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April 1, 2010

To: Supervisor Gloria Molina, Chair
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From: William T Fujioka
Chief Executive Officer

**DEPARTMENT OF HEALTH SERVICES – INDEPENDENT REVIEW SERVICES: EVALUATION OF THE OFFICE OF MANAGED CARE (AGENDA OF APRIL 13, 2010)**

On December 16, 2008, your Board instructed the Chief Executive Officer (CEO) to issue a Request for Statement of Qualifications (RFSQ) for an independent review entity or contractor, reporting directly to your Board, to examine, assess and make appropriate recommendations on the administration, operations, and functions of the Department of Health Services (DHS). Further, the CEO was instructed to bring the highest-ranked proposers (up to six) to your Board for review.

## BACKGROUND

The RFSQ was issued on February 10, 2009, and proposals were due by March 11, 2009. In our memorandum dated July 28, 2009, we advised your Board that the six proposals received in response to the County's RFSQ for the DHS Independent Review Entity were transmitted to your Board on June 30, 2009, including the evaluations of the proposals which had been prepared by an evaluation panel. Inasmuch as the Independent Review Entity would serve at your Board's direction, a Closed Session was conducted on September 22, 2009 for your Board to review the proposals and the evaluations.

Following the Closed Session, we advanced two firms to the contract negotiations phase: The Abaris Group and Health Management Associates (HMA). As part of this phase, we executed Agreements with each, under this Office's delegated authority, to complete pilot study projects with separate scopes of work and to make presentations to your Board.

Based on input from your offices, we selected the evaluation of the DHS Medical Malpractice/Quality Improvement unit as one area of review and entered into a Delegated Authority Agreement with The Abaris Group for that pilot study project. The Abaris Group is in the process of consolidating its findings and recommendations to present to your Board in early May 2010.

The second study area was to evaluate the DHS Office of Managed Care (OMC)/Community Health Plan (CHP) and its readiness for pending health reform changes. The HMA consultants are scheduled to present their report as a set item for discussion at your Board's meeting on April 13, 2010. The HMA report is attached and discussed further below.

**EVALUATION OF THE OFFICE OF MANAGED CARE**

Under their Delegated Authority Agreement, HMA was asked to: 1) conduct a comprehensive assessment of the DHS OMC's current operations to evaluate its readiness to participate in the expanded managed care opportunities potentially available under pending healthcare program regulations and requirements; 2) evaluate the extent to which the County may uniquely benefit from healthcare reform opportunities by continuing its operation of OMC under County governance; 3) evaluate DHS' ability to retain its current patient base as well as serve in an expanded capacity as a medical home and compete with the private sector for new managed care enrollment; and 4) provide written analyses and recommendations regarding these areas.

Based on the Statement of Work, the HMA report addressed the following critical question:

> *If the County of Los Angeles is going to continue to operate a comprehensive health care delivery system in the face of impending changes related to the coverage of Medi-Cal patients and the conversion of a large proportion of those patients into managed care plans, what changes does it need to make in the way that it delivers services and relates to managed care and forms partnerships with other providers, what assistance can the Office of Managed Care--or others--provide in making this transformation, and what steps must be taken to secure that assistance?*

**Key HMA Findings:**

- Whatever the final form health reform takes, it is likely that a large number of previously uninsured people will be added to the Medi-Cal rolls and that a significant proportion of those enrollees will be assigned to managed care plans.

- DHS is not now well positioned to retain its patients who, if converted to Medi-Cal managed care, will have a choice to go into other systems, as the DHS system lacks the infrastructure and orientation to compete in a managed care environment.

- DHS OMC is today almost entirely devoted to the operation of a health plan. It does not have the personnel, expertise or the resources to provide DHS with the assistance that it needs to develop a managed care approach to caring for patients in the coordinated way that is required of managed care providers.

- L.A. Care, as the Local Initiative in Los Angeles County, has the mission to "protect the community safety net," the resources to provide assistance to DHS to make its transformation into a well-managed and integrated delivery system, and the incentive to partner with DHS as an effective provider for its assignees.

- The DHS approach to ambulatory care organization needs to be refocused as the entry point to the system, particularly in a heavily managed environment, rather than as an appendage to the system's hospitals.

- The County, through DHS collaboration with the Departments of Mental Health (DMH), Public Health (DPH) and Public Social Services (DPSS), uniquely possesses all of the elements of an innovative approach to designing and implementing integrated care for those patients that the State will be looking to put into Medi-Cal managed care systems.

**Key HMA Recommendations:**

- CEO convene DHS and L.A. Care leadership to start a negotiation process that, within six months, should result in a newly integrated relationship between the two organizations that must assure mutual benefit and long-term sustainability.

  - Among other things, the negotiations should include a joint commitment to develop an integrated "safety net delivery system" which would include DHS, community clinics, other safety net hospitals, and behavioral health providers, and be best aligned to take on the population of patients who

will, under the likely tenets of a renewed California 1115 Waiver, move into Medi-Cal managed care.

- If negotiations are successful, transition DHS out of the operation of the CHP.
- Integrate the DHS Office of Ambulatory Care (OAC) and OMC into a separate and distinct entity by transitioning the administration of ambulatory care services (primary and specialty) out of the control of the hospital clusters.
  - Serve as the basis for an integrated delivery system that is prepared for patient care management.
  - Integrate the Public/Private Partners into the DHS delivery system.
  - Play a significant role in establishing strategy and policies for outpatient practice and managed care for the system.
- Coordinate the County's DHS, DMH, DPH, and DPSS to develop integrated care pilot projects that will highlight the unique potential and resources the County of Los Angeles has to develop innovative, cost-efficient, and clinically effective models that will combat the most complex, expensive types of patient care.

**CEO Recommendations:**

We have reviewed the HMA report, and we recommend that your Board approve the report, in concept. We believe the HMA findings and recommendations are particularly timely and relevant given the recent passage of federal health reform legislation and the current discussions on the next 1115 Waiver. They are also relevant to the current efforts undertaken by DHS, as directed by your Board and approved in the County Strategic Plan Update for 2010, to develop integrated and coordinated healthcare systems in Los Angeles County.

In addition, we recommend that this Office convene DHS and L.A. Care representatives to engage in negotiations to determine whether the new relationship, as outlined in the HMA report, can be developed. If the negotiations are successful, the County will work with L.A. Care to formalize the new relationship in an Agreement, which will be subject to approval by your Board and the Board of Governors for L.A. Care.

We further recommend that this Office convene workgroups of affected County Departments and other stakeholders, including, but not limited to, representatives of the community clinics, behavioral health providers, labor groups, hospitals and other health care providers, and health care advocates, to develop an implementation plan, with specific timelines and projected costs, to address the recommendations in the HMA report.

It should be noted that any changes to the DHS infrastructure, including the potential of transitioning out of CHP or consolidating the DHS Ambulatory Care operations, or pilot project proposals for integrated services, if recommended, would be subject to further action by your Board.

