
Urban Health Care in Transition: Challenges Facing Los Angeles County

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The authors examine the Medicaid Section 1115 Demonstration Project currently underway in Los Angeles County. The waiver was designed as part of a response to a financial crisis the Los Angeles County Department of Health Services (LACDHS) faced in 1995. It provides financial relief to give the county time to restructure its system for serving the medically indigent population. Los Angeles County's goal is to reduce its traditional emphasis on emergency room and hospital care by building an integrated system of community-based primary, specialty, and public health care. This case study describes activities completed through the spring of 1997, approximately 1 year after the waiver was approved.

INTRODUCTION

Over the last decade there has been significant restructuring of the U.S. health care system. Although the forces bringing about these changes are affecting all providers, the pressure on public providers may be greatest (Baxter and Mechanic, 1997). Public providers not only need to develop strategies to live with managed care and reduced public funding of health care, they also need to continue to provide care to those without health insurance who simply cannot afford to pay. This task is made all the more difficult by the fact that the revenue needed to cross-subsidize care

to the poor is eroding, while the population without health insurance is increasing (Fronstin, 1997). In the face of these systemic changes, the local health departments that run public hospitals and clinics have no well-charted course to follow (Andrulis, 1997). In an effort to remain viable, public providers are taking a range of approaches, including closing or selling some facilities, downsizing others, reducing staffing, reorganizing operations, and contracting with private providers for selected services. In this article, we address the efforts of one large public health care system—Los Angeles County—to transform itself in response to changing markets and policies.

The LACDHS operates the public safety net for a county of 9.4 million people, including more than 2 million people living in poverty. Approximately 30 percent of the non-elderly population in the county lacks health insurance (Schauffler and Brown, 1998). To meet its obligation under California law to serve as the provider of last resort for the medically indigent population (section 17000 of the Welfare and Institutions Code), Los Angeles County maintains a large, complex system of public facilities (hospitals, comprehensive health centers, and clinics).¹ In 1995 Los Angeles County faced a projected budget deficit of \$1.3 billion, of which \$655 million was estimated to be in LACDHS' operating

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¹In 1991 the State of California transferred fiscal responsibility for indigent health care programs to the counties as part of a State-county realignment. State block grants aimed at easing counties' financial burden of caring for medically indigent populations ceased. In place of these State funds, the county received a dedicated funding stream created from an increase in the State sales tax and an earmarked portion of the vehicle license fee dollars.

budget of \$2.3 billion (Los Angeles County Department of Health Services, 1997a). Because of a succession of natural disasters (earthquakes, fires, and floods), civil unrest, and a prolonged recession, combined with falling Federal, State, and local revenues, and no authority to increase tax rates,² the projected deficit represented a significant financial crisis for the county and, especially, LACDHS.

This financial crisis led the county to close or plan for the closing of a number of its health care facilities and to cut back on services across the public safety net. At the same time, the State of California and Los Angeles County solicited assistance from the Federal Government regarding longer term solutions to the county's financial difficulties. In September 1995 President Bill Clinton announced a \$364 million Federal fiscal relief package that was to be tied to a section 1115 Medicaid research and demonstration project waiver for the county. In February 1996 the application for the Medicaid Demonstration Project for Los Angeles was submitted to HCFA. HCFA approved it in April 1996. The demonstration project covers the period from July 1, 1995 (retroactive), through June 30, 2000.

The Medicaid Demonstration Project for Los Angeles was designed to address the county's immediate financial crisis and to allow the county to undertake an ambitious 5-year restructuring of LACDHS' administrative and provider systems. Although the financial stabilization of LACDHS was the primary impetus for the waiver, the restructuring plans have taken on a more prominent role as the financial crisis has

² Los Angeles County, like all other counties in California, has virtually no capacity to raise significant tax revenues on its own. County revenues in California are derived primarily from State-controlled sources, such as program-specific State aid, the property tax, and the sales tax (Legislative Analyst's Office, 1995). Voter-imposed restrictions on local property taxes under 1978's Proposition 13 have limited the county's ability to increase revenues through the property tax.

eased. If successful, LACDHS' restructuring efforts will improve access to and the efficiency of its system for providing ambulatory care and preventive services to Medicaid and uninsured populations by making significant changes in the county's health care system. LACDHS' goal is to shift away from its traditional emphasis on emergency room and inpatient care toward preventive and outpatient care, while building an integrated system of health care that includes better links between inpatient and outpatient settings, primary and specialty care providers, personal health care and public health, and public and private institutions. The primary theme of the restructuring effort is to promote the use of a coordinated and cost-effective system of community-based primary, specialty, and preventive care.³ LACDHS expects that this system of community-based preventive and primary care will help to control the demand for inpatient and specialty services and thereby provide more appropriate and less costly care.

