California Health Care Foundation

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Regional Market Report 2026: Los Angeles

California Health Care Almanac
Regional Markets Series

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Los Angeles: Massive, Fragmented Health Care Safety Net Braces for Impact

Summary of Findings

Vast and complex, the Los Angeles County health care market balances the needs of nearly 9.8 million people — almost half covered by Medi-Cal — in a fragmented ecosystem anchored by a resilient safety net. The Los Angeles County Department of Health Services (LA Health Services) operates four public hospitals and a countywide network of 23 clinics and provided 2.9 million patient visits in 2025.[1] In addition, a strong cadre of community health centers (CHCs) provides care, mostly to people with low incomes, at nearly 300 sites across the county. In recent years, state-funded Medi-Cal expansions have extended coverage to hundreds of thousands of Los Angeles residents, but federal Medicaid cuts and state budget shortfalls threaten coverage gains not only for people who are undocumented and other immigrants but also for many low- and middle-income residents.

Other than LA Health Services and a network of CHCs, only one health system — Kaiser Permanente, a nonprofit integrated delivery system with a health plan, hospitals, and employed physicians serving primarily commercial and Medicare patients — has a countywide footprint. Scores of other hospitals, health systems, and large physician organizations tend to serve distinct geographic submarkets in a county about three times the size of Rhode Island and over eight times the population.

Given the county's diversity and size, characterizing Los Angeles at the county level masks huge variation in population characteristics and health indicators, with more affluent areas tending to report better health. Nonetheless, the county performs remarkably well on some overall public health indicators, including a lower suicide rate and fewer drug-related deaths per capita than statewide.

Los Angeles has experienced a number of changes since the previous study in 2020–21 (see page 28 for more information about the Regional Markets Study).[2] Key developments include the following:

- **Coverage gains of recent years are under threat in the face of federal and state cutbacks.** Federal House Resolution 1 (HR 1), also known as the One Big Beautiful Bill Act, is expected to hit Los Angeles hard, resulting in reduced Medi-Cal enrollment and more uninsured people. Reduced availability of premium subsidies for people enrolled in Covered California, the state's health insurance marketplace, will compound the problem. At the same time, state budget shortfalls prompted a Medi-Cal enrollment freeze statewide for undocumented adults and others with unsatisfactory immigration status (UIS), which will disproportionately affect the county.
- **The hospital market has seen some acquisition activity and ownership changes but remains fragmented.**

Only two health systems — Kaiser and Cedars-Sinai — each account for more than 10% of inpatient discharges from acute care hospitals in Los Angeles County, and the largest eight health systems by number of beds collectively account for less than 60% of discharges. By comparison, the Bay Area hospital market is significantly more concentrated. Hospital acquisitions in Los Angeles, including those by UCLA Health and Adventist Health, have typically involved one or two independent hospitals rather than systems.

- **Grappling with growing costs, hospitals report varying degrees of financial health.** Hospitals in more affluent areas of the county have experienced healthy financial margins in recent years, while those in poorer, underserved areas report intensifying financial pressures. For example, Kaiser, Prime Healthcare, and Cedars-Sinai all had net income margins at or above 5% in 2023. At the same time, Martin Luther King Jr. Community Hospital received assistance through the state's Distressed Hospital Loan Fund, and Beverly Hospital went bankrupt. More recently, some hospitals reported they are examining service lines with an eye toward cutting unprofitable services, including emergency departments (EDs).

- **Risk-bearing physician organizations continue to play a major role in Los Angeles, with ongoing consolidation and growth in corporate ownership.** Optum Health, a subsidiary of publicly traded UnitedHealth Group, has shifted from acquiring to integrating physician practices across Southern California; Astrana, also publicly traded, grew significantly with the acquisition of Community Family Care Medical Group and Prospect Medical Group; and Altais, a for-profit offshoot of Blue Shield of California, entered the Los Angeles market. Anchored by a network of over 30 CHCs, a nonprofit independent practice association (IPA) — Health Care LA IPA — accepts professional risk for about 730,000 patients, almost all covered by Medi-Cal. Similarly, AltaMed, the largest CHC in Los Angeles, launched AltaMed Health Network in 2020 to accept financial risk for both professional and facility services in the Medi-Cal market and has grown enrollment significantly in recent years.

- **CHCs have grown in scale and scope and play a major role in supporting the county's large homeless population with medical care and housing.** CHCs, most of which are designated as Federally Qualified Health Centers (FQHCs), have long been central to ensuring access to care for Medi-Cal members and the uninsured, and their role has expanded over time. Several large CHCs have created street medicine teams that visit encampments and set up clinics at homeless services hubs. Some CHCs operate recuperative care sites with temporary housing to facilitate appropriate discharge of people from an inpatient setting who need a safe place to recover.

- **County government plays a critical role in the safety net, with responsibility for physical health, mental health, and substance use treatment divided across three departments.** LA Health Services operates an integrated delivery system of hospitals and clinics serving Medi-Cal and uninsured patients. The Department of Mental Health runs the County Mental Health Plan, providing specialty mental health services, while a bureau within the Department of Public Health provides a continuum of specialty substance use disorder (SUD) services. Collectively, these three county entities provide services to hundreds of thousands of Angelenos. Respondents noted that coordination and collaboration among the three is an ongoing challenge.

Market Background

With nearly 9.8 million residents, Los Angeles County is the nation's most populous county and home to almost a quarter of California's population (Table 1). The county includes 88 cities — the largest is the city of Los Angeles with about 3.8

million people — yet almost two-thirds of the county's 4,070 square miles remain unincorporated.[3] The county includes a coastal plain surrounded by mountain chains filled with valleys and canyons. While portions of the county include sparsely populated desert, the region is one of the most densely populated urbanized areas in the country. Among the largest manufacturing centers in the US by employment, Los Angeles County also is home to the nation's busiest port complex. Key drivers of the local economy include international trade, entertainment, aerospace, and tourism, along with high-tech industries, finance, telecommunications, health care, and education.[4]

Between 2019 and 2024, Los Angeles County's population declined (-2.8%) more than the state overall (-0.2%). The county is among the most racially and ethnically diverse regions in the country. A near majority (48.6%) of residents identify as Latino/x, followed by 25.3% who identify as White, 15.4% as Asian, and 8.0% as Black. The county has a higher proportion of foreign-born residents than the state overall — 33.5% versus 27.3%, respectively — and the highest among the seven study sites. County residents generally have lower incomes and less formal education and are slightly more likely to experience unemployment compared with residents elsewhere in the state. About 1 in 7 county residents live in households earning below 100% of the federal poverty level, or $30,000 for a family of four in 2023,[5] compared to 1 in 8 statewide.

Mirroring California overall, housing affordability remains a major issue; only 12.6% of county households can afford a median-priced home, compared with 13.6% statewide (also a very low number). Despite housing affordability challenges, the Los Angeles Homeless Services Authority reported a 4% drop in people experiencing homelessness from 2024 to 2025, with an estimated 72,308 people experiencing homelessness countywide, including 43,699 people in the city of Los Angeles.[6] However, recent research by RAND estimates that the 2025 official county homeless count may have missed up to 7,900 people living on the streets.[7] In November 2024, a half-cent countywide sales tax (Measure A) was approved by voters to fund homelessness and housing programs, doubling the previous revenue stream. The first spending package was approved in March 2025, totaling $908 million.[8] In January 2026, Los Angeles County launched a new Department of Homeless Services

TABLE 1. Population Characteristics,
Los Angeles vs. California, 2023 Unless Noted

	Los Angeles	California
POPULATION STATISTICS		
Total population (2024)	9,757,179	39,431,263
Share of state population	24.7%	100%
Five-year population growth	-2.8%	-0.2%
AGE OF POPULATION, IN YEARS		
Under 18	20.2%	21.7%
18 to 64	64.1%	62.1%
65 and older	15.7%	16.2%
RACE/ETHNICITY		
Latino/x	48.6%	40.4%
White (non-Latino/x)	25.3%	34.3%
Black (non-Latino/x)	8.0%	5.6%
Asian (non-Latino/x)	15.4%	15.8%
Other (non-Latino/x)	2.8%	3.8%
BIRTHPLACE		
Outside the United States	33.5%	27.3%
EDUCATION (AGE 25 AND OLDER)		
High school diploma or higher	80.7%	84.6%
College bachelor's degree or higher	35.5%	36.5%
ECONOMIC INDICATORS		
Income below 100% federal poverty level	13.7%	12.0%
Household income $100,000+ (%)	44.3%	48.4%
Median household income*	$87,760	$96,334
Average (mean) household income	$125,539	$136,730
Unemployment rate	5.0%	4.8%
Households able to afford median-priced home (2024)	12.6%	13.6%

* A weighted blend of county-level median household income figures.

Sources: *Annual Estimates of the Resident Population for Counties in the United States, April 1, 2020 to July 1, 2024* (CO-EST2024-POP), *County Population by Characteristics: 2020–2023* (CC-EST2023-ALLDATA-06 and CC-EST2023-AGESEX-06), *Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019* (CO-EST2019-ANNRES-06), "US Census, American Community Survey (ACS) 1-Year Supplemental Estimates, K200503, Place of Birth in the United States" (2019 and 2023), "ACS 5-Year Estimates Subject Tables, S1501, 2023, Educational Attainment by County" (2023), "US Census, ACS 5-Year Estimates Subject Tables, S1901, Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars), 2023 and (in 2019 Inflation-Adjusted Dollars), 2019," US Census Bureau; "Current Industry Employment and Unemployment Rates for Counties," California Employment Development Department; and "Housing Affordability Index – Traditional" (Q2 2024), California Association of Realtors.

and Housing, combining housing, health, and social services to consolidate the county's response to homelessness.[9]

Mixed Physical and Behavioral Health Indicators

Los Angeles County residents are more likely to report being in fair or poor health than Californians overall — 16.5% versus 15.5%, respectively (Table 2). However, the infant mortality rate is lower in Los Angeles County than statewide — 3.9 deaths per 1,000 live births compared to 4.1 statewide. Moreover, across the seven study sites, Los Angeles has the lowest rate of drug-related ED visits at 109.4 visits per 100,000 population, markedly lower than the statewide number of 137.4. Similarly, Los Angeles County has a lower number of drug overdose deaths than statewide — 23.4 deaths per 100,000 population versus 29.1 statewide. The county also has the distinction of the lowest suicide rate across the seven sites — 8.0 suicides per 100,000 population versus 10.1 statewide.

Dramatic Variation in Economic and Health Indicators Across Los Angeles

Given the county's diversity and size, characterizing Los Angeles at the county level masks huge variation in population characteristics and health indicators. To target services to local needs, the county Department of Public Health divides the county into eight subregions, known as service planning areas (SPAs), which vary dramatically in terms of geography, demographics, socioeconomics, health status, and access to health care (see Figure 1).[10] Los Angeles County includes densely populated urban areas (Metro, South, East, and South Bay), the affluent coastal area (West), large suburban areas (San Fernando Valley and San Gabriel Valley), and vast desert areas to the north (Antelope Valley). Table 3 illustrates the stark variation in economic and health care indicators within Los Angeles County by highlighting the Antelope Valley, Metro, West, and South SPAs. Variation in income is particularly pronounced, with nearly half of households in the West (45.5%) earning more than $135,000, compared with less than 1 in 10 in the South (7.6%). Health indicators also diverge sharply across the county, with residents in lower-income areas reporting chronic conditions like diabetes at more than twice the rate of those in more affluent areas. Interestingly, access to care as measured by ability to always or usually get a doctor's appointment within two days (among those with health insurance and/or a usual source of care, seeking an appointment due to sickness or injury) was better in less affluent areas. For example, 42% of South residents and 48.7% of Antelope Valley residents reported being able to get a timely doctor's appointment compared to 39.6% of West residents.

