

Los Angeles: Thriving or Surviving in a Fragmented Market

Summary of Findings

Los Angeles is a large, densely populated, racially and ethnically diverse county with considerable income variation among its 10 million residents. These characteristics have contributed to a fragmented health care market, with many hospital systems, physician organizations, and community clinic organizations that tend to serve distinct areas where residents live and work, rather than a few provider organizations serving the whole market. Given the expansiveness of the market, this study largely focuses on the core Los Angeles Hospital Service Area (HSA), which is home to a subset of 16 hospitals including nationally renowned academic medical centers (Cedars-Sinai Medical Center and the University of California, Los Angeles [UCLA]), Kaiser Permanente, community hospitals, and public and private safety-net hospitals that serve many Medi-Cal and uninsured patients.

Key developments since the last round of this study in 2011-12 include:

- ▶ **While leading hospital systems and safety-net hospitals fared better under the Affordable Care Act, many community hospitals struggled.** Prominent health systems have benefitted given their relatively large base of affluent, commercially insured patients and reputations as the region's premier hospitals. Kaiser Permanente has grown in enrollment and prospered by providing high value and a seamless patient experience as an integrated delivery system with its own health plan. Meanwhile, the historically vulnerable safety-net hospitals are doing slightly better, as many of their uninsured patients gained Medi-Cal coverage. However, many community hospitals continue to struggle with excess capacity, poor payer mix, and an inability to differentiate themselves. Their lack of leverage with payers has often required these hospitals to choose between either rejecting low payment rates and losing patient volume, or accepting low rates and suffering financially. Two community hospitals closed in the past few years.
- ▶ **Cedars-Sinai and UCLA have pursued several strategies to maintain their roles as providers of highly specialized care while also responding to market pressures to provide more efficient, integrated care.** As payers and purchasers adopt narrow-network insurance products and value-based payment structures, these hospitals are filling gaps in services and establishing more convenient and cost-effective community settings in which to treat patients with less-acute needs. They are doing this both through acquisitions and through partnerships with each other and with additional hospitals, outpatient providers, and physician organizations.
- ▶ **The Los Angeles physician market stands out for the diversity and complexity of arrangements in which physicians can practice.** Two large physician organizations that are unaffiliated with a hospital — HealthCare

Partners and Heritage Physician Network — dominate the physician market and have grown in recent years. Other physicians continue to be drawn to the stability of Kaiser Permanente's large physician group: the Southern California Permanente Medical Group. However, the competitive landscape is changing as large hospitals including Cedars-Sinai and UCLA have accelerated their rate of physician acquisition as they expand their service and geographic reach. To appeal both to physicians who want to retain autonomy as well as to those who want greater stability and security, the physician organizations and the non-Kaiser hospital systems are offering physicians options to remain independent yet gain administrative and clinical support through an independent practice association model, or to become employed through medical groups.

HealthCare Partners and Heritage have long accepted full financial risk for patient care and have prospered by controlling the total cost of patient care. Their large patient volume allows them to act as payers, with considerable influence over which hospitals to contract with and at what payment rates. Because of the undifferentiated nature among the community hospitals, price is a strong factor for HealthCare Partners and Heritage in choosing hospitals with which to contract. At the same time, long-term contracts with select hospitals also have been important in developing the staff and processes needed to successfully manage care and costs. In addition, these physician organizations are participating in Medicare and commercial accountable care organization (ACO) models, providing them access to Medicare fee-for-service and PPO patients as the non-Kaiser HMO model erodes in the market.

- **Hospital systems in the region have historically operated on a primarily fee-for-service payment basis but also have started sharing risk through ACOs.** Further, Cedars-Sinai, UCLA, and Good Samaritan have begun taking part in a high-profile and revolutionary joint venture called Vivity, in which seven hospitals and Anthem share

risk. While still small in terms of enrollment and infrastructure to integrate care across the hospitals, Vivity represents an experiment in whether hospitals can serve patients in the most efficient settings and reduce unnecessary care, and overcome longstanding incentives to generate more services and direct patients to their own facilities.

- **Los Angeles County remains dedicated to providing health care to low-income people and continues to develop its extensive public and private safety net.**

The county and safety-net providers made considerable preparations to transition uninsured residents into coverage under the Affordable Care Act's expansion of the Medi-Cal program. Both Los Angeles County Department of Health Services, and a growing number of Federally Qualified Health Centers have embraced strategies to enhance primary care services through a medical home model to help align both Medi-Cal and uninsured patients more closely to providers who manage their care. New strategies to provide specialty care and other services may have broadened the safety net to help provide care closer to home. Safety-net providers in this market are relatively advanced in their efforts to coordinate care across the care continuum and to move toward risk-based payments. Still, capacity constraints remain in this large county, home to many low-income people.

Market Background

With approximately 10.1 million residents, Los Angeles County is home to more than a quarter of California's population. Los Angeles County is geographically large (4,058 square miles), with the population concentrated in numerous distinct areas, including 13 of the top 50 densest census areas in the US.¹ The county's rate of population growth is slightly lower than the state average, at 3% over the past 5 years, compared to 5% for the state as a whole (see Table 1 on page 3).

Los Angeles stands out for its large supply of hospital beds and physicians relative to the size of the population. Despite

a few hospital closures over the last few years, the county's hospital market remains over-bedded, with approximately 12% more beds than average for its population. In 2014, Los Angeles had 203 acute care inpatient beds per 100,000 people, compared to the California average of 182. The county also has more physicians per capita than the state as a whole, likely reflecting the area's strong educational and training opportunities, and the desirability of living in Los Angeles given its coastal location plus cultural and entertainment offerings.

Given the tremendous size of the county and the 80 hospitals that serve it, this study focuses on the core Los Angeles Hospital Service Area (referred to herein as the HSA), which is also over-bedded.² This HSA includes 16 hospitals in the city's Downtown core, parts of South Central and East Los Angeles, and neighborhoods as far west as Westwood and Bel Air. The area is home to almost two million residents, or about a fifth of Los Angeles County's total population.

Like the county as a whole, the HSA is racially and ethnically diverse, with stark economic disparities across its geographic area. In 2012, Latinos composed about half of the HSA's adult population, compared to a third for the state overall. The HSA also had higher proportions of black residents (14% vs. 6% statewide) and of noncitizens (33% vs. 18%).³ The area is low-income overall: In 2012, 23% of adults lived in poverty, compared to 13% statewide. However, the western areas of the HSA, including Beverly Hills, Bel Air, and Westwood, are known for their extreme wealth and stand in sharp contrast to the impoverished areas of South Central and East Los Angeles. More recently, the Downtown area has become more gentrified, attracting a

Table 1. Demographic and Health System Characteristics: Los Angeles vs. California

	Los Angeles	California
POPULATION STATISTICS, 2014		
Total population	10,116,705	38,802,500
Population growth, 10-year	3.1%	9.1%
Population growth, 5-year	2.7%	5.0%
AGE OF POPULATION, 2014		
Under 5 years old	6.9%	6.6%
Under 18 years old	23.4%	24.1%
18 to 64 years old	64.5%	63.1%
65 years and older	12.1%	12.9%
RACE/ETHNICITY, 2014		
Asian non-Latino	13.5%	13.3%
Black non-Latino	8.3%	5.5%
Latino	49.3%	38.9%
White non-Latino	26.5%	38.8%
Other race non-Latino	2.4%	3.5%
Foreign-born	36.1%	28.5%
EDUCATION, 2014		
High school diploma or higher, adults 25 and older	79.8%	83.4%
College degree or higher, adults 25 and older	35.2%	37.9%
HEALTH STATUS, 2014		
Fair/poor health	19.3%	17.1%
Diabetes	10.0%	8.9%
Asthma	11.4%	14.0%
Heart disease, adults	5.7%	6.1%
ECONOMIC INDICATORS, 2014		
Below 100% federal poverty level	21.0%	18.4%
Below 200% federal poverty level	45.1%	40.7%
Household income above \$100,000	19.9%	22.9%
Unemployment rate	8.3%	7.5%
HEALTH INSURANCE, ALL AGES, 2014		
Private insurance	48.9%	51.2%
Medicare	8.8%	10.4%
Medi-Cal and other public programs	28.9%	26.5%
Uninsured	13.1%	11.9%
PHYSICIANS PER 100,000 POPULATION, 2011		
Physicians	201	194
Primary care physicians	62	64
Specialists	139	130
HOSPITALS, 2014		
Community, acute care hospital beds per 100,000 population†	202.6	181.8
Operating margin, acute care hospitals*	0.0%	3.8%
Occupancy rate for licensed acute care beds†	55.3%	53.0%
Average length of stay, in days†	4.4	4.4
Paid full-time equivalents per 1,000 adjusted patient days*	17.4	16.6
Total operating expense per adjusted patient day*	\$3,333	\$3,417

*Kaiser excluded.