If the recommendations of this Office are approved, we will provide your Board with the status of negotiations with L.A. Care and an initial implementation plan by June 30, 2010.

If you have any questions, please contact me or your staff may contact Sheila Shima, Deputy Chief Executive Officer, at (213) 974-1160.

WTF:SAS:MLM
AMT/AY:bjs

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Department of Health Services
Department of Mental Health
Department of Public Health
Department of Public Social Services

040110_HMHS_MBS_DHS OMC Review Agenda of 041310

HMA

HEALTH MANAGEMENT ASSOCIATES

# *Evaluation of the Office of Managed Care of the Los Angeles County Department of Health Services*

MARCH 2010

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

ATLANTA, GEORGIA • AUSTIN, TEXAS • CHICAGO, ILLINOIS • COLUMBUS, OHIO • INDIANAPOLIS, INDIANA
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# Introduction

Health Management Associates (HMA) was retained by the Los Angeles County Board of Supervisors in December of 2009 to:

1) *Conduct a comprehensive assessment of the current operation of the Office of Managed Care (OMC) to evaluate its readiness to participate in the expanded managed care opportunities potentially available under pending health care program regulations and requirements;*
2) *Evaluate the extent to which the County may uniquely benefit from health care reform opportunities by continuing its operation under County governance;*
3) *Evaluate the ability of the Department of Health Service (DHS) to retain its patient base as well as serve in an expanded capacity as a medical home and compete with the private sector for new managed care enrollment; and*
4) *Provide written analyses and recommendations regarding these areas.*

The approach that the HMA team has taken, over the past two months, to address the issues above has included the following activities:

- reviewing all of the available data from OMC describing the operations of its Community Health Plan (CHP);
- meeting with OMC leadership on three occasions to go through that data and further explore questions raised;
- meeting with the DHS clinical, financial and health services leadership multiple times to discuss programmatic, planning, organizational and finance issues and to clarify utilization data;
- participating in site-visits to each of the DHS clusters (Harbor/MLK, LAC+USC, Rancho Los Amigos, Olive View/Valley Care/High Desert) and meeting with key clinical and administrative leaders of each to determine both current activity related to the OMC/CHP and potential opportunities for retaining Medi-Cal managed care patients within DHS;
- holding two meetings with the leadership of LA Care, the County's Local Initiative, to explore current and possible new relationships with the County and DHS and reviewing data related to CHP;
- interviewing the leadership of organizations representing Public-Private Partners (PPPs) in the CHP provider network (MedPoint for Health Care LA and Altamed);
- meeting with the leadership of other LA County entities with responsibility for services related to the ability of DHS to take advantage of opportunities to gain and retain Medi-Cal managed care patients (Department of Public Health, Department of Mental Health, Department of Public Social Services);

- reviewing other County/managed care relationships within the State of California to glean lessons learned and potential opportunities;
- discussing California 1115 Medicaid Waiver and federal health reform initiatives with key players to determine implications for the County and potential scenarios related to OMC and DHS; and,
- checking- in regularly with the CEO project team to discuss assumptions and developing conclusions.

It should be noted that HMA, because of its historic focus on public health care financing and safety net organization, has clients throughout California (hospitals, counties, health plans, unions and foundations) for whom it provides advice on Medi-Cal issues. This is particularly true today as the attention on the renegotiation of the California 1115 Medicaid Waiver and national health reform have caused significant uncertainty in the health care industry. It is a firm policy to take all precautions to avoid any conflict of interest between clients and this policy has been strictly adhered to with this project for the Los Angeles County Board of Supervisors.

HMA has appreciated the opportunity to contribute to this important assessment and has generated recommendations that, we believe, are in the best interests of Los Angeles County, the Department of Health Services and, most importantly, the populations and communities that rely on a robust health care safety net in these difficult economic times.

Pat Terrell
*Managing Principal*

Terry Conway, MD
*Managing Principal*

## Executive Summary

Over the past several months, Health Management Associates has reviewed data, interviewed key stakeholders, visited provider sites, discussed the implications of California and federal health reform efforts and tested assumptions and preliminary conclusions with the CEO project team. The focus of this effort has been to find a rational and practical answer to the following critical question:

> *If LA County is going to continue to operate a comprehensive health care delivery system in the face of impending changes related to the coverage of Medi-Cal patients and the conversion of a large proportion of those patients into managed care plans, what changes does it need to make in the way that it delivers services and relates to managed care and forms partnerships with other providers, what assistance can the Office of Managed Care---or others--provide in making this transformation, and what steps must be taken to secure that assistance?*

The findings generated through this process are described on the pages of the report in great detail. Very briefly, the major conclusions reached by HMA are:

1) Whatever the final form health reform takes (through both the California 1115 Medicaid Waiver renewal process and through federal coverage initiatives), it is likely that a large number of previously uninsured people will be added to the Medi-Cal rolls and that a significant proportion of those enrollees will be assigned to managed care plans.

2) LA County's health care delivery system, the Department of Health Services (DHS), is not now well positioned to retain its patients who, if converted to Medi-Cal managed care, will have a choice to go into other systems as the system lacks the infrastructure and orientation to compete in a managed care environment.

3) DHS' Office of Managed Care (OMC) is today almost entirely devoted to the operation of a health plan. It does not have the personnel, expertise or the resources to provide DHS with the assistance that it needs to develop a managed care approach to caring for patients in the coordinated way that is required of managed care providers.

4) OMC's Community Health Plan (CHP) does not, in HMA's opinion, provide DHS with either a significant volume of patients or enough revenue to make it a significant resource for Los Angeles County. In fact, its presence actually serves as a distraction (a sense that "something is being done related to managed care") that helps to prevent DHS from implementing the system reorganization needed to meet the needs of its patients who will have a choice to go elsewhere or to effectively manage the care (and the cost) of those who don't.

5) LA Care, as the County's Local Initiative has the mission to "protect the community safety net," the resources to provide assistance to DHS to make its transformation into a well-managed and integrated delivery system, and the incentive to partner with DHS as an effective provider for its assignees. If skillfully negotiated, a new relationship could be forged between LA Care and DHS for the mutual benefit of both organizations.

6) The DHS approach to ambulatory care organization is significantly behind where many well-functioning public health systems have evolved and needs to be refocused as the

entry point to the system, particularly in a heavily managed environment, and not as an after-thought or as an appendage to the system's hospitals.

7) The current relationship that DHS has with the Public Private Partner (PPP) clinics does not build on the opportunities for an integrated system of care but actually provides financial disincentives for the effective management of patient populations. This connection should be strengthened and restructured.

8) The County, through the collaboration of its Departments of Health, Mental Health, Public Health and Public Social Services, uniquely possesses all of the elements of an innovative approach to designing and implementing integrated care for those patients that the State will be looking to put into Medi-Cal managed care systems. This collaboration should be actively pursued.

