's most significant strategic moves over the past few years was the introduction of its own health plan, Sutter Health Plus. The new plan offers HMO products centered around Sutter's own providers, and is aimed at competing aggressively for employer-sponsored business—particularly in the mid-sized segment—against Kaiser HMO products and low-premium high-deductible products. A central objective in sponsoring its own health plan is to keep the savings from Sutter's cost-reduction efforts within the Sutter system, rather than having to share them with external health plans.

Launched on a rolling basis across Sutter's Northern California markets, Sutter Health Plus will begin offering coverage in the five Bay Area counties for 2016 enrollment. If the same pattern holds in the Bay Area as in Sacramento, the new plan will have success in building initial enrollment by offering premiums priced lower than Kaiser's. Market observers suggested, however, that Sutter Health Plus is able to undercut Kaiser premiums only because of substantial subsidies it is receiving from the Sutter system, and that maintaining such subsidies over time would not be a viable strategy. Although Sutter continues to emphasize cost reduction as an organizational strategy, its cost structure is still widely viewed as significantly higher than that of Kaiser, which is also engaged in ongoing efforts to improve efficiency.

Sutter's strategy of transforming itself into a value provider represents a major departure for a system whose success has been based, to a large extent, on leveraging its consolidated market power to command high prices in a fee-for-service environment. One market observer described Sutter as an

organization currently “trying to straddle [the] twin worlds” of fee-for-service and value-based payment, which involves many conflicting incentives internally. Observers pointed to Sutter's recent, highly contentious contracting dispute with Blue Shield of California (resolved in early 2015) as evidence that the system has yet to transition away from the fee-for-service culture under which it has been so successful.

More Competition, More Choices for Consumers Expected

From the developments described above, it is clear that major Bay Area providers are taking very different approaches to expanding their presence throughout the region. While Sutter is largely trying to harness the power of its existing operations by consolidating and centralizing, providers with smaller existing footprints—like UCSF and Muir—are pursuing regionalization primarily through strategic partnerships. Provider approaches to regionalization also reflect different underlying strategies: While Stanford's approach appears targeted primarily toward winning business from high-margin, high-wage employers in the technology sector, Sutter and the BAACN partnership are pursuing more of a value-based population management strategy, seeking to develop regional networks that can deliver and manage care efficiently enough to compete vigorously with Kaiser in the commercial market.

Most respondents expected providers' growing regional reach to ramp up price competition and expand the range of insurance-product and provider-network choices available to consumers. This is likely to be particularly true in certain areas of the East Bay such as the Oakland/Berkeley submarket, where provider competition and available care networks have been limited to date. Market observers cautioned, however, that increased provider competition, and its resulting benefits to purchasers and consumers, will be sustainable only as long as providers can continue lowering their cost structures and moving toward more integrated and efficient care delivery. Several observers also expressed concern that, after an initial increase in price competition aimed at gaining market share, growing provider consolidation might ultimately result in less

competition and higher prices, as other health care markets have experienced.

Strong Safety Nets Pressured by Rising Demand

Compared to most other California communities, San Francisco and Alameda counties historically have had very strong safety nets, reflecting elected officials' and community residents' deep-seated commitment to provide care for low-income populations.¹⁰ Both counties have developed extensive, stable networks of safety-net providers, and collaboration historically has flourished among these providers to an extent not often seen in other communities. Recently, these robust safety nets have been pressured by increased demand stemming from the Medi-Cal expansions. Overall, the San Francisco safety net weathered these challenges with far fewer major problems than its Alameda County counterpart.

Divergent Paths for County Hospitals

San Francisco General Hospital (SFGH), owned by the county and operated by the San Francisco Department of Public Health (SFDPH), continues to anchor the county safety net. In 2014, SFGH accounted for 40% of the county's inpatient discharges for Medi-Cal and county medically indigent patients. Historically, the hospital has run operating deficits (at times approaching 20%), relying on supplemental funding from both the Medi-Cal waiver and county general revenues to make up shortfalls. Recently, revenues from the Medi-Cal expansion helped the hospital's bottom line, particularly because SFGH—like other county-owned hospitals in California—receives enhanced, cost-based reimbursement for treating newly eligible Medi-Cal enrollees. SFDPH also engaged in successful cost-cutting efforts in recent years, reining in purchasing and other administrative costs. As a result, SFGH posted a healthy 7.7% operating surplus in 2014.

