CALIFORNIA
HEALTH CARE ALMANAC

California Health Care Foundation

REGIONAL MARKETS ISSUE BRIEF / JUNE 2016

San Diego: Major Providers Pursue Countywide Networks and New Patient Care Models

Summary of Findings

San Diego has long been a geographically well-defined health care market with high managed care penetration and a consolidated provider sector. In recent years, hospital systems have faced increasing cost pressures as commercial health plans have responded to employer demands for more affordable premiums by offering limited-network health maintenance organization (HMO) and high-deductible preferred provider organization (PPO) products. In the health care safety net for low-income people, providers expanded capacity to deal with the large Medi-Cal expansion that began in 2014, but continue to grapple with how to provide adequate care for a new enrollee population that is far sicker, with more complex medical and social service needs, than their previous patient base.

Key developments include:

- **Market positions shifting slightly among major hospital systems.** The hospital market remained largely stable in recent years, with no major closures, acquisitions, or affiliation changes. However, the competitive positions of the two largest systems did change somewhat, with Sharp Healthcare gaining and Scripps Health losing both inpatient and outpatient market share. Payers' increasing emphasis on provider affordability and value has strengthened Sharp's market position, while it created challenges for Scripps — historically a higher-cost system. Despite cost pressures, both systems continue to achieve strong financial performance, as has Kaiser Permanente. Kaiser's presence in the market is growing, with its health plan now covering one in five insured county residents. UC San Diego Health (UCSD) has increased both patient volume and financial margins in recent years, in part by expanding affiliations with community providers to gain more tertiary referrals. In contrast, most of the smaller hospitals have been losing volume and struggling financially; some also lack the major capital needed to comply with state seismic regulations, raising doubts about their future.
- **Major systems pursuing population health strategies.** Kaiser, Sharp, and Scripps are building countywide networks that can manage care efficiently enough to compete vigorously for coveted commercial and Medicare Advantage patients. While Kaiser and Sharp have long focused on these approaches, population health represents a major strategic shift for Scripps. Systems are increasingly using provider-sponsored health plans to take full risk for more patients; Sharp's long-established plan expanded its market presence in 2014, while Scripps obtained an insurance license in 2015. These systems all have expanded their clinical footprints into areas of the county where they had little or no previous presence — most notably the fast-growing North Inland region. These expansions have been focused on development of ambulatory facilities and services, with the aim of increasing access and convenience for patients and reducing costs for the systems.

- **Private practice increasingly less viable for physicians, particularly in primary care.** Low reimbursement from public and private payers, along with the long and unpredictable work hours required in independent practice, are leading many primary care physicians (PCPs) to choose employment at system-affiliated groups over the autonomy of small practices. This trend, also present in other California markets, poses a threat to independent practice associations (IPAs), with many seeing a decline in their PCP membership base and commercial HMO volume. However, the market's largest IPA, Sharp Community Medical Group, has been able to adjust successfully so far, by expanding geographically and adding sizable primary care practices as members. To accommodate PCPs seeking the stability and security of employment but reluctant to join a large group, Sharp is launching a new practice model, SharpCare Medical Group, whose members will practice in relatively small, community-based settings and will belong to the Sharp Community Medical Group IPA for managed care contracting.

- **Large Medi-Cal expansion exposes safety-net access gaps.** In the two years since Medicaid eligibility was first expanded under the ACA, San Diego's Medi-Cal managed care enrollment almost doubled, to a total of nearly 700,000. The county's strong, stable network of community clinics increased their capacity substantially to prepare for surging demand from the expansion. As a result, although clinics did face primary care capacity constraints, these appeared less severe than in some other California communities. However, many Medi-Cal enrollees without a regular primary care provider sought care at hospital emergency departments (EDs). Access gaps for many kinds of specialty care and behavioral health care were more severe, reflecting not only the shortage of many of these providers in the county overall, but also the lack of willingness among many providers to accept low Medi-Cal payment rates, and the multiple, complex, and challenging health needs of many new Medi-Cal enrollees.

- **Community clinics increasingly collaborating among themselves and with hospitals.** Twelve Federally Qualified Health Centers (FQHCs) belonging to San Diego's clinic consortium recently announced a collaboration, Integrated Health Partners of Southern California, that will conduct unified contracting with Medi-Cal managed care plans and aim to build a clinically integrated network with the goal of improving quality and efficiency. With the state expected to replace its current method for paying FQHCs with a new capitated approach over the next few years, the new partnership is an effort to prepare the diverse group of clinics to assume financial risk for patient care. Individual FQHCs continue to form — or at least explore — more collaborations with hospitals; several of these joint efforts are focused on linking low-income hospital patients to sources of primary care as a way to relieve hospital ED overuse and prevent avoidable readmissions.

- **Mixed views of county government's safety-net role.** San Diego County's commitment to providing health care for low-income residents has long been limited. The county sets stringent eligibility criteria for subsidized health services, and it operates neither a county-run hospital nor primary care clinics. While the county provides both inpatient and outpatient behavioral health services for low-income residents, hospital systems expressed frustration that the county's limited funding for these services has shifted costs onto their own organizations. In recent years, the county Health and Human Services Agency (HHSA) has played an increasing role in collaborations to improve health care for low-income people, including initiatives to link health services with related social services, such as food and housing. Some HHSA collaborations extend beyond the safety net, including a joint effort with local hospital systems to reduce readmissions among high-risk Medicare beneficiaries.

Market Background

San Diego County occupies an area of more than 4,500 square miles, with well-defined geographic boundaries: the Pacific Ocean to the west, Mexico to the south, the desert to the east, and Marine Corps Base Camp Pendleton to the north (see map on page 23). With 3.3 million residents, it is California's second most populous county. The county's population grew by 11% over the past decade, moderately faster than the state's average growth rate.

San Diego is somewhat less racially and ethnically diverse than the state as a whole, with a higher proportion of white residents and lower proportions of Latino, Asian, and foreign-born residents. County residents have moderately higher education and income levels, on average, than state residents. In recent years, the county's unemployment rate consistently has been lower than California's overall rate by more than a full percentage point. (See Table 1.)

The county's health insurance coverage mix is slightly more favorable than the state average. However, from 2007 to 2014, the proportion of San Diego residents covered by private insurance declined substantially, from 63.9% to 53.8%. The key factors driving this trend include the ACA making many low-income residents eligible for Medi-Cal, an aging population becoming increasingly eligible for Medicare, and employer-sponsored coverage eroding during the major recession of the late 2000s and not completely recovering afterward.

While San Diego is more affluent than California overall, large socioeconomic disparities exist within the county. Generally, northern regions of the county are much more prosperous than the central city and southern regions.

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

	San Diego	California
POPULATION STATISTICS, 2014		
Total population	3,263,431	38,802,500
Population growth, 10-year	11.2%	9.1%
Population growth, 5-year	6.9%	5.0%
AGE OF POPULATION, 2014		
Under 5 years old	6.7%	6.6%
Under 18 years old	23.5%	24.1%
18 to 64 years old	61.5%	63.1%
65 years and older	15.0%	12.9%
RACE/ETHNICITY, 2014		
Asian non-Latino	10.2%	13.3%
Black non-Latino	4.7%	5.5%
Latino	33.2%	38.9%
White non-Latino	47.2%	38.8%
Other race non-Latino	4.7%	3.5%
Foreign-born	25.5%	28.5%
EDUCATION, 2014		
High school diploma or higher, adults 25 and older	86.8%	83.4%
College degree or higher, adults 25 and older	40.5%	37.9%
HEALTH STATUS, 2014		
Fair/poor health	14.1%	17.1%
Diabetes	6.9%	8.9%
Asthma	15.6%	14.0%
Heart disease, adults	5.6%	6.1%
ECONOMIC INDICATORS, 2014		
Below 100% federal poverty level	16.7%	18.4%
Below 200% federal poverty level	37.3%	40.7%
Household income above $100,000	22.3%	22.9%
Unemployment rate	6.4%	7.5%
HEALTH INSURANCE, ALL AGES, 2014		
Private insurance	53.8%	51.2%
Medicare	11.9%	10.4%
Medi-Cal and other public programs	23.6%	26.5%
Uninsured	10.7%	11.9%
PHYSICIANS PER 100,000 POPULATION, 2011		
Physicians	211	194
Primary care physicians	64	64
Specialists	147	130
HOSPITALS, 2014		
Community, acute care hospital beds per 100,000 population†	155.6	181.8
Operating margin, acute care hospitals*	7.8%	3.8%
Occupancy rate for licensed acute care beds†	58.2%	53.0%
Average length of stay, in days†	4.3	4.4
Paid full-time equivalents per 1,000 adjusted patient days*	16.1	16.6
Total operating expense per adjusted patient day*	$3,179	$3,417

*Kaiser excluded.
†Kaiser included.

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.

