



SACRAMENTO REGION HEALTH CARE PARTNERSHIP

Market Analysis Findings and Key Opportunities



SIERRA HEALTH
FOUNDATION



JOHN SNOW, INC.

Commissioned by
Sierra Health Foundation

Conducted by John Snow, Inc.

FEBRUARY 2017

In partnership with Congresswoman Doris Matsui, Sierra Health Foundation launched the Sacramento Region Health Care Partnership in 2011 to strengthen the health care delivery system in the region. The partnership was comprised of policymakers and leaders from community health centers, health systems, health plans, associations and foundations committed to preparing the region for the implementation of the Patient Protection and Affordable Care Act (ACA). To this end, the foundation commissioned a market analysis of the region's primary care system, which informed the development of a strategic plan to better position safety net providers for the enormous changes ahead. The strategic plan became the starting point for the foundation's \$3 million investment in clinic capacity building to improve access, coordination, care quality and financial stability of primary care community health centers.

Since the 2012 market analysis, ACA has dramatically changed the health care landscape. An external evaluation conducted by the Group Health Research Institute found that Sierra Health Foundation's investment strengthened the regional primary care safety net's ability to respond to the influx of new patients, although the demand created by the newly insured over time outpaced the supply of primary care services. To assess the larger picture of the primary care safety net in this new environment, the foundation commissioned John Snow, Inc. to conduct an update to the 2012 market analysis.

We are pleased to share this information about the challenges, opportunities and achievements experienced by the region's health care safety net between 2012 and 2016. The report shows that increases in health insurance coverage exceeded what was predicted for the region, and identifies challenges such as the lack of access to specialty care and the growing need for behavioral health services. It also recognizes that health care utilization, costs and outcomes are driven by social determinants of health such as neighborhood parks, employment opportunities, education and other environmental factors beyond the health care system.

Clearly, there is more work to be done, particularly as the future of the ACA is uncertain. We hope this report will inspire further conversation and action by the region's leaders to remain committed to expanding and strengthening the health care safety net so that everyone has true access to high quality care.

Sincerely,

A handwritten signature in black ink, appearing to read "Chet P. Hewitt". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Chet P. Hewitt
President and CEO
Sierra Health Foundation

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INTRODUCTION

In 2012, Sierra Health Foundation and the Sacramento Region Health Care Partnership (SRHCP) conducted a market analysis of the Sacramento region primary care safety net. The years since then have marked historic change for health care services organization, financing and delivery. Implementation of the Patient Protection and Affordable Care Act (ACA) in 2014 expanded the role of community health centers (CHCs) and Medi-Cal, and introduced insurance exchanges and subsidies to facilitate the purchase of health insurance in the private market. In addition, Sierra Health Foundation launched the Community Health Center Capacity Building Program to improve operations and care quality, as well as to increase patient access to care. The initiative included grants to five CHCs for specific projects and the Safety Net Learning Institute, a series of workshops open to all CHCs in the region, which covered topics such as integrated behavioral and primary health care, telehealth and performance measurement, among others.¹ Given the 2016 presidential and congressional elections, the fate of the ACA is now in jeopardy. However, Sierra Health Foundation's commitment to advancing health equity in Northern California through convening, educating and strategic grantmaking remains strong.

To gain insight into the current landscape in Sacramento, El Dorado, Yolo and Placer counties, Sierra Health Foundation commissioned John Snow, Inc. (JSI) to perform a market analysis update. This update synthesizes the most recent data from public sources used in the 2012 market analysis, as well as new sources that shed light on the status of the region today. Between October 2015 and March 2016, JSI researchers reviewed publicly available resources for the region, with a focus on quantitative data, and conducted key informant interviews with regional thought leaders, health system leaders and payers. Finally, JSI reviewed a detailed qualitative data study conducted by Valley Vision as part of a

community needs assessment in the four-county region.

This document summarizes key findings and recommendations for regional leaders interested in advancing health and health equity going forward. An accompanying slide deck contains a detailed summary of all data reviewed. Because of some differences in data sources, as well as the complex changes in the health care landscape, the report does not include extensive comparisons to the initial market analysis. The findings point to an overarching need to convene the region's stakeholders who influence the population's health—including leaders representing health systems, payers, behavioral health and social services—in a collaborative effort to address gaps that still remain in meeting the needs of the Sacramento region's low-income and vulnerable populations.

FINDINGS

A. The Affordable Care Act increased health insurance coverage significantly and exceeded predictions in the region.

The insured population in the Sacramento region increased by more than 138,000 individuals between 2012 and 2014.² Prior to the ACA, third-party projections for the coverage increase in the four-county region ranged from a reduction of 60,000 to 80,000 in the number of uninsured individuals.³ Actual numbers of the newly insured exceeded even the most robust predictions. Between 2012 and 2014, census data for the region show a 5% decrease in the uninsured rate, and a 2.1% increase in the percent of individuals with public insurance.⁴

1 For more information about the Sacramento Region Health Care Partnership, including the external evaluation report of the Community Health Center Capacity Building Program, see: <https://www.sierrahealth.org/healthcarepartnership>.

2 United States Census Bureau / American FactFinder. "S2701: Health Insurance Coverage Status" 2012 – 2014 American Community Survey. U.S. Census Bureau's American Community Survey Office. Web. 2015

3 Estimates of the Affordable Care Act - November 8, 2012. Rep. Sacramento County Primary Health Services, n.d. Web. <http://www.dhhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Old%20Info%20-%20Do%20not%20delete/Other/MA-20130325-MCMC-ACAEstimates.pdf>

4 United States Census Bureau / American FactFinder. "S2701: Health Insurance Coverage Status" 2012 – 2014 American Community Survey. U.S. Census Bureau's American Community Survey Office. Web. 2015

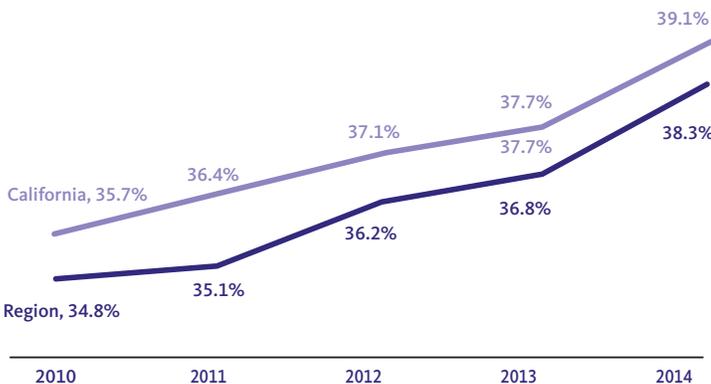
PERCENT UNINSURED



SOURCE: AMERICAN COMMUNITY SURVEY, 2010-2014

Within the four-county region, Sacramento County started with the highest rate of uninsured prior to the ACA and experienced the largest decline in the rate of uninsured (15.9% in 2012 to 10.1% in 2014).⁵ Qualitative interviews suggested that in Sacramento County, in particular, the increase in coverage uptake can be partially attributed to pervasive marketing for Covered California. In accessing the Covered California portal, many residents found themselves eligible for Medi-Cal. Other cited mechanisms for insurance uptake included Medi-Cal coverage increases due to hospital presumptive eligibility and CalFresh semi-automatically enrolling eligible individuals into Medi-Cal.