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

growing share of higher-income, young professionals seeking to live closer to work.

Low incomes and immigration status have contributed to low rates of health insurance coverage in the region: In 2011-12, 30% of adults in the core HSA lacked insurance, compared to 21% for the state.⁴ However, the uninsured rate likely has declined in the wake of the Affordable Care Act's coverage expansions as it has in the county overall, where the uninsured rate for people of all ages dropped from 17% in 2011 to 13% in 2014, although it remains slightly higher than the state average (15% in 2011 and 12% in 2014).⁵

Hospital Market Remains Fragmented

Most of the 16 hospitals in the core HSA operate as part of small systems or as independent hospitals, and no single hospital or health system captures a large share of the market's discharges.⁶ These hospitals generally fall into one of four categories that display different characteristics and face different pressures: nationally renowned academic medical centers (AMCs), Kaiser Permanente, community hospitals, and safety-net hospitals. The AMCs and Kaiser have strong payer mixes, consisting of relatively high shares of commercially insured and Medicare patients based on patient discharges (with Medi-Cal representing a relatively small proportion of their patients).⁷ The community hospitals tend to have high proportions of Medicare patients, followed by commercial and Medi-Cal. The safety-net hospitals serve mostly Medi-Cal and uninsured patients.

These categorizations do not necessarily apply to the broader Los Angeles market. Beyond the core HSA there are several large community hospital systems, including MemorialCare Health System and Providence Health & Services.⁸ While some of the member hospitals have a relatively poor payer mix given their locations, they are bolstered by their strong parent systems, which have relatively strong leverage with payers and whose competitive strategies are more similar to those of the AMCs.

West Side AMC Giants

Despite the fragmented nature of the market, two large AMCs — Cedars-Sinai Medical Center and Ronald Reagan UCLA Medical Center — are influential providers. Each has a single, large hospital facility located on the affluent west side of Los Angeles: Cedars-Sinai with about 850 licensed acute care beds and UCLA with over 450. In 2014, the year for which the most recent state data on hospitals are available, Cedars-Sinai provided 17.7% of acute discharges in the HSA, while Ronald Reagan UCLA provided 9.3%.⁹

Cedars-Sinai's and UCLA's significant role in the market extends beyond their inpatient market share. Both are widely recognized as premier hospital brands, reflecting their reputations for both high clinical quality and superior patient experience. They serve a large share of commercial patients in their immediate neighborhoods, and their tertiary and quaternary care services attract patients from the broader Southern California region, and even nationally and internationally. Cedars-Sinai in particular has the status of an elite provider that attracts celebrities and other wealthy patients, which also boosts its appeal to the broader population. The two systems' strong brand recognition and high-end services equate to "must-have" status in health plan networks and provide them extremely strong leverage in negotiating payment rates with commercial payers. According to a health plan network executive, Cedars-Sinai and UCLA command the highest commercial payment rates in Southern California.

Over the last few years, Cedars-Sinai and UCLA have continued to thrive as they maintained their strong patient base and payer mix. Cedars-Sinai's operating margin increased from 9.0% in 2011 to 10.8% in 2014. UCLA's operating margin dropped but remained healthy, falling from 15.3% in 2011 to 6.0% in 2014. This drop reportedly stems from investments the system made in several areas (including outpatient services and physician network development), as well as the University of California's new policies to bring solvency to the retirement fund for its employees, which have required increased

financial contributions from the employee and employer over the last few years.¹⁰

The HSA is home to another AMC, Keck Medical Center (KMC) of the University of Southern California (USC), with about 370 licensed acute care beds. KMC is primarily a specialty hospital, with most of its teaching program located at affiliated hospitals, including Los Angeles County + USC (LAC+USC), the main county-owned safety-net hospital.¹¹ KMC is located in low-income East Los Angeles and, lacking the strong brand and affluent patient base of the other AMCs, reportedly does not command high payment rates from commercial payers. KMC has suffered significant operating losses over the last few years.¹²

Kaiser Permanente

Kaiser Permanente has eight hospitals in Los Angeles County, with two of them located in the HSA: one on the west side and the other in the Hollywood area. One has about 300 licensed acute care beds and the other has 500; together they composed 13.4% of the HSA's acute discharges in 2014. With Los Angeles representing Kaiser's largest presence in Southern California, these Kaiser hospitals have always provided more services in-house than Kaiser hospitals in other markets, which have relied more heavily on other hospitals for certain services. In Los Angeles, Kaiser outsources only organ transplants, most of which are performed by Cedars-Sinai.

Kaiser's share of discharges understates its market presence because, as an integrated delivery system whose affiliated health plan takes full risk for patient care, the system focuses on controlling inpatient utilization and providing care in less intensive settings. The Kaiser model combines affordability and timely access to services, especially to primary care. Its share of the commercial health plan market has continued to grow over the last few years; Kaiser now covers over 1.6 million people, or a third of the commercially insured population, in Los Angeles County. While Kaiser does not report financial results at the individual hospital or local market

level, the system as a whole has had strong financial performance over the last few years.

Community Hospitals

The HSA has a few small-to-midsize community hospitals, which provide more routine care than highly specialized services. In 2014, Good Samaritan and Olympia Medical Center, both independent community hospitals, provided 5.3% and 2.5%, respectively, of the acute discharges in the HSA. St. Vincent Medical Center, which is part of the recently purchased Daughters of Charity system (and renamed Verity Health System), held 2.9% of acute discharges. These hospitals are located along the I-110 and I-10 freeways that run through central Los Angeles, and serve many of the Downtown immigrant communities largely comprised of Medicare and Medi-Cal patients.

Over the last three years, two community hospitals closed: Temple Community Hospital of Los Angeles and Pacific Health Corporation's Los Angeles Metropolitan Medical Center (LAMMC).¹³ While the market remains over-bedded in the aggregate, market observers indicated that the closures may have created access problems for some patients living near these facilities, and that the loss of emergency department services at LAMMC was particularly problematic.

The remaining community hospitals tend to be over-bedded, lack brand recognition, and have little to no leverage with payers over payment rates. These payers include the market's large, independent physician organizations that take full risk, HealthCare Partners and Heritage Provider Network. Community hospitals' margins eroded over the past few years, which some market observers suggest stemmed in part from these physician organizations' considerable leverage over payment rates, requiring hospitals to choose between either rejecting low rates and losing patient volume, or accepting low rates and suffering financially. Among the community hospitals, outpatient visits (excluding emergency department use) dropped significantly, and inpatient volume fell between 2011 and 2014, leaving them operating at only about 40% to

60% of their staffed inpatient capacity. Some also had worsening payer mixes, but there was no clear pattern in payer mix shifts among these hospitals. Good Samaritan's operating margins hovered around break-even levels since 2011, but saw a sharp decline in 2014, falling to -13.1%. Olympia Medical Center's operating margin decreased from 0.4% in 2011 to -15.8% in 2013 before recovering to break-even status in 2014.

At St. Vincent, part of the financially troubled Daughters of Charity (DOC) system, margins fell from -12.5% in 2011 to a drastically low -23% in 2014. In fact, several years of financial losses across the DOC system's six hospitals (which include one other hospital in Los Angeles County and four in other parts of California) prompted the system to seek a buyer. In December 2015, the California attorney general approved an investment deal by BlueMountain Capital Management, a New York City-based hedge fund. To preserve access to services in the hospitals' immediate service areas, BlueMountain must continue operating the hospitals (renamed Verity Health System) as a nonprofit system for 15 years and to continue providing charity care.

The other struggling hospitals remain on their own and face an uncertain future. The Downtown hospitals that have poor payer mix and need costly seismic updates are not attractive acquisitions for the strong hospital systems or other investors.