Compared to other county hospitals, SFGH enjoys several advantages. First, the hospital has a longstanding clinical partnership with UCSF, which provides physicians and

other clinical staff to treat patients, conduct research, and teach at SFGH. UCSF staff work alongside SFGH clinicians, who are employed by SFDPH. Perhaps SFGH's most significant advantage is its location in a city that is both wealthy and very supportive of safety-net services. A voter-approved bond measure enabled SFGH to replace its aging facility with a seismically compliant new hospital, which will double emergency department (ED) capacity and increase trauma and operating room capacity. Thanks to the concentration of tech wealth in the city, SFGH has attracted substantial philanthropic funding, similar to some other San Francisco hospitals—most notably UCSF—and in contrast to most county-owned hospitals.¹¹ A large philanthropic contribution will enable SFGH to convert its old hospital into an ambulatory care center.

Among San Francisco's private hospitals, Chinese Hospital and Sutter/CPMC's St. Luke's Hospital are among those with relatively high shares of Medi-Cal and uninsured patients. UCSF is an important safety-net provider of adult tertiary care, as well as pediatric specialty and inpatient care through its Benioff Children's Hospital. While located in northern San Mateo County rather than San Francisco, Seton Medical Center (see Hospital Submarkets section above) was considered by executives of some mainstream hospital systems to be a key safety-net hospital. These respondents expressed concern that a Seton closure might worsen their own payer mix and create some capacity constraints at their hospitals—particularly in the ED.

In Alameda County, the safety net is anchored by Alameda Health System, which is owned by the county but independently operated as a public health authority. Formerly known as Alameda County Medical Center (ACMC), the county hospital changed its name when it acquired San Leandro Hospital in 2013 and Alameda Hospital in 2014 to add to its existing acute care inpatient facility, Highland Hospital. Like SFGH, Highland Hospital serves as a regional trauma center and a teaching site for UCSF.

In common with San Francisco, Alameda County is characterized by strong public commitment to the safety net. A bond measure is funding a \$700 million rebuild of Highland Hospital to meet seismic requirements. When completed in 2016, the rebuilt facility will feature a new inpatient tower and renovated ED facilities. AHS also receives revenues from a dedicated county sales tax, which voters approved by a wide margin. However, Alameda County does not have as high a level of community resources relative to need as San Francisco. As a result, AHS has not benefited from the level of philanthropic funding received by SFGH.

Before Alameda and San Leandro hospitals were acquired by the county safety-net system, their payer mixes were more favorable than Highland Hospital's, which reportedly made them attractive targets to the former leadership team of APMC. However, both hospitals had long track records of operating deficits, which made many observers skeptical about the acquisitions at the time. Indeed, after the merger, AHS as a system, and the three hospitals individually, all struggled financially. In 2014, the system posted an operating deficit of about 25%, despite getting the same cost-based reimbursement for newly eligible Medi-Cal enrollees that SFGH and other county hospitals receive. The flagship Highland facility reported a 27.3% deficit, while the two smaller hospitals had deficits in the 14% to 16% range. AHS's financial crisis reportedly was exacerbated by a "tangled IT and financial accounting system," which caused severe cash flow and other problems.¹²

By May 2015, AHS had made progress on improving cash flow and other financial indicators. At that time, its board also appointed a new CEO with extensive experience managing hospitals—including county hospitals—in the Bay Area and California, and is well regarded in the safety-net community. Observers pointed to these promising signs of a turnaround at AHS, but also noted that many uncertainties remain for the system, including San Leandro Hospital's future as an acute care inpatient facility. AHS may discontinue some inpatient

services at the facility, convert it to a rehabilitation facility, or close it altogether.

In Alameda County, other key providers of inpatient safety-net care include UCSF Benioff Children's Hospital Oakland for pediatric services and Sutter-owned Alta Bates Summit for obstetric services, especially for Medi-Cal patients. St. Rose Hospital in Hayward, while accounting for only a small share of the county's safety-net inpatient volume, has a high proportion of low-income patients because of its service area and its mission. The former Doctors Medical Center, while technically located in Contra Costa County, was near Alameda County, and served a safety-net role for residents of both counties. Before its financial struggles forced it to close, its ED had long been used by many low-income patients for primary and urgent care more than emergency care. After Doctors closed, one of the East Bay's largest FQHCs, LifeLong Medical Care (see below), used funding from the state, Kaiser, and Muir to open an urgent care facility across the street from the shuttered hospital to serve some of the needs previously supported by the Doctors ED.

