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**The Medicaid Demonstration Project  
In Los Angeles County, 1995-2000:  
Progress, But Room For Improvement**

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# **The Medicaid Demonstration Project in Los Angeles County, 1995-2000: Progress, But Room for Improvement**

## **EXECUTIVE SUMMARY**

Under the Medicaid Demonstration Project for Los Angeles, Los Angeles County agreed to fundamentally restructure its Department of Health Services (LACDHS) and its approach to delivering indigent care in return for federal funds. LACDHS attempted to reduce its traditional emphasis on emergency room and inpatient care by building an integrated system of community-based primary, specialty, and preventive care. As part of the Centers for Medicare and Medicaid Services (CMS)<sup>1</sup> evaluation of this waiver, the Urban Institute conducted site visits in 1997 and 2001. This report is based on findings from both of these site visits.

The restructuring under the Demonstration Project focused on two key areas: (1) improving access to county-funded ambulatory services and (2) making hospital care more efficient. It appears that LACDHS succeeded in developing public-private partnerships to deliver ambulatory care, reduced inappropriate emergency room use and made considerable strides in expanding and integrating community-based primary care through the use of Referral Centers and community-based planning. Moreover, the County has lowered the number of inpatient beds and reengineered its hospitals to become more efficient.

Although progress was made, by 1999 the County recognized that it was not going to meet many of its restructuring targets and that it could not operate beyond 2000 without a continuation of waiver funding. Rather than simply reverting to the financial crisis atmosphere of 1995, the County applied for and received an extension of their waiver. This could be viewed as a sign that the waiver restructuring had failed to meet its objectives, but stakeholders and observers suggested a somewhat more positive assessment. The changes that took place combined with an increased level of cooperation between LACDHS, unions, and community groups were all viewed as signs that the County's large indigent population was better served in 2000 than might have been expected in light of the pre-waiver financial crisis in 1995.

Despite the financial relief that the waiver extension provides, some critical issues remain. Absent broad federal or state health reforms that substantially reduced the number of uninsured in Los Angeles, LACDHS officials have been skeptical about achieving self-sufficiency after the waiver. The LACDHS consensus is that the system would have been "near collapse" without an extension of the waiver. If the federal government follows through on its plan to end waiver funding in 2005, LACDHS could be "near collapse" again without significant restructuring and re-engineering efforts or a significant increase in state or local revenues.

In the end, the Demonstration Project pulled LACDHS out of its 1995 financial crisis and allowed it to begin to rebuild its ambulatory care system and undertake a variety of other reforms aimed at improving efficiency and patient care, but it did not create a stable financial environment for the future. Whether or not this changes as a result of actions to be implemented during the waiver extension will depend on the willingness and ability of both the State and County to make fundamental reforms in both the financing and operation of LACDHS.

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<sup>1</sup> Formerly the Health Care Financing Administration (HCFA).

## I. INTRODUCTION

In the summer of 1995, the Los Angeles County Department of Health Services (LACDHS) faced the largest budget shortfall in its history. With a \$655 million deficit in an operating budget of \$2.3 billion, the County was forced to cut back on services and close or plan for the closing of a number of its health care facilities. Consequently, the State of California and the County sought assistance from the federal government regarding longer-term solutions to the County's financial difficulties. In September 1995, President Clinton announced a federal fiscal relief package as part of a Section 1115 Medicaid Research and Demonstration waiver. In February 1996, the application for the Medicaid Demonstration Project for Los Angeles County was submitted to the Centers for Medicare and Medicaid Services (CMS),<sup>2</sup> and was approved on April 15, 1996. The approved waiver Demonstration covered the five-year period from July 1, 1995 through June 30, 2000. An agreement for a waiver extension took place in June 2000 and an official extension was granted in January 2001. This evaluation focuses on the first waiver.

While many Section 1115 waivers are state initiatives related to expanding mandatory Medicaid managed care programs or eligibility standards, Los Angeles's waiver was unusual in that it was initiated by and applied to a single County. Further, the waiver focused on providing a federal relief package for the financial stabilization of LACDHS and the restructuring of the County's public health care system. The five-year financial relief package brought LACDHS approximately \$1.2 billion in federal Medicaid funding, with the two largest components of the funding being a supplemental project pool (SPP) and an indigent care match.<sup>3</sup> The SPP is funded equally by federal and local dollars and was established so that the County could receive

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<sup>2</sup> Formerly the Health Care Financing Administration (HCFA).

<sup>3</sup> LACDHS estimates that the county received \$1.2 billion over the course of the first waiver, with \$0.2 billion of this funding allocated for mental health.

federal Medicaid funds for providing ambulatory care to indigents. The indigent care match made LACDHS eligible to receive a federal match for services provided to low-income patients in non-hospital settings.<sup>4</sup>

In return for getting federal funds, Los Angeles County agreed to fundamentally restructure its Department of Health Services and the delivery of care to the indigent. The restructuring proposed under the demonstration project focused on two key elements: 1) increasing access to County-funded ambulatory care services and 2) reducing inpatient beds in County hospitals. This restructuring represented an attempt to reduce the County's traditional emphasis on emergency room and inpatient care by building an integrated system of public and private clinics to provide community-based primary, specialty, and preventive care.

As part of CMS's evaluation of this waiver, the Urban Institute conducted an initial site visit in 1997. That site visit assessed the first two years of the waiver, focusing on the changes the County had made up to that time and implementation issues. In the Winter of 2001, the Urban Institute conducted a follow-up site visit to complete the evaluation of the County's 1995-2000 waiver. This report builds upon our preliminary findings from the initial assessment and seeks to answer some of the questions raised during the 1997 site visit. As with our initial site visit report, this report is based on interviews with LACDHS officials, as well as key associations, researchers, and organizations involved with the restructuring of the County's health care system. This report is organized in the following manner:

- **Section II** provides the reader with a background of the characteristics of Los Angeles County and the Public Health Care System and briefly describes the circumstances leading up to the waiver;
- We then examine LACDHS's waiver activities in two sections: **Section III** reviews the outcomes of restructuring under the waiver, focusing on changes in ambulatory care and

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<sup>4</sup> For more information on the components of the fiscal relief package for LACDHS, please see: Long, et al. April, 1999.

inpatient care separately, and **Section IV** discusses some of challenges faced by the County and issues that remain for the future;

- In **Section V**, we review the financial stabilization package that LACDHS operated under between 1995 and 2000, highlighting the incentives it provided and its growing importance in funding indigent health care. Although this was the initial motivation for the waiver, the finances serve as a backdrop for the restructuring that has been the primary focus of this evaluation.
- **Section VI** concludes the report with a summary of our findings and implications for the County as they begin the second phase of their Medicaid 1115 Waiver.

In this report, we review many details of the restructuring undertaken by LACDHS under its Section 1115 waiver. Broadly speaking, the objective of the 1995-2000 waiver was to stabilize LACDHS financially so that it would have the time to restructure service delivery in a way that would make it more efficient and better able to meet the community's needs. Although tangible progress was made, by 1999 the County recognized that it was not going to meet many of the restructuring targets that had been established and that it could not operate beyond 2000 without a continuation of waiver funding. Rather than simply reverting to the financial crisis atmosphere of 1995, the County applied for and received an extension of their original waiver.

The mere fact that LACDHS required an extension of the waiver to avoid a financial crisis could be viewed as *prima facie* evidence that the waiver was not a success. However, the interviews we conducted suggested a somewhat more positive assessment. The expansion of ambulatory care through partnerships with private providers, the reduced dependence on hospital-based care, and the cooperation between LACDHS, unions and community groups were all highlighted as signs that the delivery of health services to the County's large indigent population was better in 2000 than might have been expected in light of the pre-waiver financial crisis in 1995. Despite these positive signs, the evidence we will present point in the direction of a very uncertain future for LACDHS.

## II. BACKGROUND

Los Angeles County, with 9.8 million people, has the largest County population in the nation and accounts for approximately 29 percent of California's population. In addition, the geographic area that LACDHS must serve is over 4000 square miles, more than 13 times the area covered by the five counties that make up New York City. Hispanics make up more than one-third of Los Angeles' population. More than two million people in Los Angeles are living in poverty, a rate higher than for Californians in general. According to the National Survey of America's Families, in 1999, 46 percent of the non-elderly population in Los Angeles lived in families with incomes below 200 percent of the federal poverty level (FPL), compared with 31 percent nationwide.<sup>5</sup>

The demands on the County to meet the health care needs of its low-income population are enormous. Some estimates suggest that approximately one-third of the County's non-elderly population is uninsured and another 20 percent is covered by Medi-Cal. The pressures have grown in recent years as Medi-Cal enrollment in the County has slipped from about 1.9 million in 1995 to 1.7 million today and projected numbers of uninsured have increased.

