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November 23, 2005

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.   
Director and Chief Medical Officer

SUBJECT: **DRAFT OF THE FINAL PROJECT REPORT FOR THE MEDICAID  
DEMONSTRATION PROJECT**

This is to provide you with a copy of the draft of the Final Project Report (Report) for the Medicaid Demonstration Project which came to an end on June 30, 2005.

Under the Special Terms and Conditions of the Medicaid Demonstration Project Extension Period, the County is required to submit a draft of the Report for the Medicaid Demonstration Project to the State Department of Health Services by December 1, 2005. A draft of the Report is due to the Centers for Medicare and Medicaid Services (CMS) by December 31, 2005. CMS' comments must be taken into consideration by the County for incorporation into the final report. Once CMS' comments are received and the final report is prepared, it will be placed on your Board's agenda.

Please let me know if you have any questions.

TLG:ms

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Enclosure

c: Chief Administration Officer  
County Counsel  
Executive Officer, Board of Supervisor

**STABILIZING THE HEALTH CARE SAFETY NET:  
1995-2005**

DRAFT

**STABILIZING THE HEALTH CARE SAFETY NET: 1995-2005**

by

**The Los Angeles County Department of Health Services**

**The Los Angeles County  
Medicaid Demonstration Project (1115 Waiver) Final Report**

**CMS Contract No.**

**December 2005**

The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The contractor assumes responsibility for the accuracy and completeness of the information contained in this report.

## ACKNOWLEDGEMENTS

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## CONTENTS

<b>Executive Summary</b>	1
<b>Introduction</b>	3
The Los Angeles County Medicaid Waiver	3
The Local Health Care Environment	3
Challenges in Local Health Care Financing	3
The Pre-Waiver Financial Crisis 4	
Preserving the Los Angeles County Health Care System	5
About the Current County Health Care System	5
<b>Discussion</b>	7
Major Waiver Successes	8
Expanded Access to Outpatient Care	8
Restructured Hospital System	10
More Integrated Health Care Delivery System	13
Improved Health Care Financing for Low-Income, Uninsured Residents	15
Possible Areas for Improvement	17
Managed Care	17
Institutionalizing a Reform Agenda	18
Health Care Quality and Consumer Responsiveness	19
Continuing Challenges	20
Financing Care for the Uninsured	20
Overburdened Emergency Rooms	21
Competing With the Private Sector	22
<b>Conclusion</b>	23
Lessons Learned	23
Strong Leadership and Clear Directives are Needed for Change	23
Public-Private Partnerships are a Successful Care Delivery Model	23
Managed Care Principles do not Always Translate into Large Cost-Savings	23
Continued Intergovernmental Collaboration is Required	24
<b>References</b>	25
<b>Appendix</b>	30
Select Los Angeles County Health Care Service and Utilization Statistics	

## EXECUTIVE SUMMARY

In 1995, the federal government approved a five-year Medicaid Demonstration Project, or 1115 Waiver, for Los Angeles County. The Demonstration Project provided the County with immediate fiscal relief needed to reduce a significant health care budget deficit and also enabled the local Department of Health Services (DHS) to undergo a large scale restructuring process that would transform the health system from a loose network of hospitals providing emergency-driven services to a more integrated and balanced health care delivery system emphasizing primary care and prevention. A Waiver extension was granted in 2000 to allow for continued restructuring through June 2005.

In meeting the goals of the initial Medicaid Waiver and subsequent Waiver extension, Los Angeles County improved access to needed primary and preventive services for low-income, uninsured residents, reduced the size and increased the efficiency of its public hospital system, improved care coordination across County-operated facilities and between public and private safety-net providers, and increased financing for safety net health care services. Despite these successes, many of the Waiver-inspired reforms are at risk because of persistent disincentives imbedded in federal and State reimbursement policies for indigent health care services.

Ongoing improvements are also needed to enhance Medicaid managed care revenue, institutionalize a long-term planning process to maintain and further enhance reforms implemented or started under the Waiver, and increase health care quality and consumer responsiveness across the DHS health system. In addition, the County safety net health care system continues to face financial and access problems, including challenges related to paying for health care for the uninsured, meeting the increasing demand for emergency care in the face of private emergency room closures, and competing with the private sector for patient revenue.

The County's experience reforming a large, public health care system may be helpful in designing other Medicaid Waivers or crafting new federal funding policies for public safety net health care systems. Some of the lessons learned in Los Angeles County include:

- Strong leadership and clear directives are needed to overcome political and organizational barriers to change;
- Public-private partnerships can be a successful care delivery model for improving health and access to services;
- Applying managed care principles in a large public system with high patient turnover, increasing demand for services, and misaligned federal funding incentives does not translate into large cost-savings; and
- Continued intergovernmental collaboration is required to better align fiscal incentives with ongoing efforts to improve health care quality and efficiency.

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## INTRODUCTION

### THE LOS ANGELES COUNTY MEDICAID WAIVER

In 1995, the federal government approved a five-year Medicaid Demonstration Project, or 1115 Waiver, for Los Angeles County.<sup>a</sup> The Demonstration Project provided the County with immediate fiscal relief needed to reduce a significant health care budget deficit and enabled the local Department of Health Services (DHS) to undergo a large scale restructuring process that would transform the health system from a loose network of hospitals providing emergency-driven services to a more integrated and balanced health care delivery system emphasizing primary care and prevention.

Specifically, the Waiver required the County to expand access to outpatient services, reduce inpatient hospital capacity, increase operational efficiencies, and integrate the system of care – in exchange for extra Medicaid funding and an expectation that ongoing collaboration with the State and federal government would lead to revisions in existing health care financing mechanisms so that the restructured system could be supported over the long-term. Los Angeles County achieved many of its goals in the first five years of the Waiver and a Waiver extension was granted in 2000 to allow for continued restructuring through June 2005.

### THE LOCAL HEALTH CARE ENVIRONMENT

#### Challenges in Local Health Care Financing

In 1995, the Los Angeles County health system faced a \$655 million deficit in a \$2.5 billion annual health care budget.<sup>1</sup> Although counties in California are required to provide and pay for health care for the poor, they have few available tools for fixing or preventing financial problems.<sup>b</sup> Short of closing facilities, or limiting services or eligibility, counties that directly operate hospitals can do little to curb the growth of local health care expenditures. Since inpatient hospital expenditures are largely funded by non-County patient care revenues, such as Medi-Cal, and since reimbursement is based on a per-diem rate and not directly linked to the cost of patient care or resource consumption, public hospitals often lose revenue by implementing traditional efficiency improvements that would shorten hospital stays or allow for certain inpatient procedures to be transferred to a more cost-effective outpatient setting.

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<sup>a</sup> An 1115 Waiver refers to a section of the federal Social Security Act that grants authority to the Secretary of Health and Human Services to waive certain provisions of Medicaid law for demonstration projects that promote the objectives of the Medicaid program.

<sup>b</sup> Section 17000 of the State Welfare and Institutions Code requires counties to “relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.”

The ability of California counties to create new, or increase existing, tax revenues is limited due to 1978 voter-imposed restrictions on local property taxes (Proposition 13). As a result, many public systems, including the Los Angeles County health system, face chronic budget shortfalls and are in need of major capital improvements to successfully attract paying patients and compete for scarce resources. A recent RAND study of the Los Angeles County health care safety net estimated that revenue from indigent care programs and patient contributions accounted for only 79 percent of costs of caring for Medicaid and indigent patients at publicly-owned hospitals, compared to almost 90 percent of costs at private hospitals.<sup>2</sup>

The level of federal and state funding for public hospitals is also unpredictable from year-to-year, making it challenging, if not impossible for county health systems to do effective long-range planning. In the years prior to the Los Angeles County Waiver, non-County revenues were declining. In 1995, public hospitals faced substantial reductions in Medi-Cal revenue as a result of changes in federal reimbursement policy.<sup>c</sup> Local property tax revenues were also shifted to the State in the early 1990s, further reducing available funding for counties as tax dollars were used to address budget shortfalls at the state level. These funding reductions forced the County to develop and set in motion significant service cuts and staff reductions that were later reversed once Waiver funding was approved. In addition to diverting staff time and focus within the Department, the reduction plans had a destabilizing impact on the delivery system.

