

# Ambulatory Care for the Urban Poor: Structure, Financing, and System Stability

Barbara A. Ormond  
Amy Westpfahl Lutzky

*Occasional Paper Number 49*



Assessing  
the New  
Federalism

*An Urban Institute  
Program to Assess  
Changing Social Policies*

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This paper is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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**A** *ssessing the New Federalism* is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site (<http://www.urban.org>). This paper is one in a series of occasional papers analyzing information from these and other sources.



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# Executive Summary

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Ambulatory care providers are becoming an increasingly important part of the U.S. health care system. Technological progress has made many treatments previously offered only in the hospital now possible in an ambulatory setting. This shift to ambulatory care, while generally recognized as a positive move toward a less expensive and more appropriate health care setting, has often left providers scrambling to adjust to rapidly changing technology and new, complex reimbursement systems. Safety net providers, in particular, have difficulty keeping abreast of a rapidly changing health care system because they serve low-income, uninsured patients and face constraints imposed by their funding sources.

This study examines the organization and financing of ambulatory care for the poor in three urban communities—Houston, Denver, and Los Angeles—and the challenges posed to these systems by ongoing changes in the health care sector. Specifically, this study describes each community's ambulatory care safety net, the challenges each community faces and their responses to these challenges, and the possible determinants of the level of success each has achieved in meeting the ambulatory care needs of their vulnerable populations. In addition, each system is examined from the perspective of long-term stability.

This report is based on case studies conducted in the three study communities between October 1999 and February 2000. The authors interviewed local health officials, public and private clinic administrators, health department staff, and community advocates using a standard set of questions developed for each category of interviewee. A separate team gathered information on hospitals and their interactions with the ambulatory care system; these findings are presented in a separate study.

While ambulatory care generally refers to any care not provided in an inpatient setting and may even include specialty care at a hospital outpatient department, it is important to note that this report focuses on non-hospital-based primary and preventive care provided in a clinic setting. Specialty care provided at a hospital specialty clinic or physician's office is treated as a complement to clinic-based primary and preventive care.

A distinctive ambulatory care system has developed in each community, reflecting the particular constraints and history of each of the safety net systems. These systems differ in the extent to which they rely on publicly provided services for the uninsured population as opposed to public financing of privately provided services. They also differ in the level, reliability, and source of the financial contribution available in support of safety net services. The communities also differ in the strength of their



commitment to ambulatory care and in the efforts they have made to encourage ambulatory care over hospital-based care where appropriate. In addition, the broader health care market conditions within which each system operates are quite different across the three communities.

Specifically, findings show that the ambulatory safety net in Denver ranks highly on several system characteristics critical to success. It is well funded, well organized, and well led. Furthermore, it enjoys substantial local support, both political and financial, and has been given substantial independence. It has implemented a systemwide information system that links ambulatory care sites with complementary specialty and inpatient services, facilitating both referrals for nonambulatory services and referrals to ambulatory sites for follow-up care. As a system, Denver's safety net operates as an equal player in a highly competitive market; within the system, the status of ambulatory care service is equal to that of other services, including inpatient care. The community of Denver has used these assets to put together a successful integrated system to serve a defined population. Los Angeles has some of these assets; Houston has fewer.

Our case studies point to eligibility as another factor that strongly influences system success. For reasons of history, the Denver public safety net is able to strictly define the population eligible for its services and to enforce its eligibility standards. It is able to limit eligibility to residents of the city and county of Denver because a large part of its operating budget is funded by these localities and because an alternative source of care is available to those excluded from the Denver public system. By thus limiting the number of people it serves, Denver's safety net is able to improve the quality of the services it provides, if only by reducing the queue.

Denver County encompasses a small and fairly homogenous population as compared with the much larger populations in Los Angeles County and Harris County (where Houston is located). Like Denver, Houston limits eligibility for its services to Harris County residents and so it has some control over demand for its services. However, the Harris County Hospital District, from which the bulk of the safety net's funds are derived, serves a substantially larger and more diverse population and so experiences substantially higher demand for its services. Los Angeles does not impose a residency requirement at all and therefore faces nearly limitless demand.

Finally, the success of the ambulatory care safety net is linked to the degree of flexibility the public system has to direct resources toward ambulatory care. Denver receives substantial local funding for ambulatory care services as well as federal grant funding for community and public health. Los Angeles has funding under a Section 1115 waiver that is targeted toward ambulatory care. Houston's safety net, in contrast, is more dependent on disproportionate share hospital funding and graduate medical education payments, which are based on inpatient volume. As a result, it has less flexibility to direct funds toward the ambulatory sector.

Given the varying degree of success seen in the three systems, the question arises as to which of these components or combination of components is critical to the success and long-term stability of the ambulatory care safety net in these communities. Could the Denver public safety net maintain its level of accomplishment if its leadership changed? Would expanding its service area lead to an unsustainable level of

demand for its services? Might changes in the local political landscape lead to a reduction in its critical local financial support? The problems faced by the systems in Los Angeles and Houston suggest these questions but provide few answers. Nevertheless, a comparison of the three systems suggests that the characteristics of a successful safety net system are similar to those of a successful private system. The degree to which financial and organizational flexibility and managerial agility can be combined with the mission of public service under the constraints of public financing appears to be key to the successful operation of a public safety net. A strong ambulatory care system within the safety net is then the result of decisions based on the interests of both patient care and long-term institutional survival.





# Ambulatory Care for the Urban Poor: Structure, Financing, and System Stability

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## Introduction

Ambulatory care providers are becoming an increasingly important part of the U.S. health care system. Technological progress has made many treatments previously offered only in the hospital now possible in an ambulatory setting. While insurers are eager to see care moved to what is generally a less expensive setting, the pace of change in technology and reimbursement systems has often left private providers scrambling. Safety net providers are no less beset although the dynamics of change are different. Technological change offers them the same opportunities to move care to an ambulatory setting, and general budget pressures push them to contain costs. While Medicaid managed care has introduced incentives for preventive care and non-hospital-based treatment for publicly insured patients, other mechanisms for reimbursing providers of care to the publicly insured and the uninsured have been slower to evolve. In part because of the constraints imposed by the funding sources on which they depend, safety net systems have had fewer options for realizing the efficiencies offered by the shift away from hospital-based care.

This study looks at the organization and financing of ambulatory care for the poor in three urban communities—Houston, Denver, and Los Angeles—and the challenges posed to these systems by the ongoing changes in the health care sector. Distinctive ambulatory care systems have developed in each of the study communities. These systems differ in the extent to which they rely on publicly provided services for the uninsured population as opposed to public financing of privately provided services. They also differ in the level, reliability, and source of the financial contribution available in support of safety net services. Finally, the strength of the commitment to providing care in nonhospital settings, whether the care is publicly or privately produced, varies across the three systems.

Ambulatory care generally refers to any care not provided in an inpatient setting and so covers a broad range of services—from primary care at a community clinic or physician's office to specialty care at a hospital outpatient department. This report focuses on non-hospital-based primary and preventive care provided in a clinic setting. Specialty care provided at a hospital specialty clinic or physician's office is treated as a complement to this basic level of ambulatory care and not as a separate focus of this study. It is also beyond the scope of this study to determine what portion of hospital emergency department care is for actual emergent or urgent care and what portion for is nonurgent care and, therefore, more appropriately addressed in a clinic setting.

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## Methods

This report is based on case studies conducted between October 1999 and February 2000 in Houston, Denver, and Los Angeles. The authors interviewed local health officials, public and private clinic administrators, health department staff, and community advocates using a standard set of questions developed for each category of interviewee. (See the appendix for the list of interviewees.) A separate team gathered information on hospitals and their interactions with the ambulatory care system. This team has produced a companion report on safety net hospitals that examines these three communities as well as Boston and Detroit (Brennan, Guterman, and Zucker-man forthcoming).

This study is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear effort to examine changes in social policies for low-income families—and the effect of such changes—as the federal government shifts more authority over social services and health programs to the states. In this project, Urban Institute researchers conducted intensive case studies of 13 states, including Texas, Colorado, and California, and fielded a household survey nationally and in each of the 13 states. Both the case studies and the survey were conducted initially in 1996–1997, and the survey was repeated in 1999–2000 to monitor changes in welfare and health care policies and trends in the well-being of families in the wake of these changes.<sup>1</sup>

The next section briefly describes the ambulatory care safety nets in the three study communities and the challenges they face. Ways in which the communities have adjusted to meet these challenges are discussed and the determinants of the level of success each has achieved are examined. Finally, the long-term stability of each system is considered.

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## Ambulatory Care Systems and Challenges

### Comparing and Contrasting the Ambulatory Care Safety Nets

The ambulatory care safety nets in Houston, Denver, and Los Angeles are similar in their basic structure. In each city, public clinics located in community settings provide primary care to community residents with referrals to a public hospital as necessary. While the public system is the largest provider of safety net ambulatory care, private clinics supplement the public offering in each city.

Because of the dominance of publicly provided care, the structure and governance of the larger public system influence the functioning of the ambulatory care system. Structure includes not only the way ambulatory care services themselves are organized but also the degree of integration between ambulatory care and other services that support and complement ambulatory care—public health services, specialty/diagnostic services, and inpatient care. Governance concerns such issues as the degree of independence that the public system as a whole has from other municipal

services in general and, more specifically, the strength and independence of the ambulatory care system within the health system, both politically and financially. Financing for public ambulatory care depends on the financial state of the public system as well as the allocation of funds to ambulatory care within the public system's budget. Both the level and the stability of the two funding flows—to the system and to the ambulatory care sector within the system—are important.

The three systems in this study differ not only in their governance and financing but also in the level of integration of services and the eligibility requirements of their public systems. Houston's governance structure is more centralized and financing for ambulatory care is controlled at the hospital level. In contrast, Denver ambulatory care officials have a seat at the decision-making and budget-setting table, and ambulatory care providers are included as members of an integrated patient care team. Los Angeles, with its huge client population and multiple hospital system, falls somewhere in between, moving decisively but slowly toward a more decentralized authority structure and a more integrated program of patient care.