Strong FQHCs Expand Capacity, Face Challenges

Both San Francisco and Alameda County have strong, extensive networks of FQHCs that have long played a central role in the safety net. Recently, the Medi-Cal expansion has led to surging demand that has challenged the capacity of these strong networks, putting pressure on their ability to deliver both primary and specialty care. In both counties, FQHCs have been expanding to meet increased demand, but the shortage of available physicians and other clinical staff has been a significant barrier to capacity expansions.

San Francisco has nine FQHC organizations: eight private and one operated by SFDPH. North East Medical Services (NEMS), with a large Chinese-American patient base, is the county's largest private FQHC. After recent expansion, NEMS has nine sites throughout the county and a number of satellite clinics in neighboring counties. The public FQHC

run by SFDPH encompasses 22 sites throughout the county, including clinics on the SFGH campus. Besides the FQHCs, low-income residents also receive care at two free clinics and a health center affiliated with Dignity-owned St. Mary's Medical Center.

Other than NEMS, San Francisco FQHCs have not added clinic sites over the past few years. Instead, many clinics have added capacity through other means such as extending clinic hours and increasing clinician full-time equivalents (FTEs). However, capacity expansions have been constrained by recruiting and retention challenges. FQHCs reportedly have increased PCP salaries to attract new hires and retain existing staff doctors, but competing against the large system-affiliated groups—especially Kaiser—on both compensation packages and working conditions have been major challenges. Behavioral health is an area with especially serious capacity constraints, stemming from a severe shortage of both psychiatrists and licensed clinical social workers. Recruitment and retention challenges have been exacerbated by San Francisco's very high and still rising cost of living.

Like San Francisco, Alameda County's clinic network is extensive, consisting of nine FQHC organizations—eight private and one public, operated by AHS—plus several free clinics. The public FQHC, consisting of four clinic sites, has much less capacity and plays a much smaller role in direct care delivery than its San Francisco counterpart. The largest FQHCs continue to be La Clínica de la Raza (16 sites), whose patient base is predominantly Latino, and LifeLong Medical Care (nine sites), which serves many older and homeless patients. Over the past several years, both FQHCs expanded into Contra Costa County, but most of their clinic sites are in Alameda County. East Bay clinics face recruitment and retention challenges similar to those reported by San Francisco clinics, leading to the same kinds of capacity constraints.

Despite the challenges they face, FQHCs represent the strongest, most stable part of the Alameda County safety net. Among their notable achievements are strong behavioral health integration—especially in the largest FQHCs,

La Clínica and LifeLong—and robust collaboration, not only among the clinics, but also between the clinics and the county. In San Francisco, private FQHCs reportedly collaborate well with one another, aided by the clinic consortium, but their relationship with the county-run clinics has often been a competitive one.

Growing Pains for Medi-Cal Managed Care Plans

San Francisco and Alameda County both continue to operate Medi-Cal managed care plans under the Two-Plan Model, with a county-owned public plan (called a “local initiative”) competing against a private health plan.¹³ In both counties, the local initiatives historically have had much higher shares of enrollment, and performed better on quality and enrollee satisfaction measures, than the private plans (operated by Anthem Blue Cross in both counties).

In recent years, enrollment in San Francisco's local initiative, San Francisco Health Plan (SFHP), has grown dramatically, from about 36,000 in 2010, to 64,000 in 2013, to over 122,000 in mid-2015. This growth resulted not only from the ACA Medicaid eligibility expansion but also the 2011-2012 transition of Medi-Cal's Seniors and Persons with Disabilities (SPD) population into managed care. When these new enrollees entered Medi-Cal managed care, they enrolled in SFHP at markedly higher rates than in Anthem,¹⁴ pushing SFHP's market share from 75% in 2010 to 85% in 2015.

Rapid growth has strained the capacity of SFHP's provider network and left the plan struggling to meet state standards for timely access to care, for both primary and specialty care—with access problems reported to be especially acute in psychiatry, orthopedics, and dermatology. Despite these challenges, SFHP continued to receive high marks as a well-managed, financially strong and stable health plan providing high-quality care overall. Indeed, SFHP's reputation for quality is supported by data from the state's Medi-Cal Managed Care Performance Dashboard, which places SFHP among California's highest-performing Medi-Cal plans. In 2014, SFHP scored 88 out of 100 on a composite measure

of plan performance on quality and satisfaction, trailing only Kaiser plans statewide.