TABLE 2. Health Status,
Los Angeles vs. California, 2023 Unless Noted

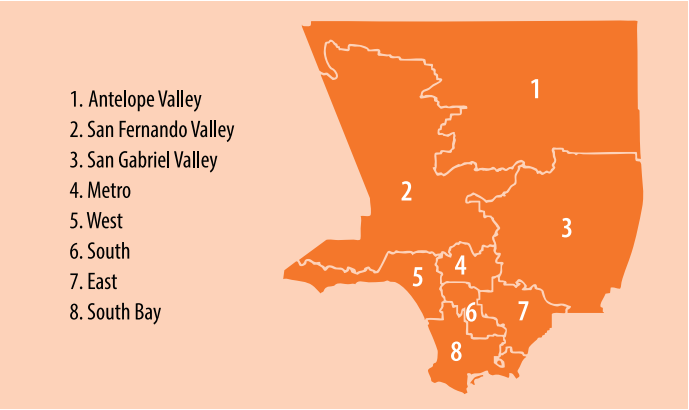
	Los Angeles	California
PHYSICAL HEALTH		
Fair/poor	16.5%	15.5%
Adults with an independent living difficulty*	5.9%	5.8%
Diabetes prevalence†	11.9%	11.3%
High blood pressure prevalence†	20.9%	21.9%
Infant mortality rate (deaths per 1,000 live births), 2019–21	3.9	4.1
BEHAVIORAL HEALTH		
Anxiety prevalence†	9.5%	10.3%
Depression, bipolar, or other depressive mood disorders prevalence†	10.1%	10.5%
Opioid or other drug-related emergency department visits (per 100,000 population)	109.4	137.4
All drug-related overdose deaths (per 100,000 population)	23.4	29.1
Suicide deaths (per 100,000 population), 2020–22, age-adjusted	8.0	10.1

* An independent living difficulty refers to, for example, difficulty doing errands alone, visiting a doctor's office, or shopping because of a physical, mental, or emotional condition.

† Prevalence reported from the Healthcare Payments Data (HPD) source reflects data from claims and encounter records, which capture instances of a condition treated during the specified time. Results may differ from prevalence rates obtained by other methods — for example, surveys or record sampling. HPD reporting of measures data suppresses counts from any group (age, sex, payer, and county-specific) with fewer than 30 people; caution is advised when interpreting results for geographic areas with fewer than 30,000 residents.

Sources: "AskCHIS," UCLA Center for Health Policy Research; "American Community Survey, 2023 5-Year Estimates, S1810, Disability Characteristics," US Census Bureau; "HPD Measures Data (2018–2023)," California Department of Health Care Access and Information; "Infant Mortality," California Department of Public Health (CDPH); "County Health Status Profiles, 2024: Tables 1–29," CDPH, last updated August 8, 2024; and "California Overdose Surveillance Dashboard," CDPH, last updated May 19, 2025.

FIGURE 1. Los Angeles County Service Planning Areas



Source: "What Is a Service Planning Area?," Community Health Services, Los Angeles County Department of Public Health, accessed October 29, 2025.

Health Coverage Sources and Trends

Between 2019 and 2023, the share of Los Angeles residents without health insurance dropped from 9.9% to 7.6%, narrowing the gap with the statewide uninsured rate of 6.4% (Table 4). Almost all of the decrease was due to increased Medi-Cal coverage, which grew from 37.8% of the population in 2019 to 46.1% in 2023 (including those dually eligible for Medicare and Medi-Cal). Although statewide Medi-Cal coverage increased at a similar rate during the same time, the share of the Los Angeles County population with Medi-Cal remained about 5 points higher in 2023. The share of county residents dually eligible for Medicare and Medi-Cal (5.6%) also is higher than statewide (4.5%). However, HR 1 will cut Medicaid spending nationally by more than $900 billion over 10 years starting in 2027, resulting in an estimated 10.3 million people losing Medicaid coverage nationwide.[11] In California, as many as 3.4 million people may lose Medi-Cal coverage, which will in turn reduce health care access and increase household financial burdens.[12]

The greater Los Angeles metro area is home to many immigrants, including almost a million undocumented people.[13] In recent years, state-funded expansion of Medi-Cal coverage for all Californians regardless of immigration status has played a major role in reducing the share of uninsured Los Angeles residents. In 2016, California began expanding

TABLE 3. Selected Indicators,
Los Angeles County Service Planning Areas (SPAs), 2024

Statistic	Antelope Valley (SPA 1)	Metro (SPA 4)	West (SPA 5)	South (SPA 6)	Los Angeles County
Population	414,006	1,101,389	647,061	993,024	9,832,684
Density (population per square mile)*	305	12,020	3,400	14,263	2,396
Below 100% federal poverty level	26.0%	20.6%	11.3%	34.0%	18.2%
Household income > $135,000	17.3%	22.5%	45.5%	7.6%	25.8%
Homeless per 1,000 population†	16.1	16.7	8.3	14.0	7.7
Always or usually get doctor appointment within two days‡	48.7%	50.6%	39.6%	42.0%	46.2%
Excellent or very good health	52.6%	55.1%	71.6%	44.4%	53.6%
Ever diagnosed with diabetes	20.2%	14.1%	7.8%	16.1%	13.9%
Leading cause of premature death (2023)**	Drug overdose	Drug overdose	Drug overdose	Drug overdose	Drug overdose

* Calculations made by Yegian Health Insights using square mileage data from ArcGIS DPH Service Planning Areas (SPA) and population data from *Los Angeles County Population Estimates* (PDF). Sources accessed October 29, 2025.

† Calculations made by Yegian Health Insights using homeless count data from "Homelessness in Los Angeles County," LA Almanac and population data from *Los Angeles County Population Estimates* (PDF). Sources accessed October 29, 2025.

‡ Among adults with insurance or a usual source of care, seeking an appointment due to sickness or injury.

**Data provided by Los Angeles County Department of Public Health Vital Stats Team.

Sources: *Los Angeles County Population Estimates* (PDF), County of Los Angeles Public Health, July 1, 2024; and "AskCHIS," UCLA Center for Health Policy Research.

Medi-Cal eligibility for immigrants by age group, with the final group — adults age 26–49 — added in 2024. However, facing state budget shortfalls, California froze new full-scope Medi-Cal enrollment in January 2026 for adults age 19 and older with UIS, which includes undocumented people and some legal immigrants.[14] Additional changes take effect in July 2026: CHCs will no longer receive prospective payment system rates for visits by patients with UIS, and Medi-Cal dental coverage except for emergency care will end for

adults with UIS. In July 2027, adults with UIS enrolled in Medi-Cal will be required to pay a monthly $30 premium.[15]

Medicare coverage in Los Angeles increased slightly to 10.9% of residents in 2023 but remained lower than the statewide rate of 12.8%. However, commercial health coverage in the county declined slightly to 44.1% in 2023, almost 7 percentage points lower than California overall.

TABLE 4. Sources of Health Insurance,
Los Angeles vs. California, 2019 and 2023

Coverages as Share of Population (Totals > 100%)*	2019		2023	
	Los Angeles	California	Los Angeles	California
Uninsured	9.9%	7.7%	7.6%	6.4%
Medi-Cal and Medicare dually eligible enrollees	4.6%	3.7%	5.6%	4.5%
Medi-Cal (non-dually eligible enrollees)	33.2%	28.6%	40.5%	35.6%
Medicare (non-dually eligible enrollees)	10.3%	12.1%	10.9%	12.8%
Commercial	44.5%	50.6%	44.1%	50.8%

* Percentages may sum to more than 100% due to people being included in more than one category.

Sources: *MA State/County Penetration* (July 2019 and July 2023), US Centers for Medicare & Medicaid Services; "Selected Characteristics of Health Insurance Coverage in the United States, American Community Survey, 1-Year and 5 Year Estimates," US Census Bureau; "By Medicare Dual Status, Certified Eligibles," California Department of Health Care Services; and Katherine Wilson, *California Health Insurers, Enrollment Almanac — 2025 Edition*, California Health Care Foundation, February 2025.

TABLE 5. Covered California Monthly Premiums,
Los Angeles vs. California, 2020 and 2025

Covered California Premiums*	2020		2025	
	Los Angeles	California	Los Angeles	California
Lowest-cost silver monthly premium, 40-year-old	$347	$398	$366	$472
Percentage higher/ lower than California average	-12.8%		-22.4%	
Average annual premium increase, 2020 to 2025			1.1%	3.5%
Per hour wage amount needed to pay monthly premium†	$2.00	$2.29	$2.11	$2.72
Monthly premium as share of state minimum wage, full-time†	15.4%	17.6%	12.8%	16.5%
Percentage of members who receive premium subsidy			86.4%	89.4%
Average net monthly premium paid by those receiving subsidy			$134	$134
Median net monthly premium paid by those receiving subsidy			$63	$57

* California premiums are weighted averages across all Covered California rating regions. Similarly, regional premiums are weighted averages for the counties that make up the region. Weighting is by enrollment.

† Assumes person pays the entire premium (i.e., no subsidy to offset cost).

Sources: *2025 Covered California Data: 2025 Individual Product Prices,* Covered California; *2020 Covered California Data: 2025 Individual Product Prices for All Health Insurance Companies*, Covered California; and Active Member Profiles: June Profile (2020 and 2025), Covered California.

In 2025, the monthly premium for the lowest-cost Covered California silver plan in Los Angeles County was markedly lower ($366) than statewide ($472) for a 40-year-old person, assuming no premium subsidy (Table 5). The average annual Covered California premium increase in Los Angeles between 2020 and 2025 was only 1.1%, while premiums statewide grew 3.5% annually during the same period. Monthly premiums (unsubsidized) in the region consumed $2.11 of an hourly minimum wage and just under 13% of a full-time minimum-wage income in 2025, compared to statewide figures of $2.72 per hour and 16.5% of minimum-wage income. In Los Angeles and statewide, over 85% of Covered California enrollees received a premium subsidy in 2025 that reduced the monthly cost of coverage, bringing the average net monthly premium paid to $134 in Los Angeles as well as statewide. Enhanced federal premium subsidies enacted during the COVID-19 pandemic expired on January 1, 2026, making premiums significantly less affordable for approximately 492,000 Los Angeles residents who had received premium subsidies in 2025.[16]

Targeted Effort Launched by County to Reduce and Prevent Medical Debt

The prevalence of medical debt in Los Angeles County, at 10.6% in 2022–23, increased slightly from 10.1% four years earlier, while the statewide prevalence dropped from 10.8% to 10.2% (Table 6). Among those with medical debt in Los Angeles, 51.5% owed more than $2,000 in 2022–23, up about a percentage point from four years earlier but lower than the share statewide (56.3%).

TABLE 6. Medical Debt,
Los Angeles vs. California, 2018–19 and 2022–23

	2018–19 POOLED*		2022–23 POOLED*	
Medical Debt	Los Angeles	California	Los Angeles	California
Prevalence (% of adults with medical debt)†	10.1%	10.8%	10.6%	10.2%
AMOUNT OF MEDICAL DEBT THEY ARE HAVING TROUBLE PAYING††				
Less than $2,000	49.4%	45.1%	48.5%	43.7%
More than $2,000	50.6%	54.9%	51.5%	56.3%

* Data are pooled across two years to increase data stability; confidence intervals on the amount of debt are broad in multiple regions.

† Prevalence figure is the percentage of people who answered yes to the question "Ever had problems paying for self or household family's medical bills in past 12 months?"

†† The amount of medical debt reflects the responses of those who said they had experienced problems paying medical bills in the past 12 months.

Source: "AskCHIS," UCLA Center for Health Policy Research.

