CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

ORANGE COUNTY • CALIF.

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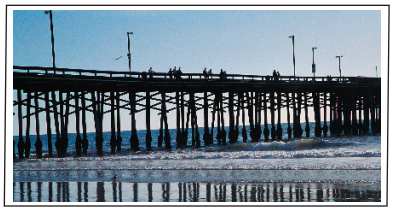


In March 2005, a team of researchers visited Orange County, Calif., to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 90 leaders in the health care market. Orange County is one of 12 communities tracked by HSC every two years through site visits. Individual community reports are published for each round of site visits. The first four site visits to Orange County, in 1996, 1998, 2000 and 2003, provide trend information against which changes are tracked. The Orange County market encompasses an area of about 30 cities south of Los Angeles.

DYNAMIC ORANGE COUNTY HEALTH CARE MARKET RESPONDS TO OPPORTUNITIES, THREATS

The Orange County market remains dynamic, as health plans and providers navigate growing threats and opportunities. Threats include inpatient capacity constraints aggravated by persistent nurse shortages, new statewide nurse-patient ratio requirements and ongoing state and county budget problems that undermine an already tenuous safety net. Physician organizations have taken the opportunity offered by a pay-for-performance initiative—designed to financially reward better care—to invest in information technology. Similarly, major hospitals have stepped up information technology investments and quality improvement activities in response to a federal quality initiative. Meanwhile, most health plans are set to expand their existing Medicare products in response to the 2003 Medicare reform law.

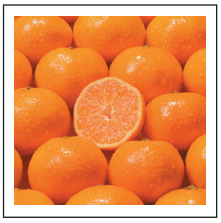
Other important Orange County developments include:

- Concern that the potential growth of preferred provider organization (PPO) and high-deductible insurance products could threaten the dominance of the health maintenance organization (HMO) model of health benefits.
- Potential shifts in hospital care as four former Tenet Healthcare Corp. hospitals adjust to new ownership and Kaiser Permanente prepares to build a new hospital.
- Financial weakening of CalOPTIMA, the quasi-governmental agency that administers Medi-Cal managed care in the county.

Hospital Capacity Constraints

As has been the case for several years, capacity constraints continue to be a major problem for Orange County hospitals and have increased as new statewide nurse-to-patient staffing ratios took effect. In 2003, hospitals already were struggling with staffing shortages and inadequate bed capacity to keep up with increasing demand from a growing population as well as less stringent managed care restrictions on the use of services. Emergency department ambulance diversions were a common occurrence, as were delays scheduling elective surgeries.

These problems have now been aggravated by implementation of a state law mandating a 1:5 nurse-to-patient staffing ratio for medical-surgical units. Gov. Arnold Schwarzenegger tried to delay the transition from 1:6, the law's first-step requirement, to 1:5 scheduled for January 2005, but a court struck down his effort and the law went into effect in March 2005. In a market where competition for nurses was already fierce and salaries far exceed the national average, the new mandate has intensified pressures on Orange County hospitals by driving personnel costs up sharply and making it difficult to keep some hospital units staffed and open. Some have reported having



Orange County Demographics

Orange County	*Metropolitan Areas 200,000+ Population*
Population[1]	
2,957,766	
Persons Age 65 or Older[2]	
10%	*10%*
Median Family Income[2]	
$32,638	*$31,301*
Unemployment Rate[3]	
*3.8%**	*6.0%*
Persons Living in Poverty[2]	
11%	*13%*
Persons Without Health Insurance[2]	
20%	*14%*

* Indicates a 12-site low.

Sources:
[1] U.S. Census Bureau, County Population Estimates, 2003
[2] HSC Community Tracking Study Household Survey, 2003
[3] Bureau of Labor Statistics, average annual unemployment rate, 2003

to close beds or units temporarily or divert patients from the emergency department because of inability to comply with the staffing ratios. Kaiser Permanente, on the other hand, reported that it already complies with the nurse-staffing requirements, consistent with a contract with the nurses' union.

