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California Health Care Foundation

Orange County:
Changing Market Fuels New Models of Provider Collaboration

Summary of Findings

Since 2010, Orange County has largely recovered from the economic downturn and remains a relatively well-educated community with high rates of private insurance coverage overall. Socioeconomic variation persists, however, with the northern and central parts of the county home to growing numbers of low-income people, as reflected in the large jump in the proportion of the population that gained Medi-Cal coverage as part of the state's expansion of the program under the Affordable Care Act (ACA).

Key developments include:

▶ **Hospital systems are partnering and expanding reach.** The major hospital systems in Orange County have been expanding their ambulatory services and geographic reach, in some cases through new partnerships. St. Joseph Health and Hoag Health entered a joint venture in 2013 to form St. Joseph Hoag Health (SJHH), while MemorialCare and UC Irvine Health (UCI) have partnered to establish a broader network of primary and specialty services. The hospitals aim to both gain more referrals of lucrative commercially insured patients in the fee-for-service environment that currently dominates, as well as shift more services to lower-cost settings. There is an increased focus on managing care more efficiently as the region's hospitals move toward taking full risk for broad patient populations, reflecting public and private-payer interest in adopting value-based payments, as well as the need to compete with

Kaiser Permanente, a growing presence in the county and a leader in population health management.

▶ **Physicians are joining larger organizations and aligning with hospitals.** Orange County physicians are increasingly giving up varying degrees of independence and joining larger physician organizations or hospital-affiliated groups to gain shelter from mounting financial pressures and administrative burdens. The traditionally prevalent IPA model is facing growing pressures as physicians leave small practices for the stability of larger groups, including Kaiser's exclusively affiliated group. Large physician organizations have also adjusted to the changing market by diversifying their options for physicians; for example, Monarch and HealthCare Partners offer both IPAs and medical groups. To build their affiliated medical groups, some hospitals are expanding medical foundations, and others are introducing new foundations. St. Joseph's foundation presence continues to grow, and MemorialCare and Tenet have more recently created foundations.

▶ **Providers are collaborating around new payment arrangements.** With provider risk for the costs of patient care largely limited to professional services capitation for HMO patients, some Orange County physician organizations and hospitals are working toward assuming more risk for more patients, particularly the growing numbers in PPOs. Large physician organizations are ahead of

hospitals in the extent to which they assume financial risk for patient care; HealthCare Partners, Heritage Provider Network, and Monarch are particularly advanced, assuming full risk for Medicare Advantage and commercial HMO patients. Some Orange County physician organizations and hospitals are experimenting with ways to assume risk for more patients, but many of these arrangements are limited to professional services capitation, shared savings, or shared risk. Some arrangements are innovative collaborations between providers and health plans, and among various providers. In a key example, Anthem's new Vivity HMO product is built on a new delivery network that aims to integrate care across MemorialCare and six Los Angeles hospital systems, in which the systems share full risk.

▶ **The proportion of residents covered by Medi-Cal has jumped.** As a well-off community overall, Orange County historically has had a relatively low proportion of its population covered by Medi-Cal. The expansion of Medi-Cal eligibility, however, enabled many individuals to gain coverage; about one in four residents are covered by the program today. The county experienced a greater proportional increase in Medi-Cal enrollment than other study sites, and a corresponding drop in its uninsurance rate.

▶ **Private providers have a significant role in the Medi-Cal expansion.** The county's Medi-Cal health plan, CalOptima, has sought strategies to extend its network of private physicians and services for the expanded Medi-Cal population. St. Joseph

Table 1. Demographic and Health System Characteristics: Orange County vs. California

	Orange County	California
POPULATION STATISTICS, 2014		
Total population	3,145,515	38,802,500
Population growth, 10-year	6.4%	9.1%
Population growth, 5-year	3.9%	5.0%
AGE OF POPULATION, 2014		
Under 5 years old	6.1%	6.6%
Under 18 years old	23.1%	24.1%
18 to 64 years old	65.2%	63.1%
65 years and older	11.7%	12.9%
RACE/ETHNICITY, 2014		
Asian non-Latino	19.8%	13.3%
Black non-Latino	1.4%	5.5%
Latino	34.6%	38.9%
White non-Latino	42.2%	38.8%
Other race non-Latino	2.0%	3.5%
Foreign-born	31.3%	28.5%
EDUCATION, 2014		
High school diploma or higher, adults 25 and older	84.8%	83.4%
College degree or higher, adults 25 and older	47.5%	37.9%
HEALTH STATUS, 2014		
Fair/poor health	17.4%	17.1%
Diabetes	7.1%	8.9%
Asthma	14.6%	14.0%
Heart disease, adults	6.3%	6.1%
ECONOMIC INDICATORS, 2014		
Below 100% federal poverty level	16.0%	18.4%
Below 200% federal poverty level	35.8%	40.7%
Household income above $100,000	28.4%	22.9%
Unemployment rate	5.5%	7.5%
HEALTH INSURANCE, ALL AGES, 2014		
Private insurance	57.5%	51.2%
Medicare	8.2%	10.4%
Medi-Cal and other public programs	23.1%	26.5%
Uninsured	11.2%	11.9%
PHYSICIANS PER 100,000 POPULATION, 2011		
Physicians	210	194
Primary care physicians	69	64
Specialists	141	130
HOSPITALS, 2014		
Community, acute care hospital beds per 100,000 population†	168.5	181.8
Operating margin, acute care hospitals*	5.2%	3.8%
Occupancy rate for licensed acute care beds†	49.4%	53.0%
Average length of stay, in days†	4.1	4.4
Paid full-time equivalents per 1,000 adjusted patient days*	17.4	16.6
Total operating expense per adjusted patient day*	$3,445	$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 Health Care Foundation, March 2014; Annual Financial Data, California Office of Statewide Health Planning and Development, 2014.

Health, UCI, and several for-profit hospitals have continued to share responsibility for caring for the growing Medi-Cal population and the remaining uninsured. After a slow start, half of the region's community clinics have attained Federally Qualified Health Center (FQHC) status, and many have expanded services. Still, safety-net provider capacity is tight, and providers are focusing on ways to provide care more efficiently, address patients' non-medical needs, and prepare to assume more financial risk for Medi-Cal patients. Concurrently, the county has reduced its safety-net role and significantly downsized its program for the remaining uninsured.

Market Overview

Orange County remains a relatively prosperous, but also socioeconomically diverse, county (see map on page 18). Its more than 3.1 million residents comprise a higher proportion of whites, Asians, and foreign-born residents, and a lower proportion of Latino and black residents, than the state as a whole (see Table 1). Residents are highly educated, with nearly 48% of the population having at least a college degree, almost 10 percentage points above the state average (among the study sites, only Bay Area residents are more educated). Unemployment is significantly lower than the state average, and approximately 28% of the population earns more than $100,000 annually, compared to the state average of 23%. The majority of the population is privately insured; approximately 58% of the population had private health coverage in 2014, a slight dip from 59% in 2011.