In 2023, the county Department of Public Health launched a major effort, in collaboration with a range of stakeholders, to address medical debt as a systemic health issue and consumer protection problem.[17] The county Board of Supervisors, the publicly run L.A. Care Health Plan (L.A. Care), and the Los Angeles County Medical Association have all contributed funding to purchase and eliminate medical debt; as of December 2025, over $363 million in medical debt had been eliminated for more than 170,000 residents. The effort created recommendations and model documents, such as a financial assistance policy and application form that hospitals can adopt, along with tools to prescreen patients to see if they qualify for financial assistance. A new county ordinance requires acute care hospitals to report on financial assistance operations and debt collection activities to the Department of Public Health, using standardized templates to increase comparability and public reporting of the results.

Medicare Advantage Continues to Grow but Outlook Is Uncertain

Over 1.6 million Los Angeles residents are Medicare enrollees, representing about a quarter of statewide Medicare enrollment (Table 7). A slightly smaller share of the Los Angeles population is enrolled in Medicare than Californians overall — 16.8% versus 17.5% in 2024 — reflecting the county's younger population. The share of Medicare enrollees in Los Angeles enrolled in private Medicare Advantage (MA) health plans increased substantially between 2019 (50.7%) and 2024 (56.2%). MA plan enrollment grew statewide as well, reaching 51.2% in 2024.

TABLE 7. Medicare Enrollment Overview,
Los Angeles vs. California, 2019 and 2024

	LOS ANGELES		CALIFORNIA	
	2019	2024	2019	2024
Total Medicare enrollment	1,488,377	1,636,212	6,239,477	6,899,496
Medicare as share of population	14.8%	16.8%	15.8%	17.5%
SHARE OF TOTAL MEDICARE				
Medicare Advantage (MA)	50.7%	56.2%	44.1%	51.2%
Original Medicare	49.3%	43.8%	55.9%	48.8%

Source: *MA State/County Penetration* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

As shown in Table 8, Kaiser has the largest MA market share by a wide margin at 35%, followed by SCAN Health Plan with 12%; all other plans have market share under 10%. Blue Cross of California Partnership Plan entered the market and gained 7% market share; other major plans gained or lost a percentage point but largely remained stable. Industry respondents reported that MA is less lucrative as a product line than it has been historically. The federal Centers for Medicare & Medicaid Services proposed a 0.09% payment increase for MA plans in 2027, though it was revised upward to 2.48% in the final announcement.[18] Some health systems are moving away from accepting inpatient risk for MA products, historically a major feature of MA plans, or are dropping MA contracts altogether.[19] But not all providers are bearish on MA: UCLA Health is among the health systems across the country launching MA plans.[20] UCLA Health's new plan, New Century Health Plan, has a full (unrestricted) Knox-Keene license, enabling the plan to enroll members directly rather than going through another health plan, and had 7,065 members in the third quarter of 2025.[21] UCLA Health is the first UC system to launch an MA plan, and others may follow suit if it proves financially successful. One cautionary tale:

The US Department of Justice has sued several MA plans for alleged fraud related to inappropriate coding practices designed to increase payments; Kaiser Permanente settled a lawsuit for $556 million in January 2026 that included Southern California Permanente Medical Group.[22]

TABLE 8. Largest Medicare Advantage (MA) Health Plans and Market Share,
Los Angeles, 2019 and 2024

Health Plan	2019	2024
Kaiser Foundation Health Plan	36%	35%
SCAN Health Plan	11%	12%
UnitedHealthcare of California	10%	9%
Blue Cross of California Partnership Plan	0%	7%
California Physicians' Service (Blue Shield of California)	4%	5%

Source: *Monthly MA Enrollment by State/County/Contract* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

Coverage options for people dually eligible for Medicare and Medicaid in Los Angeles have changed in recent years in response to a California Department of Health Care Services (DHCS) mandate requiring all Medi-Cal managed care plans to offer an MA Exclusively Aligned Enrollment Dual Eligible Special Needs Plan (EAE D-SNP) product, known as a "Medi-Medi plan" in California. People eligible for both Medicare and Medi-Cal can decide whether to enroll in a D-SNP, enroll in another MA plan, or to stay in original Medicare. If they decide to enroll in an EAE D-SNP, the state automatically enrolls the enrollee into the same Medi-Cal plan to align Medicare and Medi-Cal coverage. A key feature of the DHCS policy change is that among D-SNPs, only the EAE D-SNPs can enroll new members. Commercial plans that offer non-aligned D-SNP products cannot enroll new members in those products (though they can enroll dually eligible people into other MA products).

Medi-Cal Managed Care in Los Angeles: Large-Scale Complexity

In 2024, about 4.1 million Los Angeles residents were enrolled in Medi-Cal — just under 28% of the 14.8 million Medi-Cal enrollees statewide and an increase of about 300,000 members since 2019 (Table 9). Almost all Medi-Cal enrollees (94%) were in managed care plans in 2024, both in Los Angeles and statewide.

TABLE 9. Medi-Cal Enrollment Overview,
Los Angeles vs. California, 2019 and 2024

	LOS ANGELES		CALIFORNIA	
	2019	2024	2019	2024
Total Medi-Cal enrollment	3,794,850	4,099,892	12,778,575	14,796,389
Medi-Cal as share of population	38%	42%	32%	38%
Share of Medi-Cal in managed care	80%	94%	82%	94%

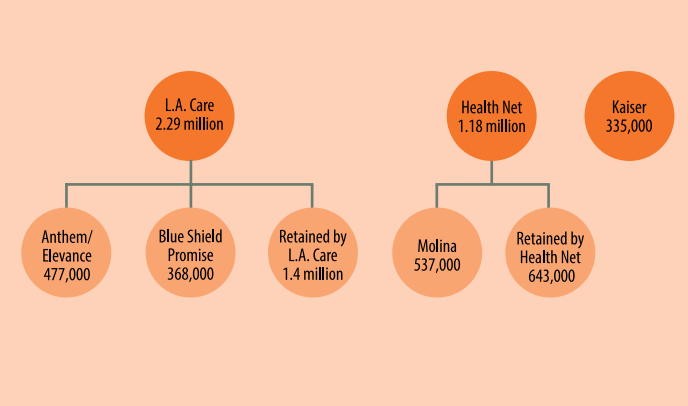
Source: "Certified Eligibles by Delivery System and Plan," California Department of Health Care Services, last updated August 9, 2024.

Los Angeles County operates under the Two-Plan Medi-Cal managed care model, with L.A. Care as the local initiative plan and Health Net as the commercial plan. L.A. Care, the largest publicly operated health plan in the country, is a local public agency created in 1997 and governed by a 13-member board; Health Net is a subsidiary of Centene, the nation's largest publicly traded Medicaid carrier.[23] Both L.A. Care and Health Net have full-risk arrangements with partner health plans but for oversight purposes remain responsible for meeting contractual requirements set by DHCS. Under these plan-to-plan arrangements, the lead plan delegates health plan functions and financial risk for both professional and institutional services to the partner plan(s), retaining a share of the capitated — per-member per-month — payment from DHCS to cover administrative costs. In 2024, L.A. Care had just over 60% of enrollment, Health Net had 30%, and Kaiser had 8%.[24] Historically, Kaiser operated as a plan partner to L.A. Care, accepting delegated enrollment, but a statewide contract between DHCS and Kaiser took effect in 2024, effectively adding Kaiser as a third plan. Despite losing membership to Kaiser during the transition, L.A. Care's enrollment has grown in recent years, in part due to expansion of Medi-Cal benefits to undocumented residents.

In addition to the statewide direct contract between DHCS and Kaiser, Los Angeles County has seen significant shifts in Medi-Cal plan participation since the previous study. The DHCS effort to reprocure commercial plan participation in Medi-Cal in 2022 resulted in awards that were challenged by several plans, leading to the cancellation of the planned contracts and announcement of new awards.[25] In Los Angeles, Molina was awarded the initial contract, replacing Health Net; ultimately, Health Net retained its contract with DHCS for Los Angeles but is required to split its enrollment evenly with Molina. Even without the primary contract award, Molina's enrollment increased dramatically — from 80,000 to over 500,000 members. The abrupt increase has reportedly led to some turmoil for providers and members.

Although several Medi-Cal managed care plans elsewhere in California have plan-to-plan contracts with delegated risk-based arrangements, the scale and complexity are greater in Los Angeles. As shown in Figure 2, in 2025, L.A. Care had 2.29 million Medi-Cal members, with 477,000 (21%) delegated to Anthem/Elevance and 368,000 (16%) delegated to Blue Shield Promise. Health Net had 1.18 million Medi-Cal members, with 537,000 (46%) delegated to Molina. Kaiser had 335,000 Medi-Cal members. In Los Angeles County, Medi-Cal managed care enrollees can select from five options — the two lead plans and their three delegated plan partners. Kaiser restricts Medi-Cal enrollment to current members who change their source of coverage to Medi-Cal or family members of current enrollees, though any foster youth or dually eligible members residing in Kaiser's footprint are allowed to enroll in the plan.[26]

FIGURE 2. Medi-Cal Managed Care Health Plans and Delegated Plan Partners,
Los Angeles County, 2025



SOURCES: Author compilation of data from L.A. Care, Health Net, and Molina, November and December 2025; and (for Kaiser) "Medi-Cal Managed Care Enrollment Report (MMCE), data through December 2025," California Department of Health Care Services, accessed 1/28/2026.

Risk-Based Provider Payment Arrangements in Medi-Cal

Full-risk provider payment arrangements are a major feature of the Los Angeles Medi-Cal market. LA Health Services continues to take full risk for Medi-Cal patients, providing care through its integrated network of public hospitals and clinics. In late 2025, LA Health Services had 366,000 full-risk patients — primarily from L.A. Care, with additional patients from Health Net and Molina. AltaMed now has a restricted Knox-Keene license from the state (AltaMed Health Network) and several full-risk plan-to-plan contracts with Medi-Cal managed care plans. According to the Department of Managed Health Care (DMHC) Health Plan Dashboard, AltaMed Health Network had 348,545 enrollees in Los Angeles in Q4 2025.[27] Community Family Care Health Plan, now managed by Astrana, and Heritage Provider Network, a major player across Southern California, each accepts full risk for over 240,000 lives in the region.

In addition to provider organizations taking full risk, many Medi-Cal managed care contracts are structured as "dual risk," with IPAs taking financial risk for physician professional services and hospitals taking financial risk for facility or institutional services. Multiple safety-net facilities in Los Angeles have built the infrastructure and capabilities to

accept risk, including Valley Presbyterian and California Medical Center. While a large majority of Medi-Cal membership is delegated to IPAs and medical groups, L.A. Care contracts directly with providers to care for over 50,000 members, primarily in the Antelope Valley area where there are fewer medical group partners.

Health Care LA IPA Supports CHCs in Serving Medi-Cal

Many CHCs in Los Angeles County belong to Health Care LA IPA (HCLA), a nonprofit established in 1991. HCLA's network includes more than 30 CHCs with over 160 practice locations and 24 hospital partners, serving 730,000 people. Most (92%) are covered by Medi-Cal, with Covered California (5%) and dually eligible Medicare and Medicaid patients accounting for the rest. HCLA negotiates professional risk contracts with health plans on behalf of the CHCs and contracts with specialists to ensure the full range of services is available to patients and to meet network adequacy requirements. The IPA also supports CHCs with data analytics and performance reporting to health plans, identifying high-priority care gaps and conducting patient outreach and scheduling in collaboration with the CHCs. HCLA coordinates closely with management services organization MedPOINT, which handles core tasks such as claims payment and utilization management, to support the CHCs.

Hospital Market Remains Fragmented

With 80 hospitals and more than 850,000 inpatient discharges in 2023, the hospital sector reflects the vast scale of Los Angeles County (Table 10). Relative to the state overall, Los Angeles has more beds per capita, and both average operating expenses per adjusted patient day and net income margin are somewhat lower than statewide.