9) The change in health care delivery will come rapidly; the County should act now so as not to be left caring (and paying) for only those who have no other choice.

The recommendations generated by this evaluation are summarized briefly below:

- The Los Angeles County CEO should convene the leadership of DHS and the leadership of LA Care to start a negotiation process that would, within six months, result in a new, integrated relationship between the two organizations. It is imperative, however, that **all** of the issues listed below are addressed to assure mutual benefit and long term sustainability.

  a) Transition DHS out of the operation of a County-owned health plan (CHP).

  b) Conduct an independent audit to determine the real "profits" generated by CHP which LA Care would then agree to maintain the same level of profitability for the County, directing these resources into managed care infrastructure for the DHS safety net delivery system.

  c) Use investment from LA Care to build managed care infrastructure within the DHS delivery system, allowing it to meet the challenge of attracting and retaining a significant new number of Medi-Cal assignees and managing costly uninsured patients.

  d) Realign the DHS Office of Managed Care into a component of a new DHS approach to ambulatory care services oversight (described below).

  e) Streamline administrative functions for DHS' Medi-Cal managed care and IHSS assignees and its Healthy Way LA patients under LA Care.

  f) Assure the maintenance of at least the current level of Medi-Cal managed care and IHSS assignees into the DHS system and commit to growing that patient volume as additional patient populations move into Medi-Cal managed care.

  g) Build a joint LA Care/DHS "managed care unit" that would be dedicated to the development of managed care infrastructure within the DHS system and promotion of DHS facilities and providers within LA Care.

h) Commit to the joint development of an integrated "safety net delivery system." DHS and LA Care would identify the elements of an integrated delivery system (including DHS providers, PPPs, other safety net hospitals, County behavioral health providers) that would be best aligned to take on the population of patients who will, under the likely tenets of a renewed California 1115 waiver, move into Medi-Cal managed care.

i) Address the constraints in the LA County system which negatively impact the current contracting process between DHS facilities and other health plans and providers.

j) Assure the accountability and progress of the negotiation process. It is critical that the development of a mutually beneficial new relationship between the County and LA Care proceed with some haste, given the implications of both the California waiver and health reform. The CEO should insist upon regular reports and benchmarks for the negotiation process and they should also be shared with the Board of Supervisors and the LA Care Board, particularly with the County representatives on that body.

- DHS, with the support of the Los Angeles County Board of Supervisors and the CEO, should restructure its current approach to the oversight of Ambulatory Care services. Specifically, the restructuring should:

  a) reorganize all primary care and ambulatory specialty services delivered within DHS under a single organization that would be the basis for an integrated delivery system prepared for the management of patient care;

  b) integrate the current Office of Ambulatory Care (OAC) and the Office of Managed Care into one entity, on par with DHS' hospitals;

  c) include the responsibility for DHS relationships with the Public Private Partners (PPPs) and their integration into the DHS delivery system;

  d) provide the new ambulatory organization with the leadership and the infrastructure elements needed to organize DHS services to most effectively participate in managed care; and

  e) assure the new entity has a significant role in the establishment of strategy and policies for outpatient practice and managed care for the system.

- The leadership of the Los Angeles County's Departments of Health Services, Mental Health, Public Health and Public Social Services should be directed to develop and implement integrated pilot projects to address the needs of patients targeted by the California Medicaid 1115 waiver renewal proposal, as well as current patients routinely utilizing services throughout the various departments without coordination. LA County should build upon its unique role and scope of resources to develop innovative, cost-efficient and clinically effective models that target the most complex—and expensive—patients, both in the Medi-Cal system and those that are uninsured and the responsibility of the County taxpayer.

# Findings

## *General Context*

At the time of the writing of this report, the final conclusions of health reform efforts at the national level and negotiations related to the renewal of the California Medicaid 1115 waiver have not been reached. In addition, the State of California's budget situation—and the implications for Los Angeles County, make the continuation of business as usual uncertain. However, the findings below reflect the general environment facing the County regardless of any change in Medi-Cal coverage and also identify those issues most likely to be implemented in any State or federal health care reform changes.

- It is likely that, over the next 2-4 years, a significant number of Medi-Cal patients currently covered through fee-for-service reimbursement will be moved into managed care programs through a new California Medicaid 1115 waiver. These patient populations (Seniors and Persons with Disabilities—SPDs, the dual eligibles, adults with severe mental illness and children with special health care needs-CCS) consume the bulk of Medi-Cal funding and the containment of the cost of their care is critical for a state with budget problems as over-whelming as those faced by California. In fact, the very nature of the waiver is that it must demonstrate budget neutrality while expanding access-thus the cost of care for these expensive populations must be decreased. The movement of these patients into managed care will likely have a significant impact on the County's ability to retain patients with some third party coverage, as Medi-Cal is by far the County's most important payer.

- If national efforts at health reform are successful, it is likely (as the provision is contained in both the House and Senate bills) that there will be a massive expansion of Medicaid coverage, up to, at minimum, 133% of the federal poverty level without restrictions on category (except for documented status). If approved, this action will likely transform a large number of patients for whom the County is now totally responsible to covered patients with choice of providers. Further, it is also likely that the expansion will be coupled with an increase in reimbursement, perhaps over time to Medicare rates. DHS, like public systems across the country, experienced a massive decrease in the utilization of their pediatric and obstetric services by Medi-Cal patients in the mid-1990's when those patients became more attractive to private providers; that experience (like the exodus of patients from the public system when they become old enough to be eligible for Medicare) needs to be remembered and learned from.

- Health reform efforts at the federal level will also likely significantly limit, over time, some avenues of creative financing traditionally available to public hospital systems

which have allowed them to negotiate subsidies to assure their continuation as the hubs of community health care safety nets. The sense in Washington appears to be that, when most people are covered, the preservation of individual institutions will not be as necessary as it is today. However, it is important to understand that the State will still need to retain local governments (and LA County, in particular) as partners in implementing new initiatives like the establishment of integrated delivery systems and the movement of complex patients into managed systems of care. Thus, public systems like DHS will continue to be important but must shift their operations to meet the demands of a more managed population.

- If enacted, State and federal reform efforts will, in all probability, present a significant challenge to Los Angeles County: more of their current patients will be funded but will have a choice to go elsewhere (or be taken elsewhere by their health plans) and those covered patients that stay enrolled in managed care plans will present participating providers (like DHS) with clear expectations related to cost, utilization and quality. A determination will need to be made at the highest levels of the County about its commitment to remain in the health care business after State and federal reform. If the commitment is there, attention will need to be paid now to making the changes necessary to retain Medi-Cal patients in its delivery system, a source of revenue that will be necessary to offset the cost to the County of continuing to care for those who will remain uninsured.

- Advocacy efforts currently underway by the California Association of Public Hospitals to seek "preferred provider status" for patients currently in public hospital systems that convert to Medi-Cal managed care under the proposed waiver is an essential strategy but will only provide a defined time (several years) for the system itself to become ready to function in a way that will allow it to successfully compete to maintain that patient base. If this provision is successfully negotiated, it certainly should not be squandered. In particular, DHS, and LA County, should look hard at creating effective models for caring for difficult patient populations targeted in waiver negotiations including SPDs and persons with serious mental illnesses.