Growth in lower-wage workers over the last three years and the state's expansion of Medi-Cal eligibility under the ACA have contributed to some shifts in insurance coverage. The share of the population with incomes below 200% the federal poverty level (FPL) rose from 30% in 2011 to 36% in 2014, reflecting the growth in the service sector and other jobs that offer low pay and fewer benefits.[1] While the proportion of residents enrolled in Medi-Cal remains relatively low compared to the state average, it jumped from 17% in 2011 to 23% in 2014 — a proportionately higher increase than California overall and the largest jump of all the study sites (although essentially tied with San Diego). This large increase reflects the shift of many uninsured low-income adults into Medi-Cal as a result of the expansion (including many low-wage workers who previously were ineligible for Medi-Cal because they did not fall into a particular eligibility category), as well as those who were previously eligible but not enrolled.[2] Medi-Cal enrollment growth was a major factor in reducing the uninsured rate from 15% in 2011 to 11% in 2014.

Socioeconomic status varies across Orange County. The coastal and southern areas are quite affluent, while the northern and central areas are home to many people with low-to-middle incomes. In a key exception to this pattern, availability of previously undeveloped land has enabled the centrally located city of Irvine to develop into a high-growth, high-income area, with both increased employment opportunities and new residential development. The socioeconomic variation affects the types of patients that health care providers see in their facilities, and influences where providers invest and expand. Overall, Orange County does not face the significant physician shortages found in some other California markets; the number of Orange County physicians per capita is slightly higher than the state average.

Major Hospital Systems Partner

Five years ago, the Orange County hospital market was relatively unconsolidated. Three nonprofit health systems with strong reputations shared about half of the market: St. Joseph Health System (part of the larger hospital system operating in California and beyond), Hoag Health, and MemorialCare Health System. The rest of the market was largely split among Kaiser Permanente, the academic UC Irvine Health, several for-profit hospital systems, and Children's Hospital of Orange County. The hospital systems historically served rather distinct parts of the county, but that started to change as hospitals expanded into new areas by adding or taking over inpatient and outpatient facilities.

In 2013, St. Joseph's Orange County hospitals entered a joint venture with Hoag Health, creating a new operating company called St. Joseph Hoag Health (SJHH). Led primarily by former Hoag executives, SJHH serves as an operating company through which the hospitals partner with outside organizations and implement new strategies to form a system of care and work toward population health management. St. Joseph's four-hospital system (in Orange County) includes the flagship, St. Joseph Hospital, as well as St. Jude Medical Center in the north-central part of the county, and, in the coastal and southern areas, Mission Hospital in Mission Viejo and Mission Hospital in Laguna Beach. Hoag's two hospitals include the very large Hoag Hospital Newport Beach and Hoag Hospital Irvine, which provides a more limited array of services. Together these hospitals provide the greatest share of hospital discharges in the market, at approximately 31% in 2014, the most recent year for which public data are available from the state.[3] Given their reputations and locations in the population centers and wealthy coastal areas, St. Joseph and Hoag have enjoyed "must-have" status in commercial health plans' provider networks (and negotiating clout over payment rates) and attracted many commercially insured patients.

MemorialCare continues to operate three hospitals in affluent parts of Orange County (and has three hospitals in nearby parts of Los Angeles). The Orange County hospitals include the flagship facility, Saddleback Memorial - Laguna Hills, plus Saddleback Memorial - San Clemente and Orange Coast Memorial in Fountain Valley. MemorialCare also has must-have status and continues to hold about 12% of the Orange County hospital market.

Kaiser Permanente provided 11% of the market's hospital discharges in 2014, up from 9% in 2011. Yet Kaiser's inpatient market share significantly understates its role in the market, given its strong and growing health plan presence with reportedly approximately a quarter of the commercially insured population. As both an integrated delivery system and a health plan, the system focuses on reducing, rather than growing, inpatient utilization.

The other Orange County hospitals, including UC Irvine Health (UCI) and several for-profit systems, are located in less affluent regions of the county. Their patient mix is composed more heavily of Medi-Cal and uninsured patients than the other systems. UCI, located in middle-income central Orange, has gained market share in the last three years, serving almost 8% of inpatient discharges in 2014 (up from 6% in 2011). It is pursuing strategies to attract more commercially insured patients.

The region's major hospital systems have fared well financially over the last few years. Hospital operating margins have remained strong, averaging about 5% across all non-Kaiser hospitals in 2014, in part reflecting the relatively good payer mix in the county (i.e., the high proportion of commercially insured patients). Both St. Joseph and Hoag have had mostly positive but small operating margins over the last several years; St. Joseph's had been declining in the few years preceding its affiliation with Hoag. By 2014, margins improved to 3% for St. Joseph and 5% for Hoag. MemorialCare and UCI also faced some decline, but both still had healthy margins of about 6% in 2014. Information technology implementation and other infrastructure expansions and improvements have been expenses for these hospitals in the last few years, suggesting that some of these declining margins may be temporary. Also, focused efforts to find efficiencies and trim costs — particularly administrative costs — reportedly are helping to bolster hospital margins.

Compared to many other California markets, for-profit hospitals retain a sizeable presence in Orange County, primarily in the northern region. These include Tenet Healthcare, Prime Health Care, and KPC Healthcare, each with three to four hospitals. Tenet is the largest for-profit provider, serving almost 14% of inpatient discharges; Prime Health Care and KPC each cover less than 10% of the inpatient market. Between 2011 and 2014, these hospitals reported relatively healthy financial performance.

Large Hospital Systems Expand Reach

Over the last five years, the region's major hospital systems have focused on expanding their geographic presence through a variety of ambulatory care strategies. These strategies both help the hospital systems reach more patients — especially the more lucrative populations covered by commercial insurance and Medicare Advantage — and shift more services to lower-cost settings. Geographic expansion is a profitable strategy in the current, largely fee-for-service environment, which rewards provision of greater volumes of hospital services. These expansion efforts are also helping hospital systems prepare for population health management (see "Early Movement Toward Population Health Management" below) and changing payment incentives. For example, in the short term, building a stronger primary care base can help generate more specialty and inpatient referrals; offering care in lower-cost venues can help systems gain entry as in-network providers within limited network products, and provide more options for particularly price-sensitive patients with high-deductible PPOs. In the longer term, these strategies also help manage patient care to reduce inpatient use overall and contain costs under risk-based arrangements. One respondent likened the focus on both to having "one foot on the dock and the other in the canoe."

Kaiser stands out from the other systems in providing more convenient care through a variety of ambulatory settings. It added ambulatory care centers throughout the county, reportedly meeting a goal of offering a center within 15 minutes of all members. More facilities reportedly are planned. Kaiser also has increased its use of virtual technology and other telehealth strategies to provide care outside of the traditional in-person visit, and uses a mobile medical vehicle to provide more convenient care, primarily at workplaces of large Kaiser accounts.