The County meets its state-mandated obligation to serve as the provider of last resort by operating an extensive public network of hospitals and clinics. In 1995, before the Section 1115 waiver was implemented, the LACDHS employed about 26,000 full-time equivalent employees (FTEs). The County health care system included 5 hospitals that provide inpatient and outpatient services (LAC+University of Southern California Medical Center, Harbor/University of California at Los Angeles Medical Center, MLK/Drew Medical Center, Olive View/UCLA Medical Center, and High Desert Hospital) and one hospital that provides primarily rehabilitation services (Rancho Los Amigos National Rehabilitation Center). LACDHS's

ambulatory care system included 6 Comprehensive Health Centers (CHCs) offering primary care and selected specialty outpatient services, and 39 Health Centers offering various levels of public health and/or primary care services. LACDHS estimated that together these facilities provided approximately 500,000 emergency room visits, 750,000 inpatient days, and 2.4 million ambulatory care visits in fiscal year 1995-96. This system is particularly crucial for the uninsured, accounting for about 85 percent of all uncompensated inpatient care in the country (California Office of Statewide Health Planning and Development, 1999).

In 1995, Los Angeles' Chief Administrative Officer (CAO) projected a budget deficit for the County of \$1.3 billion, about 10 percent of the total estimated budget. Of that \$1.3 billion, \$655 million represented a deficit for LACDHS. That figure represented over 28 percent of LACDHS's \$2.3 billion operating budget. This funding crisis did not emerge suddenly, but culminated from years of reductions in revenue streams, increases in demand for services, and the cost of maintaining the deteriorating County health system infrastructure (Long, et al., 1999).

In response to LACDHS's projected budget deficit, the CAO proposed two options: (1) Close the largest hospital in the system (LAC+USC Medical Center), four CHCs, and 25 Health Centers; or (2) Close four County hospitals (keeping LAC+USC and one other hospital open), all six CHCs, and 19 Health Centers. These proposals were viewed as highly undesirable by public and private providers and advocates for patients treated at County facilities. This led the Board of Supervisors to appoint a Health Crisis Task Force to help it examine these options as well as propose alternatives. The result of the Task Force was the identification of another option. This option called for closing all six CHCs, closing 29 Health Centers, and reducing hospital outpatient services by 75 percent. The Task Force recommended these cuts, but with a delay in

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<sup>5</sup> The FPL varies by family size and composition. It was approximately \$17,000 for a family of four in 1999.

implementation until the Fall of 1995 to allow time to identify outside revenues that could be used to avert the closings and service reduction. The Board of Supervisors approved this option.

As part of its efforts to solicit revenues to avert the cutbacks of the health care system, the State of California and Los Angeles County turned to the federal government for assistance. Ensuing discussions with federal officials culminated in September 1995, when a still-to-be-designed Section 1115 waiver program that included a federal fiscal relief package was announced. With these anticipated waiver funds, the Board of Supervisors voted to restore most CHC, Health Center, and hospital outpatient services, to cancel scheduled hospital closures, and to reverse some workforce layoffs. The County, with participation from the State, proceeded to design a Medicaid demonstration project waiver. In February 1996, the Medicaid Demonstration Project for Los Angeles was submitted to CMS. CMS approved the waiver, which covered the period from July 1, 1995 through June 30, 2000, on April 15, 1996.

### **III. OUTCOMES OF RESTRUCTURING UNDER THE WAIVER**

The restructuring under the demonstration project focused on two key areas:

(1) improving access to County-funded ambulatory services and (2) making hospital care more efficient, in part by reducing inpatient beds in County hospitals. Based on our most recent site visit, it appears that LACDHS continued the development of its blended public-private ambulatory care system, reduced inappropriate emergency room use and has made considerable strides in expanding and integrating community-based primary care through the use of Referral Centers and community-based planning. Moreover, the County has lowered the number of inpatient beds and reengineered its hospitals to become more efficient. Part of the change taking place in County hospitals is the development of Clinical Resource Management, an approach to inpatient care that tries to improve quality of care without raising costs. This chapter explores these developments related to ambulatory and hospital-based care. In addition, we examine another area of progress that was not an explicit goal of the waiver, but was among the most noteworthy outcomes cited in the interviews: a cultural shift toward greater cooperation among all stakeholders, including a desire to measure and improve upon the performance of the County's health care system.

#### **A. AMBULATORY CARE**

##### **1. Expansion of Community-based Primary Care through the Public-private Partnership Program**

In response to the decline in patient visits that occurred during the 1995 financial crisis, one of the primary goals of the waiver was to rebuild and expand the County's indigent ambulatory care system. Specifically, LACDHS proposed a 50 percent expansion in the number of ambulatory care visits, from 2.6 million in 1994/1995 to 3.9 million annual visits in 1999/2000. As part of the plan to accomplish this goal, LACDHS developed the Public-private Partnership

(PPP) Program so that County-financed indigent care could be received at private facilities. This enabled the County to pay for care in areas in which it did not have clinics without a large capital investment in building facilities or an expansion of LACDHS staff.

The PPP program was initially limited to non-profit community clinics (i.e., FQHCs, FQHC look-alikes, and free clinics) given the similarity of their mission to the County's mission of serving the indigent. However, the program was expanded to including private physician practices and for-profit clinics. LACDHS succeeded in expanding the points of access to community-based primary care through the PPP program, increasing the system from 45 County-operated non-hospital clinics in FY 1994/95 to 132 County and PPP sites in the blended delivery system in the fourth quarter of FY 1999/2000. Moreover, based on the LACDHS Clinic Site Survey, the County's ambulatory care system had increased the availability of primary care on weeknights and weekends, the number of clinics providing 24-hour telephone consultations, the number of bilingual Spanish clinical staff, and the number of clinics with pharmacy/dispensary and radiology services on-site (Los Angeles County Department of Health Services, 1998/99).

To fully appreciate the development of the PPP program, it is important to remember the state of the County's ambulatory care system prior to the demonstration project. Prior to LACDHS's 1995 financial crisis, there was little or no coordination between the public and private providers. With the budget shortfall in FY 94/95, LACDHS moved forward with plans to shut down some of its facilities. Announcements were made about the closing of facilities, and staff were notified of upcoming layoffs. Ambulatory care visits in 1995 were estimated to have dropped by about 17 percent from the 1994 levels as a result of LACDHS's cutbacks (Long, et al, 1999). However, rather than simply closing the doors of its health centers, LACDHS created public-private partnerships (PPPs) by offering private providers the opportunity to takeover six

public clinics slated for closure. Three private providers expressed interest in assuming financial and operational responsibility for the health centers in an August 1995 request for proposal (RFP) and were awarded contracts in October 1995. The three private providers took responsibility for two public clinics each. By the end of 1995, the private organizations were providing primary care from the previously-public sites.

With the award of the federal waiver in September 1995, LACDHS began to pursue PPPs as part of a more systematic strategy to expand primary care access throughout the County. The County elected to expand access through PPPs rather than through its own facilities because County officials believed that it was a more expeditious option that would provide greater flexibility to adjust to changing needs. In other words, the County would have greater ability to address the system's gaps by adjusting contracts with private providers than it would trying to re-establish or expand its own health centers. While the first County RFP in August 1995 did not offer any funding to the PPPs, subsequent RFPs made LACDHS funds available to pay for services delivered to the uninsured at or below 133% of FPL and provided two new arrangements in addition to the "takeover" PPPs: (1) Co-location—A private partner agrees to provide primary care services in a County health center, while DHS continues to provide public health services; and (2) Expansion—A private partner agrees to expand services at their clinic site(s).

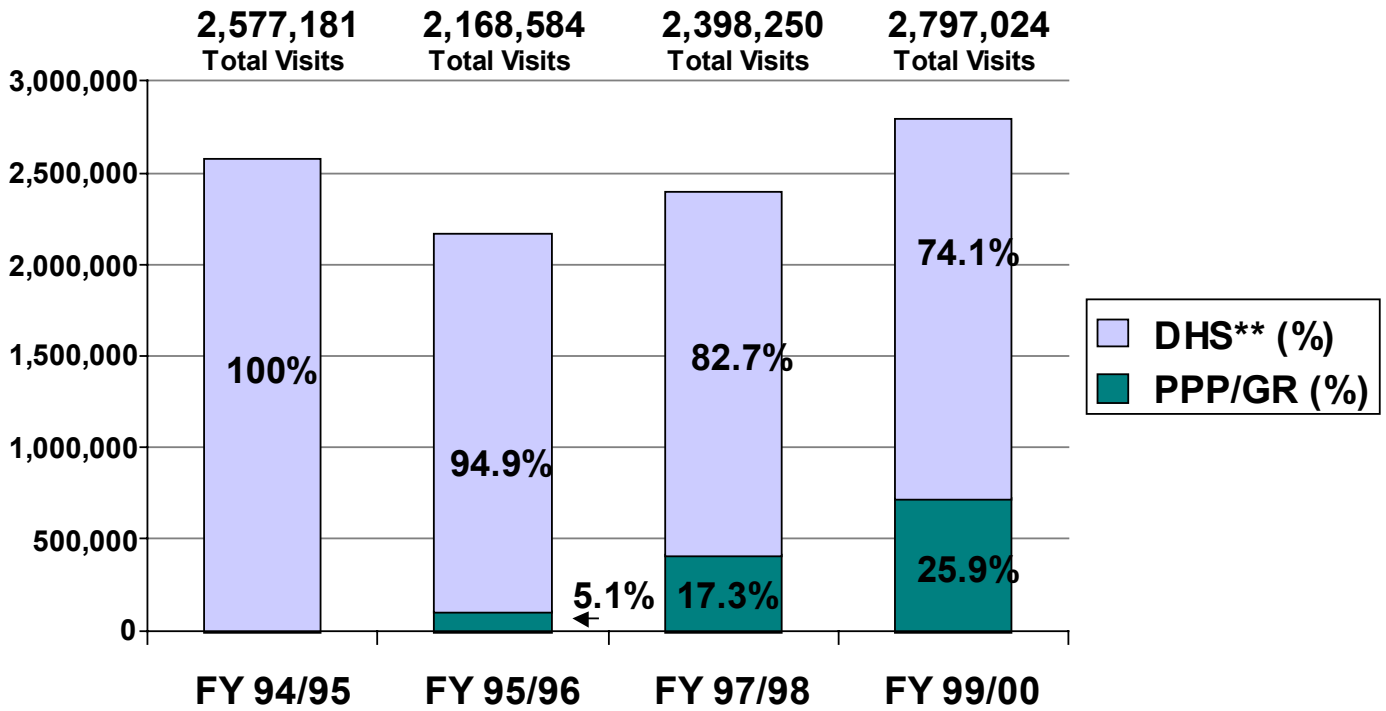
Beyond the changes in ambulatory care access, the PPP program seems to have improved communication across the safety net providers (public and private) and serves as a critical component of LACDHS's effort to create a more integrated health care delivery system in the County. Among other things, this improved communication has afforded the County greater flexibility to contract, expand, or shift the distribution of providers, based on the County's need