Like SFHP, Alameda County's local initiative Alameda Alliance for Health historically has enrolled a large share—around 80%—of the county's Medi-Cal managed care population. However, unlike SFHP's growing share of enrollment, the Alliance's market share has remained stable as overall Medi-Cal managed care enrollment has surged with the SPD transition and the ACA eligibility expansion.

The Alliance has long struggled financially, and in recent years, its fiscal solvency and ability to pay claims in a timely manner deteriorated to the point that it was placed under state conservatorship by the state Department of Managed Health Care (DMHC) in May 2014. This move was triggered by the Alliance's application to participate as a Qualified Health Plan in the state's public marketplace, Covered California. During the application process, the Alliance's inability to meet state fiscal solvency standards came to light. Respondents cited a wide range of key factors driving the Alliance's financial woes: lack of systematic financial controls throughout the organization; a long-vacant chief financial officer position; inadequate oversight from the board of directors; and high clinical costs stemming from insufficient utilization management and care management, challenges transitioning the SPD population into managed care, and high hospital payment rates negotiated with the dominant Sutter system.

Recently, the Alliance has shown promising signs of regaining its footing. The long-vacant CFO position was filled in May 2014, and a new CEO, who took over in May 2015, reportedly has been well received by the safety-net community. After improving its fiscal solvency indicators markedly, as well as meeting numerous other conditions and milestones set by DMHC, the Alliance was able to emerge from conservatorship in October 2015. However, it remains uncertain whether the Alliance's new leadership can steer the organization toward greater financial stability and whether the board of directors can exercise closer and more effective oversight than in the past.

Broader concerns also persist about the performance of both of Alameda County's Medi-Cal managed care plans. Both the public and private plans rank well below their San Francisco counterparts on composite measures of quality and satisfaction, and the private plan operated by Anthem Blue Cross ranks well below the state average as well.¹⁵

County Indigent Programs Shrink, Serve Remaining Uninsured

Prior to the ACA insurance expansions, San Francisco and Alameda County both operated programs providing care for low-income, uninsured adults that ranked among the state's most expansive county programs for the medically indigent.¹⁶ San Francisco's program, Healthy San Francisco (HSF), took a particularly broad, comprehensive approach, with an income eligibility threshold of 500% of federal poverty—much higher than the income cutoffs used by other counties. The program was open to all residents meeting income requirements, including undocumented immigrants. HSF also covered an unusually broad set of services, including primary, specialty, hospital, ED, and behavioral health services, as well as prescription drugs. This expansive, innovative approach was made possible by San Francisco's wealth and its high degree of public-private cooperation, in addition to its strong commitment to the safety net. At its peak, HSF enrollment reached approximately 54,000.

In 2011, San Francisco created SF PATH (San Francisco Provides Access to Healthcare) as the county's Low Income Health Program (LIHP), managing it as part of Healthy San Francisco.¹⁷ The state created the county LIHP program as an early ACA coverage expansion, to ease the transition of uninsured residents into expanded Medi-Cal coverage. SF PATH enrolled 12,000 residents who were transitioned into Medi-Cal in January 2014. At that time, HSF income eligibility was lowered to 400% of poverty—still far higher than any other county in California.

With many former HSF and SF PATH enrollees now covered by Medi-Cal or Covered California, HSF enrollment

had declined to about 15,000 by mid-2015. Undocumented residents account for most of the enrollment; in addition, residents eligible for Covered California but who are unable to afford the premiums also are allowed to remain in HSF. Their HSF eligibility was considered temporary until August 2015, when a unanimous vote by San Francisco's Health Commission made their eligibility permanent. At that time, the commission also voted to restore HSF's income threshold to 500% of federal poverty, and approved a new "Bridge to Coverage" provision that will allow an additional 3,000 residents with incomes up to 500% of poverty to receive both premium and out-of-pocket cost-sharing assistance for Covered California coverage beginning in 2016.