- No matter what happens at the State or federal levels, the onus of responsibility for the care of under-served populations will continue to be, at least for the next several years, local communities and, more particularly—especially in California--county governments and health systems. Clearly, that is why preparing for the eventuality of greater proportions of paying patients converted into managed care is so essential. HMA would contend, however, that the focus on local government as the hub health care safety net is also why these same bodies need to aggressively move toward more intensive management of the *non-paying* patient populations as well. Containing costs has as much benefit as increasing revenue. Further, the continuing focus on local communities is why Counties need to be looking at maximizing the benefit of being part of organized systems of care. They need to give their attention—and resources—to those services that they do

best, and that the broader community needs most while partnering with other providers to assure a comprehensive, sustainable and managed delivery system.

- Given all of the issued identified above, the real question facing the County and DHS today, HMA believes, is the following:

  *"If we are going to continue to operate a comprehensive health care delivery system in the face of impending changes related to the coverage of Medi-Cal patients and the conversion of a large proportion of those patients into managed care plans, what changes do we need to make in the way that we deliver services and relate to managed care and form partnerships with other providers, what assistance can the Office of Managed Care---or others--provide in making this transformation, and what steps must be taken to secure that assistance?"*

## *OMC and DHS*

A significant component in this assessment is exploring the OMC relationship to the rest of DHS. Among the critical findings relevant to this issue are the following:

- It is widely acknowledged that, as it stands today, there is no significant managed care infrastructure within the DHS delivery system. The OMC is the Office of Managed Care, not the Office of "Managing the Care." It would be a significant—and unfair—expectation of the current OMC that it provide management services to help the delivery system prepare for and conform to the requirements of managed care; it is essentially singularly devoted to the operation of the Community Health Plan (CHP). Of the 129 employees in OMC, all but three are dedicated to the CHP; the only resources of note to support the DHS delivery system are focused on contracting and the extension of some services to assist in the operation of Healthy Way LA and some additional administrative functions (such as securing concurrent review). **HMA concludes that the OMC, as it is now configured, is not in a position to assist DHS in preparing its hospitals, clinics, processes and policies for a significant increase in managed care patients.** The CHP staff are neither trained nor experienced in delivery system change (nor were they hired with that expectation) and they are not readily transferable to become a Management Services Organization (MSO). Further, it will take a far greater investment and infusion of resources than is currently available to OMC to effectively help DHS make that transition.

- Nearly all of the current Medi-Cal managed care patients that are assigned to DHS facilities and providers come through the CHP, even though there is some indication that there would be interest from other plans in utilizing DHS, particularly its specialty services. The CHP population that is assigned to DHS providers only represents

approximately 35% of all CHP Medi-Cal assignees, with the rest assigned to private providers. Over the past four years, the proportion of CHP patients assigned to DHS facilities has steadily decreased from 40% to 35%. Further, most of these patients are assigned to CHP in the first place by LA Care only because an agreement is in place to auto-assign into CHP 75% of Medi-Cal patients who have not picked a plan. Thus, many of these patients have no significant history with or allegiance to the DHS system. Further, while DHS facilities are assigned only about 47,000 of CHP's Medi-Cal patients, they are almost the only providers for approximately the same number of IHSS workers, another product line administered through CHP. If a significant portion of this group of workers becomes eligible for Medi-Cal under national health reform efforts (i.e., have incomes under 133% of the federal poverty level), it is reasonable to assume that DHS could lose their "preferred provider" status with this population as well.

- While CHP reports some revenue generated by the plan and returned to DHS annually, the data is questionable as CHP has both one of the highest administrative rates and, at the same time, the highest "profitability" in the State. It simply doesn't make sense. Whatever the reality now, it is likely that the risk adjustment being passed down from the State through LA Care to CHP will reduce current revenues. In independent LA Care and DHS financial analyses, it is now estimated that there will be a 4.1 % reduction in CHP revenue this year, which represents only 20% of the expected risk adjustment that potentially will be implemented by the State over the next several years.

- The value of CHP (the predominate focus of the OMC) within DHS and to the County is unclear. There have been undeniable and widely-recognized strides made in enhancing the professionalism of the health plan in recent years. Unfortunately, that fact, however laudable, is almost irrelevant to the questions raised in this engagement. It would appear that the value of CHP to the system, if retained, should be: 1) to serve as a vehicle to keep Medi-Cal patients within the DHS system; or 2) to make money to subsidize the rest of the DHS operations. Neither seems to be the case in any significant way. Further, because the CHP is by far the predominate area of concentration for the OMC, there are few resources to perform other tasks that would be of real benefit to the system: facilitating the transformation of the DHS delivery system to focus on effective management of its patients and helping to link DHS--through contracts or otherwise--into integrated delivery systems that will be necessary to effectively use scarce resources. This latter failing—it should be clearly noted—is not the fault of OMC or DHS. The focus, staffing and resources have been almost entirely directed to the operation of a health plan and that has been the directive to the relatively new leadership of OMC. However, the situation is now a conundrum: the health plan cannot be successful in relation to the County system if there is not significant change made at the DHS delivery system but those changes cannot be assisted or supported by the OMC because all of its attention (and expertise) is devoted to the health plan and also because it does not have the resources necessary to facilitate the system change that is needed.

- Today, the OMC/CHP is viewed, for the most part, as a "boutique program" by DHS providers at the network/cluster levels. This is an understandable viewpoint as CHP members make up such a small proportion of the total number of patients seen at most of the DHS hospitals and clinics that it is very difficult to make the reporting, quality, and management efforts required for managed care patients a priority. The OMC contracting assistance has been recognized as being of some help by DHS entities that are seeking formal relationships with other providers (i.e., burn and women's and children's services at LAC+USC, rehabilitation services at Rancho) but that function is basically embodied in one person and the enormous constraints inherent in the contracting process makes this effort less than adequate (e.g., County cost structure, lack of coding infrastructure, bureaucratic processes related to contracts approved, the restrictions on bargaining related to County requirements to "meet variable costs" and not enter into arrangements where there may be capacity problems).

- OMC/CHP is hampered by inadequate data coming from DHS about their patients and by lack of information technology support, in general. Most problematic is the fact that, as a County entity, OMC/CHP must move through the same human resources and purchasing systems as the rest of DHS. This bureaucracy does not allow for the flexibility necessary to change areas of focus, seek new positions and classifications, or move quickly to take advantage of opportunities.