The six regions defined by the county's Health and Human Services Agency, ranked from most to least affluent, are:

- **North Central (also popularly known as Central Coastal).** Includes coastal community of La Jolla. Wealthy, well insured.
- **North Coastal and North Inland.** Not as wealthy as La Jolla, but generally affluent and well insured. North Inland reportedly has fastest-growing population in the county.
- **East.** Middle-of-the-road on economic indicators, also fast growing.
- **South.** High rates of poverty and uninsured; highest proportion of Latino residents. Community of National City has highest unemployment rate in the county.
- **Central.** Includes core urban areas of the city of San Diego. Highest rates of poverty and uninsured; highest proportion of African American residents; very diverse region containing areas of wealth and affluence as well as poverty.

Incremental Competitive Changes Within Largely Stable Hospital Market

Strong, well-established systems continue to anchor San Diego's hospital sector, which has been defined largely by its stability. No major closures, acquisitions, or other organizational changes took place over the past few years.[1] The hospital sector is characterized by substantial consolidation: Its two largest systems — Sharp Health Care and Scripps Health — each with four general acute care hospitals, accounted for 30% and 26%, respectively, of inpatient discharges in 2014.[2,3] The county's next-largest systems have a much more limited inpatient presence: UC San Diego Health (UCSD) had 11% of inpatient discharges in 2014, while Kaiser Permanente and Palomar Health, a district hospital system in the North Inland region, each accounted for 9%. Smaller inpatient facilities include Rady Children's Hospital, which dominates inpatient pediatrics; Tri-City Medical Center, a district hospital in the North Coastal region; and for-profit Prime Health Care's two hospitals, Alvarado and Paradise Valley.

Although the hospital sector has been largely stable, a gradual shift in market positions between the two dominant systems has taken place in recent years. Sharp's share of both inpatient and outpatient volume increased, while Scripps' share declined. Sharp, which has long embraced capitation and its role as a lower-cost, more integrated delivery system, has seen its market position strengthening as both public and private payers have increasingly emphasized provider affordability and value in recent years. Those same market forces have created challenges for Scripps, historically a higher-cost provider that thrived under fee-for-service payment. (See Sharp and Scripps sections below for more detail.)

Kaiser's presence in the San Diego market has expanded in recent years, as enrollment in its health plan grew significantly. About one in five insured county residents is estimated to have Kaiser coverage, and the proportion is higher for the coveted commercially insured population. Kaiser's growing market presence is not reflected in its share of inpatient volume, which has declined as its share of health plan enrollment has increased. In part, this disconnect stems from Kaiser's policy of continuing to outsource a significant volume of inpatient services to other systems, most notably cardiac surgery to Scripps and general inpatient beds to Palomar. A broader reason for the disconnect is that Kaiser's business model does not rely on inpatient facilities to drive profits, as is the case under fee for service; instead, its hospitals serve as cost centers in a model where Kaiser's health plan takes full financial risk. As a result, Kaiser continuously seeks to improve on already efficient hospital utilization and has been able to do this while it expands health plan enrollment.

Along with Sharp, UCSD has seen its share of both inpatient and outpatient volume increasing in recent years. After long functioning as a standalone academic medical center,

in recent years UCSD has stepped up efforts to collaborate with community providers — both physician organizations and smaller community hospitals — a strategy that reportedly has helped boost tertiary referrals to the UCSD system. UCSD's first affiliation — with Rady Children's Hospital and its network of pediatric specialists — dates back to the early 2000s and was tightened in the late 2000s. More recently, UCSD has formed affiliations with Eisenhower Medical Center and El Centro Regional Medical Center in neighboring Riverside and Imperial Counties, respectively, and Tri-City Medical Center in San Diego County (see below).

Large Systems Fare Well Financially, While Most Smaller Hospitals Struggle

Despite significant consolidation, the San Diego hospital sector historically has been characterized by relatively low hospital unit prices, according to market observers. They attributed this in part to the local economy being largely composed of small to mid-sized firms that one market expert described as "very price-conscious . . . [because] for the most part, you've never had concentrations of high-margin, high-wage [businesses] here that you see in . . . San Francisco or Silicon Valley." As a result, San Diego's commercial insurance sector has never tended to be a "pass-through environment" in which payment rate increases to providers can easily be passed on to employers as premium increases of the same magnitude. Compounding these rate pressures from private purchasers and payers have been low Medicare and Medi-Cal payment rates.

Hospital executives reported that payers were continuing to exert downward pressure on rates and described having to make concerted, ongoing efforts to reduce both clinical and administrative expenses in order to achieve positive financial results. Despite those pressures, however, San Diego's largest systems continued to turn in impressive hospital operating margins in 2014, the most recent year for which public data are available from the state. Scripps — which has long achieved high margins — continued that trend in 2014, with a margin of 12.3%.[4] Sharp's margins, which were modest in the late 2000s, have improved markedly over the past five years or so. Its 2014 margin of 10.8% was in line with recent performance. After several years of breaking even or running deficits, UCSD achieved a margin of 6.6% in 2014 — not on par with the two dominant systems, but still robust.[5] Kaiser does not report financial results at either the individual hospital or local market level, but the system as a whole has achieved strong financial performance for several years in a row while increasing health plan enrollment.

In contrast to the large systems, most of the smaller hospitals have experienced financial struggles to varying degrees. The lone exception was Rady Children's Hospital, which continued to leverage its dominant position in inpatient pediatrics to achieve a 9% margin in 2014. Palomar's performance has fluctuated: After four straight years of achieving operating surpluses, the system reported deficits in 2013 and 2014 (3.7% and 0.9%, respectively). Multiple respondents suggested that Palomar had overextended itself in building a third hospital, which opened in 2012, and had too many inpatient beds. In a move aimed at rightsizing the system and reducing its cost structure, Palomar's board voted in mid-2015 to close Palomar's old hospital (the original Palomar Medical Center) in downtown Escondido and move its services to the system's remaining two hospitals, primarily to the new Palomar Medical Center in west Escondido.

Despite its recent mixed financial performance, Palomar's position is still stronger than those of other small hospitals in the market, in large part because its two hospitals occupy the North Inland submarket, which has no other inpatient facilities and is home to a fast-growing commercially insured population. One result is that Palomar has an ongoing contract to supply more than 100 inpatient beds to Kaiser at Palomar Medical Center. Palomar also benefits from an affiliation with the county's largest IPA, Sharp Community Medical Group, which has expanded its North Inland presence in recent years and participates in managed care contracts alongside Palomar (see below). One potential concern for

Palomar is that Kaiser's North County enrollment may grow enough that Kaiser decides to build its own hospital in the area, perhaps within the next decade.[6] The loss of the Kaiser contract would pose a serious setback for Palomar, according to market observers.

The other small hospitals — Tri-City and Prime Health Care — both reported operating deficits of around 4% in 2014, after several years mostly running deficits of varying magnitude. In recent years, Tri-City has lost volume to larger rivals — most notably Scripps and Palomar, which both operate hospitals in adjacent service areas and have expanded physician networks and ambulatory facilities into Tri-City's service area. In late 2015, Tri-City announced an affiliation with UCSD, surprising some market observers who believed a partnership with Scripps or Sharp might be a better fit. Tri-City has been facing management turmoil, with its board voting in March 2016 to oust the CEO, who had held the position for less than two years, and to elevate the CFO to that role.[7]

Prime's business model reportedly has long involved avoiding contracts with commercial health plans, instead capitalizing off of high billed charges to those plans when Prime hospitals "capture" their patients through emergency admissions. Recently, health plans and capitated providers have become much more proactive in repatriating their patients from Prime facilities back to the hospitals in their own networks — a development that one observer suggested might be a key factor behind Prime's weakening financial performance. Another observer noted that Prime recently has been seeking more health plan contracts, a reversal of its longstanding approach.

Seismic compliance issues loom large for Tri-City and Prime's two hospitals. Neither of these hospitals meet seismic standards beyond 2030. The amount of capital needed to make them compliant appears prohibitive for both systems and would likely act as a major deterrent to acquisition as well. Voters in Tri-City's district reportedly twice rejected bond issues to finance construction to meet seismic standards. Market observers suggested that keeping these inpatient facilities open beyond 2030 might be possible only if the state relaxes its current seismic requirements.

New Inpatient Facilities Come Online

Most hospital systems in the region either recently completed construction or are currently engaged in construction, partly to meet seismic requirements and partly to pursue other major strategies such as enhancing key service lines. Palomar became the first system in San Diego to meet full seismic compliance when it opened the new Palomar Medical Center in west Escondido in 2012. Other notable construction projects include Scripps' Prebys Cardiovascular Institute, which opened in 2015 and became the main facility for one of the system's highest-priority service lines, combining cardiac services previously provided at two other Scripps hospitals. Kaiser members make up a large share of Prebys patients, reflecting a long-term arrangement under which all of Kaiser's cardiac surgery needs are provided by Scripps. Slated to open in late 2016 is UCSD's new Jacobs Medical Center, which will house three specialty hospitals under one roof: advanced surgery, cancer care, and women and infants. The new facility is located on UCSD's Thornton campus in wealthy La Jolla, where UCSD has been expanding since 2008. UCSD has concurrently reduced services on its Hillcrest campus in central San Diego, a service area with a far less favorable payer mix. Sharp has been renovating and upgrading several facilities, including converting its Mary Birch Hospital for Women & Newborns to all private rooms. Sharp Grossmont Hospital (a district hospital in East County operated by Sharp) is undergoing extensive taxpayer-financed expansions. These include the construction of a new Heart & Vascular Center, scheduled for completion in late 2016, and a new surgical floor, slated to open in 2018. Sharp Chula Vista Medical Center will undergo a major expansion, with its new Ocean View Tower, featuring private patient rooms and high-tech operating rooms, scheduled to open in 2020.

