Clinic Design
from The Center for Health Design

Transforming Primary Care Environments Through Evidence-Based Design

The Future of California Healthcare: Life in the Gap, Life in the Game

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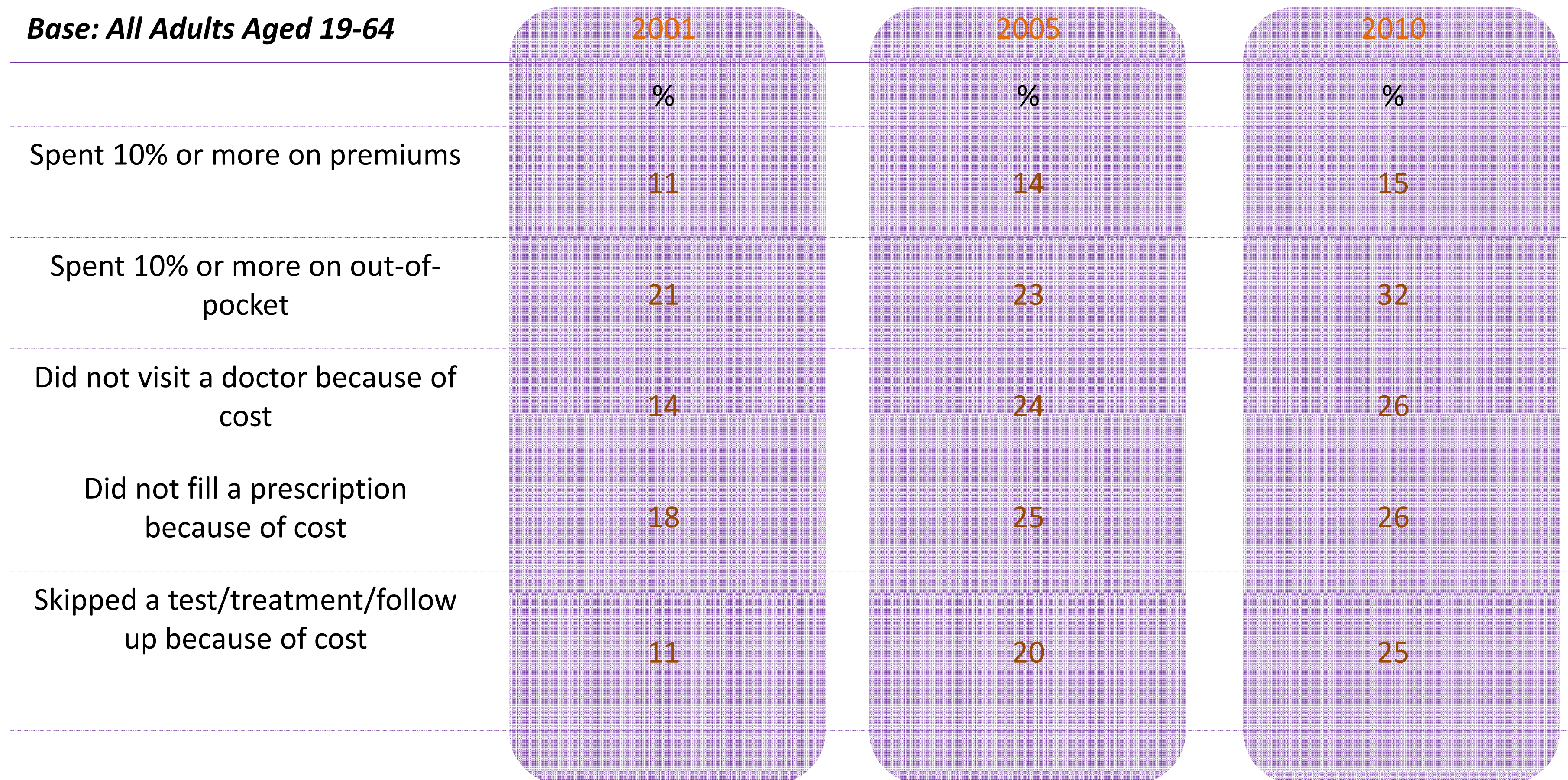
Key Driving Forces

Political and Economic Context

- Economic Meltdown has increased uninsured and underinsured
- In Search of the Next Economy
- Huge pressure on federal, state and local revenues and thus budgets
- Community Clinics: Loved by left and right for different reasons
- Political Update
    - Federal
    - State

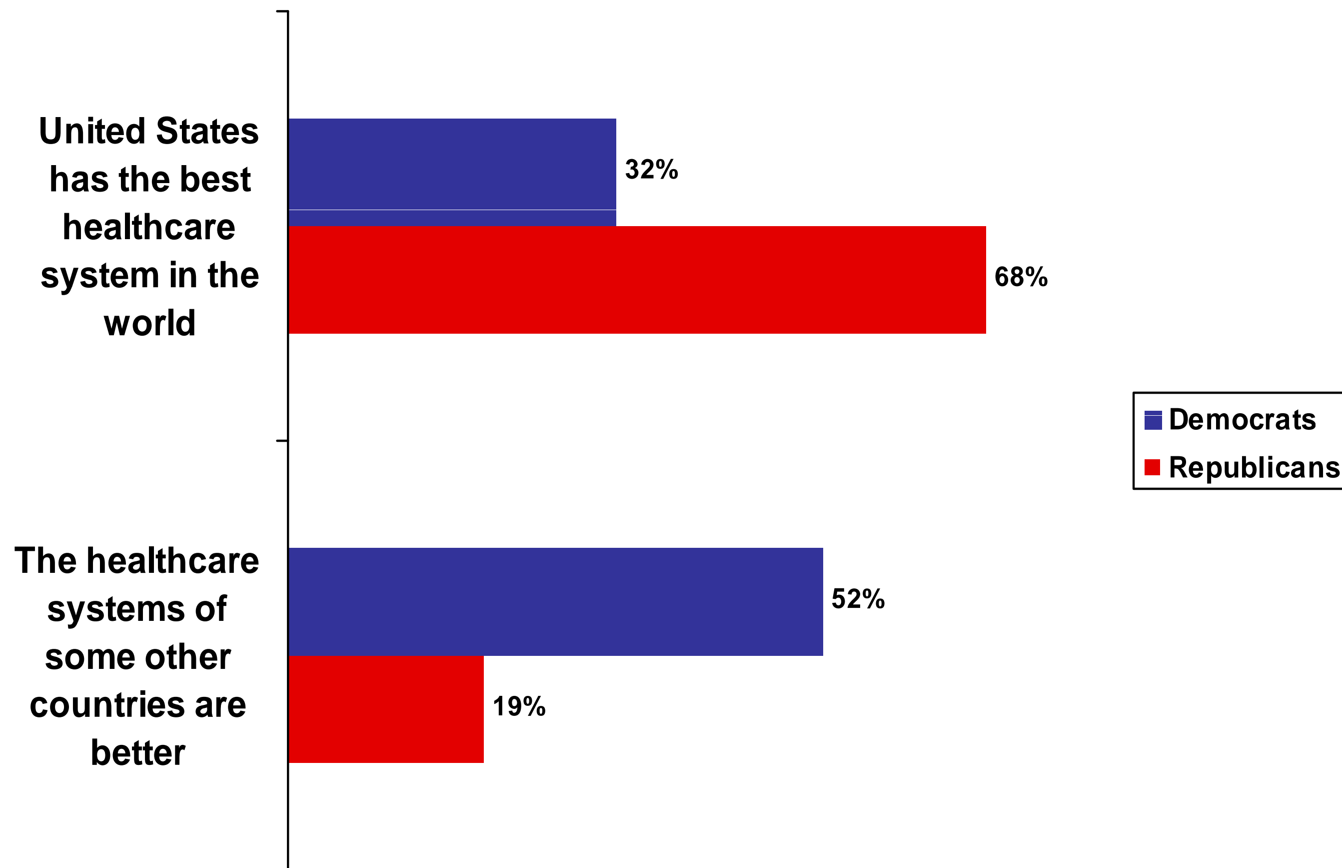
Health Insurance Coverage Has Become Worse Since 2001… By How Much?