Safety-Net Hospitals

The HSA's safety-net hospitals include the Los Angeles County Department of Health Services (LACDHS) system and several nonprofit and for-profit hospitals. The county system and some of the other hospitals have a stated mission to serve many low-income people, while others serve this role by default based on their locations in low-income neighborhoods. The safety-net hospitals are in central and East Los Angeles, historically poorer areas of the county. Reflecting their heavily Medi-Cal and uninsured payer mix, the state designates these hospitals as disproportionate share hospitals

(DSHs), which entitles them to state/federal supplemental Medi-Cal and Medicare funds.

LACDHS operates two hospitals in the HSA: LAC+USC is the flagship county facility, with approximately 600 licensed acute care beds in central Los Angeles. As a highly specialized provider, LAC+USC draws patients from throughout the county. Its smaller counterpart, Harbor-UCLA Medical Center, operates just over 400 beds just south of LAC+USC. Together these two hospitals provide approximately 19% of acute discharges in the HSA.¹⁴

The HSA has two smaller, nonprofit, faith-based safety-net hospitals, each with approximately 275 licensed acute care beds: California Hospital Medical Center, part of the Dignity Health system, and White Memorial, part of the Adventist HealthCare system. In 2014, their inpatient market shares were 6.5% and 7%, respectively.

The for-profit hospitals that play a safety-net role include Hollywood Presbyterian (Catholic Health Association), East Los Angeles Doctor's Hospital (Avanti), and Southern California Hospital of Hollywood and Los Angeles Community Hospital, both part of the Alta Hospital System. These hospitals range in size from about 100 to 400 beds and each held between 1% and 5% of inpatient market share in 2014.

The safety-net hospitals — which historically have had negative to slightly positive operating margins — have fared better financially over the last few years. They received a boost as many of their uninsured patients gained Medi-Cal coverage; the state's hospital fee program and, for some hospitals, increased DSH funding has helped.¹⁵ LAC+USC's operating margin remains negative but has improved. The noncounty safety-net hospitals have had stronger and improving operating margins, especially those owned by for-profit systems. For example, in 2014, operating margins ranged from 8% at Hollywood Presbyterian to 29% at Los Angeles Community Hospital. In contrast, California Hospital Medical Center's operating margin fell from a relatively healthy 4.4% in 2011 to -3.4% in 2014.

Cedars-Sinai and UCLA Pursue Multiple Strategies

Over the past few years, Cedars-Sinai and UCLA have pursued several strategies to maintain their roles as highly specialized providers while also striving to improve their operational and clinical efficiency in response to market changes, particularly payers' and purchasers' adoption of narrow-network insurance products and value-based payment structures. These hospitals — especially UCLA — also have been grappling with very high occupancy rates on their inpatient units, which limits availability for tertiary and quaternary admissions, hinders their teaching missions, generates backups in the emergency department, and can harm overall quality of care and patient outcomes. In response, these hospitals are filling gaps in services and establishing more convenient and cost-effective settings in which to treat patients with less-acute needs. They are doing this through extending their own capacity and working with existing providers. In a key example, Cedars-Sinai and UCLA have entered an arrangement with additional hospitals through the new Vivity joint venture (see “Hospitals Experiment with Novel Risk Arrangements” below).

Cedars-Sinai and UCLA are expanding their number of hospital beds in the community. In September 2015, Cedars-Sinai acquired the generally profitable 145-bed Marina Del Rey Hospital, located in a relatively affluent part of west Los Angeles.¹⁶ Still, Cedars-Sinai's main campus continues to function as a community hospital for its immediate service area. UCLA has focused more on partnering with, rather than purchasing, community hospitals, given the large amount of capital needed to acquire hospitals and the community hospitals' financial troubles. UCLA will soon have affiliations with 10 hospitals (up from 7 in the last round of this study) and has established hospitalist programs at each to help manage their patients. Yet the financial fragility of the smaller hospitals also limits partnership opportunities. As an executive at a large hospital lamented, “There are a lot of have-nots in this market; there are not a lot of ideal partnership options for hospitals here in this community.”

In addition, Cedars-Sinai and UCLA have entered a joint venture to develop a 138-bed acute rehabilitation hospital in a facility of a former hospital (Century City Hospital) on the west side, which will be operated by Select Medical, a national company with rehabilitation expertise. This facility will provide a new, more cost-effective option for discharging patients who need a less intensive setting, thus extending the hospitals' existing rehabilitation capacity and freeing up acute care beds for new admissions.

Cedars-Sinai and UCLA are especially focused on providing more services on an outpatient basis. Cedars-Sinai's acquisition of Marina Del Rey Hospital includes its medical office building and physician services. Cedars-Sinai also is building a new 30,000-square-foot outpatient facility for physician and diagnostic services in the larger retail and residential development in the Playa Vista neighborhood of west Los Angeles, which has a large concentration of technology employers.¹⁷ UCLA has entered into joint ventures with national companies to add ambulatory surgical centers throughout the county and is adding more imaging and physical therapy centers. It will begin providing services directly to employers in the entertainment industry, starting with primary care. Post-acute care remains a key gap in service lines for both hospitals; UCLA reportedly is planning to add skilled nursing facilities.

Physician Market Remains Diverse and Complex

The Los Angeles physician market stands out for the number of different arrangements in which physicians can practice. These include the two large, independent (not affiliated with a hospital system) physician organizations that together dominate the physician market — HealthCare Partners and Heritage Physician Network — as well as Kaiser and the large hospital systems' aligned physician networks. These entities increasingly offer physicians different options to remain independent or gain stability through an employed model.

Physicians are gravitating to the large physician organizations and the hospital systems' aligned physician networks

in the wake of growing pressures. Physicians — especially primary care physicians (PCPs) — in independent practice face growing administrative and financial challenges, including quality-reporting requirements and information technology needs. While many have long participated in IPAs for practice support and HMO contracting, enrollment in non-Kaiser HMO products has been declining in favor of high-deductible PPOs.

After previous consolidation of smaller IPAs into larger ones, a diverse set of small IPAs persists across the county. Some of these are affiliated with the smaller hospitals (for example, Good Samaritan IPA) and/or focus on particular types of physicians (for example, Hispanic Physicians IPA) and/or patient populations (commercial, Medicare, or Medicaid). Some market observers have questioned the ability of these organizations to remain viable as physicians gravitate to employed models, thus raising questions about the survival of independent physician practices more generally.

Large, Independent Physician Organizations Dominate

HealthCare Partners and Heritage Physician Network are complex, hybrid physician organizations that together dominate the physician market. Their longstanding offering of options for physicians, as well as their ability to control total costs of care, have fostered their significant growth and influence in Los Angeles and beyond.¹⁸

Both organizations offer physicians the option to remain independent through a large IPA component or to join a large, integrated medical group. In Los Angeles County, HealthCare Partners contracts with approximately 4,850 physicians through the IPA, and employs around 900 through its medical group; this represents an overall growth of about 25% between 2012 and 2015, with more growth on the IPA side. Heritage Provider Network employs or contracts with about 7,350 physicians in Los Angeles County, mostly through the IPA. According to a market observer, these organizations are more focused on strengthening their physician relationships through the IPA (by, for example, providing incentives to

be exclusive, providing additional information technology resources, etc.), rather than significantly expanding their medical groups through practice acquisition. These organizations had acquired smaller IPAs in the market about a decade ago; their recent growth has occurred through recruitment of individual physicians, including from the remaining IPAs.

HealthCare Partners and Heritage have overlapping service areas and have generally stayed out of the west side (where the large AMCs dominate). HealthCare Partners has a stronger presence in central and Downtown Los Angeles, as well as the South Bay (southwest part of Los Angeles County) and the San Gabriel Valley on the east side; Heritage's Los Angeles presence is strongest in the northern San Fernando Valley. A market observer suggests that their continued growth may be challenged as the large hospital systems also are expanding their aligned physician networks beyond the west side of the county.

Hospital System-Affiliated Physician Groups Grow

Over the last few years, the region's large hospitals have worked to grow their aligned physician networks as part of their strategy to extend their reach in the community. Cedars-Sinai has continued its pluralistic strategy of offering physicians a menu of relationship options based on their needs and preferences, which offer varied degrees of risk. Cedars-Sinai's medical foundation, the Cedars-Sinai Medical Delivery Network, has expanded considerably over the past few years; within it, its Cedars-Sinai Medical Group and Cedars-Sinai Health Associates, an IPA, have grown by about a quarter over the last few years and together are approaching a total of 600 physician members. Much of the growth has come through the medical group, as the system has acquired existing practices and helped practices add physicians. Cedars-Sinai is adding primary care and specialty groups (including cardiology, oncology, and orthopedics) in all directions around its main campus, largely mirroring its existing service area but bringing services closer to patients. While some of this expansion, particularly for primary care, is part of a strategy to help

improve overall efficiency and control costs of care, some market observers suggest that Cedars-Sinai is well-positioned to continue pursuing lucrative service line strategies, which could drive up overall costs of care.