The section 1115 waiver for Los Angeles County supports this restructuring as it allows LACDHS to receive Federal payments for non-hospital services provided to indigent individuals who are not enrolled in Medicaid. Thus, the financial structure of the waiver provides an incentive for LACDHS to move care from inpatient to outpatient settings.

In this article, we examine LACDHS' efforts to transform its large, hospital-based, decentralized public health care system into an integrated system of care.

³ In addition, the restructuring of the county's health care system will be affected by the changes being undertaken in response to the implementation of managed care for Medicaid beneficiaries in California (under a 1915[b] waiver). Under the model being implemented in Los Angeles, welfare-related Medicaid beneficiaries will be required to choose between two plans: a local initiative (that includes 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.

Table 1
Components of the Fiscal Relief Package for
LACDHS Under the Medicaid Demonstration
Project: 1995-96

Component	Total Dollars (in Millions)
Total Relief Package for 1995-96	\$364
One-Time Supplemental Payment	125
One-Time Increase in Net DSH Payment in Fiscal Year 1994-95	79
One-Time Public Health Service Grant	18
Indigent Care Match (for Non-Hospital Services)	52
Provision to Treat Intergovernmental Transfer to Fund DSH Payments to Private Hospitals as an Uncompensated Care Expense in Computing LACDHS' DSH Cap	28
Supplemental Project Pool	62

NOTES: LACDHS is Los Angeles County Department of Health Services. DSH is disproportionate-share hospital.

SOURCE: Los Angeles County Department of Health Services, 1997a.

We first outline the key components of the financial aspects of the waiver. We then consider LACDHS efforts to build an integrated system of ambulatory care, followed by a discussion of efforts to reduce the system's reliance on inpatient care. The final section contains our summary and conclusions.

The information presented in this article was derived from two types of sources. First, we conducted a detailed review of the original waiver application, HCFA's agreement to grant the waiver, and the county's plans for implementing the waiver. This was then combined with a series of semi-structured interviews with Federal, State, and county officials and other stakeholders. The interviews were conducted predominantly during the spring of 1997, approximately 1 year after the waiver was approved. A process of ongoing monitoring has allowed us to update information on selected aspects of the waiver program for this article. (A more indepth evaluation is contained in Long et al., 1998.)

FINANCIAL STABILIZATION

As outlined in HCFA's Special Terms and Conditions (Health Care Financing Administration, 1996) of the waiver, the goal of the financial stabilization effort is to identify revenue sources that will give LACDHS the ability to restore service reductions and the time it needs to reconfigure the county health care system. Before discussing the restructuring plans, it is useful to examine the financial stabilization effort briefly and consider how this may affect LACDHS' restructuring.

The waiver included several measures aimed at providing immediate financial relief to the county (Table 1): a one-time supplemental payment of \$125 million through a California program designed to increase Medicaid payments to selected hospitals in the State; a one-time adjustment to LACDHS' disproportionate-share hospital (DSH) payment limit for fiscal year 1994-95, which increased net-DSH payments by \$79 million; and a one-time Public Health Service grant of approximately \$25 million (whose net value to LACDHS was \$18 million).⁴ The supplemental payment of \$125 million is being viewed by LACDHS as an obligation that may be repayable in the future.⁵

⁴ DSH payments are supplemental Federal Medicaid payments provided to public and private hospitals that serve a disproportionate share of Medicaid and uninsured patients and, as a result, have high uncompensated care costs. All six of LACDHS' hospitals are designated as DSHs, providing much of the uncompensated care in the county (Cousineau et al., 1995). The Omnibus Budget Reconciliation Act (OBRA) of 1993 placed limits on DSH payments to individual hospitals.

⁵ There is some disagreement between the State and HCFA as to the repayment of the \$125 million. In fact, the State has sent a letter to HCFA indicating its determination that none of the funds are repayable.

The other components of the financial package are part of a longer term relief effort. First, HCFA agreed to make LACDHS eligible to receive a Federal match for services provided to indigent patients in non-hospital settings. This includes services provided at LACDHS' comprehensive health centers and clinics, as well as private clinics under contract to the county. The indigent patients cannot be eligible for Medicaid, but must be U.S. citizens or legal residents. A total of \$52 million was projected to be spent for this purpose in 1995-96, split between mental health (\$18 million) and other LACDHS services (\$34 million). Second, HCFA allowed LACDHS to claim the part of its intergovernmental transfer that is used to fund DSH payments for private hospitals as an uncompensated care expense when determining its hospital-specific DSH caps.⁶ This raises the hospital-specific DSH caps, which gave the county an additional \$28 million in 1995-96.