Inpatient capacity also is tight because few new hospital beds have been built recently, despite a 20 percent increase in population since 2000. Indeed, this year's closure of the 162-bed Brea Community Hospital has meant a net loss in hospital beds. In response, most of the major hospitals in Orange County have plans to expand bed capacity significantly, with a focus on increasing medical-surgical capacity, telemetry, and specific service lines such as obstetrics, oncology and neonatal intensive care. For example, St. Joseph Health System plans to build new towers at each of its three Orange County hospitals, Hoag Memorial Hospital Presbyterian will open a new tower in October 2005, and Fountain Valley Regional Hospital and Medical Center, Tenet's flagship facility in the county, recently increased telemetry beds and radiology capacity.

The largest capacity expansion project is Kaiser's plan for a new 150-bed hospital in southern Orange County. This addition has the potential to cause shifts in where people receive care, because the new hospital is expected to draw Kaiser patients away from hospitals that contract with Kaiser to care for the HMO's patients. In a different way, Tenet's sale of four of its 10 hospitals to a new company, Integrated Healthcare Holdings Inc. (IHHI), may cause repercussions in the county. The sale was motivated largely by Tenet's national corporate problems, and the hospitals sold were all considered to be in financial distress and in need of substantial capital investment. That IHHI owners include physicians raised concerns that the sale would shift patient referrals away from other area hospitals. Observers also voiced concerns that financial pressures would lead IHHI to limit the hospitals' provision of trauma care and care for low-income patients, both significant before the ownership change, or to close the facilities, given the potentially lucrative value of the real estate.

Performance Payments Prod Provider Initiatives

Public and private initiatives have spurred significant hospital and physician efforts to improve quality. Pay for performance, or P4P, has made a mark on physician organizations in part because it largely has been coordinated through the multi-stakeholder group, Integrated Healthcare Association (IHA). All of the major plans that contract with Orange County physicians—Blue Cross of California, Blue Shield of California, Health Net and PacifiCare—participate in the IHA program and use P4P across their HMO products (representing roughly 50% of the market). Both Blue Cross and Blue Shield plan to use the IHA measures in their PPO products soon.

Payments from P4P have varied considerably across plans, but the total amount on the table appears to be substantial. According to the IHA, the most recent payout from health plans represented about $50 million in additional income for physician organizations statewide based on their performance on standard measures. Provider organizations have passed on a portion of P4P payments to individual physicians and have used some of the additional revenue to invest in infrastructure to help better collect and report data on quality indicators. For example, one large Orange County physician organization received a multi-million-dollar P4P payout in 2004, and one-quarter of its average physician salary is tied to various quality measures. This

organization used some P4P funds to create a customer service program and to install software programs that remind clinicians and patients when tests are due. The improved capacity to collect data also enhances the ability of health plans to pay physician organizations for better care.

Medical groups and health plans alike expressed overall support for the P4P initiative, but some respondents cited key problems. Most notable was the concern that some health plans were requiring reports on their own unique performance measures in addition to those required by IHA. This was seen as undermining one of IHA's major advantages in encouraging physician participation—standardized performance measures across many payers that would reduce the administrative burden on medical groups to respond to many different reporting requirements.

Hospitals also have invested heavily in quality improvement efforts and information technology. They pointed to Medicare's Hospital Quality Initiative as a key motivator to increase investment and sharpen the focus of their quality improvement initiatives over the past two years. Many stressed that the expectation that quality data would be publicly reported was a strong incentive to obtain buy in for hospital and health care system quality efforts and to help engage physicians in this work. For example, within the St. Joseph and MemorialCare systems and at Hoag, programs for reporting hospital quality data were affecting quality improvement initiatives, increasing awareness among medical staff and motivating the entire organization with the knowledge that performance scores would be public.

As with physicians, hospital systems in Orange County have translated quality improvement efforts into financial incentives. For example, one of the large hospital systems made improving treatment for community-acquired pneumonia a system priority and tied a portion of executive and management team bonuses to how both the system and individual hospitals perform on this measure. Other hospital systems also reported tying executive compensation to hospital and system-level performance on quality measures, as well as instituting clear time frames for improvement on certain measures. In general, hospital systems noted increased emphasis on hospitals learning from one another to improve performance on quality measures system-wide.