Kaiser is building its second hospital in the county: a 550-bed facility in Kearny Mesa, scheduled to open in early 2017. The new hospital supports Kaiser's growing health plan enrollment, which topped 600,000 in early 2016. Kaiser's overall plan for San Diego reportedly calls for a total of three hospitals in the county by 2030. When the new Kearny Mesa hospital opens, some services from Kaiser's existing hospital (commonly known as Zion) will be relocated to the new hospital, and Zion will undergo major renovation, with all its rooms converted to private rooms. As of early 2016, Kaiser had not announced whether any of its currently outsourced services would be brought in-house after the new hospital opens. Most observers expected Kaiser to continue using Palomar for inpatient beds because of the significant distance and travel time between Kearny Mesa and most of the North County locations where Kaiser members are concentrated. Kaiser's contract with Scripps for cardiac surgery runs through 2020; if Kaiser were to decide to in-source this service, it would first need to hire its own cardiac surgeons, then have them practice at Scripps for a period of time before moving the service line (along with related interventional cardiology services currently performed by Kaiser physicians at Prebys) to the Kearny Mesa facility.

San Diego historically has been considered an under-bedded community, but some observers have suggested that the recent spate of hospital construction might be moving the market in the opposite direction toward at least some excess capacity. However, the overall net impact on bed capacity remains highly uncertain, in part because the systems have not made final decisions on what to do with their old capacity as new construction comes on line. Those determinations depend, in turn, on whether the state decides to relax its current seismic standards, as many providers and observers expect it to do.

Systems Focus on Ambulatory Expansions

Despite the high-profile launch of some new inpatient facilities, most hospital systems have been more focused on expanding their presence in a wide variety of ambulatory settings. This shifting emphasis from inpatient to ambulatory care — driven by changes in both medical technology and payment incentives — is consistent with trends seen in markets elsewhere across the state and the country. In San Diego, the large systems — Sharp, Scripps, and Kaiser — also have been expanding their clinical footprints to cover areas of the county where their presence had been limited until recently. These geographic expansions have helped serve the systems' population health strategies (see "Systems Pursue Population Health Strategies" below) and include the development of physician networks by acquiring practices outright as well as forming affiliations with existing physician organizations (see "Large System-Affiliated Physician Groups Continue to Grow" below). Systems also have been very active in building, expanding, or acquiring a wide variety of ambulatory facilities, ranging from medical office buildings to urgent care centers, ambulatory surgery centers, and imaging facilities.

In recent years, San Diego's hospital systems have introduced several different forms of convenience care, most notably retail health clinics. One market observer noted that systems appear to be pursuing retail-based strategies to a greater extent in San Diego than elsewhere. Since Palomar first partnered with the Albertsons retail chain in 2008 to operate Palomar Health Expresscare clinics inside Albertsons/Sav-on Pharmacy stores, Sharp affiliated with CVS/MinuteClinic in 2013, and Kaiser with Target in 2014. Scripps, which launched its first convenience clinic in late 2015, is taking a different approach: Instead of partnering with a retail chain, it teamed up with a commercial real estate firm, The Irvine Company, to open a Scripps HealthExpress clinic — perhaps the first of several — in an office tower across the street from a large shopping mall. The new clinic is slated to offer corporate wellness services as well as the usual set of convenience

care services.[8] The Irvine Company's clinic arrangement with Scripps is similar to partnerships the company has formed with other prominent providers elsewhere in California, including Stanford Health in Santa Clara and St. Joseph Hoag Health in Orange County.

Kaiser has been particularly active in introducing new types of convenience care to the market. In addition to its retail clinics in Target stores, Kaiser operates a mobile clinic called a Mobile Health Vehicle: a truck equipped to provide full primary care office visits as well as services such as basic chronic care management, lab work, and biometric screenings. Like Mobile Health Vehicles operated in Kaiser's other major Southern California markets, the truck pays regular visits to the offices of large Kaiser corporate accounts, allowing employees to attend to routine health needs without leaving their workplace. The truck also makes regular stops in areas of the county not located near a Kaiser primary care site, where enrollees would otherwise have to drive a fair distance to seek routine care.

Expanding their ambulatory presence allows San Diego's hospital systems to pursue multiple strategies, including better competing for patients on the basis of convenience and access and, in many cases, reducing the system's clinical cost structure. An example of the latter is Scripps' 2015 acquisition of Imaging Healthcare Specialists (IHS), a chain of eight freestanding radiology centers. In the past, systems typically bought such ambulatory facilities in pursuit of a fee-for-service strategy: The acquired facilities would become part of the system's hospital outpatient department, thus allowing the system to charge a higher rate to payers for the same service than a freestanding facility could charge. After the recent acquisition, however, Scripps is taking a different approach: continuing to operate IHS as freestanding facilities, using the same independent radiologists who had previously staffed these facilities. Maintaining the lower cost structure should help Scripps manage the total cost of care for the growing number of patients for whom it will be taking on financial risk (see "Systems Pursue Population Health Strategies" below). This approach also helps the system better compete for the many patients covered by high-deductible health plans, who have strong incentives to keep their own out-of-pocket costs low by price-shopping among providers. Scripps' move is similar to those recently adopted by traditionally high-priced providers in other markets to reduce their ambulatory cost structure.

Large System-Affiliated Physician Groups Continue to Grow

Many San Diego physicians have long practiced in large medical groups, each aligned exclusively with one of the major systems. Kaiser's Southern California Permanente Medical Group is the largest, employing more than 1,000 physicians and operating 25 ambulatory centers throughout San Diego County. In the UCSD system, physicians are employed by the university and belong to the UCSD Medical Group. Because a portion of their time is devoted to research and teaching, these physicians represent significantly fewer clinical full-time equivalents than the total count of approximately 750.

The other large systems continue to rely on the medical foundation model to align physicians with their systems.[9] Sharp's foundation currently contracts exclusively with one large multispecialty group, Sharp Rees-Stealy Medical Group (SRS), and one small group consisting of Sharp's cardiac surgeons. At SRS, which has about 500 physicians practicing in 21 ambulatory centers, physicians typically refer patients to other physicians within the group. Scripps' foundation contracts with multiple groups, the largest being Scripps Clinic Medical Group, with more than 600 physicians. Other groups in Scripps' foundation include Scripps Coastal Medical Center, with more than 100 PCPs at nine sites, and separate groups consisting of Scripps' cardiac surgeons and hospitalists. Palomar's foundation, Arch Health Partners, is much newer and smaller. Launched in 2010, its physician members now total more than 60, and it belongs to San Diego's largest IPA, Sharp Community Medical Group (see below), for HMO contracting.

Over the past few years, San Diego's large groups all continued to grow, especially in their PCP ranks. As in other markets, this trend has been driven in part by the preference of most new physicians — particularly PCPs — for the stability, security, and predictable work hours of the employment model over the autonomy of private practice. In addition, many PCPs currently in private practice are finding that business model increasingly less viable, and some are making the transition to system-affiliated groups. Indeed, systems have reported increasingly being approached by independent practitioners interested in being acquired.

Driving this trend has been the slow erosion of the capitated HMO model, which continued to lose ground to high-deductible PPOs in the commercial sector. Financially, physician organizations have always fared worse under PPO fee schedules than HMO capitation. PPO rates paid by commercial health plans to small independent practices were described as "horrible" by multiple physician executives. One respondent noted that "commercial [PPO] rates are below Medicare [rates] . . . and San Diego has the lowest Medicare rates in the state." (San Diego's low Medicare payment rates stem from its designation as a rural locality by the Centers for Medicare & Medicaid Services (CMS) — a designation that is scheduled to change in 2017, resulting in an expected payment boost of 6% to 9%.)[10] Capitation has long been the "lifeblood of independent physicians," according to a physician executive, who suggested that if commercial PPOs keep gaining ground on network-model HMOs, "it will put every single [small practice] out of business." More recently, financial pressures on small practices have been compounded by the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which will replace Medicare's current method for paying physicians with a new Quality Payment Program.[11]

Some systems are recognizing the need to find new approaches for aligning the many independent PCPs who are now seeking employment options. Sharp has begun forming a new medical group, SharpCare Medical Group, under its foundation. Organized along very different lines than Sharp Rees-Stealy's large integrated group model, SharpCare aims to retain some key attributes of small, community-based practices that many independent physicians are reluctant to give up, while also offering physicians the security and stability of employment. Members would practice in relatively small primary care offices with only about 3 to 10 practitioners per site and would be able to continue referring patients to community-based specialists. At the same time, they would receive clinical support from the Sharp system — for example, from care managers, pharmacists, and other clinicians, rotating among the primary care sites. Within the Sharp system, SharpCare would be most closely aligned with Sharp Community Medical Group, the IPA, and would be a member of the IPA for HMO contracting and accountable care organization (ACO) participation. Fee for service PPO contracting for the new group will be done through Sharp Healthcare, which should have the leverage to obtain better rates than small practices would have received.