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.⁷ Once the county has certified that it has provided 450,000 clinic visits to Medicaid or indigent patients, the SPP will be paid to LACDHS. The total amount of the SPP (including Federal and local funds) cannot exceed \$125 million and is paid as a lump-sum payment. The indigent care match,

⁶ Under the State's Medicaid DSH program, public entities that operate DSH hospitals transfer funds to the State through an intergovernmental transfer. These dollars are then combined with matching Federal dollars and redistributed as supplemental payments to all eligible (both public and private) DSH hospitals. See Zuckerman et al. (1998) for a discussion of California's Medicaid DSH program.

⁷ 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 Medicaid DSH program.

the allowances for DSH payments to private hospitals, and the SPP continue over the entire life of the waiver.

The fiscal relief package of \$364 million for 1995-96, combined with LACDHS curtailments of \$217 million (through service and staffing reductions across the public health care system) averted the immediate financial crisis facing LACDHS in 1995-96 (Finucane, 1997). LACDHS projections show that the county expects to receive \$925 million through the waiver package over 5 years (Los Angeles County Department of Health Services, 1997b). Although these waiver revenues are substantial and are clearly important to the county on the margin, they do not represent a very large share of the LACDHS budget. Over the 5-year course of the waiver, the sum of the forecasted annual budgets for LACDHS will equal between \$11 and \$12 billion. This implies that the waiver will account for about 8 percent of the funding for the department. Funding from regular Medicaid sources, the State, and the county are all larger sources of revenues for LACDHS.

The indigent care match and the SPP under the waiver provide an incentive for LACDHS to move care from inpatient to outpatient settings, while the ongoing Medicaid DSH payment system encourages hospital-based care.⁸ On the margin, the indigent care match reduces (but does not eliminate) the DSH-related incentive to treat indigent patients in the hospital. In contrast, 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, the SPP provides little incentive

⁸ Regardless of the changes as a result of LACDHS restructuring efforts, Medicaid DSH payments to California will fall as a result of the 1997 Balanced Budget Act (BBA) (Coughlin and Liska, 1998). However, the BBA also incorporates a special provision for California that raises the cap on hospital-specific DSH payments from 100 percent up to 175 percent of their uncompensated care costs through October 1, 1999.

to shift any patient from the hospital to the clinic setting. The net result is that, if LACDHS is successful in moving care out of the hospital as it outlined in its restructuring plans under the waiver, it would see a reduction in DSH revenues that could exceed the additional revenues available for outpatient care under the waiver. The more rapidly LACDHS moves forward with the restructuring of its health care system by moving hospital-based care to community settings, the greater its revenue loss. LACDHS refers to this as the “restructuring Catch-22” (Los Angeles County Department of Health Services, 1997c).

BUILDING A SYSTEM OF AMBULATORY CARE

As previously noted, LACDHS is attempting to move from a large, decentralized, hospital-based system to an integrated and well-coordinated system of community-based care. Prior to the waiver, Medicaid and indigent ambulatory care services in Los Angeles County were provided at county hospitals, comprehensive health centers (CHCs), and clinics. Outpatient specialty services were largely concentrated in the hospitals, with some limited specialty services available in CHCs. Primary care was provided through CHCs and to a lesser extent, clinics. Clinics also provided public health services. According to LACDHS (1997a), many of the outpatient visits provided under this system were “single purpose and disease-related,” with little coordination in care across service providers and facilities. In addition, many in the Los Angeles community used the emergency room for routine care. Estimates for 1993 indicated that 38 percent of visits to trauma centers (public and private) in Los Angeles County were for non-urgent primary care (Cousineau, 1995).

LACDHS’ efforts to build an integrated system of ambulatory care services under the waiver involve three key strategies: (1) expanding access to ambulatory care services; (2) reducing the inappropriate use of emergency rooms for primary care; and (3) building links across public health, primary care, and specialty care providers.

Expanding Access to Ambulatory Care Services

Prior to the availability of Federal funds to stabilize the county health care system, LACDHS cut back on services and reduced staff across the public health system, including moving forward with plans to shut down some of its facilities. LACDHS estimates that ambulatory care visits dropped by more than 400,000 visits during the 1994-95 period of the financial crisis (Los Angeles County Department of Health Services, 1997a). However, rather than simply closing the doors on some of its clinics, LACDHS moved to create a new type of indigent care provider in the public system: public-private partnerships (PPPs). LACDHS offered several soon-to-be-closed public clinic facilities up for “takeover” by private providers. LACDHS would provide the facility, and the private provider was to provide staff and services at the clinic. Three private providers stepped forward to take over six public clinics to ensure that services continued for the indigent population at those locations. Because of concerns that the LACDHS shutdown of clinics would overwhelm the private system, the private providers believed that they “. . . had no choice [but to enter into a PPP].”