Of the 80 hospitals, four are run by the county, one is a district hospital (Antelope Valley Hospital), 46 are nonprofit, and 29 are investor owned. Of the investor-owned facilities, 10 are owned by private equity firms.[28] Five of those hospitals are owned and operated by ScionHealth, which is controlled by private equity firm Apollo Global Management.[29] Another four hospitals, all safety-net hospitals, are operated by private equity–backed Pipeline Health, which entered into a sale-leaseback agreement in 2021 with Medical Properties Trust, a large real estate investment trust.[30] About 13% of private hospitals (investor-owned and nonprofit) in Los Angeles are owned or operated by private equity firms, more than twice the statewide rate of approximately 6%. Previous research has shown that private equity "acquisitions have been associated with higher prices, increased consolidation, and mixed to worse clinical outcomes for patient populations."[31]

TABLE 10. Acute Care Hospitals Overview,
Los Angeles vs. California, 2023

Acute Care Hospitals	Los Angeles	California
Number of facilities	80	334
Beds (available) per 100,000	233	198
Number of discharges	864,977	3,148,191
Net income margin	4.0%	4.5%
Operating expenses per adjusted patient day	$5,012	$5,117

Notes: Net income margin is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. Operating expenses per adjusted patient day equal total gross patient revenue divided by gross inpatient revenue times the number of inpatient days.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

While some hospital consolidation has occurred in Los Angeles in recent years, the sector remains relatively fragmented, with the top six health systems accounting for half of all discharges in 2023, about the same as in 2018.[32] As shown in Table 11, only two health systems — Kaiser and Cedars-Sinai — each accounted for more than 10% of acute care hospital discharges in Los Angeles in 2023, and the eight largest health systems by number of beds collectively accounted for less than 60% of discharges. In the more concentrated Bay Area hospital market, the four largest health systems accounted for 73% of discharges in 2023,[33] compared to 39% for the four largest Los Angeles systems.

TABLE 11. Largest Acute Care Hospital Systems, by Number of Beds,
Los Angeles, 2023

Hospital System	Hospitals in System	Available Beds	Occupancy (Available Beds)	Share of Discharges in Region	DISTRIBUTION OF DISCHARGES BY PAYER TYPE			Net Income Margin	Current Ratio	Operating Expenses per Adjusted Patient Day
					Medicare	Medi-Cal	Commercial			
Kaiser Foundation Hospitals	7	2,269	54%	11%	45%	10%	45%	5%	n/a	$5,095
Cedars-Sinai Health System	4	1,985	79%	12%	48%	13%	37%	8%	2.6	$6,389
Providence St. Joseph Health	6	1,819	65%	9%	48%	24%	26%	-12%	1.7	$4,358
LA Health Services (County of Los Angeles)	4	1,535	67%	7%	15%	65%	7%	N/A	1.7	N/A
Dignity Health	4	1,304	57%	6%	33%	52%	13%	1%	2.1	$4,577
Adventist Health Systems	3	1,153	55%	5%	43%	41%	13%	1%	2.3	$3,698
Prime Healthcare Services	5	1,148	50%	4%	43%	46%	8%	11%	3.8	$3,000
PIH Health	3	1,008	54%	5%	53%	27%	19%	1%	1.5	$4,016
All others	44	10,307	63%	41%	39%	42%	18%	0%	1.2	$4,760
Los Angeles	**80**	**22,528**	**62%**	**100%**	**40%**	**35%**	**22%**	**4%**	1.5	$5,012
California	**334**	**77,339**	**64%**	**n/a**	**42%**	**31%**	**25%**	**4%**	1.6	$5,117

Notes: Hospital system designations exist for hospitals with at least three or more associated facilities in California. *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Adjusted patient day* equals total gross patient revenue divided by gross inpatient revenue times the number of inpatient days. *Current ratio* is current assets divided by current liabilities. This ratio shows the dollar amount of current assets per dollar of current liabilities. It is a gross indicator of the facility's liquidity. Usually, a ratio of 2.0 or more indicates a healthy liquidity position. *Distribution of discharges by payer type* may not add to 100% because "Other indigent" and "Other payers" are excluded.

N/A: Not displayed due to concerns about comparability.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

Several respondents noted a growing divide in the financial health of systems, with differing explanations. One said, "Some systems have concentrated where the wealth is. They are positioned in wealthy segments in LA County and are dominant — [and] use that dominance to leverage contract rates." Another said, "Systems that have invested in physician strategy and infrastructure are better situated today, operating busy hospitals that are capturing scale and are at the top of the charts on acuity and quality."

No major systems own hospitals in rural Antelope Valley, the expansive high desert area in the northeast of the county, though Kaiser and LA Health Services both operate ambulatory care centers in the area. The two major hospitals are Antelope Valley Medical Center in Lancaster, a district hospital with 399 beds, and the investor-owned Palmdale Regional Medical Center, a 184-bed hospital owned by Universal Health Services, a large national health system that also owns several behavioral health hospitals in the county.

Regional Powerhouse Kaiser Struggles with Labor Disputes

Kaiser's Los Angeles County operations are part of the company's Southern California division, based in Pasadena. The integrated delivery system combines a health plan (nonprofit Kaiser Foundation Health Plan of Southern California), hospitals (nonprofit Kaiser Foundation Hospitals), and physician services (for-profit Southern California Permanente Medical Group) under one corporate banner through ownership and contractual arrangements.[34] Across Southern California, the division serves 4.9 million members with 16 hospitals, almost 9,000 physicians, and 202 medical offices.[35] Kaiser Permanente's seven Los Angeles hospitals collectively have 2,269 beds. In 2023, 45% of Kaiser discharges in Los Angeles were paid by Medicare, 45% by commercial payers,

and 10% by Medi-Cal — the largest commercial share and smallest Medi-Cal share among the top Los Angeles systems. Kaiser has two hospitals in the San Fernando Valley, two in the Metro area, one in San Gabriel Valley, one in the East area, and one in the South Bay. Kaiser Permanente Los Angeles Medical in Hollywood (Metro) is the largest of the seven hospitals, with 560 beds.

With consistently high ratings for medical care quality across geographic areas and market segments,[36] Kaiser is often viewed by peers in all three sectors — health plan, hospital, and medical group — as a competitive powerhouse. However, over the past five years, Kaiser's labor relations in Los Angeles have been shaped by escalating disputes over staffing, wages, and working conditions. In October 2023, more than 75,000 Kaiser workers across multiple states — more than a third of Kaiser's national workforce — launched a three-day walkout over staffing shortages and pay.[37] In October 2025, workers held a five-day walkout, and in January 2026, 31,000 workers in California and Hawaii went on an open-ended strike that lasted four weeks.[38]

Cedars-Sinai Solidifies Strong Market Position

Cedars-Sinai Health System has four hospitals, with 1,985 beds that accounted for 12% of discharges in the county in 2023. Medicare is a major revenue source, covering 48% of discharges; commercial payers accounted for 37% of discharges, and Medi-Cal covered 13%. At the time of the previous regional study, Cedars-Sinai was in growth mode, focused on broadening the referral network for the specialized tertiary/quaternary care provided at the system's flagship 915-bed Cedars-Sinai Medical Center, located in the Metro area, and expanding availability of specialized care in local communities. Expansion efforts included acquisition of Marina Del Rey Hospital, in the coastal West area, and affiliation with Huntington Hospital in Pasadena (San Gabriel Valley) and Torrance Memorial (South Bay). These initiatives have come to fruition. In Marina Del Rey, a new nine-story hospital will open in 2026 to replace the old facility, initially with 96 beds but capacity to expand to 160 beds — a significant increase compared to the prior facility. Efforts to integrate the affiliated hospitals include deploying the Cedars-Sinai electronic health record (EHR) at Huntington, creating shared services such as facility operations and revenue cycle across the health system, and building clinical programs that bring academic medicine into the local community. The system also experienced another major change in 2024, when Cedars-Sinai's CEO of 30 years (with 45 years total at Cedars) retired; the system's new leader was recruited from Boston, a longtime executive at Massachusetts General Hospital.

The main campus, Cedars-Sinai Medical Center, needs major seismic retrofitting, which will disrupt operations at the facility over the next decade. The main bed towers — all 915 beds — are noncompliant, and state regulations require that hospitals remain fully operational during seismic retrofitting. The approved plan is to retrofit three floors at a time, starting in 2028; each cycle will take two years to complete. Administration and conference space on the plaza level will become "swing space," housing beds from the floors undergoing retrofitting. Completion is expected in the mid-to-late 2030s. At other hospitals in the Cedars-Sinai Health System, the main effect of the seismic requirements is to reduce capacity — both Huntington and Torrance have older buildings that will be decommissioned, reducing the number of available beds.

Providence Faces Post-Pandemic Financial Struggles

Providence, a Washington-based nonprofit Catholic health system with 51 hospitals and over 1,000 clinics across seven western states, operates six hospitals with a total of 1,819 beds in Los Angeles County — three in the San Fernando Valley, two in the South Bay, and one in coastal Santa Monica. Ranging from 204 to 423 beds, the six hospitals accounted for 9% of Los Angeles discharges in 2023, with 48% paid by Medicare, 26% by commercial, and 24% by Medi-Cal. One

hospital — Tarzana Medical Center in the San Fernando Valley — is a joint venture with Cedars-Sinai (51% owned by Providence, 49% by Cedars) to rebuild the facility and enable access to specialized services locally rather than referring patients elsewhere.

Mirroring financial challenges facing the larger Providence system, the six Providence hospitals in Los Angeles had a -12% net income margin in 2023. Respondents noted that the COVID-19 pandemic hit Providence particularly hard, and the system has been implementing a financial turnaround plan.[39] In April 2026, Providence reached an agreement to sell Queen of the Valley Medical Center and related assets in Napa County to NorthBay Health, a nonprofit health system based in Solano County; the deal is under regulatory review.

Dignity, Major Medi-Cal Provider, Expands Maternity Services in Downtown LA

Dignity Health merged with Catholic Health Initiatives in 2019 to form CommonSpirit Health, a national nonprofit health system with 142 hospitals in 21 states.[40] The four Los Angeles hospitals operate under the Dignity Health brand but are owned and governed by CommonSpirit Health. The hospitals — California Hospital Medical Center in the downtown area with 318 beds, Glendale Memorial Hospital with 285 beds, Northridge Hospital Medical Center with 394 beds, and St. Mary Medical Center in Long Beach with 307 beds — accounted for 6% of discharges in 2023. Dignity is a major safety-net health system in Los Angeles County, with over half of discharges (52%) covered by Medi-Cal — among the largest systems, second only to the public hospital system (65%). Medicare covered 33% of discharges, and 13% were paid by commercial plans.

In January 2025, California Hospital Medical Center completed a major rebuilding effort and opened a patient care tower with expansion of ED and trauma capacity and a new Level III neonatal intensive care unit. At a time when many hospitals are eliminating labor and delivery services, Dignity Health's expansion of services is notable — particularly in a facility with a large share of Medi-Cal patients. In 2023, 76% of the hospital's discharges were covered by Medi-Cal (and another 17% by Medicare). The new tower replaces one that dates to 1964, with plans to convert the old tower into an outpatient facility.[41]

Adventist Health Revitalizes Bankrupt Hospital

Adventist Health is a faith-based nonprofit health system with 27 hospitals in California, Oregon, and Hawaii, including three hospitals with 1,153 beds in Los Angeles County. The three hospitals — Adventist Health Glendale with 451 beds, White Memorial in East Los Angeles with 545 beds, and White Memorial Montebello (formerly Beverly Hospital) with 157 available beds in 2023 but fewer staffed beds due to financial struggles — accounted for 5% of Los Angeles discharges in 2023. Medicare covered 43% of discharges across the three hospitals, Medi-Cal paid for 41%, and commercial accounted for 13%.

Beverly Community Hospital declared bankruptcy in April 2023 and sought a buyer to avoid closure and to maintain services in Montebello and the East Los Angeles area. Hospital leadership blamed the facility's severe financial distress on steep increases in costs that outpaced revenue with a payer mix heavily dependent on public programs.[42] Labor and delivery, gynecology, pediatrics, and wound care services were all closed.