Changing Market Conditions Pose Major Challenges for IPAs

IPAs historically have played a central role in San Diego's health care market, given the county's dual characteristics of high managed care penetration and a significant proportion of physicians practicing in small, independent practices (which rely on IPAs for HMO contracting and practice support). The recent, continuing decline of this small, independent practice model — especially in primary care — means that IPAs are facing what one physician executive describes as an existential threat as well. If current trends continue, IPAs inevitably will experience declining membership that is increasingly skewed toward specialists and older physicians. In recent years, most IPAs have lost a substantial number of commercial HMO lives as a result of network-model HMOs losing volume to high-deductible PPOs (mentioned above), as well as declining PCP membership in many IPAs. While most IPAs have aggressively pursued Medicare Advantage HMO contracts

over the past decade, the gains in enrollment there have not compensated for the loss of commercial HMO lives.

Sharp Community Medical Group (SCMG), by far the largest IPA in San Diego, has been the most successful in adapting to market changes. Pursuing a long-term strategy to expand its footprint throughout the county, SCMG continued to grow both its membership (nearly 1,000 physicians) and HMO lives (107,000 commercial, 27,000 Medicare Advantage) over the past several years, bucking the downward trend experienced by nearly all other IPAs. SCMG was able to increase its patient volume primarily by adding two sizable North County groups to its membership base: Arch Health Partners (Palomar's foundation, with about 40 physicians) and Graybill Medical Group (an independent group of about 50 physicians, also located in Palomar's service area). Without the addition of these two groups, SCMG's HMO lives would have declined. About 40% of SCMG's members are now based in this submarket.

Historically (and still) tightly aligned with the Sharp system, SCMG also developed an affiliation with Palomar as it expanded into the North Inland region, where Palomar operates the only hospitals. SCMG participates in HMO contracts with Palomar, along the same lines as its longstanding arrangement with Sharp: SCMG holds its own HMO contracts, accepting professional risk; the hospital system assumes institutional risk; and the parties share a hospital risk pool.[12]

SCMG has adopted strategies aimed at accommodating physicians across a broad spectrum of practice preferences. As noted above, for PCPs choosing employment with a system-affiliated group but still seeking the qualities of small, community-based practices, SCMG has partnered with Sharp Healthcare to develop the SharpCare Medical Group, which should provide a boost to SCMG's physician membership and patient volume. For member practices choosing to remain independent but seeking more support, SCMG launched a practice management company to provide clinical and administrative services. Some of SCMG's largest members, including Graybill, are using the services of the new practice management company, which reportedly has been successful in helping practices run more efficiently and improving measures of financial performance such as income and cash flow.

SCMG also has been active in efforts to gain patient volume through diversification. Several years ago, it became the first IPA in San Diego to collaborate with health plans in commercial ACOs. Currently, it participates in three ACOs for a total of nearly 27,000 lives (see "Providers Expand Commercial ACO Participation, Despite Reservations" below). SCMG also has been developing a method for ranking its PCP members based on their patient-centered medical home capabilities and reportedly will market this tiered structure to health plans as a new "high-value network" product, with each tier corresponding to a different patient cost-sharing level.

Other IPAs in the market have far fewer physician members and HMO patients, and a more limited geographic footprint, than SCMG. They also tend to have less clinical integration and less product diversification, and most have struggled far more with declines in commercial HMO enrollment. Among the several IPAs affiliated with Scripps, the largest is Mercy Physicians Medical Group (MPMG), with about 600 physicians, primarily specialists. Closely affiliated with Scripps Mercy, MPMG has about 24,000 HMO lives, split evenly between commercial and Medicare Advantage. At its peak, MPMG's commercial HMO enrollment was twice as high as it is now. MPMG has remained independent to date, but reportedly, larger organizations — including both Scripps and MPMG's own management company, North American Medical Management (NAMM) — have shown interest in acquiring it. NAMM already owns another, much smaller Scripps-affiliated IPA, Primary Care Associates Medical Group, located primarily in the North Coastal region.[13]

In 2014, San Diego Physicians Medical Group, one of the market's larger IPAs, formed an exclusive affiliation with Scripps when it joined with two smaller IPAs to form Scripps

Physicians Medical Group, with a total of more than 500 physicians. In mid-2015, Scripps formed an affiliation with another IPA, MultiCultural Primary Care Medical Group. Tightening and expanding such affiliations is part of Scripps' strategy to build up its physician networks as it makes a return to commercial capitation (see "Scripps Returns to Commercial Capitation" below).

Systems Pursue Population Health Strategies

Population health management has long been a central strategy for two of San Diego's major systems. Kaiser's model — an integrated delivery system and a health plan taking full financial risk for all patients — was described by one market observer as "the classic case of population health management." Among the non-Kaiser systems, Sharp stands out as having the highest degree of population health commitment and capabilities. Although Sharp, unlike Kaiser, does provide a significant amount of fee-for-service, volume-based care, the system has long focused on accepting full risk for patient care and managing care efficiently for that population within an integrated system. In contrast to Sharp, Scripps spurned commercial capitation in favor of fee-for-service strategies in the late 2000s, but over the past few years, it has reversed course in response to changing market conditions. Scripps is now pursuing commercial capitation and population health — a strategy that requires significant system transformation (see Scripps section below).

Sharp Health Plan Gains HMO Volume and Market Share

Since the early 1990s, Sharp has held a full insurance license, and the system has long offered HMO products under the Sharp Health Plan (SHP) brand in the commercial group market, predominantly to small and mid-sized local employers. By 2013, SHP's group enrollment had reached about 70,000, including several thousand in Sharp's own workforce. It was in 2014 that the health plan gained greater visibility and substantially more enrollment when it entered two new market segments: the individual market (both on and off the Covered California public insurance exchange) and the California Public Employees' Retirement System (CalPERS) market. After two years competing in those segments, SHP has gained traction in both, attaining a 17% share of Covered California enrollees, and a 20% share of CalPERS enrollees, living in San Diego County. It also has continued growing steadily in the small and mid-sized employer-sponsored segments in which it has long competed. In the small-group market, SHP has had notable success competing on the CaliforniaChoice private insurance exchange, where it has captured about 30% of all San Diego enrollees. Overall, SHP's total group enrollment has reached 102,000, and its individual enrollment — both on and off the Covered California exchange — now tops 28,000. One market observer noted that "[SHP's] figures barely register as a blip if you're comparing them against the statewide [enrollment] totals . . . [but] that's not the right metric to be looking at. . . . The only market they compete in is San Diego, and in this local market, they're a force to be reckoned with."

Like other providers sponsoring their own health plans, Sharp has been motivated by the opportunity to gain more HMO lives, to counteract the commercial market trend toward PPO products. As noted above, physician practices, in general, fare much better financially under HMO capitation than PPO fee schedules. Because of Sharp's clinical integration and care management capabilities, the system's physician organizations, SRS and SCMG, reportedly have done especially well under capitation. And, unlike some California providers whose experience with capitation has been largely limited to professional risk, Sharp has long embraced the full-risk model, including assumption of risk for inpatient utilization and costs. As a result, using its own health plan to compete for patients suits Sharp's care delivery model particularly well.

Not all of Sharp Health Plan's new enrollment represents patients new to the Sharp system. Some new SHP enrollees already were using Sharp's physician network under previous coverage from other plans. Nevertheless, for providers like

Sharp, there are clear benefits to enrolling these patients in a plan sponsored by the system itself rather than by an external health plan. One benefit is the ability to retain the total savings from care management efficiencies within the system, instead of having to share the savings with external health plans. Other benefits include control over insurance product design and pricing, as well as customer service.

In addition to gaining significant enrollment in all the market segments it has entered, SHP has performed well on ratings of member satisfaction and health plan quality. In the 2015 health plan ratings by the National Committee for Quality Assurance (NCQA), SHP outperformed all commercial plans in California on consumer satisfaction, and trailed only Kaiser on overall commercial plan ratings.[14] A market observer commented that "[SHP] is a different model than Kaiser, but the two [plans] are similar in that they've both found combinations of affordability, . . . quality, [and] consumer experience that work well for a lot of people."

Scripps Returns to Commercial Capitation, Launches Its Own Health Plan

As noted above, in the late 2000s, Scripps made the strategic decision to abandon capitation in favor of fee-for-service payments in all of its commercial HMO contracts. This shift was motivated by Scripps' belief that sicker HMO patients were disproportionately choosing Scripps providers, in large part because of Scripps Clinic's strong capabilities and reputation in high-end tertiary services. Unlike Medicare Advantage payments, commercial capitation payments are not risk-adjusted, thus financially disadvantaging capitated providers who attract a less healthy patient mix. (Scripps continued accepting both professional and institutional risk in Medicare Advantage.)