Base: All Adults Aged 19-64	2001	2005	2010
	%	%	%
Spent 10% or more on premiums	11	14	15
Spent 10% or more on out-of-pocket	21	23	32
Did not visit a doctor because of cost	14	24	26
Did not fill a prescription because of cost	18	25	26
Skipped a test/treatment/follow up because of cost	11	20	25

SOURCE: Commonwealth Fund Health Insurance Survey

Republican and Democratic Attitudes about Who Has the Best Health Care System



Debating Health: Election 2008, Harvard School of Public Health/Harris Interactive. March 5-8, 2008

Politics Of Health Reform

- Country continues to remain divided on the Obama health reform
- Huge divisions in views by voters in each party
- Budget battles in new Congress will reduce the scale of implementation of the legislation
- 2012 election will resolve future of the law and its implementation
- Medicare reform will await the next election results before any action taken
- A number of wildcards may affect the future here

What Should Congress Do with New Health Care Law

By Actual Vote for Congress

	Total voters	Voters for Democrats	Voters for Republicans
Expand it	31%	59%	8%
Leave it as is	16%	24%	9%
Repeal it	48%	12%	78%
No answer	5%	5%	5%

SOURCE: 2010 Exit Polls

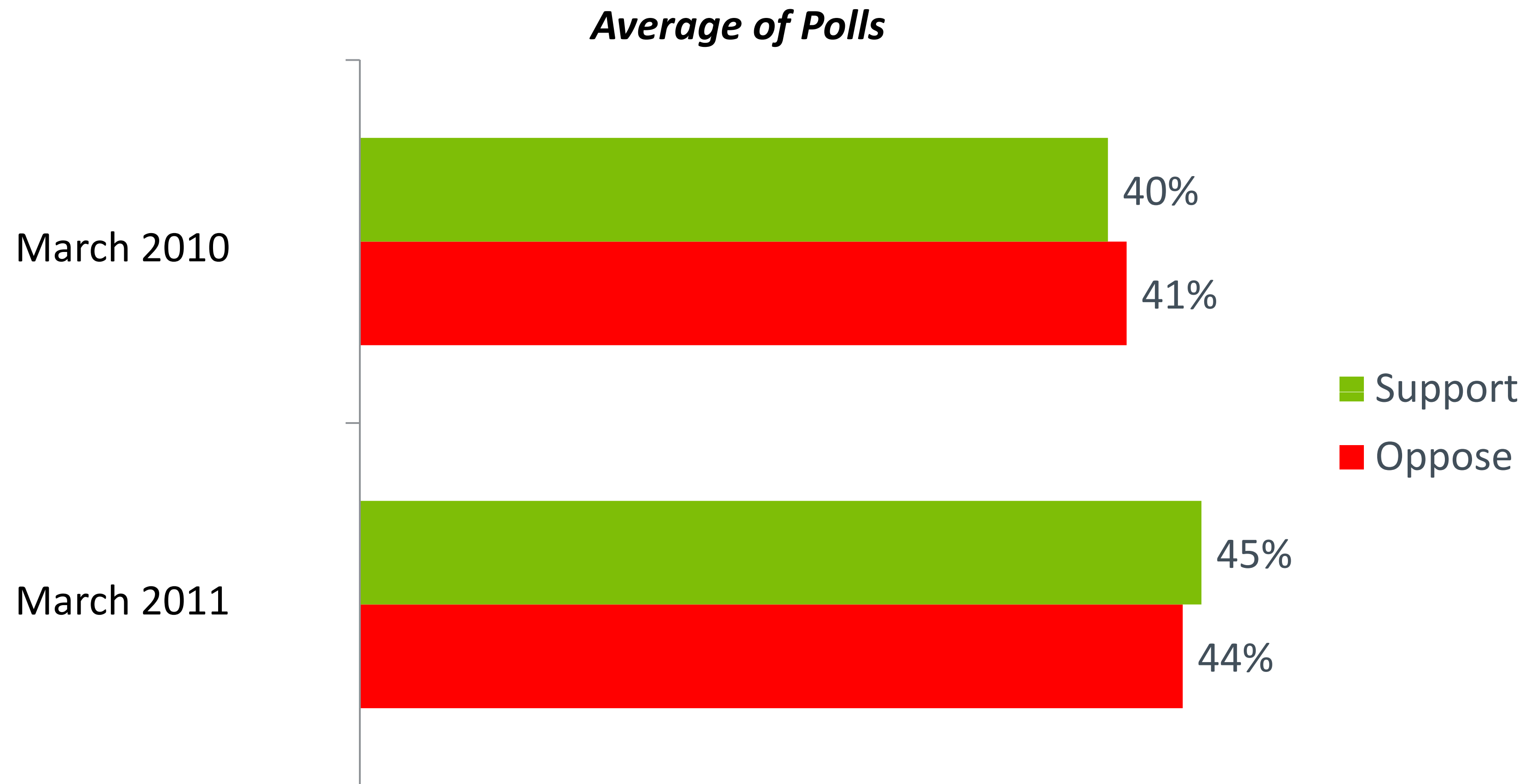
Voter Turnout in National Elections

SOURCE: Center for the Study of the American Electorate (2010)

Future Between Now and 2012 Election

- Continuing major conflicts over bill
- Serious debate but little action on Medicare reform
- Planned expenditures for enforcement, planning, technical assistance to states, comparative effectiveness, research, innovation grants, new public health initiatives will be reduced substantially in 2012 budget
- Continuing investigations of Administration's implementation efforts/few senior health appointments confirmed
- Democratic state governors will start planning for implementation / Republican governors will proceed slowly (the exception exchanges)

Approval of Health Care Bill



SOURCE: March 2010 average Associated Press, CBS News/New York Times, Kaiser Family Foundation and Pew polls. March 2011 average Gallup and Kaiser Family Foundation polls.

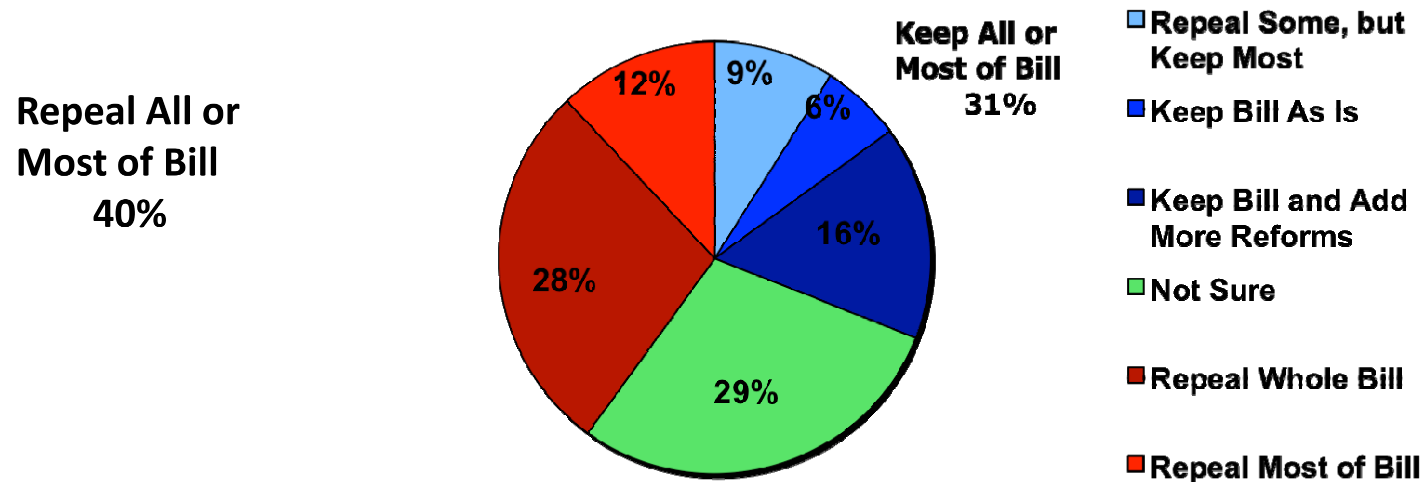
Post-Election Public Views About the New Health Care Law

	Republicans	Democrats	Difference – Republican minus Democrat
Approve	12%	62%	-50
Disapprove	77%	28%	+49

"Don't know" responses not shown.

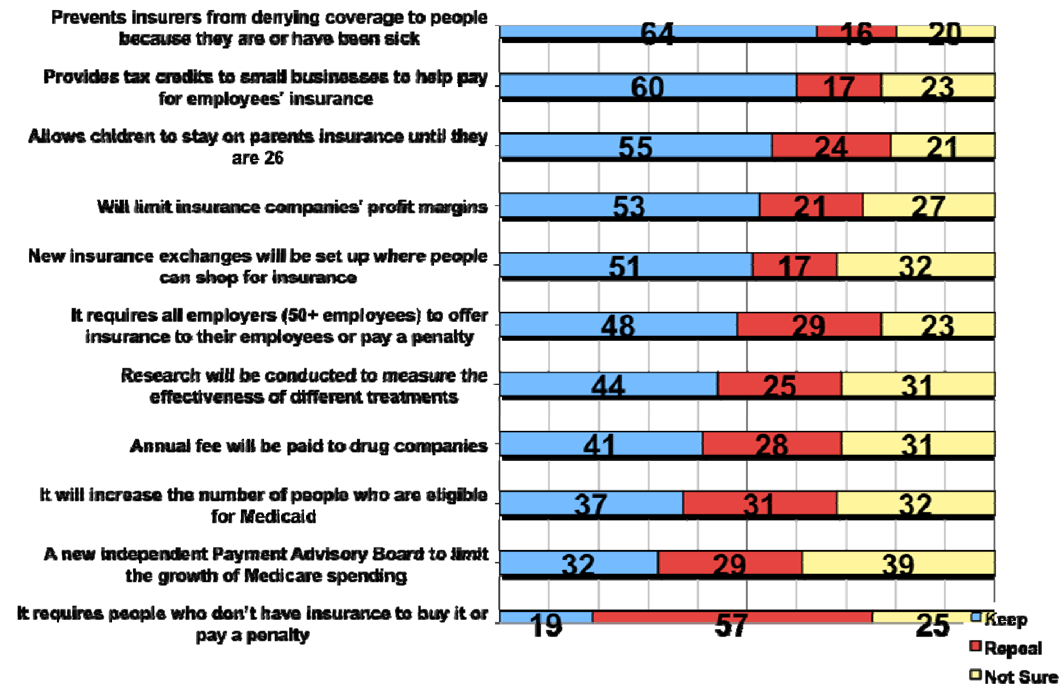
SOURCE: CBS News, February 11-14, 2011.