Private clinics, many financed through federal grants, also represent an important component of the ambulatory care safety net in each community. Unlike public clinics, most private safety net clinics lack an official affiliation with a hospital; therefore, they are affected not only by the strengths and weaknesses in the public system but also by the willingness of private hospitals to cooperate in caring for their patients. Private hospitals influence the ambulatory care safety net by the stance they take toward the public system—through direct competition for insured patients as well as through their influence on the political process by which public policies and budgets are set.

These systems and their effectiveness are also affected by one of the foremost challenges to adequate safety net care—high levels of demand. Demand for care from the safety net is determined primarily by the size of the population left unserved by the mainstream health care system, which is in turn a function of the extent of poverty and uninsurance in the low-income population. State-level decisions on Medicaid eligibility standards and private insurance markets are an important factor in the size of the uninsured population. Finally, undocumented immigrants present a particular problem for the system since they are rarely eligible for public programs and may be fearful about using the services that are available for them.

The demand for safety net ambulatory care services that each provider faces depends in large part on the size of its service area and the eligibility rules for publicly funded services at that facility. Depending on its sources of funding, each facility may be governed by a different set of rules. Federal rules govern eligibility for emergency hospital services and services at federally funded clinics. A mix of federal and state rules govern eligibility for Medicaid services, and state decisions about Medicaid eligibility are critical to the size of the uninsured population. In addition, the community may choose to establish specific eligibility standards for locally financed services not covered under federal programs. Local jurisdictions may also define the service area for locally financed providers by the area from which funds are drawn to support the providers, generally a county or hospital district. The service area definition, the stringency of the eligibility standards, and the strictness with



which these criteria are enforced will influence the quantity of free or reduced-price services that locally financed facilities are obligated to provide.

This section describes the ambulatory care safety nets in Houston, Denver, and Los Angeles, taking into account the demand for safety net services, the structure and governance of the public system, the role of the private sector, and the financing that supports the system. The constraints under which each system operates and the challenges each faces are then discussed.

## **Houston**

### ***Background***

In Texas, responsibility for health care for the indigent by law rests with the county (Wiener et al. 1997). Harris County, with a population of just over 3 million, provides care through the facilities of the Harris County Hospital District (HCHD), a public entity financed through a property tax. The city of Houston dominates Harris County, but there are other smaller cities as well as unincorporated areas in the county.<sup>2</sup>

### ***Demand***

An estimated 30.1 percent of Houston metropolitan area residents are uninsured (Employee Benefits Research Institute [EBRI] 1998). Factors contributing to the high uninsurance rate in Texas as a whole also operate in Houston—stringent eligibility criteria for Medicaid, a large proportion of Hispanics (many of whom are undocumented), and a relatively low level of employer-sponsored insurance.<sup>3</sup> Consequently, demand for safety net services is high.

### ***Facilities Serving the Indigent Population***

Harris County's ambulatory care safety net includes HCHD's three hospitals and the 11 community health clinics operated by its Community Health Program, as well as health departments run separately by the county and the city, and several private clinics. HCHD's community clinics, located throughout the county, provide a full range of acute care services and represent the major source of ambulatory care for Houston's indigent population. In addition, HCHD operates eight school-based clinics for screening, immunizations, and referrals. Ambulatory care, including specialty and diagnostic services, is also available at the outpatient and emergency departments of HCHD's hospitals. Historically, preventive services have been provided for residents of Houston proper by the nine city health department clinics, while five county health department clinics serve county residents living outside of the city borders. The city health department also operates four school-based health centers.

In addition to these public facilities, several private clinics serve individuals who either are not eligible for or choose not to use public facilities. Fees are generally based on clients' income. Although the quantity of services these clinics provide is small relative to those provided by HCHD's Community Health Program, these

clinics are an important supplement to HCHD, filling perceived gaps in the availability of public services. The private clinics serve many undocumented immigrants who reportedly avoid any contact with government agencies at any level. Outpatient departments in private hospitals also offer some indigent specialty care.

### ***Eligibility for Public Services***

Uninsured legal residents of Harris County who meet specified income criteria can apply for a “Gold Card,” which entitles them to free services at HCHD clinics and hospitals and is renewable every six months.<sup>4</sup> Those who do not qualify (because of income level or immigration status) or who choose not to apply for a Gold Card can register for a “Red Card,” which entitles them to services at full charges. HCHD facilities also accept Medicaid, Medicare, and private insurance, although these last two cover only a small proportion of HCHD clinic patients. Of the 900,000 people eligible for HCHD services in 1998, approximately half were covered by Medicaid while the other half had Gold Cards. Red Card patrons represented only a small fraction of clinic users.

The clinics screen everyone for Gold Card eligibility; those not eligible must pay Red Card rates. Hospitals, in contrast, are obligated under federal requirements to provide a diagnosis for all who present at the emergency department and treatment for those with emergency conditions, regardless of residence, income status, or ability to pay.<sup>5</sup> Although in the past undocumented immigrants could obtain a Gold Card, in recent years documentation standards have been more strictly enforced, effectively eliminating Gold Card eligibility for the undocumented. Those who cannot afford the fees associated with the Red Card often rely on hospital emergency departments for their medical needs.

Public health services at county and city facilities are available without regard to immigration status, and income criteria for eligibility vary by program. Locally financed services, such as immunization and tuberculosis screening, are open to all residents of the appropriate jurisdiction. Services funded under federal grants, such as treatment for HIV/AIDS, may be subject to federal eligibility restrictions.

### ***Financing and Governance***

Harris County is governed by the County Commissioners Court. The court appoints HCHD’s Board of Managers, sets the property tax rate that funds HCHD, and approves its budget. Furthermore, the court retains purchasing powers for the Hospital District and so holds approval authority over its purchases on a day-to-day basis. Over the last few years, relations between HCHD and the court have been strained, culminating in the replacement of HCHD’s chief executive officer in 1999.

HCHD is funded by a mix of local and federal funds, including property tax revenues, Medicaid disproportionate share hospital (DSH) payments, and Medicare graduate medical education payments. In 1998, local funds derived from the property tax accounted for 37.6 percent of HCHD’s budget.<sup>6</sup> A similar percentage came from patient revenues, of which 52.8 percent were derived from Medicaid. DSH payments accounted for 18.6 percent of total revenues (HCHD data cited in Meyer



1999).<sup>7</sup> HCHD officials reported that ambulatory care accounts for about 35 percent of the total HCHD budget. The Community Health Program represents about one-third of this portion; the rest goes to hospital-based outpatient clinics and the emergency department.

The county and city health departments each receive funding from their respective jurisdictions based on submitted budgets. More than half of the budget for each, however, comes from competitive federal grants for particular services, such as HIV/AIDS programs or maternal and child health services. Medicaid payments represent only a minor part of health department budgets.

Houston's privately operated clinics are supported primarily through donations and volunteer staff, in addition to patient fees. A few also accept Medicaid payments, but these funds represent only a minor contribution to revenues. In contrast to clinics in the other cities in this study, not one of the private clinics in Harris County is a federally qualified health center (FQHC).<sup>8</sup>

### ***Constraints and Challenges***

Current challenges to Houston's ambulatory care safety net come from three areas. First, there is a high and growing level of demand for safety net services in Houston, due in part to stringent state Medicaid eligibility standards and in part to the large undocumented immigrant population. Second, core funding for the system is unstable. Tax rates are currently below historical levels.<sup>9</sup> DSH payment levels are set to decline, and because the allocation of DSH funds to a given hospital is based on the number of Medicaid patients served by that hospital, an indirect effect of the shift in Medicaid patients to managed care has been increased competition from private hospitals for this dwindling pool of patients. The third area of challenge is the direct effect of Medicaid managed care on HCHD patient revenues. Mandatory managed care was introduced in late 1997 and, by the following year, HCHD Medicaid revenues were 31 percent below their 1994 level (calculations based on HCHD data cited in Meyer 1999). Although HCHD sponsored its own Medicaid managed care plan, it entered the market relatively late and enrollment has not met expectations. Many private providers have actively courted Medicaid enrollees.

In addition to these current challenges, Houston's ambulatory care safety net faces structural impediments to improved efficiency and client access. Chief among these is the county's ambivalent commitment to its decision to finance indigent health care services. In choosing to meet its statutory obligation to care for the indigent through the establishment of a hospital district, Harris County has signaled its intention to directly provide services for the indigent rather than purchase care from private providers. The state's decision to provide only minimal protection for safety net providers under Medicaid managed care has, in effect, placed the burden of financing indigent care squarely with the county. However, in recent years, the county has been reluctant for various reasons to make adequate local financing available to support the hospital system as currently configured. The 1996 cuts in property tax rates mandated by the Commissioners Court have had a direct effect on revenue, exacerbating the loss of Medicaid revenues that have historically cross-subsidized indigent care.<sup>10</sup>

The current structure of ambulatory care in the county also constitutes an obstacle to access and efficiency. Lack of coordination among various ambulatory care entities has created a safety net with gaps in some geographic areas and duplications in others. While HCHD clinics and the city and county health departments collaborate in some areas, each entity operates largely in isolation from the others, with little systemwide collaboration. Competition for federal funding, different legislative mandates, and perceived cultural differences among the entities hinder cooperation. Differences in eligibility requirements for each set of providers hampers collaboration since, for example, patients referred from one system might not be eligible for services at the others.

HCHD ambulatory care officials recognize that the lack of a good information system is a major weakness. The inability to transfer patient information quickly and reliably between ambulatory care providers and other system services impedes the coordination of care across services. Referrals from community clinics for specialty care at hospital outpatient clinics or, conversely, referrals from the hospitals for neonatal care at the community clinics could be more easily arranged and tracked if the Community Health Program and the hospitals used a common information system.

