



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

California Hospital Association

Environmental Scan and View of the Future

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I. INTRODUCTION

Hospitals face unprecedented challenges. Federal and state health care reform implementation, together with state and federal budget pressures and other environmental and market forces, are converging to transform health care financing and delivery. During 2012, the United States Supreme Court will address challenges to the Affordable Care Act (ACA) with possible outcomes ranging from affirming the constitutionality of the ACA as a whole, to striking down the law in whole or in part, to deferring a decision on the merits of the law to 2015. In any event, public and private payment incentives are poised to evolve over the next decade from volume-based to value-based payments, challenging hospitals to recognize challenges and opportunities and to implement strategies to survive and thrive in a new world.

California hospitals are facing pressures from every direction, led by a stalled economy that is increasing dependence on government health care programs at the same time state and federal deficits and implementation of the ACA are placing intense pressure on program funding and provider payments and shifting payment for unreimbursed costs to private payers. In addition to government and market-driven changes in how health care will be organized, delivered and paid for, important environmental factors include the aging of the population and health care workforce, and other economic and socio-demographic changes in the general population, as well as intensified pressure on hospitals and health care from public and private payers regarding cost, quality, patient safety, transparency and continuity of care. This report is CHA's *Environmental Scan and View of the Future* for 2012.

II. POLITICAL AND PUBLIC POLICY ENVIRONMENT IN 2012

- The June 2012 Primary Election will be the first statewide election subject to the state's new open primary system and using legislative districts redrawn by the California Citizens Redistricting Commission. Together, these changes may favor moderate candidates of both parties in some districts in contrast to former partisan primaries and legislatively drawn districts that favored candidates from both parties with the greatest appeal to the parties' electoral bases. Redrawn districts may also put a legislative two-thirds majority within reach of Democrats.
- During 2012 and beyond, federal deficit reduction and serious ongoing state budget constraints will put pressure on already inadequate payment levels for Medicare, Medi-Cal and other public health care programs.

- Beyond 2012, political resistance to tax increases may continue to limit the spending capacity of state government and, in turn, test the political will of elected officials to support health care programs.
- The November 2012 General Election could include several ballot initiatives of significant concern to California hospitals. The deadline for potential ballot initiatives and referenda to qualify for the November ballot is June 28, 2012. Potential November propositions include health insurance rate regulation, hospital charity care requirements and regulation of hospital charges, hard caps on state spending and several tax increases, among others.

III. FORECASTS

A. California Demographic Trends: A Graying Population and Changing Ethnic Mix

- Major demographic trends have important implications for health care providers:
 - California is aging, with older Californians the fastest-growing age group.
 - California is the most populous state in the United States and is growing larger, with most of the growth driven by births and net foreign migration. Net domestic migration is projected to be negative for the period 2012 to 2015. California's ethnic diversity far exceeds that of the United States as a whole, and California is becoming increasingly diverse.
 - The proportion of low-income residents is increasing and the gap between the wealthy and moderate income earners is widening.
- California is now home to more than 37.6 million people. California's Legislative Analyst projects that the state's population will grow to more than 39.2 million people by 2015.
- Most importantly, growth will vary significantly by age group — California is on the threshold of disproportionate growth in Medicare-eligible residents who are over 65 years old. In the 2000 Census, 3.6 million Californians were 65 years of age and older. By 2020, the California Department of Finance projects that 6.3 million Californians will be 65 or older.
- Whites are declining as a percentage of the state's total population and will be the oldest on average of the state's racial and ethnic groups. Hispanics are growing significantly as a percentage of the state's population and will remain the youngest of the racial and ethnic groups.

B. Economic Environment: Increased Demand for Services and Constrained Funding

- Substantial state budget pressures and competition for scarce funding will persist. Absent a new economic shock that precipitates a new downturn, the California economy will continue a painfully slow recovery from the 2007-10 recession. Unemployment will remain high and government revenues will be constrained. The California Legislative Analyst projects nega-

tive General Fund revenue growth for fiscal year (FY) 2011-12, with modest growth resuming during FY 2013-14.