The timing of Scripps' move away from commercial capitation coincided with a major economic recession, which put intense pressure on San Diego health plans and employers to find more affordable insurance coverage options. Health plans responded by rolling out products that charged lower premiums in exchange for restricted provider choice, and many local employers showed much greater willingness to adopt these products than they had in the past. The limited provider networks either excluded Scripps outright or relegated it to a higher cost-sharing tier. In introducing these network changes, plans were reacting not only to the fee-for-service method used in Scripps contracts but also to the high fee-for-service rates charged by the system. Enough employers adopted the new limited-network products that Scripps began losing commercial HMO volume, primarily to Sharp.

The need for providers to compete on affordability and value was reinforced when the ACA became law in 2010, establishing the public insurance marketplaces. The design and structure of these marketplaces gives individual consumers strong incentive and ability to price-shop among insurance products, while also encouraging participating plans to keep premiums low by excluding high-priced providers from their networks. In response to these changing market forces, Scripps began changing course strategically and turning back to commercial capitation. In 2011, the system began approaching commercial plans about returning to capitation but with one major proposed change: risk adjusting payments to correct for adverse selection — an unprecedented approach in commercial HMO contracts. Eventually, most of the commercial plans contracting with Scripps agreed to try retrospective risk adjustment on an experimental basis, and between 2012 and 2014, all but one of Scripps' commercial HMO contracts transitioned from fee for service to risk-adjusted, capitated payment.[15]

While the concept and the logic behind risk-adjusted payments were compelling, the actual implementation was described by respondents familiar with the process as a significant operational challenge fraught with major data gaps and other serious administrative problems. The main issue was that encounter data used to calculate retrospective enrollee risk scores were incomplete, leading enrollees to appear much healthier in the year-end reconciliation process than they were.[16] Efforts to resolve these problems consumed

substantial staff time and resources at Scripps and the health plans, leading all parties to conclude that retrospective calculations of enrollee risk scores would not be viable while encounter data still lacked reliability. As a result, Scripps is discontinuing its risk-adjustment experiment. Commercial HMO contracts coming up for renewal reportedly are being renegotiated under standard commercial capitation terms, with base rates adjusted only by age, sex, and benefit plan. If Scripps indeed suffered from adverse selection in the past on its commercial HMO contracts, and continues to do so now, it remains to be seen how significant a financial disadvantage this return to standard commercial capitation payment might represent for the system.

Besides returning to capitation in its contracts with commercial health plans, Scripps also has launched its own health plan. In August 2015, its application for a full insurance license was approved by the state, and in 2016, Scripps Health Plan began offering coverage to Scripps' own workforce. This year, the new plan also will begin offering quotes to other employers for 2017 coverage. Like many provider-sponsored health plans, the new plan is likely to focus on the mid-sized local employer segment of the market. The plan is also likely to enter the Covered California marketplace at some future point, but it will not be ready to do so by 2017, as it must first meet numerous requirements, including NCQA accreditation.

With the market's two largest systems now both sponsoring their own health plans, along with Kaiser, the impact on the market — at least in the near future — is likely to be an increase in both price competition and product choices. It is in the market segments where these plans will all be competing — the mid-sized employer market and the Covered California marketplace — where benefits will most likely be concentrated for purchasers and consumers. How sustainable those gains are, and how much impact the provider-sponsored plans will have in the longer term, depends largely on the ability of the systems to continue reducing their cost structures. This is an issue that looms much larger for Scripps than for Sharp, given Scripps' historically higher costs and greater reliance on volume-based, fee-for-service payment. In a sign of the cost pressures facing Scripps, the system announced in March 2016 plans to eliminate about 100 management and administrative positions as part of a broader, ongoing effort to reduce operating expenses.[17]

As Scripps moves toward a population health approach, one of its key challenges is developing greater clinical integration, an area where it lags behind Sharp. With clinical information exchange among its clinicians currently hampered by the use of separate, incompatible electronic health record (EHR) systems in its inpatient and ambulatory settings, Scripps is making a $500 million investment in a new, integrated EHR platform. Still in the design phase, the new clinical IT system is scheduled to begin rolling out in early 2017 and to be completed in 2018.

Further developing and tightening affiliations with its physician network is another key challenge Scripps has been working on as part of its population health strategy. As described above, Scripps' physician network encompasses multiple IPAs, including the relatively recent alignment with Scripps Physicians Medical Group. Those multiple relationships make it more challenging to pursue a population health strategy in contrast to the single, longstanding, very tight alignment Sharp has with its IPA, SCMG, which has achieved a substantial degree of clinical integration.

More broadly, Scripps' strategy of transforming itself into a value provider that competes on affordability and takes full risk for large patient populations represents a paradigm shift for a system whose success was built largely as a high-priced provider in a fee-for-service environment. Like Sutter Health in Northern California — another high-priced provider now pursuing population health — Scripps inevitably will face many conflicting incentives internally about how much, and how fast, to move away from conventional fee-for-service strategies that have served it so well in the past.

Providers Expand Commercial ACO Participation Despite Reservations

In the last round of the study in 2012, San Diego was among the first California markets to see the emergence of commercial ACO collaborations between health plans and providers. Both of Sharp's affiliated physician organizations, SCMG and SRS, had begun participating in an ACO with Anthem Blue Cross in 2011, and SCMG also had started partnering with Aetna in a much smaller ACO in 2012.[18] Both ACOs were based on a PPO platform and used attribution models to assign physicians financial responsibility for individual patients. In 2012, SCMG's patient lives from both ACOs totaled about 15,000.

Since then, the number of commercial ACOs involving Sharp physician organizations has grown to three with the recent addition of a United ACO (also based on a PPO attribution model). Across all three ACOs, SCMG has about 27,000 patient lives, and SRS has more than 35,000.[19] Scripps also has begun to participate in commercial ACOs, with a Cigna collaboration already in place and another with Anthem expected to roll out in late 2016.

Despite increasing participation in these arrangements, providers expressed several reservations and frustrations about ACOs. First, they pointed out that sharing risk with health plans in ACOs is less advanced for a provider than accepting full risk under capitation, which major systems have long done in San Diego. As one system executive observed, "[ACO risk sharing] is a step forward if your starting point is fee for service . . . but in this market, where you have the major [providers] able to take full risk for [patient care], it feels like — and it is — a step backward." Respondents from both systems and health plans noted the drawbacks inherent in the shared-savings approach used by ACOs, which require the partners to identify new sources of savings over time, in contrast to capitation, which allows providers to be rewarded consistently from one contract to the next as long as they continue to manage care efficiently. In addition, providers noted the many data and logistical challenges of ACO collaborations. While data sharing between health plans and providers has improved markedly since ACOs were first launched, the patient data currently available to providers for attributed ACO lives still are not nearly as comprehensive or timely as the data that providers have for their capitated patients, according to one physician executive. Care management is another key logistical challenge for ACOs, with health plans and providers often "treading on each other's toes" with separate programs whose lack of coordination can result in costly duplication for the ACO partners, and confusion and frustration for patients.

In spite of these limitations, providers continue to explore ways to expand their participation in ACOs, largely as a means of increasing patient volume. As one physician executive observed, "However clunky [ACOs] are . . . they allow us to reach people who have never been in, and will never be in, HMOs. . . . It gives us a chance to capture people who might not [otherwise] be our patients."

Safety Net Responds to Rising Demand with Capacity Expansions, Collaborations

Historically, San Diego's safety net has been considered weak in some respects — most notably the limited extent of county commitment to and funding for low-income health services — but strong in other dimensions, such as the extensive, well-established set of community clinics providing relatively robust primary care services to low-income residents. As in other California communities, the large expansion of Medi-Cal eligibility under the ACA has strained the capacity of safety-net providers to meet increased demand.

As one of the few large California counties not operating its own hospital, San Diego continues to rely on several community hospitals, along with its public academic medical center, to provide safety-net inpatient care. Hospitals with a disproportionate share of low-income patients include UCSD (Hillcrest campus); Scripps Mercy (both Chula Vista and Hillcrest campuses); Sharp Grossmont (El Cajon, East region); Sharp Chula Vista; and Rady Children's Hospital.

Measured as a proportion of total inpatient discharges for low-income patients (defined as Medi-Cal and uninsured), Sharp provides the most low-income inpatient care in the county (30%), followed by Scripps (21%) and UCSD (13%). When low-income discharges are measured as a proportion of each system's total discharges, UCSD has the highest rate of low-income care (37%), followed by Prime (36%), Sharp (32%), Tri-City (30%), and Scripps (26%).[20]

The hospitals providing the highest volumes of safety-net care all belong to financially strong systems, but as expected, these hospitals tend to have substantially lower operating margins than other hospitals in the same systems with more favorable payer mixes. In contrast to the other major systems, Kaiser's safety-net inpatient role is largely limited to services provided to its own, small population of Medi-Cal enrollees (see below). Other providers pointed to this unevenly distributed Medi-Cal burden as an unfair competitive advantage for Kaiser, with one system executive calling it "an 'unlevel' playing field that's a huge, huge thorn in [the] sides [of the other systems]."