for indigent primary and preventive care. Further, private providers are receiving public funding for serving a population that was previously mostly uncompensated. Moreover, the County's indigent population is benefiting from the new collaboration—not only has the PPP program resulted in increased geographic access, but the County and private providers are now working together to address barriers to health care and improving the “system-ness” of safety net ambulatory care. The new barrier reduction efforts will be discussed further in the section on community-based planning.

Although many interviewees credited the PPP program with expanding geographic access and improving linkages between County and private safety net providers, it does not appear that LACDHS has come close to achieving the waiver objective of increasing ambulatory care visits by 50 percent. Ambulatory care visit volume fell from the pre-waiver level of 2.6 million to 2.2 million in 1995/1996 largely as a result of planning to close some clinics. Since that low, volume at LACDHS clinics and the PPPs grew to 2.8 million visits in 1999/2000, or about 27 percent. However, that volume is only about 8 percent above the pre-waiver levels, or over 1 million visits below the level planned early in the waiver. Figure 1 illustrates the trend in ambulatory care visits by delivery source.

One potential problem with this trend analysis is that the definition of a visit used in 1994/1995 may not be entirely consistent with the definition used in later years. Specifically, prior to the waiver, ambulatory care visits included visits for primary care in which the patient may have only seen a nurse. In developing the trend data, LACDHS tried to remove these nurse-only visits from the baseline, but believes that some of them are still probably being counted. The staff indicated that it was not possible to quantify the potential impact this had on the baseline. If the visit definition is not truly comparable and the baseline includes types of visits

**Figure 1: Percent of Ambulatory Care Visits\* by Delivery Source  
FY 1995/96 to FY 1999/00**



\* ER and Public Health visits are excluded  
 \*\* Includes Hospital-based and CHC/HC visits

Source: DHS Finance Monthly Workload Status Report - Facilities' verified actuals through June 2000, as of November 16, 2000, based on a retained and standardized definition of an ambulatory care visit.  
 Source for PPP/GR: DHS Office of Managed Care, as of November 16, 2000, based on July 1999, June 2000 dates of service.

that are not included in later years, then this would overstate the baseline and understate the ambulatory care visit volume growth. However, we were told that LACDHS staff were “confident in the comparability” of the visit volume comparison over time.

The Public-Private Partnerships were noted as one of the biggest successes of the Demonstration Project, but there remain a number of kinks that need to be ironed out. For example, the adequacy of reimbursements rates has been an issue since the beginning of the PPP program. The County responded, in July 2000, by increasing payment rates from \$62/per visit to \$68.88/visit plus a \$15 pharmaceutical supplement/visit. LACDHS officials hope that this will improve PPPs ability to cover their actual costs of providing care.<sup>6</sup>

A larger issue with the program seems to be the County’s method of establishing the total amount paid to each PPP. Currently PPPs enter into a contract with a “maximum obligation” based on an anticipated number of patient visits each year. At approximately mid-year, when it becomes clear that some clinics are falling behind their anticipated number of visits (“under-performers”) and some are seeing more patients than anticipated (“over-performers”), the County has been re-allocating funding from the “under-performers” to the “over-performers.” There have been several problems with this approach. First, some “under-performers” increase their performance during the second half of the fiscal year after the money was already re-allocated. Second, by focusing on the clinic contracts, funds may be redistributed across geographic areas from those with high need to those with lower need. Third, some of the larger, over-performing PPPs have been taking a risk by continuing to see patients beyond their contractual obligation with no guaranty that the County will reallocate funding. One way that has been discussed to improve the reimbursement process is to stratify the PPPs into different groups based on the

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<sup>6</sup> PPPs also receive \$27/month for case management of eight identified ambulatory care sensitive conditions.

capacity, with the idea that separate contracts would be negotiated for the long standing, high performers, that need a steadier financing stream.

A number of interviewees felt that the County could have done better in increasing ambulatory care access in terms of numbers of visits. Some respondents believed that the County would have seen a larger increase in visits by being more selective with the PPP contracts, and by implementing more stringent performance measures for both PPPs and County facilities. From the County's perspective, most of the 1995-2000 waiver period focused on contracting with enough PPPs to ensure geographic access and efforts to monitor their performance came later. It was not until FY 1999/00 that the County Office of Managed Care (OMC) began monitoring PPP activities and issuing Corrective Action Plans. Among the most common deficiencies were incomplete provider credentialing, expired medications and medical supplies, deficient medical records and documentation and the hours of operation were not the same as those listed in contract (Los Angeles County Department of Health Services, 1999/00).

## **2. Integrating the System of Care**

The restructuring effort is requiring new relationships between inpatient and outpatient settings, primary and specialty care providers, medical care and public health, and public and private institutions. Under the waiver, LACDHS has focused on transforming its fragmented and hospital-based system of care into a linked system of community-based primary, specialty, and preventive care. Initiatives have included relocating some hospital-based outpatient specialty care into CHCs and providing primary care and public health services in the same clinics (Long and Zuckerman, 1998). However, interviewees cited the creation of a formal referral system for specialty care, the Referral Centers, as one of the County's biggest accomplishments undertaken since our initial evaluation.

Prior to the demonstration project, LACDHS did not have a systematic link between primary care and hospital-based specialty clinics for its indigent population. All access to specialty care for the indigent population occurred through the emergency room, regardless of whether the referring primary care physician was at a County health center or private clinic. Moreover, because the patient's paperwork (i.e., medical chart, test results, patient profile, procedure notes, etc.) did not accompany the patient through the system, the emergency room physician would have to reexamine the patient, often redoing tests and laboratory work that had been done by the primary care provider (Long, et al, 1999).

In order to improve the linkage between ambulatory care and specialty care, LACDHS created referral centers to schedule and coordinate specialty care. Each of the five DHS acute care hospitals operates a referral center, which is staffed by utilization management nurses. The referral centers serve as a gateway for primary care providers to access specialty and inpatient services in the network and operate as follows:

- A primary care provider submits a request form via fax to one of DHS's Referral Centers;
- The referral center reviews the submitted request to make sure there is sufficient medical information and that the requested services are appropriate for the medical condition;
- If the request is approved an appointment date is scheduled and a notification card is sent to the patient's home address.