Health Plans Bet on HMOs but Eye New Products

Orange County has long been a highly contested market for health plans, and this continued to be the case in 2005. HMO products remain extremely strong and have lost little, if any, enrollment, but some indications suggest PPOs are gaining popularity among small employers seeking less comprehensive coverage. The HMO apparently continues to enjoy a significant price advantage over PPO products for comparable benefits, although the gap is shrinking. Even high-deductible health benefit plans, such as health savings accounts (HSAs) and health reimbursement arrangements (HRAs), tend to cost employers more than an HMO. Increases in health insurance premiums appear to have slowed, which may explain why private purchasers reportedly have resorted less often to reducing benefits as a way to control their costs than was the case two years ago.

The type of HMO model in Orange County is distinctive, with health plans delegating considerable financial risk to providers, especially large physician organizations, which then are responsible for managing care and costs. This delegated model made it attractive for plans to participate

Health System Characteristics

Orange County	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
1.9	*3.1*
Physicians per 1,000 Population[2]	
2.0	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
41%#	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$769	*$718*

# Indicates a 12-site high.

Sources:

[1] American Hospital Association, 2002

[2] Area Resource File, 2003 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)

[3] Interstudy Competitive Edge, markets with population greater than 250,000

[4] Centers for Medicare and Medicaid Services. Site-level payment rates refer to Medicare Advantage AAPCC Payment Rates by County (Part A + Part B Aged Rates). National figure is actual payment per capita, based on payments for Medicare Coordinated Care Plans and the number of Coordinated Care Plan enrollees in April 2005.

Health Care Utilization

Orange County	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
*127**	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
*14%**	*18%*
Persons with Any Doctor Visit in Past Year[2]	
*69%**	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
5.5%	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
34%	*44%*

* Indicates a 12-site low.

Sources:

[1] *American Hospital Association, 2002*

[2] *HSC Community Tracking Study Household Survey, 2003*

in the existing Medicare Advantage HMO program, and the additional resources promised by the 2003 Medicare Modernization Act (MMA) provide a strong incentive for them to continue to do so. As a result, the new products that MMA creates—regional PPOs and stand-alone prescription drug plans (PDPs)—are viewed as likely to strengthen Medicare private plan participation in Orange County. PacifiCare, Blue Cross, Blue Shield and possibly other national managed care plans intend to offer PDPs as well as continuing local Medicare HMO plans. Blue Cross also intends to offer a regional PPO for all of California, and other companies may decide to do so if Blue Cross' product proves successful. Blue Cross' intentions constitute a change from previous lack of interest in participating in Medicare managed care. PacifiCare is especially committed to the Medicare line of business despite past troubles with the program, believing the potential rewards are too great to pass up.

The HMO model has been durable in Orange County, but some interest in other benefit designs may challenge its central role in the market. All of the major health plans in Orange County have been developing new health insurance products, especially those with less comprehensive coverage and high-deductible policies, such as HRAs and HSAs. Also, the plans that historically have been tied closely to the HMO model—Kaiser, PacifiCare and another large plan operating in the market, Health Net—have moved to diversify or add flexibility to their offerings. Kaiser, for example, is adding patient cost-sharing options, such as deductibles, to its HMO in an effort to appeal to more price-sensitive purchasers and to avoid adverse selection. And Orange County-based PacifiCare has developed a PPO product to appeal to purchasers that want greater provider choice. Both Kaiser and PacifiCare have emerged from financial difficulties and have now restored themselves to profitability and membership growth. Moreover, after a high-profile dispute and contract termination in 2001, PacifiCare has signed a new contract with the St. Joseph Health System, bolstering the plan's competitiveness in certain areas of the county.

Blue Cross, whose primary strategy is to offer an array of options that includes what any buyer might want, introduced no less than 10 products to the small group market alone in 2004, including an HMO with a narrower network and lower premium, a generic-drug-only PPO, and several high-deductible plans. Owned by WellPoint, the nation's largest insurer, Blue Cross has for many years had especially large enrollment in the small group and PPO markets.

Model Medi-Cal Agency Enters Troubled Waters

CalOPTIMA, long hailed as an exemplary county manager of Medicaid benefits and a good partner with local providers, is under financial stress. Stagnant payments from Medi-Cal, California's Medicaid program, have caused the agency's overall financial well-being to decline significantly. In turn, CalOPTIMA has constrained physician and hospital payment rates, raising concerns among the participating providers and threatening access to care for low-income Orange County residents.