The Community Health Program has been operating since the early 1970s. As one of the first systems in the country to incorporate community health centers into its public hospital system, HCHD made an early commitment to community-based care. HCHD officials and county commissioners alike have stated policies favoring the provision of care in ambulatory settings wherever possible for reasons of community preferences and cost efficiency. Nevertheless, this commitment to promoting ambulatory care is currently not well reflected in the governance of the organization. The Community Health Program is not directly involved in the final budget allocation process nor are program officials included at the upper levels of system management, in effect making non-hospital-based ambulatory care subsidiary to other HCHD departments and functions, despite the stated priorities. Physicians at the clinics come from two different medical schools and operate separately from hospital physicians, further hindering the integration of ambulatory care into the larger system. The clinics' reliance on medical school physicians and residents enhances HCHD's tendency to subordinate the needs of the clinics to the requirements of medical school curricula.

Whatever its priorities, HCHD is constrained in its ability to shift resources to ambulatory care because of its funding. HCHD is the largest recipient of Medicaid DSH in the state, but these payments, like those for graduate medical education, are based on the number of hospital discharges and so present an incentive to admit patients rather than treat them in the community. The overall financial condition of HCHD has been deteriorating over the past five years (Meyer 1999), and county officials reported that over the past two years their emphasis has been on stabilizing finances. Some success having been achieved in that area, the commissioners are now turning their attention to greater emphasis on community-based care.



## Denver

### ***Background***

The Denver metropolitan area includes the city and county of Denver and the five surrounding counties. While the entire metropolitan area has been growing rapidly in recent years, growth in the suburban areas has been greater than in the city. The population in the city and county of Denver grew by 8.3 percent between 1990 and 1999, while population growth in the suburban counties ranged from 19.2 to 155.5 percent. These geographic differences are important, since responsibility for indigent health care follows strict geographic lines.<sup>11</sup>

### ***Demand***

Compared with Houston and Los Angeles, the city and county of Denver are small, with a total population of about half a million; the metropolitan area population is 2.2 million (Colorado Community Health Network [CCHN] 1998). An estimated 17.8 percent of the metropolitan area population is uninsured (EBRI 1998). Respondents believed that the greatest growth in the number of uninsured has been in the suburban counties where the fastest population growth is occurring. As in Houston, demand for indigent health care services is driven by stringent Medicaid eligibility standards and by the large number of undocumented immigrants. In contrast to Houston, however, Denver enjoys a high rate of private insurance coverage.

### ***Facilities Serving the Indigent Population***

Within the city and county of Denver, the health care safety net—both ambulatory and hospital based—is dominated by Denver Health, an integrated, public health delivery system. Denver Health consists of a hospital, 11 community clinics, and 12 school-based clinics run under its Community Health Services program, the public health department, and other health-related services.<sup>12</sup> Additionally, several private nonprofit clinics have opened in response to what they perceived as needs not met or populations not served by Denver Health.

In the suburban counties, three nonprofit clinic networks operating at 11 sites provide the majority of ambulatory care services for the indigent. As are the Denver Health community clinics, all of these suburban clinics are federally qualified health centers. Public health services in the suburbs are the responsibility of the individual counties, and the services offered by and level of commitment to indigent ambulatory care varies. Private hospitals also offer some ambulatory care through their emergency and outpatient departments.

### ***Eligibility for Public Services***

For reasons that are based both in history and in the source of financing, inpatient care for the indigent in the suburban counties is primarily the responsibility of University Hospital—the state designated provider of last resort. In Denver proper, the

responsibility rests mainly with Denver Health, whose services are open to all residents of the city and county of Denver. Personal health services are provided on a sliding fee scale; most public health services are provided free of charge. Although Denver Health has an open-door policy toward the undocumented, the questions it must ask in order to ascertain eligibility for various reimbursement programs make some immigrants uncomfortable. In addition, University Hospital provides specified specialty services to residents of the city and county of Denver under agreement with Denver Health.

The metropolitan area community clinic networks work closely with each other through the Colorado Community Health Network (CCHN) of the Colorado Primary Care Association. The service area for each clinic site is defined by zip codes and services to residents are provided on a sliding fee scale. Independent nonprofit clinics also provide services on a sliding fee scale but, in contrast to the CCHN and Denver Health clinics, these clinics accept patients without regard to area of residence. Almost all of these independent clinics are federally qualified.

### ***Financing and Governance***

In contrast to HCHD, Denver Health has operated independently of the city and county as a quasi-public hospital authority since 1994 and so can develop its own budget without outside approval. This freedom combined with a program structure that integrates hospital, ambulatory, and public health services affords Denver Health the flexibility and the authority to pool monies from various funding sources and direct them to those areas that can contribute most efficiently to the health of their client population. Within the Denver Health system, ambulatory care has been given equal status with other medical services and so it participates fully in the budget and policy decisions that affect its operations.

Financing for safety net ambulatory care in Denver comes from several sources. The largest source is the Colorado Indigent Care Program (CICP), which covers both ambulatory and inpatient services for indigent adults and children who do not qualify for Medicaid. State funds finance CICP ambulatory services, while Medicaid DSH funds pay for inpatient services. The CICP program budget is fixed on an annual basis, however, and in recent years has covered an average of only 30 percent of the cost of care. Funding for indigent children has also been provided under Child Health Plan Plus (CHP+). Children's inpatient and ambulatory care services currently provided under both CICP and CHP+ will be consolidated under the proposed Colorado State Children's Health Insurance Program (SCHIP).

The federal government provides Bureau of Primary Health Care (BPHC) funding to support FQHCs and various grant funding for specific public health activities. In addition, the state of Colorado continues to pay FQHCs 100 percent of their reasonable costs for Medicaid beneficiaries. State/federal Medicaid funds, both DSH funds via CICP and direct patient care reimbursement, are an important source of funds for both community and hospital-based ambulatory care. The city and county of Denver provide significant local funding for Denver Health's charity care and in recent years have covered roughly half of Denver Health's uncompensated care. In



contrast, local funding for indigent care in the surrounding counties varies widely, ranging from an important supplement to insignificant amounts.

Denver Health's ambulatory care system is the most financially secure among the local clinic systems in the study communities—in part because it belongs to a larger system that aggressively and effectively pursues all available financing. Denver Health's overall financial security is strongly related to the substantial local financing it receives under its contracts with the city for indigent care, prison health services, and emergency services. In addition, it is the largest recipient of DSH monies in the state. Nearly one-fifth of its funding comes from grants, including the BPHC grants that support its community clinics. Because these clinics provide public health services, they are also eligible to apply for various public health grants. Denver Health thoroughly investigates program eligibility for all of its indigent patients, including Medicaid, Medicare, CICIP, and CHP+, to tap into any available revenue. It has also joined with a consortium of safety net providers to establish a Medicaid managed care plan, Colorado Access, which is now the largest Medicaid managed care plan in the state and dominates the Denver metropolitan area market. The Community Health Services program derives approximately 40 percent of its revenues from Medicaid, 30 percent from CICIP, 19 percent from federal grants, and 11 percent from Medicare and other funds.

The private nonprofit clinics rely primarily on federal grant funding, CICIP revenues, foundation grants, and private donations to supplement patient fees. All of the clinics participate in Medicaid and receive state-mandated safety net supplements to their Medicaid managed care reimbursement. Medicaid revenues vary across the clinics, but generally represent 25 to 30 percent of total clinic revenues.

### ***Constraints and Challenges***

Since responsibility for indigent care is divided along geographic lines, many of the challenges to Denver's ambulatory care safety net are specific to the different jurisdictions. Although Denver's undocumented immigrant population is smaller than that of either Houston or Los Angeles, caring for undocumented immigrants is a problem throughout the area. The metropolitan area as a whole is seen as underserved for safety net ambulatory care (CCHN 1998), but respondents reported that growth in demand for safety net services is highest in the suburban counties where growth in the undocumented immigrant population is highest.

The dependence of the suburban indigent population on the nonprofit clinic networks for primary care and on University Hospital for diagnostic and specialty care means that threats to the financial stability of these entities also threaten the ambulatory care safety net in the suburban counties. The suburban clinics successfully met the challenge of the introduction of managed care into Medicaid by joining Colorado Access. Possible changes to Medicaid, however, might still endanger their financial stability. Specifically, some fear that cost-based reimbursement for safety net clinics will be eliminated. In addition, recent financial stresses on University Hospital have resulted in a reduction in the number of appointments available to indigent patients for specialty and diagnostic work. The hospital is also in the process of transferring some of its departments to a new location outside the city—with unpre-

dictable effects on indigent care. While access to specialty care does not seem to be much of a problem in the city, it is a growing problem in the suburban counties. Respondents noted that as University Hospital has cut appointments for specialty care, some of the suburban hospitals have started to fill in the gaps. Nevertheless, the dwindling access to specialty care in the suburbs is an issue that suburban providers have not been able to fully address.

The weaknesses in the suburban safety net system could affect Denver Health, with the restrictions on indigent specialty care appointments at University Hospital a possible harbinger of problems to come. More broadly, Denver Health is able to maintain the quality of its system in part because demand is circumscribed by geographic boundaries. Capacity and cost could become serious issues if, in response to problems in the suburban ambulatory care safety net, patients from outside the city find ways around Denver Health's residency requirements.

Ironically, the coming of SCHIP could result in lower revenues for safety net ambulatory care providers in both the suburbs and the city. Children eligible for SCHIP are no longer eligible for CICIP, and if they are not enrolled in SCHIP, the reimbursement clinics receive for their care will decline from a small amount to nothing. The movement of children from CICIP to SCHIP could also affect DSH allocations, since these funds are based on CICIP patient volume. Furthermore, respondents feared that the remaining adults-only CICIP might have less political appeal and so could become more vulnerable to cutbacks. While SCHIP enrollment was disappointingly low at the time of our visit, steps are now being taken to increase participation.

Beyond these issues, the fate of Denver's ambulatory care safety net is linked to that of Denver Health. Denver Health's success in recent years is, paradoxically, the source of one its most significant current challenges. Its strong current financial position has allowed it to build a nontrivial budgetary surplus. Some officials fear that the existence of such a surplus could cause local officials to reconsider the level of local financing. The surplus has already led other hospitals to question the size of Denver Health's DSH allotment.