Over the past few years, San Diego's already extensive group of community clinics has continued to grow from a total of 12 full FQHCs and one look-alike in 2012 to 15 full FQHCs currently.[21] The number of clinic sites has also increased, with some of the largest FQHC organizations expanding the most. Family Health Centers of San Diego — not only the largest FQHC in the county, but also one of the largest in the state — now operates 23 clinic sites, including three mobile medical clinics, and plans to add three more clinics within the next year. Other large FQHCs include San Ysidro Health Center (16 sites); North County Health Services (10 sites); Neighborhood Healthcare (8 sites); and La Maestra Community Health Centers and Borrego Health (5 sites each).[22]

San Diego is one of only two California counties to organize Medi-Cal managed care through the Geographic Managed Care (GMC) model, with the state contracting with multiple managed care plans and paying each on a capitated basis. Under this model, there is no public, county-operated health plan. The five plans currently serving the market represent a mix of local and national, and nonprofit and for-profit, entities. The two largest by far are local nonprofit Community Health Group (with 40% of total enrollment) and national for-profit Molina Healthcare (31%). The remainder of the Medi-Cal market is split among Health Net (11%), Care1st (11%), and Kaiser (8%).[23] Two more plans, Aetna and United, are slated to enter the market in 2017.[24]

The California Department of Health Care Services' Medi-Cal Managed Care Performance Dashboard shows a large performance gap between Kaiser and the other four plans.[25] Kaiser, whose members have access to exactly the same care network as its commercial members, outperformed all Medi-Cal plans in California, with a perfect score of 100 on a composite measure of quality and satisfaction. San Diego's largest plan, Community Health Group, earned a score of 60 — the state average — while the remaining three plans scored below average.

However, Kaiser remains the plan with the lowest enrollment in the county because of its longstanding policy to limit its Medi-Cal enrollment to people who meet strict eligibility criteria: either having been Kaiser members themselves within the last 12 months or having an immediate family member who has been a Kaiser member during that period. Not only does this requirement curb Kaiser's total Medi-Cal enrollment but it also gives Kaiser favorable selection (healthier enrollees, with fewer complex or costly needs, than average). People able to meet Kaiser's eligibility criteria are significantly less likely to be homeless or have serious behavioral health issues, for example, than the average enrollee who became eligible for Medi-Cal under the ACA expansion.

New Medi-Cal Enrollees Face Large Gaps in Behavioral Health, Specialty Care

San Diego's Medi-Cal managed care enrollment soared from fewer than 350,000 at the end of 2013 to more than 670,000 by the end of 2015, a 92% increase over the two-year period.

The first wave of new enrollment under the ACA expansion in early 2014 included about 50,000 enrollees transitioned from the county Low Income Health Program (LIHP) (see below); most respondents said this transition went relatively smoothly. Most FQHCs participated in the county LIHP primary care network and were able to keep a large majority of their assigned LIHP enrollees once those enrollees gained Medi-Cal coverage in January 2014. Medi-Cal managed care enrollment continued growing significantly in 2015, but unlike many early enrollees who were highly motivated to obtain coverage (described by one clinic director as "the low-hanging fruit"), people who enrolled later have tended to require much more intensive outreach efforts to convince them to apply and more support services to help them complete successful applications for coverage.

The surge in enrollment since 2014 has put pressure on Medi-Cal managed care plans and safety-net providers to meet the increased demand for a wide variety of services (primary, specialty, and behavioral health care) in a timely manner. Most plans rely primarily on FQHCs to form the backbone of their primary care networks (the exception being Kaiser, which uses its own large network of PCPs and ambulatory facilities). In preparation for the Medi-Cal expansion, many FQHCs — especially the largest ones — had substantially expanded their capacity to handle larger patient volumes. These expansions involved expanding hours as well as opening new clinic sites.

However, several FQHCs reported that recruiting enough clinicians — particularly PCPs — has posed a major challenge, especially in a market where the clinics compete against large groups affiliated with financially strong systems. To attract more recruits, several FQHCs raised salaries significantly. The largest FQHC, Family Health Centers, launched its own family medicine residency program, which now brings in 6 new residents each year, for a total of 18 residents at any given time. Another FQHC, Neighborhood Healthcare, recruits PCPs with board certifications in both family medicine and psychiatry, an approach several other clinics are also trying, but with mixed success given the limited pool of PCPs with these credentials.

The capacity pressures facing community clinics stem not just from pure volume growth but also from the more challenging needs of newly eligible Medi-Cal patients compared to the traditional pre-expansion Medi-Cal population. Not only are new enrollees more likely to have multiple and complex health problems but many also have broader social service issues like homelessness. The leadership of one clinic described being "unprepared to take on this vastly more challenging population" because clinic services had been geared primarily toward traditional Medi-Cal "mothers and kids." Several FQHCs were better prepared, thanks to a longstanding focus on integrating behavioral health into primary care; these clinics developed considerable in-house resources and expertise to deal with mild to moderate behavioral health issues. For example, since the late 2000s, Family Health Centers (FHC) has embedded mental health services into most of its primary care clinic sites. Every primary care visit includes mental health screening, and FHC clinics handle between 125 and 200 mental health visits a day in-house. Neighborhood Healthcare (NHC) also has integrated behavioral health into its primary care sites. In addition to the double-certified PCPs mentioned earlier, NHC has a staff of psychiatrists, psychologists, and marriage and family therapists who work closely with PCPs to do "warm handoffs," where the PCP directly introduces the patient to the behavioral health provider during a medical visit as a way to establish trust and rapport and to reduce any stigma or other barriers to receiving behavioral health care.

However, even some clinics with strong behavioral health capacity reported being overwhelmed by both the volume and the severity of mental health and substance abuse problems among new Medi-Cal enrollees. Under California law, Medi-Cal managed care plans are responsible for treating mild to moderate behavioral health cases, while responsibility for severe cases rests with the county. As in other communities, the various parties responsible for Medi-Cal behavioral

health in San Diego "struggle mightily to make that distinction between what's moderate and what's severe," and coordination among the county, the managed care plans, and safety-net providers has been "spotty," according to one clinic director.

Low payment rates have long resulted in a shortage of specialists willing to treat Medi-Cal patients in San Diego. This dearth of available specialists was exacerbated by increased demand following the ACA expansion. One Medi-Cal health plan executive explained why, in the face of increasing demand, the plan had not expanded its physician network: "The [community] physicians who were going to take Medi-Cal were already contracted with our plan." A clinic director observed that there were reasons beyond low payment rates for the specialist shortage in the safety net: "Specialists in the community really don't like our patients. They are hard to serve . . . and [many] are no-shows" for appointments. Specialties highlighted as having particularly short supply relative to need include neurology, orthopedics, urology, and gynecologic oncology. As a result, staff at a large FQHC often resort to directing patients to a hospital ED when no community specialist can be found to take an urgent referral, according to that FQHC's director.

Overall, San Diego did not experience the dramatic surge in hospital ED use seen in some other California communities, at least in the first year of the Medi-Cal expansion. In 2014, total ED visits in San Diego increased only somewhat faster than they had in previous years (5% growth in 2014 vs. 2.5% to 3.5% growth in each of the previous five years). This was consistent with the fact that hospital executives in San Diego did not cite ED capacity constraints as one of the top pressures facing their systems, in contrast to hospital executives in some other communities. The hospitals with the highest increases in ED volume included three Sharp facilities: Chula Vista (9% growth in 2014), Grossmont (9%), and Memorial (8%).[26] However, some hospital executives noted that ED visits continued climbing significantly in 2015, raising capacity concerns at some facilities.

FQHCs Collaborating More Among Themselves and with Hospitals

Competition and lack of collaboration among community clinics have long been perceived to be problems in San Diego. However, that had begun to change by the time the last study was conducted in 2012, as many FQHCs were starting to step up their collaborations through the San Diego Council of Community Clinics (recently renamed Health Center Partners). This consortium provides coordination and support for activities such as funding, outreach, specialty referral, and implementation of health information technology. However, the reach and impact of the consortium has been limited by the fact that the largest FQHC, Family Health Centers, is not a member.

In a key development announced March 2016, 12 FQHC members of Health Center Partners have formed a new partnership, Integrated Health Partners of Southern California (IHP), to launch an integrated care network for their combined 500,000 patients a year.[27] IHP will function as an IPA, contracting with all Medi-Cal managed care plans (except Kaiser) as a single entity, replacing all the separate contracts each FQHC currently holds with the Medi-Cal plans. The first IHP contract with Molina, the second-largest plan, goes into effect May 2016, and contracts with other plans will follow.