Public Split on Repealing Health Care Reform Bill



Base: All Adults
Source: Harris/Health Daily Poll, November 2010

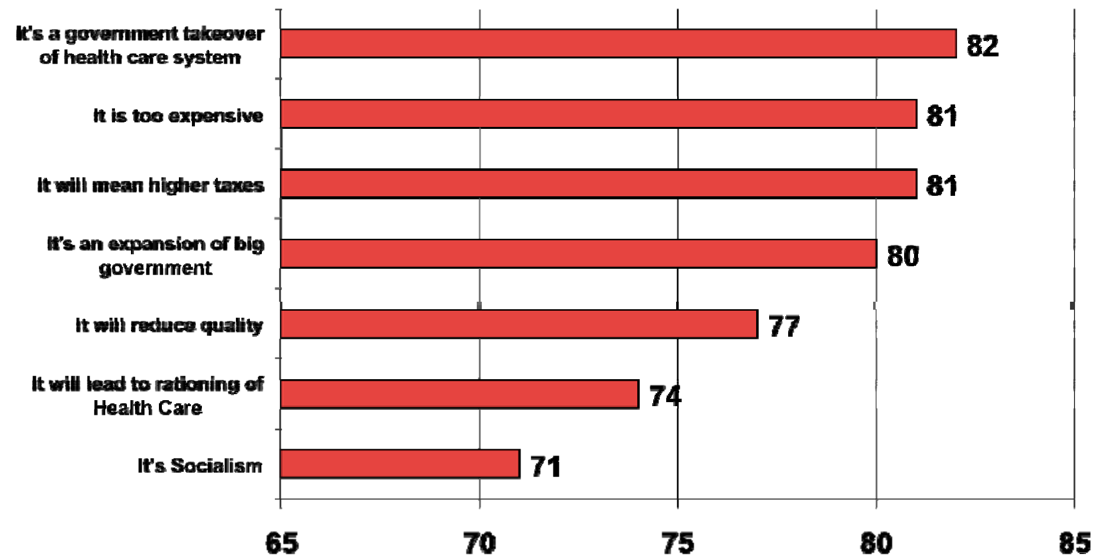
Majorities /Pluralities of Public Want to Keep Many Parts of Bill (Including many who want to repeal it)



Source: Harris/HealthDay Poll, November 2010

Opposition is to the Caricature of the Law not to the Content

Reasons Why People Want to Repeal Bill (Among those who want to repeal it)



Percent

Base: Those who want to Repeal All or Some of Bill
Source: Harris/HealthDay Poll, November 2010

Key Driving Forces

Health Reform

- Massive Expansion in coverage in 2014
  - Half through Medicaid 2-3 million
  - Half through Insurance exchanges 2-3 million
- Health Insurance Exchanges: Safety Net Providers granted most favored nations status
- Medicaid Waiver: “ A Footbridge to the Future”
- DSH disappears over time
- ACOs and Medical Homes in Medicaid and Medicare
- Substantial Private Sector re-alignment to prepare for Health Reform
  - Medicaid ACO Pilots
  - Private Equity into Medicaid Only Commercial Plans
  - Kaiser’s approach to Medicaid still undecided

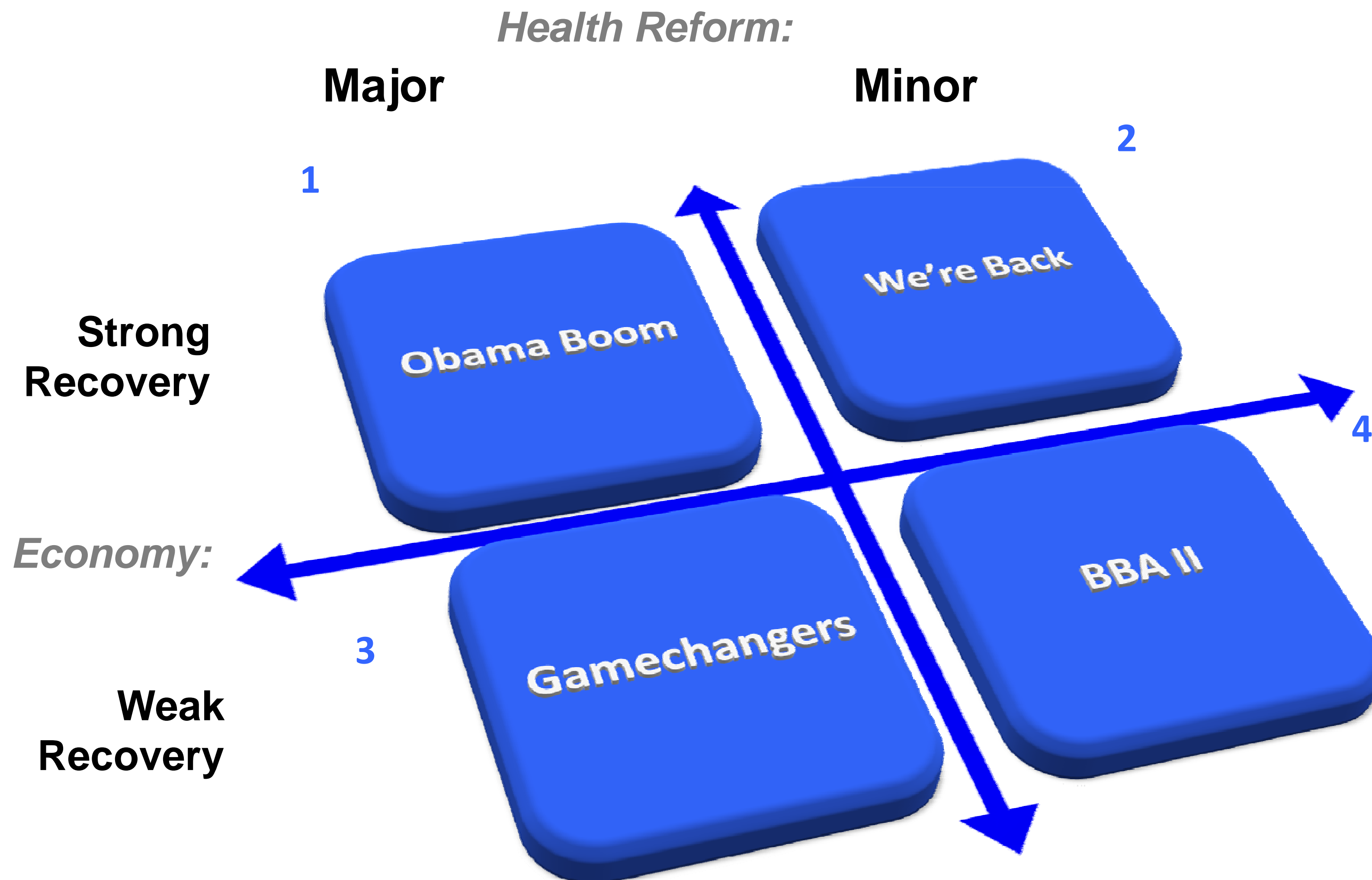
Healthcare Reform: The Basic Problem

- The Average family cannot afford the Average Premium
- There are not enough Rich People to go around (The 98/2 Problem)
- It's the Delivery System Stupid!
- We don't want less than what we have now, we want more
- Nobody wants to take a pay cut or to be denied even ineffective care