## **Los Angeles**

### ***Background***

With 9 million residents, Los Angeles County has the largest population of any county in the country, larger even than 42 of the 50 states. Responsibility for indigent health care rests with the Los Angeles County Department of Health Services (LACDHS). Service delivery is organized into five "clusters," each with a public hospital and at least one public clinic.<sup>13</sup> Because of the county's geographic breadth, this study conducted a general systemwide assessment of ambulatory care, but focused on the cluster organized around the Los Angeles County/University of Southern California Medical Center (LAC+USC). Los Angeles is currently restructuring its public health care system under a Section 1115 Medicaid waiver that includes substantial additional federal funds. The first five-year waiver period ended in June 2000; a five-year extension was approved, but includes strict performance indicators and man-

dates a phase-out of the federal role. Increased emphasis on expanding access through ambulatory care is a major component of the waiver program.

### ***Demand***

With an estimated 26.2 percent of its residents uninsured (EBRI 1998), Los Angeles has a high demand for safety net services. While its eligibility standards for Medicaid are generous compared with those in Houston and Denver, the county has large Hispanic and Asian populations that have high rates of uninsurance among the nonelderly—46 and 35 percent, respectively (*L.A. Health* 1998). Nearly 44 percent of the county's residents are Hispanic; about 12 percent are Asian. Los Angeles, like the rest of California, is also home to many undocumented immigrants. Under the previous governor, there was a distinct anti-immigrant sentiment that increased this population's reluctance to take advantage of any government services. While the current administration is more immigrant friendly, respondents reported that distrust of public programs among immigrants remains.

### ***Facilities Serving the Indigent Population***

In addition to the largest hospital in the county, the LAC+USC cluster includes three comprehensive health centers (CHCs) and one health center (HC). CHCs provide a wide range of primary care services and each, according to county officials, is roughly equivalent to the outpatient department of a 350-bed hospital. The health centers offer services that are more limited and have a greater focus on public health. The hospital, CHCs, and HCs within the cluster have standardized policies, common patient identifiers, and a system for referral among the different sites. Ambulatory care is also available at the hospital's emergency department and specialty clinics. Formerly, the hospital emergency department was the only place indigents could get specialty care. Under the waiver, however, some specialty services have been moved to the CHCs and a referral process has been put in place to allow patients access to hospital specialty services via the CHCs. While these arrangements do not as yet always work smoothly, they represent a significant departure from past procedures and a clear shift away from a hospital-centric philosophy of indigent care provision.

As in Houston and Denver, private nonprofit clinics in Los Angeles serve patients who may not be comfortable in the public system. Many of these clinics have chosen to affiliate formally with LACDHS through the Public Private Partnership (PPP) program established under the waiver.<sup>14</sup> The formal inclusion of private providers in the county's indigent care network represents a major innovation in the county's program, making the county both a provider and a purchaser of indigent care. At the time of our visit, there were 28 PPP clinics in the LAC+USC cluster. The PPPs generally refer patients in need of inpatient or specialty services to the public hospital or the CHCs through the Referral Center, a fax-based referral system established at cluster hospitals. PPP respondents reported, however, that access to these services through the Referral Center for PPP clients is less secure than for public clinic clients since the PPPs are not currently linked electronically to the public system nor do they have the personal connections that county personnel often employ to facilitate referrals. The PPPs hope to see these linkages improved under the waiver project.

Public health services are the responsibility of LACDHS and are available at the health centers. Under the waiver, many of the health centers have been colocated with PPPs in an attempt to decrease duplication of services and costs and to better integrate public and personal health services and public and private clinics.<sup>15</sup>

### ***Eligibility for Public Services***

LACDHS services are available to all. Those unable to pay are screened for eligibility for all programs, including Medicaid. Patients not eligible for Medicaid can complete an Ability To Pay (ATP) form and qualify for free or subsidized services on the basis of income, family size, and other factors. All information is self-declared and no questions are asked about applicants' immigration status. ATP eligibility must be renewed every six months. Unlike patients in Houston and Denver, patients are not assigned to a specific CHC or cluster based on geographic criteria, but may obtain services anywhere within the system.

Private clinics generally accept all patients without regard to ability to pay and usually have a sliding fee scale in effect. Uninsured patients who do not qualify for any other public program may qualify for free care under the PPP program based on their family's size and income.

### ***Financing and Governance***

Like HCHD, LACDHS is an entity of local government and is therefore subject to oversight by the county Board of Supervisors and must adhere to government labor and procurement regulations. Respondents noted that these restrictions have hampered the system's ability to respond to opportunities, such as managed care. In addition, the need to negotiate with unions has slowed efforts to restructure inpatient services. Goals for ambulatory care visits established under the waiver were seen as unrealistic but politically necessary.

LACDHS's services are funded through a variety of sources. In a 1991 initiative known as "realignment," the state transferred responsibility for indigent care and authority for certain tax streams to the counties.<sup>16</sup> Of LACDHS's nearly \$2.6 billion budget in 1999, \$842 million came from county-administered funds derived from a combination of "realignment funds" (from sales taxes and vehicle license fees) and local property taxes. Medicaid represents 30 percent of CHC revenues; a similar percentage comes from patient fees. The CHC/HC budget represents roughly 6 percent of LACDHS's total budget.<sup>17</sup>

The Section 1115 waiver was born out of the near financial collapse of the LACDHS system in 1995 and is a significant new source of funding, particularly for ambulatory care. Under the original waiver, LACDHS received approximately \$1 billion over five years and may exercise greater flexibility in the use of these funds for ambulatory care. Funds in the waiver's Supplemental Project Pool are designated for the support of nonhospital care, including care at nonpublic facilities. Under the waiver's Indigent Care Match, uncompensated care is defined as a reimbursable service at ambulatory care sites. These funds currently finance approximately half of





CHC uncompensated care. The LAC+USC cluster receives almost half of the funds available to the county through these two waiver programs.

Budgeting takes place at the county level, with cluster allocations based on past patient volume. The clusters have considerable independence in their operations. The relative position of the ambulatory sector varies by cluster from “reasonably well integrated with” to “decidedly subsidiary to” the cluster’s hospital. In the LAC+USC cluster, ambulatory care has yet to achieve a strong degree of integration.

In addition to their PPP funding, LACDHS’s private partners receive federal grant funds, private donations, and patient fees. Under PPP, clinics are paid a set fee per visit and a monthly case management fee. Most, but not all, also participate in Medicaid. PPP reimbursement rates are set below the Medicaid rate, and clinic officials asserted that the reimbursement does not cover the costs of patient care.

### ***Constraints and Challenges***

The LACDHS system faces enormous challenges over the next decade, many of which are recognized and addressed in the waiver program and extension (Long et al. 1999). Briefly, the system relies too heavily on its hospitals for indigent care, and its ambulatory care network is not uniformly integrated into the system. State funding is low, county funding is subject to cutbacks in lean financial times, and federal funding is declining. In addition, Medicaid managed care and falling enrollment have led to a decrease in the proportion of Medicaid patients using hospital and clinic-based services in the system and a reduction in Medicaid revenues.

Under the waiver program, LACDHS has made a strong commitment to ambulatory care—both through its own clinics and through financing the care provided by its private partners. Nonetheless, numerous barriers exist to achieving the waiver goals. The sheer size of the county makes dramatic change difficult to implement. The clusters have a history of independence and, despite a basic similarity in structure, they have differences in policies and procedures in numerous small and not-so-small areas (e.g., information systems and physician employment practices) that make coordination difficult. In addition, the hospitals around which the clusters are organized may be reluctant to share authority and patients with their affiliated clinics. More than five years into the waiver, the clusters are moving on different paths at different speeds toward the centrally articulated goals regarding ambulatory care.

The high demand for services and the inefficiencies inherent in hospital-centric care make the LACDHS system expensive to operate. LACDHS already represents 20 percent of the county budget. Funding streams have been tightened over the past decade, and cost-cutting programs have yet to achieve their full potential for savings. The state sets the rates for the “realignment” funding streams, and the county has limited ability to raise additional money on its own beyond property taxes. Federal DSH appropriations, a significant source of LACDHS’s funding, have been cut—although recent provisions that raise the maximum amount that public hospitals can claim have helped.<sup>18</sup> Federal funds have been strictly limited in the second five-year waiver program (Los Angeles County Department of Health Services [LACDHS]

2000; Riccardi 2000). If LACDHS can achieve the goals it has set for itself under the waiver, it will have a more efficient system.

It is not clear that adequate local and state funds will be made available to support the reorganized system. LACDHS officials claimed that current funding mechanisms, particularly DSH, favor inpatient care over ambulatory care. While an ambulatory care-focused system can result in a reduction in costs to the health care system as a whole, some officials noted that these savings may be more than offset by the reduction in revenues associated with the decline in inpatient care. The result, they asserted, will be a system that is more efficient but possibly less financially stable. LACDHS thus has the dual challenge of fundamentally reorganizing the care it provides and developing local—both state and county—funding mechanisms that will support the redesigned system.

The move to managed care in Medicaid has brought the problem of high demand into focus. LACDHS has not been able to keep its share of the Medicaid market, and while the number of ambulatory care visits has not declined since 1995, the proportion of these visits covered by Medicaid has. The addition of PPPs and improvements in the CHCs under the waiver have expanded ambulatory access as intended, but as Medicaid patients have moved to private providers, the new slots have been substantially filled by the uninsured. Although there are some indications that this trend has stabilized, the challenge posed by the combination of declining Medicaid volume and the policy of open eligibility for the uninsured will likely remain.

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## System Adjustment to the Changing Health Care Marketplace

Much has been written about what safety net providers are doing to address the challenges they face.<sup>19</sup> Leaders in the safety net ambulatory care systems in Houston, Denver, and Los Angeles have been using many of the same strategies—with the goal of making revenues match costs while continuing to meet the needs of their indigent populations. Their approaches are tailored to specific challenges their systems face.