Since the Urban Institute's 1997 site visit, utilization of the Referral Centers has increased dramatically: The referral centers processed 108,000 referral requests during FY 1999/00, which represents an 120 percent increase from FY 1997/98 levels (Los Angeles County Department of Health Services, 1999/00). The 108,000 referral requests represents significant growth in Referral Center utilization, but are still account for a relatively small percentage of the approximate 1 million specialty care visits per year. But, reflecting the general problems with

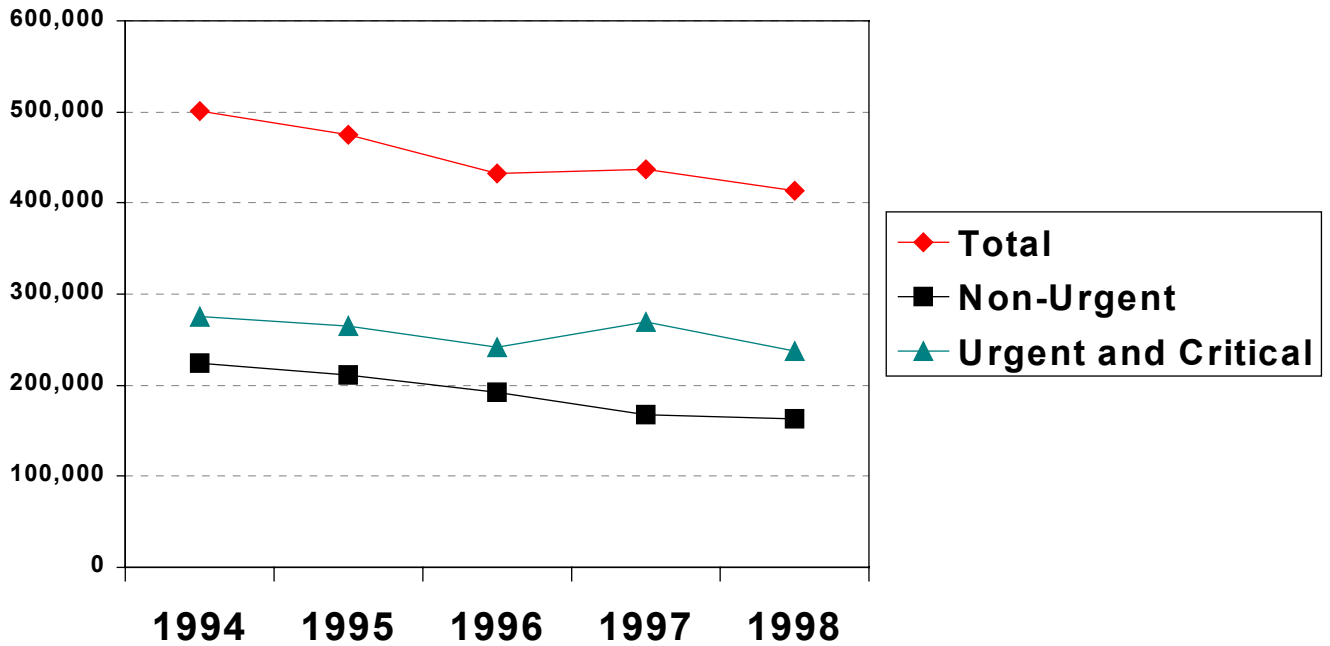
LACDHS information systems, County staff could not tell us the percentage of the total number of specialty clinic visits that resulted from patients entering the system through the Referral Centers.

The Referral Centers are available to providers at DHS health centers, private providers in the PPP program, and the Community Health Plan. However, it appears that the DHS ambulatory care facilities still rely on informal networks to schedule specialty care, and the referral centers are primarily utilized by private providers. Some PPP providers, particularly the smaller, less sophisticated clinics, feel that documentation requirements are excessive given their limited abilities to perform laboratory and diagnostic services. DHS is just beginning to track the number of referral requests that are denied due to lack of documentation. Nevertheless, based on interviews conducted during our last site visit, the Referrals Centers are viewed as a significant step toward improving specialty care access for indigents and improving the flow of patients and information between primary care and specialty care providers.

## **2. Reducing Inappropriate Emergency Room Use**

One of the major goals of the waiver was to reduce emergency room (ER) use for routine health care needs. The creation of the Referral Centers was a key step in achieving this objective. In fact, based in data compiled by the County from the California Office of State Health Planning and Development, utilization of ER services declined from about 500,000 visits to about 400,000 visits, or 19.8 percent, between 1994 and 1998. Perhaps even more significant, non-urgent visits declined by 27.2 visits over this same period (See Figure 2). Taken in isolation, these data are hard to assess. If private hospitals in Los Angeles were also experiencing a similar decline over this period, then the actions of LACDHS would not be noteworthy. Although we contacted the private hospital association and State agencies, it was not possible to acquire a

**Figure 2: Trends in ER Visits  
Calendar Years 1994 to 1998**



Notes:

Non-Urgent visits are for non-emergency injury, illness, or condition; sometimes chronic; that can be treated in a non-emergency setting and not necessarily on the same day they are seen in the EMS Dept. (pregnancy tests, toothache, minor cold, ingrown toenail).

Urgent visits for an acute injury or illness where loss of life or limb is not an immediate threat to their well-being, or for timely evaluation (fracture or laceration).

Critical visits are for an acute injury that could result in permanent damage, injury or death (head injury, vehicular accident, a shooting).

Source: Data submitted to OSHPD by the facilities

comparable ER trend only for the County's private hospitals. However, aggregate County-level data provided by California's Office of Statewide Health Planning and Development (OSHPD) shows that total ER visits provided by all of Los Angeles' hospitals (public and private) remained fairly stable between 1994 and 1998. These findings seem to support the view of representatives from the private hospitals interviewed for this evaluation who indicated that LACDHS was doing a better job of controlling ER use than its private counterparts.

One reason for this reduction in ER visits appears to be the development of pilot initiatives for LACDHS emergency rooms to identify patients who could be treated in other settings and refer them to those settings. This was being planned at the time of our initial evaluation. However, it was met with skepticism by several respondents who noted that there were so many uninsured in the Los Angeles area that even if the demonstration project was able to change the habits of a small portion of indigents, there would be a new group of indigents that would use the emergency room for primary care in their place. Nevertheless, in 1998, LACDHS identified emergency room diversion initiatives for use in its four emergency departments (LAC+USC, Harbor/UCLA, MLK/Drew, and Olive View/UCLA).

Although all four hospitals with emergency rooms have implemented such initiatives, only Harbor/UCLA had reported data as of FY 1999/00. Harbor/UCLA's initiative tracks data on emergency room patients who live within specific zip codes served by the Wilmington Family Health Center, Long Beach Comprehensive Health Center, and the Harbor Family Medicine Clinic. ER patients who require follow up and are identified as residents of one of these clinics service areas are given clinic appointments. Harbor/UCLA and the clinics then track whether the patient kept, cancelled, or broke the follow-up appointment. Fiscal Year 1999/00 data from this initiative suggest that a relatively high number of patients (20.4 percent) broke their

appointment. The data also show that during the reporting period only 0.24 percent of patients referred to a clinic returned to the ER during the reporting period (Los Angeles County Department of Health Services, 1999/00).

#### **4. Community-Based Planning**

During the first three years of the waiver, decisions about how and where to expand access to community-based ambulatory care had been made through an internal LACDHS process. Resources were allocated based on requests of DHS facilities and did not explicitly consider the overall ambulatory care needs of the County or the needs of patients seeking care at private facilities. However, in the Summer of 1998, the Los Angeles County Board of Supervisors approved a total of \$11 million for the expansion of ambulatory care services during the last half of FY 1998/99.<sup>7</sup> In order to allocate this funding, LACDHS decided that the County's system for ambulatory care planning needed to be reformed. Two major changes to the planning process were instituted: 1) decisions would be based on actual data on patient care and an explicit set of assumptions regarding the need for services; and 2) the planning process would reflect a new partnership with community stakeholders, who would have a substantial input into how available funds would be distributed (Fielding, et al. July 2000).

In order to achieve an equitable distribution of resources, LACDHS developed an approach to assessing ambulatory care needs based on actual data. This data-driven approach was aided by the Board of Supervisors' decision to define LA County by eight geographic service planning areas (SPAs). In addition to defining SPAs, the new planning efforts were aided by the completion of the 1997 Los Angeles County Health Survey, a population-based survey of more than 8,000 households that gathered data on access to health care, utilization of services,

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<sup>7</sup> Additional funding in the amount of \$21 million was approved by the board in the FY 1999/00 budget to sustain the expanded services.

health status, and health behaviors. The survey was critical in providing the County, for the first time ever, information on how unmet need was distributed across the County. Moreover, the survey also provided valuable information on barriers to access, including transportation, language and cost (Fielding, et al. July 2000).

Aided by the new health care data, 12 community groups (one in each of the eight SPAs, plus additional groups in the larger SPAs) were asked to make ambulatory care budget recommendations. Although the planning process did not result in new PPP sites getting contracts, it did lead to increases in some of the “maximum obligations” for contracts that were already in place. However, after the initial round of meetings that was designed to allocate the new funding, community advocates have expressed concern that planning has become less comprehensive and lacks adequate continuity. In addition, we were told that without new funding, planning created winners and losers and was becoming a "political football."

***Other Planning Outcomes.*** Ten of the 12 community groups went beyond simply allocating the ambulatory care funding and recommended that additional funds be targeted toward enhancing the system’s ability to continue service planning and implement specific projects to reduce barriers to care or improve the system’s infrastructure. While the process thus far has mostly focused on planning, LACDHS provided approximately \$1.8 million in FY 1999/00 for several barrier reduction and infrastructure projects, including: a pilot case management program for uninsured residents in the Metro-Central and Northeast SPAs; implementing uniform criteria and financial screening methods in PPP and County-operated facilities in the San Fernando SPA (an outgrowth of the Vida project, described below); and publishing a “consumer guide” for the South Bay area.

Another offshoot of the community-based planning process is a project implemented in San Fernando Valley called *Vida*. *Vida* is run by several community groups and provides uninsured immigrant families earning less than 200 percent FPL with a membership card to utilize health care services at participating clinics. The program screens uninsured families for public program eligibility and assigns them to a primary care provider. *Vida*'s screening process was viewed as a "friendlier front-end" than the traditional County screening tool. *Vida* does not entitle members to additional health care benefits, and uninsured families may still receive services without a *Vida* membership card. Although only a small number of the approximate 1,200 families in the program are eligible for public insurance programs, the program has resulted in some moderate benefit in continuity of care.