Obama Care: The Simple Version

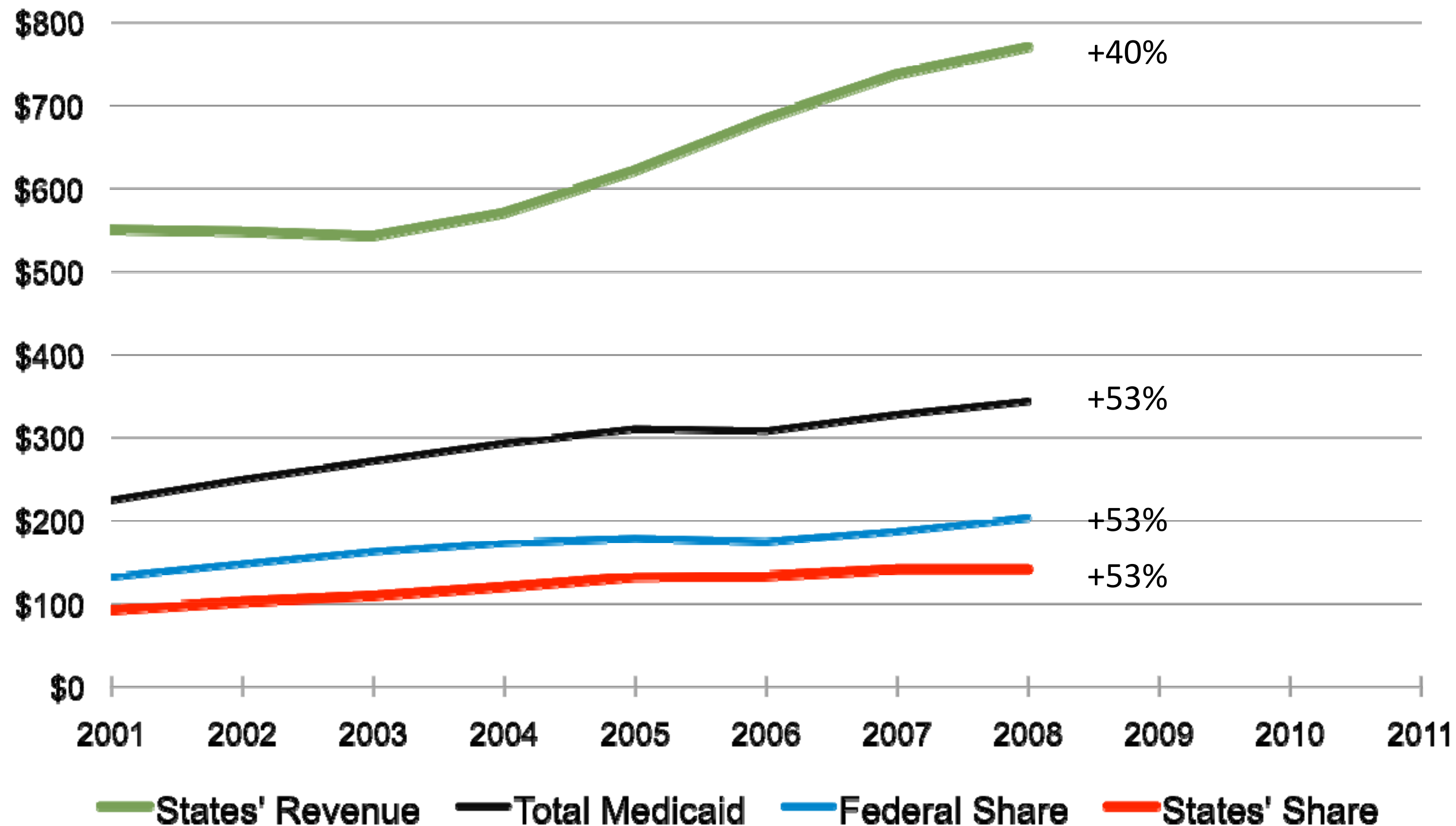
- Coverage Expansion to 32 million people in 2014
  - 16 million through Medicaid Expansion
  - 16 million through subsidized health insurance exchanges
- Regulation of health insurance practices
  - Guaranteed issuance
  - Individual Mandate
- Paid for by supplementary Medicare Tax on $250K+ earners and “voluntary” taxes on healthcare stakeholders
- Promising pilots and processes for reimbursement reform
  - Patient Centered Medical Homes
  - Accountable Care Organizations
  - Innovation Center at CMS

Four Scenarios for US Healthcare
2010-2015



States’ Tax Revenue and Medicaid Spending

2001-2008 (in billions)



Sources: Medicaid spending from CMS; Revenue data from Census Bureau

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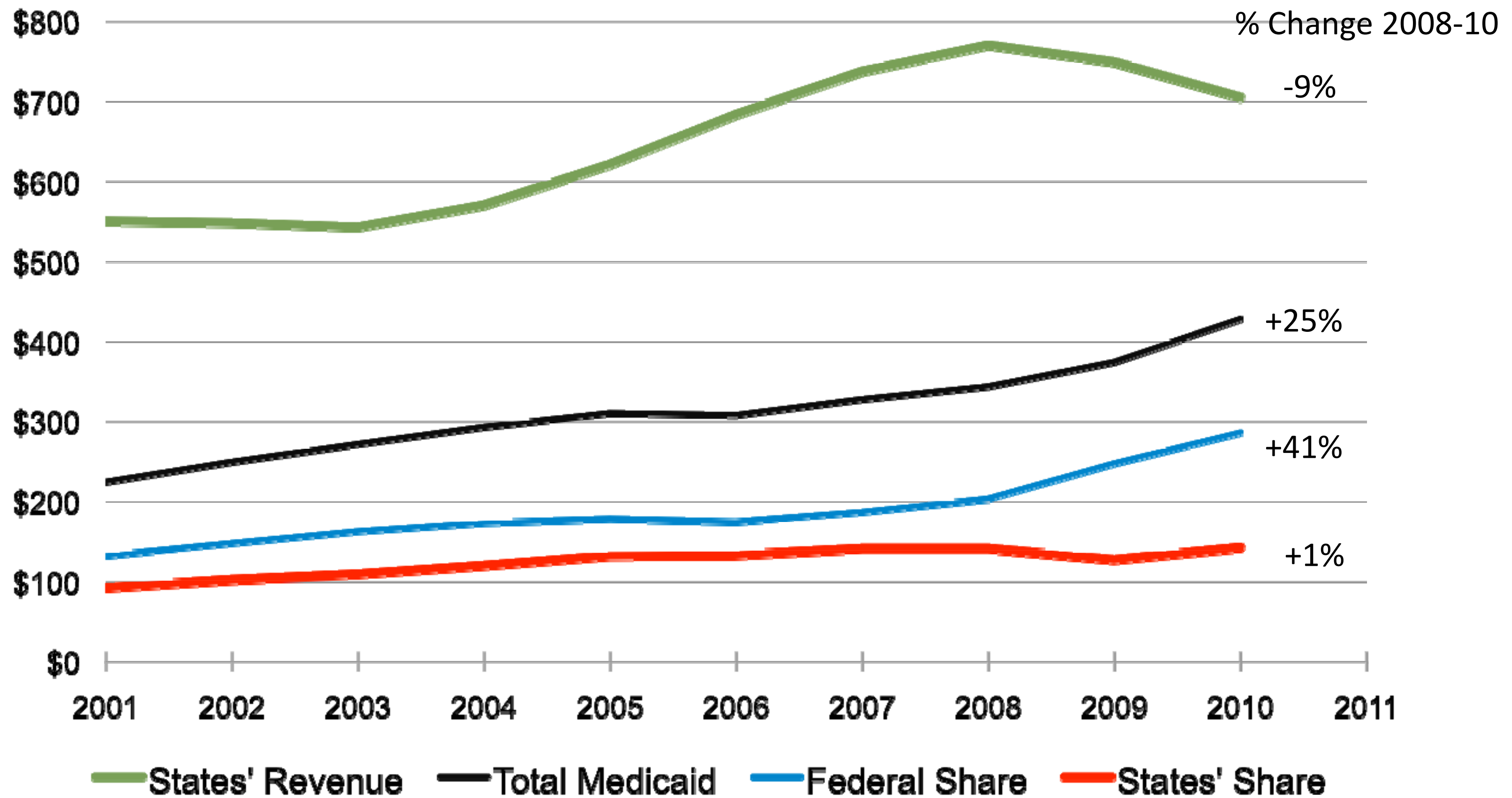