In addition, local governments must continually respond to, but can do little to influence, the demand for publicly-delivered health care services. The need for public services is particularly high in Los Angeles County. The County's uninsurance rate is higher than all other California counties and major metropolitan areas in the United States.<sup>3</sup> Furthermore, 70 percent of those without health insurance coverage – more than a million people – earn less than 200 percent of the federal poverty level, making it increasingly likely that these residents may, or already do, depend on County-operated health care services.<sup>3</sup> Unfortunately, Los Angeles County does not have the financial capacity to offer comprehensive insurance products to assist its 1.6 million uninsured residents in accessing coverage and minimize reliance on safety net services. The underlying challenges related to growing health care inflation, increasing immigration, and erosion of job-based insurance can only be addressed at a national or statewide level.<sup>4</sup>

### **The Pre-Waiver Financial Crisis**

Given the high need for public health care services in Los Angeles County and the limited ability of the County to sustain existing service levels without outside assistance, the 1995 federal Medicaid Waiver came at a crucial time. Federal and State revenues were declining, managed care had increased competition for paying patients and public funding, and

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<sup>c</sup> In 1993, Congress passed the Omnibus Budget Reconciliation Act that placed hospital-specific limits on supplemental federal payments made to public and private Disproportionate Share Hospitals.

health care costs continued to rise with new technological advances and increasing demand for services and pharmaceuticals.

In the year preceding the Waiver a number of options for addressing the County's significant health care deficit were proposed – all of them involved closure of one or more County hospitals and health centers. The County's Chief Administrative Office recommended that DHS either: (1) close the largest County hospital, four comprehensive health centers, and 25 health centers, or (2) close four of the six County hospitals (the largest hospital would remain open), all six comprehensive health centers, and 19 health centers. A Health Crisis Task Force was also later appointed by the Board of Supervisors to further examine the situation and offer alternatives. The task force recommended an initial set of service reductions, which included closure of all six comprehensive health centers, a 75 percent reduction in funding for outpatient hospital services, and closure of 29 health centers. It also called for additional reductions, if sufficient federal funding could not be obtained within 90 days. The Board of Supervisors adopted the task force plan and appointed a Health Crisis Manager to lead the County's efforts over the following six months.

### **Preserving the Los Angeles County Health Care System**

The Los Angeles County federal Medicaid Waiver prevented major health facility closures proposed by the Health Crisis Task Force and enabled system-wide reforms that have improved health care access and quality.<sup>d</sup> The Waiver was viewed as the beginning of a lasting partnership among three levels of government that would continue to work together to foster service reforms and find more permanent solutions to the chronic funding problems plaguing the system. However, 10 years later, the underlying economic incentives on which the old system was built have yet to be fundamentally changed.

### ***About the Current County Health System***

The County Department of Health Services (DHS) is an integral piece of the broader health care system in Los Angeles County. DHS is committed to "providing a balanced array of services that are dispersed geographically."<sup>5</sup> The system serves more than 700,000 unique patients annually through four general acute care hospitals, one hospital offering rehabilitation services, a Multi-Service Ambulatory Care Center, six comprehensive health centers, ten personal health centers, fifteen sites providing public health services, two school-based clinics, and more than 100 private community-based ambulatory care sites.<sup>6</sup>

DHS provides public health services to prevent disease and protect and promote the health of all Los Angeles County residents, including controlling the spread of communicable diseases, such as HIV and tuberculosis, and preparing and implementing action plans to minimize the health consequences from natural disasters or acts of terrorism. The Department

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<sup>d</sup> Los Angeles County received \$1.2 billion in federal Waiver funds as part of the initial Waiver (1995-2000) and an additional \$900 million during the Waiver extension (2000-2005).

operates extensive education and training programs for physicians, nurses, laboratory and radiology technologists, and other health care professionals (California public hospitals train almost half of all physician residents in the State), and provides and coordinates trauma and emergency services for County residents in need of emergent care.<sup>7</sup> Forty percent of trauma cases and 11 percent of emergency room patients countywide are treated by DHS physicians and other medical professionals working at County hospitals.<sup>8</sup>

The DHS system also serves a broader role in providing health care services for Los Angeles County residents who have lost, or lack access to, traditional sources of coverage. Two out of every three patients (65 percent) accessing the County health care network are uninsured.<sup>6</sup> Countywide, 84 percent of uncompensated hospital costs for uninsured or under-insured residents are incurred by DHS hospitals.<sup>9</sup> While many residents rely on the County health system for ongoing care, the vast majority access the system infrequently, suggesting the important role that DHS may play in meeting the needs of residents during periods of uninsurance.<sup>10</sup> The financial stability of all public and private hospitals and emergency rooms in Los Angeles County rests on the ability of the public sector, which includes those services directly provided or paid for by DHS, to continue caring for the uninsured.

In addition to DHS and the many private hospitals and community clinics that serve low-income populations, the Los Angeles County safety net system also includes services provided by the Department of Mental Health and the Department of Public Social Services.

The Department of Mental Health (DMH), financed primarily through local, state, and federal Medicaid dollars, serves as the County's central mental health agency. The Department develops and coordinates services that enable persons experiencing severe and disabling mental illnesses, and children with serious emotional disturbances, to access treatment and support services. DMH services include case management, inpatient care, outpatient services (including crisis intervention and emergency response), and day treatment programs provided through contracted and County-operated mental health clinics and hospitals.

The Department of Public Social Services (DPSS) administers income-support programs designed to alleviate hardship and promote health, personal responsibility, and economic independence. DPSS provides free and low-cost health care insurance (Medi-Cal), temporary financial assistance and employment services, and food benefits to eligible low-income families and individuals, as well as in-home services for elderly and disabled individuals, and financial assistance for disabled individuals.

The health of all Los Angeles County residents is dependent on the continued collaboration across safety net providers and various County Departments. From 1995 to 2005, the County's federal Medicaid Waiver helped support and improve this fragile network, enabling millions of uninsured residents to access needed health care services and be productive members of society. The remaining sections of this report discuss the major accomplishments that Los Angeles County has achieved in meeting the original goals of the Medicaid Waiver, ongoing challenges faced by the County, and lessons learned along the way.

## DISCUSSION

*The overall goal of the Los Angeles County Medicaid Demonstration Project is to transform a large, decentralized public health care system into an integrated system primarily focused on comprehensive outpatient and preventive health care to Medicaid and indigent populations through public and private providers.<sup>1</sup>*

The federal Medicaid Waiver allowed Los Angeles County to implement system-wide reforms that have improved health care access and quality of care. The goals of the initial Waiver (1995-2000) included:<sup>1</sup>

- **Inpatient Restructuring:** Reduce inpatient census at the County's four general acute care hospitals, reduce inappropriate use of emergency and inpatient services, and reduce costs of operation.
- **Outpatient Care Expansion:** Increase access to outpatient care services through a mix of public and private providers.
- **Managed Care:** Increase the number of Medi-Cal capitated lives in the DHS-operated health plan, and shift the emphasis of care from hospital inpatient services to outpatient care.
- **Services and System Integration:** Create a seamless system which promotes cost-effective, continuous care.

The Waiver extension (2000-2005) allowed for continuation of the structural changes initiated during the initial Waiver and incorporated new initiatives and strategies for improving health care access and quality, including:<sup>11</sup>

- **Clinical Resource Management:** Implement inpatient clinical pathways and disease management programs to reduce hospital stays.
- **Outreach and Enrollment Goals:** Increase enrollment in government health care programs, and simplify the financial screening process at DHS ambulatory care sites.
- **Workforce Development:** Carry out retraining and development projects for DHS employees to support reorganization strategies and objectives.

In meeting the goals of the initial Medicaid Waiver and Waiver extension, Los Angeles County has improved access to needed primary and preventive services for low-income, uninsured residents, reduced the size and increased the efficiency of its public hospital system, improved care coordination across County-operated facilities and between public and private safety-net providers, and increased financing for safety health care services. Yet, despite these successes, many of the Waiver-inspired reforms are at risk because of persistent disincentives imbedded in federal and State reimbursement policies for indigent health care services.