Although the PPPs began as an emergency response to the health care system’s financial crisis, with the promise of a Federal fiscal relief package in September 1995, LACDHS began to pursue PPPs as part of a more systematic strategy to

Table 2
Number of LACDHS Clinics and Public-Private Partnerships (PPPs) Prior to the Waiver and as of October 1997

Type of Clinic	May 1995	October 1997
Total LACDHS-Affiliated Clinics	39	145
Publicly Operated LACDHS Clinics	39	23
Privately Operated LACDHS Clinics ("Takeover PPPs")	0	9
Public and Private Providers at LACDHS Clinics ("Co-Located PPPs")	0	7
Private Clinics Receiving LACDHS Funds ("Expansion PPPs")	0	106

NOTE: LACDHS is Los Angeles County Department of Health Services.
 SOURCE: Los Angeles County Department of Health Services, 1998.

expand primary care access throughout the county. Two new PPP structures were initiated: (1) the location of public and private providers in a single public facility ("co-located PPPs") and (2) the expansion of publicly funded services at private facilities ("expansion PPPs"). In these PPPs, the private entity delivers primary care services, while the public clinic provides public health services (e.g., immunizations, family planning services, sexually transmitted disease testing and treatment). In addition, LACDHS made waiver funds available to pay for services delivered to the indigent by the PPPs—the first time county funds were shared with private providers serving the indigent population.⁹ During early 1996 LACDHS added 3 "co-located PPPs" and 38 "expansion PPPs" to its network of clinics. In addition, two more public clinics were transferred to private providers as "takeover PPPs."

Over time additional PPPs have been added as LACDHS has identified geographic areas in the county with limited availability of primary care services for the indigent. As of April 1997, LACDHS had

⁹ Although LACDHS did provide funds to support the care for indigent patients at the PPPs, a number of the private partners expressed concern about the level of the payment rates. To date, no private providers have withdrawn from the PPPs; however, several noted that they are continually reassessing their ability to make the system work financially at the level of payment that LACDHS is providing.

entered into a total of 85 PPPs with private providers. There were 116 primary care access points funded by the county at that time, an increase of almost 200 percent from 1995. LACDHS has continued to build on the PPPs since the time of our site visit.¹⁰ By October 1997 the number of primary care access points receiving county funds had increased to 145 (Table 2). The expectation within LACDHS and the community is that LACDHS will explore expanding the PPPs to include specialty care as the next step in building public-private linkages. According to LACDHS, the PPPs are to provide the anchor for a more integrated public-private system of care.

Developing relationships between public and private sector health care providers has become a critical component of the restructuring activities under the waiver. Pursuing collaboration with the private providers has significantly changed the way LACDHS delivers health services with the expectation of improved efficiency. This linkage is reported to have increased communication across the providers (public and private) who serve the indigent population and to have provided the beginnings of a more integrated health care delivery system in the county. LACDHS is no longer a closed system of care but has turned to partners in the private sector to sustain the public health care system. LACDHS' private partners include free and community clinics, federally qualified health centers, and private physician groups.

Despite LACDHS' success at building linkages with the private sector and increasing the number of points of access for ambulatory care through the PPPs, there was no evidence that the PPP

¹⁰ Setting up the PPPs was not without challenges for LACDHS and its private partners. The most frequently mentioned challenges concerned the poor condition of the public facilities, difficulties in obtaining payments for providing care, uncertainty about future funding, and limited efforts by LACDHS to inform the community of the PPPs as the financial situation was stabilized after the 1995 crisis.

arrangements had resulted in an increased number of visits across the LACDHS system for the indigent population. Cutbacks in ambulatory care services at LACDHS' hospitals and comprehensive health centers, as well as the slow return to pre-crisis levels of care at LACDHS-owned clinics, have resulted in fewer visits than were available prior to the waiver. However, the poor quality of the available data makes it impossible to assess how far below the pre-crisis levels the number of visits provided by or paid for by the county remains.¹¹

Reducing Inappropriate Emergency Room Use

LACDHS provides core emergency and trauma care for Los Angeles County. In fiscal year 1994-95, LACDHS provided nearly 500,000 emergency room visits, many of which were for non-emergency care (Los Angeles County Department of Health Services, 1997a). In addition, LACDHS' emergency rooms also processed most referrals to the county's specialty care providers. Given the significant costs associated with such inappropriate emergency room use, a key goal of the demonstration project is to reduce the use of the emergency room for routine health care needs. At the time of our site visit, the county was addressing inappropriate emergency room use only through new referral systems for specialty care (discussed later) and a toll-free patient information telephone service to assist patients in finding a primary care physician. Although not yet developed, the