Sources: Medicaid spending from CMS; Revenue data from Census Bureau

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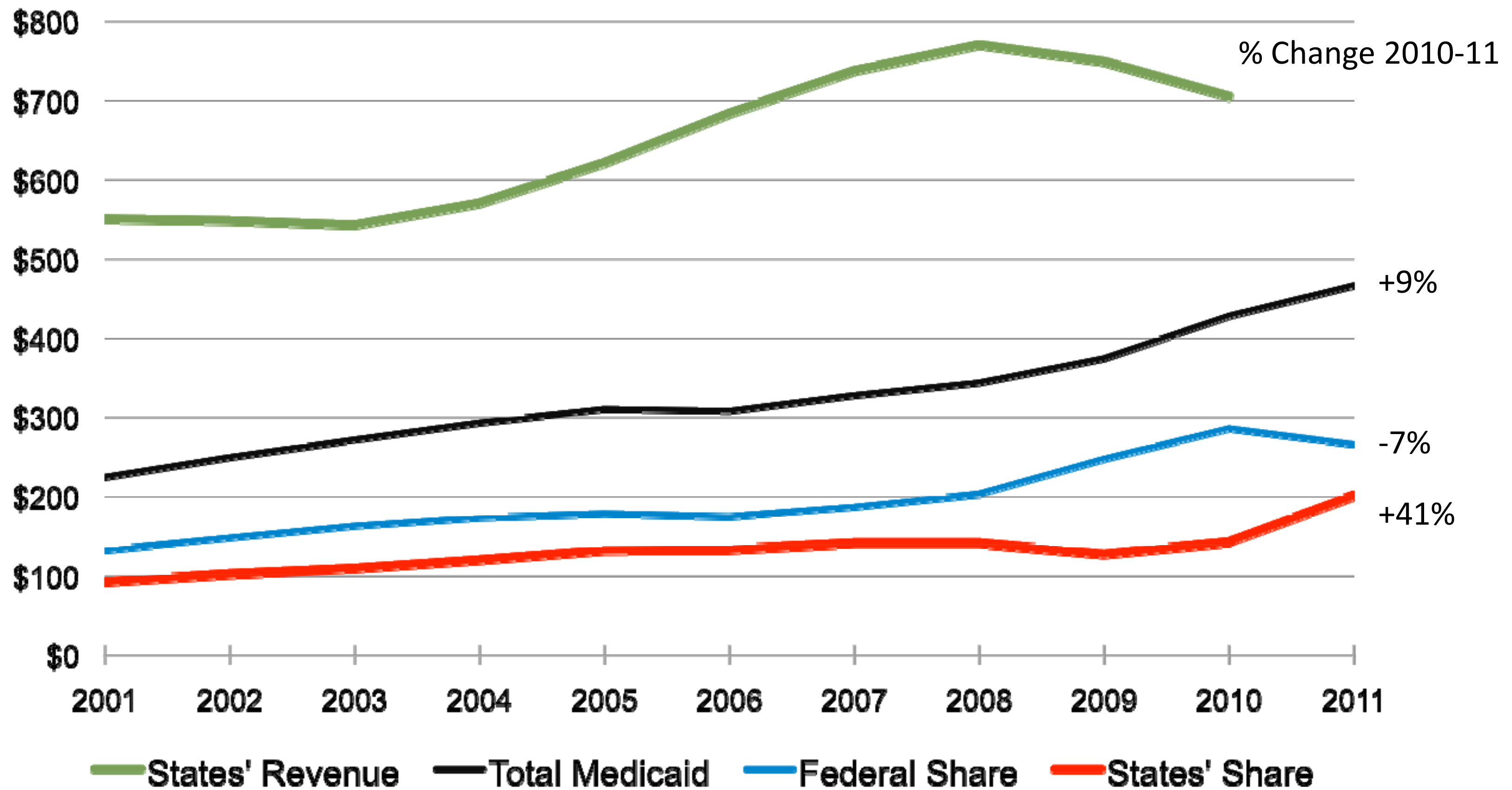
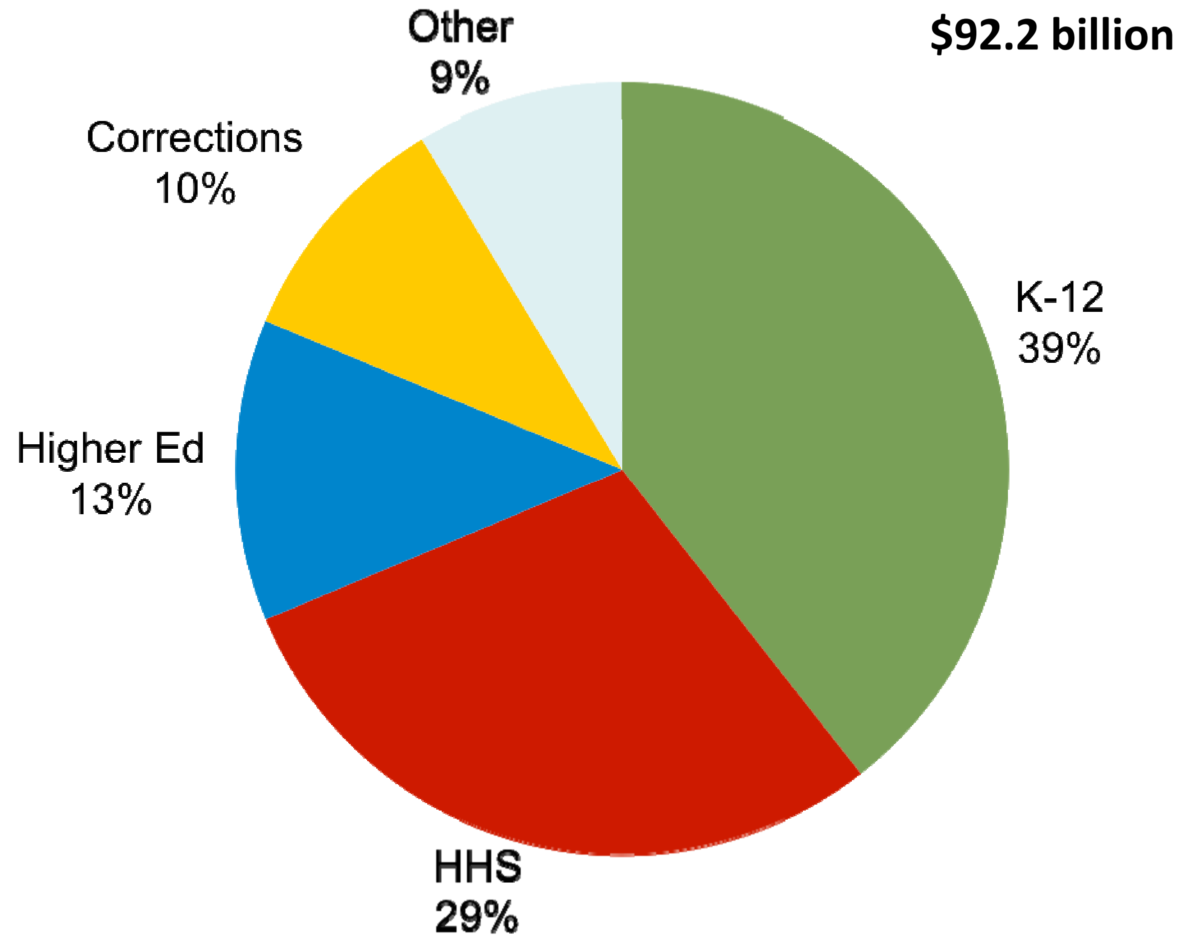


Sources: Medicaid spending from CMS; Revenue data from Census Bureau

California: General Fund Expenditures 2010-11



Insurance Exchanges

- Great Variation Across the 4 Americas
  - Active Implementers
  - Passive Aggressive Implementers
  - Put on Hold
  - Send Back
- High Cost Sharing No Matter What
- What Type of Exchange? And How Big?
  - Large Activist (California) or a Website (Utah)
  - Nobody comes to the Party versus The Exchange that Ate Manhattan
- If Activist, to do what?:
  - Just get more covered
  - Value based Purchasing to Encourage Delivery Reform (e.g. ACOs)
  - Support Robust Private Market for Health Insurance
  - Recreate Managed Competition for Small Group
  - Blend Medicaid and Exchange Business for the Low Income Consumer
  - Support the Safety Net Delivery System
  - As the Final Exit for Business

Life in The Gap: From 2010-2014

- Coverage relief is on the way, but the immediate effects are minimal.
- Commercial premiums will likely continue to increase substantially
- Employers continue to cost share
- Large Employers will see cost shift
- Small businesses and individuals will continue to be priced out, even with small tax credits
- Number of uninsured may rise substantially from 2010 to 2014 when COBRA and Medicaid subsidies from stimulus bill run out
- Continuing state budget crises hurt Medicaid
- Can states prepare for 2014?
- Help is on the way but will it arrive soon enough?

Life in the Game: 2014 and Beyond…

- Massive expansion in coverage means increased demand for services.
- Will newly covered have access? Who will take 16 million new Medicaid patients?
- Providers are bracing for Medicare and Medicaid rate cuts
- Will there be massive cost shifting to large employers?
- Will incumbent insurers win new business in the exchanges or will disruptive innovators?
- Can the payment reform initiatives be ramped up fast enough to bend the curve in the longer run? Do pilots ever take off?
- Will budget deficit forecasts continue to deteriorate, to the point where Obamacare will be unsustainable?
- Cost containment and reimbursement reform for 2014 and beyond.