Kaiser also has continued to bring services in-house, rather than contracting with other hospitals and physicians outside of the county. With the overall goal of better managing care and costs, Kaiser's decisions to insource any particular service reportedly are largely based on whether Kaiser has sufficient volume to provide good quality outcomes, and whether members can access the services within a reasonable geographic distance. Kaiser used to outsource many services when it lacked sufficient capacity at its lone hospital in Anaheim, but began insourcing more services upon opening its Irvine hospital in 2008. It also added more services after updating and expanding its Anaheim hospital in 2012. Although these changes had affected Tenet, which closed its Irvine facility after losing Kaiser's business (the hospital was later purchased by Hoag), Kaiser's more recent additions such as radiation oncology have consisted of services previously provided by Kaiser facilities in neighboring counties. As such, they have not impacted other Orange County providers. Kaiser continues to outsource cardiac surgery and some other quaternary cases to its Los Angeles hospitals, and patients needing inpatient behavioral health, skilled nursing, post-acute care, and organ transplants go to non-Kaiser Los Angeles hospitals including UCLA, Cedars Sinai, and City of Hope.[4]

The major non-Kaiser hospitals in the region are also working to expand primary care and other ambulatory services by building new facilities or affiliating with other providers. In their decision to partner, St. Joseph and Hoag reportedly saw the other as possessing complementary strengths that would help their combined entity gain a sufficient service footprint and patient volume. The SJHH partnership granted St. Joseph access to the well-insured coastal region of the county cornered by Hoag and its more attractive patient mix (more commercially insured patients and fewer Medi-Cal and uninsured patients), as well as Hoag's Orthopedic Institute, a well-known surgical specialty hospital, in Irvine. Hoag reportedly sought to overcome its limited geographic coverage and high-cost structure linked to its focus on specialty care services by accessing St. Joseph Health's primary care base. Hoag also sought to leverage St. Joseph's foundation model in order to launch its first medical group (Hoag Medical Group) and begin to align with physicians via employment arrangements

(see "Increased Physician Consolidation and Alignment with Hospitals" below).

Further, over the last five years SJHH, in collaboration with a commercial real estate firm, The Irvine Company, has opened four "wellness corners" in the community, with more planned. These centers aim to provide more convenient services for local employers' workers, including limited primary care services and urgent care, as well as wellness services (physical fitness activities, spa treatments, and nutrition/cooking classes). Through these centers, SJHH reportedly aims to ensure convenient access to its services and to elevate the visibility of its brand throughout the county. Because wellness services tend to attract healthy patients, these centers may help SJHH attain a more favorable patient mix, which is useful as it prepares to assume more risk.

MemorialCare also has worked to expand ambulatory care (both primary and specialty care) through several approaches over the past five years. The system established a medical foundation and secured relationships with other physician organizations (see "Increased Physician Consolidation and Alignment with Hospitals" below). Also, MemorialCare entered a partnership with UCI in October 2013, in which MemorialCare contributes its primary care expertise and UCI contributes more specialized services (through its 500-physician faculty practice) and together establish a broader geographic network. MemorialCare's management services organization (MSO) is managing UCI's two new primary care practices in Orange and Tustin (with about 12 physicians across the two sites), focused on commercially insured patients.[5] Further, MemorialCare has entered joint ventures with or acquired ambulatory surgical centers and freestanding imaging centers to provide patients lower-cost options throughout the county, which serve a dual purpose of competing on unit price and pursuing population health management.

Early Movement Toward Population Health Management

The ambulatory expansion strategies underway in the Orange County region are positioning its hospital systems for population health management: a system of inpatient and outpatient services aimed at managing care more efficiently. Aiming to eventually take full risk for broad patient populations, the hospitals are motivated both by public and private payer interest in adopting value-based payments and the need to compete with Kaiser, a growing presence in the county and a leader in population health management.

However, the non-Kaiser hospitals have a long way to go in managing population health. The systems need to integrate and coordinate clinical care, which requires steps such as rationalizing services across providers, cultivating a unified and supportive physician culture, establishing team-based care models, and building integrated health information technology. A particular challenge to the latter is the diversity of electronic health record (EHR) systems within and across the hospital systems and affiliated physician groups. While the Orange County hospital systems have made some progress in integrating EHR systems with their affiliated physicians, hospital systems partnering with one another typically continue to use different, incompatible EHRs.

Even with the formal partnership, SJHH is reportedly struggling to unite the St. Joseph and Hoag hospitals into an integrated system with a cohesive culture. Even before its partnership with Hoag, St. Joseph had traditionally operated as a collection of four separate hospitals, rather than as an integrated system. Each had different cultures and processes and separate medical foundations; some St. Joseph hospitals competed against each other in certain sectors. Under the partnership, efforts to coordinate and rationalize services across sites of care and to pursue greater clinical integration have lagged, which poses major challenges to the system's ability to fare well under new risk arrangements. In addition, SJHH will likely face further change with the anticipated merger of St. Joseph and Providence Health & Services (based

in Renton, Washington) into one corporation (Providence St. Joseph Health).[6]

Further, most of the non-Kaiser hospitals have had less experience assuming and managing financial risk and lack health plans capable of assuming global risk for patient care. Traditionally, HMO patients have composed a small share of the total patient base; for commercial HMO patients, hospitals typically have not accepted institutional risk. Over the last five years, however, SJHH and MemorialCare have gradually been taking more risk — mostly for Medicare Advantage patients but also for a smaller proportion of commercial patients. Also, MemorialCare received a Knox-Keene license and started its own health plan, Seaside Health Plan, in 2013, which currently has about 30,000 enrollees. Other arrangements mostly involve shared risk (see "Collaboration Around New Financial Arrangements" below).

The region's smaller hospital systems do not have the geographic reach or financial resources to transition to a population health model. To date, they have not been particularly focused on establishing an ambulatory service presence that includes primary care. However, as a way to gain volume by competing on price, some smaller hospitals are purchasing freestanding ambulatory facilities (including ambulatory surgery centers, imaging centers, and urgent care centers) as a way to expand their geographic coverage and provide more convenient, lower-cost options to consumers with high-deductible health plans.

Many smaller hospitals also face costly investments to make their facilities seismically compliant by the state's current 2030 deadline, adding significant financial pressures unless the state grants them a reprieve. Tenet is building a new hospital as a replacement for one of its older facilities, and the other smaller systems (Prime Health Care and KPC Healthcare) still have several hospitals that are not yet compliant. In contrast, the major hospital systems are already mostly compliant.