¹¹ LACDHS' inability to document the number of ambulatory care visits is the result of both the lack of a consistent definition of an ambulatory care visit across providers and the department's limited information management systems. Prior to the demonstration project, each CHC and clinic counted a visit based on its own definition. As a result, the county does not have an accurate baseline number from which to measure changes in the number of visits. Under the demonstration project, LACDHS is implementing a more systematic definition of visits across the CHCs, clinics, and PPPs, as well as improving its information management systems.

goal is to institute formal triage systems within LACDHS emergency rooms to identify patients who can be treated in other settings and refer them to those settings and to develop case management procedures for patients with selected ambulatory care sensitive conditions (e.g., asthma, diabetes, congestive heart failure).

The intent of many of the proposed changes in LACDHS' health care system is to help patients develop a "medical home" in the community for primary care services. However, even if the demonstration project were successful in creating these "homes" for a significant portion of indigent persons, there might not be a noticeable decline in emergency room visits. Because the level of need is so great in Los Angeles County, any patients moved to community-based care might well be replaced by a new group of indigent persons that turned to the emergency room for primary care.

This proposition is supported by estimates that the extent of unmet need for primary care visits in the county ranges from 1.4 to 5.0 million visits annually (Los Angeles County Department of Health Services, 1997a). In May 1997 LACDHS had not observed any reductions in emergency room use under the waiver.¹²

Linking Primary and Specialty Care

Prior to the waiver, there were long waiting lists for specialty care in the LACDHS system, in part because there was not a systematic link between primary and specialty care. Access to specialty care for the indigent population occurred through the emergency room. Neither a primary care physician at an LACDHS clinic nor one at a

¹² In later comparisons, LACDHS (1997c) reported a significant decline in emergency room use at several hospitals between fiscal year 1994-95 and fiscal year 1996-97. However, LACDHS reported that they "had not yet isolated the precise factors associated with this decline."

private clinic could refer a patient to an LACDHS specialist directly. Consequently, a patient receiving primary care at a clinic still had to go to the emergency room for an examination in order to obtain a specialty referral.¹³ In other cases, patients who had obtained services from a specialty provider continued to return to that provider for primary care. This added both to the waiting lists for access to specialty care and to the costs of providing primary care to LACDHS patients.

To improve the process by which specialty care is provided, LACDHS is developing referral centers to schedule and coordinate specialty care. The referral centers are intended to improve (1) specialty care access for indigent persons; (2) the flow of patients and information (medical care documentation) between primary care and specialty care providers; and (3) the timeliness of specialty care referrals. In addition, there is an increased effort underway to return patients to their "medical home" for primary care. The referral centers are housed in each of the hospitals and coordinate specialty care for patients served by all of the LACDHS-affiliated facilities in the hospital's service area (LACDHS' CHCs and clinics, as well as PPPs).

Given that they were quite new at the time of our site visit, it is not surprising that the referral centers did not appear to have produced any noticeable improvements in the specialty referral process. Some providers indicated that they thought that the referral system had reduced the wait time for scheduling a specialty care visit, although others did not. LACDHS is in the process of establishing uniform data collection policies for wait-time information,

¹³ Furthermore, because the patient's records (e.g., medical chart, test results, patient profile, procedure notes) did not accompany the patient through the system, the emergency room physician would have to re-examine the patient, often redoing tests and laboratory work that had been done by the primary care provider.

which will allow an assessment of the length of the wait for a specialty care appointment.

Linking Primary Care and Public Health

As in many places, the personal health care and public health systems in Los Angeles operated as separate, virtually independent parts of the county's health care system prior to the demonstration project. There was limited interaction between the systems. As part of its restructuring plan, the LACDHS is working to build better linkages between the two systems.

As part of the county's immediate response to the 1995 fiscal crisis, the county's 29 sexually transmitted disease clinics and 33 tuberculosis clinics were consolidated into 10 public health clinics. Under its post-crisis restructuring, LACDHS has increased the number of public health clinics (14 as of January 1997) and begun efforts to increase the efficiency of service delivery. The efforts at improved efficiency include the "co-located PPPs," which provide primary and public health care at a single clinic, and the provision of some public health services as part of primary care visits (e.g., testing for communicable diseases, family planning services). At the time of our site visit, the assessment within LACDHS was that the overall quantity of public health services had not changed under the restructuring efforts, but the location and providers of care had. However, some LACDHS public health providers expressed skepticism that primary care providers could do an effective job providing core public health services.