Clear Winners Under Reform

- **Low-Income people** especially those who are currently uninsured or have pre-existing conditions
- People with **chronic conditions** or pre-existing conditions especially in the individual insurance market
- **Small businesses** who were considering health insurance but couldn't quite afford it
- **Worried parents** who wanted to keep twenty somethings on coverage
- **Primary Care** Physicians, nurse practitioners and physician assistants
- Any physicians or providers with significant share of uncompensated care
- **Bio-Pharmaceutical** companies
- **Elderly** not in Medicare Advantage plans
- **Self-insured employers**

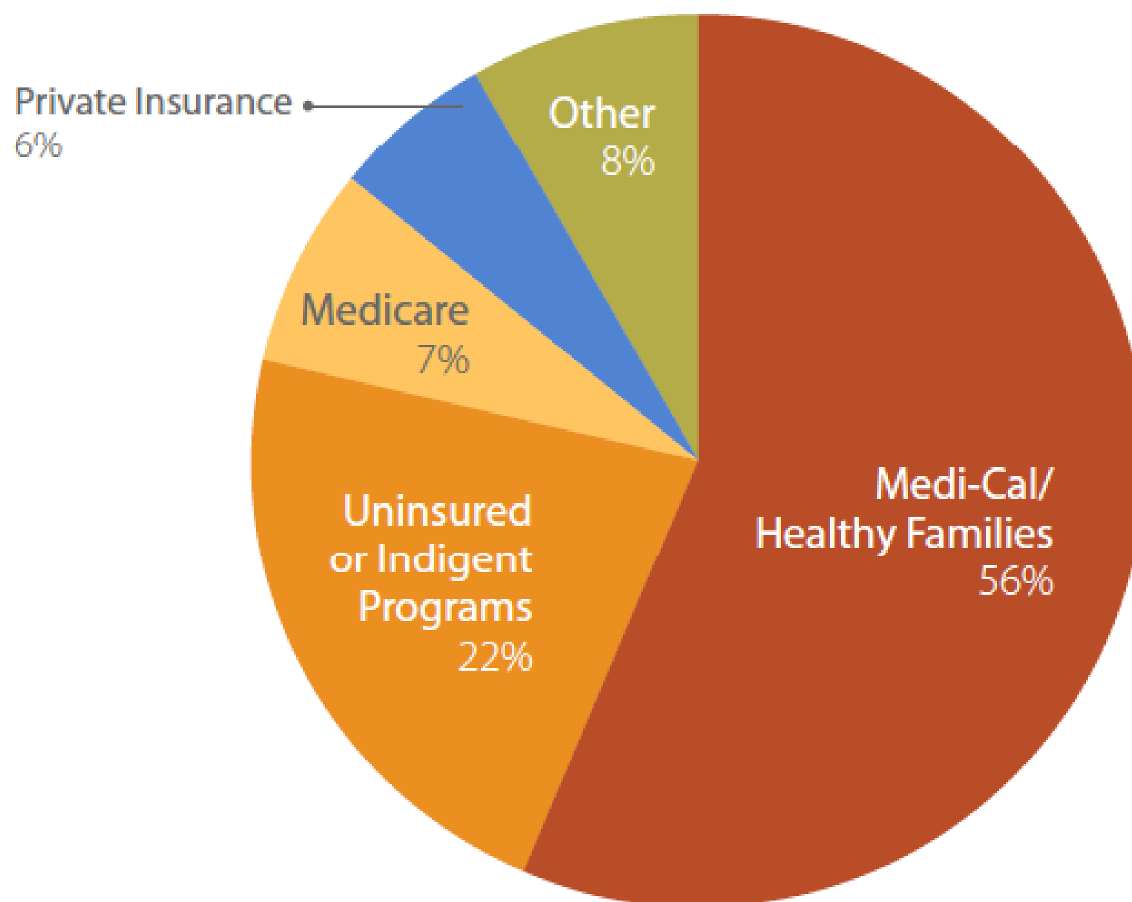
Clear Losers Under Reform

- **Tanning Salons**
- **Health Insurers**, especially executives (although they get 32 million new customers for a business that had zero source of growth)
- **Rich people** earning over a quarter million dollars a year especially from investment income (means one less Safari a year)
- **Insurance brokers** who don't add value
- **Specialists** who don't see poor people
- **30 plus youngsters** "who don't need insurance"
- **Medical Device Manufacturers**, who have hidden from view until now
- **Seniors on Medicare Advantage** who were bribed to go private
- **Hospitals with open doors** who may be overwhelmed by volume of new patients paying below costs of service
- **States who did not want to expand coverage** to low income people

The Safety Net Conundrum

- Some providers (such as community clinics)care exclusively for Safety Net populations
- But non-Safety Net providers provide a significant proportion of services to the Safety Net population (e.g. non-profit hospitals and community-based physicians)

Primary Care Community Clinic Visits,
by Payer, 2008



Community clinics are an important source of care for safety-net patients. More than half of clinic visits were made by Medi-Cal and Healthy Families enrollees and 22 percent by uninsured or county indigent patients.

Notes: Medi-Cal episodic care programs—BCCCP, CHDP, and Family PACT—are included in Medi-Cal total. Uninsured and indigent coverage are combined due to data reporting inconsistencies, but includes self-pay/sliding scale, free, and county indigent program patients. However, they play an important role in providing care to the uninsured; 18 out of 24 counties that run their own medically indigent programs rely on county clinics to provide services to indigent patients. Of these, more than half rely exclusively on their county clinics. The remaining counties rely on their own clinics and contract with select community clinics. May not total 100 percent due to rounding.

Sources: Blue Sky Consulting Group analysis of 2008 Office of Statewide Health Planning and Development (OSHPD) Primary Clinic Annual Utilization Data from California HealthCare Foundation, *Financial Profile of California Community Clinics*, March 2010 and *County Programs for the Medically Indigent in California*, September 2009.

Note: County-run clinics do no report data to the state with the other community clinics, and so are not included in the data presented.

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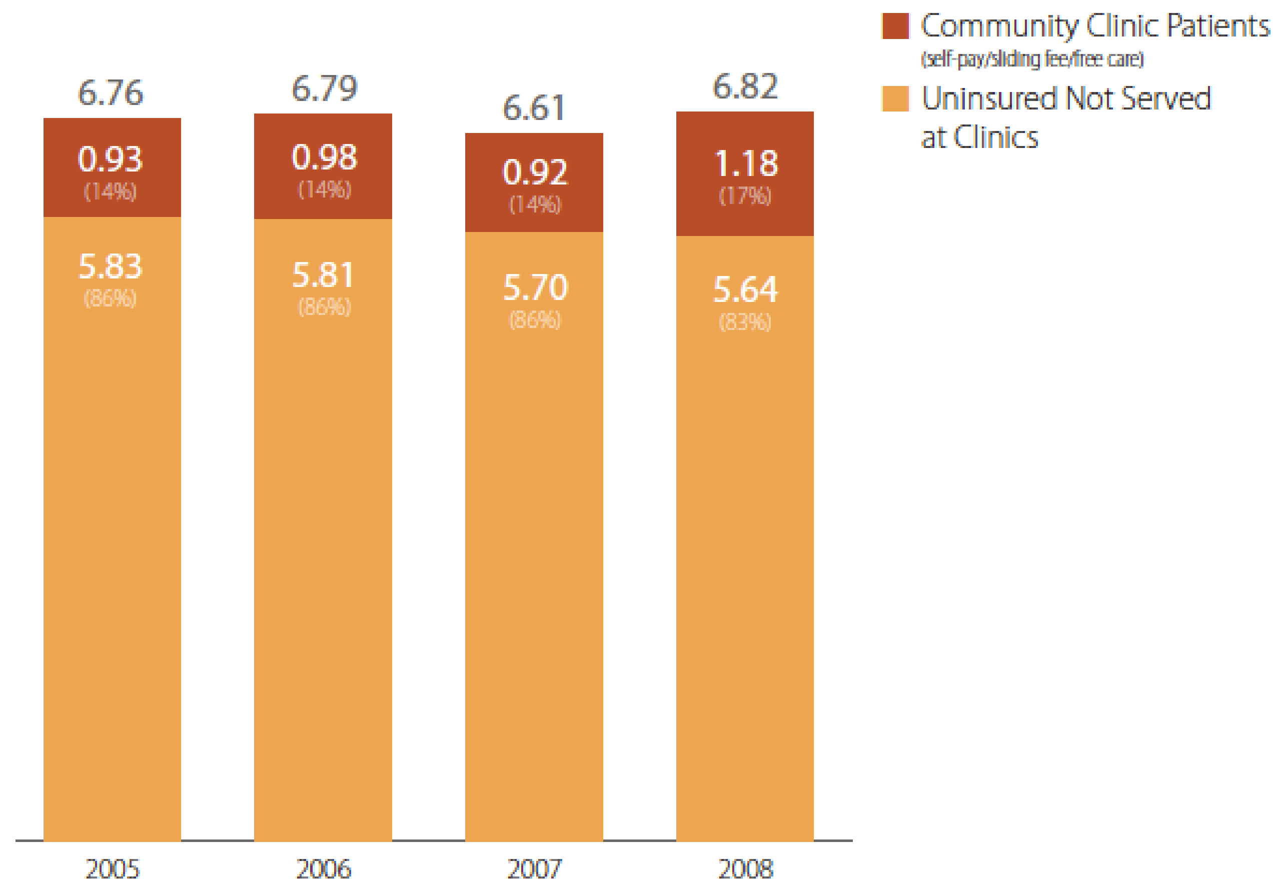
Uninsured Californians Served by Clinics,
2005–2008