## MAJOR WAIVER SUCCESSES

### 1. Expanded Access to Outpatient Care

Development of community-based outpatient services was one of the most important aspects of the Los Angeles County federal Medicaid Waiver.<sup>1</sup> Before the Waiver, DHS did not have the service capacity to provide sufficient comprehensive primary care or outpatient specialty care services. Outpatient visits delivered in the DHS system were “typically single purpose and disease-related, and not representative of client-centered comprehensive primary care.”<sup>1</sup> At the time, the County estimated that less than 25 percent of the 2.6 million outpatient visits provided in 1995 were considered primary care.<sup>1</sup> In the early 1990s, a task force appointed by the Los Angeles County Board of Supervisors to examine health care access in the County estimated that approximately 1.4 to 7 million additional ambulatory care visits per year were required to meet the need of the County’s uninsured population.<sup>12</sup>

The Waiver enabled DHS to expand access to outpatient care by: (1) improving primary care availability through contracting with private providers, (2) increasing access to needed mental health services, (3) transferring certain specialty care procedures to community-based outpatient comprehensive health centers, and (4) simplifying the enrollment process for obtaining outpatient services at DHS facilities. These initiatives were generally based on a managed care service delivery model with the goal of having “a community-based primary care provider serve as the point of access for basic non-emergency health services and the coordinator of necessary specialty care.”<sup>1</sup>

#### *Improved Access to Primary and Preventive Care Through the Public/Private Partnership Program*

Although DHS has closed 29 County-operated health centers since the Waiver began in 1995, the total number of locations where low-income, uninsured County residents can access community-based primary care services has more than doubled in the past 10 years, from 45 sites in 1995 to 122 today (see Appendix 2f-h). This expansion was made possible through contracting with private community clinics and other providers that were willing to increase service levels at their existing sites or takeover operation of County clinics that had formerly provided only limited public health services. The Public-Private Partnership (PPP) program currently consists of 54 partner agencies that provide services at more than 100 different locations.

In addition to increasing the number of primary care locations, the PPP program has improved geographic access to services through strategic partnering with PPP clinics located in areas of high need. For example, in the South Service Planning Area (SPA 6) around King/Drew Medical Center, primary care access points have more than doubled from six DHS-owned clinics in 1994 to a total of 19 DHS and PPP clinics in 2005. PPP clinics have also improved access

and continuity of care in other ways by extending their hours of operation, hiring culturally-sensitive providers, offering comprehensive services in one location, and serving as a regular source of care, or medical home, for patients seen through the PPP program.

In addition, the PPP program has improved the availability of care management services for patients suffering from chronic conditions like diabetes and asthma. In Fiscal Year 2003-04, more than six out of every ten PPP visits were for patients with one or more ambulatory-care sensitive chronic conditions.<sup>13</sup> To meet the need of these patients, many PPP agencies (at least 30) provide comprehensive disease management services to coordinate care and keep patients healthy and out of the hospital. A new diabetes care management pilot program will soon be implemented at select partner sites to test a new payment methodology that provides reimbursement based on improved patient outcomes.

The PPP program is also relatively cost-efficient for the County. Providers are paid a flat per-visit reimbursement rate that is substantially less than their cost of providing services. A 2002 cost analysis of six PPP clinics commissioned by the Community Clinic Association of Los Angeles County estimated that the total cost per PPP visit, including pharmaceuticals, was \$148 – approximately \$60 more than the current reimbursement rate paid by the County.<sup>14</sup> PPP providers fill this funding gap through private fundraising and grants, which has increased private investment in health care for the poor and saved the County millions of dollars.

#### *Improved Access to Mental Health Care Services*

During the Waiver extension, mental health visits provided by the Department of Mental Health (DMH) and community contractors were included as part of the County's ongoing strategy to expand outpatient services.<sup>15</sup> Since 2000, DMH has increased the number of ambulatory mental health visits provided to low-income, uninsured County residents suffering from schizophrenia, personality disorders, major depression, and other mental illnesses by 28 percent and has more than doubled the number of patients receiving face-to-face mental health visits from approximately 90,000 in Fiscal Year 2000-01 to 187,000 in Fiscal Year 2003-04 (see Appendix 3e for mental health visit data).<sup>16</sup>

#### *Expanded Access to Outpatient Specialty Care*

Before the federal Medicaid Waiver, specialty care services were typically provided in DHS hospitals and often on an inpatient basis – despite changes in technological advances making it possible, and even desirable from a quality-of-care perspective, to perform many of the procedures in an outpatient setting.<sup>1</sup> By partially off-setting the loss in inpatient revenue, supplemental Waiver funding enabled DHS to move certain cardiology, dermatology, endocrinology, nephrology, neurology, and other specialty services from DHS hospitals to the County's six Comprehensive Health Centers.<sup>17</sup> This has improved specialty care access, quality, and operational efficiency.

DHS also contracts with PPP agencies for dental and other specialty care services. In Fiscal Year 2003-04, PPP clinics provided more than 4,000 specialty care visits and 36,000 dental visits to low-income, uninsured patients.<sup>18</sup>

### *Simplified Enrollment Process*

DHS implemented the Outpatient Reduced-Cost Simplified Application (ORSA) form at all County ambulatory care sites in January 2001 to decrease the administrative burden and documentation requirements for accessing outpatient care. DHS now uses the ORSA form, which requires patient self-certification of income, to assess eligibility for low-cost outpatient care at all County outpatient facilities. The form was based on the screening process used by the VIDA Program, a health care membership and education program available for certain uninsured families in the San Fernando Valley.<sup>19</sup>

## **2. Restructured Hospital System**

The federal Waiver made it possible for Los Angeles County DHS to restructure its hospital system by reducing its emphasis on inpatient care and increasing the operational efficiency of its hospitals. The goal was to improve health care delivery and affordability by redesigning the system to have a more balanced mix of inpatient and outpatient services, a necessary change in an increasingly managed care driven environment.

### *Decreased Emphasis on Expensive, Inpatient Hospital Care*

Significant downsizing of DHS hospitals was contemplated under the Waiver as a means of containing costs and improving the long-term financial stability of the system. While cost reduction was the motivating factor behind the reduction in hospital beds, the demand for inpatient beds both locally and nationally was also declining due to increased managed care penetration and increased use of new outpatient technologies. The Project Management Plan for the initial Los Angeles County Waiver projected, using four different methodologies, a significantly lower demand for inpatient hospital beds at DHS facilities by the year 2000.<sup>1</sup> These projections were supported by a 1994 Report by the Steering Committee for the Study of Los Angeles Health Resources that predicted “excess capacity of inpatient beds in all regions of the County and for almost all bed types, even if anticipated renovation projects are not completed.”<sup>20</sup>

Today, the Los Angeles County public hospital system is significantly smaller than it was at the beginning of the Waiver. Despite legal challenges that have delayed implementation of additional reductions initiated in 2002, the number of budgeted hospital beds at DHS facilities is 39 percent lower than it was in 1995 (see Appendix 4a). Countywide, the number of licensed hospital beds declined by almost 8 percent during this period.<sup>21</sup> The proportion of DHS visits delivered in a hospital versus community-based setting has also declined. In 1995, three-quarters (74 percent) of all DHS visits were delivered in a hospital setting; five years later, after

implementation of Waiver-required expansions in outpatient care and growth of the PPP program, only 57 percent of all visits provided in the DHS network were hospital-based. This proportion has subsequently increased after outpatient care reductions were implemented in 2002 to help offset the future loss of Waiver funding (see Appendix 4k).

### ***Improved Operational Efficiency***

Improving the operational efficiency at DHS hospitals was an important part of the inpatient restructuring required under the initial 1995 Waiver. To meet this requirement, DHS underwent an extensive review of work processes to identify potential cost reduction and efficiency improvements that would increase service levels while also improving or maintaining quality. Implemented improvements ranged from group purchasing of drugs and supplies, which resulted in large savings, to hundreds of smaller reforms such as reduced linen usage, renegotiation of monthly pager fees, standardized employment exams, elimination or downgrading of staff positions, changed management structures, reduced overtime, and other changes.