Within each safety net system, the ambulatory care sector faces particular challenges that arise from its reliance on complementary specialty and inpatient care and from the ways in which safety net care is financed. The treatment of pregnant women provides a good example of how restrictions on funding based on where the treatment is provided result in a redistribution of costs and revenues between ambulatory and hospital-based providers. Hospital deliveries for undocumented pregnant women who meet Medicaid eligibility standards other than legal immigration status are reimbursable under emergency Medicaid provisions. Prenatal care, an ambulatory service, is not reimbursable for such women. Respondents in all three study sites reported that hospitals are eager to admit women under emergency Medicaid financing since the reimbursement rate is seen as quite favorable. As a result, clinic respondents in suburban Denver and Houston reported that they are able to, in effect, trade referrals of their prenatal clients to specific hospitals in exchange for favorable

consideration of their requests for charity care for other patients needing hospital services—a mutually beneficial arrangement.

The outcome is more one-sided in the case of Medicaid-eligible women. Respondents in both Houston and Los Angeles reported incidents of pregnant women being recruited by managed care plans after they had received an initial workup at the public clinics. The managed care plans receive the reimbursement for prenatal care and delivery, while the public clinics bear the costs of outreach and initial screening. In addition, since both HCHD and LACDHS have their own managed care plans, the loss includes the capitation associated with two potential plan enrollees—the mother and her newborn. In the case of Denver Health, the clinics and the hospital are part of an integrated system, so the costs and reimbursement for prenatal care and delivery accrue to the same system, regardless of the woman’s eligibility status.

This section considers five ways in which ambulatory care safety nets in the study communities have adjusted to the changing health care marketplace. The actions discussed here—eligibility control, improved information management, the development of public sector managed care organizations, the organization of medical care within the public system, and coordination with the private sector—were chosen because they illuminate broader issues in the provision of ambulatory care for low-income people. Safety net providers can affect demand for their services and so control costs by changing the eligibility criteria for their programs. The systems that have invested in information management systems have seen returns in higher revenues and lower costs. The difficulties that public systems have had in launching and sustaining managed care plans highlight the deficiencies in their systems. Finally, the systems have had different degrees of success in translating their extensive ambulatory care networks into integrated systems of care, and they have taken different approaches toward private safety net providers.

## Eligibility Control

The level of demand for indigent care is determined in large part by the number of uninsured in the safety net’s service area. Local jurisdictions that benefit from state-level decisions to support a more generous Medicaid program have less remaining demand for care that has to be met through local initiatives. The number of undocumented immigrants and the level of private insurance coverage also influence demand. Texas and Colorado cover a smaller proportion of their indigent populations under Medicaid than does California, leaving more people to be served by the safety net. Colorado, however, has a high rate of employer-sponsored insurance coverage (Moon et al. 1998), mitigating the effect of its stringent Medicaid eligibility standards.

Public liability for the remaining uninsured can be controlled to some extent by limiting eligibility for subsidized services and enforcing eligibility standards and service area restrictions. By controlling eligibility, public programs can contain costs and improve quality, if only by reducing the queue. Control of eligibility becomes even more important as a means to regulate demand for locally financed services as other barriers to access fall, particularly as publicly financed care expands at community sites. The study communities have used eligibility policies to varying degrees to limit

access at their facilities, with differences in both the stringency of the rules and the degree to which they are enforced.

Part of Denver Health's success in maintaining both high quality and a healthy balance sheet can be attributed to its ability to limit its service area and so tightly control eligibility for its programs. In response to spiraling demand for its services from non-Denver residents in the 1980s, Denver Health decided to limit access to its subsidized services to residents of the city and county of Denver. Responsibility for non-Denver residents then fell to University Hospital, which, in turn, limited the services it would provide to indigent Denver residents to those not available at Denver Health. Since half of Denver Health's funding for uncompensated care comes from the city, its geographic restrictions are not without justification. University Hospital, on the other hand, is a state-sponsored institution, which implies a broader mandate. Thus, for historical reasons, Denver Health has a clearly defined and relatively small service area. It maintains a "don't ask" policy toward undocumented immigrants but its residency requirement is strictly enforced. Much of the growth in the uninsured population in the Denver area is in the suburban counties, beyond Denver Health's service area. Denver Health is thus shielded from the full impact of this important source of system stress. Private clinics have opened in the suburbs to help meet the ambulatory care needs of this population.

Similarly, HCHD eligibility is restricted to residents of Harris County. HCHD's service area includes all of Harris County, which encompasses a much broader and more diverse population than that found in Denver Health's service area and contains Houston's suburbs with all their potential for growth. HCHD is funded in large part by county property taxes, and its service area reflects this broader base. While its residency requirement is strictly enforced, it has in the past ignored its restriction against providing subsidized services for undocumented immigrants. In recent years, however, it has enforced this criterion, effectively reducing demand for its services. This restriction on services forces the undocumented out of the potentially more efficient ambulatory care system and into HCHD's own emergency department, where federal regulations require that all comers be seen. Restricting ambulatory care access by undocumented residents thus has the perverse effect of shifting their care to the system's hospitals. Therefore, costs are shifted out of ambulatory care but remain within the HCHD system. This policy is currently being reconsidered (*American Health Line* 2000).

In contrast, part of LACDHS's struggle to meet demand at its expanded network of ambulatory care sites comes from the fact that it has defined its mission more broadly than either Denver or Houston, in a service area that is even larger than HCHD's. Along with its private partners, LACDHS is trying to serve the health care needs of indigent patients without regard for residence or legal status. The effect of this open-door policy has been nearly endless demand and is seen in the composition of the population served by the expanding ambulatory care network—a large proportion of new clients at the PPP clinics, for example, are uninsured. The county continues to provide financial support for the system, but the expansion program has been largely funded with special federal monies. In the waiver extension approved in July 2000, federal funding will be gradually reduced and state funding is scheduled



to increase. The proposed breadth of financial support for the system is consistent with the breadth of eligibility for its services.

The eligibility policies that are in force in the three systems reflect a mixture of state policy, legal mandates, and local or system choice. Denver's decision to limit eligibility to Denver residents is possible because alternative sources of publicly supported care—University Hospital, in particular—exist for those who are excluded. Neither Houston nor Los Angeles has that luxury. Much of Houston's uninsured population is undocumented. HCHD has used this eligibility criterion specifically to limit demand for services, but because this exclusion can only be enforced in ambulatory settings, the savings to the system may be illusory. Los Angeles appears to have decided that, rather than controlling eligibility, it will seek funding appropriate to the population it has decided to serve.

## Information Management

Given the complexities of medical care and the financing available for indigent care, enormous amounts of information are required to achieve both efficiency and solvency. The management information systems in the three sites are at different points along a continuum of development and implementation. Denver sees information technology as an instrument of change and has a fully functional information system for patient care, billing, and eligibility. Los Angeles is working to standardize information systems within its clusters so that it can begin integrating its systems across clusters. Improving information management between ambulatory and hospital sites within clusters is included as a goal of the waiver project. Houston officials recognize the need for a new information system, but have not yet begun to implement it. The differences in the information systems are reflected in how smoothly the systems operate, particularly with respect to the coordination of care across ambulatory and hospital or specialty care sites.

With respect to both patient care and financial stability, Denver Health officials see effective management information as central to the success of their system, playing a role in such diverse areas as patient satisfaction, management, financial operations, and Medicaid enrollment (Morefield 1999). Early on, these officials recognized that in order for Denver Health to operate as an integrated system of care it would need to be able to track patients and manage their care across the various service sites. They set as a goal the establishment of lifetime records of care for their patients and even considered coordinating with other safety net providers in establishing unique patient identifiers. Software has been standardized at all levels of the system. At the time of our site visit, medical records imaging was being implemented so that hospitals and clinics could have access to the same patient files. Denver Health information specialists claimed that the system has, among its other accomplishments, improved patient access and care. Denver Health managed care administrators reported that the system allows them to track patients' eligibility for various reimbursement, even allowing identification of potential retrospective reimbursement for newly enrolled Medicaid patients. In addition, repeat users of uncompensated inpatient care can be identified and efforts made to establish a regime of pre-

ventive care for them at the clinics, in effect establishing a managed care program for the uninsured.

The system that Los Angeles is struggling to put in place has, for now, much less ambitious goals. The complexity inherent in a much larger system with clusters that have historically operated with relative independence means that the task of standardizing technology must come first. Within the LAC+USC cluster, recently implemented systems facilitate the referral of ambulatory care patients to other sites for specialty care when necessary and back to the clinics for follow-up care. Advocates reported that not all the “bugs” have been worked out of the system, but it does show promise.

Comparing the reports from Denver with those from Houston reveals the benefits of better information management for ambulatory care clients and for the system as a whole. Houston clients who are referred to the hospital often must refile eligibility applications or repeat tests that have been done at the clinic level. Birth reports for prenatal clients who deliver at HCHD hospitals are not routinely filed with the clinics so that postpartum and well-baby care can be initiated. Even when there are problems with deliveries or the newborns themselves, the appropriate clinics are not notified and clients run the risk of having problems left untreated until they become critical. While Denver Health’s information system has been expensive to install and operate, its information specialists claimed that improvement in patient care, as well as the returns on both the cost and revenue sides, have justified the expense—an instance of spending money to save money. The relative autonomy and financial security that Denver Health enjoys have allowed it to make this investment in information technology.

## **Public Managed Care Plans**

In all three cities, the public system’s response to Medicaid managed care has included the development of its own managed care plan, although the level of commitment to public sector managed care varies among the three systems. The primary goal for each has been to maintain Medicaid market share in order to protect Medicaid revenues and DSH allocations where these funds are tied to Medicaid volume. Recent reports, however, suggest that publicly sponsored plans frequently experience financial difficulties and often fail even to retain the system’s patient base (Gray and Rowe 2000). Clearly, it is possible to make public managed care work well. Colorado Access is recognized as one of the most successful safety net managed care plans in the nation (Sparer and Brown 2000). HCHD’s plan, however, has had little success and its operations have been significantly cut back (Rutledge 2000). LACDHS does not consider its managed care plan to be crucial to its overall success.