The UCLA Medical Group has grown its PCPs from about 275 a few years ago to 400 today; its number of specialists has remained relatively stable at about 1,200. UCLA has been particularly focused on increasing PCP membership across a broad geographic area, even into Ventura County. Part of this has occurred through purchasing existing practices, but UCLA is also focused on growing organically by building new clinic sites that are staffed in part by newly trained physicians, including former UCLA residents. As a University of California hospital, UCLA is exempt from California's corporate practice of medicine ban so it can employ physicians. But given the capital costs of acquiring practices and some physicians' desire to retain some independence, UCLA also is pursuing new alignments with physicians that are alternatives to acquiring and employing them, such as by providing them administrative and infrastructure support including billing, insurance contracting, and electronic health record (EHR) systems.

Kaiser Permanente's exclusive affiliated physician group, the Southern California Permanente Medical Group has continued to grow and currently has about 7,000 physicians in Los Angeles County. In Los Angeles as elsewhere in the state, Kaiser is a strong draw for physicians for reasons including more predictable work hours, competitive compensation, and stability of the employment model.

Large Physician Organizations Lead in Risk Arrangements

HealthCare Partners and Heritage Provider Network have led the way in the movement to risk-based payments in Los Angeles. These organizations have long accepted full financial risk, meaning that they bear financial responsibility for the total cost of care for their HMO patients. These two organizations reportedly hold much of the non-Kaiser HMO business in the market, but as the commercial HMO market

has stagnated more recently, they have become more reliant on Medicare Advantage and PPO patients for further growth.

These physician organizations have benefited from the over-bedded and relatively undifferentiated nature of many of the smaller hospitals in the market. The organizations' large patient volumes allow them to act as payers, with considerable influence over which hospitals to contract with and at what payment rates. Some market observers report that these hospitals are viewed as largely interchangeable, or even commodities, because they are similar in their services, quality, and lack of brand name recognition. However, the physician organizations' ability to shift business among hospitals for the best price is limited by several key considerations: They need to cultivate long-term relationships with hospitals and provide a positive work environment for their care managers and physicians to enable strong coordination of care and to manage total costs.

Hospitals Experiment with Novel Risk Arrangements

In contrast, hospitals in the region have historically taken little financial risk. Health systems have taken risk primarily for professional services, rather than institutional (hospital) services. For example, UCLA reportedly has about 115,000 patients in risk arrangements, with 4,000 to 5,000 of those patients in arrangements also involving institutional risk.

However, the larger hospital systems are now entering some shared risk arrangements. UCLA, Cedars-Sinai, and Good Samaritan have entered a high-profile, experimental joint venture called Vivity, in which seven hospital systems in the broader Los Angeles market (and Orange County), as well as Anthem Blue Cross, share full financial risk for patient care.¹⁹ Vivity attempts to create a virtual integrated delivery system through a selective network that has the infrastructure to manage population health collectively. As a market observer described UCLA's and Cedars-Sinai's participation: "Vivity has been one avenue they have both pursued to integrate and connect with other community hospitals in a health plan product to connect the dots, to serve a bigger population."

The participating organizations work to create the necessary infrastructure to manage patient care — for example, by implementing a shared EHR and establishing processes for referrals and care coordination.²⁰ Vivity recently started allowing primary care providers from one hospital system to refer patients to the other systems for specialty care.²¹

Market observers report that while Vivity represents a willingness for competing hospitals to collaborate and lower the overall costs of care, this arrangement requires a complete shift in how these hospital systems traditionally have attracted patients, and in their model for performing well financially under fee-for-service payments. Some observers are skeptical about hospitals' ability to direct patients to systems outside their own (e.g., lower-cost community hospitals) when warranted and to limit unnecessary care.

At this stage, Anthem has marketed Vivity as an HMO product solely to large employers to grow enrollment gradually. The California Public Employees' Retirement System (CalPERS), which manages health benefits for public active and retired workers, was the first employer to offer the product. To compete with Kaiser, Anthem reportedly is offering Vivity at substantially subsidized premiums.²² The product also provides modest, predictable out-of-pocket costs for members through first-dollar coverage (i.e., no deductible or co-insurance requirements) with fixed-dollar copays.²³ In 2015, its first year, Vivity slightly exceeded its goal of 15,000 members — some in Orange County, and reportedly more than half coming from Kaiser — and plans to reach 35,000 members in 2016.²⁴

ACOs Provide Vehicle to Gain Patients, Share Risk

Los Angeles providers are also participating in Medicare and commercial accountable care organization (ACO) arrangements. HealthCare Partners and Heritage have led the ACO activity in Los Angeles and have significantly more patient membership in these arrangements than other Los Angeles providers. While ACOs represent a step down for HealthCare Partners and Heritage because they already successfully

manage full risk, these arrangements give these providers the opportunity to gain more patients. With (non-Kaiser) HMO patient growth stagnating, ACOs provide access to commercial PPO patients and the Medicare fee-for-service population. For hospitals that are used to primarily fee-for-service payments, ACOs represent a step up in care coordination and management. Cedars-Sinai and UCLA have taken early steps into the ACO arena.

Large providers in the region are participating in the federal Medicare ACO models through the Center for Medicare and Medicaid Innovation. Both HealthCare Partners and Heritage participated in the Pioneer ACO Model. However, both faced financial losses in the program and transitioned into other ACO models: HealthCare Partners joined the Medicare Shared Savings program in 2015, and Heritage joined the new Next Generation ACO program in early 2016.²⁵ UCLA and Cedars-Sinai also began participating in the Medicare Shared Savings program in 2013.

On the commercial side, HealthCare Partners, Heritage, Cedars-Sinai, and UCLA are all participating in Anthem's PPO ACO that started in October 2013. HealthCare Partners has been participating in a smaller ACO with Cigna since 2013, and UCLA joined this ACO in 2015.

Safety Net Stretches with Medi-Cal Growth

Los Angeles County continues to exhibit a strong commitment to the challenging task of providing health care services to the huge numbers of low-income people living across the geographically vast, densely populated county. Under stable leadership, Los Angeles County's active preparations for the Medi-Cal expansion helped address some of the patient needs early and transition people into coverage. The county health care system, LACDHS, remains the hub of activity for hospital care and programs for the uninsured. The county continues its longstanding reliance on a growing network of Federally Qualified Health Centers (FQHCs), as well as other hospitals and physician practices, to supplement and extend the safety net's reach. The safety net has focused on

promoting primary care, improving access to specialty and behavioral health care, and managing needs more efficiently through information technology and innovative programs and strategies. The Los Angeles safety net is further along the path toward risk-based payment arrangements than safety nets in the other study sites. Still, the safety net is experiencing the strain of managing more people through outpatient settings, particularly people with a complex array of medical, behavioral, and social needs.

Medi-Cal Enrollment Swells

As in most California counties, the Low Income Health Program (LIHP) — an option under the state’s 2010-15 Bridge to Reform Medi-Cal waiver — was an important step to help transition uninsured people in Los Angeles County into medical homes and an insurance-like arrangement in preparation for the Medi-Cal expansion. Los Angeles County implemented its LIHP — called Healthy Way LA — relatively early, in 2010. It grew out of several existing county programs for the medically indigent, but Healthy Way LA expanded services and enrollment. LACDHS, FQHCs, community clinics, and other participating providers found that the program helped serve more patients early and foster patients’ allegiance so they were likely to remain with their provider once they gained Medi-Cal coverage. Over 300,000 people transitioned from Healthy Way LA to Medi-Cal in January 2014.

Approximately 1.5 million Los Angeles residents have gained Medi-Cal coverage since 2014, and Los Angeles has far more Medi-Cal enrollees than any other county in California. Medi-Cal enrollment in Los Angeles grew almost 60%, from approximately 2.6 million people in December 2013 to over 4.1 million people by February 2016.