As part of this reform process, DHS implemented almost 500 different cost-improvement ideas and successfully reduced expenditures by an estimated \$87 million from Fiscal Year 2000-01 onward.<sup>22</sup> The Department later achieved an estimated \$202 million in savings over the five years of the Waiver extension through additional standardizing, centralizing, and outsourcing of services.<sup>23</sup> Today, the cost per patient-day at DHS' four teaching hospitals is 31 percent less than other comparable public and private hospitals in the State and 45 percent less than University of California hospitals.<sup>24</sup>

### ***Workforce Development***

The Los Angeles County Workforce Development Program was started as a partnership between DHS and the Service Employees International Union (SEIU) Local 660 to support restructuring efforts required under the Waiver and prevent worker displacement through retraining, education, and skill-enhancement opportunities. Program goals include supporting restructuring to improve quality and access to services, preparing workers with skills for stable employment, and providing portable or transferable skills to avert lay-offs.<sup>25</sup> Since the program was implemented in 2001, more than 10,000 DHS employees have received job-related training or education in patient financial services, medical record coding, clinical resource management, nursing, communications, computer literacy, and other areas.

### ***Improved Clinical Effectiveness and Efficiency***

A central goal of the Waiver extension was to improve the clinical effectiveness and efficiency of care provided at County facilities. This was accomplished through the Clinical Resource Management (CRM) program, which combines two major initiatives that use standardized, evidence and expert-based approaches to clinical decision-making. CRM's

Inpatient Clinical Pathways and Disease Management programs have improved the quality of patient care and optimized the use of scarce County resources.

### Inpatient Clinical Pathways

Inpatient Clinical Pathways are interdisciplinary care plans that organize the sequencing and timing of major clinical interventions for patients with select diagnoses. They are designed to minimize delays and errors and optimize health care quality and resource utilization through the use of multiple tools, including:

- Physician Orders: pre-printed, diagnosis-specific forms with the suggested course of treatment for pathway patients;
- Daily Care Documentation: pre-printed, comprehensive documentation forms, which list daily goals and expectations;
- Inpatient Teaching Guides: pre-printed, pathway-specific documents that provide information to patients and their families about their conditions while they are in the hospital; and
- Post-Discharge Teaching Guides: pre-printed, pathway-specific documents that provide information to patients and their families about how to continue appropriate care after discharge from the hospital.

In the past five years, DHS has implemented 16 different pathways in the surgical, orthopedic, obstetrical and medical domains. The use of these structured treatment protocols has helped reduce unwarranted variation in patient care within and across DHS facilities, improved patient safety, decreased the length of stay when appropriate, and enhanced clinical outcomes related to medication use, readmission rate, and emergency department use. For example, after implementing the pathway for congestive heart failure, the average length of hospital stay for pathway patients decreased by 7 percent, and the 30-day readmission rate dropped by 40 percent.<sup>26</sup> Since the program's inception, Inpatient Clinical Pathways have been used to deliver evidence-based care to more than 10,000 DHS patients.

### Disease Management

DHS Disease Management programs are targeted at patients with Heart Failure, Diabetes and/or Asthma and Chronic Obstructive Pulmonary Disease (COPD). These programs proactively identify, risk stratify, and treat patients in comprehensive outpatient and home care environments, and minimize the need to respond reactively and emergently to clinical crises.

DHS has implemented two pilot disease management programs for patients with asthma and diabetes at County outpatient facilities and school-based clinics. In 2002, the CRM Program's Pediatric Asthma program was the first disease management program to be certified and receive the Award of Distinction from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). By establishing multidisciplinary teams of health care professionals,

including school nurses, the CRM pediatric asthma program helps children with asthma get the care they need to control their disease *before* they have an asthma attack, reducing the need for emergency department visits and hospitalization. More than 5,000 pediatric asthma patients have received ongoing care through this program.

The DHS diabetes pilot program is based on an outpatient, nurse-care manager model that has proven to reduce high blood sugar levels effectively and risk factors for cardiovascular events in less than 6 months. Recently, DHS has expanded this program across the County. When fully implemented, countywide disease management programs will electronically identify, risk stratify, and match patients to an appropriate level of care.

### **3. More Integrated Service Delivery System**

Increasing health system integration was closely linked to Waiver restructuring and outpatient expansion goals. Before the Waiver, there was little coordination across different County facilities or between DHS and other community providers serving the same low-income population. “This resulted in complex service networks, complicated and unclear referral pathways, inappropriate use of ERs and urgent care services for otherwise routine health care needs, and potentially preventable hospitalizations for individuals with ambulatory care sensitive medical conditions.”<sup>1</sup>

In the past 10 years, Los Angeles County has improved patient flow and health system planning by establishing specialty care referral centers, integrating services, and collecting and using data to better inform patient care and resource allocation decisions.

#### ***Improved Patient Flow Through Referral Centers***

One of the most notable examples of improved system integration has been the placement of specialty care referral centers in County hospitals. The five referral centers coordinate specialty and inpatient care appointments for patients seen at DHS and PPP clinics, including screening referrals for completeness and appropriateness, facilitating communication between referring providers and specialty clinics, and scheduling patient appointments.<sup>27</sup>

While DHS referral centers are in need of additional staffing and technical support, they have helped facilitate integration and standardization across DHS facilities and between DHS and PPP providers. By enabling primary care physicians to schedule specialty care appointments for their patients, referral centers minimize unnecessary emergency room utilization and increase care coordination. In the past, the hospital emergency room served as the primary entry point for patients in need of specialty care services. In Fiscal Year 2003-04, DHS referral centers processed approximately 140,000 referrals, 80 percent of which were complete and appropriate referrals resulting in a scheduled appointment (see Appendix 3g).<sup>28</sup> Referrals will soon be processed through a new web-based system that will allow providers to schedule and track appointments online.

### *Increased Integration of Services Within and Across Departments*

The federal Medicaid Waiver was also a catalyst for forging new working relationships between different types of health care providers in Los Angeles County. As a result of the pre-Waiver financial crisis, public and primary health care providers were forced to operate out of different clinics, making it impossible for patients to access both types of services during a single visit (i.e., immunizations at a public health clinic and treatment for an injury, illness, or chronic disease at a primary care clinic). Today, six DHS-operated public health clinics are housed in the same location as a PPP or DHS health center and many PPP clinics offer both public health and clinical primary care services.

In addition, during the first five years of the Waiver, DHS, DMH, and the Department of Public Social Services (DPSS) developed and implemented a number of joint initiatives aimed at integrating treatments for health, mental health, and substance abuse problems, including:

- Establishment of assessment centers across the County to provide substance abuse and mental health clinical assessments for CalWORKS and General Relief program participants;
- Provision of alcohol and drug treatment programs in DMH and contractor clinics to improve treatment services for people with co-occurring mental illness and substance abuse conditions; and
- Placement of drug and alcohol treatment counselors in primary care settings to enhance provision of care for patients with substance abuse problems.

### *Increased System-wide Data Collection and Utilization*

Increased data collection and utilization for planning purposes was a direct result of Waiver requirements to report and measure progress. Prior to the initial Medicaid Waiver in 1995, minimal utilization data was collected at DHS outpatient clinics and few standardized processes or incentives existed for collecting, reporting, or using data. This made it extremely difficult for County administrators to track patients or compare service or resource utilization patterns across facilities. With the development of itemized data collection systems at DHS outpatient clinics and hospital emergency rooms, certain DHS and PPP data elements are now reported and stored in a central office. The DHS Data Warehouse Group translates the information into compatible data files and assigns a unique patient identifier so that the data can be analyzed and/or combined with other data sources and used for planning and evaluation purposes.

For example, DHS has implemented a performance management system that uses data to monitor and track improvements in quality of care, access to care, operational efficiency, and quality of work life at different health care facilities. The system allows for benchmarking against other organizations and provides incentives to improve performance.<sup>29</sup> The Department has also conducted three population-based Patient Assessment Surveys to measure satisfaction

with services, wait times, access barriers, perceived health status, and other information that has been used to evaluate and enhance the quality of services provided.

In addition, the establishment of the Public Health Office of Health Assessment and Epidemiology in 1998 has enhanced data collection and reporting of public health indicators of disease burden and health behaviors of County residents. Information collected in the Los Angeles Health Survey is used to identify new policy and program areas that are needed to improve health and evaluate the effectiveness of existing programs.

