

Washington, D.C., Area Health Care Market Sticks to Fee for Service; Dips Toe into Value-Based Payment

With a strong, stable economy anchored by the federal government, a large high-wage professional-services sector and unemployment well below the national average, the National Capital Region (NCR) has one of the most affluent, educated and well-insured populations in the United States. The region includes the District of Columbia; Montgomery and Prince George's counties in Maryland; and Arlington, Fairfax, Loudoun and Prince William counties in Northern Virginia.¹ Despite the region's overall affluence, significant pockets of poverty exist, most notably in Washington, D.C., and Prince George's County.

The federal government sets a relatively high benchmark for health benefits, but many employers—including law firms, lobbying firms, high-end government contractors and others competing for high-wage workers—outdo the government in benefit richness. Most employers take a conservative approach to health benefits; they are less likely to self-insure and less aggressive in seeking cost-containment innovations than comparably-sized employers in other markets.

Health care leaders acknowledge the inevitable shift from fee-for-service to value-based payment and the need for their organizations to develop population-management capabilities. Yet, most hospitals continue to emphasize fee-for-service strategies in an updated hub-and-spoke model—with newer ambulatory venues such as freestanding emergency department (EDs) and urgent care centers strategically located to drive more patients—especially affluent, well-insured patients—to a particular system. In some cases, however, hospitals are using these new ambulatory networks to position themselves for population health management under value-based payment. This persistence of fee-for-service strategies likely stems from the commercial insurance market's "pass-through" environment that allows provider rate increases to be passed

on to employers through premium increases because the market has many employers able to absorb the additional costs and no large, influential employers pushing for cost-containment innovations.

Market Highlights

- ▶ **Moderately competitive health plan market.** The region's leading health plan, CareFirst BlueCross BlueShield, is dominant in the small-group and non-group (individual) segments. Three national insurers—UnitedHealth Group, Aetna and Cigna—provide strong competition in the large-group segment, where they reportedly are gaining business from CareFirst. Kaiser Permanente, with its unique role as both an insurer and an integrated delivery system with a closed, limited-provider network, has market share in the high-single digits but may be poised to grow under the new health insurance marketplaces.
- ▶ **Complex hospital market with multiple overlapping submarkets.** The hospital sector is characterized by significant geographic segmentation, especially between Northern Virginia—where Inova Health System is dominant—and the rest of the region. Geographic boundaries are more porous between the District and Maryland. Besides Inova, the only other system with a major regional presence is MedStar Health. Most other hospitals belong to systems based elsewhere that only operate one or two community hospitals locally. The major hospitals are all expanding their ambulatory care networks, with head-to-head competition especially heating up in affluent and fast-growing Northern Virginia communities.
- ▶ **Increased physician consolidation, though small, independent practices persist.** Historically fragmented,

the physician market has undergone substantial consolidation over the past decade, with hospital-owned groups and two large physician-owned groups recruiting aggressively and growing dramatically. Still, many physicians remain in small, independent practice, with a small but noticeable subset of physicians in the most affluent submarkets choosing some form of concierge medicine. For the much larger number of private-practice primary care physicians not taking the concierge route, participating in CareFirst's patient-centered medical home program has made remaining independent more viable.

- ▶ **Fee for service still dominant.** Many payment and care delivery trends well underway in other markets are only slowly beginning to emerge in the NCR. Most providers have little or no experience with risk sharing or population health management. Accountable care organization (ACO) activity is nascent and scattered, with no Medicare Pioneer ACOs and only a few Medicare Shared Savings Program ACOs.
- ▶ **Unique Maryland hospital rate-setting system.** For decades, payment rates for Maryland hospitals have been set by a state commission so that all payers, public and private, pay similar rates to each hospital. This unique system required a waiver from the Centers for Medicare and Medicaid Services (CMS) to allow the state to set rates for Medicare patients. In 2013, Maryland negotiated an ambitious new waiver with CMS, aimed at controlling the total cost of care per capita for Medicare beneficiaries in the state. Over a five-year period beginning in 2014, all hospital revenue will transition toward global payment models. Although unproven, this new hospital payment system stands out as the most innovative payment approach, by far, in a region that otherwise lags in payment innovations.
- ▶ **Troubled health insurance exchange rollouts.** Technical failures, plus complicated and changing federal and state rules, caused serious challenges for insurers and consumers participating in the region's three new health insurance exchanges under the federal Affordable Care Act (ACA). Maryland's rollout was considered worst in the region and Virginia's best—though still problem plagued. In the District,

the exchange performed better than many expected, but the requirement that all small groups purchase health benefits only through the exchange is causing consternation among insurers and small employers. Beyond the exchanges, the ACA's impending "Cadillac" tax on high-cost coverage is a major concern in this benefit-rich community.

- ▶ **Contrasting approaches to public coverage.** Reflecting their strikingly different political orientations, the District and Virginia have adopted opposing stances on Medicaid and other public coverage for adults. The District's eligibility standards rank among the most expansive in the nation—exceeding ACA standards—while Virginia has rejected the ACA's Medicaid expansion to date. Maryland falls between the two, having partially expanded Medicaid eligibility several years ago and then further in 2014 in accordance with ACA standards.
- ▶ **Safety net generally strong but lacks cohesion.** Overall, the region has a broad array of safety-net providers, including numerous large community health centers focusing on primary care for low-income people. The region has no dedicated safety-net hospital; much low-income inpatient care is provided by mainstream hospitals that play a significant safety-net role because of their location, size and/or range of services. Despite strong safety-net providers and programs, the region lacks significant collaboration among safety-net organizations and between those organizations and local governments.

An Affluent, Well-Insured Community with Notable Disparities

Currently totaling 4.8 million people, the National Capital Region's population has grown rapidly over the past decade, at almost twice the national rate of 8.7 percent (see Table 1). By far the fastest growth has occurred in the Northern Virginia counties of Loudoun and Prince William, but all jurisdictions in the region have grown over the past decade.

The region's residents are among the most affluent and well educated in the nation. More than half of adults have at least a college degree, compared to less than 30 percent nationwide. The region's 8.7 percent poverty rate is about half the national rate, while median family income is

Table 1
Washington, D.C., Metropolitan Area Demographics and Health System Characteristics