REDEFINING THE ROLE OF HOSPITALS

With the financial incentives in place prior to the demonstration (more generous

Medicaid payments for hospital-based care and DSH payments tied to hospital-based services), the LACDHS health care system was centered around hospital care. In 1995 the county's hospitals represented 75 percent of LACDHS expenses (Los Angeles County Department of Health Services, 1997a). Given the importance of the hospitals in its budget, it is not surprising that reforming how the county hospitals function and interact with the rest of the system is a key component of LACDHS' waiver. One aspect of that interaction is the expected decline in avoidable hospitalizations through improved access to preventive and primary care. However, LACDHS is also proposing significant changes in the basic structure of its inpatient services, with the goal of redefining the role of hospitals in the county's health care system. LACDHS is in the process of relocating selected specialty care from its hospitals to CHCs, reducing inpatient beds, and creating a more cost-effective hospital system. The intention is to make these changes while maintaining LACDHS' role as the key provider of trauma and emergency services and emphasizing services that are least available in the private sector (e.g., high acuity and specialty services).

Relocation of Hospital Ambulatory Care Services

Prior to the demonstration project, LACDHS' health care system was organized around its six hospitals. Nearly 50 percent of all outpatient visits across LACDHS' facilities (hospitals, CHCs, and clinics) were provided at its hospitals (Los Angeles County Department of Health Services, 1997a), including almost all of the specialty care. A key element of LACDHS' restructuring is to relocate some hospital outpatient specialty care to more cost-effective and accessible settings—its

CHCs. Selected services related to cardiology, dermatology, endocrinology, nephrology, neurology, and other specialty areas have been moved to CHCs. In addition, most laboratory work associated with these services was transferred to outpatient settings as well. Specialty services that could not be moved to a separate outpatient setting remain at the hospitals; these include services requiring special equipment only available at the hospitals or treatment modalities only appropriate for hospital-based settings.

The transfer of specialty services from the hospital to ambulatory care facilities has forced operational and staffing adjustments in the system. With many doctors now caring for their patients at CHCs or clinics instead of only at the hospital, CHCs have had to ensure that there are enough physicians and nurses; that there is a culturally diverse mix of providers; that appropriate equipment is available; that sufficient space for parking, waiting rooms, and exam rooms exists; and that hours of operation are extended, if necessary. Hospitals have had to educate staff about the shift of services, realign staff, reconfigure space, and re-evaluate revenues and expenses in an effort to redefine their role in the LACDHS health care system.¹⁴ As a result of the shift of specialty care services to the CHCs, the CHCs have assumed a more prominent role in the LACDHS system.

¹⁴ Along with the shift of services away from the hospitals to the CHCs, LACDHS has promoted a corresponding shift of physician education, training, and practice in the county. Historically, physician training and residency followed the traditional, teaching-hospital approach, emphasizing inpatient and subspecialty care. With LACDHS' restructuring, there has been an increasing emphasis on outpatient preventive and primary care and clinic-based teaching. Many residents have been gaining primary care experience at clinics. Also, interns and residents have been rotating through CHCs in addition to the hospitals to gain familiarity with the specialty services that are now provided in the CHCs. This represents a significant change in the graduate medical education system, given that 50 percent of physicians in Southern California were trained in LACDHS-affiliated medical schools (Los Angeles County Department of Health Services, 1997a).

Reducing Inpatient Beds

At the onset of the demonstration project, LACDHS planned to reduce the number of inpatient beds at the county hospitals by almost 40 percent—from 2,595 beds (1994-95) to 1,583 by 1999-2000 (Los Angeles County Department of Health Services, 1977a). LACDHS anticipated achieving those goals by replacing the earthquake-damaged LAC+USC Medical Center with a smaller facility, selling two hospitals (Ranchos Los Amigos Medical Center and High Desert Hospital) to private providers, and reducing the number of inpatient beds at the remaining three county hospitals by a total of 26 percent. Those plans have been modified as the waiver has developed. In summer 1997 LACDHS developed revised inpatient bed target levels that are at somewhat higher levels than the initial plans. These levels reflect both the slower-than-expected reduction in inpatient beds¹⁵ and the fact that neither Ranchos Los Amigos nor High Desert were privatized and thus remain under LACDHS' control.