#### **4. Improved Health Care Financing for Low-Income, Uninsured Residents**

Although nearly all major health care financing decisions are made at the State or federal level and are largely out of the control of individual counties, the County did secure additional funding for the uninsured during the Waiver and Waiver extension by increasing Medi-Cal enrollment, increasing the number of capitated lives in the County's managed care plan, and assisting PPPs in obtaining enhanced reimbursement (FQHC status) for primary care services provided to low-income residents. The Waiver also provided short-term fiscal relief to stabilize the County health system and enable system-wide reforms.

##### ***Improvements in Safety Net Financing***

###### **Increased County and State contribution**

The County has more than tripled its General Fund contribution to DHS over the 10 years of the Waiver from \$92 million in Fiscal Year 1994-95 to \$430 million in Fiscal Year 2004-05. New County funding dedicated to the Department includes tobacco settlement money (\$85 million in Fiscal Year 2004-05) and Measure B funds, a \$0.03 per square-foot parcel tax on structural improvements passed by Los Angeles County voters in November 2002 (\$145 million in Fiscal Year 2004-05).<sup>30</sup> The Los Angeles County Board of Supervisors also approved a \$125 million General Fund increase for health care services in Fiscal Year 2005-06, which will partially offset the loss in Waiver funding.

In addition, during the Waiver extension, the State invested an additional \$45.5 million annually (on average) in the Los Angeles County health care system through Cost-Based Reimbursement Clinic (CBRC) payments to DHS and PPP ambulatory care sites, made possible by a 2000 Medicaid State Plan Amendment secured.<sup>31</sup>

###### **Increased enrollment in coverage programs**

The number of certified eligible Medi-Cal beneficiaries has more than doubled in the past 10 years from 600,000 in 1995 to almost 1.4 million in 2005. The growth in program enrollment has improved access to health services for many uninsured families and children in Los Angeles County and is at least partially the result of broad outreach and retention efforts by DPSS, DHS, and many community-based organizations.

In 2003, the Los Angeles County Children's Health Initiative implemented the Healthy Kids program, a comprehensive insurance program for low-income children and youth that is funded through private donations. While not a specific requirement under the Waiver, the program, which was the product of a collaborative effort of hundreds of local organizations, including DHS, has successfully reduced the number of uninsured children in Los Angeles County by nearly 34,000 since it began.<sup>32</sup> However, funding limitations due to an unexpectedly large demand for coverage has forced the program to limit new enrollment of children ages six years and older.

While increased enrollment in Medi-Cal, Healthy Kids, and other coverage programs has improved access to health care, newly insured patients do not always continue to seek care at County facilities once they are enrolled and have greater choice of providers. In Los Angeles County, increased Medi-Cal enrollment has been associated with a decrease in the number of Medi-Cal patients seen at DHS hospitals. From 1995-2003, discharges at DHS hospitals for patients enrolled in Medi-Cal declined by 13 percent from 53 percent of all discharges in 1995 to 46 percent in 2003, while the proportion of uninsured discharges increased by 9 percent.<sup>33</sup> The associated decline in patient revenue has contributed to the ongoing financial problems of the Department.

#### Increased enrollment in the County-operated managed care plan

Enrollment in the County's managed care plan, the Community Health Plan (CHP), has increased from 13,000 before the Waiver to almost 160,000 today (see Appendix 5a). CHP is a state-licensed, federally-qualified Health Maintenance Organization that provides health services at County DHS and other sites for patients enrolled in Medi-Cal managed care, Healthy Families, and other publicly-sponsored programs.

#### Increased community clinic funding

During the Waiver extension, DHS provided technical assistance to community clinic partners (PPPs) interested in seeking Federally Qualified Health Center (FQHC) status, or similar designation (FQHC Look-Alike status), which allows for higher reimbursement for services provided to Medi-Cal patients. With the help of expert consultants, who provided advice to partner agencies on how to restructure their governing boards and complete the application, the Department enabled 13 PPPs to obtain FQHC or FQHC Look-Alike status.

#### *Short-term Fiscal Relief*

While the Waiver failed to establish a long-term, flexible financing mechanism that rewards, rather than penalizes quality and efficiency improvements, it did provide much needed fiscal relief to preserve the network of hospitals and clinics serving the Los Angeles County safety net throughout the life of the Waiver and Waiver extension. The federal investment

prevented closure of one or more DHS hospitals in 1995, and enabled the County to provide 11 million primary care visits that would not have been provided otherwise through the PPP program.<sup>34</sup>

## **POSSIBLE AREAS FOR IMPROVEMENT**

The Los Angeles County health system is more coordinated and more efficiently run than it was 10 years ago. However, the County has not fully achieved the vision it embraced during the initial Waiver planning process. This vision of an integrated system of care included many elements that have yet to be realized, including the development and use of strong information systems, and an effective referral system that enables public and private providers to schedule and track patient care across the network. Ten years after the beginning of the initial Los Angeles County Waiver, data collection is still not fully standardized across providers; efforts to implement system-wide monitoring of quality and cost-effectiveness of services provided has just begun; private primary care providers (PPPs) cannot easily access patient records or results of procedures performed at County facilities; referral centers have no capability to refer patients seen in specialty care clinics or presenting in DHS emergency rooms for routine health needs to an appropriate ambulatory care provider; wait times for certain specialty care services can be as long as 10 to 12 months; and there is no countywide system in place to triage patients based on relative need for services.

Los Angeles County also did not fully capitalize on the growth of managed care or institutionalize a lasting process for improving on or sustaining Waiver-driven reforms. In addition, there is much room for improvement in quality of care and consumer responsiveness.

### **Managed Care**

At the time the initial Waiver was granted, California was undergoing one of the largest expansions of Medicaid managed care of any state in the nation. By 1999, nearly 2.5 million Medi-Cal beneficiaries were enrolled in a managed care program. The reform plan proposed under the Waiver recognized the growing role of managed health care and included as one of its goals to "align the Medicaid Demonstration Project with major Medi-Cal Managed Care initiatives by the year 2000."<sup>1</sup>

While DHS played a lead role in creating LA Care Health Plan (a publicly-sponsored, not-for-profit health plan, or Local Initiative, that contracts with HMOs to serve Medi-Cal managed care enrollees), it did not pursue entry into the managed care market as aggressively as it could have.<sup>35</sup> Even with Waiver funding, the capital costs required to renovate and modify DHS facilities so the system could compete with private managed care providers were overwhelming and seemingly unrealistic for a system on the brink of collapse. Because of these and other real and perceived barriers, the County failed to put growth of its managed care plan front and center in health system decision-making and planning. In the past 10 years, the County has lost Medi-Cal market share to private systems and is poorly situated to benefit from the possible expansion of Medi-Cal managed care to aged, blind, and

disabled populations, who account for a significant proportion of the County's existing Medi-Cal patients. Enrollment in the County's managed care plan never reached the levels anticipated at the beginning of the Waiver, and only 3 percent of patients seen at County comprehensive health centers are currently enrolled in Medi-Cal managed care.<sup>1,6</sup>

In other public systems, managed care has served as a mechanism for driving continued system integration and information management, while also bringing in patient revenue.<sup>35</sup> Fully embracing managed care principles early on in the planning process may also have led DHS to implement a capitated delivery system with defined benefits for the indigent population – as proposed by the Department in 2002 (the DHS proposal required a large infusion of funds and, as a result, has yet to be implemented).<sup>36</sup> Development of a health coverage plan for the uninsured could improve access to services, force greater integration and coordination across public and private providers, and require ongoing evaluation of benefits provided within the County network.

### **Institutionalizing the Reform Agenda**

The Waiver initially generated a lot of momentum for change within DHS. An Integrated Delivery System Council was proposed to make policy and resource allocation recommendations to the DHS director, set priorities, establish goals and outcome standards, and hold geographic areas accountable for implementation.<sup>37</sup> Consultants were hired to assist in policy and strategic planning, change management, and community education; new executive management positions were added to support the vision of a policy-based executive office; and community planning meetings were held in each Service Planning Area to assess need for ambulatory care services.<sup>1</sup>

However, once funding was secured, and especially once it was apparent that Waiver funds would be phased out by 2005, the focus on developing a highly integrated system of care, as contemplated under the Waiver, shifted more to meeting the requirements laid out in the terms and conditions of the Waiver and planning for the pending loss of funds. The lack of sustained energy and commitment to fulfilling the vision of an integrated system was largely due to the failure of all levels of government to create a financial structure that would support the Waiver-driven reforms and incentivize ongoing efficiency improvements. It was also due to a lack of a clear, enforceable blueprint for change. As a result, as time went on, the attention of DHS leadership was diverted to more emergent health system problems, reforms were not uniformly implemented or sustained across geographic networks, and an ongoing long-term planning process was not formally established to support and implement the vision of an integrated system.