| | WASHINGTON, D.C. | MONTGOMERY | PRINCE GEORGE'S | ARLINGTON | FAIRFAX | LOUDOUN | PRINCE WILLIAM | ALEXANDRIA | NATIONAL CAPITAL REGION | U.S. |
|---|------------------|------------|-----------------|-----------|-----------|---------|----------------|------------|-------------------------|-------------|
| POPULATION STATISTICS | 632,323 | 1,004,709 | 881,138 | 221,045 | 1,118,602 | 336,898 | 430,289 | 146,294 | 4,771,298 | 316,128,839 |
| POPULATION GROWTH, 5 YEAR | 9.2% | 6.9% | 8.4% | 7.1% | 11.4% | 20.6% | 20.2% | 3.5% | 10.6% | 4.0% |
| POPULATION GROWTH, 10 YEAR | 14.7% | 10.6% | 6.1% | 19.7% | 13.0% | 57.7% | 34.8% | 15.5% | 15.8% | 8.7% |
| AGE | | | | | | | | | | |
| PERSONS UNDER 18 YEARS OLD | 17.3% | 23.6% | 22.7% | 16.6% | 24.0% | 29.8% | 28.4% | 17.7% | 23.0% | 23.3% |
| PERSONS 18 TO 64 YEARS OLD | 71.3% | 63.1% | 66.5% | 74.0% | 64.9% | 62.9% | 63.7% | 72.8% | 66.1% | 62.6% |
| PERSONS 65 YEARS AND OLDER | 11.4% | 13.3% | 10.8% | 9.4% | 11.1% | 7.4% | 7.9% | 9.5% | 10.9% | 14.1% |
| RACE/ETHNICITY | | | | | | | | | | |
| WHITE | 35.6% | 46.7% | 14.3% | 63.3% | 52.5% | 59.7% | 46.6% | 52.3% | 42.5% | 62.4% |
| BLACK | 48.0% | 17.0% | 62.8% | 8.5% | 9.3% | 7.1% | 20.6% | 22.0% | 27.1% | 12.3% |
| LATINO | 10.1% | 18.3% | 16.2% | 15.6% | 16.2% | 13.1% | 21.5% | 16.9% | 16.1% | 17.1% |
| ASIAN | 3.4% | 14.2% | 4.3% | 9.5% | 18.2% | 15.2% | 7.8% | 6.4% | 10.9% | 5.0% |
| OTHER RACE OR MULTIPLE RACES | 2.8% | 3.7% | 2.4% | 3.2% | 3.7% | 4.9% | 3.7% | 2.3% | 3.4% | 3.2% |
| FOREIGN BORN | 14.4% | 32.7% | 20.6% | 21.4% | 30.0% | 22.2% | 22.8% | 29.5% | 25.1% | 13.1% |
| LIMITED/NO ENGLISH | 5.5% | 14.4% | 9.7% | 6.1% | 13.4% | 9.9% | 11.4% | 13.4% | 11.1% | 8.5% |
| EDUCATION | | | | | | | | | | |
| HIGH SCHOOL OR HIGHER | 90.1% | 91.3% | 85.2% | 95.6% | 92.1% | 93.4% | 89.9% | 89.6% | 90.4% | 86.6% |
| BACHELOR'S DEGREE OR HIGHER | 55.1% | 56.4% | 30.3% | 74.3% | 60.0% | 56.7% | 38.6% | 62.2% | 52.1% | 29.6% |
| ECONOMIC INDICATORS | | | | | | | | | | |
| LESS THAN 100% OF FEDERAL POVERTY LEVEL (FPL) | 18.9% | 6.9% | 9.8% | 9.8% | 5.8% | 3.9% | 7.0% | 8.2% | 8.7% | 15.8% |
| LESS THAN 200% OF FPL | 33.6% | 18.3% | 24.8% | 17.6% | 15.4% | 10.9% | 19.7% | 23.9% | 20.5% | 34.8% |
| LESS THAN 400% OF FPL | 54.1% | 40.1% | 54.0% | 33.2% | 34.3% | 32.3% | 44.3% | 44.5% | 42.7% | 64.8% |
| HOUSEHOLD INCOME ABOVE \$100,000 | 35.8% | 49.2% | 33.3% | 52.6% | 55.9% | 60.4% | 48.0% | 42.1% | 46.4% | 22.6% |
| RECIPIENTS OF INCOME ASSISTANCE AND/OR FOOD STAMPS | 16.6% | 7.2% | 12.0% | 5.0% | 5.1% | 4.5% | 7.1% | 4.9% | 8.6% | 14.2% |
| UNEMPLOYMENT RATE 2008 | 6.6% | 3.2% | 4.4% | 2.5% | 2.8% | 2.8% | 3.3% | 2.8% | 3.7% | 5.8% |
| UNEMPLOYMENT RATE 2013 | 8.3% | 5.1% | 6.8% | 3.6% | 4.3% | 4.2% | 4.9% | 4.1% | 5.5% | 7.4% |
| FEDERAL GOVERNMENT EMPLOYEES | 28.3% | 10.3% | 8.8% | 18.2% | 4.1% | 2.7% | 5.9% | 15.1% | 13.6% | 2.1% |
| GOVERNMENT EMPLOYEES | 33.0% | 19.6% | 29.3% | 25.3% | 14.2% | 15.5% | 23.3% | 23.7% | 23.4% | 15.6% |
| HEALTH INSURANCE | | | | | | | | | | |
| UNINSURED | 6.7% | 11.1% | 15.5% | 10.6% | 11.6% | 9.0% | 14.1% | 17.0% | 11.7% | 14.5% |
| MEDICAID/OTHER PUBLIC | 19.0% | 8.4% | 13.7% | 2.1% | 4.5% | 3.0% | 6.9% | 7.3% | 9.0% | 13.6% |
| PRIVATELY INSURED | 57.4% | 64.4% | 55.9% | 74.1% | 67.9% | 76.3% | 63.4% | 63.4% | 63.9% | 52.9% |
| MEDICARE | 9.9% | 10.1% | 7.9% | 7.8% | 7.6% | 5.7% | 5.4% | 6.7% | 8.2% | 12.5% |
| MILITARY | 0.9% | 1.7% | 1.9% | 1.3% | 3.5% | 2.2% | 5.7% | 1.7% | 2.4% | 1.4% |
| OTHER COMBINATIONS | 6.1% | 4.3% | 5.2% | 4.1% | 4.8% | 3.7% | 4.5% | 3.8% | 4.8% | 5.1% |
| HOSPITALS | | | | | | | | | | |
| HOSPITAL BEDS SET UP AND STAFFED PER 1,000 POPULATION | 7.2 | 2.1 | 1.2 | 1.6 | 1.7 | 0.9 | 0.4 | 2.3 | 2.2 | 3.1 |
| AVERAGE LENGTH OF STAY, 2010 (Days) | 7.9 | 4.7 | 4.9 | 4.2 | 5.1 | 6.8 | 3.9 | 4.6 | 5.7 | 5.8 |

Sources: U.S. Census Bureau, 2013; American Community Survey, 2013; Bureau of Labor Statistics, 2013; American Hospital Association, 2011

among the highest of all U.S. metropolitan areas.

These overall indicators, however, mask wide disparities within the region. Loudoun, Fairfax, Arlington and Montgomery counties rank among the most affluent in the United States, while Washington, D.C.—and, to a

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lesser extent, Prince George's County—have relatively high poverty and unemployment rates. Like many major cities, Washington has a vast divide between the haves and have-nots, largely along racial lines. While the District's poverty rate is the region's highest by far, it also has many affluent, highly educated and well-insured residents. Also, the wealthier suburban counties have pockets of poverty, related in part to growth in the Latino population.

The region's strong and stable economy is anchored by the federal government, which helps keep the local economy relatively robust even during downturns. In the Great Recession, for example, unemployment peaked at 7.0 percent regionally, compared to 10.0 percent nationally. In 2013, unemployment averaged 5.5 percent in the region vs. 7.4 percent nationally, but again, wide disparities exist within the region, with most Northern Virginia communities ranging from 3.6 percent to 4.3 percent, while Washington reached 8.3 percent.

The region's proportion of residents without health insurance is lower than the nation—11.7 percent vs. 14.5 percent in 2013. Within the region, Washington again stands out, but this time as the best-performing jurisdiction by far. The District's uninsured rate of 6.7 percent reflects broad eligibility standards for public insurance, including early expansion of Medicaid for all adult residents who are U.S. citizens or meet immigration requirements with incomes up to 200 percent of poverty.

In addition to the federal government, the region's economy is bolstered by a wide variety of employers in the

professional services sector, including government contractors, lobbying and law firms, and technology companies. Keen competition for high-wage labor in these industries means that health and other employee benefits tend to be very comprehensive—often exceeding federal benefits. In addition, the region has many nonprofit groups, whose health benefits also tend to exceed federal workers' benefits—even though wages in the nonprofit sector may not be as high.

The nature of white-collar jobs concentrated in the region helps drive a distinguishing feature of the area's health insurance market: Many small employers not only offer comprehensive health benefits but also offer multiple product choices to their workers—unlike small employers in most other markets. The distinction between large and small NCR employers' health benefit offerings tends to be less clear cut than elsewhere. Overall, benefits consultants and brokers rank the region's health benefits among the richest in the country and on par with the high-wage markets of New York City and Silicon Valley.

Rich Benefits, Little Innovation Characterize Insurance Market

Both employees' share of premium contributions and their out-of-pocket expenses for medical care have risen over time in the National Capital Region, as in other markets nationwide. Both, however, started from a much lower base than in most other markets. And, some high-wage firms, public employers and nonprofit associations in the region continue to maintain exceptionally rich benefits, with little employee premium contribution or out-of-pocket cost sharing required.

Market observers noted that employers tend to take a more conservative approach to health benefits than employers of comparable size in other markets: They are less likely to self-insure and less ready to adopt significant benefit design changes for cost-containment purposes. High-deductible health plans (HDHPs), for example, have gained less traction in the region than in many markets. Several experts estimated HDHP penetration in the employer-sponsored insurance market to be about 20 percent regionally—much lower than the 50 percent that one health plan executive estimated as the HDHP penetration for the adjacent, more blue-collar Baltimore market, for

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instance. When NCR employers offer a HDHP, they often make it an option alongside one or two other product choices; this is common even within the small-group segment, in contrast to many markets where small firms, in particular, have moved to full replacement with HDHPs. And, NCR employers offering HDHPs often contribute to an accompanying health savings account, with contribution amounts varying widely but often totaling at least half the HDHP deductible.