The capitated payments that IHP is negotiating on behalf of its clinic members will not cover all professional services, but rather, a smaller bundle of services described as "primary care plus," covering the services "provided within the four walls of the clinic," which often include services such as basic behavioral health. Although the payments from health plans are capitated, FQHCs are not yet truly assuming financial risk for the Medi-Cal or Medicare services covered by the capitated payment, because the FQHCs remain eligible to receive wraparound payments from the state in a year-end reconciliation process aimed at bringing their total reimbursement up to the cost-based payment level to which their FQHC status entitles them.[28] Because these wraparound

payments effectively protect FQHCs from most risk except for cash-flow risk, one respondent described the current capitation-plus-wraparound arrangement as "training wheels for FQHCs to practice taking on risk." (However, another respondent noted that providing care to the uninsured population has given FQHCs considerable experience in assuming financial risk for patient care.)[29]

Over the next few years, California is expected to replace the current enhanced, cost-based Medi-Cal reimbursement approach with true capitation for FQHCs. With that transition slated to begin with a 2017 pilot program in selected markets, the coming of capitation is regarded as inevitable, and IHP is a collaborative effort by the majority of San Diego FQHCs to prepare for that change. One of the key ways in which IHP aims to improve the efficiency and quality of care provided by member clinics is by collecting and sharing a rich set of clinical data. The member clinics have agreed to share those data on an unblinded basis, allowing the group to identify weaker performers and help those clinics boost their performance. Among IHP's top priorities is providing support to member clinics with less-advanced patient-centered medical home capabilities to help them develop those capabilities.

IHP represents, by far, the most ambitious collaborative effort in the San Diego safety net to date. It is too early to tell what impact it may eventually have on FQHC quality, efficiency, and ability to assume financial risk. While member clinics will have strong incentives to work together to boost their collective performance, one clinic director cautioned that because clinics are used to operating as "fiercely independent organizations [that] all have very different histories . . . [and] also tend to treat different patient populations," productive collaboration among clinics — and the ability of IHP to act as an integrated entity — will face challenges.

Over the past few years, FQHCs have been increasingly collaborating with hospitals as well. However, one safety-net respondent described these joint efforts as "a patchwork, . . . a multitude of small [collaborations]" that tend to form between single hospitals and clinics operating in that hospital's service area. Some major hospitals with large low-income populations — most notably Scripps Mercy and Sharp Chula Vista — have partnerships with multiple clinics. For example, Family Health Centers recently built a clinic site next to Scripps Mercy's Hillcrest campus to provide primary care for hospital patients who lack an established primary care provider. That arrangement represents one of the most common collaborations between FQHCs and hospitals, with the latter seeking not just to relieve ED capacity constraints, but also to prevent avoidable readmissions by linking patients to primary care. Scripps Mercy and UCSD also participate in a three-way partnership with another FQHC, San Ysidro, for a family medicine residency program, with UCSD providing the education and training, Scripps Mercy the funding and inpatient facilities, and San Ysidro the outpatient facilities.

Hospitals and FQHCs both perceived the need for more collaborations overall between the two types of providers, and the need to forge better, more productive collaborations — but both cited barriers to achieving those goals. According to one hospital executive, a tentative partnership with a neighboring FQHC stalled when it became clear that the FQHC would have trouble mustering enough primary care capacity to adequately staff a proposed new primary care clinic to be located near the hospital's ED. The clinic perspective was captured by an FQHC director who observed, "The hospitals are not used to the world of clinics . . . and many don't know how to partner with us . . . [but] they realize if they don't do something different so that patients can be seen in an ambulatory setting, they get a lot of re-treats and readmissions . . . [so] hospitals are coming to the table more [since the ACA expansion]. . . . Hospitals are sharing their data more, and they are very interested in what we can do together. It's a new day."

County Continues Playing Active Coordination Role

Historically, San Diego County has demonstrated limited commitment to the health care safety net, with the County Board of Supervisors focusing on keeping county health spending low overall and preventing undocumented

immigrants in particular from receiving any subsidized services. The county has not owned a hospital since the 1980s, and it does not operate any primary care clinics. Behavioral health is the one major area where the county directly provides health services to low-income residents. It owns and operates the Psychiatric Hospital of San Diego County, which provides inpatient care and crisis intervention for people with serious mental illness. The county also operates several of its own mental health clinics, as well as contracts with community-based providers to provide additional outpatient services to low-income patients with serious mental health and substance use disorders.

As reported in the last round of this study, the leadership team that has directed the county Health and Human Services Agency since the late 2000s has played an increasingly proactive role in efforts to improve health and health care in San Diego. HHSA's Live Well San Diego (LWSD) initiative, at first a 10-year plan with the broad aim of improving the health and well-being of San Diego residents, now provides the framework for developing the county operating budget and for collaborating with public and private partners on federal grants and other joint efforts. LWSD also was used as a guide for designing care delivery in the LIHP, which consisted of a network of FQHCs serving as patient-centered medical homes.

The initiatives on which the county is collaborating with providers and other local organizations include joint efforts that extend well beyond the safety net. One such initiative is the San Diego Care Transitions Partnership (SDCTP), a collaboration among the county and four systems — Scripps, Sharp, UCSD, and Palomar — aimed at reducing hospital readmissions for high-risk Medicare patients discharged from hospitals into the community. (As a group, the four systems provide care for more than 90% of Medicare fee-for-service patients in San Diego.) SDCTP is the largest among 27 programs in CMS's Community-Based Care Transitions Program, and it has been very successful at reducing readmissions and costs for CMS since its 2013 launch. Although CMS is likely to discontinue the program nationwide in late 2016 to focus on alternative payment models, the local participants in SDCTP have agreed to continue some of the program's most effective interventions. Most notably, the county will continue to provide a bundle of "care enhancement" social services to a subset of frail patients deemed most at risk for readmissions, with funding provided by the four systems to replace CMS funding. One respondent observed that participating in SDCTP had shown the systems how cost-effective the targeted provision of social services could be in preventing readmissions and other costly outcomes; as a result, the systems became willing to pay the county to provide these services to some of their most at-risk patients.

Another key collaborative effort for the county is Cal MediConnect, a three-year demonstration in seven California counties to provide coordinated care for patients dually eligible for Medicare and Medicaid across a continuum of care settings, including medical, behavioral health, long term care, and home health. In Cal MediConnect, the county collaborates with health plans and community-based organizations. Unlike SDCTP, however, the results have proved disappointing: Enrollment in the program has been low, and disenrollment has been high. That pattern has been evident not just in San Diego but across all Cal MediConnect sites. Dual eligibles have shown great reluctance to change the regular providers — particularly the PCPs — they already have under Medicare fee for service. Many of these providers declined to participate in the Cal MediConnect network because of low payment rates.

The county continues to play an active coordination role in behavioral health issues. It sponsors an annual summit on integrating behavioral health and primary care. As noted above, the county is responsible for dealing with severe behavioral health issues for low-income residents, and it has been working with Medi-Cal managed care plans, community clinics, hospitals, and others to determine which enrollees fall into severe versus moderate categories, and to improve care transitions. These coordination efforts "are not going terribly

well yet" and face challenges related to inadequate funding and lack of mental health and substance abuse resources overall in the community, according to one respondent.

While acknowledging the coordination role HHSA plays in behavioral health, respondents from hospital systems expressed frustration about the adverse impact that the county's limited overall funding of behavioral health has had on their own systems. "When the county doesn't provide enough psych beds, those patients who should be [treated at county mental health facilities] end up in our ERs. . . . It's the wrong setting for them; it's very disruptive for our staff and our other patients . . . and very costly for the hospital. We're seeing the county shifting a big part of its obligations onto private providers," asserted one hospital executive.

Limited Care Options for the Residually Uninsured

There has never been significant support among San Diego County's elected officials or residents for using county funds to provide health services for undocumented immigrants. Historically, San Diego's County Medical Services program (CMSP) for medically indigent adults has maintained more stringent eligibility standards than many other California counties. It has been open only to US citizens and legal immigrants with incomes up to 165% of federal poverty who have an immediate medical need. CMSP coverage has never encompassed primary care; instead, it has been limited to hospital stays and follow-up visits. These stringent standards still apply to the program, which has now shrunk dramatically in the wake of the Medi-Cal expansion. At its peak, CMSP had served many thousands of low-income adults annually, but over the past year, fewer than 400 people reportedly received services from the program.

Many of San Diego's remaining uninsured residents are undocumented immigrants. When they receive care within the county, it is typically at community clinics and hospital EDs; some also continue to cross the border into Mexico for care, according to respondents. However, many undocumented immigrants go without needed care, or delay seeking care until their medical conditions become severe. As one hospital executive observed, "When [undocumented immigrants] show up at the ER, they tend to be in bad shape."

Issues to Track

- Will San Diego's large hospital systems be able to maintain strong financial performance in the face of cost pressures from public and private payers? If their operating margins erode, what will be the implications for the inpatient safety-net roles played by these systems?
- How well will the county's smaller hospitals weather their current struggles? Will these smaller hospitals find ways to remain viable as independent institutions, or will they face closure or acquisition? What role will state seismic standards play in these hospitals' future prospects?
- How effective will the market's two largest systems be in implementing their population health strategies? How committed, and how successful, will Scripps prove to be in its return to commercial capitation? To what extent will adverse selection prove to be an issue for Scripps in its commercial risk contracts?
- Will network-model HMOs continue losing ground to high-deductible PPOs and Kaiser HMOs in the commercial market? To what extent will the health plans sponsored by Sharp and Scripps be able to reverse — or at least reduce — that trend? How much impact will competition from these provider-sponsored plans have on prices and product choices faced by employers and individual consumers?
- Will the region's IPAs find ways to keep independent practice viable, particularly for primary care physicians? To what extent will SharpCare's new, smaller-scale employment model successfully emerge as an alternative to existing models of primary care practice? Will other systems follow suit in sponsoring new primary care models?