### **Health Care Quality and Consumer Responsiveness**

While patients are generally satisfied with the care they receive at DHS and PPP facilities, much more could be done to improve and document quality of care and customer service.<sup>38</sup> In implementing the goals of the Waiver extension, DHS established a system-wide quality improvement committee to track certain disease-specific performance indicators and

compare them to national benchmarks. Yet, ongoing quality improvement efforts continue to be hindered by the inability of current data systems to capture information needed to flag potential patient-safety problems before they occur, inflexible personnel policies that make it difficult for the Department to institute performance-based incentive programs and other measures necessary for promoting a culture of quality and responsibility, and ongoing political and financial considerations that often conflict with department-wide quality improvement goals.

The DHS system is also not as patient-oriented as it could be. Unlike most health systems, which have processes in place to assist patients in locating appropriate care or information, little resources are available to help patients navigate the DHS system. This creates access barriers and inefficient patient care practices. For example, there is no designated phone number for DHS patients to call for help or advice; and, of the few patients who are able to reach a County facility by telephone, less than half receive the help they need.<sup>38</sup> DHS also does not have a strong triaging system in place to re-direct non-emergent patients seeking care in hospital emergency departments to a more appropriate level of care. A recent DHS survey found that 41 percent of adult patients who had sought medical care from an emergency department in the proceeding 12 months would have accepted an appointment to see a physician within 24 hours – instead of going to an emergency department.<sup>38</sup>

To address some of these patient flow problems, a workgroup with representatives from all five DHS hospitals has begun to systematically examine how patients move through the hospital system. The group is working to identify bottlenecks, causes, and potential solutions to improve inpatient, outpatient, and emergency room flow. While this is an important first step, broader, system-wide changes in organizational structure and culture are needed to foster development of a truly patient-centered delivery system.

## **CONTINUING CHALLENGES**

Despite the progress made over the 10 years of the Los Angeles County Waiver and Waiver extension, the safety net health care system in Los Angeles faces ongoing financial and access problems that can only be addressed through continued collaboration across all levels of government. Some of these challenges include paying for outpatient care, meeting the increasing demand for emergency care, and competing with the private sector for patient revenue.

### **Financing Care for the Uninsured**

Paying for health care for the uninsured is constant struggle in Los Angeles County. Sixty-four percent of patients seen by DHS and PPP outpatient providers are uninsured; 73 percent live in poverty (annually household income less than 100% of the federal poverty level); and 65 percent are immigrants born outside the United States.<sup>38</sup> These demographic factors translate into significant uncompensated costs for Los Angeles County hospitals and make balancing the County health care budget a continuous challenge. Furthermore, since most funding sources are not indexed for inflation, new revenue must be found each year just to maintain existing service levels.

Paying for needed capital improvements and outpatient services has proven to be particularly challenging for Los Angeles County and other public systems. Under the Waiver and Waiver extension, the County had access to supplemental federal funds that were linked to the provision of outpatient visits at DHS and PPP sites, and received federal matching funds for ambulatory care services provided to uninsured, low-income residents who did not qualify for public coverage programs. During the Waiver extension, a Medicaid State Plan amendment also enabled DHS and PPP providers to receive cost-based reimbursement for ambulatory care services provided to Medi-Cal patients in hospital and non-hospital settings. While the new Statewide Medicaid Waiver may provide some funding for ambulatory care, it is still unclear if the levels will be sufficient to support the outpatient expansions enabled under the Los Angeles County Waiver over the long term.

Even if the County is able to maintain existing service levels, the current DHS/PPP network only meets a fraction of the demand for low-cost outpatient services in Los Angeles County. PPP program visits are limited by the amount of available funds, requiring many partner agencies to restrict the number of new PPP patients they serve. Thirty-one partner agencies are currently closed to new PPP patients.<sup>39</sup> In addition, expanded access to comprehensive primary care services through the PPP program has resulted in an increased demand for specialty care at DHS facilities. Because supplemental Waiver funding was insufficient to cover the added cost associated with recruiting and hiring medical specialists, the County has had difficulty managing the growing demand for specialty care. To relieve some of the unmet need, the County contracts with a few PPP agencies to provide additional specialty services and has implemented improvements in appointment scheduling and processing. The new web-based referral system, which is currently being tested at one referral center, will also help County administrators pinpoint and correct problems in the primary-to-specialty care referral chain that are contributing to system delays.

However, paying for needed specialty and other ambulatory care services remains an ongoing challenge for the County that will become even more critical as the population ages and demands more services. In addition, the availability of certain funding under the State's new Medicaid hospital financing waiver is contingent on the expansion of Medi-Cal managed care to the aged, blind, and disabled, which, without enhanced access to needed specialty care services at County facilities, will likely result in mass migration of this population from DHS to private providers, as managed care patients would have the opportunity to enroll in private HMOs and receive care outside the County system.

### **Overburdened Emergency Rooms**

In 1997, a report by the Steering Committee for the Study of the Health Delivery System of Los Angeles County projected a significant shortage in emergency room capacity in years 2000 and 2005 based on trends in population demographics, service use, and migration patterns. Many of the reforms initiated by Los Angeles County under the Waiver are aimed at reducing demand for emergency care. Disease management programs keep patients with certain chronic conditions healthy and prevent disease complications requiring emergency treatment or

hospitalization; and increased access to community-based primary care services through the PPP program and establishment of specialty care referral centers across the DHS network provide patients with convenient alternatives to visiting hospital emergency rooms for more routine health care needs. Despite these positive contributions, emergency rooms are increasingly filled to capacity.

Since 2000, seven Los Angeles County hospital emergency rooms have closed – a loss of more than 130,000 emergency visits annually, and many others are at risk.<sup>40</sup> Meanwhile, ambulance diversion rates due to saturation of the Emergency Department at DHS facilities have increased steadily from 9 percent in 1995 to 57 percent in 2004 (see appendix 4i); private hospital diversion rates have also tripled during this period (1995 to 2003).<sup>41</sup> Emergency room overcrowding is a growing risk to public safety that can increase pre-hospital transport time and paramedic delays, lower staff morale, and diminish the ability of hospitals to respond to large scale emergencies or disasters. It also leads to prolonged pain and suffering as patients wait for basic care or leave without being evaluated.<sup>41</sup>

Continuation or expansion of outpatient services and disease management programs for low-income, uninsured patients, as well as increased funding and flexibility for providing emergency room services to all County residents, is needed to curb demand, reduce overcrowding, and sustain the emergency and trauma network in Los Angeles County. The interconnectedness of public and private providers in the County is illustrated in a recent National Health Foundation study, which found that closure of 16 DHS outpatient clinics in 2002 corresponded with an 8 percent increase in self-pay (uninsured) emergency department visits countywide.<sup>40</sup>

### **Competing With the Private Sector**

Public hospitals were initially established to care for patients who lack insurance or the means to pay full-cost for needed health care services, and have since evolved to fill gaps in services not readily available in the private sector, such as trauma and burn care. However, it has become increasingly difficult for public providers to fulfill this mission. Public hospitals must be able to successfully compete with private hospitals to retain patients enrolled in both publicly and privately-funded health care programs. Yet, the competitive ability of many County-operated systems is severely hampered by rigid civil service rules that make it difficult to recruit and retain needed medical professionals, chronic underinvestment in capital improvements, and rudimentary information systems (when compared to the private sector). These and other factors make competition a losing battle. The long-term survival of public hospitals requires the creation of new funding sources that are not tied to the number or proportion of patients enrolled in government-funded health programs; greater administrative flexibility in recruiting, hiring, and establishing performance-based personnel policies; and major institutional culture change.

## CONCLUSION

The Los Angeles County Medicaid Waiver and subsequent Waiver extension enabled numerous system reforms that have improved the health and quality of care received by many County residents, despite ongoing challenges in health system financing and access. The County has also learned several lessons that may be helpful in the designing of other state or local Medicaid Waivers or in crafting new federal funding policies for public safety net health care systems.