Replacing LAC+USC Medical Center

LAC+USC Medical Center is among the largest public hospitals in the country. At the time of our site visit, although it was licensed for almost 2,000 beds, it was staffed to operate at an average daily census in the 800s. Because LAC+USC was damaged during a 1994 earthquake, the Federal Emergency Management Agency (FEMA) has provided funding to repair or replace the facility. There has been much

¹⁵ As part of LACDHS' restructuring plans, a proposed reduction in inpatient beds was developed for each of the county hospitals. However, rather than directing each of the facilities to reduce the number of beds by a specific amount, LACDHS provided each hospital with a budget reduction target and allowed administrators at each hospital to determine how best to reach those targets. This has resulted in fewer inpatient bed reductions than outlined in LACDHS' initial plans.

debate within the county about the appropriate size for the LAC+USC replacement facility (Meyer, 1997). Because of the excess capacity in the private hospital sector, some county supervisors thought that private providers could take on a portion of the patient load. In contrast, other county supervisors wanted a significant public hospital presence in the part of the county served by LAC+USC, both as an economic center of the community and in anticipation of the future health care needs of the county's growing population. In addition, powerful labor unions expressed strong opposition to any significant downsizing of LAC+USC because of the associated loss of public sector positions. These ongoing institutional and political issues prevented the county from making any headway on this matter for many months. A threat by FEMA to withdraw funding led the Board of Supervisors to address the issue. In November 1997 the Board of Supervisors voted to replace LAC+USC with a facility no larger than 600 beds.¹⁶

Selling Two Public Hospitals to Private Providers

At the beginning of the demonstration project, LACDHS hoped to relinquish ownership of Ranchos Los Amigos Medical Center and High Desert Hospital by selling them to private purchasers. The expectation was that privatizing these hospitals would generate cost savings for the county and contribute to the county's target for inpatient bed reduction—once the facility was privatized, all of the beds at the facility would be removed from LACDHS' control.

¹⁶ Most recently, the California State Legislature attempted to influence the size of the LAC+USC replacement facility by passing legislation that would have provided funds to Los Angeles County to cover debt service on construction so long as the replacement facility included the capacity for 750 beds. California Governor Pete Wilson vetoed the legislation (Bureau of National Affairs, 1998).

LACDHS' experience in attempting to privatize these two hospitals has led the county to reassess the privatization efforts. First, no private providers expressed any interest in purchasing the facilities, and only a few providers were even interested in leasing arrangements. Second, LACDHS realized that the expected cost savings from privatization of Ranchos Los Amigos were not likely to be as high as had originally been anticipated, leading LACDHS officials to speculate that the hospital had already been operating relatively efficiently. As the result of a re-engineering of hospital operations in early 1996, the county estimated that they had realized \$18 million in savings at Ranchos Los Amigos (Los Angeles County Department of Health Services, 1997c). Finally, there was increasing resistance to privatization within the county. The union representing the health care workers strongly opposed privatizing the hospitals because of the potential of job losses. The Board of Supervisors had second thoughts about privatizing public hospitals, a major source of employment within the county, especially in the absence of an immediate financial crisis.

Re-Engineering Inpatient Service Delivery

Although LACDHS began its restructuring efforts with a goal of hospital bed reduction, the success of its re-engineering effort at Ranchos Los Amigos in 1996 led LACDHS to undertake a similar effort at each of its hospitals as an alternative means of cutting inpatient costs. The re-engineering process is intended to identify excess beds, fragmented and duplicative services, inappropriate staff mix and staff levels, uncoordinated clinical and ancillary services, inefficient purchasing systems, and antiquated or non-existent data systems. To date, the hospital re-engineering effort

has focused on four areas within each of the hospitals (Los Angeles County Department of Health Services, 1997d): (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 (including clinical guidelines and disease management protocols); and (4) redesigning health services administration to identify cost savings and inappropriate levels of management.

Under the re-engineering process, LACDHS is projecting a cut of approximately \$294 million from the hospitals' budgets over the remaining 3 years of the waiver (Los Angeles County Department of Health Services, 1997c). (This would represent approximately 13 percent of LACDHS' annual operating budget of \$2.3 billion.) LACDHS has also begun to expand the re-engineering process to its CHCs and clinics. It believes that those facilities could also operate more efficiently, leading to additional savings for the county.

SUMMARY AND CONCLUSIONS

Under the Medicaid Demonstration Project for Los Angeles, LACDHS is undertaking an ambitious restructuring of its entire health care system. LACDHS is attempting to reduce its traditional emphasis on emergency room (ER) and inpatient care by building an integrated system of community-based primary, specialty, and preventive care.

As of summer 1997, the most tangible element of LACDHS' restructuring related to the start it had made at improving access to ambulatory care services. However, these services represent a small share of the care LACDHS provides under its safety net system and a small share of its operating budget. LACDHS had made

changes in three areas: (1) expanding the points of access to community-based primary care through partnerships with private providers; (2) relocating selected specialty care services from county hospitals to county CHCs; and (3) improving the efficiency of care delivery across its facilities and across public health, primary care, and specialty care providers. The latter includes an increased emphasis on a “medical home” in the community for preventive and primary care, the beginning of formal systems for the referral of patients to specialty care, and improved linkages between primary care and public health. At the time of our site visit, little had changed with respect to inpatient care and the use of the emergency room for routine care needs.