- As DHS approaches its patient populations in "silos," it is difficult for the system to provide OMC with a vision as to where they are going as a delivery system and what the implications should be for their managed care operation. For example, the approximately 100,000 CHP enrollees in DHS facilities (Medi-Cal, IHSS, Healthy Families) are approached very differently than the 57,000 Healthy Way LA patients (who may well become eligible for Medi-Cal coverage under health reform and would likely convert to managed care). The PPP relationships could offer a significant opportunity to DHS (through their contractual agreements with the County, their status in Healthy Way LA and as CHP providers) but there seems to be little integration of these approaches. OMC does not serve in a planning role for DHS in identifying new strategies (for example, how to keep the current 40,000 SPD patients in DHS when they are transitioned into managed care or how to develop an approach to caring for behavioral health patients, another target of the waiver for transition into managed care). This strategic function does not seem to be within the scope of OMC.

- A successful approach to "managing the care" of a patient population requires a firm grasp on the primary providers responsible for coordinating the care of enrollees, the medical home. The focus of attention in a well-managed delivery system must be on the ability to keep its patients as healthy as possible and out of emergency departments and inpatient beds, a goal that requires effective clinics and connections between levels of care (see discussion in next section). DHS' approach to the leadership of both its ambulatory services and managed care is neither integrated nor moving forward with a common vision. While the leadership of OMC and DHS' Ambulatory Services are

collegial, neither has historically been a focal point of the system. Although new efforts are underway in "ambulatory care restructuring," the vision for and expectations of DHS ambulatory and managed care remain elusive.

- In exploring the value of CHP and the current configuration of OMC to DHS and the County, it has been important to assess the rationale behind maintaining the County's possession of a Knox-Keene license. There have been two "benefits" expressed during the course of this assessment: 1) maintaining the CHP "gives the County control," and 2) having a license offers the opportunity for the County to get into another product line, such as a managed care plan for its employees. HMA believes that neither of these issues are convincing.

## *DHS, Los Angeles County and Managed Care*

If DHS was prepared for competing for patients in an increasingly managed care environment, the issue of the future of OMC would not be as significant. However, the following are findings related to that readiness and potential opportunities:

- Medi-Cal is such an important source of funding for the County that impending changes (including likely expansion of eligibility and transitioning large new populations into managed care) make it imperative that the DHS change its organization and approach to delivering health care services. To address the burden of cost and to expand Medi-Cal coverage, the State legislature and administration want to move to a more organized—managed--health delivery system and away from the fragmented fee-for-service approach currently taken for its most costly enrollees. The federal government may also require population management within organized systems of care under health reform. HMA believes that the uninsured that seek care within DHS should also be considered as a population and have their health care needs addressed and managed proactively within an organized system of care in order to assure the maximum efficiency of the County-funded services provided to them. All of this change requires leadership, vision, infrastructure and accountability. Now is the time to start this process.

- There are large populations that receive services within the DHS system whose care, in the near future, will be required to be provided within a more managed approach. Several highly likely groups include: the disabled and SPD patients, expanded Coverage Initiative (Healthy Way LA) enrollees, the Seriously Mentally Ill patients, children with special needs, and the dual Medicaid-Medicare eligibiles. Care for these patients under a capitated system will actually offer opportunities that are not available to DHS currently. HMA believes that the Obama Administration may be more flexible in allowing other

payment methodologies that could result in the County being paid more than cost and taking away the financial disincentives that currently make shifting care to a less expensive ambulatory setting not financially attractive. Also, current federal caps do not exist for managed care payments and are replaced with actuarially-determined rates that provide greater flexibility in financing and in providing care. Capitated rates provide funding for a return on investment up to 6 percent profit. Further, costly and complicated prior authorization and audit requirements are not necessary under a capitated rate. Finally, these payments have more flexibility to pay for services, such as case management, needed to reduce the cost of care. Thus, there is a financial incentive to moving the DHS system to a more managed care environment.

- DHS, particularly when coordinated with other departments and programs within LA County government (public health, mental health and public social services), possesses all the health care resources necessary for a robust and organized delivery system targeting exactly those patient populations of greatest interest to the state as they move toward a more managed environment. Further, the contractual relationship between DHS and the PPPs has the potential for forming the basis of an integrated delivery system that does not now exist. These are the most important and expensive elements of the organized system of care that will be required of safety net providers within California. However, the delivery of care provided today within DHS is performed in a reactive way, as is care within many public safety net systems. Care is "siloed," the parts of the system are, at times, structured to be competitive with each other. They are not population-focused and expend resources excessively on duplicative and high cost care. The infrastructure needed to support an organized system of care is largely missing, underdeveloped or misdirected.

- A managed system of care must be able to clearly define the population that it manages, and must monitor its health status and utilization in near real time. The system actively focuses and directs care for its members into the ambulatory setting. A medical home is assigned to all members enrolled in the system of care and the patient and the medical home accept this assignment. The medical home is the first place that all health concerns are brought. It is linked to urgent care, specialty care (including Behavioral Health), diagnostics, inpatient care and long term care. The right kind of care is delivered at the right time within the right location and level of the system. Transitions are managed back to lower levels of care efficiently and mainly to the medical home. Care is coordinated. Care coordinators and case managers assist the patient to access needed care, transition back to the medical home, and assist the patient with their own self management of their conditions. The workforce within the system is trained and incentivized to provide the type of care envisioned here. To begin the conversion of the DHS health programs into an organized and managed system of care requires a "forced march" toward a new way of delivering services, a path that is now being approached only in fits and starts.

- Ambulatory care should be the centerpiece of any managed system of care. Over the past decade, public systems across the country have begun to recognize that they are not just

hospitals anymore and the most effective of them (Denver, New York City, Dallas, etc.) have transitioned the administration of ambulatory care services (primary and specialty) out of the control of hospitals—and medical schools—and given this level of care the prominence and infrastructure that it needs. The oversight of ambulatory care within DHS resides primarily within hospital clusters and specialty outpatient care is oriented more to the hospitals than to the primary care medical homes. Comprehensive Health Centers (CHCs) provide a relatively small amount of primary care for such a large system and are somewhat second-class citizens within the hospital regional networks. Multi-service Ambulatory Care Centers (MACCs) provide necessary services but have hospital partners remote and separate from themselves, and are not tightly aligned with primary care resources. The Office of Ambulatory Care has little planning, funding or operational control over these ambulatory resources. Much of the primary care delivered within the system is provided by Public Private Partners (PPPs). The Office of Ambulatory Care is consumed with managing PPP contracts but the PPP relationship is treated, on both sides, as more of a vendor arrangement than a component of a County-operated health delivery system. PPPs and private providers who are providers within CHP share that perspective and even more are precluded from using DHS specialty consultants due to a lack of contracts between CHP and DHS outpatient specialty, inpatient and diagnostic centers. DHS ambulatory care would have to be reorganized and structured to provide a system of care for DHS to participate in and benefit from the changes that will be required as more patients move into managed care. One approach is to consolidate all primary care and specialty ambulatory clinics under a separate structure that has status at least equivalent to a hospital or medical center. It would require its own administrative, clinical, financial, and operational leadership. It would plan the resources required and reimburse its providers in a manner that incentivizes and supports the management of population based care. There are other models; the key is to recognize and support the role of ambulatory care as the entry point to a well-managed delivery system.