CalOPTIMA is a county organized health system, or COHS, one of California's three types of delivery systems for Medi-Cal. As a COHS, the agency is paid a set amount per member each month and so is at financial risk to provide most services covered under traditional Medi-Cal fee-for-service. Enrollment in CalOPTIMA is mandatory for most Orange County Medi-Cal beneficiaries. Until recently,

most observers hailed the agency's innovative care and cost management practices, and CalOPTIMA was fiscally sound and successful. However, state revenue has not kept up with rising health care costs, largely because of an estimated $8 billion state budget gap—attributed by some observers to tax cuts and limitations dating back to the 1978 Proposition 13 property tax cap, and unrelenting increases in state health care spending. The budget gap—combined with a state economy that appears not to have fully recovered from the 2001 recession—has continued despite the abrupt change in administrations when Arnold Schwarzenegger unseated Gray Davis in a 2003 recall election.

To address the spending side of the state budget problem, the Schwarzenegger administration has embarked on a Medi-Cal redesign initiative. Most notably, this planning process is expected to propose extending mandatory managed care to more counties and to all of the aged, blind, and disabled population, usually the individuals with the most complex and costly medical care needs. Neither of these ideas would have a direct impact on CalOPTIMA, as Medicaid managed care is already mandatory in Orange County, and the agency already enrolls this beneficiary group. Indeed, state officials cite CalOPTIMA as a successful model in doing both.

But local observers noted that holding up CalOPTIMA as a model is ironic, as the organization is now struggling to sustain what was once considered one of the most successful community-based Medicaid reform initiatives in the country. Until a recently awarded 3 percent increase from the state, CalOPTIMA's payment rates for serving more than 300,000 enrollees had not risen since 2000. During that time, the costs of drugs and other services for this high-need population grew at double digits, and agency officials now calculate that they are being paid at about 76 percent of the fee-for-service equivalent for the aged population and 72 percent for the disabled—a far cry from the 95 percent originally set by the Legislature as the target for COHSs like CalOPTIMA. The result is that CalOPTIMA has had to spend accumulated reserves at a rapid rate, which could jeopardize its viability if reserves fall below levels mandated by the state. It has also had to limit payments to its providers, causing the loss of some contracted physician-hospital networks and restrictions by some hospitals on which public program enrollees they will serve.

Growing Demand Strains Safety Net, New Funds Expected

California's widely publicized budget problems have led to a slowdown in efforts to expand Medi-Cal, and Healthy Families, California's State Children's Health Insurance Program. Some effort to strengthen the capacity of safety net providers has begun, but they too are threatened by public budget cuts.

The effect of the state budget deficit on Medi-Cal and Healthy Families enrollment has been palpable. Though enrollment continues to grow in Orange County, that growth has slowed dramatically. The two programs added about 27,000 enrollees from 2002 to 2003, but that dropped to only 5,600 additional beneficiaries in 2004. The state not only has limited Medi-Cal funding increases, but it has attempted to cut provider payments, which observers reported has made care providers reluctant to take on new program patients, despite their being insured.

The safety net in Orange County continues to rely on the University of California-Irvine Medical Center (UCI), Children's Hospital of Orange County, and 18 independent com-

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The demands on the safety net are expected to continue to grow, as the population of undocumented immigrants grows.

State Initiatives Bring New Funds

In 2004, California voters passed two initiatives that will benefit safety net organizations in Orange County and the people they serve. Proposition 63 will generate funding for new mental health services through a 1 percent tax on individuals with incomes of more than $1 million. The tax will raise an estimated $600 to $800 million a year statewide by 2006, with Orange County receiving $50 million to $60 million annually. Planning began in 2005 for distribution of the funding, which is to be spent on innovative programs and preventive activities rather than ongoing services. The initiative was promoted as a way to address the statewide problem of homeless, mentally ill persons. Proposition 62 authorized a $750 million state bond issue to grant up to $74 million to each of the state's eight freestanding children's hospitals. Children's Hospital of Orange County is planning to use these funds to add outpatient clinic capacity and critical care beds. In contrast to initiative-led tax cuts, these two propositions mark a relatively new trend in mostly western states of voters directly approving targeted tax increases for earmarked purposes.

munity clinics, but these providers face considerable financial and service challenges. Compared with other large urban areas, this community has few federally qualified community health centers, a designation that allows for higher payments for Medicaid patients. UCI operates the only two such clinics for a population of 3 million, although a Huntington Beach clinic has applied for federal status.