In each city, the existence of an ambulatory care network in a community with an established Medicaid clientele should have provided the public system with a head start in the emerging Medicaid managed care market. Instead, in many ways, the coming of managed care served to highlight the weaknesses in these systems. A well-functioning managed care network features primary care providers with established referral patterns for specialty and inpatient care—that is, an integrated system—or the same qualities found in a well-functioning ambulatory care system. In Houston



and Los Angeles, only the building blocks of such a system were in place; the coming of managed care made the lack of integration among the parts of the system apparent. It also underscored the need for better information management, since managing care requires providers to track the care their patients receive.

The safety net ambulatory care system has costs associated with certain client characteristics, such as a higher incidence of substance abuse and mental illness, greater problems with noncompliance with treatment regimes, and a higher number of appointment no-shows—characteristics that may not be present in non-safety net settings. This problem was recognized in Denver and Los Angeles and some protections were offered to the safety net, particularly in the areas of default enrollment share, guaranteed contracting, and preferential reimbursement (Draper and Gold 2000; Moon et al. 1998). In contrast, Texas offered its safety net providers minimal protection. Such protection, however, cannot remedy a situation in which patients, once assigned, choose to leave the public system.

The poor integration of ambulatory care within the larger system and the inability to coordinate care across the different parts of the system are not the only factors limiting the success of public managed care in Houston and Los Angeles. The three markets are also very different with respect to managed care penetration, the amount of competition from other providers, and the strength of political support for the public system. Moreover, Denver Health officials pursued entry into the Medicaid managed care market early and aggressively as part of a consortium of private community clinics that extend its ambulatory care capacity and specialty hospitals that complement its ambulatory care strength. In contrast, HCHD entered the market late and LACDHS entered less aggressively as part of a loose consortium of plans. Finally, the managed care mentality may be at odds with the mission of safety net providers that historically have placed meeting the needs of those who have nowhere else to turn ahead of saving money. If safety net managed care plans are to succeed, they will need to find, as Denver Health appears to have done, some compromise that will allow them to reconcile their mission with their need to survive in the new health care environment. As one LACDHS physician noted, good medical care most often means efficiently provided care, and that means lower total costs. Efficiency and quality, he claimed, are not irreconcilable.

## **Organization of Care and System Integration**

Officials in all three systems recognize the importance of giving high priority to ambulatory care and are at different stages of reorganizing to realize this goal. Denver has almost all of the pieces in place, Los Angeles has system reorganization as a major waiver goal, and Houston is in the conceptual stage. The specifics differ in each site since the constraints and challenges are different, but each reorganization has two main goals. The first is to make primary care available in community settings, both to improve access by the client population and to reduce pressure on hospital emergency departments. The second is to encourage the delivery of care in the least expensive setting that is appropriate by establishing the primary care providers as effective gateways into the larger system of care. Formal referral pathways can then

be established, both “upward” for nonprimary care and “backward” for follow-up care.

The similarity in the basic structure of the three systems, nevertheless, masks very different ways of operating. Houston has a long history of providing ambulatory care in the community. Clinic officials are proud that the community clinics offer “one-stop shopping” for their clients, including pharmacy, podiatry, and optometry services. However, because systems to coordinate care into and out of the HCHD specialty clinics and hospital system are not reliable, ambulatory care is effectively a parallel system rather than a gateway. Officials at all levels—county, hospital district, hospital, and clinics—recognize the need to reorganize. The HCHD system has been struggling primarily with serious financial strains for several years and, at the time of our site visit, had yet to formulate a formal path for the future. County officials reported that a task force has been formed to address the issue.<sup>20</sup>

System integration and coordination of care between the ambulatory and hospital settings is also influenced by the structure of physician employment. Physician staffs at the HCHD clinics and hospitals are separate, and two different medical schools supply the clinic staff, hampering standardization and coordination of care. Some respondents also feel that, at times, the needs of the medical curriculum have taken precedence over the needs of the clinics. In addition, public health services are provided under separate governmental structures, so that in areas where public and personal health services overlap, the required coordination is difficult to arrange.

Los Angeles has as a waiver goal a degree of system integration similar to that seen in Denver. It is already several steps down that road, although the level of progress varies among clusters. Redesign of the information system has begun. Some specialty services have been relocated from the hospitals to the community clinics and local advocates reported that access to care has improved. For other services, referral networks have been established and are operating with varying degrees of effectiveness across the clusters. The LAC+USC cluster has set up a nationally accredited health care network with formal linkages between ambulatory care and other services. As in Houston, however, physician contracts may impede effective reorganization. Within most of the clusters, ambulatory clinicians remain in a separate employment system and are not regarded as equal to the physicians at the public medical centers at the core of each cluster. This situation has potentially detrimental effects on physicians’ willingness to coordinate care across service sites. Organizationally, both public and personal health services operate under the authority of LACDHS, although historically these functions have been separated in practice between the comprehensive health centers and the health centers. The reorganization plan has instituted joint service provision between the public and personal health sectors, but respondents reported that clinic personnel and clients generally still view the two systems as separate.

In contrast, under Denver Health, Denver has an ambulatory care system that is nationally recognized for quality and efficiency, with fewer of the access and waiting problems seen in many public systems (Moore 1997). Most significantly, system officials reported that patient care is organized under teams that regard ambulatory care, specialty diagnostic care, public health services, and inpatient care all as tools with which to improve patient health rather than as components to be integrated into a





system. They emphasized that because they directly employ all system physicians, they have greater control over how care is delivered across service sites.

The Los Angeles system is huge, and the reorganization required is substantial. The goals of the first five-year waiver were ambitious and are as yet unmet, suggesting that change may require more time than planners thought. Respondents in Denver claimed that Denver Health has been an integrated system from the outset. Denver Health may appear farther along in its adjustment to the changing health care marketplace in part because it did not have as far to go. The impetus for Los Angeles's drastic system redesign was the financial crisis of 1995. A similar crisis may be necessary in Houston to motivate change in what has been until recently a reasonably successful system of indigent care.

## **Coordination with Private Ambulatory Care Providers**

While Denver's system appears to have significantly fewer problems than either Houston's or Los Angeles's, the fact that private clinics have sprung up to serve indigent populations outside of the Denver Health system suggests that even a system this effective may be unable to meet all of the demand for indigent ambulatory care despite its geographically circumscribed service area. Denver Health welcomed a private clinic in one neighborhood where it admitted that demand had grown more rapidly than it could meet. In another area, however, Denver Health officials viewed a private clinic as potential competition and claimed that its services were not needed in that community. That clinic is affiliated with a private hospital and with one of the other Medicaid managed care plans.

There are private safety net clinics in Houston and Los Angeles as well. In Houston, these clinics effectively serve as a safety net for the safety net and are not integrated at all with the HCHD system. LACDHS is trying to walk a middle path, one that neither ignores private clinics nor treats them as competition, but rather takes them on as partners to help meet the needs of a broadly defined population. Under its Public Private Partnership program, LACDHS recognizes that it cannot have a nonrestrictive eligibility system and still meet all of the demand for care. By incorporating private clinics as additional gateways into its system, it adds to its ambulatory care network a dimension not available in the other study sites. In fact, many county respondents believe that the inclusion of private partners has strengthened the ambulatory care safety net by giving LACDHS greater flexibility to match its capacity to the changes in the geographic distribution of demand and to the available funding.

Using its information management and physician employment strategies, Denver Health has integrated its ambulatory care network into the larger public health care system to a noteworthy degree. Los Angeles is moving in the same direction, but has, as it did in the case of eligibility, defined its task more broadly. The integration of private safety net ambulatory care providers into the LACDHS system represents a degree of coordination not present in Denver and one that is consistent with the larger population that LACDHS has chosen to serve.

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## Determinants of System Stability

When a private provider fails, the result may be bankruptcy or the transfer of its assets to another owner. When a public provider begins to fail, however, the result is more likely to be system instability; the system becomes less able to meet its charge of providing for its clients without increased funding or other preferential policies, a trend that most local governments cannot sustain over the long term. The long-term stability of public systems is, in large part, a function of their ability to continually adapt to the changing health care market.

Each of the study communities has made a policy commitment to ambulatory care for reasons of both access and efficiency, but the ability of system officials to put this policy into action differs across the sites. Providers in the private sector have found that the ability to respond quickly and decisively to changes as they occur is critical to success. While this is no less true in the public sector, public systems face constraints on their flexibility that private providers do not, constraints that are felt most strongly in the areas of governance and finance. In addition, public systems play a different role in the local health care marketplace than do their private counterparts. Finally, even a strong commitment to ambulatory care cannot guarantee a strong ambulatory care sector if the larger public system itself is not adequately funded. A comparison of the experiences of Denver, Houston, and Los Angeles suggests that differences in governance, financing, and market conditions are crucial.

### Governance

Private providers generally have the flexibility to adjust their actions to the needs of the market at any given time. Public providers, on the other hand, are often hampered in their ability to develop system goals by the political process and in their ability to implement policies by public sector purchasing and personnel regulations. Early on, officials at Denver Health saw the need for independence from rules that would impede its operating flexibility. Denver Health's 1994 restructuring as a hospital authority gave it freedom from the regulations governing other public entities. Rather than operating as an arm of the county or city government, Denver Health has contracts with the county government to provide specific services—including indigent care—subject to specific performance requirements. Its personnel work for the Denver Health authority rather than for the government. Denver Health, thus, has the freedom both to set its own course without first seeking higher approval and to implement policies without bureaucratic restrictions.

The LACDHS system is larger and much more complicated. Although overall policy is set centrally, the six clusters have relative independence in implementing central policies. In addition, the county Board of Supervisors has considerable say in system decisions. The day-to-day activities of HCHD are also subject to board oversight, but its board includes not only political appointees but also representatives of other local health care institutions. Decisions as to the direction of change are therefore both subject to the political process—as in Los Angeles—and overseen by the system's competitors in the health care marketplace.



The position of the ambulatory care service within each system also varies across the study communities. Within the current management structure at HCHD, ambulatory care officials do not always participate directly in decisions that affect their sector. Within the LACDHS system, responsibility for ambulatory care does not rest clearly in one place, even at the central level. In contrast, ambulatory care within the Denver Health management structure is on an equal footing with other services, including inpatient care.