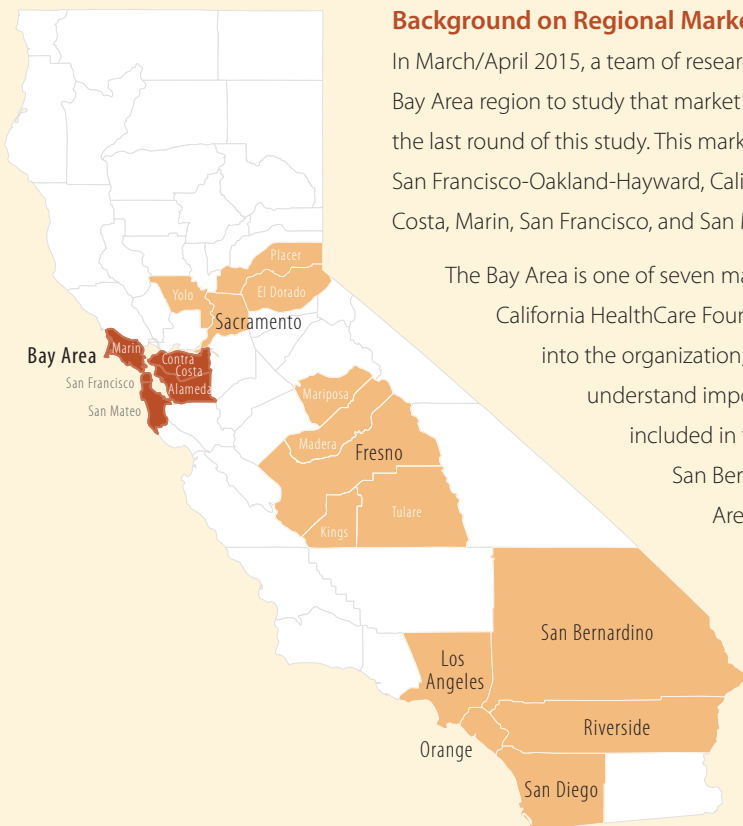
Before the ACA expansions, Alameda County's medically indigent program, Health Program of Alameda County (HealthPAC), covered more than 40,000 adult residents, including undocumented immigrants, up to 200% of poverty. With the transition to Medi-Cal coverage, HealthPAC enrollment fell but remained quite high, at nearly 33,500 as of October 2015. Its income threshold remains unchanged, and undocumented residents now account for almost the entire enrollment base. Maintaining funding for HealthPAC, whose costs total about \$50 million a year, poses a serious ongoing challenge for Alameda County. Like other California counties, a large portion of Alameda County's health budget was redirected to social services under state Assembly Bill 85.¹⁸

Issues to Track

- ▶ Will the systems that are pursuing regionalization strategies be able to successfully expand their clinical footprints across the region? Will geographically broader provider networks ramp up competition in submarkets that have seen limited competition to date, such as those in the East Bay? Will the new insurance products based on these new networks make significant, lasting inroads on Kaiser's commercial market share? What will the ultimate impact be on purchasers' and consumers' choices, costs, quality, and access?
- ▶ Will the region's struggling hospitals find ways to meet seismic requirements and remain viable, or will they face closure or acquisition? What will the impact be on low-income patients and on neighboring providers?
- ▶ To what extent will the region's IPAs or other physician organizations find ways to keep private practice viable for primary care physicians? Will new, smaller-scale models of integrated group practice successfully emerge as alternatives to the large system-affiliated practices?
- ▶ To what extent will safety-net providers be able to meet increased demand resulting from the Medi-Cal expansion by continuing to expand capacity? Will safety-net clinics manage to recruit sufficient numbers of primary care physicians and other clinicians? At what pace will demands on the safety net continue to increase?
- ▶ Will Alameda County's troubled county hospital system and local initiative Medi-Cal plan be able to gain management and financial stability? Will the county hospital system have to close one of its inpatient facilities?
- ▶ Will the county medically indigent programs be able to maintain public support and county funding now that undocumented adult immigrants are the primary beneficiaries of the programs?