The partnerships between LACDHS and private sector health care providers represent a fundamental change in LACDHS’ service delivery system and have become a critical component of LACDHS’ restructuring activities under the waiver. Historically, the public and private providers in Los Angeles have worked independently of each other within the county’s safety net. The public-private partnerships, which began as an emergency response to LACDHS’ financial crisis, have become the foundation of the strategy for expanding community-based primary care and filling gaps in service areas. These partnerships resulted in an increase in the points at which LACDHS-funded care could be accessed by the indigent by more than 50 percent. However, because of service reductions across other components of the LACDHS system, the overall number of ambulatory care visits provided by LACDHS to the indigent population in summer 1997 remained below that provided prior to the 1995 financial crisis. Although the county has succeeded in

expanding its system for providing care, it has yet to expand the volume of care available to indigent persons in the community.

Under the waiver, much of LACDHS’ proposed restructuring relates to changes in its hospitals. LACDHS proposed reducing inpatient beds and creating a more cost-effective hospital system, while maintaining its role as the key provider of trauma and emergency services and selected specialty services. At the onset of the demonstration project, LACDHS anticipated replacing LAC+USC Medical Center with a smaller facility, selling Ranchos Los Amigos Medical Center and High Desert Hospital to private providers, and reducing the number of inpatient beds at the remaining county hospitals by more than a quarter. With the exception of replacing LAC+USC with a smaller facility, those plans have been modified as the waiver has evolved. Because there was less interest by the private sector in Ranchos Los Amigos Medical Center and High Desert Hospital than LACDHS had anticipated, those hospitals have not been privatized. And hospital bed reductions have moved forward more slowly than initially planned, as LACDHS has turned to re-engineering efforts to improve the efficiency (and reduce the costs) of hospital operations. These re-engineering efforts were still in the planning stages at the time of our site visit. It remains to be seen whether LACDHS will be able to achieve the significant planned savings in hospital costs from its re-engineering efforts.

As LACDHS moves into the final years of the waiver, many questions hang over the success of its restructuring of the safety net. First, will increasing the number of places where medically indigent persons can seek primary care actually increase the number of services they receive?

Although there had not been an increase in the level of services at the time of our site visit, an increase is one of the central goals of the waiver. Unfortunately, shortcomings in LACDHS data systems will always leave the answer to this question in doubt. Significant inconsistencies existed, and continue to exist, in how visits are measured between and within the public and private providers. Because there are not consistent data prior to and following the waiver, it will not be possible to determine whether the number of visits has increased under the demonstration.

Second, will LACDHS' proposed triage system for the ER have a significant impact on the level of services provided through the ER? As CHCs, clinics, and public-private partnerships become available to serve the non-emergency needs of medically indigent persons, the implicit expectation is that ERs will be focusing on truly urgent care. However, at the time of our visit, LACDHS had made few changes in its system of ER care. If the proposed triage system is to have any affect during the waiver, it will need to be designed and implemented quickly.

Third, will LACDHS be successful in improving the efficiency of its system, particularly the efficiency of its hospitals? The financial assistance provided through the waiver is intended to give LACDHS the time it needs to adapt to the funding constraints it faced at the time of the 1995 financial crisis. LACDHS is planning to undertake re-engineering efforts to produce significant cost savings in the operation of its hospitals. In addition, LACDHS hopes that the improved linkages between primary care, specialty care, and public health will create a more efficient health care system. It remains to be seen whether LACDHS will be able to reduce staffing levels without service or quality reductions or expand services within cur-

rent budgets as a result of efficiency gains achieved by the county in its restructuring.

Fourth, will the changes taking place under the waiver allow the county to serve the needs of its indigent population without the special waiver funds? Based on the waiver revenue projections by LACDHS, operating expenses in fiscal year 2000-01 will need to be more than \$200 million below those in the year immediately preceding the end of the waiver if LACDHS is to avoid a shortfall when the waiver ends.

Finally, LACDHS' restructuring efforts under this waiver are taking place within the context of a broader set of changes in the county's health care system. The two-plan model of Medicaid managed care, welfare reform, and the Children's Health Insurance Program (called Healthy Families) will interact with the county's restructuring efforts. The section 1115 waiver that the county is operating under cannot be viewed in a vacuum. If welfare reform led to significant reductions in the numbers of Medicaid beneficiaries or if the two-plan managed care initiative caused fewer Medicaid beneficiaries to seek care at LACDHS facilities, then the county health care system could feel additional fiscal stress. Alternatively, if the Healthy Families initiative leads to an expansion of coverage among previously uninsured children and if these children seek care at county facilities, then LACDHS' financial picture could be more optimistic than has been projected to date.

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