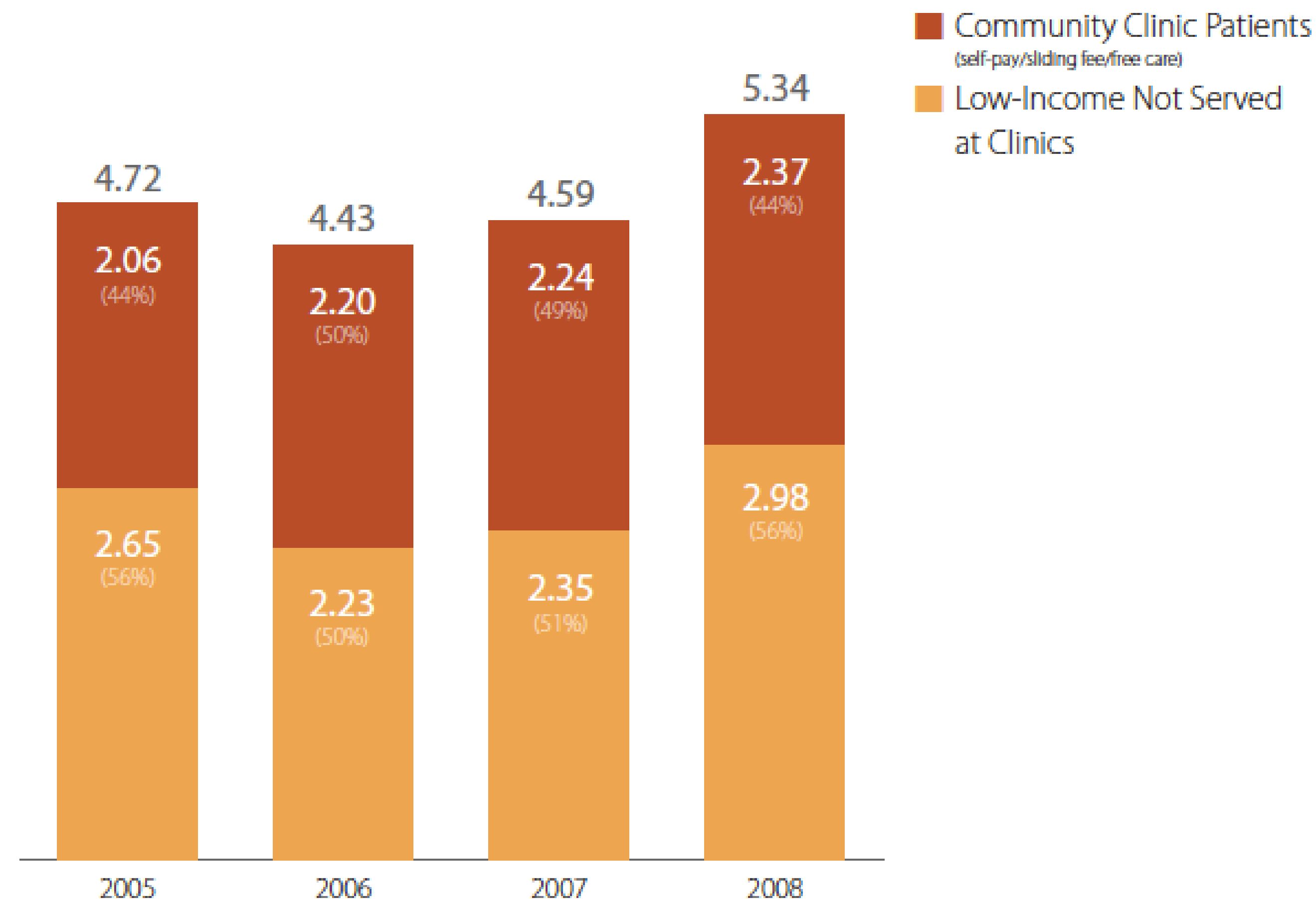
IN MILLIONS



Note: Segments may not add to totals due to rounding.
Source: Capital Link, *California Community Clinics — A Financial Profile*, 2010.

California's uninsured population grew less than 1 percent from 2005 to 2008, but the proportion served in clinics increased 27 percent. In 2008, clinics treated 17 percent of uninsured people, which means that 83 percent were not served in a clinic.

Low-Income Californians Served by Clinics,
Patients Below 100 Percent of FPL, 2005–2008



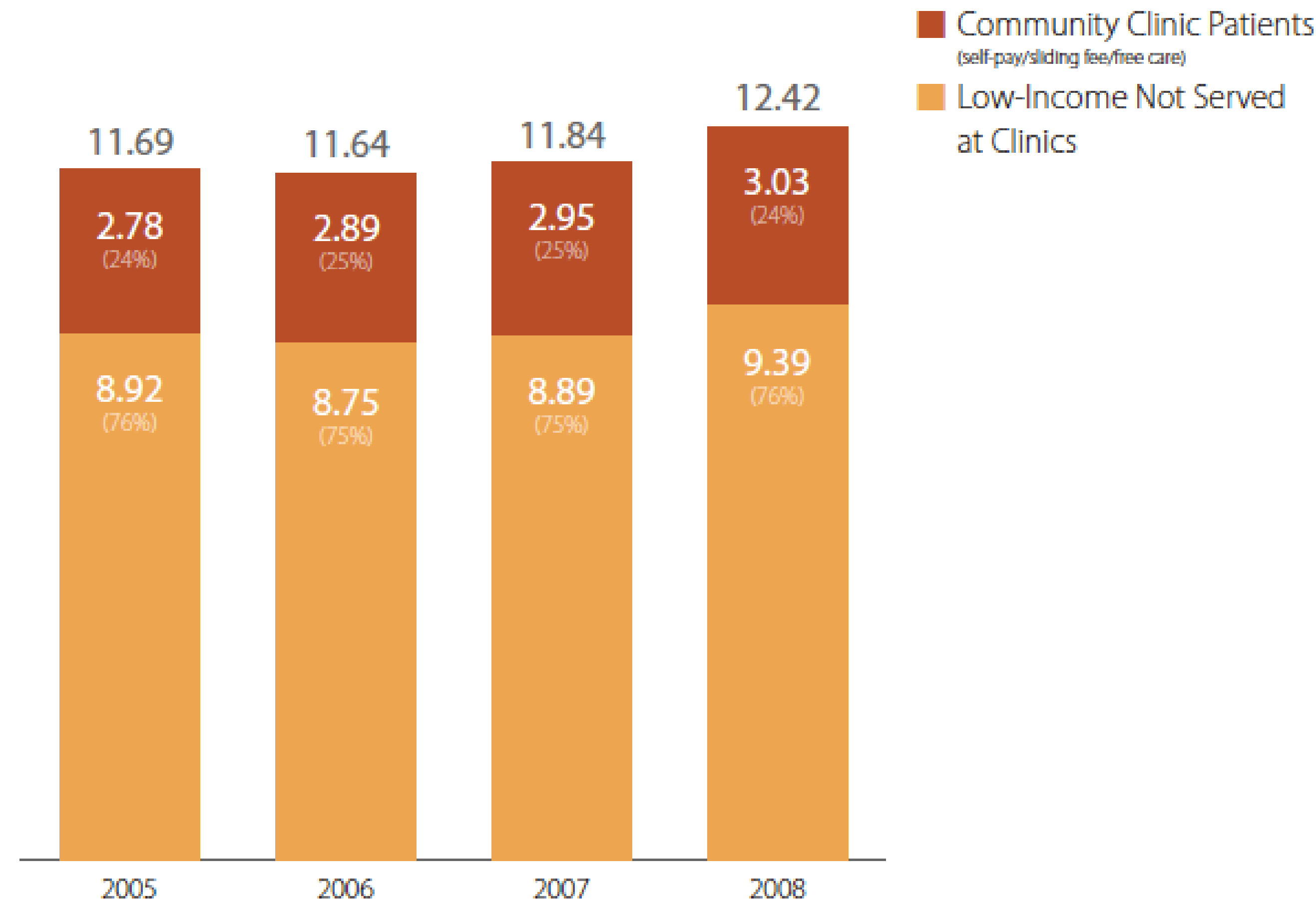
Notes: FPL stands for federal poverty level. Segments may not add to totals due to rounding.

Sources: Capital Link, *California Community Clinics—A Financial Profile*, 2010. U.S. Census Bureau, California Population Census, *Current Population Survey's Annual Social and Economic Supplement*, www.census.gov.

The number of Californians living below 100 percent of FPL grew 13 percent from 2005 to 2008, and, on average, almost half of those individuals used a clinic for primary care. During that period, the number of low-income individuals treated in clinics rose by nearly 15 percent.

Low-Income Californians Served by Clinics,
Patients Below 200 Percent of FPL, 2005–2008

IN MILLIONS



Nearly one-fourth of Californians living below 200 percent of FPL were treated at clinics in 2008, while three-fourths were not. Between 2005 and 2008, the total population of Californians under 200 percent of FPL grew 6 percent while the number of those treated by clinics rose 9 percent.

Notes: FPL stands for federal poverty level. Segments may not add to totals due to rounding.

Sources: Capital Link, *California Community Clinics—A Financial Profile*, 2010. U.S. Census Bureau, California Population Census, *Current Population Survey's Annual Social and Economic Supplement*, www.census.gov.