ENDNOTES

1. Annual Financial Data, California Office of Statewide Health Planning and Development, 2014. Data reflect each hospital system's fiscal year.
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, to which federal matching dollars are added; these funds are then redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. Payments began in 2010. The program has been renewed three times and is currently set to expire at the end of 2016. However, California voters could approve a ballot initiative in November 2016 that would eliminate the program's end date and require voter approval of further changes to the program.
3. Sutter completed a seismic upgrade and expansion of Alta Bates Summit's Oakland campus in 2014.
4. In the first two years of the Pioneer ACO program, B&T earned shared savings payments; in the third year, it generated savings within the minimum savings rate, and therefore did not receive a shared savings payment. B&T reportedly decided to discontinue participation as a Pioneer ACO as of late 2015.
5. Because IPAs must distribute all surplus earnings to their members at the end of each year, they tend to lack sufficient capital internally to fund such initiatives.
6. One Medical, which accepts most commercial and Medicare insurance as well as cash-pay patients, supplements revenues by charging patients modest (\$150 to \$200) annual membership fees, which many employers pay on behalf of employees. The model reportedly is popular with technology companies.
7. The Bay Area Accountable Care Network is the working name for the new entity, but a final name had not been decided on as of late 2015.
8. Chris Rauber, "Shocker: Stanford Health Care CEO to Leave at Year-End to Take Job at a Huge Insurer," *San Francisco Business Times*, September 24, 2015, www.bizjournals.com.
9. Under a limited Knox-Keene license, BAACN would not contract directly with purchasers, but instead would partner with health plans that would provide marketing and enrollment services.
10. While Contra Costa, Marin, and San Mateo Counties are also part of the study, most interviews were conducted in San Francisco and Alameda Counties; therefore, the discussion focuses on these two counties.
11. Victoria Colliver, "Zuckerberg, Wife Give \$75 Million to S.F. Hospital," *San Francisco Chronicle*, February 6, 2015, www.sfgate.com.
12. Chris Rauber, "Big, Financially Challenged Bay Area Health System Names New CEO," *San Francisco Business Times*, May 27, 2015, www.bizjournals.com.
13. Kaiser also covers Medi-Cal enrollees in both counties through subcontracts with the local initiatives. Kaiser's Medi-Cal population consists largely of people who either had Kaiser coverage themselves, or have an immediate family member who has had Kaiser coverage, within the past 12 months.
14. In part, SFHP's disproportionate growth stems from auto-assignment rules used to assign new beneficiaries who do not choose a plan; all the rules favor auto-assignment into SFHP. The auto-assignment algorithms include assigning new beneficiaries into plans with (1) higher quality scores, (2) higher discharges at Disproportionate Share Hospital (DSH) program hospitals, and (3) PCPs within the county public hospital system.
15. Scores for the Alameda County public and private plan were 50 and 31, respectively, compared to San Francisco's public and private plans' respective scores of 88 and 58. The statewide weighted average was 58. Medi-Cal Managed Care Performance Dashboard, California Department of Health Care Services, June 16, 2015, www.dhcs.ca.gov (PDF).
16. California counties have an obligation to provide health services to their lowest-income uninsured residents through so-called "medically indigent programs," but counties are given considerable latitude in determining eligibility and services under their programs.
17. The San Francisco Health Plan serves as the third-party administrator for Healthy San Francisco.
18. In an arrangement known as 1991 realignment, California counties receive funds from state vehicle license fees and sales tax revenues to support county health, mental health, and social services programs. With the expectation that many uninsured residents would gain Medi-Cal or other coverage under the ACA and that the need for county medically indigent programs would decline, Assembly Bill 85 transfers either 60% or a formula-based percentage of each county's health fund to social services. Alameda is one of the counties to have a formula-based percentage of its county health funds redirected.



Background on Regional Markets Study: San Francisco Bay Area

In March/April 2015, a team of researchers from Mathematica Policy Research visited the San Francisco Bay Area region to study that market’s local health care system and capture changes since 2011-2012, the last round of this study. This market (referred to in this report as the Bay Area) encompasses the San Francisco-Oakland-Hayward, California, Metropolitan Statistical Area and includes Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.

The Bay Area is one of seven markets included in the Regional Market Study funded by the California HealthCare Foundation. The purpose of the study is to gain important insights into the organization, delivery, and financing of health care in California and to understand important differences across regions and over time. The seven markets included in the project — Fresno, Los Angeles, Orange County,* 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.

Mathematica researchers interviewed more than 200 respondents for this study, with 27 specific to the Bay Area market. Respondents included executives from hospitals, physician organizations, community clinics, Medi-Cal health 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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*Orange County was added to this study this year; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

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