UCI and Children's provide the bulk of inpatient care to low-income county residents, many of whom are uninsured, undocumented immigrants, or both. For this care, these two organizations receive a large amount ($50 million and $11 million a year at UCI and Children's, respectively) of federal disproportionate share hospital (DSH) funds designed to compensate major charity care hospitals. DSH dollars represent the difference between profitable and unprofitable status for both hospitals, so they are concerned about potential changes in that program that may ensue from ongoing state-federal negotiations. How a June 2005 agreement between California and the federal government on Medi-Cal financing reforms affects DSH payments to UCI and Children's remains to be seen. And, while a new state bond issue will make grants available to children's hospitals across the state (see box above), officials at Children's Hospital of Orange County are concerned about the ongoing costs of additional beds, given that half of the hospital's patients are covered by Medi-Cal, on which the hospital loses money.

The demands on the safety net are expected to continue to grow, as the population of undocumented immigrants grows. This population is often difficult and costly to care for because of language barriers, lack of familiarity with how to use the health care system, and delay in seeking care because of fear of deportation. Because of its proximity to the Mexican border, Orange County is a major destination for new immigrants. Jobs in agricultural and service businesses, which usually do not offer affordable health insurance, provide an economic base for these families.

The Orange County Medical Services for the Indigent (MSI) program, a county-operated program to pay providers for services to uninsured persons, continues to suffer from what

most see as lack of political support, insufficient funding and low provider payments. Some progress has been made in broadening physician participation and moving more ambulatory care away from UCI, which has long contended that it carries an undue burden in the MSI program. A few years ago, UCI instituted a policy to limit ambulatory care at its central facility only to MSI patients who live within five miles of the hospital; non-area patients were to be referred to clinics closer to their residences. That policy prompted the county to institute changes in the MSI program, including a case management program to promote more equitable sharing of the patient load by referring patients to other community providers. The result is that MSI outpatient care at UCI is down by 50 percent from two years ago, but inpatient care continues to climb with up to 40 percent of all hospitalized MSI patients in the county being cared for at UCI on any given day.

Despite these various and sizeable challenges, some bright spots exist for access to care for low-income Orange County residents. The county continues to do reasonably well in getting Medi-Cal or Healthy Families coverage for eligible adults and children. Additional efforts are underway by county officials, community clinics and local philanthropies to see if the remaining children ineligible for public coverage can be enrolled in CaliforniaKids—a privately funded insurance program that pays for preventive and outpatient care for otherwise uninsured children and links them to a medical home. New leadership among the county's community clinics, as well as other interests, may focus more attention on strategies to build the strength of those key organizations. And, two new state initiatives will soon infuse considerable new funds for additional capacity at Children's Hospital and new initiatives for low-income residents with severe mental illness.

Issues to Track

Changes in Medicare and new public- and private-sector quality improvement initiatives have presented significant new opportunities for Orange County health plans and providers. The results include new health benefit product designs and additional organizational capacity to collect and use patient and administrative information. But other forces threaten to darken the picture, as the state's budget challenges persist and the system's capacity is constrained by a stagnant supply of hospital beds and a worsening nurse shortage. Important issues to track include:

- What effects will nurse staffing ratios have on access, quality and costs in Orange County over the next two years?
- Will the state find the funds to ensure that CalOPTIMA can remain a model system for managing Medicaid and ensuring access to the county's most vulnerable residents?
- Will PPO and consumer-driven products grow in the market, and what effect will this have on the delegated model of managed care?
- Will P4P and quality reporting programs yield measurable improvements in health care delivery?
- Will IHHI's purchase of the four Tenet hospitals lead to further closures in the community and significant changes in physician referral patterns?

Despite various and sizable challenges, some bright spots exist for access to care for low-income Orange County residents.

Orange County is one of 12 metropolitan communities tracked through site visits by the Center for Studying Health System Change.

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