Strong leadership commitment to ambulatory care is also critical. Ambulatory care has strong support centrally at LACDHS. At the cluster level, however, leadership commitment to ambulatory care varies, as does the ability to move that cluster's system toward the centrally articulated goal of improved ambulatory care. At Denver Health, the current leadership has risen through the ranks and understands the system at all levels. With its forceful leadership and strong commitment, Denver Health has been able to achieve a greater degree of system integration than either HCHD or LACDHS. The recent change in HCHD's leadership has set the stage for progress, but it remains to be seen how ambulatory care will be treated under the new administration.

Finally, Denver Health's direct employment of physicians means it has not only the authority to act but also direct control over the personnel most critical for success. In contrast, both HCHD and LACDHS rely on medical schools for a large part of their clinic staff, and clinic physicians' affiliation with their medical school may compete with their loyalty to the public health care system. Denver Health officials noted that the importance of direct employment of physicians should not be underemphasized.

## Financing

Both Denver Health and LACDHS currently have secure funding streams. Denver Health's funding, however, is primarily local, while LACDHS is dependent for the next five years on federal funding under its Section 1115 waiver and on future state dollars leveraged by the terms of the waiver extension. There were no indications that local financing for Denver Health is in jeopardy. LACDHS's federal funding, however, is nonrenewable under the current terms of its waiver. There has been movement toward greater state funding, as required under the waiver extension, and greater local funding through the allocation of the county's share of the tobacco settlement to health care, but such developments are not assured. HCHD has been subjected to variable funding over the years and, despite recent increases in the property tax rate that funds it, history suggests that there is no guarantee that that funding stream is secure.

The importance of an adequate level of financing for indigent care is indisputable. However, a comparison of these communities suggests that flexibility in the use of available funds is also critical for the strength of the ambulatory care sector. Much of the funding available for indigent care is directed toward hospitals or based on the level of hospital care provided. Decisions about where to provide care may, therefore, be distorted by the need to ensure that the criteria for qualifying for these funds are met. Often, respondents claimed, qualifying for funds means maintaining

higher-than-desired levels of inpatient care. LACDHS respondents made the point that providing care in a presumably more efficient ambulatory setting reduced system costs, but because non-hospital-based care for this population is not reimbursable under any standard federal program (while the same care provided under emergency conditions at the hospital is reimbursable), this policy reduces system revenues more than it reduces system costs. In general, reimbursement for inpatient indigent care is more reliably funded than that for ambulatory care.

Among the three study communities, Denver Health has the most flexibility in the use of available funds. All of the Denver Health clinics are federally qualified and receive grants for indigent ambulatory care. They have also secured competitive grants for the public health services they provide. The funds that Denver Health receives under its county contract for indigent care are not directly linked to the provision of inpatient services, and the state provides funding for indigent ambulatory care through its contribution to CICP. Moreover, Denver Health has the legal authority to issue debt. Denver Health financial officials are able to consider available funds as earmarked for patient care rather than for hospital care or clinic care, in much the same way they consider staff as treating patients not as treating inpatients or outpatients. While part of Denver Health's flexibility comes from the fact that it is adequately funded, part is also due to the fact that it is freer than HCHD—with its centrally controlled budget—to spend funds as needed for patient care.

Under its waiver, LACDHS has gained a larger overall budget and some flexibility in financing between hospital and ambulatory care. The enhanced federal funds and the associated flexibility are being phased out, however, over the five years of the waiver extension. It is unclear whether the resources needed to continue the current level of ambulatory care access, let alone the level envisioned in the waiver goals, will be available from state and local sources when the waiver ends. System officials are aware that funding community-based care under an open-door eligibility policy has had the effect of identifying a higher level of demand for care than had been previously recognized, the so-called “woodwork effect.” Providing ambulatory care in the community effectively reduces the barriers to access and, while such care may be more efficient on a patient-by-patient basis, the increased volume may entail overall costs that are greater than the system can absorb at current or foreseeable funding levels.

In the three study communities, the level of funding available is a major factor in the strength of the public system. Furthermore, within the public system, funding flexibility is clearly correlated with the strength of the ambulatory care sector. Denver Health has the most flexibility and the strongest ambulatory care sector. LACDHS has increased its commitment to ambulatory care while it has enjoyed the flexibility afforded it under its waiver. HCHD has the most hospital-centric program and the least flexibility in its funding. Whether their success in promoting ambulatory care is due to funding flexibility or whether these systems have sought such funding because of a commitment to ambulatory care is unclear. More critically, HCHD and LACDHS each have a larger service area and consequently a broader patient base than does Denver Health. Whether they could sustain the ambulatory care access offered in Denver Health's more circumscribed service area would be a question of larger county and/or state budget priorities and not just of the orienta-



tion of the public health care system. Broader eligibility in Los Angeles and Houston could require a higher overall allocation to the public system in addition to the larger investment in ambulatory care availability.

## Market Conditions

The market in which each system operates has an enormous influence on its success. Both Los Angeles and Denver exhibit high levels of managed care penetration and the hospital market in all three communities is highly competitive. Los Angeles and Houston are each home to large undocumented populations and resulting high levels of uninsurance. All of these factors are associated with high stress on the safety net (Norton and Lipson 1998). What differs substantially across the three communities is the level of support enjoyed by the public system and the role that the public system plays in the broader health care market.

Denver's health care market has seen substantial consolidation in the past decade among non-safety net providers as managed care has spread rapidly through the metropolitan area (Pollock 1996). In contrast to Houston and Los Angeles, however, there is only one academic medical center and one children's hospital, reducing the usual competition for Medicaid patients. In addition, these hospitals are both part of the consortium sponsoring the public sector Medicaid managed care plan and so must view Denver Health as a partner as much as a competitor. Denver Health moved early to ensure its place in Medicaid managed care by forming this alliance with University Hospital and Children's Hospital. Its ambulatory care clinics represented the bulk of safety net ambulatory care providers in Denver proper, and including the coalition of private safety net clinics in the suburbs in its Medicaid managed care alliance effectively completed the network of safety net providers. The system's current leadership enjoys great local deference, and local political support for the system is strong. Denver Health and its partners have been able to secure the bulk of the Medicaid business in Denver, and Denver Health has local financial support for the uncompensated care load that completes its safety net function.

In contrast, respondents suggested that private hospitals in Houston were willing to support HCHD politically and financially only to the level necessary to ensure its survival and so avoid an influx of demand from the uninsured. The prominent medical centers in Houston have considerable political clout and, because HCHD is subject to local political control, they can effectively control the system's competitive capacity. HCHD's position within the Houston health care sector is, thus, much weaker than is Denver Health's within the Denver health care sector.

The situation in Los Angeles is somewhat different. The academic medical centers are the core of the LACDHS system. As participants in the public system, they do not compete against it. However, they are not dominant enough to deflect other competition. As a result, Medicaid managed care has hit the system hard. Local support, both financial and political, for the system is good, but the larger health care sector neither supports the system (as seen in Denver) nor threatens to undermine it (as in Houston). Los Angeles is a large market and LACDHS is just one of many players.

## Overall Stability of the Systems

The stability of the ambulatory care safety net appears to depend on the strength of the larger safety net and the relative position of the ambulatory care service within that system. The public safety net in Denver is relatively better financed and has better local political support than those in Los Angeles and Houston. Furthermore, within the larger system, Denver Health's ambulatory care safety net is more secure than that of either HCHD or LACDHS. By including ambulatory care in the upper management structure, Denver Health has made an organizational commitment to ambulatory care that HCHD has not made and that is ambiguous in the LACDHS hierarchy despite LACDHS's official policy of enhancing access to ambulatory care.

Denver Health has also demonstrated its fuller commitment to ambulatory care in other ways. Respondents in both Houston and Los Angeles, in contrast to those in Denver, noted that the physician staffs of the clinics were accorded less respect than those of the hospitals. During its 1995 financial crisis, LACDHS's proposed response included closing clinics. While neither HCHD nor Denver Health have had to deal with an equally serious financial threat, it is not certain that they would not respond in a similar fashion. Denver Health's ongoing investment in its clinic system, however, makes clinic closures seem less likely. HCHD's insecure financial position in the last few years has given it little opportunity to invest in its clinics, but neither has it threatened to close them.

The companion study of hospitals in the study communities found that local financial support and the size of the uninsured population were important determinants of safety net hospital success. Local funding is particularly important for ambulatory care because it generally comes with fewer restrictions on its use than do federal funds. The effect of the size of the uninsured population also plays out differently in the ambulatory care sector.

Denver Health also enjoys more secure funding and greater flexibility in its financing than does HCHD, both because of the source of the financing and because of its independence from local government. Significantly, Denver Health has chosen to use that flexibility to support ambulatory care. LACDHS gained a similar flexibility under its waiver program and has also been able to devote greater resources to ambulatory care. It has not, however, been successful in making the changes in its hospital system envisioned under the waiver program that would allow it to sustain its ambulatory care focus once federal funding is withdrawn. In the HCHD system, respondents did not foresee greater proportions of the budget being devoted to ambulatory care in the future. Because of its precarious financial position in recent years and its resulting inability to forgo revenues available as a function of inpatient admissions, HCHD has not been able to shift its emphasis and investment to the ambulatory care sector. In HCHD's situation, financial security and flexibility go hand in hand.

Public systems can effectively control demand for ambulatory services by adjusting eligibility standards or the number of ambulatory care sites. Hospitals are subject to federal and local regulations that limit their ability to turn away patients so that, without closing their emergency departments, they are unable to limit access. Den-



ver Health's ability to limit its service area and control the size of its eligible population contributes significantly to the relatively smooth functioning of its system. It benefits from the fact that its county boundaries exclude its suburbs and so it has a geographically delimited service area. In contrast, Los Angeles County encompasses both city and suburbs, giving LACDHS a large service area with a diverse population. LACDHS's decision to offer broad access to its services has led to growing demand for its services, and whether LACDHS will be able to sustain this policy remains an open question. Harris County also represents a large service area, and HCHD has tried to limit demand for its services primarily through its policy on serving the undocumented. However, because the larger system remains responsible for these patients, the cost savings have been elusive.