Increased Physician Consolidation and Alignment with Hospitals

Traditionally, many Orange County physicians favored independence and operated in small practices, and belonged to IPAs to gain clinical and administrative support. The strong IPA presence in Orange County has reflected the local prevalence of HMO products operating under the delegated model, where the health plan pays physician organizations a fixed rate per enrollee (capitation) to provide a range of services.[7] However, the IPA model has faced growing challenges as physicians' (especially primary care physicians') ability to practice independently becomes more difficult and non-Kaiser HMO enrollment erodes.

Facing a number of growing financial pressures, physicians in the region have increasingly given up varying degrees of independence in favor of arrangements that provide greater security and resources, including more leverage with insurers over payment rates, administrative and clinical support, and access to health information technology. Kaiser has become a particularly strong draw, especially for younger, new physicians who want the stability of employment, a competitive compensation package, and a more predictable work schedule. Kaiser's exclusively affiliated physician group, the Southern California Permanente Medical Group, has expanded from about 550 to 750 physicians in Orange County over the last five years. Other physicians are joining larger independent or hospital-affiliated groups.

Physician Organizations Respond to Growing Pressures and Physician Needs

Over the last five years, three of the largest physician organizations in the market — HealthCare Partners, Monarch Healthcare, and Greater Newport Physicians — have become part of larger organizations and have created additional options for physicians.[8]

Monarch Healthcare remains the dominant physician organization with 2,500 independent physicians. Primarily an IPA, Monarch has added a medical group option that

currently has about 100 primary care physicians (PCPs) and 40 hospitalists/specialists in Long Beach and Orange County. In 2011, Optum, a division of UnitedHealth Group, purchased Monarch. This provided Monarch access to upgraded technology, clinical management programs, and more capital to aid further growth.[9] Optum's acquisition of Monarch initially created tensions with other insurers, in part because of concerns that contracting with Monarch could potentially mean sharing data with a competing insurer.[10] Blue Shield of California sued Monarch for breach of contract, which Monarch ultimately settled in 2013.[11,12] The purchase by Optum also affected Monarch's relationship with Anthem (see "Collaboration Around New Payment Arrangements" below).

Based in Los Angeles, HealthCare Partners is a large hybrid physician organization that started as a medical group; it entered Orange County about five years ago with its acquisition of Talbert Medical Group, a large physician organization with locations in northern Orange County and Los Angeles. HealthCare Partners has since expanded and developed its IPA options to appeal to physicians who wish to remain independent. Across its medical group and IPA models, HealthCare Partners currently has nearly 250 PCPs in Orange County (concentrated in the central region). HealthCare Partners was purchased by dialysis provider DaVita in 2012, which provided HealthCare Partners with the capital to expand to new geographic markets outside of California.[13]

Greater Newport Physicians IPA has grown from about 500 to 900 physician members over the past five years (although a portion of these are located in Long Beach, Los Angeles County). The IPA primarily serves the coastal and southern regions of Orange County. It was historically affiliated with Hoag, but was acquired by MemorialCare in 2012. Because Greater Newport is no longer required to admit patients solely to the traditionally high-cost Hoag hospitals, its physicians can refer more patients to MemorialCare. However, referral patterns reportedly have not changed considerably (i.e., patients with established relationships and/or in proximity to Hoag have continued using those hospitals).

Hospital Foundations Increase Presence

The hospital foundation model has continued to grow in Orange County as hospitals seek to align closely with physicians and as more physicians accept or seek greater security over autonomy. California's prohibition on the corporate practice of medicine precludes private hospitals from directly employing physicians, but hospitals can provide physicians an employment-like environment through a hospital foundation. Foundations offer physicians considerable assistance, whether by, in the case of medical groups, purchasing their assets and providing more staff and facilities, or for medical groups and IPAs, providing administrative services and information technology.

St. Joseph was a pioneer of the foundation model in Orange County and has long had separate foundations associated with its individual hospitals. Over the last five years, SJHH's total membership across its foundations grew from approximately 1,800 to almost 2,000 physicians. Two key developments contributed to this growth: the creation of the Hoag Medical Group, with approximately 40 physicians, and the acquisition of the Mission Internal Medical Group (now Mission Heritage Medical Group), with over 90 physicians, which had been the county's remaining large independent medical group.

More recently, MemorialCare and Tenet also have created medical foundations. MemorialCare Medical Foundation has grown significantly from 100 physicians in two small practices five years ago to more than 250 physicians. The formerly independent Bristol Park Medical Group joined in 2011 and several smaller medical groups soon followed; the foundation is now called MemorialCare Medical Group. When acquired by MemorialCare, Greater Newport Physicians also joined MemorialCare's foundation. Tenet's foundation, First Choice Physician Partners, remains small, with 25 physicians in Orange County.

Collaboration Around New Payment Arrangements

In line with population health management strategies, hospitals and physicians are accepting more financial risk than five years ago. Orange County physician organizations have a long history of taking risk for the cost of professional services for commercially insured and Medicare Advantage patients (and Medi-Cal patients; see "Movement Toward Medi-Cal Value-Based Payments" below) under the HMO delegated model. HealthCare Partners and Monarch are more advanced than other Orange County providers in the degree of risk they assume. Monarch assumes full risk for the majority of its Medicare Advantage population and has begun to take full risk for a smaller percentage of its commercial population. HealthCare Partners and Heritage assume full risk for their Medicare Advantage and commercial populations.

Many Orange County physician organizations perceive ACOs as a way to assume financial risk for new populations. While Medicare Advantage enrollment has been on the rise over the last few years, commercial, network-model HMO enrollment has eroded as both high-deductible PPO products and Kaiser HMO products have gained popularity.[14] While physicians are typically paid fee-for-service for their patients in PPO products, ACOs provide a vehicle for physician organizations to assume at least some financial risk for this population.[15] Monarch and HealthCare Partners participated in the Medicare Pioneer ACO program, although HealthCare Partners left in 2015 and joined the Shared Savings ACO program, which exposes providers to less risk than the Pioneer program. Monarch is completing the five-year Pioneer program and is slated to join the new Medicare Next Generation ACO program in 2017. MemorialCare also joined the Next Generation program in partnership with Greater Newport Physicians and UCI physicians.

To date, however, only a small portion of the commercially insured population receives care through commercial ACOs, and they primarily consist of shared savings only (i.e., no risk of financial loss). As noted, Optum's purchase of Monarch initially created tensions with other insurers, and

Anthem discontinued its PPO ACO with Monarch in 2012. However, Optum has restored some of its health plan relationships, reportedly aided by creating an identity separate from, and independent of, UnitedHealth Group. Monarch rejoined Anthem's PPO ACO in January 2016. HealthCare Partners also is in the Anthem ACO and joined a Cigna ACO in 2013.