Most of the new Medi-Cal enrollees entered a managed care arrangement. Los Angeles continues to operate under the Two-Plan Medi-Cal model. L.A. Care Health Plan is the public plan (also called the “local initiative”) and Health Net (which Centene has acquired) is the private plan option. By

May 2016, L.A. Care had over 1.9 million Medi-Cal enrollees, maintaining its two-thirds market share, while Health Net’s enrollment grew to over one million enrollees.

However, the “Two-Plan” label is a bit of a misnomer in Los Angeles because L.A. Care Health Plan is an umbrella entity over its own directly operated health plan, plus several commercial health plans. Offering several health plan options is a way to both provide enrollees more choice and to help manage the sheer number of enrollees. Since 2006, L.A. Care has offered its own plan, Medical Care Los Angeles (MCLA, also referred to as Medi-Cal Direct), while also subcontracting with Care1st Health Plan (purchased by Blue Shield) and Anthem Blue Cross, which both have more of a private practice network but still contract with many safety-net providers. Kaiser also treats a limited number of Medi-Cal enrollees in its exclusive provider network.²⁶ In addition to offering its own Medi-Cal plan, Health Net also subcontracts with Molina for Medi-Cal services.

Much of L.A. Care’s Medi-Cal expansion population is in MCLA. MCLA currently receives most of the enrollees who do not actively choose a plan, based on the state algorithm that rewards higher-performing plans and those that contract with more safety-net providers.²⁷ LACDHS and Health Care LA, an IPA comprised of FQHCs, are the largest provider groups in the MCLA network, and LACDHS becomes the medical home for the majority of enrollees who otherwise do not select a provider. MCLA also had gradually expanded its network of private providers over the last several years in advance of the expansion, to respond to the earlier transition of the seniors and persons with disabilities (SPD) population into managed care and to help ensure that most people transitioning from Healthy Way LA could retain their primary care provider. MCLA’s new enrollees reportedly have been a mix of relatively healthy adults and adults with significant specialty care, behavioral health, and housing needs, creating challenges for the plan to provide access to these services in appropriate settings. MCLA delegates professional risk to IPAs participating in the program and varying degrees of risk

to safety-net providers (see “Safety-Net Providers Poised to Assume More Financial Risk” below).

L.A. Care is the only local initiative in the state that participates in Covered California. Its product, L.A. Care Covered, has relatively low enrollment to date and reportedly does not aim to grow significantly. The plan’s main intent is to help provide coverage continuity for people whose incomes fluctuate frequently between eligibility for Medi-Cal and subsidized private coverage. MCLA and L.A. Care Covered offer many of the same providers, but Covered California has more providers that typically focus on Medicare and commercial patients, which means a person might have to switch providers when changing coverage, thus potentially hindering care continuity and coordination.

Continued Commitment to the Remaining Uninsured

In late 2014, Los Angeles County launched a countywide program called My Health LA to manage care for people ineligible for any other coverage, including undocumented immigrants. My Health LA is an extension of the component of the county’s LIHP program that enrolled people who would not become eligible for Medi-Cal under the 2014 expansion (referred to as Healthy Way LA “unmatched”). The program is led by the former director of Healthy San Francisco, a longstanding, expansive program for uninsured people in that community. The program funds the FQHCs to provide enrollees a primary care home; LACDHS provides any needed specialty and inpatient care. In July 2016, the county added substance abuse treatment benefits as well.

After a planning grant from the Blue Shield of California Foundation, ongoing operations of My Health LA are supported through \$60 million annually in county general revenues.²⁸ Enrollees face no cost sharing. Enrollment in My Health LA has grown to just over 145,000 enrollees by May 2016, which is nearly its full capacity of 146,000 people. However, it took a while for the program to reach this enrollment level because of several barriers, many of which have since been addressed. According to FQHC respondents, one

such barrier was that the enrollees in the former medically indigent program did not automatically transition to the new program, in part because of greater screening requirements to ensure applicants live in Los Angeles County, and obtaining needed documentation from patients was difficult. Another barrier was that enrollment could initially occur only at full-time clinic sites and not at mobile or satellite locations, which reportedly impeded connections with certain populations, including the homeless. Other barriers included slow technology, which resulted in enrollment taking nearly an hour to complete, and limits at some clinics in the number of people they could enroll because of capacity constraints.

In addition, LACDHS retains a similar program (called Ability to Pay) for approximately 130,000 uninsured patients who use its primary care clinics and range of clinical services. With approximately 300,000 enrollees between them, Ability to Pay and My Health LA are quite large programs compared to many of the other study sites’ post-Medi-Cal expansion programs, and are reaching many uninsured people the county previously had not served. The available funding and concerted efforts to enroll people in these programs demonstrate the county’s ongoing commitment to funding and providing care for this population, even after losing, in 2015, approximately \$80 million of state realignment funds that historically funded such programs.²⁹ Still, about a million uninsured Los Angeles residents remain outside of these programs, many lacking medical homes, which may result in these residents going without care or seeking services through urgent care or emergency departments.

Medi-Cal Expansion Strengthens County Hospital System

Overall, the county system has retained its role as the main safety-net hospital system since the Medi-Cal expansion. While some low-income people have selected other providers who are closer to where they live or for other reasons, LACDHS reportedly treats many of the same patients it saw before, but more of these patients now have coverage. The LACDHS hospitals continue to eclipse all other hospitals

in the size of their safety-net role: Together, LAC+USC and Harbor-UCLA provided 38% of the total low-income (Medi-Cal and uninsured) inpatient discharges in the HSA in both 2011 and 2014; the hospital with the next highest level (12%) was California Hospital Medical Center.³⁰

Respondents suggested that the LIHP and other earlier programs to care for the uninsured paid off in getting patients into a system of care and tempered what otherwise could have been a large spike in demand after many of these patients gained coverage. Indeed, overall utilization at LACDHS has been relatively stable; between 2011 and 2014, the system experienced a 9% decline in inpatient discharges, which aligns with a trend of declining inpatient use as many hospitals treat more conditions in outpatient settings.³¹ LACDHS's increase in emergency department (ED) use during the same period is consistent with more people gaining coverage. Respondents were relieved that ED use did not rise more than 5%; the fact that the hospital was not inundated with additional patients in the ED may reflect the safety net's focus on linking patients to a medical home, and some patients may be using other hospitals and providers. Some safety-net hospitals experienced much higher increases in ED visits. Also, LIHP patients who stayed with FQHCs and community clinics after becoming insured are now in different specialty and hospital networks outside of LACDHS (see "Risk Arrangements with FQHCs and Community Clinics" below).

A considerable shift in payer mix from uninsured to Medi-Cal helped the county system financially. LACDHS and its main hospital, LAC+USC, have struggled with chronic negative operating margins. The hospital's deficit improved markedly between 2011 and 2014, which is linked to the additional revenues from more Medi-Cal patients and declines in uncompensated care costs, but was still very large (operating margins improved from -35% to -17%). Still, because of its relatively poor payer mix as a safety-net hospital (with relatively little more-lucrative commercial and Medicare business), the hospital has relied on county general revenues to address the shortfalls, and its total margin has

been positive. In addition, specific Medi-Cal payment policies and programs further supported LACDHS over the last few years, such as the state's hospital presumptive eligibility policy, which was particularly helpful soon after Medi-Cal expanded, by paying the hospital for treating patients before they were officially enrolled in Medi-Cal. Also, as a county hospital, LAC+USC receives cost-based reimbursement for inpatient care for new Medi-Cal enrollees. LAC+USC's payer mix and relative funding continued to improve; by 2016 the hospital had doubled its Medicare payer mix (from 5% to 10%) and achieved an inpatient uninsured rate of only 5%, in what one respondent thought would be the hospital's best year ever financially.

However, other funding sources for LACDHS are in flux, in part because many were tied to the Bridge to Reform waiver, which expired in October 2015. Sources such as DSH, realignment, and safety-net care pool (which helps cover uncompensated care costs) funds have dropped and are expected to decline further because many previously uninsured patients now have Medi-Cal coverage. Respondents expressed concern that additional Medi-Cal reimbursement from more insured patients alone would not offset these losses. Namely, many of these funds and the care they support have been counted toward the 50% match that counties (rather than the state) must provide to receive the federal Medi-Cal matching reimbursement, so their decline means the county must provide its own direct funding through locally generated revenues or make up the difference with increased managed care business to replace these losses.