All three systems have been deeply affected by the coming of managed care to Medicaid. The ability of the safety net to adjust to the changing health care marketplace is one indicator of its long-term stability. This ability is also, however, a reflection of the strength of the components of the safety net—ambulatory care, public health, specialty care, and inpatient care—and of their ability to communicate and coordinate with each other.

Denver Health respondents noted that managing care makes sense whatever reimbursement system is in place. Its strong network and the agility afforded it by its independence from local government allowed Denver Health to capitalize on its historical position as provider for the Medicaid population. Cost-based reimbursement for safety net ambulatory care providers under Colorado's Medicaid managed care program contributed to Denver Health's ability to maintain its position. Denver Health's decision to obtain FQHC status for its clinics has allowed it to take advantage of this preferential reimbursement. LACDHS and HCHD have not taken this step. The major source of Denver Health's success in managed care, however, is its integrated network with linkages among the various sites of care. Its investment in information technology to streamline those connections has enhanced its ability both to manage care and to claim reimbursement. As noted in Brennan et al. (forthcoming), Medicaid managed care presented the safety net systems with both problems and opportunities. While not immune to the problems, the strength of Denver Health's ambulatory care network has allowed it to make the most of the opportunity.

The reorganization that LACDHS is undertaking as part of its waiver program is moving in a direction similar to that of Denver Health. Because LACDHS reacted slowly in a highly competitive, Medicaid managed care arena, however, it may not achieve the same measure of success. Nevertheless, the reorganization will result in a stronger system if it can be sustained once federal funding is withdrawn, leaving it better positioned for future developments in the health care marketplace. HCHD, on the other hand, faces governance, financing, and staffing issues that will need to be resolved if it is to respond successfully to changes in the broader health care sector.

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## Conclusion

In summary, Denver Health is currently well funded, well organized, and well led. It enjoys substantial local political support and independence. As a system, it operates as an equal player in a highly competitive market; within the system, the status of ambulatory care is equal to that of other Denver Health services. Denver Health has used these assets to put together a successful integrated system to serve a defined population. Los Angeles has some of these assets; Houston has fewer.

Given the varying degree of success seen in the three systems, the question arises as to which component or combination of components is critical to the success and long-term stability of the ambulatory care safety net in these communities. Could Denver Health maintain its level of accomplishment if its leadership changed? Would expanding its service area lead to an unsustainable level of demand for its services? Might changes in the local political landscape lead to a reduction in its critical local financial support? The problems faced by LACDHS and HCHD suggest these questions, but provide few answers.

A successful safety net system mirrors a successful private system. The degree to which financial and organizational flexibility and managerial agility can be combined with the mission of public service under the constraints of public financing appears to be key to a successful public safety net. A strong ambulatory care system within the safety net is then the result of decisions based on the interests of both patient care and long-term institutional survival.





# **Appendix—List of People Interviewed**

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## **HOUSTON, TEXAS**

### ***Harris County Hospital District***

Bill Adams, Interim Chief Executive Officer  
Alicia Reyes, Senior Vice President, Community Health Program  
Ora Roberts, Director, Settegast Health Center

### ***Harris County Health Department***

Thomas Hyslop, M.D., Director  
Binh Nguyen, Health Services Areas Administrator  
Carol Pierson, Health Service Area Manager, Southeast Health Center

### ***City Health Department***

Marty Engel, Assistant Director, Community and Personal Health Services  
Judy Harris, Clinic Operations  
Donna Travis, Riverside Clinic  
Antonia Stewart, Casa de Amigos, Northside  
Hazel Thorpe, Lowndes Clinic  
Deborah Duncan, Sunnyside Clinic  
Michael Robertson, Westwood Clinic  
Leo Venegas, Magnolia Clinic

### ***Harris County Administration***

Rebecca Rentz, Policy Director, Health and Environment

### ***Casa Juan Diego and Casa Maria Clinics***

Mark and Louise Zwick, Directors

### ***San Jose Clinic***

Gilda Taylor, Interim Executive Director

### ***Policy Experts***

Charles Begley, Professor, University of Texas, School of Public Health

Cliff Dasco, M.D., Vice Chair for Clinical Affairs, Department of Internal  
Medicine, Baylor College of Medicine

Hardy Loe, Associate Dean and Associate Professor, University of Texas School of  
Public Health

Julie Ann Sakowski, Professor, Texas Women's University

### ***Advocates***

Barbara Lashley, Director of Advocacy, Christ of Good Shepherd Church

Pat Macy and Cathy Doran, Department of Social Ministry, Christ of Good  
Shepherd Church

Gail Bray and Karen Williams, Episcopal Health Charities

Melba Johnson, Chairperson, Council at Large (Consumers) for HCHD  
Community Clinics

Sheila Savannah, People in Partnership

## **DENVER, COLORADO**

### ***Denver Health***

Patricia Gabow, M.D., Chief Executive Officer and Medical Director

Richard Wright, M.D., Executive Director, Community Health Services

Michael Earnest, M.D., Vice President, Quality Improvement

Sheri Eisert, Director of Health Services Research

Frederick Morefield, Information Systems

Douglas Clinkscales, Chief Executive Officer, Denver Health Medical Plan

### ***University Hospital***

Dennis Brimhall, Chief Executive Officer

### ***Inner City Health Center***

Kraig Burleson, Business Manager

### ***Clinica Campesina***

Peter Leibig, Director

### ***Metropolitan Denver Community Provider Network***

Dave Meyers, Director

### ***Salud Family Health Center***

Stanley "Jerry" Brasher, Executive Director

Mary Ann Martinez-Gofigan, Director of Client Services  
John Santistevan, Director of Accounting and Finance

***Colorado Access***

Don Hall, President and Chief Executive Officer  
Sherry Rohfling, Vice President of Market Development

***Colorado Community Health Network***

Annette Kowal, Executive Director

***Advocates***

Gary Van Der Arck, M.D., and Chet Seward, Coalition for the Medically  
Underserved

**LOS ANGELES, CALIFORNIA**

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

Mark Finucane, Director  
Maria Elena Sanchez, Director of Ambulatory Care  
Renee Santiago, Director, Medicaid Demonstration Project Office  
Jonathan Fielding, M.D., Director of Public Health  
Roberto Rodriguez, Executive Director, LAC+USC Medical Center  
Zina Glodney, Chief Information Officer  
Kathy Shibata, Information Technology  
Gary Wells, Director of Finance  
Jeff Guterman, M.D., Associate Medical Director, Olive View Medical Center  
Carolyn Clark, Director, H. Claude Hudson Community Health Center  
Edna Briggs, Associate Director, H. Claude Hudson Community Health Center

***Community Health Foundation of East Los Angeles***

Rudy Diaz, Executive Director

***Hollywood Sunset Free Clinic***

Teresa Padua, Executive Director  
Terry Sanders, Physician Assistant  
Celia Garza, Medical Technician  
Virginia Halstead, Clinic Administrator

***T.H.E. Clinic***

Sylvia Drew Ivie, Executive Director

***Community Clinic Association of Los Angeles County***

Mandy Johnson, Executive Director



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## Notes

1. The other *Assessing the New Federalism* (ANF) states are Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Washington, and Wisconsin. For more information on the *Assessing the New Federalism* project, see Kondratas, Weil, and Goldstein (1998). Reports produced under the project and a public use data file from the household survey are available on the ANF Web site at <http://newfederalism.urban.org>.
2. For more information on the health care system in Houston, see Wiener et al. (1997), Meyer et al. (1999), and Norton and Lipson (1998).
3. Zuckerman et al. (1999).
4. Gold Card eligibility is currently set at 200 percent of the federal poverty level (FPL). Applicants must show proof of county residency.
5. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that all hospitals that participate in the Medicare program, which includes almost all hospitals, provide an appropriate medical screening exam to anyone coming to the emergency department seeking medical care and treat and stabilize any emergency medical condition.
6. The percentage of the budget derived from taxes rose in 1999 and was projected to rise again in 2000.
7. The Disproportionate Share Hospital (DSH) program is funded through Medicaid and provides additional funds to hospitals that serve a disproportionate share of Medicaid and uninsured patients. The allocation of DSH funds is, within certain guidelines, a state prerogative.
8. Federally Qualified Health Centers are community clinics that meet specific service and governance criteria and receive federal grant funding from the Bureau of Primary Health Care under Section 330 of the Public Health Service Act. They provide primary and preventive health care services in medically underserved areas.
9. Property values have risen in recent years, a fact that county officials asserted offsets the lower rates to some degree.
10. At the time of our visit, consideration was being given to raising property tax rates to a level that was expected to bring HCHD funding from this source back to nearly the level it had enjoyed before the cuts. Although the actual rate would be lower than before, property values were said to have risen sufficiently to make up the difference (AHL 1999). Furthermore, a change in the way that services for prisoners were financed would mean that HCHD's expenses would be lower.
11. For more information on the health care system in Denver, see Moon et al. (1998) and Norton and Lipson (1998).
12. For more information on Denver Health, see Gabow (1997).
13. For more information on the health care system in Los Angeles, see Zuckerman et al. (1998).
14. Private physician groups may also participate as private partners.

15. Under colocation, both a private and a public clinic provide services from a public Health Center site.
16. See Zuckerman et al. (1998) for a discussion of realignment.
17. Calculations based on data from the Department Operating Budget, *FY 97/98 Medicaid Demonstration Project Annual Report*.
18. The state has a supplemental DSH-like program, commonly referred to as the “1255” program. LACDHS revenues from this program have grown substantially over the last five years, nearly matching the decline in federal DSH funds.
19. See, for example, Lewin and Altman (2000).
20. Since our site visit, a new system CEO has been named and change has begun.

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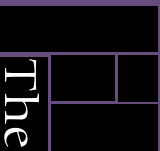
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