The larger hospital systems' physician organizations have entered commercial ACO arrangements as well, as a way to transition to risk-based payments. MemorialCare participates in PPO ACOs with Anthem and Aetna, while SJHH participates in a PPO ACO with Cigna and an HMO ACO with Blue Shield called Trio. In some commercial ACOs the hospitals within the system also participate in the ACO; in other commercial ACOs only the affiliated physician organizations participate. These arrangements extend payment incentives and other support to these providers. As one respondent noted, "Commercial ACOs are a way to make this [population health] work and have helped us build the infrastructure we need. That's a win-win." But these products have limited reach and, as noted, providers still lack the infrastructure to foster extensive risk adoption.

Some systems are also developing novel ways to share risk with employers. SJHH and MemorialCare separately created tiered-network PPO or HMO products for self-insured employers. In these arrangements, the hospital system and employer set a total cost of care target for serving an employer's enrolled population and share in the savings or losses. While the hospitals have invested in data analytic technology to support them in this new role, the health plans serving as third-party administrators also provide critical support by providing real-time claims data.[16] These arrangements are quite new, and the number of employers and enrollment in these arrangements remains relatively low to date.

In a significant departure from the largely fee-for-service environment, MemorialCare, Anthem, and six other Los Angeles hospital systems collaborated to form an HMO product, Vivity, launched in 2014. Vivity is built on a new

delivery network that aims to integrate care across the seven separate systems. The network includes MemorialCare's six hospitals, plus the medical groups in its medical foundation and IPA across Los Angeles and Orange County. In this arrangement, the participating systems share full financial risk for patients across the two counties and members can use any of the participating providers. Market observers report that the goal is to create a unified provider system characterized by full exchange of clinical data through an interoperable EHR, standardized care protocols, and uniform patient experience across sites of care. Vivity aims to compete with Kaiser both by offering tertiary services across more locations, and on cost, although it is unknown how Vivity's premiums currently compare and how they align with actual costs. Enrollment remains relatively low to date.[17,18] Vivity is an experiment that has a very long way to go to achieve the goals of efficient, integrated care and collaboration as a single entity instead of the participating providers competing with one another for patients.

Private Providers Key to Serving Medi-Cal Population

The role that the Orange County government has traditionally played in the health care safety net for low-income people has been mixed: The county has been actively involved in administering Medi-Cal managed care and has operated programs for the uninsured that are expansive in some ways but not others, and has been less involved in the direct provision of medical services (but does provide mental health services).[19] Instead, area hospitals and a limited set of private, independent community clinics and private practice physicians have shared this role.

Over the last five years, the Orange County safety net prepared extensively for the 2014 Medi-Cal expansion, but faced challenges keeping up with the growing demands of a significantly larger Medi-Cal population. Physicians have long accepted financial risk in serving Medi-Cal patients, and community clinics are trying to move in this direction. Overall,

the safety-net role of private providers has increased as more people have gained coverage, while the county's role and resources dedicated to the remaining uninsured have declined.

CalOptima Enrollment Surges

Orange County continues to operate under the County Organized Health System (COHS) model for Medi-Cal managed care, wherein a single health plan serves Medi-Cal managed care enrollees. In Orange County, the COHS plan is CalOptima, created by the County Board of Supervisors and governed by an independent commission. CalOptima also subcontracts with Kaiser Permanente to serve a portion of the county's Medi-Cal enrollees.[20]

Since California expanded Medi-Cal eligibility in January 2014, CalOptima's enrollment increased 60%, from 470,000 enrollees in December 2013 to 762,000 by April 2016. This sudden growth was accompanied by a number of challenges. Respondents noted that this surge was largely the result of extensive outreach efforts and education by the county, providers, community organizations, and CalOptima, as well as early preparations such as the Low Income Health Program (LIHP). The LIHP was an option for counties under the state's 2010-2015 Bridge to Reform Medi-Cal waiver to transition low-income people to a Medi-Cal-like program in preparation for the Medi-Cal expansion.

Orange County implemented its LIHP in 2010, earlier than many other California counties. According to respondents, the program helped uninsured people gain access to a primary care home and services, and aided safety-net providers in establishing allegiances with patients. CalOptima had contracts with the same providers as in the LIHP, so new Medi-Cal enrollees typically were able to keep their established PCPs. The county set income eligibility for the LIHP relatively high at up to 200% FPL, while many other counties set eligibility at up to 138% FPL to match that of the eventual Medi-Cal expansion. In 2014, approximately 43,000 individuals entered Medi-Cal directly from the LIHP. LIHP enrollees with incomes between 138% and 200% FPL

were expected to access subsidized coverage through Covered California, although the extent to which that has occurred is not known.

This significant enrollment growth presented some challenges, as CalOptima had previously served primarily mothers and children and had less experience serving the many childless adults that composed the Medi-Cal expansion population. Many of these new enrollees had particular needs that were relatively new to CalOptima, including complex chronic conditions, behavioral health issues, and non-health-related challenges such as homelessness. To address the needs of the expansion population, the plan has begun to make some changes in its provider networks and services provided. For example, in the wake of the state's decision to give Medi-Cal health plans responsibility for mild to moderate mental health conditions, CalOptima is working with the same vendor the county uses to manage the more serious issues to help coordinate these services. Also, CalOptima and UCI are collaborating (with the help of some federal matching funds) on a recuperative care program for homeless patients when they are discharged from the hospital.

CalOptima also made efforts to expand its network of private practice physicians, on which it relies heavily to serve existing and new Medi-Cal enrollees; the plan reportedly contracts with approximately 80% of all physicians in the county. The plan historically has contracted with physicians through IPAs; over the last five years, the plan increased the number of IPAs with which it contracts from almost a dozen to 14. About a year ago, CalOptima also created its "Community Network" to allow physicians who did not want to join an IPA to contract directly with the plan. With 3,100 physicians (primary care providers and specialists), the Community Network is larger than any of its IPA networks. However, because of the loss of some other physicians for various reasons (including a contract termination with a physician organization related to performance issues), the total number of physicians CalOptima contracts with has not changed significantly since the Medi-Cal expansion.

To attract new physicians and encourage existing physicians to accept more Medi-Cal patients, CalOptima has required physicians in its program for dual eligibles (individuals enrolled in both Medi-Cal and Medicare, see next paragraph) to also treat patients who only have Medi-Cal. It has also increased payment rates, particularly for specialists. Higher payments from the state relative to the plan's costs for the expansion population allowed CalOptima to increase payments; these payments reportedly were significantly higher than what the plan receives for its traditional Medi-Cal enrollees. In fact, despite some different health needs and early pent-up demand, overall the plan has found that the new enrollees are not significantly more costly to care for than their traditional population, in part because the LIHP helped address needs earlier for a portion of the enrollees and may reflect the relatively larger working population that gained coverage in this community.