The state attorney general conditionally approved the sale of Beverly Community Hospital to Adventist Health for $39 million in July 2023.[43] The agreement specified that Adventist Health would use "commercially reasonable efforts" to maintain services that remained operational at Beverly and to reinstate services that closed during bankruptcy but avoided any guarantees of specific services. Respondents agreed that earlier intervention would have been preferable to bankruptcy

but that bankruptcy was preferable to closure, even temporary closure, when "meds expire, equipment goes out of compliance, staff disappears, [and] everything evaporates."

Adventist Health brought Beverly under the White Memorial hospital license, renaming it White Memorial Montebello (WM Montebello). Since September 2023, the White Memorial leadership team has been responsible for both facilities. Reported turnaround priorities included a thorough staffing review, reducing the patient census to 50 to ensure sustainability and patient safety, and evaluating all service lines (all outpatient services except wound care were closed initially). WM Montebello has since reopened outpatient radiology, lab services, and surgery and launched a new gastroenterology service line. Leaders report a current focus on building out more specialized surgery such as urology and gynecology. Staffing is shared between the two hospitals, other than nursing, which is unionized at WM Montebello and not at White Memorial. Beverly's outdated EHR, on an unstable and insecure platform, was replaced with White Memorial's EHR system.

UCLA Health Expands, UC Irvine Health Enters LA County

University of California–affiliated health systems have been active in hospital acquisitions across multiple regions, including the Bay Area and San Diego, Orange, and Los Angeles Counties. In recent years, UCLA Health acquired two community hospitals, West Hills and Olympia. West Hills, in the San Fernando Valley, was purchased from HCA Healthcare in 2024 and renamed UCLA West Valley Medical Center. UCLA Health plans to replace the facility; the campus is large enough to accommodate building a new facility while operating the existing facility during construction. Olympia was acquired to create a new home for the Resnick Neuropsychiatric Hospital, currently housed on the campus of flagship 446-bed Ronald Reagan UCLA Medical Center, adjacent to the UCLA campus in Westwood. Construction is expected to be completed in summer 2026, resulting in the expansion of Resnick from 74 to 119 inpatient psychiatric beds. UCLA Health also operates the 281-bed Santa Monica UCLA Medical Center, about four miles from the Reagan campus.

Orange County–based UC Irvine Health also has been in growth mode with the acquisition of four Tenet hospitals — Lakewood Regional Medical Center in Los Angeles and three other hospitals in Orange County.[44] Several respondents expressed concern about increased costs at acquired facilities as the UC-affiliated health systems bring community hospitals under their academic medical center licenses. Teaching hospitals and their affiliated physicians typically have higher facility and professional fees and other charges than community hospitals, given their size and market leverage, their specialized services, and graduate medical education and research activity.

Higher Costs, Revenue Pressures Prompt Hospitals to Scrutinize Service Lines

Multiple hospital respondents expressed concern about rising costs and the prospect — or current reality — of slower revenue growth or even revenue declines. Cost drivers cited included the state's health care minimum wage, labor costs, inpatient staffing ratios, and hospital building codes. Seismic safety requirements were a major consideration across the board, with several respondents noting that the cost of a new hospital bed in California is double or triple the US average, resulting in some hospitals deciding to rebuild smaller or not at all. The investment needed to bring all facilities into seismic compliance is reportedly significant; a 2019 study conducted by the RAND Corporation with support from the California Hospital Association suggested countywide costs ranging from $9 billion to $40 billion.[45]

The revenue outlook is particularly concerning for safety-net hospitals.[46] HR 1 has been estimated to reduce federal Medicaid revenue in California by $30 billion annually in the coming years.[47] Additionally, Medicaid Disproportionate

Share Hospital (DSH) funding, which provides extra money to eligible hospitals serving large numbers of Medicaid and uninsured patients, is also under threat.[48] One hospital respondent wondered, "How can we become at least 25% commercial? I have about 8%." Another commented, "Congress has no idea the devastation they have created."

One response to the growing financial sustainability concerns is to revisit existing service provision with an eye toward profitability. Lucrative service lines include commercially insured patients in cardiology, oncology, and procedure-based specialties like orthopedics, while pediatrics, obstetrics, and behavioral health are "money-losers." Labor and delivery units have been closing at a rapid clip across the state due in part to declining birth rates, staffing and patient safety considerations, and relatively low payment rates. In Los Angeles County, 11 hospitals (seven for-profit, four nonprofit) have closed labor and delivery units since 2020, most recently the University of Southern California (USC) Verdugo Hills Hospital in Glendale in 2024.[49] As one respondent noted, "Before, we could sustain ourselves; now, we're forced to pick apart which programs are sustainable and which are not." Service lines mentioned by respondents as under consideration for elimination included emergency services, pediatrics, acute rehabilitation services, and wound care. Indeed, Adventist Health White Memorial closed pediatric services in December 2025 due to low volume and financial losses.

The ongoing financial struggles of Martin Luther King Jr. Community Hospital provide a stark example of the challenges facing safety-net hospitals and are particularly concerning because of the hospital's critical role in an underserved area of South Los Angeles and solid performance on patient safety and quality.[50] According to 2023 the California Department of Health Care Access and Information data, over 90% of discharges from the 131-bed hospital were covered by government payers — 64% Medi-Cal and 29% Medicare. The hospital received a $14 million loan through California's Distressed Hospital Loan Program in August 2023 to stabilize operations, maintain staffing and emergency services, and prevent disruption of care while the hospital undertakes longer-term financial recovery. Subsequent infusions of $25 million from the state and $8 million allocated by the Los Angeles County Board of Supervisors provided additional short-term support.[51] Any realistic recovery plan will require grappling with the drivers of the hospital's financial woes, including extremely high ED volume.[52]

Large Physician Organizations Solidify Operations

Southern California has long been a stronghold for capitated, delegated physician organizations. In the "cap/del" model, health plans delegate responsibility to physician organizations for functions such as provider credentialing and utilization management and pay them a fixed per-member per-month amount for the agreed-upon scope of services.[53] According to the DMHC, 91 risk-bearing organizations (RBOs) operate in Los Angeles County. The groups range in size: 40 had fewer than 5,000 lives, while 15 had at least 75,000 lives, and 9 of those had more than 200,000.[54] (For RBOs operating across multiple counties, numbers represent total enrollment, not just Los Angeles County.) Historically, many large physician organizations in Los Angeles have operated independently, but most now are owned by health systems or other corporate entities, such as Optum Health. The large health systems in Los Angeles typically operate at least one RBO and often hold one or more restricted Knox-Keene licenses from the DMHC, enabling them to contract with a health plan to accept full financial risk for both facility and professional services.

Optum Focuses on Integration, Astrana Focuses on Growth

Optum Health, the medical services arm of UnitedHealth Group, employs or is affiliated with about 5,500 primary care providers and 13,000 specialists in California.[55] The 2020–21

regional study highlighted Optum's dramatic growth in Southern California; a core strategy was to build both a strong group model presence and a strong IPA in all markets, which has largely been achieved.

Now, Optum's focus reportedly has turned to integrating the many practices and other clinical sites acquired over the past decade. Study respondents noted that a major milestone was achieved in September 2025 when all California clinics completed transition to Optum's Epic EHR. However, Optum still functions largely as separate units, with four claims systems, plan and provider network contracting that varies by geography and IPA/medical group (e.g., Monarch, AppleCare, DaVita/HealthCare Partners), and four restricted Knox-Keene licenses for different geographies and products.

One reported advantage of Optum's combination of medical group and IPA offerings is that as independent practice physicians age out of IPAs, Optum can place the practice in a nearby medical group clinic and support the physician's transition to employment or retirement while retaining the practice's patients. Optum's primary payment arrangement is global risk, with over 500,000 members in Los Angeles in the Medicare and commercial markets through Optum Health Plan (formerly DaVita/HealthCare Partners). In Orange County, Optum also has large global risk enrollment in Medi-Cal through Monarch Health Plan's contract with CalOptima.

Astrana Health is a California-based, publicly traded organization with clinicians in three states that holds risk-based contracts across commercial, Medicare, and Medicaid lines of business and has been expanding through acquisitions in the Los Angeles area in recent years. Astrana's early geographic focus was the San Gabriel Valley, anchored by Allied Physicians of California, a large IPA. In 2024, Astrana's Metropolitan IPA acquired Community Family Care Medical Group (an IPA) and an affiliated health plan with a Knox-Keene license covering over 200,000 Medi-Cal lives.[56]

In 2025, Astrana acquired California-based Prospect Medical Group (PMG), with a network presence across Los Angeles and other parts of Southern California.[57] PMG was not part of the 2025 bankruptcy filing of its parent company, Prospect Holding Systems, which affected multiple hospitals nationally, including six facilities in Los Angeles.[58] In addition to PMG, the Astrana acquisition included a health plan with a restricted Knox-Keene license. PMG has approximately 100,000 members in Los Angeles, primarily professional risk for Medi-Cal and commercial and global risk for MA.

Respondents had diverse perspectives on whether independent practice in Los Angeles — and the IPAs supporting physicians — was fading or holding strong. One noted that physicians in independent practice are aging out, and newly minted physicians prefer work-life balance and a salary. Another pointed to physicians interested in leaving hospitals and systems to regain lost autonomy. Yet another highlighted growing interest in dropping insurance contracts and moving toward concierge medicine to increase revenue and reduce administrative hassle. Most agreed that some level of scale and shared services is required: "Long gone are the days of ones and twos; they aren't equipped to invest in the infrastructure to run a practice."

Altais Teams Up with Family Care Specialists to Enter Southern California

Altais is a physician organization launched in June 2019 as a for-profit subsidiary of Blue Shield of California. In January 2025, both Altais and Blue Shield of California became subsidiaries of Ascendiun, a new parent company. Altais's first major acquisition was Brown and Toland Physicians in the Bay Area in 2020. In 2022, Altais entered the Los Angeles market through acquisition of Family Care Specialists (FCS), created in 1988 with a mission to provide community-centered care for medically underserved populations. FCS partnered with Adventist Health White Memorial to build a family medicine residency program, which offers opportunities to teach and

mentor young physicians — many of whom joined FCS or opened their own practices in the area. Respondents noted that FCS viewed the partnership with Altais as an opportunity to demonstrate affordability, combining population health management and care management principles with an advanced "tech stack" and support services. Altais has invested in FCS, including upgrading the EHR system to provide a more robust platform for ambient AI-generated data analytics and performance.

Following the acquisition, the four FCS locations became Altais sites, and one of the founding physicians at FCS moved to Riverside to open the first Altais practice in the Inland Empire. Altais reportedly plans to grow the IPA, Altais Care Network, and the staff model medical group, Altais Medical Group, throughout Southern California. A major focus is value-based payment ranging from shared savings to full risk. A statewide Medicare Shared Savings Program accountable care organization, Altais Care Alliance, was launched in 2024 and had about 6,000 members by 2025. Altais Provider Services, the management services arm, aims to support small independent practices, as well as the Altais network, with practice enablement and administrative services.

County Government Anchors Fragmented Safety Net

With a $6.5 billion annual operating budget, LA Health Services is the second largest municipal public health system in the country. The county-run delivery system provided 2.9 million patient visits in 2025 and operates four hospitals and a network of 23 outpatient health centers across the county.[59] The four county-operated hospitals are Los Angeles General Medical Center in downtown Los Angeles, with 670 available beds (676 licensed beds); Harbor-UCLA Medical Center in the South Bay, with 415 available beds (453 licensed beds); Olive View-UCLA Medical Center in the San Fernando Valley, with 292 available beds (355 licensed beds); and 158-bed Rancho Los Amigos National Rehabilitation Center in southeast Los Angeles. Collectively, LA Health Services hospitals accounted for 7% of the region's discharges in 2023, with 65% of discharges paid by Medi-Cal, 15% by Medicare, and 7% by commercial.