While the state has received a new Medi-Cal waiver for 2016-20 that will continue funding public hospitals and their outpatient services, available funding is significantly less than under the previous waiver and below what the state requested. The waiver will also require more measurement and reporting of the impact of these funding streams and value-based payment arrangements (see "Risk Arrangements with the County System" below). The net impact of these changes on LACDHS is unknown at this time, although two key

pieces — Public Hospital Redesign and Incentives in Medi-Cal (PRIME), which replaces the current Delivery System Reform Incentive Payments (DSRIP) program, and Whole Person Care, a pilot program to coordinate physical health, behavioral health, social services, and other supportive services — are expected to generate almost \$1.4 billion for LACDHS over the next five years. Despite capacity constraints, the system is working to gain more Medi-Cal, Covered California, and other commercial insurance contracts to help gain more patients and to diversify its patient revenues.

Safety Net Focuses on Care Delivery Innovations

As noted, LACDHS is a significant provider of outpatient care for low-income people. LACDHS provides primary care through its Ambulatory Care Network of 19 clinics and at its four medical centers; about half of the clinic sites also provide outpatient specialty care. Since the last round of this study, the county clinics sites have grown by a few colocated public health clinics as part of the recent integration of the county public health department into the health department (see “Risk Arrangements with County System” below). The system also has expanded its primary care capacity within its four hospitals but has had limited resources (funding, provider supply, and space) to expand its capacity significantly over the last few years. The county hosts internal medicine residency programs at its three acute care hospitals and a family medicine training program at Harbor-UCLA to help cultivate more PCPs over the longer term.

LACDHS has been implementing a patient-centered medical home (PCMH) model. The intent is to encourage patients to use a single clinic or clinician for primary care as a way to identify and address issues early and to control chronic illnesses, which could potentially help reduce patients’ use of inpatient and ED services and duplication of services. While many safety nets are pursuing similar models, Los Angeles seems relatively advanced in adoption of specific PCMH strategies that some of the LACDHS leaders had prior experience with in San Francisco. Key strategies include

patient empanelment (in which providers are responsible for ensuring the patients assigned to them receive appropriate screenings and services), as well as team-based care supported by new types of staff (such as complex care managers, clinical pharmacists, and dietitians). LACDHS also has adopted strategies to provide services outside of traditional face-to-face visits with physicians, including self-care, nurse clinics and advice lines, group visits, and video and phone encounters. DSRIP from the Medi-Cal Bridge to Reform waiver provided funding to implement these changes, and, as noted, payments from the new program (PRIME) that replaced DSRIP in the new waiver will be more outcomes-based.

LACDHS reportedly has made progress in encouraging patients to use their medical homes consistently, but implementing the PCMH changes has taken time, and implementation of an EHR system has reduced provider productivity in the short term. LACDHS has struggled to provide immediate access for its newly assigned Medi-Cal patients, which likely has led some to choose other medical homes. Indeed, the FQHCs and community clinics remain important partners in extending primary care capacity and also have implemented similar changes in care delivery.

Specialty care has remained difficult for low-income people to obtain. One strategy to help improve access is LACDHS’s e-Consult system, created several years ago by the former chief medical officer of San Francisco General Hospital, who now serves in the same role for LACDHS. With e-Consult, LACDHS specialists review a referral and the patient’s case online through the LACDHS EHR; the specialist then either advises the referring PCP how to treat the patient, or if needed, system staff schedule the patient for an in-person consultation with the specialist. The e-Consult system reportedly has reduced by a third the number of patients referred who require a face-to-face visit with a specialist, reducing wait times for specialty appointments substantially. Another factor that may have reduced demand on LACDHS is that the previously uninsured patients whose medical home is outside the LACDHS system (e.g., with an FQHC, community clinic,

or other private provider) are referred instead to private practice specialists. The FQHCs and community clinics also use e-Consult for their insured patients through L.A. Care and their IPA's affiliated specialists (see "Risk Arrangements with FQHCs and Community Clinics" below).³²

Community Health Centers Expand

Unlike LACDHS, FQHCs have grown significantly and compose an ever-larger part of Los Angeles's safety net. Across Los Angeles County, FQHCs and community clinics served approximately 1.4 million patients and provided almost 3.4 million visits in 2014, a 25% growth from 2011. This is considerably larger than the primary care volume provided through LACDHS's Ambulatory Care Network. AltaMed is the largest FQHC in the county; it serves much of Los Angeles County through approximately 20 sites (also operating the clinics for Children's Hospital of Los Angeles) and recently has been expanding into the southern part of the county (AltaMed also serves neighboring Orange County). The other large FQHCs (all operating multiple sites) include Northeast Valley Health Care, QueensCare, and St. John's Well Child and Family Center. Most of the FQHCs collaborate on a variety of administrative and clinical strategies through the Community Clinic Association of Los Angeles County.

In addition, more community health centers have attained FQHC designation over the last few years. FQHC status allows health centers to apply for federal grants, medical malpractice insurance and, for some FQHCs, student loan forgiveness for physicians, as well as Medi-Cal encounter-based payments based on allowable costs for the range of services they provide, among other benefits (FQHC Look-Alikes receive some of these benefits but not grants).³³ The Medi-Cal payment rates are particularly helpful for clinics as many of their uninsured patients enrolled in Medi-Cal and other sources of funding (such as state grants) declined. The number of health center organizations in Los Angeles with federal status has increased by about a third since 2011, to over 50 designees by 2014.³⁴

FQHCs also have added sites of care, aided in part by Affordable Care Act (ACA) grants. The number of FQHC sites grew over 30% throughout the county between 2011 and 2014, from approximately 150 to 200.³⁵ Some of these new sites represent an FQHC taking over an existing clinic or physician practice. Plus, a few Los Angeles health center organizations have expanded into Riverside and San Bernardino Counties, with sites directly adjacent to their existing service area or in new underserved areas.

Some FQHCs have built new sites on hospital campuses, and some hospitals have established their own health centers. These arrangements aim to create better access to a range of services for a set of patients, in which health centers focus on providing primary care (which might help reduce patients' use of the ED for non-emergent reasons), and the hospitals are expected to provide specialty and inpatient care. While some of these affiliations are longstanding and even involve risk arrangements (see "Safety-Net Providers Poised to Assume More Financial Risk" below), many of these collaborations are newer and remain less formal.

FQHCs' pace of growth slowed in recent years following the uptick in patients from the LIHP, even though Medi-Cal enrollment continued to grow significantly. According to a respondent, growth in patient encounters decreased from 13% annually between 2010 and 2013 to 8% between 2013 and 2014. Respondents reported several factors for this. Clinics faced difficulties transitioning some patients into Medi-Cal or My Health LA, and in some cases patients used fewer services while in limbo. Also, many clinics faced growing difficulty recruiting and retaining sufficient numbers of clinicians and other staff, as other hospitals and physician organizations also are heavily recruiting physicians and can typically offer higher compensation and potentially more favorable working conditions. Productivity of clinics' clinical staff declined as well, related to the time needed to assess and address the needs of new Medi-Cal patients, implement EHRs, integrate behavioral health, and adapt to similar PCMH strategies the county is pursuing. Reportedly, nearly

all FQHCs and community clinics use EHRs to manage care, about two-thirds offer behavioral health services, and a third are recognized as PCMHs. As one respondent observed, “I’m not surprised [community clinics] flatlined on growth; there’s too much going on.”

The Medi-Cal expansion coupled with new costs and inefficiencies had mixed impacts on FQHCs and community clinics. On average, approximately 40% of FQHCs’ total patients had Medi-Cal coverage in 2011, which by 2014 grew to over 60%. Uninsured patients dropped from almost half of all patients in 2011 to about a quarter in 2014. Yet this shift did not clearly benefit FQHCs’ bottom lines; average margins continued to hover around break-even levels in 2014, although some centers fared quite well while others faced greater and growing financial challenges.³⁶ Many reportedly struggle with slow payment from Medi-Cal and low cash on hand.

Safety-Net Providers Poised to Assume More Financial Risk

Overall, safety-net providers in Los Angeles are further along the path to value-based payments than their peers in the other study sites. LACDHS and FQHCs receive risk-based payments for Medi-Cal patients, but also later receive “wrap-around” payments from the state to make up the difference between these rates and their more cost-based payment rates to which they are entitled. Despite these payment protections, respondents reported that these arrangements still prompt providers to better manage care and control expenses, which have helped them weather delays in wraparound payments, assume risk for other patients, and prepare for still greater risk in the future.