### LESSONS LEARNED

**Strong leadership and clear directives are needed to overcome political and organizational barriers to change.**

Changing the direction of a large, government-run health system is a slow process that requires strong leadership and clear directives to sustain a reform agenda. Implementing the vision laid out in the initial Los Angeles County Waiver called for downsizing facilities and a change in organizational culture and structure – all of which were controversial and opposed by various stakeholders. In the end, communicating and implementing uniform reforms across the health system proved more difficult than anticipated due to the large size and geographic area of the health system and the historical independence of hospital networks in different areas of the County.

**Public-private partnerships can be a successful care delivery model for improving health and access to services.**

The Los Angeles County PPP program proved to be a successful model for expanding outpatient services to low-income, uninsured residents. The program has helped force greater integration of public and private safety net health care providers across the County and increased geographic access to primary care and other outpatient services for hundreds of thousands of residents.<sup>13</sup> DHS would not have been able to initiate this program, and may not be able to sustain it, without the extra supplemental funding and indigent care match provided through the County's initial Medicaid Waiver and Waiver extension.

**Applying managed care principles in a large public system with high patient turnover, increasing demand for services, and misaligned federal funding incentives does not translate into large cost-savings.**

One of the initial goals of the Waiver was to better align the County health care system with major Medi-Cal managed care initiatives by “shifting the emphasis of care from hospital inpatient services to outpatient care.”<sup>1</sup> In a traditional managed care environment, where patients remain in a closed system for many years, primary care services are an important means of controlling costs through disease prevention and management, keeping patients healthy and out of the hospital. However, these cost-control principles do not apply to the Los Angeles County health system.

DHS has a 60 annual percent patient turnover rate – compared to 10 to 30 percent in most private health systems, which makes it difficult for the County to reap the long-term financial benefits that result from increased provision of primary care and preventive services.<sup>42</sup> These benefits, however, are reaped by the overall health system. Federal funding formulas also create little financial incentive to better manage patients and reduce unnecessary hospitalizations, or to implement efficiency improvements that reduce the length of hospital stays. Actual utilization improvements are also hard to detect in DHS hospitals, as there is always unmet demand for services by new patients.

**Continued intergovernmental collaboration is required to better align fiscal incentives with ongoing efforts to improve health care quality and efficiency.**

The Los Angeles County Waiver began as a collaborative effort between three levels of government. The goals were to stabilize the health system, transform it into a smaller, more cost-efficient system, and find a funding solution to sustain it. California has negotiated a new statewide hospital financing Waiver that includes \$180 million in possible federal funds that were previously earmarked for Los Angeles County under the County's Waiver Extension.<sup>43</sup> While the statewide Waiver includes some limited reimbursement opportunities for ambulatory care, it is not a long-term solution. The new funding formula encourages inefficient resource use by linking reimbursement to actual expenditures for Medi-Cal and uninsured patients, and shifts the financial risk and responsibility from the State (large tax base) to counties (small and unstable tax base).

Continued collaboration is needed across all levels of government to develop long-term funding solutions that encourage efficiently-provided, high-quality health care and allow public systems to focus on their role as safety net providers. Health care financing is not something counties, or even states, can tackle alone. As stated by a 2000 Institute of Medicine report on the state of America's safety net system:

“Until the nation addresses the underlying problems that make the health care safety net system necessary, it is essential that national, state, and local policy makers protect and perhaps enhance the ability of these institutions and providers to carry out their missions.... Failure to support these essential providers could have a devastating impact not only on the populations who depend on them for care but also on other providers that rely on the safety net to care for patients whom they are unable or unwilling to serve.”<sup>44</sup>

The Los Angeles County Waiver helped preserve and enhance an important public health care system that is utilized by hundreds of thousands of County residents. In the future, other creative and long-term solutions are needed to assist local governments in funding health care for a growing number of uninsured and under-insured residents.

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<sup>43</sup> The \$180 million represents the average amount of funds received by Los Angeles County during the Waiver extension (2000-2005).

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- <sup>6</sup> DHS/PPP Patient Profiles, Office of Planning, Los Angeles County Department of Health Services, Fiscal Year 2003-04.
- <sup>7</sup> "On the Brink: How the Crisis in California's Public Hospitals Threatens Access to Care for Millions," California Association of Hospitals and Health Systems, 2003.
- <sup>8</sup> Fiscal Year 2004-05 trauma data and Calendar Year 2004 emergency room data obtained from Los Angeles County Department of Health Services, Emergency Medical Services (September 2005).
- <sup>9</sup> Estimate based on 2003 Hospital Annual Financial Data reported to the California Office of Statewide Health Planning and Development (uncompensated care includes charity care and bad debt).
- <sup>10</sup> An analysis of DHS patient data from Fiscal Years 1999-00 through 2002-03 by Los Angeles County Department of Health Services, Office of Planning found that 60 percent of patients accessing DHS/PPP services in one year do not return for services in the subsequent year; although 10 percent return in year three.
- <sup>11</sup> "Interagency Agreement Regarding the Medicaid Demonstration Project for Los Angeles County," Extension Period, 2001, page 16 (CRM); "Operational Protocol Section 1115 Medicaid Demonstration Project," Extension Period for Los Angeles County, October 30, 2001, pages 1-3, 14.

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<sup>12</sup> “Closing the Gap: A Report to the Los Angeles County Board of Supervisors,” Task Force for Health Care Access in Los Angeles County, November 24, 1992.

<sup>13</sup> “The Power of Partnership: Solutions Created and Lessons Learned by the Public Private Partnership Program in Los Angeles County,” Prepared by Darryl Leong for the Community Clinic Association of Los Angeles County (CCALAC), May 2005. (Ambulatory-care sensitive chronic conditions include: asthma, diabetes, hypertension, and lipid/cholesterol problems.)

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<sup>16</sup> Data from the Los Angeles County Department of Mental Health.

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<sup>22</sup> “Conclusion of the Reengineering Project,” internal DHS memo from Reengineering Director to Acting Director of Health Services, October 9, 2001. The estimated \$87 million in savings were not audited by the Auditor-Controller.

<sup>23</sup> Department of Health Services, Office of Finance, Summary of Waiver Austerity Savings, Fiscal Years 2000-01 through 2004-05 (Fiscal Year 2004-04 estimated as of April 2005).

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<sup>24</sup> Hospital Costs Per Day based on Fiscal Year 2002-03 Hospital Financial Data from the Office of Statewide Health Planning and Development (analysis performed by Los Angeles County Department of Health Services, Office of Finance). Comparable hospitals includes the following other large public or private general acute care teaching hospitals in California: Alameda County Medical Center, Brotman Medical Center, California Hospital Medical Center, Cedars-Sinai Medical Center, Fresno Community Medical Center, Huntington Memorial Hospital, Kern Medical Center, Loma Linda University Medical Center, Long Beach Memorial Medical Center, UCSF Medical Center, Riverside County Regional Med Center, San Francisco General Hosp Medical Center, Santa Clara Valley Medical Center, Scripps Mercy Hospital, St Mary's Medical Center - SF, Stanford University Hospital, UCLA Hospital, UC San Diego Medical Center, UC Davis Medical Center, UC Irvine Medical Center, Ventura County Medical Center, White Memorial Medical Center.

<sup>25</sup> Health Care Workforce Development Fact Sheet, Administrative Services, Los Angeles County Department of Health Services, October 2004.

<sup>26</sup> PowerPoint Presentation to Waiver Oversight Committee on January 12, 2005: "Clinical Resource Management: Rationalizing Health Care Delivery in Los Angeles County and Beyond."

<sup>27</sup> "Medicaid Demonstration Project for Los Angeles County Extension Proposal," October 1, 1999, page 10.

<sup>28</sup> Monthly DHS Referral Center Reports, Medicaid Demonstration Project Office, Los Angeles County Department of Health Services, Fiscal Year 2003-04.

<sup>29</sup> "Performance Measures Results July 2003 to June 2004," Performance Management Development Team, Los Angeles County Department of Health Services, Dec 12, 2004.

<sup>30</sup> Actual Expenditures and Financing Trends for Fiscal Years 1994-95 through 2004-05. Los Angeles County Department of Health Services, Office of Finance. In Fiscal Year 2004-05, DHS received 81 percent of all Measure B revenue collected.