In recent years, Los Angeles General Medical Center — renamed in 2023 from Los Angeles County + USC Medical Center — has changed its staffing model, shifting from mostly USC-employed contracted physicians to mostly county-employed physicians for primary care and most specialty care, while retaining the USC contract for subspecialty services. To staff up at Los Angeles General, the county actively recruited hundreds of new physicians. An ongoing affiliation with the USC Keck School of Medicine supports Los Angeles General's enormous residency programs — more than 1,000 physicians train at the site, which also serves as a US Navy training site. Los Angeles General is a relatively new hospital, replaced in 2008 following damage from the 1994 Northridge earthquake.

Harbor-UCLA, built in 1962, is undergoing a full campus rebuild to meet seismic requirements at an estimated cost of $1.8 billion, with completion scheduled for 2028.[60] The existing facility will remain operational until the replacement is complete. Additional facility updates are needed across the massive system, and LA Health Services must identify resources to cover the costs.

In addition to outpatient care provided on hospital campuses, LA Health Services' 23 community-based clinics and mobile clinics form a network that spans every region of the county, including sites in the Antelope Valley and the South Bay. While most clinics provide core primary care services, certain sites such as MLK Jr. Outpatient Center and High Desert Regional Health Center serve as regional hubs offering specialty care, urgent care, ambulatory surgery, dental care, and other ancillary services. In 2025, LA Health Services

provided about 502,000 primary care visits and 873,000 specialty care visits.[61]

LA Health Services has built a provider network that covers over 50 specialties, ranging from women's health to neurosurgery. Most physicians, both primary and specialty care, are employed by the county. Because LA Health Services is vertically integrated, with a shared EHR, patients benefit from economies of scale across the massive county. LA Health Services uses eConsult extensively, enabling primary care clinicians to obtain peer-to-peer consultations from specialists, in conjunction with a centralized referral and scheduling system that steers patients who need specialized services to the closest geographic location. LA Health Services offers neurosurgery at two sites — Los Angeles General and Harbor-UCLA — funneling all patients to those facilities. Highly specialized services such as liver transplants are contracted out, but over 95% of specialty services needed by the approximately 500,000 assigned patients can be provided within LA Health Services. In recent years, LA Health Services launched an award-winning cancer navigation program and an initiative to reduce avoidable lower-limb amputations resulting from uncontrolled diabetes by expanding access to podiatric care and rapid response to infection.[62]

LA Health Services also plays a major role in the county's correctional health system. County staff provide medical care in the county's jails (tagline: "Doctors Without Boredom"[63]) and for youth residing in juvenile halls and residential treatment facilities, and run the Office of Diversion and Reentry, aimed at diverting people with serious physical and/or behavioral health needs away from jail and into community-based care.

From 2014 until 2024, LA Health Services ran a program called MyHealth LA that served hundreds of thousands of low-income, uninsured county residents who did not qualify for public health insurance. LA Health Services contracted with more than 50 FQHCs, which provided primary care at more than 200 sites. Uninsured residents also received emergency, specialty, urgent, and inpatient care at LA Health Services clinics and hospitals. The My Health LA program ended in January 2024, after all of the participants became eligible for full-scope Medi-Cal as the state expanded eligibility regardless of immigration status.[64] However, given federal Medicaid changes, including work requirements and semiannual eligibility redeterminations, and state Medi-Cal cuts for undocumented people and others with UIS, the uninsured population is expected to increase in Los Angeles County. HR 1 has already resulted in funding losses to LA Health Services, with more expected in the coming years.[65] In response, a community coalition led by CHCs and organized labor, Restore Healthcare for Angelenos, proposed a five-year, half-cent tax increase that was placed on the June 2026 ballot in Los Angeles County. Narrowly passed, the initiative is projected to raise about $1 billion annually to cover public funding gaps in Los Angeles County and help pay for medical and behavioral health care for uninsured people.[66]

CHCs Expand Scope and Scale

Along with LA Health Services' 23 health centers, almost 300 CHC sites provide access to care for low-income Medi-Cal and uninsured patients across Los Angeles County, collectively serving more than two million patients in 2023 (Table 12). Almost three-quarters of CHC patients in Los Angeles had incomes below 100% of the federal poverty level, and Medi-Cal provided 84% of CHC revenue in 2023. The key role many CHCs played during the COVID-19 pandemic, including rapid adoption of telehealth to enable virtual access to care and leadership in vaccine outreach and administration, along with ongoing Medi-Cal expansions, has generated funding to expand the scale and scope of services locally. Now, federal and state budget cuts threaten these gains. One respondent commented, "Not all health centers are going to survive this."

TABLE 12. Community Health Centers, Overview,
Los Angeles vs. California, 2023

Community Health Centers, Overview*	Los Angeles	California
Number of sites	295	1,139
Patients with incomes under 100% poverty level	74%	70%
Patients per capita	0.21	0.21
Encounters per capita	0.72	0.69
Medi-Cal as share of net patient revenue	84%	78%

* Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region, as this information is not reported to the California Department of Health Care Access and Information.

Source: *2023 Primary Care Clinic Annual Utilization Data* (November 2024), California Department of Health Care Access and Information, last updated October 31, 2024.

Overall, CHCs provided nearly seven million patient encounters across Los Angeles County in 2023 (Table 13). Among the largest CHCs are AltaMed Health Services Corp., St. John's Community Health, North East Valley Health Corporation, JWCH Institute, and Planned Parenthood Los Angeles.

TABLE 13. Largest Community Health Center Systems, by Number of Encounters, Los Angeles, 2023

	Encounters	Patients with Income Under 100% Poverty Level	Medi-Cal as Share of Net Patient Revenue
AltaMed Health Services Corporation	875,415	97%	94%
St. John's Community Health	468,421	84%	89%
North East Valley Health Corporation	356,653	64%	90%
JWCH Institute	280,541	77%	93%
Planned Parenthood Los Angeles	252,630	65%	67%
All others	4,718,331	69%	80%
Los Angeles	6,951,991	74%	84%
California	26,871,453	70%	78%

Note: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region as this information is not reported to the Department of Health Care Access and Information.

Source: *2023 Primary Care Clinic Annual Utilization Data* (November 2024), California Department of Health Care Access and Information, last updated October 31, 2024.

AltaMed Health Services Corporation

AltaMed provided over 875,000 patient visits in the county in 2023 and additional services at clinic sites in neighboring Orange County. In Los Angeles, AltaMed sites cluster in the downtown area, with several locations to the east and south. Acquisition of four Crown City Medical Group sites in 2021 and eight Community Health Alliance of Pasadena (ChapCare) clinics in 2023 added new sites and introduced AltaMed to the San Gabriel Valley. Established in 1969 with roots in the Latino/x community, AltaMed has expanded services and product lines over the years. While most patients are Medi-Cal enrollees, AltaMed participates in other lines of business — Covered California, Medicare, and commercial — contracting with a wide array of health plans and operating its own IPA distinct from the FQHC.

In 2020, AltaMed Health Network was launched, a health plan with a restricted Knox-Keene license with enrollment of almost 350,000 Medi-Cal lives. AltaMed Health Network has full-risk contracts with L.A. Care, Blue Shield Promise, Health Net, and Molina, plus CalOptima in Orange County. In addition to a robust primary care and specialty network, managing full risk for a large population requires risk stratification capabilities, hospitalist programs at contracted hospitals, and effective management of ED visits and other costly services. AltaMed's management services organization, Altura Management Services, supports AltaMed Health Network — and other clients — with claims payment, data analytics and reporting, and related services.

St. John's Community Health

St. John's provided over 468,000 patient visits in 2023 in Los Angeles, providing care at community sites, school-based health centers, and mobile clinic units, as well as via street medicine teams. St. John's started in 1964 as a volunteer-run pediatric health clinic in South Los Angeles and has grown to serve the downtown core, with sites across the east and south of the county. St. John's played a major role during the COVID-19 pandemic in vaccinating residents, including purchasing and storing large quantities of vaccine. Invitations from Inland Empire organizations to run vaccine clinics led to St. John's opening three clinics in San Bernardino and Riverside Counties (in San Bernardino, Indio, and San Jacinto).

With Inland Empire's growing population and relatively low CHC penetration, St. John's has seen rapid growth at the new clinics. During recent federal immigration activity in Los Angeles County, St. John's launched the "Healthcare Without Fear" program, sending doctors and medications to the homes of immigrant patients afraid to venture out to a clinic. Foundation grants helped offset the cost, since CHCs cannot be reimbursed for home visits. St. John's was recently awarded two major projects: serving as the CHC for the new Robert Ross Health Village to be developed in East Los Angeles[67] and designing and running a new health center at Compton College expected to serve 40,000–50,000 patients annually.[68]

North East Valley Health Corporation

North East Valley Health Corporation, founded in 1971, provided over 356,000 patient encounters in 2023 at clinic sites in the San Fernando and Santa Clarita Valleys, including several school-based sites and dental centers. North East Valley has a large program for people experiencing homelessness, including street medicine and sites colocated with housing. The health center's longtime leader retired in 2024 after 50 years, 28 of them as CEO; the new CEO comes from a CHC in Washington State. To accommodate population growth in the area, the CHC plans to build a new clinic in Reseda to provide medical, dental, and behavioral health care and to expand the Santa Clarita Health Center to accommodate more patients.[69]

JWCH Institute

JWCH Institute was established in 1960 by physicians associated with the John Wesley County Hospital and is commonly known as Wesley Health Centers (Wesley). With over 280,000 patient visits in 2023, Wesley is a major provider in several geographic areas, including southeast Los Angeles, Skid Row, and East Hollywood. In recent years, Wesley has expanded from core primary care services into residential SUD treatment, bridge housing for people in recovery, and recuperative care for patients following an inpatient stay.

In the early 2020s, Wesley took over a failing CHC in rural Antelope Valley and built a presence in Lancaster and Palmdale, where Wesley now serves about 24,000 patients despite the operational challenges that come with staffing clinic sites over 70 miles away from its headquarters. Staffing is a core issue — clinicians often live in the San Fernando Valley or metro Los Angeles and commute to Antelope Valley. HCLA, the IPA that supports Wesley's other sites, doesn't operate in Antelope Valley, so Wesley contracts with other IPAs (Astrana's Community Family Care and Heritage's High Desert Medical Group) and directly with providers for specialty care and related services, resulting in members frequently having to travel to the San Fernando Valley or other parts of metro Los Angeles County for specialty care.

Planned Parenthood Los Angeles

Founded in 1965, Planned Parenthood Los Angeles offers primary and reproductive care at 23 sites across the county, including Antelope Valley, providing over 252,000 patient visits in 2023. Planned Parenthood Los Angeles also operates at over 20 high schools, in partnership with the county Department of Public Health. A provision of HR 1 enacted in July 2025 ended Medicaid payments for primary care and non-abortion services to organizations providing abortion care. Planned Parenthood Federation of America, the national umbrella organization, sued to challenge the provision. A preliminary injunction extended relief to all California Planned Parenthood affiliates, enabling Planned Parenthood Los Angeles to continue receiving Medi-Cal payments while the case is litigated. DHCS issued an All Plan Letter to clarify guidance on payment,[70] and California has provided short-term funding to help close the gap in federal funding while the lawsuit continues.[71]

Workforce Investments Expand Training, but Demand Outstrips Supply

Los Angeles is home to many physician residency training programs and practice opportunities, including academic medical centers, health systems, and CHCs. Unsurprisingly, the supply of physicians and other clinicians in Los Angeles County matches or modestly exceeds statewide figures. For example, there were 376 physicians per 100,000 population in Los Angeles compared to 358 statewide in 2024 (Table 14). Among physicians working at least 20 hours a week, Los Angeles has more specialists per 100,000 population, including psychiatrists, but fewer primary care physicians than statewide. Reportedly, many physicians — particularly specialists — work across county boundaries in the densely populated area, splitting time between Los Angeles and adjacent counties like Orange and Riverside.