Orange County is one of seven counties to participate in California's demonstration project to serve individuals dually eligible for Medi-Cal and Medicare through managed care, called Cal MediConnect. This program is an effort to provide coordinated care across settings, including medical, behavioral health, long term care, and home health. To attract sufficient numbers of providers, CalOptima's plan, OneCare Connect, conducted extensive outreach and decided to pay higher Medicare payment rates. The plan struggled with many beneficiaries opting out of the program — reportedly, in part, because they were attached to their fee-for-service providers. However, CalOptima received state approval to enroll patients by long term care facility to help reach more people directly and encourage them to stay in the program (rather than through the previous automatic enrollment process, which included an opt-out provision). Now the plan's opt-out rate is on par with the state average, and its retention rate is among the highest in the state.[21]

Even with the significant enrollment growth and other changes, CalOptima's performance remains strong: It is among the highest-rated Medi-Cal health plans in the state

on a composite score of quality and access.[22] Still, safety-net providers report that Medi-Cal patients continue to face difficulties accessing specialists, especially in rheumatology, cardiology, and pulmonology, among others. To improve access, CalOptima reportedly plans to add more physicians to its network. However, the state's recent move to reduce Medi-Cal payment rates to health plans for the expansion population could dampen provider participation in Medi-Cal.

Hospitals Continue to Share Safety-Net Role

A number of Orange County hospitals continue to share the responsibility for serving many of the Medi-Cal and uninsured patients across the market. St. Joseph has a stated mission to serve low-income people, and UCI is the only public hospital and Level I adult trauma center in the county. The for-profit hospital systems (KPC, Tenet, and Prime) play a larger role in the Orange County safety net compared to for-profits in other study markets, due to the location of some or all of their hospitals in low- to middle-income areas. KPC, which previously was a nonprofit system, continues to have the largest county contract for inpatient psychiatric care, and holds the county contract to provide health care for prisoners. The Children's Hospital of Orange County (CHOC) remains the main provider of hospital care for low-income children in the county, and operates four health centers in the community.[23]

In 2014, St. Joseph, Tenet, KPC, and UCI provided similarly large portions of the total low-income inpatient discharges (Medi-Cal and uninsured) in the county (excluding CHOC, as it focuses only on children).[24] These shares remained relatively stable from 2011, although UCI's grew slightly and KPC's declined slightly. St. Joseph and UCI serve the largest role in low-income outpatient visits, and UCI operates two FQHCs in Anaheim and Santa Ana, which serve as the hospital's family practice residency teaching sites. St. Joseph continues to financially support several community clinics.

The Medi-Cal expansion contributed to increased patient volumes. While Orange County's hospitals experienced slight decreases in inpatient and outpatient visits and relatively stable emergency department (ED) visits overall, between 2011 and 2014, many safety-net hospitals were inundated with new patients, especially in the ED. St. Joseph, Hoag, and UCI experienced particularly high increases in ED encounters (a jump of approximately 25% from 2011 to 2014). Further, due to a severe shortage of behavioral health providers and psychiatric beds in the community, it was noted that more of these patients remained in the ED longer than necessary. The county is seeking partnerships with medical facilities to help to expand psychiatric services.[25]

The Medi-Cal expansion has helped the financial performance of some hospitals in the county as previously uninsured people gained coverage and sought more services. Hospitals now provide fewer uninsured encounters than before, and uncompensated care costs (bad debt and charity care) declined significantly across the market as people gained coverage. The safety-net hospitals also have continued to benefit from several additional subsidies: As a public hospital, UCI receives disproportionate share hospital (DSH), safety-net care pool, and Delivery System Reform Incentive Payments (DSRIP) funds through the state's Medi-Cal waiver. DSRIP helped the hospital expand the hours of operation at its FQHCs and convert its senior center into a patient-centered medical home, among other changes. Many other hospitals in the market that don't play a large enough safety-net role to gain some of these subsidies have still benefited from the state's Medi-Cal hospital fee program over the past five years.[26]

Community Clinics Attain Federal Status and Expand

Orange County has historically lacked a robust set of community clinics and lagged behind many other California communities in its pursuit of federal status for these providers. Today, the county has 26 community clinic organizations, and about half of them have federal status. Federally Qualified Health Center status offers federal grants, enhanced Medi-Cal payments, and loan forgiveness to recruit physicians, among other benefits ("look-alike" status provides many of these benefits but not grants). Beginning five years ago, the county and

the community clinics started devoting more attention and resources to developing the infrastructure and services required for federal status and pursuing the application process.

Over the last five years, anticipation of more Medi-Cal revenues from the Medi-Cal expansion provided additional impetus and opportunity for FQHC growth. Many clinics in the county gained federal status: The number of FQHC organizations in Orange County grew from 4 in 2011 (three full FQHCs and one look-alike) to 12 by 2014 (10 full FQHCs and two look-alikes). Reportedly, three additional health centers are in the process of gaining FQHC status. AltaMed, based in Los Angeles, expanded into Orange County six years ago, and with 10 sites is now the largest FQHC in the community. Hurtt Family Health Clinic, Central City Community Health Center, and Vietnamese Community of Orange County are the other longer-standing FQHCs. With the help of federal expansion grants under the ACA, each FQHC has added one to three new sites over the last five years; Share Our Selves (SOS) is the exception, which grew from one to seven sites. Further, additional FQHCs based in Los Angeles and San Diego have added sites in Orange County.

Out of concern that their patients might choose other providers once they gained Medi-Cal coverage, many community clinics in Orange County, as elsewhere, have worked on becoming "providers of choice rather than last resort." They made considerable efforts to retain their LIHP patients once they gained Medi-Cal coverage, and to enroll additional patients into Medi-Cal. They've updated their facilities, improved administrative and clinical processes, worked to find new ways to provide timely access to services, and coordinated care. In fact, 10 FQHCs have achieved national Patient Centered Medical Home accreditation at a high level. In addition to linking patients to social services in the community as they've done traditionally, the clinics are engaged in a pilot funded by private foundations to offer more nonmedical services, including acupuncture, yoga, and food banks. In part, providers expect this "whole person care" approach to help control costs and patients' demand for medical services.

Across the board, the community clinics reportedly experienced a 20% to 30% increase in Medi-Cal patients since the Medi-Cal expansion — a combination of their existing uninsured patients gaining coverage and new patients. Although these clinics historically have served a relatively low proportion of commercially insured patients (about 5% of their patients on average), since 2014 they have been treating more commercially insured patients, including through Covered California. The rise in Medi-Cal patients and decline in uninsured patients has helped many community clinics financially, and most of the FQHCs in the county had better operating margins in 2014 than in 2011.[27]

Community clinic directors reported strained capacity and are trying to develop additional resources to address both general growth in demand as well as the specific needs of the new Medi-Cal enrollees. As one respondent reported, "Health centers are bursting at the seams and struggling to accommodate [the increased demand] but so far are not turning patients away." The FQHCs increased their clinical workforce by almost a third between 2011 and 2014, yet are still trying to add more specialists and behavioral health providers. Health center directors reported that integrating behavioral health into the primary care setting is a top priority, but struggle with a shortage of these providers, combined with regulatory restrictions that prohibit health centers from billing for more than one encounter per patient in a single day. The health centers also face challenges developing their clinical staffs to help implement EHRs, including sufficiently and accurately entering patient information.