- 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 FQHCs manage to recruit sufficient numbers of PCPs and other clinicians? Will viable strategies be identified for addressing access gaps for specialty care and behavioral health care?
- To what extent will the new partnership among FQHCs succeed in improving efficiency and quality and increasing the FQHCs' collective ability to assume financial risk? Will collaborations between hospitals and FQHCs continue to expand, and will they prove effective in providing more appropriate, less costly care for low-income people?

ENDNOTES

1. Fallbrook Hospital, a small district hospital in the far northern portion of the county, stopped providing inpatient services in 2014. The downtown Escondido campus of Palomar Medical Center stopped providing inpatient services in mid-2015.
2. Scripps' four hospitals are spread across five campuses.
3. Annual Financial Data, California Office of Statewide Planning and Development (OSHPD), 2014. Data reflect each hospital system's fiscal year. Data on inpatient discharges and market shares exclude Rady Children's Hospital.
4. State reporting requirements make OSHPD financial data (reported above) inconsistent with accounting guidelines and hospital systems' audited financial statements. Reports issued by credit rating agencies Moody's and Standard & Poor's showed 2014 operating margins by Scripps and Sharp to be 6.0% and 7.8%, respectively.
5. In previous years, UCSD's audited financial data diverged significantly from OSHPD data (e.g., in 2010, OSHPD reported negative operating margins, while UCSD audited financials showed a solidly positive margin).
6. The contract between Kaiser and Palomar has a five-year term and is renewed on a rolling basis every year.
7. Chris Jennewein, "Tri-City Medical Center Appoints New CEO from Its Ranks," *Times of San Diego*, March 21, 2016, **timesofsandiego.com**.
8. Paul Sisson, "Scripps Health Expands with Clinics, Insurance Plans," *San Diego Union-Tribune*, December 1, 2015, **www.sandiegouniontribune.com**.
9. Because California's corporate practice of medicine law prohibits hospitals from directly employing physicians, some hospitals sponsor medical foundations as a way to align with physicians. Under a medical foundation model, physicians either contract with the foundation through an affiliated IPA or belong to a medical group that contracts exclusively with the foundation through a professional services arrangement. University of California hospitals, county hospitals, and some nonprofit organizations such as community clinics are among the entities allowed to employ physicians directly, through exceptions to the corporate practice of medicine prohibition.
10. Paul Sisson, "Medicare Pay to Increase for SD Docs," *San Diego Union-Tribune*, March 14, 2016, **www.sandiegouniontribune.com**.
11. MACRA's Quality Payment Program has two paths: the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). The vast majority of physicians will be paid under MIPS; small practices are expected to fare substantially worse than large practices on MIPS performance metrics and therefore to receive significantly lower payments.

12. For managed care contracts that SCMG participates in with the Sharp system, Sharp Rees-Stealy also holds its own separate professional risk contracts and participates in the hospital risk pool.

13. Because most of Primary Care Associates Medical Group's members are located in the North Coastal region, which includes Tri-City's hospital service area, the IPA also participates in HMO contracts with Tri-City.

14. "NCQA Health Insurance Plan Ratings 2015-2016 — Summary Report (Private)," National Committee for Quality Assurance, **healthinsuranceratings.ncqa.org**. The overall health plan rating is based on a combination of clinical quality, member satisfaction, and NCQA Accreditation Survey results.

15. Under this approach, at the end of the contract year, encounter data is used to calculate a risk score for each enrollee based on health conditions diagnosed and health services utilized over the previous 12 months. If enrollees had higher risk scores than expected at baseline, Scripps would receive additional payments from the plan; if enrollees had lower risk scores, Scripps would return a portion of its payments to the plan.

16. Because providers are capitated, there is no additional payment tied to the submission of encounter data. As a result, providers in the HMO network are not as focused on submitting complete, accurate encounter data as they would be on submitting claims for payment of services.

17. Melanie Evans, "Scripps Health Moves to Reduce Workforce, Expenses," *Modern Healthcare*, March 21, 2016, **www.modernhealthcare.com**.

18. SRS joined the Aetna ACO in August 2013.

19. The Sharp hospitals participate in the Aetna and United ACOs but not the Anthem Blue Cross ACO.

20. 2014 OSHPD hospital data. Overall, Rady has the highest proportion of low-income discharges relative to total discharges in the county. This reflects more expansive Medi-Cal eligibility standards for children than for adults.

21. FQHC status allows community clinics to receive benefits including federal grants, enhanced cost-based Medi-Cal payments, and student loan forgiveness for physicians. FQHC look-alikes are eligible for many of the same benefits but not federal grants.

22. Borrego also has numerous clinic sites in Riverside County.

23. Health Net is being acquired by Centene Corporation, and Care1st is being acquired by Blue Shield of California.

24. Under the GMC model, the state does not limit the number of plans that can participate. Plans are eligible to enter a GMC market if they meet financial solvency, network adequacy, and other regulatory requirements.

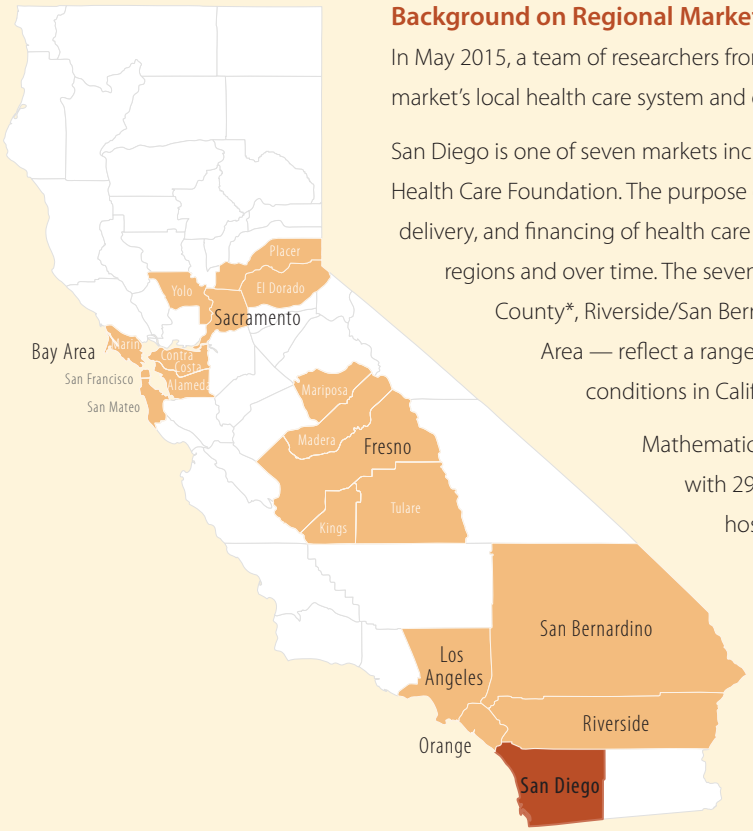
25. *Medi-Cal Managed Care Performance Dashboard*, California Department of Health Care Services, March 16, 2016, **www.dhcs.ca.gov**.

26. Overall, the hospital with the largest ED increase in 2014 was Palomar Medical Center (21%), but respondents suggested that a key factor may have been the ED closure of Fallbrook Hospital (a district hospital north of Palomar), resulting in PMC absorbing much of Fallbrook's ED volume.

27. Paul Sisson, "A Dozen Health Centers to Share Patient Management," *San Diego Union-Tribune*, March 1, 2016, **www.sandiegouniontribune.com**.

28. FQHCs receive enhanced encounter-based payments to cover a range of medical and social services; these are called Prospective Payment System (PPS) rates, and are based on historical allowable costs and are updated for medical inflation.

29. FQHCs are required to offer services to all people, regardless of ability to pay, and to establish a sliding fee discount program. Besides accepting risk in treating uninsured patients, FQHCs also currently accept risk for some insured patients (e.g., those with Covered California coverage and some types of commercial coverage).



Background on Regional Markets Study: San Diego

In May 2015, a team of researchers from Mathematica Policy Research visited San Diego to study that market's local health care system and capture changes since 2011/2012, the last round of this study.

San Diego 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 San Diego. 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.

ABOUT THE AUTHORS

Ha Tu, Lara Converse, Annie Doubleday of **Mathematica Policy Research**, and Paul Ginsburg of the University of Southern California and the Brookings Institution. Mathematica is dedicated to improving public well-being by conducting high-quality, objective data collection and research. More information is available at **www.mathematica-mpr.com**.

ABOUT THE FOUNDATION

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system. For more information, visit us online at **www.chcf.org**.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to **www.chcf.org/almanac**.