The *Vida* project is also important because it served as a pilot for a broader effort - the Outpatient Reduced-Cost Simplified Application (ORSA) Plan - at creating a simplified screening program for indigents. ORSA was piloted in the *Vida* project as an alternative to the County's complex Ability to Pay (ATP) screening tool. ATP procedures have been criticized for being time-intensive, as they require staff to spend extensive time interviewing patients and obtaining documents to determine an uninsured patient's cost-sharing liability, even though most are subsequently determined to have no liability. Based on field tests, LACDHS believes that ORSA processing time will be less than half that of ATP. Consequently, the County decided to implement the screening program on a County-wide basis in January 2001 as part of its waiver extension agreement to implement a simplified financial screening program for indigents at DHS ambulatory care sites. However, ORSA will not replace ATP for inpatients and for ambulatory patients who are not interested in applying for the programs available through ORSA.

## **5. Public Health**

Respondents noted that one result of the demonstration project was a new focus on public health. As part of a broader waiver objective to improve the integration of public and personal health care services and systems, LACDHS began restructuring the Public Health Programs and Services (PHP&S) division in fiscal year 1997/98. The restructuring process was guided by a UCLA analysis of the division and by four task forces designed to solicit input from the community and local organizations.<sup>8</sup> In addition to the task forces, LACDHS established various work groups to address public health restructuring issues related to the area of health office structure and facilities improvement plans.<sup>9</sup> These task forces and work groups formulated a number of restructuring recommendations. As a result, public health and personal health services have become more integrated as public health services are increasingly being provided in primary care settings. For example, patients presenting with STD symptoms are now screened and treated in the primary care setting and TB prophylaxis is provided at all Health Centers and Comprehensive Health Centers.

### **B. HOSPITAL-BASED CARE**

#### **1. Reducing inpatient beds and admissions**

One goal of the waiver was to reduce the focus of LACDHS on hospital-based care. Previously, financial incentives provided through Medi-Cal (California's Medicaid program)—namely, higher reimbursements for inpatient care and Medicaid disproportionate share hospital

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<sup>8</sup> The four task forces include: 1) The Community Health Task Force focused on the function, organizational structures, accountability systems, and job descriptions for the Area Health Offices/Area Health Officers; 2) The Planning Task Forces focused on department-wide population-based planning; 3) The Information Systems Task Force focused on the development of a data repository warehouse to assist in population-based planning; and 4) The Affiliation Agreement Task Force focused on developing a scope of work for an affiliation agreement with the UCLA School of Public Health.

(DSH) payments - discouraged movement away from hospital-centered care. In FY 1995/96, the County's six hospitals represented 75 percent of LACDHS's expenses. By providing a supplemental project pool linked to the provision of ambulatory care visits and an indigent care match, the waiver made it somewhat financially easier for LACDHS to shrink its inpatient operations. Consequently, waiver activities included restructuring the County's inpatient care system—specifically through the reduction of inpatient beds and the average daily census

During the crisis period just before the award of the waiver, the County considered closing LAC+USC Medical Center. While the waiver enabled the County to avoid this action, LACDHS realized that it needed to significantly reduce inpatient costs. At the beginning of the demonstration project, LACDHS proposed reducing the number of inpatient beds at the County hospitals from 2,595 beds in FY 1994/95 to 1,583 by 1999/00, with an interim reduction to 2,079 beds in FY 1996/97. The County had anticipated achieving the initial inpatient bed reduction goals by replacing LAC+USC Medical Center with a smaller facility, and selling Rancho Los Amigos Medical Center and High Dessert Hospital to private providers. It was believed that privatization of the two hospitals would yield relatively expedient cost savings as their beds would be removed from the County's control. LACDHS has subsequently revised initial privatization plans based on several factors: private providers' lack of interest in purchasing either Rancho Los Amigos or High Dessert Hospital; realizing that expected cost savings from privatization of Rancho Los Amigos were overestimated as it was already operating relatively efficiently; strong resistance from the union representing health care workers; and resistance from some of the Board members whose districts benefited from the hospitals serving as a major source of employment.

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<sup>9</sup> The work groups were comprised of Department staff, consultants, labor representatives, and community members.

Although the County's privatization plans did not materialize, LACDHS was able to downsize LAC+USC hospital, and achieve a 295 inpatient beds decrease (28 percent) at that facility. Overall, budgeted beds in the LACDHS system have been reduced by 29 percent (751 beds) during the waiver, falling from 2,595 beds in FY 1994/95 to 1,844 beds in FY 2000/01 (See Figure 3). Inpatient days have declined by 27 percent over the same period. While average length of stay has dropped from 6.4 days 1994/95 to a low of 5.9 days in FY 1997/98, there was a slight upward trend to 6.1 days in 1999/00. However, the County maintains that length of stay is stabilized at 6.1 days (Los Angeles County Department of Health Services, 1999/00). This reduction in inpatient capacity and service volume has been accompanied by a reduction in full time equivalent positions (FTEs) in LACDHS of roughly 16 percent (from 25,732 FTEs in FY 1994/95 to 21,655.5 FTEs in FY 1998/99) (Berliner, et al., 2000).

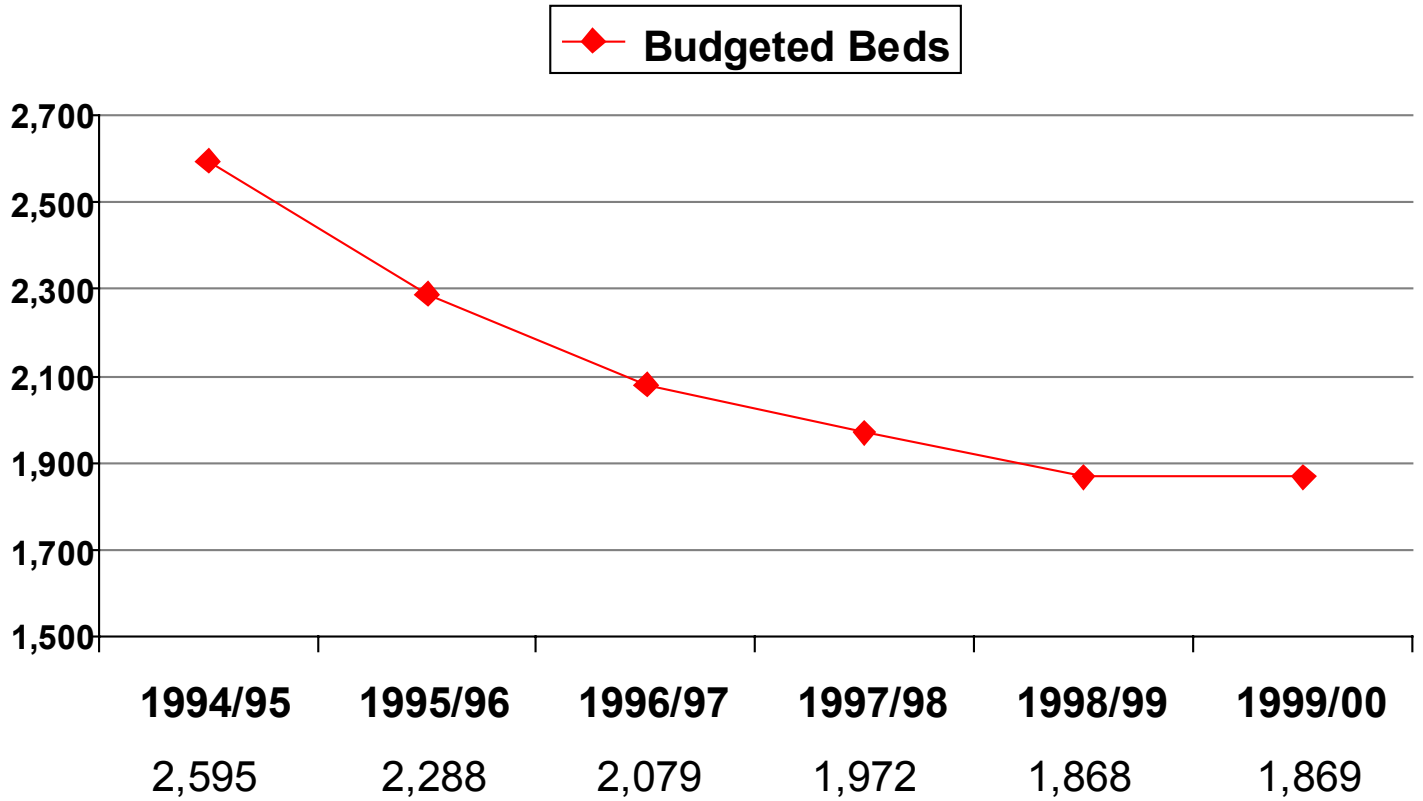
## **2. Improving Efficiency of Inpatient Care Delivery: Reengineering**

The realization that it was not feasible to privatize any of its hospitals combined with the success of 1996 efforts to make Rancho Los Amigos more efficient through "reengineering" (LACDHS, 1997) led LACDHS to explore broader reengineering as an alternative means of cutting inpatient costs. The hospital reengineering effort has focused on four areas:<sup>10</sup> (1) more prudent purchasing of supplies, equipment and pharmaceuticals; (2) reducing costs and improving efficiency by standardizing, centralizing and outsourcing services; (3) improving clinical efficiency and service utilization through Clinical Resource Management (CRM); and (4) redesigning health services administration to identify cost savings and inappropriate levels of management. Across these areas, LACDHS reports that there are over 450 individual projects. Consultant estimates from 1997 suggested that the reengineering process could save LACDHS

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<sup>10</sup>"Los Angeles County Department of Health Services Re-engineering Project Kickoff," LACDHS presentation, August 7, 1997.