Some health centers have referral relationships with safety-net hospitals in their service areas (e.g., SOS has a clinic across the street from a Hoag hospital) but respondents indicate that these are mostly informal relationships, which facilitate patients receiving primary care at the health centers and follow-up specialty or inpatient services at the hospital. Still, access remains insufficient for low-income people, in terms of number of physicians, appointment availability, and cultural and linguistic appropriateness of care.

Movement Toward Medi-Cal Value-Based Payments

CalOptima offers a wide spectrum of payment arrangements with its network providers, ranging from straight fee-for-service to full risk, depending on the providers' willingness and ability to assume risk. Most CalOptima members receive care through private-practice physicians belonging to IPAs. CalOptima has long made capitated payments to these IPAs for professional services (primary and specialty care and ancillary services), while retaining risk for hospital services. Providers in its new Community Network, however, are not part of IPAs and receive fee-for-service payment. In its hospital contracts, CalOptima has long used a Shared Risk Group model, in which it pays the IPAs shared savings if they control hospital use; it also offers a Physician Hospital Consortium model, in which an IPA and a hospital partner each receive capitated payments. In its contracts with large providers long accustomed to accepting full capitation — including Kaiser and Heritage — CalOptima passes on full risk.

Orange County's safety-net clinics are typically further behind the IPAs in the movement toward accepting risk. Unlike community clinics in some of the other study sites, Orange County clinics do not have their own IPA structure through which to contract with health plans, and instead contract individually (an exception is AltaMed, which has its own IPA). The health centers attempted to form an IPA network, but CalOptima declined to contract with them, in part because they lacked a specialist network. As a first step toward taking risk, six health centers formed what is called the Orange County Safety Net Foundation, which receives capitation for primary care only. FQHCs receiving capitated payments are protected from risk because FQHCs later receive "wraparound" payments up to their standard enhanced payment rates — although the wraparound payments can take many months, causing cash flow challenges for the health centers in the interim.

Safety-net providers perceive the need to prepare for more risk, in part because the state's recently authorized 2016-2020 Medi-Cal waiver places considerable focus on achieving improved clinical outcomes and moving toward value-based payment arrangements in the Medi-Cal program (such as through the new PRIME program that will replace the DSRIP for UCI). Further, California plans to pilot capitated payments for FQHCs that would not include a wraparound payment. While some FQHCs welcome the flexibility such payments would provide, FQHCs' ability to bear risk for patient care is unproven. Since many health centers in Orange County have only recently gained FQHC status, they are still adjusting to their encounter-based payments.

Market observers suggest that hospitals need to do more to establish access to primary care and other nonhospital services to fare well under value-based payments. For example, CHOC and SJHH formed an ACO in 2014, in which they and several other hospitals, physician organizations, and clinics share risk for Medi-Cal and commercially insured children. It is still too early to know how effectively these providers are sharing risk. Other affiliations between hospitals and FQHCs are sparse; respondents indicate that more collaboration, coordination, and data-sharing on patients is needed among safety-net hospitals, community health centers, and other entities.

Lack of Programs for the Remaining Uninsured

Despite the market's significant rise in Medi-Cal coverage and corresponding fall in the uninsurance rate, more than 300,000 Orange County residents remained uninsured as of 2014. While more people have since gained coverage, respondents reported that many uninsured people are ineligible for insurance due to their immigration status; Orange County has a higher percentage of noncitizens than the other study sites and the state as a whole.[28]

With considerable discretion from the state in the extent to which counties need to support care for the medically indigent, Orange County's Medical Safety Net (MSN) program (previously called Medical Services Initiative, or MSI) has relatively high income eligibility but does not extend eligibility to undocumented immigrants.

In fact, with the transfer of many medically indigent enrollees into the LIHP and then to Medi-Cal, the county has shrunk its role in providing medical care for uninsured people. Expenditures for indigent care now come out of the county general fund, as the county's remaining realignment dollars are now designated for public health services.[29] The MSN program currently enrolls only about 150 residents who earn between 138% and 200% FPL (those earning too much to qualify for Medi-Cal), and only covers urgent and emergency medical services, not preventive care. It is set up as a bridge to coverage, so that enrollees will transition to Covered California during the next open enrollment period. Enrollees face copayments for services to mirror what they would encounter in a bronze-tier Covered California plan; these copayments reportedly contribute to low uptake in the program.[30]

Many uninsured people lack access to a program that provides a full range of coordinated services. However, some providers, especially the Lestonnac Free Clinic, are focusing on serving this population. By 2015 Lestonnac had added a few clinics in neighboring counties as well and served over 7,600 patients. The organization has been able to expand over the last few years by intensifying fundraising activities and partnerships with hospital residency programs to bring in more volunteer physicians. With funding from Kaiser, Lestonnac partners with the Coalition of Orange County Community Health Centers to provide access to a broad array of volunteer specialists for its uninsured patients, as well as those from other community clinics.

Overall, however, many uninsured individuals in Orange County likely continue to go without needed services or rely on EDs and other safety-net providers who offer charity care or services at a reduced fee. As noted, some safety-net hospitals continue to receive subsidies, and FQHCs continue to receive federal grants to help them with these costs. Still, with increased demand for services from Medi-Cal patients, capacity across other providers is strained, likely creating more difficulties for uninsured people to obtain care.

Issues to Track

▶ Will large hospital systems prove successful in establishing true systems of care that provide services more efficiently in order to compete with Kaiser? Will any of the innovative new insurance products, such as the Vivity collaboration and the risk-sharing arrangement between self-insured employers and hospital systems, gain traction? Will Kaiser continue to expand its market share of commercially insured patients?

▶ Will the state make changes to its current seismic requirements? If not, will some smaller hospitals need to close? What impact would closures have on access to care for low-income people?

▶ Will the small independent practice model, particularly for PCPs, remain viable in this market? To what extent will hybrid physician organizations attract more physicians? Will hospital-physician alignment continue to grow through system-affiliated medical groups?

▶ To what extent will providers be able to attract sufficient numbers of PCPs to meet the increasing needs of population health strategies and the expanded Medi-Cal population?

▶ To what extent will providers be able to meet the needs of the new, large Medi-Cal population? To what extent will safety-net providers' efforts to improve their efficiency and address nonmedical needs succeed? Will community clinics prove themselves capable of taking on more financial risk for Medi-Cal patients?

▶ Given the considerable downsizing of the county's program for the uninsured and increased demand on safety-net providers by Medi-Cal patients, how will access to care change for people who remain uninsured?

ENDNOTES

1. *Orange County on the Cusp of Change,* UCI Community & Labor Project and UCLA Labor Center, July 2014.