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Key Driving Forces

Broader Healthcare Market Context

- Significant horizontal and vertical consolidation
  - Hospitals consolidating regionally
  - Physician groups consolidating and new physicians joining groups
  - Hospitals and medical groups running towards each other to consolidate through fear and frustration as well as opportunity
- Broader risk envelope for providers who are being made more accountable across the continuum of care and over time for overall performance, errors, and readmissions
- Ubiquitous and non-negotiable measurement, public reporting and (hopefully) management of cost and quality
- Cost pressures to “make money on Medicare” as key to long term survival
- Strong interest but significant apprehension about ACOs
- Willingness to pilot and experiment for fear of missing the future

Key Driving Forces
Safety Net Competitiveness

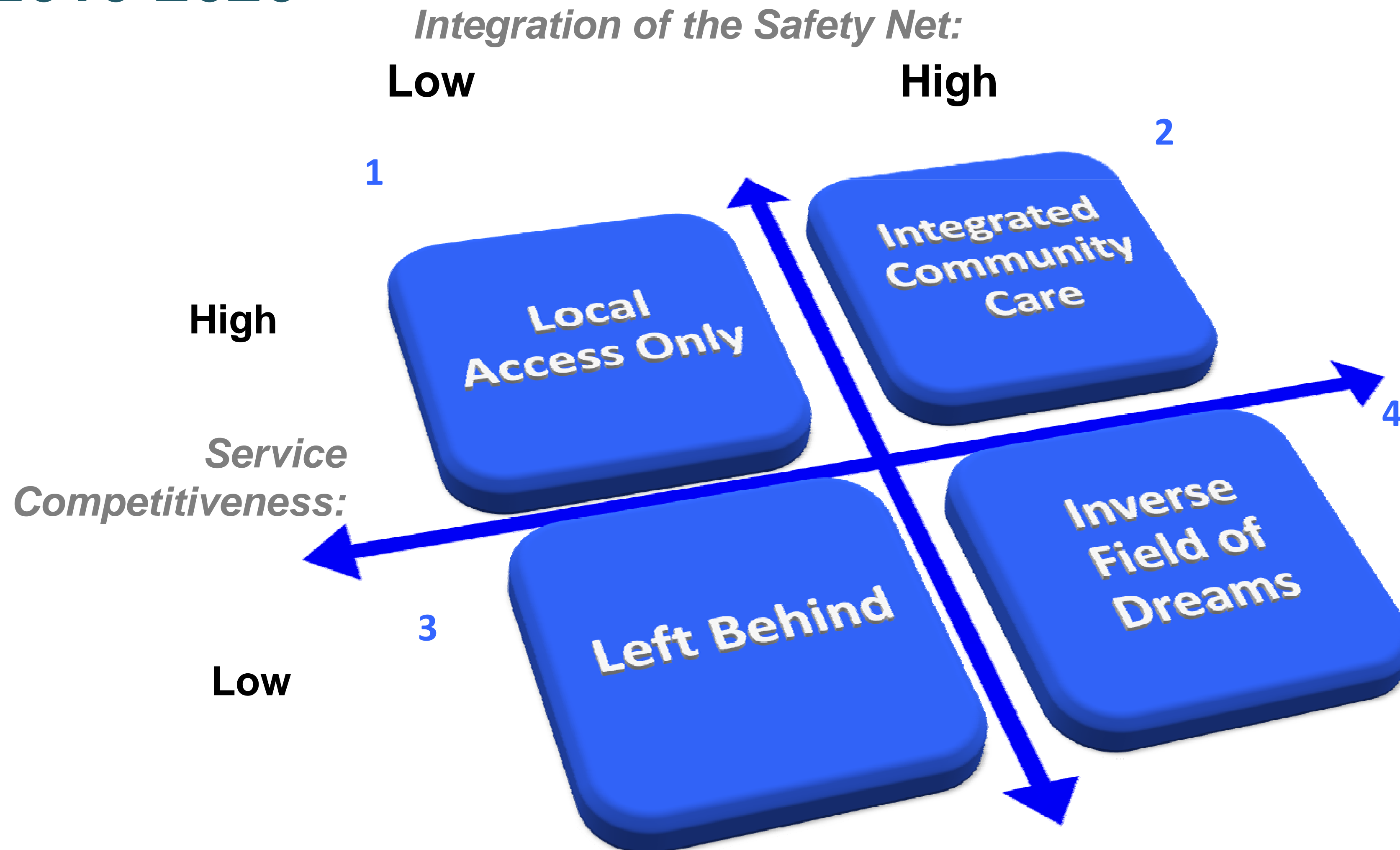
- The Shoemaker Principle
- Can existing providers flourish and grow?
- When Safety Net Population has choice, who will they choose? Arguments both ways:
  - The OB experience in Alameda and LA
  - The 70/30 share of County Organized Medicaid
- Will competitiveness vary for primary care, specialty care, complex acute care, and behavioral health?

Key Driving Forces

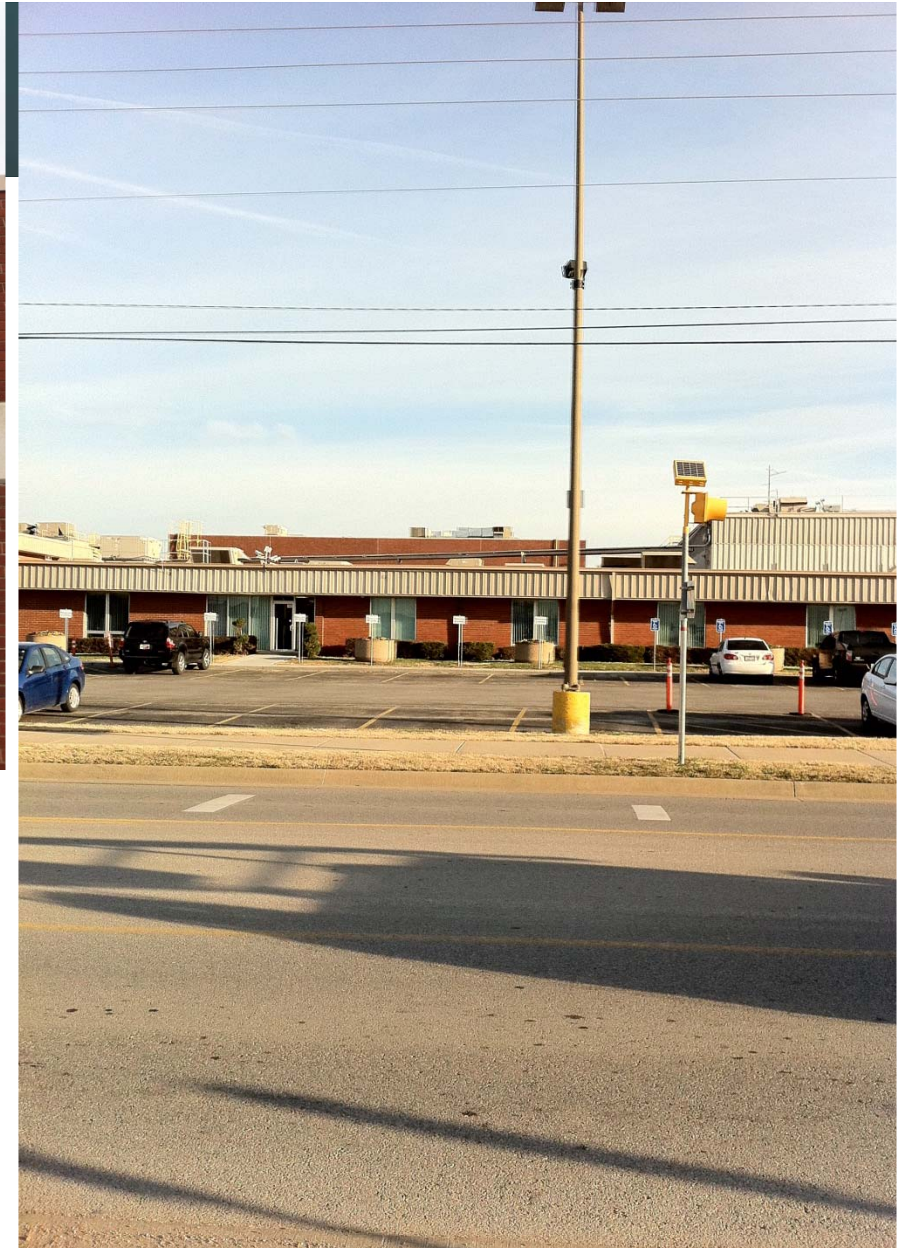
Mission, Culture, Management and Leadership

- Noble service to local communities in need…
- Can lead to self-righteousness:
  - "Send us the money, and leave us alone"
- Enormous variation in capacity, organizational style, local context and history
- Fierce Institutional Independence
- Evidence of innovation and team-centered approaches to determinants of health
- Apparent significant returns to scale, yet….
- Poor history of collaboration, consolidation, and integration
- Suspicion of standardization and performance measurement
- CCs Low or no appetite for consolidation, more interested in geographic expansion

Four Scenarios for the California Safety Net *2010-2020*



Medici



The Largest Corporation in the World

$408 Billion in Sales in 2010

Comfortably in the Top 30 Economies

That's CEO Michael Duke's Office
He made $35 million in compensation in 2010

Implications

- Quality of the built environment for healthcare sends powerful signals to the patients and the community
- Facilities can be a service competitiveness differentiator if you have to "earn" the newly covered
- Can good design support quality and patient safety?
- Can good design support affordability and sustainability?
- Can we build a true healthcare system that works for patients, providers, and payers?
- What are the best practices?
- How can we make them widespread?