Health Services
LOS ANGELES COUNTY

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Christina R. Ghaly, M.D.
Deputy Director, Strategic Planning

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

November 26, 2012

TO: Supervisor Zev Yaroslavsky, Chair
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STEPS REQUIRED TO SUCCESSFULLY ADAPT THE DEPARTMENT OF HEALTH SERVICES (DHS) AND LOS ANGELES COUNTY FOR THE AFFORDABLE CARE ACT (ACA) (Agenda Item #28, November 27, 2012)**

INTRODUCTION

The ACA is a complicated piece of legislation and long articles have been written concerning its many provisions. Further complicating matters, federal rules guiding implementation of several of the Act's provisions have not yet been released (e.g., the formula for the decrease in disproportionate share hospital (DSH) dollars); also some aspects of the Act's implementation will depend on future actions by the State of California (e.g., what the Medicaid benefit package and income ceiling will be).

I do not intend, in this first of a series of requested reports on how DHS and the county is preparing for the ACA, to review all of the provisions of the ACA or to speculate about how unresolved issues will be dealt with. Instead, I would like to focus on the two major features of the ACA, and the broader health reform environment, that will have the most pronounced effect on DHS: 1) patient choice; 2) payment based on per member per month capitation or some form of bundled payment rather than based on expenses. In the process of explaining these two elements, I would like to emphasize the necessary steps for a successful implementation. Subsequent memos will provide more detail on the specific steps, other provisions of the ACA, unresolved issues, and chart our progress in successfully implementing the ACA.

We are only 13 months from the Medicaid expansion. Failure to rapidly take the necessary steps, detailed below, to prepare for the ACA implementation will result in huge financial shortfalls or closure of facilities, or both.

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MAJOR IMPACTS OF ACA ON DHS AND NECESSARY STEPS FOR SUCCESSFUL IMPLEMENTATION

Patient choice

The best available estimates are that 70% of the currently uninsured in Los Angeles will be eligible to gain health insurance either through Medicaid or through the State of California Health Benefit Exchange. At the current time, an uninsured person must be seen within the safety net (DHS or one of our community partners) or pay substantial out-of-pocket costs. When they choose care within the safety net, even if they choose primary care with a community partner, any specialty care, advanced diagnostics, or hospitalization they require will be with DHS since these services, with a few small exceptions, are not provided at community partner sites. Starting in January 2014, these patients will no longer have to stay with DHS.

The group that will be most directly affected by the gain in choice are the 200,000 persons currently enrolled in Healthy Way LA (HWLA). This group will transition directly into Medicaid on January 1, 2014. At the current time 50% of our expenses for caring for this group are reimbursed by the federal government under the Medicaid 1115 Waiver bringing in an estimated 140 million dollars of federal money.

Starting in January 2014, HWLA patients will have a choice of the two managed care providers under the State Medicaid two plan model: L.A. Care (the public sector health plan) and Health Net (the private sector health plan). Once the patient chooses their health plan they will next choose a primary care provider (doctor, nurse practitioner, or physician assistant) within a health center. If the patient does not make a choice, they will be auto-enrolled at whatever Medicaid managed care provider they previously received the most care. Subsequently they would have the opportunity to choose a different provider if they desire. This is one of the reasons why it is so important that the transition of these patients to managed care protects existing patient-provider relationships to the fullest extent possible.

What would be disastrous for LA County would be for the vast majority of HWLA patients to choose a different provider. This is not an idle worry. The last time a large number of uninsured persons received Medicaid, the 1990s' State expansion of Medicaid to include pregnant women and their children, the number of deliveries in DHS hospitals plummeted from about 43,000 deliveries a year to fewer than 3,000 in recent years.

Some observers unfamiliar with the cost structure of health systems might think if the newly insured patients go elsewhere, Los Angeles County won't receive the revenue but also won't have the expense of caring for these patients. Therefore, it will not be disastrous. They are missing the point that hospitals have huge fixed expenses which are not decreased by decreases in volume. The reality is that a decrease in volume of say 30%, may result in a decrease in expense of only about 5-10%, because the decrease in volume will result in need for fewer bedside nurses and pharmaceuticals but will not affect the big cost drivers of hospitals (e.g.,

physical plant, billing system, coverage by specialized physicians in different areas, etc.). Therefore, a large volume drop in paying patients could result in our seeking tens to hundreds of millions of dollars of additional county support to maintain our system. And because some studies estimate that there could be as many as 1.3 million remaining residually uninsured in Los Angeles after the ACA is fully implemented, we will be required to continue to provide a full range of services.