The most popular commercial insurance options in the market are still traditional preferred provider organization products with very broad provider networks and deductibles in the \$250 to \$500 range for single coverage. As noted, consumers' out-of-pocket cost sharing has increased over time but from a lower base and at a slower pace than in many other markets.²

Among the health plans competing for the region's large, affluent commercial population, the leader is CareFirst BlueCross BlueShield. The Blue plan's market share reportedly is in the 40- to 50-percent range overall but varies substantially by segment—more dominant in the small-group and nongroup markets than for large groups. Competing with CareFirst are three national carriers—UnitedHealth Group with roughly 20 percent market share, Aetna with slightly below 15 percent and Cigna with about 8 percent—and Kaiser Permanente with about 8 percent market share.³ All compete most strongly in the large-group market, with Cigna focusing solely on this segment.

Large employers—especially self-insured employers with a national or multi-state presence—often prefer

the national carriers to CareFirst for a variety of reasons, including a more seamless, “one-stop shopping” experience; stronger data capabilities, such as customized and closer to real-time reporting on enrollee cost and utilization; and integration of comprehensive wellness programs with health benefits. Primarily for these reasons, CareFirst has been losing large-group market share in recent years. CareFirst even has lost some local public accounts to the national carriers—a development that respondents considered more troubling for the carrier, since public employers tend to be loyal to regional Blue plans. Like Blue plans in other markets, CareFirst historically has enjoyed an edge over rival insurers in the breadth of its provider networks and size of its provider-rate discounts. Respondents reported, however, that both advantages have narrowed in recent years, eroding CareFirst's competitive advantage to some degree.

With an integrated delivery system and distinctive health maintenance organization (HMO) products, Kaiser occupies a unique place among the region's commercial insurers. Most respondents believed Kaiser has progressed beyond the “niche” stage but is not yet a major competitor in the market. Most of Kaiser's commercial enrollment comes from large-group “slice” business—where a Kaiser product is offered alongside another carrier's offerings. Small employers are less likely to offer a Kaiser option, because other insurers—which believe Kaiser benefits from attracting a higher proportion of healthy enrollees—resist having a Kaiser option offered alongside their products when risk pools are small.

Several respondents observed that the Kaiser delivery system has an increasing reputation for high quality and offers better convenience and access—especially for primary care—than most other providers. But many employers and consumers in the market still are not familiar or comfortable with the unique Kaiser model. Particularly in a market accustomed to comprehensive provider networks, many are unwilling to accept a closed, limited network of providers—especially when it involves changing primary care physicians, as it inevitably does when switching between a traditional insurer and Kaiser.

Aside from Kaiser's distinctive limited-network HMOs, the region's commercial market currently does not feature any limited-network products.⁴ The national carriers

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reportedly are all exploring some form of limited networks, but CareFirst—whose brand relies in part on network breadth—reportedly is not. Among the nationals, Aetna has proceeded the furthest in exploring limited networks. In 2012 Aetna formed a joint venture with Inova, called Innovation Health, to offer products centered on Inova providers. To date, however, Innovation Health's products do not feature limited networks, except for Inova's own workforce.

More generally, the region's commercial insurance market is characterized by a lack of innovation. In some markets, the largest employers take the lead in demanding and implementing innovative approaches to health benefits. For example, the California Public Employees' Retirement System, the purchaser of benefits for state employees and retirees, has been a leader in implementing such value-based strategies as commercial ACOs, reference pricing and centers of excellence. In contrast, the National Capital Region's largest purchaser—the federal government—has not pushed benefit innovations. In addition, market observers noted that the NCR has many highly profitable private-sector companies. As one benefits consultant observed, while these employers “[would] prefer better health care cost-containment...their business survival doesn't depend on it...so they haven't focused on the innovations as much [as employers in some other markets].”

Multiple, Overlapping Hospital Submarkets

The region's complex hospital market is composed of several geographic submarkets for inpatient care, rather than a single market (see map on page 7). The hospital submarkets, however, overlap with one another significantly, especially between the District and the Maryland suburbs, with significant patient flows from Montgomery and Prince

George's counties into the District's teaching hospitals, in particular. Submarket boundaries are not as porous between Northern Virginia and the rest of the region; it is less common for patients to cross the Potomac River in either direction to receive inpatient care.

Taken as a whole, the NCR's hospital sector is less consolidated than in many metropolitan areas. The region's largest systems, Fairfax-based Inova Health System and Columbia, Md.-based MedStar Health, account for 26 percent and 19 percent of regional discharges, respectively. However, given the geographic segmentation in the market, consolidation is effectively higher than those overall numbers indicate. In Northern Virginia, Inova commands a market share of nearly 70 percent; in the District, MedStar's two teaching hospitals, MedStar Washington Hospital Center (MWHC) and MedStar Georgetown University Hospital, together account for nearly 50 percent of the market.

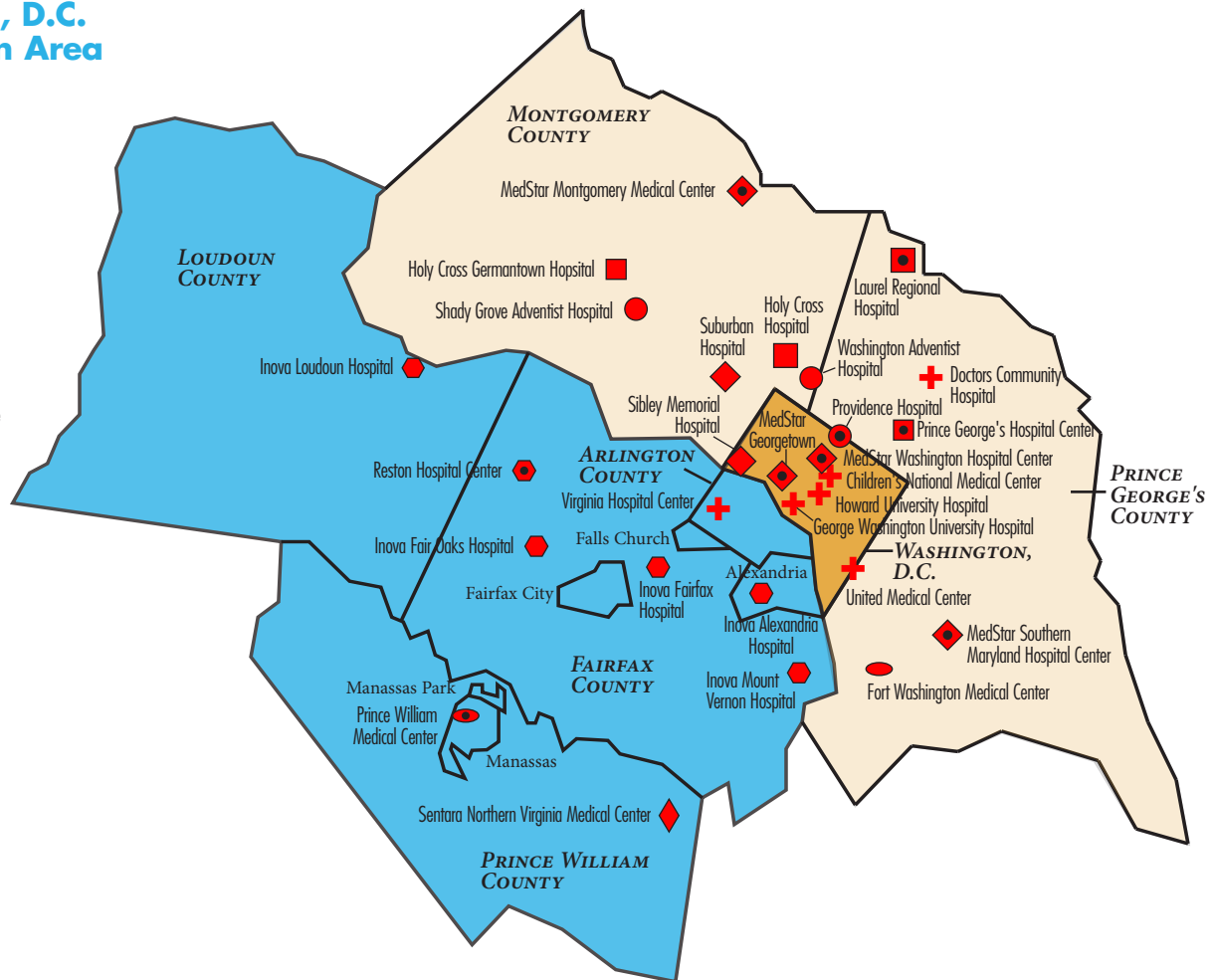
Of the region's many hospitals, most belong to systems; however, only Inova with five acute-care hospitals and MedStar with four acute-care hospitals⁵ have large market shares and several inpatient facilities in the region. Most other hospitals belong to larger systems based elsewhere that only have one or two community hospitals within the NCR. These systems include The Johns Hopkins Health System (JHHS), which has Suburban Hospital in Montgomery County and Sibley Memorial Hospital in the District; Trinity Health, which has Holy Cross Hospital and Holy Cross Germantown Hospital in Montgomery County; HCA, which has Reston Medical Center in Fairfax County; and Sentara Healthcare, which has Sentara Northern Virginia Medical Center in Prince William County. In addition, Universal Health Services has one teaching hospital in the District, George Washington University (GWU) Hospital.