Risk Arrangements with FQHCs and Community Clinics

IPAs provide an infrastructure through which FQHCs and community clinics contract with health plans on a capitated basis. In addition to providing a single referral network with specialists and hospitals, the IPA structure provides health centers administrative and clinical support, such as health

plan contracting, claims processing, care protocols, and discharge planning services. In part a function of its large size, AltaMed contracts with insurers through its own IPA, which receives capitation for professional services, and has applied for a limited Knox-Keene license in order to assume more risk.

Together, other community clinics formed Health Care LA IPA about 25 years ago (many of which later became FQHCs). Today the organization comprises most of the FQHCs and community clinics, although a handful belong to other IPAs or contract directly with health plans. Health Care LA receives capitation for professional services only — at least primary care, but some contracts also include other services (laboratory, radiology, or specialty care). With the Medi-Cal expansion, the IPA has grown substantially in patients and providers and currently serves approximately 360,000 patients through over 40 FQHCs and community clinics, and approximately 1,200 specialists and 25 hospitals. The IPA capitates the member clinics just for primary care, and the clinics receive wraparound payments from the state. The IPA also pays the clinics primary care capitation for Medicare and some commercially insured patients (but not those in Covered California products); the clinics do not receive wraparound payments from these payers, although they represent just a small proportion of their overall business so the risk is relatively small.

Additionally, Health Care LA IPA has held full-risk arrangements for a number of years with several Medi-Cal health plans for a portion of their patients. Several safety-net hospitals — including California Hospital Medical Center, Hollywood Presbyterian, Valley Presbyterian, Citrus Valley, and more recently, St. Francis — have separate risk pools, each with a single or several health centers in their geographic service area. Any savings or losses are shared between the hospital and the IPA. Reportedly, the health centers fare well under these arrangements.

In 2017, the state plans to implement a new FQHC payment model under a federal Alternative Payment Methodology option, which means they will abide by

underlying funding protections for FQHC payments but restructure the flow of payments, replacing the encounter and wraparound payments with a capitated rate. Viewing such a change as an inevitability, the Los Angeles FQHCs partnered with the state on developing this pilot, and a handful of Los Angeles centers plan to participate. FQHCs expect the new capitated payments to provide flexibility around current regulations in how they provide care. For example, the state's rule that FQHCs typically can receive payment for only one visit per patient per day for medical and mental health services has challenged health center efforts to integrate behavioral health services into primary care — a particular area of focus given the increased demands from the Medi-Cal expansion population. Also, FQHCs' inability to receive payment for many non-visit encounters and support services, and certain types of clinician encounters, hinder many of their PCMH strategies. Still, health center directors voiced that they face considerable challenges gathering data to capture all of their costs to help negotiate sufficient capitated rates with the state.

Also, My Health LA (MHLA), the county program for the uninsured, changed from fee-for-visit payments to primary care capitation in early 2015. At that time, health center directors were uncertain how they would fare under the new arrangement, expressed concern that the payments would be insufficient relative to enrollee needs, and that smaller clinics likely would face more difficulty handling the risk. More recently, however, several respondents indicated that capitation has been a positive change for many centers, by providing more regular, predictable cash flow and greater flexibility in care delivery.

Risk Arrangements with the County System

Since 2014, LACDHS has received capitation from L.A. Care for both professional and institutional services for its assigned Medi-Cal patients. LACDHS's large size and composition as an integrated delivery system offering a full range of outpatient and inpatient services, as well as employed physicians, fostered this arrangement.³⁷ While the system does receive wraparound payments for inpatient services, it is bearing risk for outpatient care.

In addition to the PCMH model and other strategies to provide care more efficiently, LACDHS is implementing additional changes to better position itself to handle growing degrees of financial risk. The new Medi-Cal waiver will require public hospitals to gradually take on more risk for Medi-Cal patients, which will ultimately end LACDHS's cost-based reimbursement and introduce global payments for programs for the uninsured. To prepare, LACDHS recently completed implementation of a systemwide EHR system and other information systems to help calculate and manage its costs of providing services.

Additionally, given the significant socioeconomic challenges of its patient population, LACDHS is focusing on better managing some of the greatest needs that present significant costs to the system. One particularly significant investment is LACDHS's funding of housing units for its homeless population, which provide primary and behavioral health care and prescriptions on-site; the county calculates this should cost less per month than this population's typical use of inpatient and emergency services. Also, the county recently created the Los Angeles County Health Agency to oversee the services of LACDHS, the mental health department, and the public health department, with a goal of better integrating all services and improving patient care. The current director of LACDHS, Dr. Mitchell Katz, will lead this new entity.³⁸

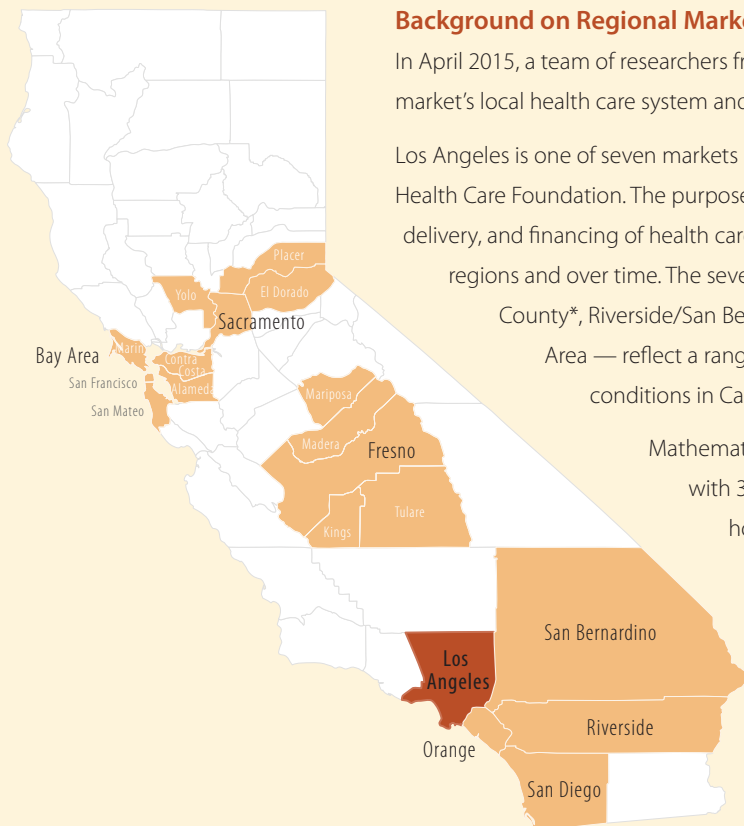
Issues to Track

- ▶ How effective will the two largest hospital systems be in broadening their reach to provide more inpatient and outpatient care in the community and maintain their strong tertiary/quaternary services on their main campuses? How well will they integrate care across these settings? What will be the implications for overall cost of patient care?
- ▶ Will participation in Vivity, along with ACOs and other forms of risk contracting, produce incentives for hospitals to create meaningful changes in care delivery and enable them to control total costs of care?
- ▶ Will the small community hospitals continue to survive despite their low occupancy rates and financial struggles? To what extent will Vivity and other efforts to create broader networks of care impact these hospitals?
- ▶ To what extent will physician consolidation into the large, independent physician organizations and hospital system-affiliated networks continue? Will small IPAs be able to survive?
- ▶ To what degree will LACDHS, FQHCs, and community clinics be able to improve capacity in traditional and new ways to meet the needs of a growing Medi-Cal population and the remaining uninsured population?
- ▶ How will LACDHS fare financially under the new Medi-Cal waiver? Will additional revenues gained from having more insured patients exceed the reductions in subsidies?
- ▶ To what extent will safety-net providers continue to assume more financial risk for more patients? Will these new payment arrangements help providers better address the range of medical and nonmedical needs for their patients while also reducing overall costs? What impact will these arrangements have on provider finances and on patient outcomes?
- ▶ What impact will Los Angeles County's program for the uninsured have on patient access and outcomes? Will it expand the program further to help the many remaining uninsured find their way to appropriate services?
- ▶ Will the new Los Angeles County Health Agency prove successful in providing residents more integrated and coordinated services across the range of medical, behavioral, and other needs?