- Federal, state and local governments will continue to shift health care costs to the private sector, and both government and private-sector payers will ratchet up pressure on health care providers with respect to cost, patient safety, accountability, transparency and quality, including variations in practice patterns.
- Components of the health care delivery system, including safety-net and rural hospitals, will become increasingly fragile unless private marketplace practices and government programs improve. Even with a recovering economy, most California hospitals face increasing financial challenges. Medicare margins will worsen, driven by ongoing federal budget deficits and increasing costs. Access to capital will be a problem for many hospitals.
- Cost pressures on hospitals will persist and intensify, driven by increasing labor and staffing expenses, the cost of the inflationary and unfunded seismic mandate, technology-related demands and expectations, increasing costs for prescription drugs, other increased input costs, quality and safety initiatives, disaster preparedness, regulatory burdens, on-call physician specialists and uncompensated care. These forces (including unfunded state mandates) will cause hospitals to reduce capacity and access, eliminate services or close completely, negatively affecting access.
- Underpayments by public programs will contribute to private health insurance premium increases during 2012 and beyond, creating the climate for another round of payer- and employer-driven health care cost cutting and cost shifting, and labor-sponsored legislative and ballot efforts to regulate health insurance and hospital rates.
- Enactment of legislation or any of several November 2012 ballot propositions to constrain insurance rates, deductibles and copayments; institute new hospital charity care requirements; and regulate hospital charges would compound financial pressures on hospitals and other health care providers.
- Absent enactment of insurance rate regulation, the cost shift from public to private payers will continue. Health insurance premiums will increase at a rate higher than the consumer price index, prompting employers, to the extent allowed by federal law, to cut back or modify health coverage, and to continue to shift more of the cost of coverage and care to employees. Increased self-rationing may reduce consumer demand initially, but also will negatively affect health status in the long term, especially among those least able to pay an increased share of costs, and will increase hospital bad debt and charity care.
- In the near term, despite regulatory and market pressures, health care spending will continue to increase as a percentage of the gross domestic product. Passage of the health insurance rate regulation ballot initiative in November 2012 would create a vise on the state Medi-Cal program because there would be no safety valve to relieve the pressure of Medi-Cal payment shortfalls.

C. Health Care Delivery

1. Hospitals and Systems: Reform, Regulatory and Market Pressures Mount

- Forces set in motion by enactment of federal health care reform, federal and state budget deficits, unsustainable increases in health care costs, and other environmental and market forces will combine to require health care providers to adopt and implement strategies to adapt to public and private payment incentives poised to evolve from volume-based to value-based payments, challenging hospitals and physicians to change the way they deliver health care.
- Most hospitals will identify and implement must-do strategies that include, among others, aligning hospitals, physicians and other providers across the continuum of care; using evidence-based practices to improve quality and patient safety; improving efficiency through productivity and financial management; developing integrated electronic information systems; creating accountable care and medical home models; and restructuring the delivery system.
- The cost of meeting statutory mandates, including the cost of compliance with the unfunded seismic mandate and the associated inflation rate in the cost of hospital construction, as well as nurse-to-patient staffing ratios and multiplying regulatory requirements and penalties, will contribute to the closure of more hospitals and additional reductions in capacity, services and access.
- Ambulatory service centers will continue in the expansion mode of the last decade as physicians build or invest in additional and new ambulatory technology. Competition will heat up as physicians move former inpatients into their ambulatory settings.
- Retail medicine located in “big box” stores and pharmacies will grow and reach beyond basic preventive or primary care to management of chronic conditions.
- Average length of stay for acute-care beds was 5.4 days for the four quarters ending in June 2011. Average length of stay will remain short, driven mostly by medical management, new technologies and pharmaceuticals, partially offset by increasing acuity of hospitalized patients.
- Total inpatient days may trend up slightly, reflecting expanded public and private health coverage under federal health care reform, demographic changes and population growth, offset by continued short lengths of stay and continued migration of services to outpatient settings.
- Average occupancy rates will trend up, driven by limited utilization and counter forces from increased demand generated by federal health care reform, decreasing hospital capacity, changing demographics, and patient acuity and intensity of services.

- Timely access to hospital beds and services will become more problematic in many markets. Driven by increased demand generated by health care reform, shortages of health personnel and unavailability of on-call physicians to emergency departments, functional shortages of hospital beds and restrictions on services will become increasingly common and widespread. Hospitals in some markets will experience regular functional capacity crises.
- Uncompensated care will rise as government payers constrict payments and private payers shift risk and costs to patients. The volume of uncompensated care will be dependent on the economy, state and federal implementation of health care reform, and Medicare and Medi-Cal payments.
- Hospital emergency departments and trauma centers will continue to be overused and underfunded. Inadequate trauma and emergency capacity, compounded by an acute shortage of on-call specialist physicians, will challenge an already fragile emergency system.
- On balance, nurse-to-patient staffing ratios will continue to increase costs. Hospitals less able to compete financially for recruitment and retention of nurses will be especially threatened.
- Closure of hospital services and institutions will accelerate. Mergers and acquisitions will increase, especially with venture capital monies.
- Safety-net hospitals, including rural hospitals, public hospitals, academic medical centers, private disproportionate-share hospitals and children's hospitals, will continue to struggle under the burden of uninsured and underinsured patients, the shift of Medi-Cal patients to managed care, price-driven private markets, and severe federal and state constraints on funding.
- Closures, bankruptcies and the financial deterioration of rural and other hospitals will continue, with inadequate payments from public and private payers; shortages of nurses, pharmacists and other personnel; nurse-staffing standards; aging facilities; the seismic mandate; and lack of capital contributing to the declining viability of vulnerable facilities.
- Rural hospitals will increasingly rely on telemedicine and technological partnerships with other hospitals to deliver health care services. Many rural hospitals will affiliate with hospital systems.