The region's smattering of independent hospitals includes a couple of noteworthy institutions: Children's National Medical Center in the District, the region-wide pediatric inpatient and subspecialty referral center; and Virginia Hospital Center (VHC) in Arlington County, a successful hospital in an affluent submarket, which reportedly has rebuffed merger offers from multiple systems. (A number of additional hospitals that primarily serve a safety-net role also operate in the region and are described later.)

Some respondents regarded Inova as the only true sys-

Washington, D.C. Metropolitan Area

- Adventist HealthCare
- Ascension Health
- Trinity Health
- Dimensions Healthcare
- ◆ HCA Virginia
- ◆ Inova
- ◆ Johns Hopkins Medicine
- ◆ MedStar Health
- Nexus Health
- Novant Health
- ◆ Sentara Healthcare
- + Non-System Hospitals



tem and Inova Fairfax Hospital as the only clear flagship hospital in the region. These respondents perceived other systems as having cobbled together inpatient facilities without rationalizing resources within the enterprise. However, MedStar has long rationalized cardiac-care resources between its two teaching hospitals, MWHC and Georgetown, and in recent years, has created joint clinical programs for other major service lines across its facilities.

Kaiser plays an interesting, though limited, role in the hospital market. Lacking its own hospitals, Kaiser contracts with a subset of hospitals to admit Kaiser patients when they need care. Some hospitals—including Suburban, VHC, MWHC and Holy Cross—appear to welcome the Kaiser relationship and view it as an opportunity to learn from the integrated delivery system about cost-effective care delivery and population health management—in addition to being able to fill beds with Kaiser patients.

However, not all hospitals are willing to accept Kaiser’s model of inpatient care, which calls for Kaiser hospitalists—and, increasingly, other Kaiser specialists—to oversee or directly care for Kaiser patients. In a well-publicized 2013 split, Inova and Kaiser allowed their contract to lapse, reportedly because they could not agree on an inpatient care delivery model.

The financial performance of the region’s hospitals and systems varies widely, reflecting in large part the differing payer mixes among hospital submarkets. Inova hospitals have a healthy margin in the aggregate (6.4% in 2011), with all system hospitals except Mount Vernon doing well financially. MedStar has more financial challenges, largely reflecting less favorable payer mixes in some of its service areas. Still, all of MedStar’s hospitals managed to achieve positive operating margins, ranging from a high of 8.1 percent at Georgetown to lows in the low-single digits at the system’s

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three other acute-care facilities in the NCR in 2013. Beyond these two systems, most Northern Virginia hospitals achieve robust margins—some as high as 15-16 percent—while Maryland and D.C. hospitals’ financial performance has been more mixed. Specifically, several hospitals in Prince George’s County and lower-income areas of the District are in the red, reflecting less favorable payer mixes.

Geographic Competition Increases

With the key exception of Maryland—which operates under a unique all-payer rate-setting program (see page 9)—the region’s hospitals continue to operate in a fee-for-service environment. Hospitals are pursuing multiple competitive strategies that reflect what one observer termed the “schizophrenia of living in a fee-for-service world... [while] anticipating and trying to prepare for major payment changes down the line”—namely, the move toward risk sharing and value-based payment arrangements. Key strategies currently pursued by hospitals include:

- increasing physician employment, both to support traditional objectives—referrals, service lines, emergency department and call coverage—and to prepare for future value-based payment through nascent efforts to build clinically integrated models;
- aligning more strongly with community physicians, using a variety of approaches such as joint ventures—a strategy hospitals emphasize more when direct physician employment falls well short of targets;
- exploring or expanding ownership of health plans, either as a joint venture with a health plan, or as an independent system; Inova is pursuing the first approach, partnering with Aetna, while MedStar is pursuing the second course, operating its own Medicaid and Medicare plans;⁷ and

- expanding ambulatory care networks—a central strategy for most hospitals—reflecting the pressure that hospitals feel to expand their patient base, combined with an awareness that reimbursement models will increasingly reward outpatient care relative to inpatient care, and a recognition that ambulatory care investments are less costly and risky ways to expand a geographic base than investments in inpatient facilities.

The region has seen abundant recent examples of hospital systems expanding ambulatory care networks. In the District, MedStar opened new urgent care centers in parts of the city where the system had no previous ambulatory presence—at times causing consternation and pushback from safety-net providers in those communities, which perceive MedStar as a competitive threat. MedStar also is building the Lafayette Center, a multispecialty hub in the city’s central business district, and plans to consolidate and shift many ambulatory services to the new complex. The Lafayette Center’s location will put MedStar into more direct head-to-head competition with the region’s leading independent multispecialty physician group, George Washington University Medical Faculty Associates.

Northern Virginia is the submarket where hospital systems are most actively expanding ambulatory care networks into rival territory. Inova recently added six urgent care centers—with the newest in the Ballston area of Arlington—an affluent, densely populated community in VHC’s territory. JHHS recently opened a medical office in Ballston that offers care in a number of specialties—the system’s first foray into Virginia. Inova is expanding its HealthPlex facilities, which combine comprehensive outpatient, urgent care and emergency department services. In June 2014, Inova broke ground on its Ashburn (Loudoun County) HealthPlex—a facility that will open first with a freestanding ED and imaging center, to be followed later by a medical office building. Inova’s Ashburn facility will escalate direct competition with HCA, which has its own freestanding ED in Ashburn, in the midst of the region’s wealthiest and most rapidly growing county.

In describing their strategies, representatives from nearly all systems and individual hospitals spoke of the inevitable shift from fee-for-service to value-based payment and

Hospital Rate Setting in Maryland

In 1971, Maryland established the Health Services Cost Review Commission (HSCRC) to set prices for all payers for inpatient and outpatient hospital services. Payment rates were set annually using a formula that took into account each hospital's patient population—for example, if the hospital served many uninsured patients and, therefore, had high uncompensated care costs—and allowed for some modification based on hospital efficiency and quality scores. Although rates varied somewhat across hospitals, all payers—including Medicare, Medicaid and private insurers—paid similar rates to a given hospital.

When Medicare adopted an inpatient prospective payment system for hospitals in 1983, Maryland received a waiver from the Health Care Financing Administration—now the Centers for Medicare and Medicaid Services (CMS)—allowing the state to continue setting rates for Medicare patients. The waiver required that the growth rate of Medicare payments per hospital admission in Maryland stay below the national rate, but a 2012 HSCRC report to the governor found that Maryland's growth rate was about equal to the national average between January 1981 and June 2012.

While the impact of Maryland's longstanding rate-setting system on hospital cost growth is unclear, the system did have wide-ranging effects on the health system. In the hospital market, rate setting is widely believed to have helped safety-net hospitals by allowing higher rates to offset uncompensated care; it may have helped keep some Prince George's County hospitals afloat. Some respondents suggested that, in helping to contain hospital outpatient prices, it might have played a role in suppressing the development of freestanding facilities. And, in the com-

mercial market, rate setting was widely perceived as having diminished CareFirst's advantage over rival insurers, as it took away the dominant carrier's ability to negotiate preferential hospital discounts.

In 2013, Maryland negotiated a new waiver with CMS, which took effect in January 2014. Over the course of the five-year Phase I of the program, from 2014 through 2018, all hospital revenue will transition to global-payment models,⁶ incentivizing hospitals to work with other providers to coordinate care, reduce unnecessary services and improve population health. The new waiver tests are as follows: (1) total hospital per capita revenue growth is limited to the long-term state economic growth rate per capita (3.58% annual rate); (2) Maryland must generate at least \$330 million in Medicare savings over five years (measured by comparing the state's Medicare per capita total hospital cost growth to the national Medicare growth rate); and (3) Maryland must meet quality targets, including reducing the Medicare readmission rate to the national Medicare rate over five years and a 30 percent reduction in hospital-acquired conditions over five years.