PERCENT WITH PUBLIC HEALTH INSURANCE (OF THOSE WITH HEALTH INSURANCE)



SOURCE: AMERICAN COMMUNITY SURVEY, 2010-2014

Public insurance enrollment accounted for most of the increase in coverage rates. Reflecting both the ACA impact and the expansion of Medi-Cal managed care in two of the counties, Medi-Cal managed care enrollment reached almost 547,000 in October 2015 compared to about 330,000 in November 2013.⁶ Because more residents than expected enrolled in Medi-Cal, capacity issues have become overwhelmingly clear for Federally Qualified Health Centers (FQHCs) and other Medi-Cal providers. Despite the pre-enrollment of patients through the Low Income Health Program (LIHP) and various provider efforts to prepare for ACA expansion, Medi-Cal providers report feeling underprepared for the volume of new patients entering the system. Interviewees also noted that the increases in demand for the newly insured have created a “crowd-out” effect in which the remaining uninsured, many of whom are undocumented, are finding it especially difficult to get into clinics. Interviews conducted by Valley Vision underscored this point, also noting that lack of care is particularly acute for the undocumented and that emergency rooms may often be this population’s only option for care.

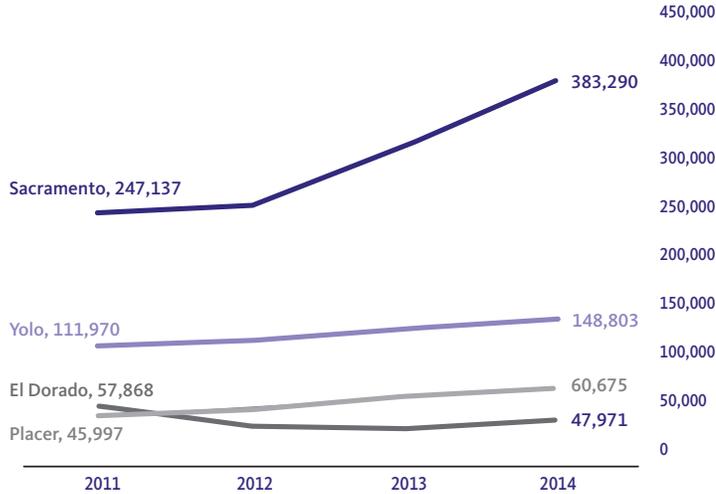
B. Access to care and appropriate utilization of the health system continue to challenge newly insured Medi-Cal populations.

The issues surrounding access to health care for Medi-Cal populations have changed since ACA implementation. Pre-ACA difficulties largely concerned specialty care access. Interviewees noted challenges with both primary care and specialty care access in the region now. Both improving access and promoting proper navigation of the health system were repeatedly noted as key opportunities.

⁵ United States Census Bureau / American FactFinder. “S2701: Health Insurance Coverage Status” 2012 – 2014 American Community Survey. U.S. Census Bureau’s American Community Survey Office. Web. 2015

⁶ California Department of Health Care Services. “Medi-Cal Managed Care Enrollment Reports” 2013 – 2015

PRIMARY CARE CHC ENCOUNTERS

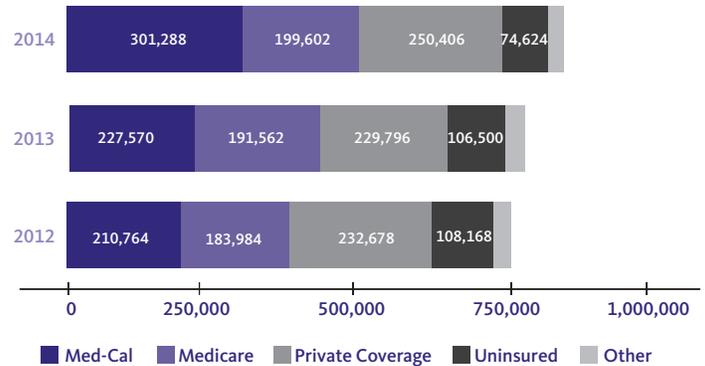


SOURCE: OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, 2011-2014

Timely access to primary care is reportedly a challenge for both newly insured and previously insured Medi-Cal populations. This challenge has arisen despite community clinics adding capacity in terms of providers and total encounters. Indeed, publicly available data shows that CHC primary care encounters increased by 41% between 2012 and 2014,⁷ yet interviewees cited significant challenges with access to primary care for Medi-Cal beneficiaries. Barriers included long wait times, a lack of available appointments and rescheduling with little notice to patients or navigators. These barriers were considered to stem from provider shortages within safety net clinics and a lack of providers who accept Medi-Cal elsewhere in the health care system, rather than from a lack of FQHC sites or FQHC expansion. Spikes in emergency department (ED) utilization in the region over the last four years suggest that challenges in primary care access may contribute to individuals seeking care in the ED. Data from the Integrated Healthcare Association across all payers shows that the Sacramento region's ED utilization is higher than three quarters of regions in the state.⁸ Between 2012 and 2014, ED utilization in the region increased by 12%; Medi-Cal ED utilization increased by 30%.⁹ Additionally, while Medi-Cal visits accounted for 28% of all ED visits in 2012, Medi-Cal paid for 35% of all ED visits by

2014 (7% increase). At the same time, the number of ED visits from the uninsured have decreased from 14% of all visits in 2012 to 9% of all visits in 2014 (5% decrease),¹⁰ suggesting that the newly insured may seek primary care in the ED despite their new insurance status.