ENDNOTES

1. “QuickFacts Los Angeles County,” US Census Bureau, www.census.gov; “2010 Census Data,” US Census Bureau, www.census.gov. The state-level estimates differ slightly from those in the data table because the former are for the adult population only.
2. The HSA had 230 beds per 100,000 people in 2012 and 236 physicians per 100,000 people in 2011 (unable to compare to the countywide and state-level estimates in the same years).
3. *American Community Survey: 5-Year Summary File, 2008-12*, US Census Bureau, www.census.gov.
4. California Health Interview Survey, UCLA, 2011-12.
5. HSA-level data not yet available for 2014.
6. As defined by the Dartmouth Atlas as of 2008 (the first round of the study), the core HSA includes 16 hospitals: California Hospital Medical Center, Cedars-Sinai Medical Center, East LA Doctors Hospital, Good Samaritan Hospital, Hollywood Presbyterian Medical Center, Kaiser Sunset, Kaiser West LA, Keck Hospital of USC, LAC/Harbor-UCLA, LAC+USC, LA Community Hospital, Olympia Medical Center, Ronald Reagan UCLA, Southern California Hospital at Hollywood, St. Vincent Medical Center, and White Memorial Medical Center. Temple Community Hospital was part of the HSA but closed in September 2014.
7. By virtue of its size, Cedars-Sinai reportedly is the largest hospital provider of Medicare services in the state (almost 20,000 discharges in 2014). Cedars-Sinai and UCLA provided approximately 4,600 and 4,100 Medi-Cal discharges, respectively, in 2014 — more than some of the small community and safety-net hospitals. Hospital Annual Utilization Data, California Office of Statewide Health Planning and Development (OSHPD), 2011 and 2014, www.oshpd.ca.gov.
8. MemorialCare is based in Orange County and has two hospitals in LA County (in Long Beach), with a total of 508 acute care beds. Providence is based in Renton, WA, and has six hospitals in the county (dotting the northern and southwestern areas) with a total of 1,634 acute care beds.
9. Including UCLA Medical Center, Santa Monica, which is outside the HSA, UCLA’s market share is 16%.
10. UC Office of the President, “Retirement Plan Contributions to Increase July 1 for Most Employees,” UCLA, June 9, 2014, www.newsroom.ucla.edu.
11. Keck Medicine of USC is the clinical medical enterprise of USC, comprised of three hospitals, more than 40 affiliated clinics, and the USC Care Medical Group with 500 physicians.
12. In July 2013, USC Keck acquired the 116-bed Verdugo Hills Hospital in Glendale, a more affluent area north of the HSA than that of its main campus, which may help the system attract more commercially insured patients.
13. Temple, with 150 licensed acute care beds just northwest of Downtown, closed in September 2014 citing low revenue, increasing costs of maintaining its aging building, and its inability to fund upgrades required to meet California seismic safety standards. The 212-bed safety-net hospital LAMMC closed mid-2013 in the wake of federal fraud allegations related to inappropriate billing for homeless patients.
14. The county also operates two hospitals outside the HSA: Olive View-UCLA in the northern part of the county and Rancho Los Amigos National Rehabilitation Hospital in southern Los Angeles. Also, a previous county hospital in South Los Angeles that closed in 2007 amid quality and operational troubles reopened in July 2015 as Martin Luther King Jr. Community Hospital and is operated by a new, independent, nonprofit corporation.
15. Passed by the California legislature in 2009, the Hospital Quality Assurance Fee Program (commonly known as the hospital fee program) generates additional funding for hospitals serving relatively large numbers of Medi-Cal patients. Hospitals pay a fee based on their overall volume of inpatient days to which federal matching dollars are added; these funds are then redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. With payments beginning in 2010, the program has been renewed three times and currently is set to expire at the end of 2016. However, California voters could approve a ballot initiative in November 2016 that would eliminate the program’s end date and require voter approval of further changes to the program.
16. “Cedars-Sinai Acquires Marina Del Rey Hospital” [press release], Cedars-Sinai, September 1, 2015, www.cedars-sinai.edu.
17. Nick Shively, “Cedars-Sinai Looks to Join Playa Vista’s Fast-Growing Tech Scene,” *Los Angeles Times*, August 4, 2015, www.latimes.com.
18. Both Heritage and HealthCare Partners serve other Southern California markets. Also, in 2012, HealthCare Partners was purchased by DaVita, a national dialysis provider, in part as a way to gain access to new geographic markets. Anna Wilde Mathews, and Anjali Athavaley, “Dialysis Firm Bets on Branching Out,” *Wall Street Journal*, May 21, 2012, www.wsj.com.
19. The other hospitals are Huntington Memorial Hospital, MemorialCare Health System (which also has hospitals in Orange County), PIH Health, and Torrance Memorial Medical Center.
20. Michelle Evans, “Reform Update: Anthem’s Vivity Experiment Will Be One Test of Reform’s Progress,” *Modern Healthcare*, September 24, 2014, www.modernhealthcare.com.

21. “Vivity by Anthem Blue Cross Launches New Feature for Members” [press release], *Business Wire*, February 25, 2016, www.businesswire.com.
22. Bob Herman, “Reform Update: Will Anthem’s Vivity Gain Traction Among Large Employers?” *Modern Healthcare*, September 18, 2014, www.modernhealthcare.com.
23. Tamara Rosin, “One Year Later, How Is Vivity Stacking Up to Kaiser? Checking In with MemorialCare CEO Dr. Barry Arbuckle,” *Becker’s Hospital Review*, August 20, 2015, www.beckershospitalreview.com.
24. Brett Brune, “How Anthem’s Vivity Venture Is Faring in Southern Calif. Showdown with Kaiser,” October 23, 2015, www.modernhealthcare.com; Evans, “Reform Update.”
25. *Pioneer ACO Quality and Financial Results: Performance Years 1-3*, Centers for Medicare & Medicaid Services, innovation.cms.gov.
26. Kaiser’s Medi-Cal population consists largely of people who either had Kaiser coverage themselves, or who have an immediate family member who has had Kaiser coverage, within the past 12 months.
27. L.A. Care demonstrates average performance on quality/access among all plans in the state (Health Net is slightly below average), www.dhcs.ca.gov.
28. Sara Geierstanger, Annette Gardner, and Louise McCarthy, “Expanding the Public-Private Partnership Program (PPP) to Meet the Needs of the Medically Underserved,” UCSF, healthpolicy.ucsf.edu (PDF).
29. In an arrangement known as 1991 realignment, California counties receive funds from state vehicle license fees and sales tax revenues to support county health, mental health, and social services programs. With the expectation that many uninsured residents would gain Medi-Cal or other coverage under the ACA and the need for county medically indigent programs would decline, Assembly Bill 85 transfers either 60% or a formula-based percentage of each county’s health fund to social services.
30. Hospital Annual Financial Disclosure Data, California Office of Statewide Health Planning and Development (OSHPD), 2011 and 2014. Data reflect each hospital system’s fiscal year, www.oshpd.ca.gov.
31. Ibid.
32. e-Consult, L.A. Care, www.econsultla.com.
33. FQHCs receive encounter-based payments to cover the range of medical and social services they are required to provide. These payments are called Prospective Payment System (PPS) rates and are based on historical allowable costs and are updated for medical inflation.
34. With a smaller overall presence than the FQHCs, many clinics without federal status continue to extend the safety net but have not grown as much as FQHCs (many operate only a single site and/or serve a particular population).
35. Primary Care Clinic Annual Utilization Data, California Office of Statewide Health Planning and Development (OSHPD), 2011 and 2014, www.oshpd.ca.gov.
36. Ibid.
37. Through exceptions to the state’s prohibition on the corporate practice of medicine, county hospitals, University of California hospitals, and some nonprofit organizations such as community clinics are allowed to employ physicians directly.
38. Abby Sewell, “Mitch Katz Poised to Lead L.A. County’s Consolidated Healthcare Agency,” *Los Angeles Times*, September 29, 2015, www.latimes.com. See also “The Los Angeles County Health Agency,” Los Angeles County, priorities.lacounty.gov.



Background on Regional Markets Study: Los Angeles

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

Los Angeles 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 30 specific to Los Angeles. Respondents included executives from hospitals, physician organizations, community clinics, Medi-Cal health plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.

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

*Orange County was added to this study in 2015; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

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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.

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