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TO: Each Supervisor

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

SUBJECT: ESTABLISHMENT OF A BENEFIT PACKAGE

On July 13, 2004, your Board directed the Department to provide a "status on the establishment of a specific benefit package for the services provided to patients across the healthcare system." This report proposes a benefit definition for uninsured patients and a timeframe for its implementation. The Department's philosophy with regards to benefit design includes services that fit within the following framework:

- Provide high medical value to the patient, both in terms of the clinical outcomes and the costs associated with the provision of care.
- Benefits are consistent with those currently provided under the Medi-Cal program. The vast majority of DHS patients are uninsured or covered by Medi-Cal.
- Benefits are consistent with sound operational needs and to assure that facilities have the capabilities expected in institutions that provide emergency care.

DHS is recommending the broad categories for inclusion and two levels of benefit restrictions attached in Appendix I. Level One restriction includes those services that will not be provided in any DHS facility, such as liver transplants. Level Two restrictions are those which will not be available to the medically indigent unless there is clear fiscal and programmatic benefit to the

Department. If the Department can assure a net fiscal benefit, funds generated by approved activities will enable us to provide additional care to the indigent.

DHS does not anticipate that the application of this structured benefit program will yield large savings. However, the Department believes that defining eligibility and benefits is important for County and Departmental planning and to patients who should know what services they can expect to receive.

If your Board approves of the proposed concept, the Department will provide you with an implementation plan and timelines within 90 days.

Please let me know if you have any questions.

TLG:jg

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

AVAILABLE AND UNAVAILABLE SERVICES

(Subject to Available Resources)

Medical Criteria

The County will provide medical care for an eligible patient whose presenting health condition or symptoms* meet the following general criteria:

- Presenting health condition/symptoms are life-threatening**

  Examples include major trauma, myocardial infarctions, cerebral vascular accidents, etc.

- Presenting health condition/symptoms are acute (could lead to medical complications or disability)

  Examples include fractures, gallbladder and ulcer disease, infectious diseases, etc.

- Presenting health condition/symptoms are chronic (conditions that are progressive and require ongoing medical management)

  Examples include diabetes, hypertension, asthma, rheumatoid arthritis, etc.

- Presenting health condition/symptoms constitute a communicable disease which is a threat to the general public

  Examples include tuberculosis, sexually transmitted diseases, all childhood vaccine-preventable diseases such as measles, mumps, rubella, diphtheria, pertussis, varicella, etc.

* An evaluation conducted to determine the nature and severity of a symptomatic condition and to order indicated treatment, is a covered service.

** Welfare and Institutions Code §16953(b) defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment of bodily functions; or (3) serious dysfunction of any bodily organ or part.

Available Services

- Evaluation and treatment of acute or chronic health conditions
- Emergency department care for emergencies as defined**
- Emergency medical transportation
- Urgent care
- Inpatient care
- DHS formulary medications
- Specialist referrals
- Surgical and diagnostic procedures
- Rehabilitation

Unavailable (Excluded) Services

The Medical Benefits and Coverage Group has identified two categories of unavailable (excluded) services. The medical services in Group I are services that will not be offered or available at DHS facilities. Group II are services that will be available only if providing the services makes good programmatic and business sense (as determined by the Department through benefit-cost analysis and other means) and patients provide adequate third-party coverage or can remit full charges.

Group I

- Organ transplants including bone marrow and solid organs other than kidneys (such as heart, lung, liver, etc.)
- Custodial Care
- Board and Care
- Cochlear Implants
- Adult day care health services

Group II

- Acupuncture
- Chiropractic
- All procedures and treatment designed primarily to improve appearance or self image (e.g., cosmetic surgery) rather than ameliorate disability.
- Lasik eye surgery
- Treatment of sexual dysfunction
- Infertility services
- Reversal of voluntary sterilization
- All diagnostic, therapeutic, and rehabilitative procedures and services which are considered experimental or of unproven medical efficacy pursuant to the California Medical Assistance Act (Medi-Cal)
- Routine dental care, routine dental studies, orthodontia, and fixed prostheses
- Routine injections of antigens
- Hearing aids
- Routine audiology exams for patients without a medical problem
- Routine physician examinations for adults for school, employment or immigration
- Non-emergency medical services for residents outside County
- Treatment in an extended or long-term care facility, including skilled nursing and intermediate care services

Known Exceptions to Excluded Services

Medical care is delivered based on the individual needs of the patient. As such, there are certain exceptions to the excluded services based upon clinical circumstances (see following detail). Even if the patient does not have an a priori exception, the patient (or their family) may choose to appeal the exclusions via the formal appeals process (see page 5).

Known Exceptions

- Routine dental care, routine dental studies, orthodontia, and fixed prostheses Exceptions Include:
    - Patients with neurological conditions (e.g. quadriplegic, spastic cerebral palsy) that severely limit dental hygiene.
    - Patients with implanted grafts in cardio-vascular or joint space (valves, Gortex aortic grafts, total knee replacements, etc.)
- Routine injections of antigens to ameliorate allergic conditions Exceptions Include:
    - Asthma
    - Life-threatening anaphylaxis
    - Patients with severe discomfort not responsive to other medical management

PROGRAM GOVERNANCE AND OVERSIGHT

Medical Benefits Committee

The Medical Benefits Committee (MBC) is established to assist the Program Director in managing three major elements of Program governance and oversight: (1) resolving Program governance problems which arise in relation to the operation of the Program; (2) review patient/practitioner appeals and determine if disputed services should be provided under the guidelines of *medical necessity*; and (3) periodically review *unavailable* (*excluded*) services and to manage the Program benefit package. The MBC is comprised of nine members including the DHS cluster medical directors (one of which will serve as Chair on a one-year rotation basis), two facility/program CEO's (to serve one-year rotational terms from pool of available DHS CEOs), and one representative from the DHS Financial Management Committee (FMC to serve a one-year rotation from FMC membership).

The Appeals Process

It is the intention of the MBC to ensure that patients receive medically necessary care. To formalize this process there is four-tiered appeals process governed by the MBC and patterned after the CHP appeals process.

Local review by the cluster Medical Director or designee

Local review by the Medical Executive Committee (MEC) or designee

Central review by the MBC

Central review by the Director or his designee. The Director reserves the right to review any appeal resolved at a lower level.

There will be a tracking mechanism for each appeal filed.