- The PPP arrangement in Los Angeles County is a unique one. Most of the PPPs are Federally Qualified Health Centers (FQHCs) and are expected, by the federal government that certifies them, to provide a certain level of care to the uninsured. They receive direct grants, cost-based Medicaid and Medicare reimbursement, tort coverage, 340b drug pricing—all benefits meant to allow them to better serve under-served communities. LA County has entered into an arrangement that basically "covers" the uninsured for these providers. While this assures the availability of care to many people who would otherwise have no access and significantly extends the safety net for the County, it also should offer the groundwork for a more integrated delivery system model with DHS, where joint planning determines the best use of all available resources. Part of that planning should review the current fee-for-service reimbursement methodology between DHS and the PPPs, a system which can provide incentives to churn visits rather than to effectively manage populations. A capitation model may offer better opportunities for comprehensive and integrated care and should be explored.

- It is widely recognized within DHS, including in OMC/CHP, that the data systems, or at least their current use, provide inadequate support for managing the health care delivery

for a defined population or operating an organized system of care. Managers are unable to tell how many persons might actually be considered to be within the DHS system today. For example, the number of SPD patients can only be estimated and the estimate has changed drastically several times. The conditions and level of acuity or risk of the population is unknown. The most basic piece of information in most health information systems is the claim, or the diagnosis and billable service a person in the system has received at each encounter. Due to the unique method in which DHS has been reimbursed in the past, even these basic data elements have never been accurately entered. A basic information system for an organized network of care meeting managed care requirements, must offer the following: real time data as to who is a member of the system, their health status and a risk assessment; a registry for chronic conditions that contains a care plan and relevant clinical information including relevant medications, lab, diagnostic and utilization data; access to all members of the healthcare team and organizations within the system; assurance of the appropriateness of care (i.e., electronic-referral with appropriateness screen, tele-medicine support by midlevel providers); support of care transitions and care coordination; support of utilization management; and support of peer review, quality improvement and continuous innovation. This information technology does not currently exist within the DHS system.

- DHS identifies the major Disease Management (DM) resource (essential for effectively caring for the populations that will likely be transitioned into managed care) within DHS as the Clinical Resource Management (CRM) program. This program has put much of its effort into inpatient clinical pathways and several outpatient chronic illnesses. It appears to offer benefits that would be helpful within a comprehensive disease management program. However, a comprehensive disease management and care coordination program does not currently exist. Some case management personnel meant to provide these services to CHP patients have been assigned to mainly clerical and billing functions due to the lack of an actual DM/care coordination program. Contemporary organized systems contain approaches that identify high risk conditions in entry and in an ongoing way. They then apply interventions that are appropriate to the individual's risk profile. DM and care coordination staff are considered part of the health care team at the medical home, share a care plan with the medical home and communicate regularly with patients and clinicians, including face to face visits. This approach is not in place within DHS.

- Organized delivery systems cannot succeed without the support and effort of its clinicians. Often, the reimbursement of these clinicians is driven by quality and cost efficiency. DHS receives a large number of its providers from medical schools and reimbursement is paid through Medical Services Operating Agreements. These agreements would require significant change to reflect the needs of an organized and managed delivery system; particularly as such arrangements impact the vast resource inherent in the DHS specialty outpatient services that are controlled, to a large degree, by faculty physicians and delivered by residents and fellows. The agreements do not explicitly assure access to these needed services by specifying a required volume of care to be provided. Specialty outpatient services are key resources for other providers caring for Medi-Cal patients and could serve as a vehicle for creating integrated delivery

systems more broadly than simply within DHS. There is also little financial incentive for physicians hired under these agreements to effectively manage their patients' care. Ironically, many of the University departments and physicians are experienced in being paid for performance or through risk sharing arrangements at the private University hospitals and clinics; they know how to practice in this manner.

- HMA was impressed by the opportunities inherent in the fact that the County operates behavioral health and public health programs that could be harnessed to create integrated care models with DHS providers targeting the very patients that the State is attempting to focus more control over. There seems to be a willingness-even an enthusiasm—at the highest levels of these "sister" departments to work together to create a more managed environment for these patients who, more often than not, are utilizing services in all departments in an uncoordinated fashion now.

- Most critically, DHS will need to reconfigure their leadership structures to assure that all elements of the delivery system are aware of and committed to the vision of the evolution of the current operation into an organized system of care, ready to compete for and retain large numbers of patients who will be covered by managed care plans, as well as to effectively and efficiently manage the care of those patients for whom the County will likely remain the primary payer. The transformation will require resources, focus, accountability and no distractions. HMA believes that, today, the CHP is a distraction from DHS' ability to "managing the care" of its patients.

## *LA Care Potential Collaboration*

HMA spent considerable time reviewing LA Care's role with the County/DHS/CHP and its potential for future interaction and partnership. The following are findings resulting from discussion with LA Care's leadership and other stakeholders:

- As Los Angeles County's Local Initiative, LA Care has a mission to "protect the community safety net" and understands that the County and DHS are the hub of that safety net, particularly for certain specialty services. The County is well represented on its Board of Directors. Further, it is important to note, a DHS delivery system that is able to effectively and efficiently manage the care of its patients is a significant benefit for LA Care as well.

- LA Care has the ability—and, seemingly, the willingness—to invest in helping DHS solve real operational problems that impact cost of care, patient retention, development of integrated networks and the potential of the system to successfully compete in the

managed care environment, particularly for Medi-Cal patients. These operational problems include, but are not limited to: pharmacy refills, hospital contracting (to minimize out-of-network liabilities), decreasing emergency department (ED) visits and inpatient lengths of stay, addressing unnecessary use of supplies and durable medical equipment (DME). Because LA Care functions independently of the County, it has greater flexibility in providing services to the delivery system than OMC/CHP, which must operate under its constraints. LA Care could also extend its administrative and patient management services to help to integrate Healthy Way LA enrollees (many of whom could become Medicaid eligibles under health reform) and could work with the County to coordinate more aggressive enrollment efforts through LA Care's use of *one e app.*

- A partnership between LA Care and DHS could present a significant opportunity to forge joint approaches to the patient populations that will most likely be moved into managed care under the new California waiver. There are an estimated 270,000 SPDs living in Los Angeles County—with only about 40,000 seeking regular care in the DHS system. LA Care could work with DHS to develop "Enhanced Medical Homes" in DHS' Comprehensive Health Centers (CHCs) and Multi-service Ambulatory Care Centers (MACCs) to become effective providers for this population, targeting those currently utilizing the DHS system as well as new enrollees. The same partnership (DHS and LA Care) could develop approaches to those with serious mental illness (also involving the County's Department of Mental Health), children with special needs and the duals. This effort would require considerable attention over the next several years from both agencies but could result in an approach that would likely be viewed favorably by the State.