TABLE 14. Health Care Workforce Supply,
Los Angeles vs. California, 2024

	Los Angeles (Percentage of Statewide Average)	California
LICENSED PROVIDERS PER 100,000 POPULATION		
License Group*		
Physicians	376 (105%)	358
Advanced practice providers	130 (101%)	128
Nurses	1,317 (97%)	1,353
Behavioral health providers	431 (112%)	384
PHYSICIAN DETAIL BY SPECIALTY AND HOURS WORKED†		
Physicians Per 100,000 Population		
Physicians working 20+ hrs/week	308 (105%)	294
Primary care	113 (95%)	118
Specialty	195 (111%)	176
Psychiatry	19 (105%)	18

* License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). *Physicians* are MDs and DOs; *advanced practice providers* are nurse practitioners and physician assistants; *nurses* are licensed vocational nurses and registered nurses; *behavioral health providers* are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychologist, registered psychological associate, and psychiatric technician.

† Allocation of physicians into specialties and hours of practice used the HCAI Physicians by Specialty and Patient Care Hours, as of April 3, 2024.

Source: "2024 license renewal survey data, representing active licenses as of December 3, 2024," custom data request, HCAI, received April 14, 2025.

TABLE 15. Physician and Health Workforce Characteristics,
Los Angeles, 2024

	Physicians	Advanced Practice Providers	Nurses	Behavioral Health Providers	Population
RACE/ETHNICITY OF PROVIDERS*					
Latino/x, any race	9.4%	19.3%	27.0%	27.0%	48.6%
Asian, non-Latino/x	36.9%	32.2%	37.4%	37.4%	15.4%
Black, non-Latino/x	5.0%	10.4%	8.8%	8.8%	8.0%
White, non-Latino/x	44.7%	31.8%	21.2%	21.2%	25.3%
LANGUAGES SPOKEN†					
English only	48%	48%	44%	62%	
Spanish	17%	20%	21%	26%	

Notes: License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). *Physicians* are MDs and DOs; *advanced practice providers* are nurse practitioners and physician assistants; *nurses* are licensed vocational nurses and registered nurses; *behavioral health providers* are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.

* Not shown: Other, non-Latino/x.

† Spoken fluently/well enough to provide direct services to clients. Some providers speak multiple non-English languages (e.g., 8% of physicians statewide); these languages are not captured here.

Sources: 2024 license renewal survey data, representing active licenses as of December 3, 2024, custom data request, HCAI, received April 14, 2025; and *Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023* (CC-EST2023-ALLDATA), US Census Bureau.

The race/ethnicity profile of physicians and other providers in Los Angeles does not reflect the composition of the population (Table 15), with the largest discrepancy for the Latino/x population. Less than 10% of physicians, 20% of advanced practice providers, and 30% of nurses and behavioral health providers are Latino/x compared to almost half of Los Angeles residents. By contrast, a greater share of providers is Asian (32% to 37%) compared to the population (15.4%). White physicians are overrepresented (44.7% of physicians versus 25.3% of the population) and Black physicians are underrepresented (5.0% of physicians versus 8.0% of the population); Other provider categories (advanced practice providers, nurses, and behavioral health providers) match population representation more closely.

Los Angeles provider supply figures closely matching statewide supply does not indicate adequate workforce or patient access; statewide figures are not a recommended benchmark. Multiple respondents commented on post-pandemic

provider workforce shortages and resulting challenges with access, both for primary and specialty care. One health system respondent noted, "Especially in primary care, there are not enough docs coming out of residency programs that want to stay. We have expanded physician recruitment nationally, trying to find people with ties to the Los Angeles area." Another respondent said, "Independent specialty practices are joining the UCLAs and Providences of the world and don't take Medi-Cal." One respondent described an "arms race" for a limited number of physicians, with Kaiser, Optum, and the health system–affiliated medical foundations paying 20% to 30% more than CHCs or independent practices.

L.A. Care Leads Safety-Net Workforce Investments

L.A. Care's Elevating the Safety Net is a $255 million initiative launched in 2018 with a multipronged approach to increasing physician supply in the area.[72] The provider recruitment program provides up to $125,000 per physician, while the provider loan repayment program offers $5,000 per month for 36 months (with potential for a two-year extension) to physicians practicing within the safety net. L.A. Care supported the establishment of the Keck Graduate Institute's Master of Science in Community Medicine program and provided funding to help launch Charles R. Drew University of Medicine and Science's (Drew's) new medical school program. A scholarship program provides eight medical school scholarships annually, four each to the medical schools at UCLA and Drew. From 2019 to 2021, L.A. Care invested $12.8 million to establish 44 new residency positions at five training sites in Los Angeles: Adventist Health White Memorial, AltaMed, Drew, Children's Hospital Los Angeles (affiliated with USC Keck School of Medicine), and the David Geffen School of Medicine at UCLA.[73] The initiative also has funded a community health worker training program, a value-based care training program for clinical and administrative staff at AltaMed, a community-based health equity program under Adventist Health White Memorial's family medicine residency program, fellowships for medical students from across the country to spend six weeks with a CHC (with a $5,000 stipend), and summer internships for college students interested in health care careers at CHCs, community-based organizations, and L.A. Care (with a $4,200 stipend).[74]

Additionally, Blue Shield Promise, Health Net, and Molina all invest in the provider workforce in Los Angeles, though on a smaller scale, focused primarily on strengthening the behavioral health workforce and expanding availability and integration of community health workers; Anthem's investments are typically statewide. In 2025, Health Net, and the philanthropic arm of parent company Centene, awarded $5.5 million to Drew for full-tuition scholarships, financial support for medical residents, and recruiting and retention efforts.[75]

CHCs in Los Angeles also pursue a range of initiatives to address health workforce shortages and build a supply pipeline. Efforts include launching family medicine residencies and nurse practitioner fellowships, creating community health worker training academies, partnering with academic institutions for clinical rotations and internships for behavioral health professionals, and focusing on recruitment and retention. For example, AltaMed leverages its scale with multiple training programs and other workforce initiatives. Launched in 2024 and a recipient of L.A. Care's residency investments, the AltaMed Family Medicine Residency program enrolls six residents in each cohort and is academically affiliated with the UCLA David Geffen School of Medicine. In addition, family medicine residents from the USC Keck School of Medicine rotate through AltaMed for primary care training in a CHC setting. In 2024, seven physicians joined AltaMed through the Licensed Physicians from Mexico Pilot Program, which allows licensed physicians from Mexico to practice in the United States for three years.[76]

Kaiser and Drew Increase Pipeline for Medical Students

Two medical schools have opened in Los Angeles County in recent years. The Kaiser Permanente Bernard J. Tyson School of Medicine in Pasadena graduated its first cohort of students in 2024. To date, 37 students have graduated, and the school is expected to produce about 50 new physicians annually once fully ramped up. In the first graduating class, 62% of students remained in California for residency, and 19% matched to a Kaiser residency.[77] Drew's College of Medicine in South Los Angeles enrolled its first class in 2023 and will eventually graduate about 60 new physicians annually.[78] The program, one of only four medical schools in the country located at a historically Black institution, has an explicit focus on caring for medically underserved communities, particularly communities of color.[79]

CalAIM Generates Enthusiasm and Skepticism

The state launched the CalAIM (California Advancing and Innovating Medi-Cal) initiative in 2022, with major changes to many aspects of the Medi-Cal program planned for phased implementation over several years.[80] Two foundational aspects of CalAIM are Enhanced Care Management (ECM) and Community Supports (CS) services. A new Medi-Cal benefit, ECM provides resources for care coordination and care management for patients with complex needs. CS services, which are optional for managed care plans to offer, expand Medi-Cal beyond traditional health care services, adding services for health-related social needs such as housing supports, medically tailored meals, and sobering centers.[81] Medi-Cal managed care plans are responsible for implementing and coordinating these services. These CalAIM programs have prompted more social service organizations to contract with Medi-Cal managed care plans and more health care organizations, especially CHCs, to offer social services directly or through partnerships.

In Los Angeles County, about 1% of Medi-Cal enrollees received ECM or CS services in 2024, below the statewide rate of 1.5% for ECM and 1.9% for CS (Table 16). In the fourth quarter of 2024, the most-used CS service in the county was housing tenancy and sustaining services (11,240 members), followed by medically tailored meals (9,455 members) and housing transition navigation services (7,988 members).[82]

TABLE 16. Medi-Cal and CalAIM,
Los Angeles vs. California, 2024

	Los Angeles	California
ENHANCED CARE MANAGEMENT (ECM) ENROLLMENT*		
ECM enrollment	43,275	206,501
Share of Medi-Cal managed care enrollees receiving ECM	1.1%	1.5%
COMMUNITY SUPPORTS (CS) ENROLLMENT†		
CS enrollment	35,525	258,141
Share of Medi-Cal managed care enrollees receiving CS	0.9%	1.9%

* *ECM enrollment* is the number of unique members who received ECM in the last 12 months of the reporting period ending September 30, 2024.

† *CS enrollment* is the number of members receiving services in the 12 months of the reporting period ending September 2024.

Source: *ECM and Community Supports Quarterly Implementation Report* (data through September 30, 2024), California Department of Health Care Services, last updated March 2025, data tables for charts 1.7.1 and 3.9.1.

Respondents gave ECM and CS a mixed review. Some had a good experience; one described the programs as "labor intensive but worth it," with an effective set of interventions targeting a population with significant need. Another positive: The programs resulted in additional capacity in clinics to deal with co-occurring primary care and behavioral health conditions. One CHC respondent mentioned bringing psychiatry services to clinic teams, including using a train-the-trainer psychiatry program to expand the scope of primary care clinicians. However, ECM and CS requirements were viewed as extensive and burdensome, and numbers were generally viewed as small for the level of effort — in part because patients request services but do not complete enrollment. "Many patients want the service but not all the consent and administrative hurdles," according to a respondent. One community-based organization started a new division to provide ECM and CS services but faced substantial

variation among Medi-Cal managed care plan contracts, including different rates for the same services.

More broadly, as concerns about the effects of HR 1 and state budget cutbacks have increased, questions about continued investment in programs with small enrollment, significant administrative burden, and questionable cost-effectiveness have intensified — even among strong supporters of addressing health-related social needs. Several respondents noted that CalAIM programs are still launching — the Justice-Involved Reentry Initiative deadline is October 1, 2026, but the federal Medicaid waivers underlying CalAIM end in December 2026. One commented: "It's crazy to keep rolling things out when we aren't clear whether it will be allowed to continue. Should we be doing bells and whistles when we are cutting elsewhere?"

One community-based organization respondent noted that creation of a new division to provide ECM and CS services was a "heavy lift" for programs that are barely breaking even and have an uncertain future. Several noted that cost-effectiveness has not been a sufficient focus. One respondent, citing the requirement of budget neutrality for the waiver, commented, "I'm concerned the feds will take action against the state if we don't tighten up." Medi-Cal funding for medically tailored meals reportedly attracted "bad actors" and "very entrepreneurial people." Another noted that services such as housing navigation only work if housing is available to place people: "If there is nowhere for people to land, it's just cost with no end." Although DHCS is confident that CS services (also known as "In Lieu of Services") will be allowed to continue after the waiver ends,[83] the current policy environment is rife with uncertainty.

CHCs Play Major Role in Street Medicine, Supportive Housing

Supporting people living on the street or at risk of homelessness is a major function of several large CHCs in the county, with diverse funding sources that include federal, state, county, city, and philanthropic dollars. The aggressive federal immigration activity in Los Angeles that began in summer 2025 created fear among many — including CHC clinicians caring for homeless patients throughout the county. "ICE hit our mobile once and our street team once, hard core," a CHC respondent said. "They actually put machine guns in the faces of our street team and providers."