**Figure 3: Budgeted Beds  
FY 1994/95 to FY 1999/00**



Source: DHS Finance Monthly Workload Status Report - Facilities' verified actuals through June 2000, as of November 16, 2000.

between approximately \$264 and \$294 million from hospital budgets over the last three years of the waiver.<sup>11</sup> However, delays and the inability to get some ideas implemented produced audited savings over the last *two* years of the waiver of about \$110 million, well short of the targets.

County auditors confirmed this estimate of savings from reengineering and indicated that the two parts of reengineering that produced the greatest share of the savings were (1) group purchasing of supplies through the University Healthcare Consortium and (2) participating in the Public Health Service 340B Drug Pricing Program that allows some safety net providers to purchase drugs at lower prices. Together, these two initiatives accounted for over 20 percent of re-engineering savings in 1999/2000. Although there were other savings from a series of changes in work processes and staffing patterns, officials felt constrained to work within the existing labor classifications that were approved by the Department of Human Resources and this tended to limit LACDHS options. However, it is not clear how much savings might have increased if LACDHS had been given the authority to develop its own set of personnel classifications.

Does the fact that savings were less than expected mean that reengineering was not successful? The process may have started slowly, but audited annual reengineering savings were between 3 and 3.5 percent of the LACDHS budget by FY 1999/2000, or about \$70-80 million. This annual level of reengineering savings is reasonably close to the consultant estimates and, in this sense, the process was a success. Although these savings could allow LACDHS to restore some services, one respondent noted they were small relative to the federal dollars that would be gradually phased-out as the waiver extension ends. In budgetary terms, it seems clear that

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<sup>11</sup> On average, this would have represented about a 4 percent reduction in LACDHS's annual operating budget of \$2.3 billion.

reengineering in its present form is not likely to be the guarantor of future financial viability for LACDHS. It was also suggested that increasing re-engineering targets in the future would likely prove difficult. In fact, based on the methods being used, County auditors were not certain that some of the areas of savings already realized could be maintained into the future.

We were also told that the need to get approval for many personnel changes from Los Angeles County Department of Human Resources kept LACDHS from implementing many of its re-engineering goals. For example, LACDHS recognized that it had a problem recruiting and retaining therapists because the salaries it could offer were too low. In response, there was a proposal to create “career ladders” so that therapists could advance within LACDHS and achieve salary growth. According to LACDHS management, Human Resource has been studying this proposal for five years and has yet to act. In the interim, LACDHS has been forced to hire therapists from a registry. Some of the job descriptions that still influence personnel practices within LACDHS date back to the 1930s, according to one of our respondents.

A Blue Ribbon Health Task Force (BRHTF) established by the Board of Supervisors in 1999 found “many areas of concern” in its examination of reengineering activities (BRHTF, 2000).<sup>12</sup> Nevertheless, observers felt that there have been benefits to reengineering that go beyond the fiscal bottom line. Specifically, the reengineering process seems to be nurturing a “cultural change” within LACDHS that is allowing for greater collaboration between the labor unions and management and encouraging employees at all levels to think about ways to improve services with existing or fewer resources.

In 1997-98, LACDHS and the Service Employees International Union (SEIU), representing over 80 percent of the LACDHS workforce, agreed to the creation of the Labor

Management Restructuring Council (LMRC) as a way of guiding the re-engineering process. The LMRC consisted of 18 members - 9 from labor and 9 from management. In 1998-99, SEIU actually “sponsored” re-engineering projects related to a range of administrative and clinical issues. The union and County also jointly submitted the Rehabilitation Classification/Compensation Study to the Department of Human Resources. However, one observer noted that the decision to only undertake re-engineering projects that were agreed to by a consensus of the LMRC forced the “elimination of bold moves.” While the waiver, and some have noted the leadership of Mark Finucane, have improved the labor/management relationship, SEIU is concerned that the County is approaching a point of diminishing returns on reengineering efforts focused on reducing staff.

***Clinical Resource Management (CRM).*** Clinical Resource Management (CRM) is a program that utilizes an integrated approach of Clinical Pathways, Disease Management, and Case Management to improve the efficiency of clinical resource utilization. The CRM initiative came about as a key activity under the waiver. Initially, it was developed by consultants retained by the County in 1997, but was redesigned in 1998 by a team of County employees, several of whom had private sector and academic affiliations. The resulting product thus benefited from commercial savvy, academic theoretical construct, and an implementation-minded approach.

LACDHS originally expected CRM to yield considerable reengineering savings. However, this expectation was modified mid-way through the waiver when it became clear that CRM savings were uncertain given the likelihood that it may ultimately result in substantial losses in federal and state revenues because of the decline in inpatient days. Nevertheless, many respondents noted that the CRM initiative, although not an immediate source of savings, was a

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<sup>12</sup> This broad review also raised concerns regarding linkages between LACDHS and other County departments, the lack of a shared vision, a propensity toward crisis-based solutions and a bias toward cost-cutting as opposed to

significant step toward improving the management and quality of care because of its focus on outcomes-based measures and quality-of-care standards for inpatient and outpatient services.

The purpose of the CRM initiative is to reduce unnecessary variation in patient care and secure appropriate levels and duration of care. Under CRM, LACDHS has developed inpatient clinical pathways (ICPs), which identify the optimal sequence and timing of important events to advance patients toward improved health. The ICP for congestive heart failure has already been implemented and in FY 1999/00, inpatient clinical pathways (ICPs) were field tested for the following diagnoses: appendectomy, community-acquired pneumonia, congestive heart failure, active labor, postpartum vaginal delivery, and uncomplicated cesarean section. Twenty-five additional ICPs have been developed and are scheduled for final review and implementation over the next few years. While the County has primarily focused on ICPs thus far, CRM also includes a pediatric asthma disease management program. The Department has included CRM development and implementation as a key goal under the Waiver extension proposal.

### **C. CULTURAL CHANGE**

While County officials, policy experts, advocates, and associations interviewed for this study varied in their assessments of the demonstration project implementation, all agreed that the County was better off now as a result of the waiver. The reason behind this was the somewhat intangible notion that there had been a “cultural change” among stakeholders in the indigent health care system, and that this was one of the biggest accomplishments of the waiver. Among other things, the waiver has resulted in an effort to measure and improve upon LACDHS performance. Specifically, interviewees noted that LACDHS is more focused on meeting patients needs, broadening quality of care to include being more culturally and linguistically

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investments in the future.

sensitive, and redesigning processes to achieve more with the same or fewer resources. Beyond the experiences related to indigent health care, the waiver experience has led some observers to the broader realization that some County departments may need reorganization, particularly human resources and other support departments.

As examples of the enhanced focus on patient needs, several respondents noted the approach to community-based planning based on data collected through the LA Health Survey (discussed previously) and a new effort to measure beneficiary satisfaction and access to health services through the completion of the 1999 LACDHS/UCLA Patient Assessment Survey. The Patient Assessment Survey was designed to evaluate beneficiary satisfaction and the impact of the ambulatory care expansion in Los Angeles County (The Los Angeles County Department of Health Services, 1999). Specifically, the survey collected data on access and barriers to health care, satisfaction with and perceptions of care, and quality of health care.<sup>13</sup>

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<sup>13</sup> The survey gathered data from more than 2,500 face-to-face interviews with patients at primary care clinics across four different types of facilities (CHCs, HC, Hospital Outpatient Clinics, and PPPs.) Highlights from the survey include: Patients received services at rates comparable to, or higher, than other patient populations; Patient satisfaction for LAC-DHS patients is high and comparable to other patient populations; A significant portion of patients experienced financial and language barriers to needed medical care; LACDHS patients have a higher burden of disease than other patients in care; and The overall health status of LACDHS patients is worse than that of other patient populations

## **IV. CHALLENGES TO RESTRUCTURING**

The previous section discussed the progress LACDHS made toward many of the restructuring goals established under the waiver. However, as we noted, there were instances in which they fell short of the specific targets. This chapter discusses some of the challenges that may have hindered LACDHS's ability to meet the waiver targets. These challenges were raised both by the individuals we interviewed for this evaluation as well as The Blue Ribbon Health Task Force that was established to examine re-engineering.<sup>14</sup> Although it is difficult to identify all of the challenges, three that we highlight in this section are (1) delays in implementation of information technology initiatives; (2) the governance of LACDHS and its management authority; and (3) vacancies in LACDHS senior management.