- Because of its long-standing and seemingly overall positive relationship with PPPs (a claim substantiated in several discussions with clinic providers), LA Care would have the ability to work with DHS to reinforce new integrated relationships with the clinics. There is currently little interaction between the PPPs and DHS related to the Medi-Cal population (for example, some PPPs would like to have access to high risk obstetrical services at DHS but have no clear way of forging these contracts, although CHP is trying to move through the County contracting process). As many of the patients currently covered by the County through the PPP program may well move into Medi-Cal with health care reform, having LA Care participate in creating a more integrated—and mutually beneficial--delivery system now makes sense for all participants. DHS, the PPPs and LA Care could also explore the potential of administering the PPP relationship with the County in the same capitated modality as they do under Medi-Cal managed care.

- If CHP were to be transitioned out, there would need to be clear protections negotiated for the County to assure that any replacement (whether LA Care's own health plan or other arrangement) would guarantee that DHS retain, at minimum, its current level of assignees, as well as clearly detail the level of investment by LA Care in the DHS delivery system to make it more responsive to a managed care environment. Specifically,

DHS would need to be assured to retain the current level of IHSS assignments. This change may require a transition period, perhaps having LA Care assume the operations of CHP over time while DHS concentrated on the development of a management services infrastructure. This new partnership would need to be very specific regarding the expectations and protections for each side.

- Despite the fact that LA Care's management has been very positive about the potential for a new and more integrated relationship with DHS, any such agreement would require authorization and approval from the plan's Board of Governors. There is also language contained in LA Care's enabling legislation regarding situations where LA Care would assume functions currently assigned to the County and, in certain circumstances, this language could trigger significant changes related to mandating that LA Care recognize the County's current labor agreements when taking over functions. Thus, significant conversations would need to commence and, potentially, agreements struck with key stakeholders including organized labor.

## Recommendations

Based on the findings above, HMA makes the following recommendations to the Los Angeles County Board of Supervisors and the CEO related to the Office of Managed Care and the Department of Health Services:

1) **The Los Angeles County CEO should convene the leadership of DHS and the leadership of LA Care to start a process that would, within six months, result in the negotiation of an agreement for a new, more integrated relationship between the two organizations. <u>It is imperative that all of the issues</u> listed below are addressed to assure mutual benefit and long term sustainability.**

   a) <u>Transition DHS out of the operation of a County-owned health plan (CHP).</u> It is HMA's conclusion that there is no significant value for the County to operate a health plan and, in fact, the presence of CHP is actually a distraction from the focus that needs to be placed on the development of a system-wide approach to the management of DHS patients and the establishment of an integrated delivery system. It is likely that the transition to LA Care operation of CHP could take at least one year to accomplish. Whether or not the County decides it wants to maintain the Knox-Keene license should be part of this negotiation. It is important, however, that CHP is not dissolved or otherwise transitioned until the other issues listed below are addressed appropriately.

   b) <u>Conduct an independent audit to determine the real "profits" generated by CHP.</u> LA Care would then agree to maintain the same level of profitability for the County,

directing these resources into managed care infrastructure for the DHS safety net delivery system.

c) Build managed care infrastructure within the DHS delivery system, allowing it to meet the challenge of attracting and retaining a significant new number of Medi-Cal assignees and managing costly uninsured patients. DHS and LA Care will agree on a "bundle" of services and personnel on which to invest that will be the most helpful in moving the delivery system forward with greater capacity to manage the care of their patients and to position the delivery system for the expected significant increase in the number of Medi-Cal patients that will be transitioned into managed care over the next several years. These investments should include, but not be limited to IT, care management, quality, reporting, concurrent utilization review and contracting. The infrastructure investments by LA Care in the DHS system should be transparent, on-going and integrated into other delivery system restructuring (see below) accomplished within the DHS.

d) Realign the DHS Office of Managed Care into a component of a new DHS approach to ambulatory care services oversight (described below). By transferring the administration of the CHP to LA Care, OMC should focus on becoming, through both resource investment from LA Care and integration with the DHS Office of Ambulatory Services, a function within a new structural entity charged with leading DHS into a more comprehensive managed care environment. Currently, few of the CHP staff would have the expertise to provide these management services functions and would likely need to be transitioned into other DHS jobs or to LA Care (see below). There are several OMC leaders who could provide assistance to this transition and participate in this newly structured entity.

e) Streamline administrative functions for DHS' Medi-Cal managed care and IHSS assignees and its Healthy Way LA patients under LA Care. As it is anticipated that most Healthy Way LA patients will likely be eligible to move onto the Medi-Cal rolls over the next several years (the expansion to category-blind eligibility of all of those under 133% of the Federal Poverty Level is contained in both the House and Senate bills), it makes sense for one administrative entity to handle all three groups. LA Care would need to be able to add the IHSS and Healthy Way LA programs into its scope of business (less than Knox-Keene licensed product) and would need to assure that it would cost DHS no more—and, likely, significantly less--for these administrative services than it is costing internally now. Further, LA Care and DHS, with the participation of the PPPs, should explore the potential for LA Care to take on the administration of the County's PPP contracts, perhaps moving to a capitation plan. In order to take on the administration of these additional programs, LA Care should agree to interview existing CHP employees for possible transition to LA Care jobs. This action will, it is acknowledged, require an agreement with organized labor.

f) Assure the maintenance of at least the current level of Medi-Cal managed care and IHSS assignees into the DHS system and commit to growing that patient volume as additional patient populations move into Medi-Cal managed care. There will need to be an agreement to maintaining the current level of auto-assignment of patients into DHS through LA Care directly. The provider network for IHSS patients would need to remain as currently defined: primarily focused around DHS facilities. Finally, LA Care would facilitate the inclusion of DHS facilities, providers and services into other plans.

g) Build a joint LA Care/DHS "managed care unit" that would be dedicated to the development of managed care infrastructure within the DHS system and promotion of DHS facilities and providers within LA Care. This commitment would require a dedicated unit within LA Care to work alongside a dedicated unit within DHS focused on delivery system managed care infrastructure.

h) Commit to the joint development of an integrated "safety net delivery system." DHS and LA Care would identify the elements of an integrated delivery system (including DHS providers, PPPs, other safety net hospitals, County behavioral health providers) that would be best aligned to take on the population of patients who will, under the likely tenets of a renewed California 1115 waiver, move into Medi-Cal managed care. This process will assess the best use of all available resources and will provide direction to DHS on the focus of its Comprehensive Health Centers, Multi-service Ambulatory Care Centers and specialty care services.

i) Address the constraints in the LA County system which negatively impacts the current contracting process between DHS facilities and other health plans and providers. The CEO should convene a working group from DHS, LA Care and other relevant County agencies to review the steps in and policies related to the existing process that appear to make it extremely difficult for DHS to enter into beneficial contracts which would bring paying patients into the DHS facilities.

j) Assure the accountability and progress of the negotiation process. It is critical that the development of a mutually beneficial new relationship between the County and LA Care proceed with some haste, given the implications of both the California waiver and health reform. The CEO should insist upon regular reports and benchmarks for the negotiation process and they should also be shared with the Board of Supervisors and the LA Care Board, particularly with the County representatives on that body.