If Maryland fails any of these tests over the five-year period, Maryland hospitals will transition over two years to the national Medicare payment system. The demonstration contract terms between Maryland and CMS preclude administrative and judicial review, meaning the state will have no right to appeal any CMS calculations of payment levels.

Although the new waiver took effect in January 2014, many important program details have yet to be finalized. Various workgroups have been working on these issues and issuing recommendations; final program details are slated to be decided by late 2014.

the need for their organizations to develop population-management capabilities. Yet, the progress made to date toward those stated objectives varies widely among the region's providers. While most hospitals are pursuing an updated hub-and-spoke model—with the aggressive introduction of newer ambulatory venues such as freestanding EDs and urgent care centers—only some appear to be using these new ambulatory networks as part of a larger population-management strategy.

MedStar's placement of some ambulatory centers in low-income neighborhoods, for example, is consistent with the system's strategy of managing its Medicaid managed care plan's growing population. However, for other providers—especially those expanding ambulatory networks in affluent, already well-served areas—this approach appears to represent a continuing fee-for-service emphasis on driving more well-insured patients to a particular system. This persistence of fee-for-service strategies likely stems from

Small, independent practices have long been the dominant form of physician organization across the region. However, primarily over the past decade, physician consolidation has accelerated.

the commercial insurance market's "pass-through" environment that allows provider rate increases to be passed on to employers through premium increases because the market has many employers able to absorb the additional costs and no large, influential employers pushing for cost-containment innovations.

Physicians Consolidating, but Many Stay Independent

Small, independent practices have long been the dominant form of physician organization across the region. However, primarily over the past decade, physician consolidation has accelerated. The largest physician groups include:

- Mid-Atlantic Permanente Medical Group (MAPMG), the physician-owned group exclusively affiliated with Kaiser. With about 900 physicians, MAPMG has grown substantially, in keeping with an overall expansion of Kaiser's ambulatory care facilities. In primary care physician (PCP) recruiting, MAPMG is seen as having an edge over hospital systems. The group's specialist base also has expanded substantially; in the past few years, it has grown to include specialty types Kaiser used to outsource to community providers, such as anesthesiology and interventional radiology.
- George Washington Medical Faculty Associates (MFA), a multispecialty group that is the region's only large, independent physician group. MFA's original core was the GWU medical faculty practice; the group maintains a strong affiliation with GWU Hospital, although it is legally separate from both the hospital and the university. With 800 physicians, MFA has grown rapidly in recent years; it now includes many community physicians who reportedly found small, independent practice

increasingly less viable or attractive but wanted to retain as much autonomy as possible and, therefore, were reluctant to accept hospital employment.

- Hospital-owned groups, including:
 - MedStar Medical Group, with more than 900 physicians in the NCR, predominantly specialists; grew by about 75 percent in the past five years;
 - Inova Medical Group, with about 400 physicians in the NCR, predominantly specialists; doubled in size in the past two years; and
 - Johns Hopkins Community Physicians, with 110-120 physicians in the NCR, predominantly specialists; has grown rapidly from a small base.

The hospital-employment model is still relatively new to the region, and market observers regarded most hospital-owned groups as having somewhat of a patchwork feel, with their composition more reliant on which practices and specialties have been willing to be acquired, rather than any master strategies by hospital systems. Hospitals reportedly find it especially challenging to meet PCP recruiting targets and sometimes lose acquired PCPs, for example, to MAPMG.

Despite substantial growth, the number of hospital-employed physicians is still low relative to both the total number of physicians in the region and the number of hospital admissions—with the key exception of MedStar, where employed physicians account for 70 percent of admissions to the system's hospitals. The region's physician market remains less consolidated than those in many metropolitan areas, and despite growing pressures, many physicians have been able to remain in small, independent practice.

The region's affluent demographics have helped blunt financial pressures for some small practices, particularly those in high-income submarkets, where a significant minority of physicians has been able to opt out of health plan networks. Some of these physicians still maintain full patient panels and are not changing the nature of their practices, but they are shifting the burden of dealing with insurance claims to patients. Other physicians opting out of health plan networks are pursuing the classic concierge-medicine model—reducing patient panels by as much as

75 percent and charging their remaining patients a sizable annual fee—typically thousands of dollars—in exchange for enhanced access, such as shorter appointment wait times and longer visits. This concierge model—reportedly concentrated in the upper Northwest area of the District but also seen in some affluent parts of Northern Virginia and Montgomery County—has caused access issues among well-insured patients, who have difficulty finding new PCPs who accept insurance.

For the much larger number of physicians remaining in small, independent practice and still participating in health plan networks, collaborating with payers often is viewed as preferable to joining hospital systems. The most prominent payer-physician collaboration is CareFirst's patient-centered medical home (PCMH) program, which is aimed at increasing care coordination and reducing utilization, especially hospital readmissions and ED use. Participating PCPs—more than 80 percent of CareFirst's PCP network—receive enhanced fee-for-service payments, plus bonuses for meeting global spending and quality targets. The program reportedly has helped make it financially feasible for some PCPs to remain in independent practice. The national carriers are either exploring or beginning to implement their own PCMH programs.

Across the region, some small practices have begun working together in a variety of practice models aimed at allowing them to retain autonomy while realizing economies (for example, in administration or information technology), gaining leverage for rate negotiations with health plans, and positioning them to accept value-based payment. These models include:

- Independent practice associations (IPAs) that negotiate risk contracts with insurers, including ACO-like commercial contracts, on behalf of all member practices. The model has deep roots in some other markets—most notably California—but is new to the National Capital Region. One example is the HealthConnect IPA, a partnership of Fairfax County primary care practices.
- Federated models where single-specialty practices create what has been described as a blend of an independent group and an IPA; the original, smaller practices remain distinct business units but share many functions (e.g. administration, IT, marketing, strategy) across the larger

The region's large systems—Inova and MedStar—are widely perceived as having substantial leverage with health plans, as is the large multispecialty group MFA.

enterprise. Orthopedics, gastroenterology and obstetrics/gynecology practices in the region are among those that have implemented federated models.

- Variations that combine management services organization back-office support for practices with an emphasis on wellness/health coaching services for patients. One such organization active in the region is investor-owned Privia Health.

While these models differ in key ways, what they share are strategies aimed at allowing physicians to retain as much autonomy as possible while finding ways to ease the financial and administrative pressures of independent practice.

Little Innovation in Value-Based Payment

The region's large systems—Inova and MedStar—are widely perceived as having substantial leverage with health plans, as is the large multispecialty group MFA. However, multiple respondents observed that none of the region's provider organizations have the outsized leverage to extract rate premiums nearly to the degree exercised by Partners Healthcare in the Boston area or Sutter Health in Northern California. While many observers regarded Inova and MedStar as “must-haves” in health plan networks, they noted that enough alternatives exist—for example, VHC and Reston Medical Center in Northern Virginia and GWU and the JHHS hospitals in the District and Montgomery County—in case the large systems make what one benefits consultant called “outrageous demands.”

Another reason the large providers have not tended to push health plans too hard on rates, according to market observers, is that it would not be in the best interests of providers for any one insurer to gain too much dominance. Accordingly, providers are said to refrain from

extracting too many rate concessions from the national carriers to keep premiums competitive with CareFirst. At the same time, observers noted that insurers in the market tend not to push providers too hard on rates, in large part because insurers, in turn, are not pushed as hard by the region's employers on premiums. As noted earlier, a pass-through environment still persists in this region's commercial insurance market to a greater degree than seen in many other markets. As a result, most negotiations between providers and health plans tend not to be too contentious. Indeed, respondents remarked on the absence of plan-provider contract showdowns in recent years, noting that the only contract to lapse was between Kaiser and Inova. As indicated previously, the termination of that relationship stemmed from differing views about how Kaiser members should receive inpatient care and not from a rate dispute.

Many providers speak of 'population health' as a central strategy for their organizations, yet the path to achieving it remains unclear and uncertain for most providers—particularly those not focused on primary care delivery.

As described earlier, the Kaiser system and the Maryland all-payer hospital rate-setting program are key exceptions to the region's pervasive fee-for-service environment. Provider payment and care delivery trends well underway in other major markets have only slowly begun to emerge here. Activity around ACOs, for example, is still nascent. None of the region's providers have formed Medicare Pioneer ACOs. A few providers—including JHHS, HealthConnect IPA and Privia Quality Network—recently launched Medicare Shared Savings Program (MSSP) ACOs. Inova is among the providers exploring MSSP participation. HealthConnect IPA reportedly is negotiating ACO-like commercial contracts with insurers, and many other physician organizations are experimenting with or exploring similar arrangements. In an effort to share information across care settings to better manage

patient care, the District government is convening providers and payers to develop—with the support of federal grants—health information exchanges.