2. Health Care Workforce: Shortages, Aging Workforce and Increasing Labor Costs

- The concurrent graying of the health care workforce and aging of the post-World War II baby boomers will compound health care workforce shortages by decreasing the pool of health care workers and increasing the demand for health care services. The ratio of working-age Californians to those 65 and older will steadily worsen over the next 20 years.
- As the California economy slowly recovers and as 4 million or more people obtain coverage under federal health care reform, short-term demand for hospital services may increase.

Structural shortages of nurses and other health care professionals will become more apparent, creating crisis-level challenges to maintaining adequate staffing in hospitals and other health care settings. If not effectively addressed, workforce shortages will force significant service cutbacks in many hospitals, as well as other health facilities and service organizations.

- Hospitals and health systems will intensify recruitment and retention strategies, but system-specific strategies will not provide long-term solutions and will exacerbate shortages for less competitive health care employers.
- Preparatory educational programs may be expanded to help meet the need for health care professionals, but not enough to significantly alleviate structural shortages.
- New technologies increasingly will be employed to increase productivity and job satisfaction. The most successful and cost-effective technologies will become an integral part of many hospitals' recruitment and retention strategies.
- Remote patient management technologies increasingly will be deployed as their contributions to productivity and quality are recognized.
- Compensation for personnel in short supply will rise disproportionately.

3. Labor Unions: Continued Aggressive Organizing

- Unions will spend considerable money and effort to organize health care workers.
- Organizing strategies will be more aggressive and sophisticated, and will continue to target the public, media and elected officials.
- Organizing strategies and contract negotiations will be characterized by harsh anti-hospital rhetoric and "corporate campaigns," and will focus on hospital charges and profits, executive compensation, charity care, quality and patient safety, working conditions and employee safety, wages and benefits, and the role of unions in staffing and operations, among other issues.

4. Technology: Accelerating Adoption

- The demand for investment in new and updated clinical technologies will continue unabated. The cost of implementing new clinical technology will outpace many health care providers' ability to adopt and deliver, and health care payers' willingness to pay for, new products and services.
- New technologies will positively impact health status and longevity, but, on balance, will increase health care spending because of the costs of implementing and delivering them and because of the additional health costs incurred as people live longer.

- Notwithstanding technical, practical, legal and financial hurdles, as well as competing demands for scarce capital, most hospitals will comply with government mandates to implement ICD 10, digitize their clinical operations, adopt electronic health records and attain “meaningful use.”
- Health information will undergo continual change and evolution, empowering patients, increasing transparency, linking providers and patients, enhancing communication and quality, strengthening uniform classification of patients and enabling comparative shopping for health care services. The Internet and other information technologies will continue to expand the public’s knowledge base, increase consumer expectations, and boost consumer-driven demand for services and prescription drugs.
- Use of remote patient-management technologies will increase with expansion of new delivery models, and may have a significant impact on inpatient days. Deployment of remote management technologies will increase as their contributions to productivity and quality are recognized. Telemedicine and telehealth services will be an integral part of health care delivery and will be used to address geographic access barriers in rural and underserved communities, as well as in urban areas.
- Information technology supporting both business processes and care processes will consume a growing percentage of operating budgets, driven by regulatory mandates and business imperatives.

5. Physicians: From Surpluses to Some Functional Shortages

- Shortages of primary-care physicians and other primary-care providers will worsen. Demand for primary-care and other services will be driven by demographic changes and extension of coverage pursuant to federal health care reform.
- Evolving changes in expectations about work will influence physicians’ choices about location, mode of medical practice and specialty.
- Complex diagnostic and therapeutic options, management of diseases as chronic conditions that once were terminal and increased patient sophistication will produce pressure to spend more time and money per patient for physician and related services.
- The number of non-physician practitioners, including physician assistants and nurse practitioners, will grow. Partially in response to physician shortages, nurses will take on new roles in patient care. Fully integrated systems and larger medical groups, including those with medical clinics located in retail settings, will effectively use non-physician practitioners. Increasing use may result in expansion of the scope of practice for these non-physician providers.
- Clinical guidelines will have a significant impact on medical practice during the period of this forecast as clinical variation comes under increasing scrutiny.

- Increased clinical integration driven by market forces and health care reform will result in more inpatient hospital care being delivered and overseen by hospitalists, intensivists and other hospital-based specialists. Hospitalists will play important roles in hospitals' adaptation to a value-based payment system, including increasing efficiency, reducing readmissions, enhancing care coordination and reducing practice variation.