ED VISITS BY PAYER SOURCE IN THE SACRAMENTO REGION



SOURCE: OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, 2011-2014

Interviewees noted that increases in ED utilization may also have other root causes. Key informants suggested that increases in ED utilization are likely due to a confluence of underlying reasons, including insufficient access to primary care, lack of understanding among the newly insured about how to appropriately use the health system, and prevalence of physical and behavioral health issues among the newly insured. Of these potential reasons, only data on the adverse effects of increased drug and alcohol use and misuse was available. Indeed, for Medi-Cal beneficiaries, data indicates that between 2011 and 2014, non-fatal hospitalizations associated with substance use more than doubled, and ED visits related to substance use increased 76%.¹¹ Interviewees acknowledged

7 Office of Statewide Health Planning and Development "Primary Care Clinic Annual Utilization Data" 2012 – 2014

8 Integrated Healthcare Association. "Healthcare Effectiveness Data and Information Set (HEDIS) By Geography" Online. 2000-2016. <https://hbg.ihc.org/>

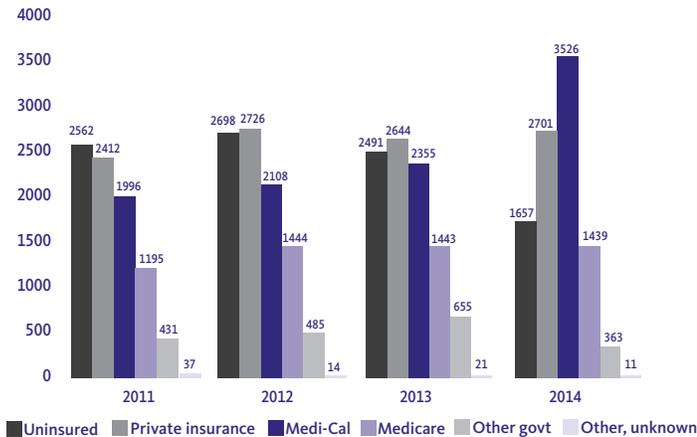
9 Office of Statewide Health Planning and Development "Hospital Annual Utilization Data" 2012 – 2014

10 Office of Statewide Health Planning and Development "Hospital Annual Utilization Data" 2012 – 2014

11 California Department of Public Health. "Alcohol and Other Drug Health Consequences" EpiCenter – California Injury Data Online. 2011-2014

that improving access to primary care would optimally include integrated behavioral health services in primary care settings.

ALCOHOL AND DRUG HEALTH CONSEQUENCES: NON-FATAL ED VISITS IN THE REGION



SOURCE: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, 2011-2014

C. Primary care needs more time and capacity building to meet demand.

In anticipation of the ACA, the region’s primary care safety net made multiple efforts to increase capacity. According to interviewees and Sacramento County Health and Human Services records, this effort included FQHC expansion in size and number of sites, as well as FQHC acquisitions and mergers.

Despite these efforts, many interviewees agreed that primary care access continues to be an ongoing challenge. They described a “saturation of primary care,” evident in clinics with no open appointments and long wait times, despite sometimes reporting empty office space. Most agreed that the answer to this challenge was not to create more FQHCs in the region, but to allow the current ones to fully realize their expansion plans to meet new demand. Primary care providers and Independent Practice Associations (IPAs) representing primary care providers seemed optimistic that demand could eventually be met, given more time and capacity-building measures.

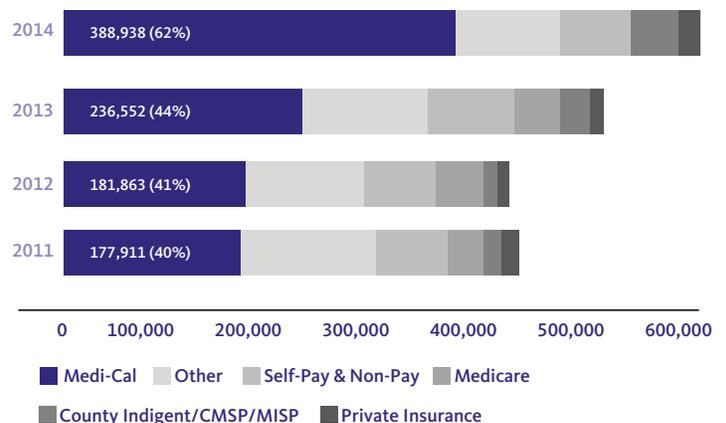
However, interviewees viewed primary care provider shortages as a potential long-term challenge that needs to be addressed systematically through region-wide workforce planning and ongoing capacity building within community clinics. They acknowledged that a range of capacity-building needs exists among CHCs.

Representatives also pointed to a need for strengthened relationships between larger health systems and primary care, such as discussions about the workforce ecosystem (see Recommendation D), in order to better meet demand.

D. Community health centers have not benefitted uniformly with the ACA

CHCs represent a critical segment of the primary care provider Medi-Cal network and have long had a mission to serve all individuals regardless of an ability to pay. Experts predicted that CHCs would fare well financially under the ACA as many of their uninsured patients gained coverage. While the Sacramento region has seen an improvement in CHC financial outcomes in aggregate, financial performance at the clinic level has been mixed.

COMMUNITY HEALTH CENTER ENCOUNTERS BY PAYMENT SOURCE FOR REGION



SOURCE: OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, 2012-2014

Overall, CHC revenue increased by 35% from 2011 to 2014.¹² Since 2011, net income across all CHCs increased by \$14 million, bringing the region into net positive income in 2014 for the first time since 2011.¹³ However, this gain was largely accounted for by two centers that had a combined \$13 million gain in net income, as they introduced new services and expanded the populations they serve. Another large contributor had a \$1.6 million loss in net income¹⁴ as it shifted to new sources of funding; despite this shift, there were not concerns about the clinic’s long-term financial viability.

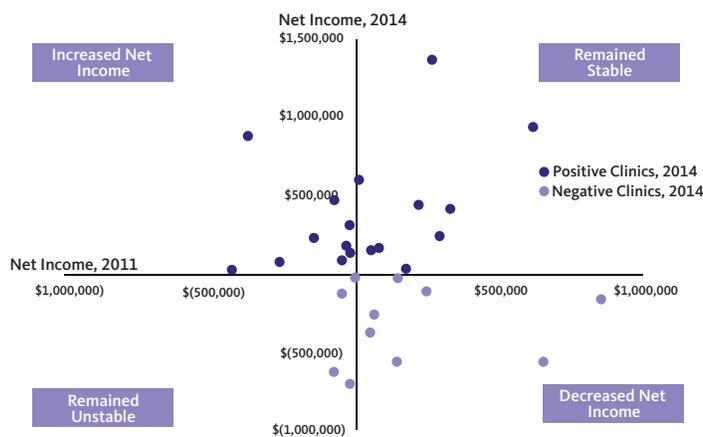
At the clinic level, 21 of 33 (64%) CHCs in the region reported positive net incomes in 2014.¹⁵ Previously, just over half of these 21 clinics had reported a negative net income in 2011. This suggests that the ACA has indeed catalyzed financial recovery for about a third (11 of 33) of all clinics. On the other hand, 12 clinics (36%) reported negative net incomes in 2014, seven (58%) of which had reported positive net incomes in 2011. This suggests that the ACA has not necessarily been associated with positive financial outcomes for all.

This data is consistent with state trends. A recent report on post-ACA increases in clinic Medi-Cal market share shows that more than 1.3 million (54%) of new Medi-Cal managed care members were assigned to safety net clinics and that safety net clinics have a 41% share of overall enrollment.¹⁶ Nonetheless, some clinics suffer from a lack of capital and unfavorable payer mixes that are largely Medi-Cal and uninsured.¹⁷ In other words, because FQHCs are a major source of primary care for Medi-Cal patients, current demands underscore the importance of these clinics maintaining financial viability. Some interviewees suggested that one potential strategy for clinics to stay solvent would be to explore mergers or acquisitions. Several experts agreed that further research into these opportunities could help to reveal operational and financial strategies to ensure safety net clinics remain viable into the future.