These experiments all represent provider efforts to prepare for the coming world of risk sharing and value-based payment, but aside from Kaiser—and, to a lesser extent, MedStar—providers in the market have little or no experience accepting financial risk or delivering clinically integrated care. Many providers speak of “population health” as a central strategy for their organizations, yet the path to achieving it remains unclear and uncertain for most providers—particularly those not focused on primary care delivery.

Challenging Rollout for Exchanges

Health plans found the rollout of public health insurance exchanges challenging across all three jurisdictions in the region but to varying degrees. Respondents consistently rated Maryland's ambitious, highly anticipated state-run exchange as the region's worst performing, by far. “Disastrous” was a term often used to describe the Maryland exchange. Virginia's federally facilitated exchange was seen as the least problematic in the region, although it was still plagued by serious, persistent technical flaws. The performance of DC Health Link, the District's exchange—rated by most as significantly better than Maryland's and worse than Virginia's—exceeded expectations overall.

A major concern raised by insurers and brokers about the District's implementation of the ACA is that it is the only jurisdiction to require all small groups to purchase health benefits solely through the exchange.⁸ With most small groups renewing their policies early to avoid dealing with this requirement for 2014, many expect problems to become apparent when policies are renewed for 2015 coverage. The concerns stem not only from technical problems with the functioning of the DC Health Link website but also from a narrowing of benefit options for small employers—most notably the coalescing of benefits around the ACA-required metal tiers—bronze, silver, gold and platinum—that approximate the relative comprehensiveness of different products. This would represent a reduction in benefits for the numerous groups whose benefit richness currently exceeds the platinum level. In addition, insurers and brokers expressed concerns about

the increased complexity of calculating premium rates for members of groups on the exchange.

In the insurance exchanges' first year, health plan participation was limited across the three jurisdictions, with Maryland having the most participants. Only CareFirst and Kaiser offered both nongroup and Small Business Health Options Program (SHOP) products in all three jurisdictions, with United and Aetna participating more selectively. In 2014, the lion's share of exchange enrollment went to CareFirst, especially in Maryland. In part, that result had been predicted, as CareFirst had the strongest brand as the Blue plan. That advantage was compounded by the lower premiums on CareFirst exchange products, as well as the technical problems with exchange websites, which likely disadvantaged other carriers more than CareFirst. Many consumers, unable to shop directly through the exchange websites, had to purchase insurance through brokers instead—a development that favored CareFirst, which has the most comprehensive, longstanding broker networks among the region's carriers.

However, CareFirst's pricing advantage on exchange products does not appear to have resulted from an intentional strategy by the insurer to underprice rivals' products. In Maryland, for example, CareFirst had sought higher premiums for 2014 products, but its proposed rates were disallowed by state regulators.⁹ As a result, CareFirst products were some of the lowest-priced on the Maryland exchange—particularly important because the exchange website displays products in ascending price order. For 2015, CareFirst sought substantial rate increases, ranging from 23 percent to 30 percent, while Kaiser and Evergreen, a co-op plan, sought rate reductions of 10 percent to 12 percent. Although regulators only approved a portion of CareFirst's proposed increases,¹⁰ the final 2015 rates for several Kaiser and Evergreen products undercut CareFirst.¹¹ Maryland's nongroup exchange has two new entrants for 2015—United and Cigna—a development touted by state officials as a boon to competition. However, offerings by these two plans—especially Cigna—tend to have higher prices, so any impact on competition and enrollment is likely to be muted.

Given the richness of employer-sponsored benefits in the region, the expected imposition of the ACA's Cadillac tax provision poses serious concerns. Scheduled to begin

The District, Maryland and Virginia have adopted very different political stances on providing public health coverage and health services for low-income people, contributing to variation in the strength of safety nets for low-income people across the three jurisdictions.

in 2018, the Cadillac tax is a 40 percent excise tax on health insurance coverage valued above certain thresholds—\$10,200 for single coverage or \$27,500 for family coverage. Market observers noted that this tax—if left intact by federal policymakers—has an unprecedented potential to disrupt the region's longstanding culture of rich health benefits.

Wide Variation in Approaches to Public Coverage

The District, Maryland and Virginia have adopted very different political stances on providing public health coverage and health services for low-income people, contributing to variation in the strength of safety nets for low-income people across the three jurisdictions. In breadth of coverage, programs for the uninsured, and availability of providers to treat Medicaid and low-income uninsured people, the District's safety net is quite strong, Maryland's is mixed and Virginia's is relatively weak, yet the whole region lacks significant collaboration and coordination among providers and others involved in care for low-income people.

While all three jurisdictions have relatively generous criteria for children and pregnant women to qualify for public coverage,¹² their eligibility standards for other adults vary dramatically. In the decade preceding enactment of the ACA, the District had gradually expanded public coverage eligibility to progressively more categories of adults. In 2001, the District established the DC Healthcare Alliance program to provide fairly comprehensive health services—except mental health—to adults up to 200 percent of poverty who were ineligible for Medicaid. Later, through Medicaid waivers, the District began making cer-

tain low-income adults—such as HIV-positive residents—eligible for Medicaid. In 2010, the District used the early expansion option in the newly enacted ACA to expand Medicaid to childless adults up to 138 percent of poverty; later that year, it received a waiver to increase eligibility to 200 percent of poverty.

To a lesser degree, Maryland also has expanded public coverage for adults. In 2008, parents up to 116 percent of poverty became eligible for Medicaid, and childless adults with the same income limits became eligible for limited coverage through the state-funded Primary Adult Care program. Locally, Montgomery County operates the Montgomery Cares program to provide primary care to uninsured adults through a 12-clinic network. Under the

In addition to AmeriHealth, which now commands almost two-thirds of the market, the District’s Medicaid managed care sector is served by two relatively recent local entrants: provider-owned MedStar Family Choice and for-profit Trusted Health Plan.

ACA, Maryland expanded Medicaid for all adults with valid immigration status up to 138 percent of poverty in 2014.

In contrast, Virginia has not extended public coverage to adults beyond federal requirements. After passage of the ACA, the state opted out of the law’s Medicaid expansion. Terry McAuliffe, the Democratic governor who took office in January 2014, has pushed to expand Medicaid but has been unable to reach a compromise with the Republican-controlled Legislature.

In all three jurisdictions, most Medicaid enrollees are served by managed care plans. The Medicaid managed care sector is mature in the sense that it has served the local communities for many years. However, the market has been somewhat unstable over the past few years, with a number of plan exits and entries. By far the greatest turmoil has been in the District, where for-profit D.C. Chartered Health Plan—which had been the leading Medicaid plan—became mired in financial and political scandal and had its assets seized by the District government. Many of its

assets were sold—and its 100,000 enrollees transferred—to Philadelphia-based AmeriHealth. The shake-up reportedly did not create significant disruptions in access to care for enrollees but caused delays in provider payments.

In addition to AmeriHealth, which now commands almost two-thirds of the market, the District’s Medicaid managed care sector is served by two relatively recent local entrants: provider-owned MedStar Family Choice and for-profit Trusted Health Plan. These plans also serve DC Healthcare Alliance enrollees. The Maryland market is served by five Medicaid plans: two subsidiaries of national for-profits, Amerigroup (part of WellPoint) and UnitedHealthcare Community Plan (part of UnitedHealth Group)—which command the largest market shares—and three local, provider-owned entities—each with limited enrollment. In Northern Virginia, a WellPoint subsidiary (Anthem HealthKeepers Plus) is the dominant plan (approximately 65% market share), followed by an Inova-owned plan (approximately 30%). Kaiser entered the Medicaid markets in both Maryland and Northern Virginia in mid-2014, but it remains unclear how large a Medicaid presence Kaiser aims to have. In other markets where Kaiser participates in both the commercial and Medicaid sectors, it tends to limit Medicaid enrollment largely to existing Kaiser commercial enrollees who “churn” between the two types of coverage.

Although the recent impact of the ACA Medicaid expansion has been more modest in the region than in many communities nationwide, Medicaid health plans and providers still have either seen or are expecting to see increasing demand for some services as people without insurance or with more limited insurance gain broader benefits under Medicaid. In the District, for example, plans are grappling with high demand for HIV and hepatitis C services—including expensive new specialty drugs—among new Medicaid enrollees. In both Maryland and the District, demand for mental health and specialty care has increased; Maryland has increased its payment rates to Medicaid plans to account for the greater needs of the new enrollees.