D. Health Coverage

1. Access to Coverage: Federal Health Care Reform

- Absent a decision in 2012 by the United States Supreme Court striking down all or significant parts of the ACA, by 2014 federal health care reform will mandate or provide coverage to 4 million or more Californians who are now uninsured, and increase demand for health care services, both through expanded public programs and mandated private coverage.
- The California Health Benefits Exchange (CHBE) will seek to be an active purchaser/change agent, approving qualified health plans (QHPs), negotiating premiums QHPs can charge for essential benefits inside and outside CHBE, and in setting the market for individuals and groups.
- An important unknown is how employers will respond to the coverage requirements of the ACA. If many employers elect to "pay and walk away" instead of providing health coverage to their employees, then exchange-provided coverage would increasingly supplant employer-provided coverage. Payments for patients with exchange-provided coverage will be significantly less than payments under current employer-provided coverage.
- Wild cards, such as passage of ballot initiatives to regulate health coverage rates and consumer costs, impose charity care requirements on not-for-profits hospitals or limit hospitals' allowable charges, could cause major market disruptions and/or reconfigurations in health coverage and delivery.
- Federal expansion of Medi-Cal eligibility will be challenged by state budget operating shortfalls and competing priorities, and will increasingly expose a growing gap between access to coverage and access to timely and appropriate care.
- Federal and state budget-driven redesign of the Medi-Cal program will place increasing pressure on Medi-Cal payments providers.
- Access to care will be an increasing challenge for Medicare beneficiaries, including Medicare/Medi-Cal dual eligibles.

2. Health Plans and Insurers: Continued Consolidation and New Models

- Increases in health coverage premiums will redouble pressure by payers and others to contain (and shift) health care and health coverage costs.

- Unions will resist cost shifts from employers to employees, and health coverage costs will continue to figure prominently in management/labor disputes.
- Health plans and health care providers will experience the impact of purchaser-driven cost and quality initiatives. Purchasers, payers and consumers increasingly will use clinical performance measures to choose hospitals and physicians. As measurement tools are refined they will become more widely accepted and used.
- Driven by federal health care reform, new models of health coverage and health care that involve new partnerships among insurers, physicians and hospitals will be implemented. No single model will emerge as dominant in the near term and different models will be successful in different markets. Health care insurance companies will expand their holdings to include reinsurance, administrative services options and ownership of physician organizations.
- The existing oligopoly of a few large health plans and insurers will be further solidified.
- California will continue to have the highest managed care penetration in the nation. State-wide, the vast majority of the commercially insured population will continue to be in some form of managed care. “Accountable care” will supersede “managed care” as a label for a variety of coverage and care models.
- Most plans and insurers will continue to offer health maintenance organization and preferred-provider organization products in addition to “consumer-directed” and other “innovative” benefit packages.
- Quality, performance/outcomes and patient satisfaction will be factored into most payment systems.
- Failure of efforts to achieve sustainable cost growth and increased value could lead a single-payer system or other governmental control-oriented policy.

IV. WILD CARDS

Initiatives headed to the ballot for the statewide General Election in November 2012 could change the landscape. If health insurer rate regulation, charity care or billing controls over hospitals, a hard cap on state expenditures, and/or multiple tax-increasing measures are enacted by voters, impacts on health care will be immediate. Funding will be revolutionized and provider restructuring will dominate strategic planning by hospitals, physicians and other key stakeholders.

If the United States Supreme Court overturns the ACA in part (the individual mandate) or in whole, a new round of Medicare and Medicaid cuts will surface. As Congress wrestles with growing federal debt and annual deficits, entitlements will be the primary targets for governmental savings.

It is possible that forces within the private sector will stimulate more dramatic structural changes than would occur in normal transitional cycles. This phenomenon could occur as a reaction to initiatives, court decisions or unanticipated legislative or regulatory actions.

Regardless of outside influences, it is likely that the California Health Benefits Exchange (CHBE) will move forward to influence individual and small group markets in California. Based on evidence thus far, CHBE may attempt to create a “new” market for individuals and small groups, followed by expansion to large groups in 2017.

V. CONCLUSION

The period ahead will be a time of unprecedented challenges, disruptive change and great opportunity. CHA and the Regional Associations will work together during 2012 to pursue a strategy that aims both:

- To assist hospitals and their partners in restructuring themselves into accountable care models and systems founded on collaborative engagement, aligned financial and clinical incentives, and coordination of services across the continuum of care.
- To protect and improve current payment levels from governmental programs and obtain modifications in payment methodologies that promote innovation and adaptation to population health, while preserving all types of hospitals, including academic medical centers, teaching hospitals, safety-net organizations, rural health care facilities and community hospitals.

RESOURCES

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California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
(916) 443-7401
www.calhospital.org