Two of the CHCs providing robust street medicine services and housing supports are Wesley and Venice Family Clinic. Wesley operates recuperative care sites, providing residential care for patients ready for hospital discharge who lack a safe place to go, on the campuses of Los Angeles General and Martin Luther King Jr. Community Hospital; each site has 96 beds. An additional 50-bed site for women is available on Skid Row. The programs provide medical care, case management, personal care, meals, housing placement services, and social services referrals. Wesley's other housing-related programs focus on residential SUD treatment, sober housing for treatment graduates, tiny homes, and interim housing for people interacting with the corrections system.

Venice Family Clinic operates a large street medicine program, with eight teams visiting encampments with the goal of stabilizing patients in need of treatment. The teams work closely with social services, providing medical care while others handle case management, and bring in psychiatrists when possible. Given the scarcity of psychiatrists, the CHC's street medicine physicians and physician assistants may complete psychiatry fellowships to gain competency and bring those skills to the team. Venice Family Clinic also works with the county Department of Mental Health on a Full Service Partnership (FSP), an intensive, wraparound mental health program designed for adults with serious mental illness at risk of homelessness, incarceration, or repeated psychiatric hospitalization. FSPs operate on a "whatever it takes" model, providing 24/7 crisis response, clinical care, case

management, housing, employment, and peer support to help clients achieve recovery and stability.[84]

Both Wesley and Venice Family Clinic participate in the Los Angeles County Field Medicine Program, launched in 2024 by L.A. Care and Health Net.[85] The 22 providers participating in the program, many of them CHCs, deliver primary care and social services to people experiencing homelessness in 20 distinct regions across the county. The program includes five years of performance incentives for providers to deliver care in the street and in shelters, provide follow-up care to people once engaged, and to deliver housing navigation and other social services in field-based environments. It also includes funding for 10 new field medicine teams to be deployed in regions with the highest need. A key element of the program is Care Collaboratives in high-density areas, the first of which launched on Skid Row in 2024 with a second planned for MacArthur Park. The Care Collaborative features specialty care, expanded service hours for pharmacy and urgent care, community respite beds, and hygiene and harm-reduction services — all delivered through a coordinated set of operating guidelines and connected via a dedicated local transit shuttle.[86]

Massive County Behavioral Health Efforts Operate in Parallel

The scale of Los Angeles County's behavioral health services is daunting, as is the scale of change underway in California behavioral health policy. Since 2022, no fewer than eight CalAIM behavioral health initiatives have rolled out.[87] In addition, California Behavioral Health Community-Based Organized Networks for Equitable Care and Treatment (BH-CONNECT), California's five-year Medicaid Section 1115 demonstration that launched in 2025, includes components focused on the workforce, evidence-based practices, incentives for outcomes, and support for children and youth.[88] Unlike other counties across California, Los Angeles operates two distinct units to handle specialty mental health and SUD services, respectively.

With a budget of $4.1 billion, the county's Department of Mental Health serves approximately 250,000 people annually, with most enrolled in Medi-Cal.[89] Inpatient and residential services are provided through contracts, including with LA Health Services. Outpatient mental health services are delivered through a combination of county staff providing direct services and contracts with a large provider network.

CalAIM's Behavioral Health Payment Reform, launched in 2023 and just one of many changes underway, is transitioning payment for specialty behavioral health services from cost-based reimbursement to fee-for-service payment. Over time, the change should result in less administrative burden and more timely payment by eliminating cost reconciliation.[90] However, implementing a new payment model across 1,000 Department of Mental Health contractors has been a formidable task involving thousands of clinicians with multiple EHRs — all of whom must adjust to a new fee schedule, more granular procedure coding, and revised documentation standards. For community-based organizations contracted with the county to provide services such as residential treatment, the transition has its own set of challenges. Not surprisingly, new coding and billing requirements have led to claims denials at the county or state level, and delays in claims processing and adjudication make it difficult for community-based organizations to resolve and resubmit claims within the allowed time. One organization reported losing at least $200,000 on services that were provided because billing issues could not be addressed before the claims aged out. Another point of tension is that county staff receive higher pay and better benefits than staff at contracted organizations, exacerbating workforce challenges for community-based organizations that are also competing with private-sector companies offering virtual mental health services.

SUD services are provided through the Los Angeles County Department of Public Health's Bureau of Substance Abuse Prevention and Control (SAPC). With a budget of $760 million, SAPC provides services through contracts with over 150 community-based organizations. County staff answer phone lines 24/7 and serve as technical experts but are not direct service providers. SAPC's contracted provider network covers prevention, treatment, harm reduction, and recovery bridge housing. SAPC served over 35,000 unique patients — 97% covered by Medi-Cal — admitted to contracted treatment programs in fiscal year (FY) 2024–25.[91]

SAPC was an early adopter and is a strong supporter of the Drug Medi-Cal Organized Delivery System (DMC-ODS), which went live in Los Angeles County in 2017. DMC-ODS expanded access to SUD services through a continuum of care approach that standardized patient assessment based on national criteria and facilitates ongoing treatment after residential care.[92] DMC-ODS substantially increased funding and flexibility in Los Angeles, with budget growth from $214 million in FY 2016–17 to $760 million in FY 2024–25, resulting in expanded capacity.[93] At SAPC, the 2023 CalAIM Behavioral Health Payment Reform initiative introduced practitioner-based billing (higher rates for clinicians than other providers) and county flexibility with incentives, enabling SAPC to launch a value-based payment initiative. The program provides financial incentives to contracted agencies to meet performance benchmarks in core areas like finance and business operations, workforce development, and access to care.[94] Examples of workforce incentives offered for the FY 2025–26 program include a bilingual bonus of $100 to $150 per eligible staff member, a $5,000 sign-on/loyalty bonus for full-time eligible licensed providers, and start-up funding to expand prescribing capabilities for addiction medications for SUDs.[95]

Several respondents noted that California's transition from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), with an implementation deadline of July 2026, could increase integration among the historically siloed county Department of Mental Health and SAPC. BHSA shifts focus from broad prevention to treatment and recovery, expands allowable uses of funds to include SUD treatment, increases standardization and accountability, and requires counties to invest more heavily in behavioral health workforce, housing, and facility infrastructure.[96] The Department of Mental Health is leading development of the BHSA plan for Los Angeles County, in collaboration with SAPC; stakeholder meetings will take place throughout 2026.[97]

Acute Shortage of Community-Based Mental Health Beds Afflicts County

Los Angeles has a significant shortage of subacute and residential beds in the community (i.e., outside of inpatient and institutional settings) for adults with behavioral health needs. A lack of stepdown services creates bottlenecks in discharging people from inpatient settings. As a result, patients may be stuck in a locked facility, waiting for a community bed to become available, and hospital administrators grapple with payment denials for patients who no longer meet criteria for inpatient services but have nowhere to go. According to one respondent, "That's part of why we have a cycle of streets, hospitals, and jail system — just not enough beds." Recommendations from a report commissioned by the Department of Mental Health at the direction of the Los Angeles County Board of Supervisors included expanding subacute capacity and reducing high readmission rates — in part by strengthening the county's operational approach to managing the full continuum of mental health resources, shifting from siloed oversight to a broader and more comprehensive view of access, availability, and resources.[98]

The state Behavioral Health Continuum Infrastructure Program (BHCIP) is intended to help address the shortage of treatment options, though awarded projects will take years to come online. The county Department of Mental Health

received Round 3 BHCIP funds to support construction of a 128-bed mental health rehabilitation center on the Los Angeles General campus, part of a Restorative Care Village; the groundbreaking ceremony took place in October 2025.[99] In May 2025, the most recent round of funding, associated with Proposition 1 bonds (Bond BHCIP), resulted in 35 awards for projects in Los Angeles County totaling just over $1 billion.[100] The largest award was $119 million to build a new continuum of care facility at Olive View-UCLA Medical Center, an LA Health Services hospital in the San Fernando Valley, to expand capacity for treatment and stabilization of people with serious mental health and SUD needs, spanning multiple levels of care.

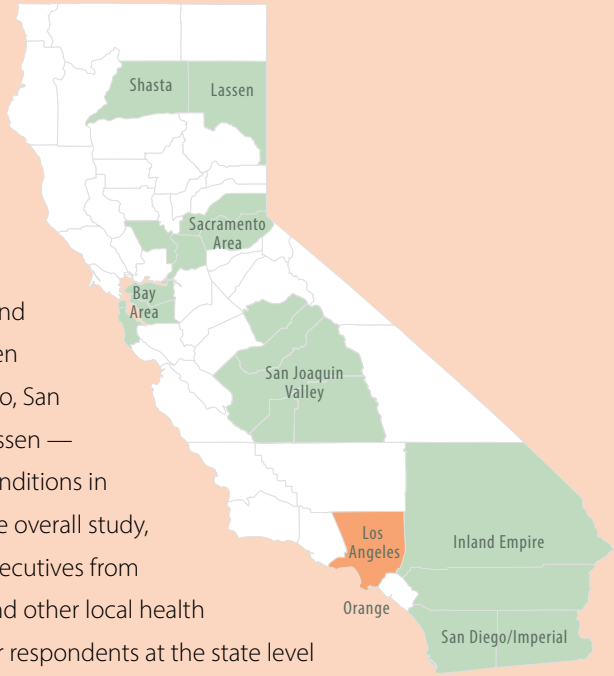
Acknowledging the severe shortage of behavioral health infrastructure and the long distance to travel for care, Antelope Valley, in the rural northeast area of the county, was a major recipient of Bond BHCIP funds. The city of Lancaster was awarded $83.7 million for a new 96-bed behavioral health facility, and the nonprofit Tarzana Treatment Centers received $66.6 million to build a campus offering residential treatment beds, outpatient SUD treatment, outpatient mental health treatment, and medication-assisted treatment for opioid use disorder.[101] A third awardee in Lancaster, a for-profit corporation, 44049 Sierra Hwy Propco, LLC, received $83.7 million to expand capacity across the continuum of care.

Issues to Track

- Will increasing financial pressure finally drive greater consolidation in the Los Angeles hospital market?
- What will happen to the DSH funding and directed payments critical to private safety-net hospitals? Will Martin Luther King Jr. Community Hospital's financial picture stabilize, preserving a key point of access in an underserved area?
- Will consolidation of independent physician practices continue? Will remaining small IPAs be acquired by health systems and other corporate owners?
- How will Los Angeles County respond to the expected increase in uninsured Angelenos, and how will California's response to state budget shortfalls and HR 1 impact that response? How will LA Health Services maintain its massive system of public hospitals and clinics with fewer resources as expected reductions in Medi-Cal occur?
- How will the robust CHC sector fare as the expected Medi-Cal coverage losses and restrictions on payment for undocumented residents take effect?
- Will the investments made by L.A. Care and others, including new medical school capacity, begin to turn the tide on workforce shortages? What new investments and innovative approaches to meeting health workforce demand will emerge?
- Will behavioral health infrastructure investments address the acute shortage of community-based mental health beds? What changes will the transition from MHSA to BHSA bring about in behavioral health services delivery, integration, and outcomes?

Background on Regional Markets Study

Between October and December 2025, researchers from Yegian Health Insights, LLC, conducted interviews with health care leaders in Los Angeles County to study the market's local health care system. Los Angeles is one of seven markets included in the Regional Markets Study funded by the California Health Care Foundation. The purpose of the study is to gain key insights into the organization, financing, and delivery of care in communities across California and over time. This is the fifth round of the study; the first set of regional reports was released in 2009. The seven markets included in the project — Inland Empire, Los Angeles, Sacramento, San Diego/Imperial, San Francisco Bay Area, San Joaquin Valley, and Shasta/Lassen — reflect a range of economic, demographic, care delivery, and financing conditions in California. Yegian Health Insights interviewed over 200 respondents for the overall study, with 25 to 30 interviews specific to each region. Respondents included executives from hospitals, physician organizations, CHCs, Medi-Cal managed care plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.



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ABOUT THE FOUNDATION

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system.

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