Broad Safety Net Lacks Cohesion

Because the NCR spans a large geographic area composed of multiple state and local government jurisdictions, low-income people receive health services from multiple safety

nets instead of a single one. On the whole, low-income people appear relatively well served by a broad set of inpatient and ambulatory safety-net providers, despite little coordination among providers, or between providers and governments, across or within the region's safety nets. While safety-net access reportedly is generally good across the region, low-income Southeast D.C. and adjacent Prince George's County have notable pockets of unmet need.

On the inpatient side, the region has lacked a dedicated safety-net hospital since the closure in 2001 of the District of Columbia General Hospital, which primarily served D.C. residents. A few of the region's hospitals have stated missions to serve low-income people, but most hospitals that serve a safety-net role do so largely by default because of their size, location and/or range of services.

In the District, five hospitals play key safety-net roles:

- MedStar Washington Hospital Center in Northwest D.C. provides the largest volume of safety-net services because of the large low-income population near its campus and its role as a major regional tertiary referral center and trauma care center.
- Providence Hospital—owned by Ascension Health, a national Catholic system—is located in Northeast D.C. but very near MWHC. Only half MWHC's size and more limited in services, Providence has a longstanding mission to serve low-income people.
- Howard University Hospital—in Northwest D.C. and not far from MWHC and Providence—has long been a key provider for many of the city's African-American residents but has been mired in financial and quality problems.
- United Medical Center (UMC)/Greater Southeast Hospital, the only full-service hospital east of the Anacostia River in the District, serves a largely low-income population. UMC has long faced serious management, financial and quality problems; the city assumed ownership in 2010 after UMC's private owner defaulted on a loan. Although recent turnaround efforts have improved patient volumes and financial status, UMC's future remains uncertain as city leaders debate whether to rebuild the facility and/or seek a private partner to own or operate the hospital.¹³

- Children's National Medical Center in Northwest D.C. is the leading pediatric inpatient and subspecialty referral facility for the region and serves as the main safety-net hospital for children.

In suburban Maryland, Washington Adventist Hospital, part of the Adventist HealthCare system, in Takoma Park is the main safety-net hospital. Located in Montgomery County, it receives about one-third of its patients from Prince George's County. The facility is outdated, which poses problems attracting both physicians and well-insured patients. Secondary safety-net hospitals in Montgomery County include Shady Grove Adventist, also part of the Adventist system, in Gaithersburg and Holy Cross Hospital in Silver Spring.

While safety-net access reportedly is generally good across the region, low-income Southeast D.C. and adjacent Prince George's County have notable pockets of unmet need.

In Prince George's County, Prince George's Hospital Center in Cheverly, one of two hospitals in the Dimensions Healthcare System, is the main safety-net hospital, but respondents lamented the facility's poor condition and subpar quality. Dimensions is partnering with the University of Maryland and the county to rebuild the facility but awaits certificate-of-need approval from the state for the project. Doctor's Community Hospital in Greenbelt also serves a key safety-net role.

In Northern Virginia, Inova is the main provider of safety-net inpatient services by default, as it is the dominant system in the community. Inova Fairfax Hospital is the main safety-net hospital in the region based on its size; it also reaches out to low-income people in certain ways, such as operating clinics providing pediatric, HIV, obstetric and transitional (post-hospital discharge) care. In the Alexandria area, Inova's Mt. Vernon and Alexandria campuses are key safety-net hospitals. However, respondents indicated that Inova provides relatively little specialty care to low-income people, causing many low-income people to travel to the University of Virginia Health System in

While the region’s safety nets generally provide good access to primary care, respondents reported that access to specialty, mental health and dental services can be difficult—in common with most communities across the nation.

Charlottesville—more than two hours away—for specialty appointments.

For ambulatory care, much of the region is well served by community health centers (CHCs) and other clinics that focus mostly on providing primary care—along with some specialty and dental services—to low-income people. As in many communities, the number and capacity of CHCs with federally qualified health center (FQHC) status, which makes them eligible to receive federal grants and enhanced Medicaid payments,¹⁴ has expanded over time, made possible in many cases by grants under the ACA or the American Recovery and Reinvestment Act of 2009.

Most communities in the NCR have strong, extensive CHC organizations. The largest by far is the District’s Unity Health Care, an FQHC with 13 major, full-service sites throughout all wards of the city, plus many smaller sites focused on specific services. Prince George’s County has less CHC capacity relative to need than other areas of the region. As a result, many low-income Prince George’s residents travel to the District, or to a lesser extent, Montgomery County, for care.

Indeed, although each jurisdiction has a distinct set of safety-net providers, many low-income people cross borders—particularly from Northern Virginia and Prince George’s County into the District—in search of free or low-cost care. According to some respondents, border crossing may be increasing as a result of gentrification in District neighborhoods, which has led many low-income people to move into suburban areas—such as Prince George’s County—that lack the District’s safety-net resources. Also, public transportation options in and out of the District are better than transportation within Northern Virginia

or Prince George’s County. Because some safety-net providers and programs view their mission as providing care primarily to residents of their immediate communities, they sometimes turn away patients from elsewhere in the region. In response, some low-income patients reportedly use the addresses of friends and relatives.

In common with local health departments across the country, some county health departments in the region have pulled back in recent years on the direct provision of preventive and primary care services. They typically now focus on core public health functions, such as vaccinations and screenings for certain communicable diseases. In Maryland and the District, this scaling back has resulted in CHCs providing more services and increasing their patient base. For example, Unity now runs the health department’s public health clinics at the former D.C. General Hospital campus. In contrast, Northern Virginia health departments still operate several primary care clinics.

While the region’s safety nets generally provide good access to primary care, respondents reported that access to specialty, mental health and dental services can be difficult—in common with most communities across the nation. Low-income people in the NCR reportedly turn to a small subset of hospitals for these services—for example, MWHC stands out for providing a significant volume of specialty care. Low-income people also rely on physicians and dentists in private practice. Physician participation in Medicaid is reported to range from decent to good in the region, aided by relatively high Medicaid payment rates—especially in the District, where Medicaid rates approach Medicare levels.¹⁵

Despite having some strong safety-net providers and programs, the region lacks significant collaboration among safety-net organizations both within each jurisdiction and across jurisdictions. Montgomery County, Northern Virginia and the District all have active primary care coalitions that bring CHCs and other clinics together to discuss policy, funding and service issues, but the degree of actual collaboration among CHCs and clinics varies across the region. Collaboration between hospitals and CHCs historically has been more limited, making coordination and continuity of care for low-income people particularly challenging. According to one respondent, “Connections between the clinics and spe-

cialty care and hospitals are very reliant on duct tape and Band-Aids.”

Market observers rated the District highly for an expansive approach to Medicaid and other public coverage and committing ample public resources to safety-net funding. At the same time, they lamented the persistent political wrangling and many financial scandals that have hindered better performance and cohesion of the District’s safety net. Examples cited by respondents included the recent scandal-plagued demise of the Chartered Medicaid plan and ongoing issues surrounding United Medical Center.

Prince George’s County is widely regarded as having a weaker safety net than other jurisdictions in the region. Market observers described the county as less focused on and organized in meeting the health care needs of low-income residents, with scarce county and private funding dedicated to the safety net. However, the Prince George’s County Health Department is implementing a strategic plan for an integrated delivery system of primary and hospital care, anchored by the proposed new regional medical center to replace Prince George’s Hospital Center and expand services in the county. The county is expected to fund about a third of the project.¹⁶ Respondents viewed this as a step in the right direction, but it remains unclear how effective the strategic plan will be in improving the county’s safety net.

Muted ACA Impact on Safety Net to Date

Because the District and Maryland both began expanding public coverage years before the ACA’s widespread Medicaid expansion, much of the increased demand for safety-net services in these jurisdictions—particularly for primary and other ambulatory care—also predated January 2014. For example, after the District expanded Medicaid to childless adults in 2010, Unity Healthcare began seeing a surge in homeless male patients. Previous public coverage expansions meant that the District—and, to a lesser extent, Maryland—did not experience a significant surge in demand in 2014. In Virginia, safety-net demand has remained largely stable for a different reason: The state has opted not to expand Medicaid to date.