### **A. INFORMATION TECHNOLOGY**

A number of respondents noted that the County's Information Technology (IT) system and deficiencies in current staff's computer skills were a significant obstacle to improving efficiency and fostering "system-ness." LACDHS has not yet established standardized information systems that allow hospitals to exchange data with near-by clinics that regularly refer patients, thus integrating systems throughout the County appears to be a long way off. While the Referral Centers may be a promising means of system integration and improving the link between ambulatory care and specialty care, the Centers are currently a fax-based system. In general, respondents felt that other priorities have displaced information systems and technology, perhaps due to Y2K preparations and lack of funding. Nevertheless, the County's commitment to IT improvements seems unclear - a perception affirmed by a recent report by outside researchers that found:

While DHS has a system-wide plan in place to improve information systems, we found no comprehensive plan to address changes in technology. Interviews showed little evidence that the technology issue had been discussed or addressed in a comprehensive or systematic way...In addition, neither interviews nor documents revealed where DHS would get funding for technology and information systems upgrades, beyond the limited resources provided through the 1115 waiver (Berliner, et al., 2000).

## **B. GOVERNANCE ISSUES**

The ability of LACDHS to make the multitude of changes in the way it does business seems to be affected by the governance structure in which it operates. Both our interviews and the BRHTF report conveyed that LACDHS is limited in its ability to restructure itself as a result of constraints imposed by the County Board of Supervisors and the Department of Human Resources. While some believe that these constraints were loosened and governance was changed de facto by bringing the federal government into the process through the waiver, many believe that LACDHS faces substantial limitations. Indeed, the BRHTF still felt that options such as making LACDHS an independent health authority should be considered.

Although there was a sense that the Board of Supervisors was better informed about the health care system now than it was five years ago, many interviewees noted that the oversight by the Board made it difficult for LACDHS to undertake major parts of its re-engineering program or to make other decisions related to the operations of this complex health care system. At a time when many health care providers have become more aggressive competitors in the market, the need to subject all contracts to review in political process was viewed as putting LACDHS at a strategic disadvantage. For example, LACDHS has been trying to contract with private managed care plans to serve as a network provider for publicly-insured patients, but has not yet

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<sup>14</sup> The BRHTF did not simply focus on the specific reengineering activities undertaken by LACDHS. Instead, BRHTF “elected to highlight recurring themes impacting the reengineering process.” (A copy of the BRHTF Report is included as an Appendix to this study.)

been successful. One observer felt that the very open review of contracts by the Board slows action.

Staff at LACDHS was not enthusiastic about the idea of becoming a health authority, believing that the Board has gradually shifted from being focused on “finances and constituent services” and is thinking more broadly about “efficiency and health care outcomes.” In fact, counter to the BRHTF report and many of our interviews, we also heard a more positive characterization of the role played by the Board of Supervisors. One respondent indicated that, according to County rules, the Board acts as the governing board of LACDHS. In this capacity, it was appropriately involved in final decisions on restructuring, approved PPP contracts and monitored the access expansions. We were told that the process of spending waiver funds on non-County clinics required building a political consensus and that the Board played a central role in making this happen. Even before the waiver was granted, we were told that the Board members made the necessary political contacts with the federal government to get the waiver process started.<sup>15</sup> Perhaps ironically, the Board was also a major public critic of LACDHS for not moving quickly enough on restructuring, when neither the state or federal governments were providing much oversight. The criticism was so open, we were told, that some Board members had to be convinced that LACDHS had actually accomplished a lot when it came time to seek the waiver extension.

### **C. VACANCIES IN SENIOR LACDHS MANAGEMENT**

At the time of our site visit three high-level positions within the LACDHS management structure were vacant: the Director of Operations for Health Services, the Medical Director and the Director of the Office of Managed Care. The absence of the Operations Director created

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<sup>15</sup> The Board of Supervisors was also involved in the federal policy change that allowed California public hospitals to receive gross Medicaid DSH payments up to 175 percent of their uncompensated care costs starting in 1998.

concern that the people at the highest levels of LACDHS who are primarily responsible for developing and implementing policies were being forced to divert attention to dealing with day-to-day operational problems. The potential seriousness of this particular vacancy is emphasized by the fact that the BRHTF noted that LACDHS “lacks system-wide operational leadership” and recommended that the salary for the position should be adjusted “to attract the most highly qualified candidates.”

The Operations Director vacancy influences waiver-related activities through its effect on how the Director of Ambulatory Care is able to influence hospitals and their relationships with the LACDHS clinics. If the Director of Ambulatory Care, who does not have direct administrative control over the LACDHS clinics, felt there was a problem, that person would work through the Operations Director. In essence, the Operations Director provided some centralized control over the hospitals. Since that individual’s retirement in March 2000, there may have been some backsliding into the hospital fiefdoms that operated prior to the waiver. For example, if the Director of Ambulatory Care observes problems with the clinics, contacts must be made directly with each hospital involved.

The vacancy at the Office of Managed Care affects the PPP-side of waiver activities. Although the Director of Ambulatory Care is responsible for overseeing PPP activities, responsibility for monitoring PPP contracts and performance rests with the Office of Managed Care. Specifically, the Office of Managed Care monitors PPPs with respect to medical credentials and quality oversight as well as contract compliance. For example, PPPs that are likely to be over- or under-performers relative to their contract limits are supposed to be identified by this Office so that the Director of Ambulatory Care can make adjustments. However, these PPP responsibilities seem to have been layered on top of other commitments

and, as a result, the Office of Managed Care seems to be under-staffed. Not having a Director complicates the ability of this over-committed staff to prioritize and meet its obligations.

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The uncertainty related to senior staff vacancies that we observed during our January 2001 site visit no doubt increased on March 15, 2001 when the *Los Angeles Times* reported that Mark Finucane, the Director of LACDHS, would resign effective in June 2001. This resignation seems to be related to the role played by the Board of Supervisors who, the *Los Angeles Times* reported, “clashed frequently” with Finucane. Although Finucane’s departure and its potential effect on indigent health care in Los Angeles do not directly affect the study period for this evaluation, it is a further indicator that the Board of Supervisors will face significant hurdles as it tries to direct LACDHS through the waiver extension and toward financial self-sufficiency. In addition to Finucane, Roberto Rodriguez, the top official at the LAC+USC Medical Center will also be leaving in June 2001. Although the Board of Supervisors has already appointed Finucane’s chief of staff, Fred Leaf, as interim Director of LACDHS after June 30, 2001, it is too early to tell what course the Board or LACDHS will follow as the waiver extension unfolds.

## V. FINANCIAL STABILIZATION

Media reports regarding the financial stabilization component of the demonstration project have characterized it as a “bailout.” However, CMS’s Special Terms and Conditions for granting the waiver required the State and County to “identify revenue sources to ensure the viability of the County health care system ... after the (Demonstration) Project ends.” Despite this explicit requirement, the annual reports submitted by LACDHS to CMS did not report on the progress the County was making toward being financially self-sufficient. Although this evaluation does not focus on financial stabilization, this chapter briefly reviews the components of the stabilization package and the role it has played in financing LACDHS.<sup>16</sup>

### A. THE FINANCIAL PACKAGE

The elements of the financial assistance provided under the waiver were all established during the first year of the waiver. The initial projection of total value of the first year funding was \$364 million. LACDHS indicates that the total value of the waiver revenues was approximately \$1.2 billion in federal funding by the year 2000, with \$0.2 billion of this going to the county mental health department through the provisions of the indigent care match. The financial package included components that were clearly one-time solutions to the crisis LACDHS was facing when the waiver was applied for, and others that could potentially offer longer term relief. The one time components included a supplemental Medi-Cal payment made through California’s SB1255 program, an adjustment to the LACDHS Medi-Cal DSH limit for the year prior to the waiver period that allowed an increase in net DSH payments, and a Public Health Service grant.<sup>17</sup>

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<sup>16</sup> Greater detail of the financial stabilization package is provided in our initial report on the waiver (Long et al. 1999).

<sup>17</sup> SB1255 is a supplemental payment program designed to increase Medi-Cal payments to hospitals that are part of the State’s Selective Contracting program, qualify for Medi-Cal DSH payments, and operate an emergency room

The other components of the financial package were part of the longer-term relief effort. First, CMS agreed to make LACDHS eligible to receive a federal match for services provided to indigent patients in non-hospital settings (e.g., CHCs and Health Centers). The waiver did not require that these facilities be County-owned and operated, allowing a federal match for PPP services, but did require that the indigent patients be U.S. citizens or legal residents. Second, CMS allowed LACDHS to claim the part of its Medi-Cal DSH intergovernmental transfer that is used to fund DSH payments for private hospitals as part of its uncompensated care expenses when computing its DSH caps. Finally, the waiver established a supplemental project pool (SPP), funded equally by federal and local funds, that allows the County to receive Federal matching funds for providing care to indigent patients.<sup>18</sup> Once the County has certified that it has provided 450,000 clinic visits to Medi-Cal or indigent patients, the SPP – that cannot exceed \$125 million and is paid as a lump-sum payment - will be paid to LACDHS.