2. Ibid.

3. Annual Financial Data, California Office of Statewide Planning and Development, 2014. Data reflect each hospital system's fiscal year.

4. Depending on the service, Kaiser members receiving care at these other facilities are either treated by a Kaiser physician or a physician at that facility, where Kaiser pays them on a fee schedule.

5. UCI also has primary care on campus and operates two community health centers for low-income people.

6. Patti Payne, "Renton-Based Providence Health & Services Plans to Merge with St. Joseph Health," *Puget Sound Business Journal*, March 4, 2016, **www.bizjournals.com/seattle**.

7. Typically professional services and certain specified ancillary services.

8. Based in Los Angeles, Heritage Provider Network is another large physician organization serving the market. It is not affiliated with a hospital or owned by another entity.

9. Rebecca Vesely, "Marriage of Convenience: As They Adapt to Reform, Insurers Court Historic Adversaries: Physician Practices," *Modern Healthcare*, January 2, 2012, **www.modernhealthcare.com**.

10. Joy Grossman, Ha Tu, and Dori Cross, "Arranged Marriages: The Evolution of ACO Partnerships in California," California Health Care Foundation, September 2013, **www.chcf.org**.

11. "ACO Is DOA with Monarch-Optum Union," Decision Resources Group, November 30, 2011, **decisionresourcesgroup.com**.

12. Courtney Perkes, "Monarch to Pay Blue Shield $2.5M," *Orange County Register*, February 20, 2013, **www.ocregister.com**.

13. Anna Wilde Mathews and Anjali Athavaley, "Dialysis Firm Bets on Branching Out," *Wall Street Journal*, May 21, 2012, **www.wsj.com**.

14. Medicare Advantage enrollment grew 20% between 2012 and 2015; Orange County has the third-highest Medicare Advantage market penetration of all counties in California. Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS).

15. IPAs, usually barred from negotiating with insurers on PPO rates, benefit from an exemption from this restriction within ACO products because the entity assumes some risk.

16. The health plans providing this support are Seaside Health Plan for MemorialCare, Cigna, and Anthem for SJHH. SJHH also has claims data support from Blue Shield on an exclusive product for CalPERS via Blue Shield.

17. Tamara Rosin, "One Year Later, How Is Vivity Stacking Up to Kaiser? Checking in with MemorialCare CEO Dr. Barry Arbuckle," Becker's Hospital Review, August 20, 2015, **www.beckershospitalreview.com**.

18. Brett Brune, "How Anthem's Vivity Venture Is Faring in Southern California Showdown with Kaiser," *Modern Healthcare*, October 23, 2015, **www.modernhealthcare.com**. As of October 2015, 13 large employers had signed on and 24,000 individuals enrolled in Los Angeles and Orange County combined.

19. Under California Welfare and Institutions Code Section 17000, all California counties are responsible for providing health care services to their neediest residents, although counties have considerable discretion in setting eligibility criteria (e.g., income and immigration status) and the level of services they provide.

20. Kaiser's Medi-Cal population consists largely of people who either had Kaiser coverage themselves, or who have an immediate family member who has had Kaiser coverage, within the past 12 months.

21. March 2016 enrollment data, CalDuals, **www.calduals.org**.

22. *Medi-Cal Managed Care Performance Dashboard*, California Department of Health Care Services, September 17, 2015, **www.dhcs.ca.gov**. Based on a composite measure of health plan quality and satisfaction.

23. CHOC recently transferred the operations of another health center to an independent FQHC organization.

24. OSHPD data, 2011 and 2014.

25. Jordan Graham, "Shortage of Psych Beds has O.C. Supervisors Considering Partnership Options," *Orange County Register*, April 13, 2016, **www.ocregister.com**.

26. 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. With payments beginning 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.

27. OSHPD community clinic data, 2011 and 2014.

28. Based on CHIS data, the percentage of noncitizens (which includes undocumented immigrants) in Orange County was 17.3% in 2014, compared to 14% for the state as a whole.

29. 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 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. Orange County has adopted the formula approach and had to return 52% of its funds to the state.

30. Medical Safety Net Program Patient Handbook, Orange County Health Care Agency, 2015-2016. Copayment amounts range from $20 for a minute clinic visit to $300 for an emergency department visit or inpatient stay.
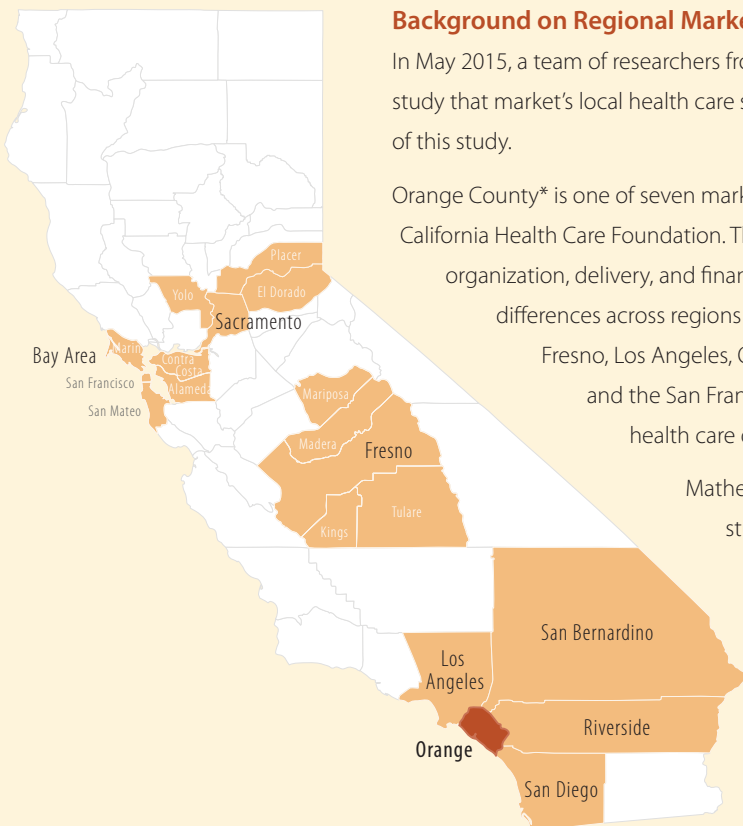
Background on Regional Markets Study: Orange County

In May 2015, a team of researchers from Mathematica Policy Research visited Orange County to study that market's local health care system and capture changes since 2010/2011, the last round of this study.

Orange County* is one of seven markets included in the Regional Market Study funded by the California Health Care 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 over 200 respondents for this study, with 29 specific to Orange County. 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.

▶ FOR THE ENTIRE REGIONAL MARKETS SERIES, VISIT WWW.CHCF.ORG/ALMANAC/REGIONAL-MARKETS.

*Orange County was added to this study in 2015; 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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