Despite ACA coverage expansions having a more limited effect in the NCR than in many communities, they still have had some impact on the strategies of both main-

stream and safety-net providers for serving the populations gaining coverage under the new law. One of the potential effects of ACA coverage expansions is increased competition from mainstream hospitals and physicians for Medicaid patients. Many of the region’s safety-net providers have expected increased competition, but to date, the only clear evidence of greater head-to-head competition from a major system has come from MedStar, which has opened five PromptCare centers providing urgent and

One of the potential effects of ACA coverage expansions is increased competition from mainstream hospitals and physicians for Medicaid patients.

other ambulatory care in the region. As described earlier, safety-net providers have reacted with consternation, noting that they have long served low-income residents in the neighborhoods where the new MedStar facilities are located. They fear that MedStar—with its much deeper pockets and greater range of services—will steer more and more Medicaid patients into its system. Meanwhile, MedStar has framed its approach as part of an overall shift from inpatient to ambulatory settings and an effort to reduce readmission rates, which were high enough for the system to be penalized by Medicare. Perhaps in response to push back from safety-net providers, MedStar reportedly has begun working on a more collaborative approach with CHCs in the District, including Unity and Mary’s Center, but these efforts are nascent.

Other hospitals have taken a different approach by pursuing collaborations with CHCs from the start. Providence Hospital, for example, is expanding primary care through a formal affiliation with Unity and Mary’s Center, with the hospital agreeing to share patients with the health centers and form a clinically integrated network with a common electronic health record. Similarly, Washington Adventist Hospital affiliated with Community Clinic, Inc., the largest FQHC in suburban Maryland, to create a community health clinic on the hospital campus. The two organizations will share patients and their medical information—a move seen as a response not only to the ACA coverage

expansions but also to the new Maryland hospital payment system, with its emphasis on primary care and population health.

The ACA coverage expansions also have the potential to increase head-to-head competition between mainstream and safety-net providers by giving the latter group incentive to pursue patients gaining subsidized commercial coverage through the insurance exchanges. Many of the region's safety-net providers are interested in serving this population and have contracts with exchange plans to do so, but most of these providers reported not yet seeing many patients with subsidized coverage. Safety-net providers noted that they have historically attracted patients with quite low incomes (below 200% of poverty) and may not be regarded as the provider of first choice to people of more moderate incomes who receive subsidized coverage (up to 400% of poverty).

While safety-net providers across the region have benefited financially from more people gaining coverage in recent years, they voiced concern about financial changes on the horizon that are expected to have a negative impact on their finances and their ability to continue serving undocumented immigrants and others who remain uninsured.

While safety-net providers across the region have benefited financially from more people gaining coverage in recent years, they voiced concern about financial changes on the horizon that are expected to have a negative impact on their finances and their ability to continue serving undocumented immigrants and others who remain uninsured. The DC Healthcare Alliance program is expected to continue operating, but the future of Montgomery Cares is less certain. Hospitals are bracing for future reductions in their Medicare and Medicaid disproportionate share hospital (DSH) funds but were uncertain about the size and impact of these cuts.¹⁷ Respondents were particularly concerned about the future viability of Northern Virginia's

CHCs if the state does not expand Medicaid. Northern Virginia's free clinics are already facing dwindling financial support, with funders and donors apparently perceiving need as having declined, although the state has not expanded Medicaid, and people with incomes below poverty have no path to subsidized coverage.

Issues to Track

- How much—and in which submarkets—will hospitals increase head-to-head geographic competition and expansion of ambulatory care networks?
- To what extent will physician consolidation continue to gain traction? Will it primarily take the form of hospital employment, membership in large physician-owned groups or alternative models that emphasize more autonomy, such as IPAs or federated models?
- To what extent will mainstream providers move beyond fee-for-service strategies and pursue more risk sharing and value-based payment approaches?
- How will the region's longstanding culture of rich benefits change as the ACA's Cadillac tax provision approaches? How will that impact delivery of care?
- How will suburban Maryland hospitals fare under the new Maryland waiver and the phasing-in of global budgets? How will the state perform overall in the new waiver tests?
- Will Virginia's governor and Legislature reach a compromise to expand Medicaid eligibility in the state? If not, how will Northern Virginia low-income residents and safety-net providers fare?

Notes

1. Five independent cities—Alexandria, Falls Church, Fairfax, Manassas and Manassas Park—also fall within the boundaries of the National Capital Region. These cities do not belong to any county and are considered county-equivalents for census purposes.
2. According to the Kaiser Family Foundation's 2014 Employer Health Benefits survey, average annual deductibles for single coverage in the U.S. ranged from

- \$843 to \$1,215, depending on product type.
3. In Northern Virginia, CareFirst's presence is limited to the area east of Route 123, the city of Fairfax and the town of Vienna. Anthem of Virginia is the Blue Cross Blue Shield licensee in the rest of Virginia. Source: Anthem of Virginia website, 2014 provider manual.
 4. In the NCR, as in many markets, it is not uncommon for hospital systems to offer their own employees a narrow network limited to providers belonging to the employer's own system.
 5. A fifth hospital, MedStar National Rehabilitation Hospital, is licensed as an acute-care facility but used as an inpatient rehabilitation facility.
 6. Under global payment, providers receive fixed payments per set time period to provide care for their assigned patients, rather than receiving a fee for each service performed. To reduce the provider's incentive to stint on care or cherry pick healthy patients, global payment contracts generally contain provisions for adjusting payment based on patient case mix and provider performance on quality measures.
 7. MedStar first introduced its Medicaid managed care plan, MedStar Family Choice, in 1998. MedStar launched a Medicare Advantage plan in 2013.
 8. The District enacted this provision largely because the nongroup exchange was expected to be very small—in part due to the District's small population, and in part due to expansive Medicaid eligibility—so policy makers considered a sizable SHOP exchange necessary to the viability of DC Health Link, the District's exchange.
 9. Sun, Lena H., "CareFirst Proposes Hefty Rate Increases; Kaiser Cuts Rates for Individual Health Plans," *The Washington Post* (June 6, 2014).
 10. Sun, Lena H., "Maryland Approves Smaller Rate Hikes for CareFirst, Lowers Rates for 3 Others," *The Washington Post* (Aug. 22, 2014).
 11. Premiums differ by enrollee's age, smoking status and geographic area, as well as metal tiers and specific products offered within each metal tier by each health plan. For a 30-year-old non-smoker living in Montgomery County, CareFirst still offers the lowest-priced bronze-tier products but has higher-priced platinum-tier products than Kaiser and Evergreen; the three plans now offer comparably priced products in the silver and gold tiers.
 12. The pre-ACA income limits for children in Medicaid/Children's Health Insurance Program were 300 percent of poverty in the District and Maryland and 200 percent of poverty in Virginia. For pregnant women, the limits were 300 percent in the District and 250 percent in Maryland and Virginia.
 13. DeBonis, Mike, "D.C.'s United Medical Center is on Financial Upswing, but its Future is Mired in Politics," *The Washington Post* (Aug. 3, 2014).
 14. Medicaid reimburses FQHCs through a prospective payment system, which provides a set payment per encounter and accounts for the comprehensive services a FQHC provides beyond primary care, such as dental, mental health, pharmacy, care management, transportation and other support services.
 15. The ACA provided a further temporary boost to Medicaid primary care rates, raising them to Medicare levels through December 2014.
 16. Reed, Tina, "3 Things to Know About Dimensions Healthcare System's Proposed Hospital in Prince George's," *The Washington Business Journal* (Aug. 6, 2014).
 17. Medicaid DSH cuts have been delayed until 2016.

Data Source

With funding from the Jayne Koskinas Ted Giovanis Foundation for Health and Policy, Mathematica Policy Research examined how health care is currently organized, financed and delivered in the Washington, D.C., metropolitan area. A key goal was to gain early insights on how the federal Affordable Care Act is impacting the market as a whole and to capture differences across the three jurisdictions of Washington, D.C., and suburban Maryland and Virginia. Researchers defined the market as the National Capital Region, which includes the District of Columbia and the suburban areas of Maryland (Montgomery and Prince George's counties) and Northern Virginia (Arlington, Fairfax, Loudon and Prince William counties), as well as the independent cities within these boundaries.

This qualitative project involved approximately 40 in-depth interviews with local health care leaders between April and June 2014 across three main sectors: providers, including hospitals and physician groups; commercial health insurance, including health plans, benefits consultants, brokers and insurance exchanges; and safety-net organizations, including hospitals that serve many low-income people, community health centers, Medicaid agencies and health plans; as well as other experts in these areas. The study also incorporated information from other reports and media articles as well as quantitative data to capture differences in socio-economic, insurance coverage and other indicators across the region.

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