E. Medi-Cal provider shortages in the region create access challenges and have multiple root causes.

Both quantitative and qualitative data point to a critical challenge in the shortages in providers who will accept Medi-Cal. Health system representatives cited three main factors underlying a lack of Medi-Cal providers: low Medi-Cal reimbursement rates; the acquisition of medical groups by health systems; and FQHCs being unable to compete with large health systems in their search for providers.

NET INCOME OF CHCs IN THE REGION: CHANGE FROM 2011 TO 2014



SOURCE: OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, 2011-2014

12 Office of Statewide Health Planning and Development “Primary Care Clinic Annual Utilization Data” 2011 – 2014

13 Ibid.

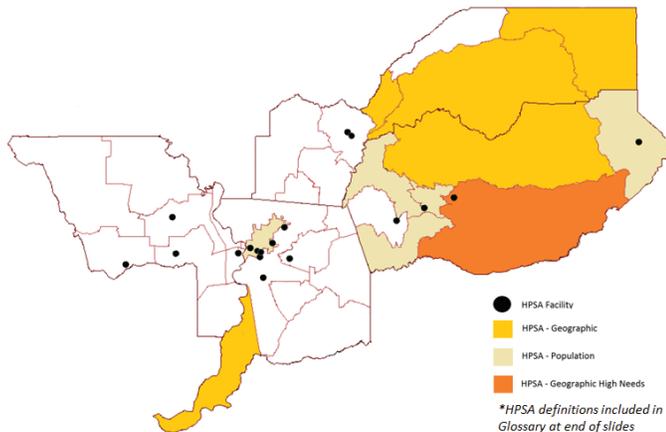
14 Ibid.

15 Ibid.

16 Wunsch, Bobbie. “Medi-Cal Managed Care Plans and Safety-Net Clinics Under ACA.” Briefing — ACA’s Impact on Medi-Cal Managed Care Plans and Safety-Net Clinics. Sacramento, CA. California Health Care Foundation. Web. <http://www.chcf.org/events/2015/briefing-medical-plans-clinics>.

17 Ibid.

PRIMARY CARE — HEALTH PROFESSIONAL SHORTAGE AREAS



SOURCE: HEALTH RESOURCES AND SERVICES ADMINISTRATION, 2015

Medi-Cal reimbursement issues affect provider shortages in the safety net in several ways. First, according to interviewees, many providers that were not already serving the Medi-Cal population took little notice of one key ACA opportunity intended to increase provider acceptance of Medi-Cal: the increase of primary care Medi-Cal rates to Medicare levels for two years (known as the “ACA bump”). This is rooted in the fact that many providers simply do not participate in Medi-Cal at all. Second, many traditional Medi-Cal providers—even providers who stood to gain from the increases in reimbursement—were unaware of this ACA policy. For example, when an IPA leader encouraged one group of Medi-Cal providers to fill out the necessary paperwork to show they qualified for the increase, the providers’ annual income grew substantially.

Second, health system representatives report that a large proportion of the region’s doctors are affiliated with large medical groups or hospital systems that have chosen—and are increasingly choosing—not to contract with Medi-Cal managed care plans. In addition, as is happening elsewhere, Sacramento has seen a trend of hospital systems buying both medical groups and smaller provider practices. The hospital systems then control, and frequently limit, the amount of Medi-Cal participation. This process has affected

both primary and specialty care providers, but interviewees reflected that this movement has severely curtailed Medi-Cal specialty care access in recent years. Indeed, interviewees reported that the number of specialists who accept Medi-Cal has decreased in the region as large hospital systems have bought specialty practices and medical groups.

Finally, FQHCs themselves face challenges in addressing provider shortages. Interviewees noted that large health systems commonly recruit physicians and medical assistants, as well as billing technicians and administrative staff, from FQHCs. Though many of these staff view safety net clinics as a training ground or are attracted to the mission, large health systems are ultimately able to offer better pay and benefits and attract staff away from the clinics. This flow leaves clinics with many vacant medical and administrative positions and in a perpetual state of hiring and training new clinicians and staff, which is frustrating for clinic management and exacerbates provider-related clinic capacity issues.

F. The newly insured population appears to be comprised of both sicker than average and healthier than average groups.

Pre-ACA, many hypothesized that the ultimate impact of insurance expansion would depend partly on “how sick” the newly insured population turned out to be. Simulations projected that new Medi-Cal enrollees would have pent-up demand for medical services and, once insured, would utilize health systems more than pre-expansion adult beneficiaries. Publicly available data regarding the utilization patterns and disease burden of the newly insured was unavailable. However, multiple interviewees reported that as a population, the newly insured have not met the anticipated utilization or costs of care on average. These interviewees cited the fact that multiple health plans in the Sacramento region have struggled to meet or have not met

the required 85% medical loss ratio for the Medi-Cal expansion population (i.e., if plans did not spend at least 85% of the capitation received on direct medical care and/or quality efforts, funds would need to be returned to the government), which further suggests that the average cost of care for the expansion population was less than estimated during managed care rate setting. However, this average obscures an important point that emerged in interviews: the newly insured may actually fall into one of two groups — healthier than anticipated or exceptionally sick and complex.

A potential reason cited for a portion of the Medi-Cal expansion population utilizing less care than anticipated was the varying demographics of the three major groups in the newly insured—individuals who had been in the county indigent care programs, children in the Healthy Families program, and single, childless adults who were disproportionately single, adult men. Some interviewees suggested that those with the most medical need had already been served through county programs and the Low Income Health Program (LIHP), a California strategy to connect eligible individuals with coverage and care before the 2014 ACA Medi-Cal expansion. An arrangement between Molina Healthcare, a plan focused on the Medi-Cal population, and Sacramento County allowed Molina to cover LIHP members in anticipation of the ACA. Many of these early expansion members were high-utilizing, and interviewees report that Molina made an effort to tackle pent-up demand before expansion. Once the ACA transition took place, these members were re-distributed between plans. Interviewees also postulated that the Healthy Kids population and a portion of the single, childless adult population tended to be relatively healthy and, thus, low utilizers of services. Some interviewees also cited the fact that a number of young, healthy adults may have become eligible for Medi-Cal due to declining economic prospects in the region.

In contrast to those who reported low utilization among the newly insured, other interviewees affirmed that the newly insured have been a challenging population that met or exceeded expectations of high utilization, high costs, and both social and medical complexity. These interviews suggested that those who were in LIHP or county indigent programs often had significantly more chronic needs than those in traditional Medi-Cal. The expansion population was also reported to be especially difficult to manage because chronic health issues often were complicated by needs extending beyond medical care into needs for mental health, substance use and social services such as housing. Several interviewees cited vast underestimations of the size of the homeless population in the Medi-Cal expansion as an example.