<sup>31</sup> The amount is listed is the average net benefit since the State was already providing DHS with limited Medi-Cal outpatient revenue prior to the Waiver; CBRC replaced this revenue and generated an additional average net benefit of \$45.5 million annually. Los Angeles County Department of Health Services, Office of Finance.

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DRAFT

## APPENDIX

Note: Los Angeles County Medicaid Waiver funding was gradually phased out during the Waiver extension (2000-2005). Declining federal funds and a large projected budget deficit in future fiscal years, led to system-wide reductions in DHS outpatient and other services in 2002. While some of these reductions were contrary to the goals of the Waiver (for example, the PPP program was cut by 20 percent), no long-term funding solution has been found to enable Los Angeles County to realistically maintain all of the Waiver-driven service expansions.

	1995 <sup>1</sup>	2000 <sup>2</sup>	2005 <sup>3</sup>
<b>1. COUNTY DEMOGRAPHICS<sup>4</sup></b>			
a. Uninsured residents	2.7 million <sup>5</sup>	1.8 million <sup>6</sup>	1.6 million <sup>7</sup>
b. Unemployed residents <sup>8</sup>	343,000	254,000	316,000 <sup>9</sup>
c. Residents living in poverty	2 million	1.6 million	1.6 million <sup>10</sup>
<b>2. DHS FACILITIES</b>			
a. General Acute Care Hospitals	5	5	4 <sup>11</sup>
b. Rehabilitation Hospitals	1	1	1
c. Community Hospitals	1	1	0
d. Multi-Service Ambulatory Care Center (MACC)	0	0	1
e. Trauma Centers	3	3	2 <sup>12</sup>
f. Comprehensive Health Centers	6 <sup>13</sup>	6	6
g. Personal Health Centers	39	29 <sup>14</sup>	10
h. PPP Clinics <sup>15</sup>	0	125	106 <sup>16</sup>
i. Public Health Clinics	45	14	15
j. School-based Clinics	0 <sup>17</sup>	4	2
<b>3. COUNTY OUTPATIENT SERVICES<sup>17,18</sup></b>			
a. CHC visits	704,000	638,000	594,000
b. HC visits	592,000	288,000	163,000
c. PPP visits <sup>18</sup>	0	724,000 <sup>19</sup>	605,000 <sup>20</sup>
d. MACC visits	0	0	69,000
e. Mental health visits <sup>21</sup>	1.1 million	1.3 million <sup>22</sup>	1.5 million
f. Public health visits	666,000	525,000	418,000
g. Specialty care referrals <sup>23</sup>	0	127,000	140,000
<b>4. DHS HOSPITAL STATISTICS<sup>24</sup></b>			
a. Budgeted beds <sup>25</sup>	2,595	1,869	1,643
b. Inpatient days	899,000	656,000	550,000
c. Admissions	141,000	103,000	83,000
d. ER visits	508,000	335,000	289,000
e. Trauma visits <sup>26</sup>	7,055	8,119	6,935
f. Outpatient visits	1.3 million	1.3 million	1.2 million
g. Total hospital encounters <sup>27</sup>	1.9 million	1.7 million	1.6 million
h. Full-time employees <sup>28</sup>	20,200	15,800	14,500
i. ER diversion rates for ED saturation <sup>29</sup>	9%	41%	57% <sup>30</sup>
j. ER visits per inpatient admission <sup>31</sup>	3.8	3.2	3.6
k. Percent of all personal health care visits provided in hospital setting <sup>32</sup>	74%	57%	62%
<b>5. OTHER</b>			
a. Community Health Plan enrollment <sup>33</sup>	13,000	129,000	159,000

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- <sup>1</sup> Based on Fiscal Year 1994-95 data unless otherwise noted.
- <sup>2</sup> Based on Fiscal Year 1999-00 data unless otherwise noted.
- <sup>3</sup> Based on Fiscal Year 2004-05 data unless otherwise noted.
- <sup>4</sup> Calendar year data from US Census Bureau unless otherwise noted.
- <sup>5</sup> 1995 Current Population Survey Data, as reported in the June, 30 1997 Los Angeles County Medicaid Project Management Plan, page 5 (see reference 1).
- <sup>6</sup> From 2001 California Health Interview Survey, UCLA Center for Health Policy Research.
- <sup>7</sup> From 2003 California Health Interview Survey, UCLA Center for Health Policy Research.
- <sup>8</sup> Based on census estimates as reported by the Employment Development Department, [www.labormarketinfo.edd.ca.gov](http://www.labormarketinfo.edd.ca.gov) (Accessed August 4, 2005)
- <sup>9</sup> Based on 2004 US Census estimates.
- <sup>10</sup> Based on 2003 US Census estimates.
- <sup>11</sup> High Desert Hospital was converted to a Multi-service Ambulatory Care Center in Fiscal Year 2002-03.
- <sup>12</sup> Martin Luther King/Drew's trauma center was closed December 2004.
- <sup>13</sup> Mid-Valley Health Center is included in this list even though it was not formally classified as a Comprehensive Health Center until after 1995. At the time, it had significantly more services than a typical DHS Health Center but also did not have the full range of CHC services.
- <sup>14</sup> Based on number of health centers listed in Fiscal Year 2000-01 DHS Patient Profiles.
- <sup>15</sup> Count of individual PPP and GR clinic sites providing contracted primary, specialty, and/or dental care services to low-income, uninsured residents. Data from Los Angeles County Department of Health Services, Office of Ambulatory Care, PPP Program, Contract Administration Unit.
- <sup>16</sup> Does not include one mobile van site.
- <sup>17</sup> Source unless otherwise noted: Los Angeles County Department of Health Services MIS Patient Workload and Financial History Reports for Fiscal Years 1994-95, 1999-00, and 2004-05 (estimated as of June 2005).
- <sup>18</sup> Includes General Relief visits provided by community partners.
- <sup>19</sup> Fiscal Year 1999-00 visits were not certified.

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<sup>20</sup> Fiscal Year 2004-05 Certified PPP Ambulatory Care Visits, Los Angeles County Department of Health Services, Medicaid Waiver Office.

<sup>21</sup> Fiscal Year 1994-95 data is from the October 1, 1999 Waiver Extension Proposal (see reference 37) and was not verified by the Department of Mental Health (the initial Waiver did not require certification of visits); other years are certified waiver-related ambulatory care visits reported by the Department of Mental Health, excluding nurse-only and other visits not certifiable under the Terms and Conditions of the Waiver Extension.

<sup>22</sup> Data from Fiscal Year 2000-01.

<sup>23</sup> Fiscal Year 1999-00 data from July 24, 2002 1115 Waiver Modification Proposal (see reference 48); Other year estimates are from Los Angeles County Department of Health Services, Medicaid Waiver Office.

<sup>24</sup> Source unless otherwise noted: Los Angeles County Department of Health Services MIS Patient Workload and Financial History Reports for Fiscal Years 1994-95, 1999-00, and 1994-05 (estimated as of June 2005).

<sup>25</sup> Fiscal Year 2004-05 data from Los Angeles County Department of Health Services, Office of Finance; Other years are from the 1115 Waiver Modification Proposal (see reference 48).

<sup>26</sup> Data from Los Angeles County Emergency Medical Services Agency.

<sup>27</sup> Includes hospital inpatient admissions, ER visits, and outpatient visits.

<sup>28</sup> Does not include employees at High Desert Hospital, which converted to a Multi-service Ambulatory Care Center during Fiscal Year 2002-03.

<sup>29</sup> Average incidence of ED saturation (percent of hours the hospital is on diversion to 911 traffic due to ED saturation) at DHS 911 receiving hospitals; Calendar Year data from Los Angeles County Emergency Medical Services Agency.

<sup>30</sup> Calendar Year 2004.

<sup>31</sup> Admission data excludes hospitals without Emergency Rooms (Rancho and High Desert).

<sup>32</sup> Total visits represents all hospital encounters, and all CHC, HC, and PPP personal health care visits (public health visits not included).

<sup>33</sup> Data from 1115 Waiver Modification Proposal (See reference 48); June 2005 actual CHP enrollment from Los Angeles County Department of Health Services, Office of Managed Care.