## **B. IMPLICATIONS FOR LACDHS'S RESTRUCTURING**

The financial structure of the waiver provided an incentive for LACDHS to move care from inpatient to outpatient settings, while the Medi-Cal DSH payment system encouraged hospital-based care. If LACDHS was successful in moving care out of the hospital as it outlined in its restructuring plans under the waiver, it could have seen a reduction in DSH revenues that exceeded the revenues under the waiver. This led to an LACDHS projection that hospital DSH payments would fall short of those allowed under the waiver's budget neutrality limits. The

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(however, two LACDHS hospitals that receive SB1255 payment have been exempted from this emergency room requirement). This program is financed with intergovernmental transfers that are made by public hospitals on a voluntary basis. In contrast, all public hospitals must make intergovernmental transfers to finance the Medi-Cal DSH program.

<sup>18</sup> Approximately \$62.5 million in federal funds were committed for this purpose. The "State" share will be set according to the Federal Medical Assistance Percentage (FMAP) rate and will be financed through an intergovernmental transfer from the County in a manner similar to the approach used to finance the Medi-Cal DSH program.

shortfall was projected to be about 10 percent over the five years of the waiver. Presumably, this projection were based on some assumption about the rate at which care moved out of the hospital; the more rapidly care is moved to non-hospital settings, the more rapidly hospital DSH payments would fall.

Although the financial incentive related to changes in DSH funding were for the County to slow down the rate of hospital downsizing, the indigent care match and the SPP offset this to some extent. If the County treated more indigents in non-hospital settings, it received the indigent care match. On the margin, the indigent care match reduced the DSH-related incentive to treat indigent patients in the hospital. The SPP also provided for additional payments related to providing non-hospital visits to indigents and Medi-Cal patients. However, because the SPP is a lump-sum fixed payment that the County has easily qualified for in each year of the waiver, on the margin, it provided little incentive to shift any patient from the hospital to the clinic setting.

In addition to the direct effects of the Section 1115 waiver requirements, the restructuring of the County's health care system was linked to the changes being undertaken in response to the implementation of managed care for Medi-Cal beneficiaries (under a 1915(b) waiver). Under the model being implemented in Los Angeles, welfare-related Medi-Cal beneficiaries were required to choose between two plans: a local initiative (that included all disproportionate share hospitals and traditional safety net providers) and a commercial plan. Implementation of this Two-Plan Model began in Los Angeles in April 1997 for the local initiative and July 1997 for the commercial plan.

### **C. EFFECTS ON LACDHS MEDI-CAL REVENUES AND THE EXTENSION**

It was clear, according to almost every interview we conducted, that the financial stabilization effort succeeded by allowing LACDHS to undertake its restructuring plans without

the closing any of its major facilities. However, as evidenced by the need to apply for a waiver extension, the County had not succeeded in identifying the revenue sources it needs to ensure viability after the Demonstration Project. The County admitted that “the major goals of the Demonstration Project had not been accomplished” and that “without continuation of federal assistance through a Waiver extension and new amendments, accomplishments to date could be jeopardized.”

To understand why LACDHS was compelled to seek the waiver extension, it is useful to consider changes that took place in its Medi-Cal funding. Medi-Cal accounted for slightly over 40 percent of LACDHS revenues in 1994 and this has remained fairly stable through 2000. However, the sources of this Medi-Cal funding changed. In the year immediately prior to the waiver, about 55 percent of Medi-Cal revenues were received as payments for direct service provision, with the remainder from DSH and other supplemental payments. By fiscal year 1999-00, payments for services fell to about 38 percent of Medi-Cal revenues (including payments to the County-run HMO), DSH and other supplemental payments remained steady at slightly about 45 percent and the waiver provided about 17 percent of LACDHS’ Medi-Cal revenues.

On the surface, it might appear that the Medi-Cal program cut its basic rates and substituted federal waiver spending for state spending. However, the reduction in Medi-Cal payments for direct services does not appear to be associated with a cut in payment rates. Instead, LACDHS Medi-Cal revenues seems to have fallen because of the overall drop in Medi-Cal enrollment that occurred after welfare reform and the implementation of the Two-Plan managed care program that caused a shift of patients toward private plans and providers.

Under the waiver extension that was granted, the federal government will provide about \$900 million in funding over the 2001-2005 period, but this funding will phase-out over time.

The waiver extension is clearly designed to force LACDHS to move toward reduced dependence on federal funding. To this end, the State will provide an additional \$300 million dollars in combined state and federal matching funds through cost-based reimbursements to all County clinics and private clinics with County contracts for Medi-Cal ambulatory care. In addition, the County will commit \$400 million over the five years, with \$300 million coming from the tobacco settlement and \$100 million from general revenues, and maintain reengineering savings at \$91 million annually.<sup>19</sup> Finally, the State and County agreed to put a total of \$40 million dollars into a worker retraining program. These funds can come from any source, including federal worker training dollars allocated to the State and the County under various U.S. Department of Labor programs.<sup>20</sup>

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<sup>19</sup> Prior to the waiver extension agreement, the County Board of Supervisors had already voted to target a large share of its tobacco settlement to fund LACDHS programs and almost double the current County contribution. However, the commitment to \$91 million in annual Austerity Program savings may be difficult to achieve based on the fact that audited annual savings are still under \$80 million and, according to the County auditors, may be difficult to maintain.

<sup>20</sup> The agreement also requires that the County meet certain performance standards as a condition for receiving the full amount of federal funding. First, the County must continue to provide 3 million ambulatory care visits in each of the five years. Second, the County must add staff to review eligibility for Medi-Cal and Healthy Families and enroll 175,000 new eligibles during each year of the waiver (excess enrollment in one year will be credited toward the target in the next year). Related to this, the County must also simplify screening procedures for its indigent care program. Third, LACDHS must start a process to assess the potential eligibility of its clinics and the private partner sites for Federally-qualified Health Center (FQHC) status. Fourth, there must be improvement and standardization in data reporting requirements across LACDHS facilities. Failure to meet these performance standards could result in the County losing up to 10 percent of federal matching funds for related services.

## VI. CONCLUSION

In 1995, Los Angeles County's health care system was in the midst of fiscal crisis and was on the verge of closing major public health care providers. The Section 1115 waiver that was granted by the Federal government provided fiscal relief that was intended to give the County the opportunity to restructure its approach to indigent health care. As part of the restructuring, all of the LACDHS hospitals and Comprehensive Health Centers were kept open and the number of places that the indigent population could access health care services was expanded through the PPP program. As part of the PPP program, LACDHS contracted with more than 81 private partners to deliver primary care at over 100 sites (Los Angeles County Department of Health Services, 1999/00). In addition, some specialty care was moved out of the hospital into CHCs, Referral Centers were established to improve scheduling at hospital-based specialty clinics and public health was given greater priority within the Department.

Improving efficiency turned out to be a more difficult task than expanding access. Given that 75 percent of LACDHS expenses were related to hospitals in 1995, what was clear was that Department-wide efficiency would only improve if hospital costs could be lowered. At first, LACDHS planned to privatize two of its smaller hospitals – High Desert Hospital and Rancho Los Amigos Hospital, but the predicted financial benefits of this move were less than expected and the plan was shelved. But, LACDHS was able to reduce the number of hospital beds throughout its hospital system substantially as its average daily census of inpatients declined. In addition, a large reengineering program was initiated that produced annual savings of about 3.5 percent of LACDHS expenses by the end of the 1995-2000 waiver. However, as County auditors pointed out, these reengineering savings would not be large enough to offset the loss of waiver funds if or when that occurs.

One question that we posed after our initial case study regarding the ability of LACDHS to operate without the waiver funding after the year 2000 has been answered: the changes that took place under the initial waiver have not allowed the County to serve the needs of its indigent population without the special waiver funds. Despite the immediate financial relief that the waiver extension provides, some critical issues remain unresolved. Absent some broad federal or State health reforms that substantially reduced the number of uninsured in Los Angeles, LACDHS officials have been skeptical about achieving self-sufficiency after the waiver. The large number of uninsured in the County are not being reduced as a result of the waiver or other policy changes and the obligation to meet their health care needs remains. Further complicating the job of meeting this obligation is the fact that the Director of LACDHS has resigned (replaced on an interim basis) and that many other senior management positions remain vacant.

The consensus at LACDHS is that the system would have been “near collapse” without an extension of the waiver. If the federal government follows through on its commitment to end waiver funding in 2005, LACDHS could be “near collapse” again without significant changes in restructuring and re-engineering efforts or a significant increase in state or local revenues. In the end, the Demonstration Project pulled LACDHS out of its 1995 financial crisis and allowed it to begin to rebuild its ambulatory care system and undertake a variety of other reforms aimed at improving efficiency and patient care, but it did not create a stable financial environment for the future. Whether or not this changes as a result of actions to be implemented during the waiver extension will depend on the willingness and ability of both the State and County to make fundamental reforms in both the financing and operation of LACDHS. If past is prologue, it is hard to be optimistic.

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