2) **DHS, with the support of the Los Angeles County Board of Supervisors and the CEO, should restructure its current approach to the oversight of Ambulatory Care services. Specifically, the restructuring should:**

a) Reorganize all primary care and ambulatory specialty services delivered within DHS under a single organization that would be the basis for an integrated delivery system prepared for the management of patient care. There are numerous models in other public health and hospital systems of such organizational structures and DHS will need to identify what configuration makes the most sense for its system. Such recognition of the importance of ambulatory care, however, is critical as DHS moves more and more into an environment dominated by managed care—and "managing the care" of expensive but uninsured patient--that depends upon most services being delivered at the lowest (and most preventive) level of care. Within DHS, this structure should organizationally mirror the structure of its hospitals with budgetary inclusion of all personnel, space and support services from the Comprehensive Health Centers, Multispecialty Ambulatory Care Centers, and hospital-based ambulatory primary and specialty care centers. Strategically, the ambulatory care organization must be able to set standards and demand accountability within one system approach. While hospital-based ambulatory care would continue to be provided where it is now (and remain on the hospital license), it is important that oversight of those services is included in this new entity as the connections between primary and specialty outpatient services are essential for sound patient management. It should be clear, however, that the ambulatory leadership would also have a responsibility to the hospitals in the system to work collaboratively to address issues such as transition from inpatient to ambulatory care and on projects related to the minimization of unnecessary ED utilization.

b) Integrate the current Office of Ambulatory Care (OAC) and the Office of Managed Care into one entity. This new organization should be charged with the reorganization of ambulatory care throughout the system, including the development of a defined role for the outpatient services delivered within DHS as Medi-Cal managed care Medical Homes (or Enhanced Medical Homes for more complex patients) and as specialty consultants for other Medical Homes where appropriate. The new entity would provide an ambulatory vision for the system, target areas for development (such as outpatient rehabilitation centers in collaboration with Rancho Los Amigos to be in a position to serve as Medical Homes for persons with disabilities) and also be dedicated to working with DHS hospitals in support of their EDs and inpatient units in order to decrease inappropriate use, inpatient length of stay, and unnecessary admissions.

c) Include the responsibility for DHS relationships with the Public Private Partners (PPPs). Currently, the Office of Ambulatory Care administers PPP contracts. The new organizational entity should have the responsibility for working with the PPPs to become better integrated into the DHS system and facilitate their participation in the planning of various roles for DHS and PPP providers (i.e., PPPs could function as primary care Medical Homes, CHCs as Enhanced Medical Homes, MACCs and hospital-based specialty services as coordinated consultants). The new DHS ambulatory care department should also, in collaboration with DMH, define and lead the integration of behavioral health and primary care services consistent with the direction of the California 1115 waiver reauthorization.

d) Be provided with the leadership and the infrastructural elements needed to organize DHS services to most effectively participate in managed care. It is important to note that, today, most of the staff in the OMC are dedicated to running a health plan and most of the effort within the OAC is consumed with the administration of PPP contracts. Thus, while senior leadership of the two entities may function well within a new organizational structure devoted to ambulatory and managed care, it would be a mistake to believe that this could be accomplished by simply merging the two existing Offices. The DHS ambulatory department must include adequate Senior Leadership in administration, clinical affairs, finance, contracts, and human resources—all of which are functions that have different skill sets and areas of expertise than are required for hospitals. Many of these positions may be found within the current DHS budget and transferred to this reorganized department. However, it will be critical to identify leaders with significant experience in such massive systemic oversight, as well as attention to operations and strategic thinking. In addition, infrastructure such as care management, telephone advice and assistance, contracting, information technology, and non-ED urgent care resources will be essential supports for this effort and the leadership of this new department should be involved in negotiating the relationship between DHS and LA Care in order to secure needed resources.

e) The new ambulatory department should play a significant role in establishing strategy and policies for outpatient practice and managed care for the system. These areas of focus would include, but not be limited to: determining the appropriate use of specialty resources; setting standards and screens for referrals for sub-specialty consultation and diagnostics; implementing benchmarks for provider productivity; identifying access and quality goals; and, identifying priorities for DHS system capacity. The ambulatory department will need to have a clear role in the negotiation of DHS agreements with its medical school partners to assure that there is accountability in delivery of and reimbursement for outpatient services, both primary care and specialty. Finally, the ambulatory department will serve as a critical partner to LA Care in the development of an integrated safety net delivery system.

3) **The leadership of the Los Angeles County's Departments of Health Services, Mental Health, Public Health and Public Social Services should be directed to develop and implement integrated pilot projects to address the needs of patients targeted by the California Medicaid 1115 waiver renewal proposal, as well as current patients routinely utilizing services throughout the various departments without coordination.** LA County should build upon its unique role and scope of resources to develop innovative, cost-efficient and clinically effective models that target the most complex—and expensive—patients, both in the Medi-Cal system and those that are uninsured and the responsibility of the County taxpayer. While such collaboration is difficult in massive public systems like Los Angeles County, there is a clear interest expressed by all of the Department leaders interviewed by HMA in further integration and, in addition, existing collaborative initiatives on which to build. The Department of

Mental Health (DMH), for example, is already working with DHS at Olive View and Harbor hospitals on psychiatric urgent care and crisis resolution programs and would be open to exploring the integration of behavioral health and medical services at some DHS CHCs and/or MACCs, as they currently do with several PPPs. The Department of Public Health (DPH) administers approximately $250 million in dollars targeted for substance abuse treatment; dollars that are currently paid out primarily in contracts to private vendors but could also provide some resources for an integrated approach to patients within DHS with medical, physical and mental health problems. Finally, the Department of Public Social Services (DPSS) plays a significant role throughout the County (including within DHS facilities) in screening patients for Medi-Cal eligibility and in administering the IHSS program. Once these pilots are implemented, the County should work with the State and LA Care to promote these integrated efforts as an effective and efficient approach to taking on the management of its complex patients.

## Conclusion

HMA has been honored to provide this analysis for the Los Angeles County Board of Supervisors and the Office of the CEO; the issue is both timely and critical. It would be less than gratifying, however, if this evaluation were to be viewed as simply a competent report and failed to convey the urgency that HMA truly feels faces the County. While it may appear that the issues addressed here are over-whelming, the fact is that the solutions are relatively straight forward. There are significant opportunities available to the County and key stakeholders appear ready to participate in making necessary changes in the County's delivery system and its approach to managed care, both in order to retain the Medi-Cal population and to more efficiently care for those for whom the County will likely remain responsible. This is a unique point in time when much is in flux; LA County could lead in creating new models and not wait for change to be imposed upon them.