Fortunately, there is no reason why we cannot learn from our own history. Indeed over the last two years we have taken a large number of steps to maintain our volume of paying patients, including:

- Developing and instituting a primary care home model in our health centers and hospital-based outpatient clinics.
- Empaneling close to 300,000 patients in primary care homes.
- Ending block appointments (all patients having the same appointment time).
- Installing a disease management registry to track the interventions patients need longitudinally.
- Creating a contract for being a direct care provider under L.A. Care (necessary to retain 25,000 patients with Medicaid including Seniors and Persons with Disabilities—SPDs).
- Developing a new training for direct care providers on providing an improved patient experience.
- Increasing the number of primary care appointments.
- Successfully launching eConsultation for primary care doctors and specialists to use to communicate about needed care and treatment.
- Completing the bid process and contract negotiations for a comprehensive, integrated, system-wide Electronic Health Record (EHR).
- Co-locating physical and behavioral health services in DHS clinics

Although these initiatives have been successful, it is especially important that we make a lot of progress in the next two years on initiatives that will maximize the number of paying patients seen within our system:

- Increase enrollment in HWLA.
- Increase number of primary care, specialty care, and diagnostic outpatient appointments.

- Complete staffing and increase cohesion of primary care teams.
- Complete configuration of disease management registry.
- Expand use of eConsultation and Central Referral Unit to all primary care sites within DHS and our Community Partners.
- Expand use of teledermatology, teleophthalmology, and other mechanisms to rapidly increase DHS' capacity to provide specific specialty services.
- Install a new telephone system for ambulatory care sites.
- Develop contracts with independent physician association of community partners so that we can receive referrals of capitated patients who see community providers for their primary care.
- Develop an integrated electronic health record with decision support and prescription writing software.
- Develop a patient-centered scheduling system (same and next day appointments for established patients with an immediate need).
- Develop contracts with health plans for specialty services for which we have excess capacity (e.g., acute rehabilitation, burn unit).
- Develop contracts that will facilitate service to dual-eligible clients.
- Expand labor-management activities that help to increase focus on front-line customer service, e.g., Unit-Based Teams, DHS-wide Innovation Award, customer service training, etc.

Change in payment model from payment of expenses to per member per month or other set payments

Historically, DHS has received most of its revenue through federal waivers whereby we have been paid for unreimbursed *expenses* of providing care. Under such a model, there is no incentive to keep expenses low or to expend effort and money to closely track costs of different service modalities. After all, if you are paid on the basis of your expenses, the cost of individual services (e.g., a clinic visit, a hospital day) is not so important.

This model of payment is quickly going away. In future years, the predominant way we will be reimbursed is per member per month. In addition, the Centers for Medicare and Medicaid Services is rapidly developing payment models that will pay for outcomes rather than process. Already, there is a list of "should never occur outcomes" such as line infections; if such events occur; we are not paid for associated costs. In future models, we are likely to receive decreased

reimbursements if our quality measures, including measures such as patient satisfaction, are not improved.

Also one of our larger sources of federal money, Disproportionate Share Hospital (DSH) funding, will be decreased under the ACA. The ACA specifies an overall 50% decrease in funding, starting at $500 million in 2014, $600 million in 2015 and 2016, $1.8 billion in 2017, $5.0 billion in 2018, $5.6 billion in 2019, and $4.0 billion in 2020. DHS received an estimated $415 million in Medicaid DSH in 2012-13. It is also possible that the State will seek to decrease realignment funding, citing the new Medicaid revenues that the County will be receiving for patients who were previously uninsured despite the fact that Counties will still be responsible for caring for a large number of residually uninsured.

To survive in this environment, DHS must decrease the cost of our services while simultaneously improving quality and service levels. The only way to do this is to provide the right service in the right place by the right person. For example, we will not succeed if we continue to have a large number of patients in our inpatient hospitals who would be better served in a lower level of care (e.g., board and care, supportive housing, respite unit, home with support).

To prepare for these changes, we have:

- Rolled out new Key Performance Indicators, a financial dashboard to improve oversight of department and unit level costs and ensure that employees are assigned to the correct cost center.
- Instituted a new State of California endorsed system of determining whether hospital admissions and continued stays are appropriate in real time. This system is already being used at LAC+USC and Olive View-UCLA Medical Centers and will begin to be used at our other two hospitals in February 2013.
- Restructured our ambulatory teams and reassigned nurse managers and nursing assistants to the inpatient areas where they are needed and there are existing funded items.
- Raised expectations regarding direct care provided by licensed clinical personnel serving in administrative roles.
- Improved attention to cost and quality in selection of diagnostics and therapeutics (e.g., reduced use of Factor VII, shifted from screening colonoscopy to FIT testing).
- Secured contract for Central Fill of refill prescription medications.