Quantitative and qualitative data suggest that the Medi-Cal expansion population has a high degree of variation in need. Interviewees expressed that going forward, health systems, providers and payers will need to refine care and payment strategies to address these diverse needs. Many also suggested that such strategies will need to involve closer coordination between health, behavioral health and social services systems.

G. Specialty care access will require new levels of collaboration between health systems and continued innovation.

Specialty care access was reported as a more acute challenge than primary care access. In primary care, capacity increased in 2012-2015, although not enough to meet demand. In specialty care, the supply of providers decreased, even as demand went up.

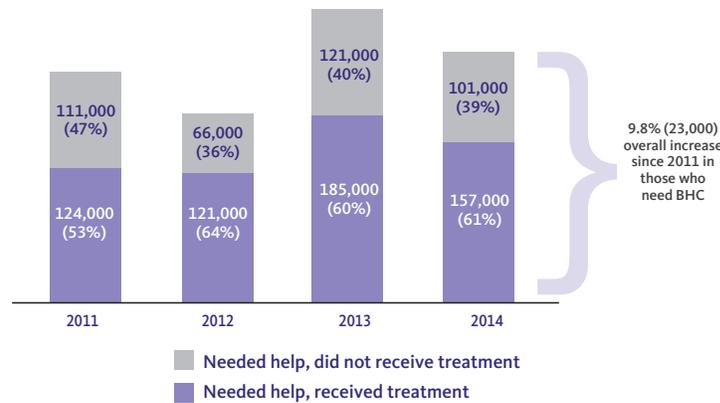
Indeed, specialty providers in the region are unable to see a sufficient number of Medi-Cal patients to meet the large need that accompanied Medi-Cal expansion and the ACA enrollment surge. In addition to the region's struggle to bring in new specialty providers who will accept Medi-Cal

patients, existing practices are unable to meet a growing need. According to interviewees, this is largely due to a decreasing specialty care Medi-Cal network in the wake of a trend of health systems buying medical groups and then limiting or eliminating Medi-Cal contracts. Some representatives postulated that a reason for this practice is that the supply of specialists is too small even for commercial patients; others expressed that the low reimbursement for Medi-Cal patients was insufficient to cover the cost of care. Stakeholders shared that solutions to the Medi-Cal specialty care access challenge will require new levels of cooperation among large health systems and continued innovations in access. Current but inadequate approaches to the lack of specialty care access involve long wait times, a lot of rescheduling, patients traveling long distances, and IPAs resorting to flying in specialists from other parts of the state. Many interviewees reported a need for improving referral pathways from FQHCs to hospitals. Others saw an opportunity for health systems to collaboratively decide that each system would provide a portion of the specialty care needed in the region. Interviewees also cited small missed opportunities, pointing out that access to specialty ambulatory care could be provided in open clinic space if large health systems would supply physicians, even on a part-time basis. Further, multiple interviewees emphasized the need to further develop and scale non-traditional models for delivery of specialty care, such as e-consults, telemedicine and IPA-owned staff model specialty clinics.

H. The region has a growing unmet need for behavioral health care services.

Behavioral health care in the region is widely lamented as being inadequately addressed. Despite added capacity and an improving regulatory framework, new partnerships and programing will be required to build on efforts in physical and mental health integration and leverage new policy opportunities.

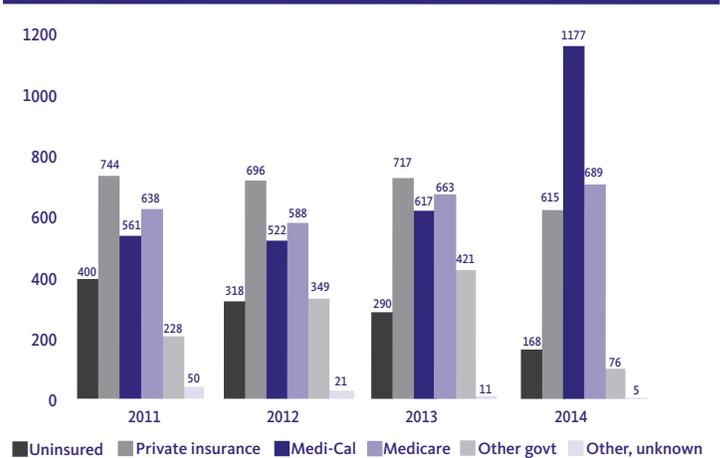
POPULATION NEEDING AND ACCESSING BEHAVIORAL HEALTH CARE (BHC) IN THE REGION



SOURCE: CALIFORNIA HEALTH INTERVIEW SURVEY, 2011-2014

Behavioral health care has not increased dramatically since 2011, yet quantitative and qualitative data reveal a significant unmet need. Deaths due to alcohol and other drugs increased 17.3% between 2011 and 2013.¹⁸ Non-fatal ED visits and hospitalizations due to substance abuse have increased disproportionately in the Medi-Cal population compared to non-Medi-Cal populations.¹⁹

ALCOHOL AND DRUG HEALTH CONSEQUENCES: NON-FATAL HOSPITALIZATIONS IN THE REGION



SOURCE: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, 2011-2014

18 California Department of Public Health. "Alcohol and Other Drug Health Consequences" EpiCenter – California Injury Data Online. 2011-2013

19 Ibid.

In Valley Vision focus groups and in the interviews, community members identified substance abuse and mental health as key priorities, and expressed concern over inadequate services despite a great need, especially for providers who are culturally sensitive to diverse communities. According to interviewees, the inadequate supply of mental health and substance use services may be partly a result of county policies before the ACA, in which payment for behavioral health was difficult unless the patient had been admitted to the emergency room through law enforcement. Other interviewees saw potential opportunity in the implementation of the new Drug Medi-Cal waiver that allows for substance use services across a broader continuum of outpatient and inpatient care compared to previous policies.

Since the ACA, several efforts have emerged to improve access to behavioral health care services. Key informant interviewees from the health systems noted that there has been a push for a new regulatory framework and for more geographically based crisis centers. Sacramento County is participating in a workgroup and reportedly shows signs of long-term plans to work toward solutions. The desire to make behavioral health specialists more available as part of primary care and more available for special populations in managed care, such as homeless individuals or those in the criminal justice system, was another theme in the interviews. In addition, the four hospital systems in the region have begun to collaborate on mental health. Some have begun to run behavioral health centers and are collaborating more with the county after recognizing that the problem was costly, unsafe to patients and creating negative publicity. Representatives reported that though there is work to be done around appropriate contracting, care coordination and reimbursement structures, these efforts are positive steps in creating a framework for a stronger, more coordinated and more responsive behavioral health system in the region.

I. Sacramento's Geographic Managed Care (GMC) model creates challenges at plan, provider and patient levels.

Sacramento County is the only county in the region, and one of only two counties in the state, that organizes Medi-Cal managed care through the Geographic Managed Care (GMC) model. In this model, the California Department of Health Care Services (DHCS) contracts with several commercial plans. No local initiative plan established by the county is offered. As of October 2015, there were approximately 433,000 Medi-Cal managed care enrollees in Sacramento County alone.²⁰ Four private health plans compete among this population. Anthem Blue Cross (39%) has the largest market share, followed by Health Net (29%), Kaiser (18%) and Molina Healthcare (14%).²¹ The state announced that United and Aetna will be added to the Sacramento GMC market.

Key informants suggested that the GMC model has proved to be problematic in multiple ways. In theory, having additional plans should provide more options for patients. Also, plans with multiple products should be able to leverage commercial and Medicare lines of business to encourage providers to accept Medi-Cal. However, interviewees reported that such leveraging to increase access to care for Medi-Cal beneficiaries has not been the case to date. According to interviewees, the presence of additional plans has not substantially increased access or expanded patients' options for providers. There continues to be a high degree of overlap in provider networks, with the result being little change in access when a patient switches plans. Further, for providers, contracts with multiple plans or IPAs, which all have different administrative procedures and formularies, have increased the complexity of the system.

With no local initiative plan and no public hospital in Sacramento's GMC model, commercial plans and large health

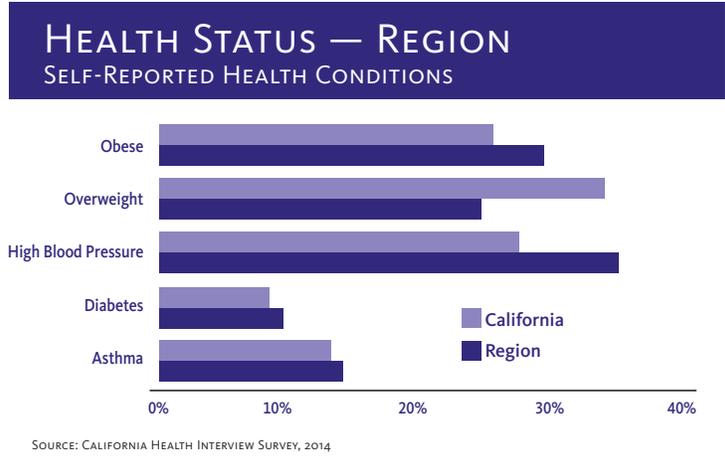
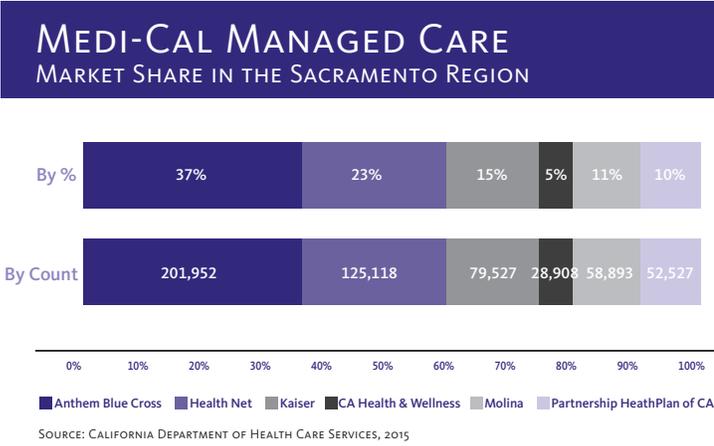
²⁰ California Department of Health Care Services. "Medi-Cal Managed Care Enrollment Reports" 2015

²¹ Ibid.

systems create the dominant market forces in the region. Recent years have shown that the large health systems in particular have stepped back from serving the Medi-Cal population for a variety of reasons. This has left an increasing number of plans with a smaller network of providers. For example, one large health system, historically serving in a key role as a safety net health system, has been caught in a legal battle with Sacramento County over lack of payment and has limited the number of Medi-Cal patients. Multiple interviewees also reported that at least one other large regional health system has restricted its medical groups from accepting Medi-Cal patients.²² Actions such as these have limited network adequacy. However, unlike California's other GMC county (San Diego), Sacramento County does not have a clear arrangement to address network adequacy issues. Further, despite GMC being in place since 1992, key informants stated that no regulatory body has taken responsibility for the decreased access for Medi-Cal patients, and there has been no evaluation of the GMC model's effectiveness, revealing a potential key opportunity to systematically evaluate the GMC model going forward.

J. Social determinants of health are increasingly being recognized as key drivers of health care utilization, costs and outcomes.

Even as this project was intended to focus on the changes in safety net health care in the wake of the ACA, interviewees frequently spoke of the importance of addressing social determinants of health, reflecting a broadening definition of health and health care. Community health indicators such as obesity and asthma show that the region fares worse than the state and that low-income populations are disproportionately affected by these conditions. This is particularly notable because both obesity and asthma are health conditions that are influenced by social and environmental factors such as neighborhood zoning for grocery stores, air quality, and adequate and safe housing. Furthermore, housing and transportation, as well as culturally sensitive behavioral health and substance abuse services, were often cited as crucial components of a comprehensive health system. Despite this recognition, interviewees reported that those in the health care field were struggling to pinpoint their appropriate role in addressing social issues, often perceiving it to be outside of their purview to do so.



22 (1) Interviewees; (2) Tu et al. "Sacramento: Pressures to Control Costs Persist Alongside Growing Capacity and Access Challenges." California Health Care Foundation, Mathematica Policy Research. 2016.

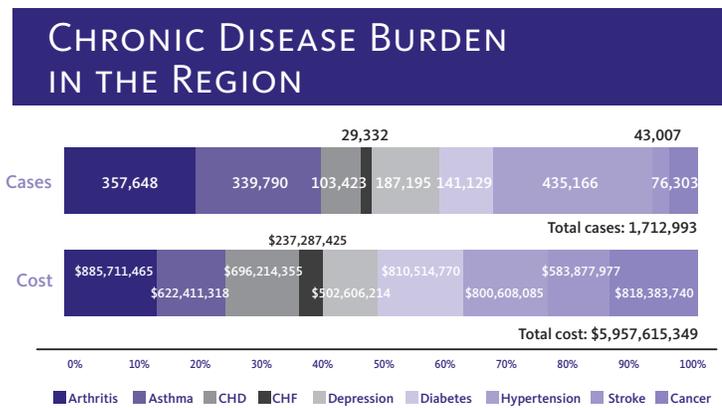
According to the key informant interviews, collaborations among the health system, agencies and organizations are essential if the region is to achieve improved health, cost and health equity outcomes. Many viewed including non-traditional providers and interdisciplinary teams as part of the solution to problems that the health system and the community face. Several also highlighted the importance of initiatives that target bringing the infrastructure of social services into medical care programs. Specific strategies mentioned by interviewees to support medical and social services integration included basic toolkits (a compilation of the best contacts and procedures for providers to reference), education on “social prescriptions” and referrals, and investigation of root causes of health problems.

Another theme in the interviews was the need for “health in all policies” approaches and for refining the managed care model to meet the needs of special populations to better address social determinants of health. In particular, homeless populations and populations within the criminal justice system were highlighted as two groups that have difficulty with the current set-up of managed care, including often needing services and support that are not available or are not reimbursable under Medi-Cal. In these conversations, interviewees identified siloed funding streams, lack of or incorrect data on

homelessness, and the inflexibility of services to integrate special populations as key barriers to improving health for these particularly vulnerable populations.

Some interviewees suggested that incipient coalitions that increase connectivity between providers and social services are beginning to break down barriers between sectors by clearly outlining pathways for providers to get their patients what they need. Some interviewees pointed to early successes in addressing social determinants of health. For example, Yolo County’s Housing First initiative aimed to combat homelessness through collaboration of agencies and re-organization at the county level for service coordination. Sacramento Steps Forward and a grassroots church-food bank-clinic coordination effort also were highlighted as examples of community-based coalitions to address social factors that affect health. Lastly, hospitals strategically using community benefit funding for initiatives to address determinants such as domestic violence or housing were also mentioned as taking steps in the right direction.

While Sacramento County interviewees were not aware of any efforts to pursue Whole Person Care Pilots available under California’s 1115 Waiver at the time of this research, Placer County was awarded a \$20 million Whole Person Care pilot in late 2016.²³ Both quantitative and qualitative data suggest that in the years ahead, one key challenge for the Sacramento region will be to identify ways to better coordinate health, behavioral health and social services for the whole population, with a particular focus on those most vulnerable.



SOURCE: UNIVERSITY OF CALIFORNIA MERCED, 2014

23 California’s Department of Health Care Services has also indicated that it will accept a second round of proposals due March 1, 2017, with approximately \$132M in federal matching funds available to counties.

KEY OPPORTUNITIES FOR THE SACRAMENTO REGION

To improve health and health equity in the post-ACA era, leaders in the Sacramento region have the opportunity to come together to address the following seven recommendations derived from synthesis of the Market Analysis data and qualitative interviews.

A. Address FQHC capacity building through strategic investment.

The increase in funding in the safety net due to the Medi-Cal expansion represents an opportunity for critical FQHC capacity building. Bringing together clinics, plans and health system leaders to identify strategic investments to strengthen clinics over the long term could help ensure that these new dollars are spent in a way that best strengthens the Sacramento region safety net, a large part of which is comprised of FQHCs.

Interviewees reported plans to use new funds to broaden services and/or build out clinics, and to seek contracts that support clinics and patient care. One commonly cited area where there is a need for strategic spending was FQHC workforce. As one health system representative expressed, attempts to expand capacity without adding providers would be short-sighted. Other investments could incentivize improved quality and access to care.

Strategic investment opportunities (some of which are already being pursued) include:

- Collaboration with nearby medical schools interested in training residents in community health to formalize pipelines for providers to work at FQHCs
- Grants for filling empty space with specialty care physicians from outside of the county or who normally work for hospitals in the region and can give part-time office hours

- Supplemental funding to FQHCs to incentivize behavioral health and primary care visits on the same day
- Technical assistance to improve quality processes and data analytics at FQHCs
- Capacity building for FQHC providers to better link patients with social services (e.g., through use of “social prescriptions”)
- Ensuring FQHCs are prepared to be community-based care management entities under the Health Homes for Patients with Chronic Conditions initiative anticipated to begin in Sacramento in 2018

B. Implement short-term and long-term strategies to improve specialty care access.

Specialty care access is a pressing challenge in the region. Collaboration among health systems is critical to build on existing solutions and to develop long-term plans to address this unmet need.

Stopgap measures currently under way can be leveraged in the short term. These include contracting arrangements, referring to specialists outside the region and flying in specialists to use empty offices. Increased collaboration could smooth out the logistics and facilitate these approaches. Ultimately, while these approaches can help meet immediate needs, ensuring specialty care access will depend on long-term planning. New innovations — and accelerated progress — could emerge from bringing together health systems and medical education systems to collectively address specialty care access.

C. Seek equitable distribution of care for Medi-Cal and uninsured populations.

The demand for care among Medi-Cal and uninsured populations exceeds supply. FQHCs and a small number

of other providers are disproportionately caring for these populations, especially in light of some health systems' limitations on Medi-Cal intake. Collaboration is needed to develop a shared strategy to ensure access to care for the region's low-income and uninsured residents.

This effort will require a large collaborative undertaking among government representatives, health plans, safety net providers and the region's health systems to:

- foster a shared understanding that being part of the Medi-Cal program, and partnering strategically to manage it, is more beneficial than remaining outside the system
- establish a collective vision of equitable health care access in the region
- identify key barriers to collaboration, including elucidating legitimate business concerns
- identify benefits from collaboration and fair collective actions
- determine how systems will change practices to ensure adequate access to care for Medi-Cal and uninsured populations in the region.

To this end, it will be important to start with data showing that Medi-Cal beneficiaries are a growing population group. Inasmuch as the current lack of infrastructure directs flows to hospitals, investing in infrastructure and better care coordination could lead to shorter and less expensive hospital stays.

Additionally, the region needs to directly address the barriers to care for those who remain uninsured, many of whom are undocumented and frequently have legal, social, linguistic and economic vulnerabilities in addition to health concerns. With systems already struggling with access challenges for the Medi-Cal insured, the remaining uninsured can often suffer from "crowd out" effects as clinics reach capacity. Other alternatives to care, such as volunteer specialists and free student-run clinics, are not viewed as long-term sustainable solutions.

D. Clarify the workforce ecosystem for the benefit of providers, health systems and communities.

A collaborative assessment of current workforce realities could benefit both small and large health systems, as well as the communities they serve.

One such reality is the dynamic between safety net clinics and larger health systems: medical and administrative staff members often flow from the former to the latter. Formalizing a version of this dynamic could prove beneficial to all entities. For example, stakeholders could discuss a potential "pipeline" model in which clinics are formally established as a training ground for primary care, specialty care and behavioral health staff, with the expectation that a good portion will move on to larger health systems. Key partners would include regional medical schools and other educational institutions. By formalizing clinics' role as a formative training ground, clinics and health systems might be able to mutually agree on ongoing strategic investments in arenas such as staff training, health information technology, data infrastructure and quality improvement best practices. As equal partners, clinics might be able to advocate for additional resources and infrastructure and to make strategic investments in provider recruitment and retention. Such a plan could mitigate clinic challenges in competing with large health systems and could alleviate their frustration by formalizing a constant flow of staff from regional medical schools.

Community focus groups conducted by Valley Vision revealed another potential win-win opportunity related to clearly articulating a safety net workforce ecosystem. Low-income community residents expressed interest in being able to work in the health sector for economic opportunity and job security. Clinics have an ongoing need for culturally competent staff in a wide range of roles. Bringing stakeholders together to identify ways to help interested individuals from low-income communities get the education and training necessary to work in clinics could result in mutual benefits for clinics and communities.

Finally, further discussions about the workforce ecosystem could reveal opportunities to integrate whole-person care strategies across sectors and to ensure culturally competent care that meets patient, payer and health system needs. For example, scarce resources could be extended by providing basic care management training to emergency service workers, who frequently engage with individuals in need. Another opportunity could include more robust use of community health workers to address patient navigation needs within the health system and to connect patients with other community resources, such as housing, food or enrollment in public programs, while fulfilling the community's desire to see members represented in the health care workforce.

E. Address the unmet need for mental health and substance abuse services.

There is a substantial need for better access to and integration of behavioral health care services. Regional efforts are emerging to create a regulatory framework for behavioral health and to identify funding streams. This presents an opportunity for health plans, hospitals and the counties (Sacramento in particular) to work together to envision and create a health system that integrates behavioral health. Importantly, interviewees recognized that stakeholders may have different solutions. Collaboration is needed to weigh the strengths and weaknesses of each proposition and identify win-win solutions.

Working together, stakeholders can identify, build on and scale up behavioral health care and primary health care integration efforts that hold promise for the region.

Existing efforts include universal depression screening and partnerships to integrate mental and physical health, such as “reverse integration” of placing primary care clinics inside mental health facilities.

There are four state policy opportunities that could be considered by counties in the region to expand care opportunities for Medi-Cal populations, with particular benefit for individuals struggling with mental health and substance use:

- The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver is an opt-in waiver available to counties. It promotes and supports access to a broad range of care models for substance use disorder treatment services that also coordinate with other systems of care.²⁴
- The Whole Person Care (WPC) Pilot aims for the coordination of health, behavioral health and social services to care for particularly vulnerable, high-utilizing Medi-Cal beneficiaries. In October 2016, DHCS announced that the state is inviting a second round of applications for Whole Person Care pilots, an opportunity to which Sacramento region counties could respond by the March 1, 2017, deadline.²⁵
- SB147 (Hernandez) creates an opportunity for FQHCs to adopt an alternative payment methodology that would maintain the same level of per member revenue, while allowing increased flexibility to use a wider range of health home team members and implement non-traditional encounters to increase access to patient-centered care.²⁶
- Health Homes for Patients with Chronic Conditions (anticipated to start 2017 in Yolo County and 2018 in Sacramento County) will provide health plans with additional care management and care coordination funds for Medi-Cal beneficiaries with serious mental

24 California Department of Health Care Services (DHCS). “Drug Medi-Cal Organized Delivery System” <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>

25 California Department of Health Care Services (DHCS). “Whole Person Care Pilots” <http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>

26 Senate Bill No. 147. SB-147, Hernandez. Federally qualified health centers. (2015-2016). http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB147

illness and for select high-risk individuals with multiple chronic conditions.²⁷

These opportunities have the potential to bring significant funds to improve behavioral health care services. Determining how the region can best respond to such opportunities will require collaboration and planning.

F. Collaborate around community health needs assessment process.

While the new federal administration creates many uncertainties in health policy, at the time of this writing, multiple organizations conduct community health needs assessments as part of their funding requirements. Greater coordination between these efforts could extend resources, enhance efficiency and enable community-wide prioritization. To facilitate the process, efforts could be made to synchronize the regulations and data collection cycles.

G. Broaden the vision of health. Bring in non-health providers/services to collaborate with health around whole-person care.

In the California 1115 Waiver, the aim of whole-person care is defined as “the integration of systems that provide physical health, behavioral health, and social services to improve members’ overall health and wellbeing, with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.”²⁸ Indeed, coordinated efforts to address social determinants of health are needed to move the region toward being more healthy and equitable. With the broad understanding that health is more than health care, the Sacramento region would benefit from increased collaboration between sectors that enables continuity of care as individuals move between systems (e.g., jail and community; hospital and home; substance use treatment and primary care), better follow-up and strengthened linkages to social services. Moving toward whole-person care will likely require a “health in all policies” approach and the creation of infrastructure that

connects those receiving medical care to organizations that provide social services. Opportunities for whole person care identified in other research include the removal of silos in financing, as well as potential re-organization at the county level to better coordinate services.

Whole person care will also likely entail bringing together sectors that have not traditionally collaborated. Creating multidisciplinary, multisector teams could help address barriers and promote cross-cutting solutions. Participants might include health care representatives overseeing community benefit funding; medical staff and non-health providers (e.g., probation officers) who work on the ground with special populations, and staff from social service agencies (including housing), county government and local industries. Such multidisciplinary teams might benefit from coming together to identify new strategies for special populations frequently cited in interviews, such as the homeless or the criminal justice populations, who need services and support that have not traditionally been reimbursable.

Finally, a new Federal Managed Care Medicaid rule finalized in mid-2016 could serve as the impetus to explore new opportunities for creative care solutions with health plans in the region. For example, the new rule expands the definition of care coordination to include coordination with entities outside of managed care, including social services; puts in place both time and distance standards to define “network adequacy”; expands “improving quality” to include improving health disparities starting in 2018; and codifies a policy that states can allow plans to cover services “in lieu of” services in the state plan, as long as they are “medically appropriate and cost-effective.” Many have pointed to this change opening the door for plans to cover short stays (less than 15 days per month) for inpatient services for substance use disorder or psychiatric care.²⁹

27 California Department of Health Care Services (DHCS). “Health Home for Patients with Complex Needs (HHPN)” <http://www.dhcs.ca.gov/services/Pages/HealthHome>

28 Williams, Norman (DHCS). “CMS Approves Medi-Cal 1115 Waiver Renewal.” Message to DHCS Stakeholders. 30 Dec. 2015. E-mail.

29 Musumeci, MaryBeth and Paradise, Julia. “CMS’s Final Rule on Medicaid Managed Care: A Summary of Major Provisions.” The Henry J. Kaiser Family Foundation. Issue Brief. 09 June 2016. <http://kff.org/report-section/cmss-final-rule-on-medicare-managed-care-issue-brief>

CONCLUSION

California's policy environment and the Affordable Care Act set in motion a period of significant transformation in Medi-Cal over the last four years. Indeed, since 2012, El Dorado, Sacramento, Placer and Yolo counties have experienced marked progress in coverage expansion and increases in primary care access. At the same time, significant strategic and implementation challenges involving primary care, behavioral health, specialty care and coordination with social services will require new levels of collaboration across all of the region's payers, health systems, providers and communities before the Sacramento region can realize the vision of achieving improved access to care and ultimately health for all residents. Indeed, as we stand at the beginning of 2017, the coming years will represent an even more critical time than ever for the Sacramento region to harness collective action to achieve tangible health and equity outcomes for all residents.



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