In the next two years we will need to make more progress on:

- Producing expenditure reports in real time (no more than a two week lag) that track expenditures by cost center and includes both salary and contractual costs (e.g., registry use).
- Decreasing the number of days in the hospital of patients who are not acutely ill.
- Increasing through-put in ambulatory care, including specialty care, outpatient diagnostics, and ambulatory surgery at our hospitals.
- Developing, in collaboration with our community partners, an empanelment model to increase the efficiency of care for the residually uninsured.
- Obtaining 340-B pricing for medications dispensed from our ambulatory care centers either through obtaining FQHC look-alike status for our clinics or tying episodes of outpatient care to inpatient or specialty care so as to qualify medication for 340-B pricing (more cumbersome and will only qualify a portion of our drug costs).
- Developing a stronger case management/community health worker/promotora model of care for chronically ill patients who are costly to care for.
- Improving coordination of care transitions (e.g., inpatient to outpatient, inpatient to lower level of care, out-of-network to in-network)
- Housing more chronically ill, expensive to care for, homeless patients in supportive housing.
- Standardizing inpatient, Emergency Department (ED), and outpatient nurse staffing ratios.
- Expand use of utilization management tools to curb unnecessary use of costly services (e.g., MRI).
- Further integrating DHS' services with those provided by the Departments of Mental Health (DMH) and Public Health (DPH) for those with behavior health and/or substance abuse diagnoses.
- Expanding focus on outpatient managed care/quality program.
- Continuing organizational restructuring to maximize economies of scale and internal efficiencies (e.g., HIM department, centralized nursing functions).

Ways the County family can help assure that DHS is a success in Health Reform

The County of Los Angeles faces many challenges and must prioritize scarce resources to meet the needs of all Angelenos. A narrow reading of this part of my report may cause people to say

that my request to prioritize the needs of DHS in the next several years is unfair because all departments within the county need the things that I am asking for, and that the needs of DHS need to be interdigitated with the needs of other departments.

Although I certainly understand this point of view, the fact is that DHS will be the only County Department that must compete for the bulk of its future income, and our failure to succeed will result in our requiring large infusions of county money or service closures, either of which will be very disruptive for the County and the departments within it.

It is unlikely that DHS can succeed under the ACA under the current county processes. For example, implementation of the electronic health record will require classification and hiring of eighty-six IT persons (55 new; 31 vacancies). This is an undertaking that could easily take over a year under the normal county timetable, but must be accomplished for about 60 positions in 2-3 months or will result in costly delays in EHR implementation.

Besides classifying new positions we will also need to continue to reassign staff. For example, as we increasingly use electronic records we will need hundreds fewer medical records persons for filing and scanning written records. To bring down our costs we will need to reassign these staff to other clerical duties within DHS and other county departments. Because of the large number of persons involved, and because we cannot move the person until we complete unit by unit the transfer from paper to electronic records, this process could be expected to take a long time. To the extent that we make rapid progress, we will save money that will fund those new expenditures required by health reform.

The following changes in County Administrative Functions would facilitate DHS' ongoing transformation:

1) Hiring of budgeted positions must be markedly faster

2) Classification of new positions, and determination of existing and new positions must be markedly faster

3) Contracting process must be markedly faster

The CEO has committed to putting together a task force that would address and focus on key administrative functions across the county and that would ensure that positions are classified, hired, and contracts are created, as rapidly as possible. The task force will include staff from multiple offices and departments.

Efforts Needed in Other County Departments

We need to accelerate the great efforts that have occurred over the past two years in integrating services among DHS and its sister departments. For example, DHS and DMH are pursuing a residential care facility which we will jointly use and for which we will receive more revenue by doing it together than we would receive if either of us pursued the project separately. We are

also working actively with DMH to create primary care homes for persons with serious mental illness and in turn to have greater access to consultation for DHS patients with mental illness. Similarly, we have made arrangements with DPH to place additional substance abuse counselors in DHS EDs to improve referral of patients with substance abuse problems.

Other critical efforts needed within our sister departments include the following:

- DMH to increase residential and other placement options for mentally ill persons in acute care psychiatric beds that no longer need acute hospitalization (currently about 70 patients a day are in acute psychiatric beds that can move to a lower level of care were it available).

- DPH to increase the breadth and quantity of substance treatment options for patients in the DHS system who have serious substance abuse problems and are therefore requiring expensive medical care due to the complications of their ongoing substance use.

- The Department of Public Social Services to take on a greater role in the enrollment and re-determination of HWLA (i.e. future Medicaid) clients.

- The Department of Community and Senior Services to assist with coordinating direct placement of elderly adults seen in EDs receiving services through Adult Protective Services (APS)

CONCLUSION

Over the last two years DHS has made significant progress preparing for health reform. Now that the ACA is clearly going forward we need to accelerate the transformation especially in the areas of being a system of choice and aligning our costs to the methods by which we will be paid.

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c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors