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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.

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June 4, 2013

TO: Each Supervisor

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

SUBJECT: **STEPS REQUIRED TO SUCCESSFULLY ADAPT THE DEPARTMENT OF HEALTH SERVICES AND LOS ANGELES COUNTY FOR THE AFFORDABLE CARE ACT (ITEM # 102, JUNE 4, 2013)**

UPDATE

To ensure that our state fully benefits from the three-year 100% Federal reimbursement of the Medicaid expansion, the process of transitioning low-income health plan members to Medicaid will need to begin as soon as four months from now so that patients move seamlessly into Medicaid January 1, 2014. Although the Governor's May Revision of the State Budget signaled a good step toward a State-led Medicaid expansion, a number of budgetary and policy issues that would have significant impact on the safety-net require further attention. The Department of Health Services (DHS) and our community and advocacy partners are engaging the Brown Administration on these issues. Along with advocacy and negotiation in Sacramento, DHS and our partners are also working together to prepare our Healthy Way LA members for the Medicaid transition, as well as to transform our model of care to an integrated care delivery system that will optimize our ability to meet the challenges presented by health reform.

In this update, I will summarize our position on the Governor's May Revision proposal for Affordable Care Act (ACA) implementation. I will also provide an update on our success with implementing eConsult, an innovative consultation and referral system that is enabling DHS to provide specialty care to patients within two days of their primary care doctor's referral.

POLICY DEVELOPMENTS

The May Revision to the State FY2013-2014 budget proposes a state-based approach to Medicaid expansion, an important step toward a feasible and comprehensive health reform implementation by January 1, 2014. Under the ACA, the Federal government will provide 100% of the reimbursement for Medicaid expansion patients from January 1, 2014 through December 31, 2016, and thereafter provide no less than 90% of the reimbursement indefinitely. Implementing Medicaid expansion by

January 1, 2014 would enable California to maximize available federal funding for public hospital systems like ours and serves as the starting point for our willingness to redirect a portion of the realignment funds to help defray State costs of the expansion. Unfortunately, the mechanism by which the Governor proposes to redirect County funds to the State has several significant flaws that make the proposal unworkable for our system and would weaken the safety-net under the ACA.

Summary of Governor's May Revision Proposal

The Governor proposes using a formula that quantifies the level of county savings available for redirection to the State under Medicaid expansion. County savings would be determined by measuring actual costs for providing services to Medicaid and uninsured patients and revenues received for such services. The revenues in the formula would include federal funds, health realignment funds, and net county contributions to health care services. The difference between total revenues and total costs would be the savings that would be redirected to the state. Further, the Governor would place a cap on the cost growth of county expenditures based on historic trends for this formula calculation.

Our Position on the Formula Described in the May Revision Proposal

Several aspects of the proposed formula are problematic and require reconsideration:

- *Problem: Start date for redirecting county savings to the state*. The Governor proposes immediately reducing county funding for indigent care in FY 2013-2014. This reduction is based on assumptions rather than real data and prematurely assumes significant and immediate savings when in it is unknown whether such savings will materialize. As I have indicated in previous reports, we do not yet know precisely how many County residents will remain residually uninsured with implementation of the ACA. Further, the state does not bear any of the reimbursement costs for Medicaid expansion until 2017.
  Our position: Defer start date for redirecting county savings until FY 2016-2017, the first year when the state will have costs related to Medicaid expansion and by which time we will have real data on costs and savings under the ACA.

- *Problem: State captures 100% of the savings (State does not actually share the savings with the County)*. The May Revision suggests that 100% of any savings computed based on the formula would be diverted back to the state. As I have indicated in previous reports, DHS is working very hard to build an integrated care delivery system that would provide more efficient and coordinated health services that improve patient experience, increase quality of care, and reduces costs in the long-run. Building our system in this manner is essential to meet the needs of our patients in the safety-net and to sustain ourselves financially under the ACA as a comprehensive provider of all services, including those that all LA County residents benefit from, such as trauma and burn unit services. To do this, our system will require ongoing reinvestment of a portion of savings in infrastructure, health Information Technology (IT) applications like the Electronic Health Record (EHR) and eConsult, and integration of care across physical

and behavioral health. If the state does not share with us any of the potential savings under the ACA, our ability to secure the LA County safety-net would be weakened. In addition, this arrangement would leave our Department little financial incentive to try and reduce our costs and improve efficiencies, since any savings we could achieve would end up flowing to the state.
Our position: Savings computed through a formula-based approach should be shared on a 50-50 basis between the state and county. This would enable us to make the necessary investments in our care delivery system, as well as better align incentives for achieving low-cost and high-value care for our patients.

- *Problem: Cap on cost growth in the formula*. The May Revision indicates that level of costs the County experiences in delivering care would be capped at historic rates. With this arrangement, in the future when our costs exceed the adopted historical rate, the higher cost would not be factored in the formula. By artificially capping future cost growth based on the costs we had under the recent recession, we will have an inaccurate reflection within the formula of what our true costs will be under the ACA.
Our position: A formula mechanism for determining savings should utilize actual costs incurred.

- *Problem: State capture of savings could exceed the indigent health realignment funding*. The May Revision would not limit the gains given to the state to the amount of health realignment historically used for indigent care. With his first budget release in January, the Governor indicated that a portion of the 1991 realignment funds should be redirected back to the state to assist with costs of ACA implementation. The formula mechanism that is designed to determine shared savings between the County and the State should only impact indigent care realignment funding.
Our position: The amount of funds available to redirect to the state should be limited solely to realignment funds used for indigent care.

As you know, DHS is working closely with the Chief Executive Office (CEO), the California Association of Public Hospitals and Health Systems (CAPH), and our other advocacy and labor partners on addressing these issues with the Brown Administration. I look forward to providing you with updates on our progress.

OPERATIONAL CHANGES FOR INTEGRATING CARE DELIVERY: eConsult

We are in the midst of transforming DHS from an episodic, high-cost, hospital-focused system to an integrated care delivery system that includes community-based primary care providers (PCPs) and specialists focused on prevention, early intervention, and outpatient management of complex conditions. An integrated care delivery system enables DHS patients to receive the right care, in the right setting, by the right provider, at the right time, all with the right kind of teamwork. eConsult is a critical component of our integrated care strategy and is already enabling thousands of DHS patients to receive specialty care in an effective and timely manner.

The problem that eConsult addresses: Mario's story

Mario is a 42 year-old male who has ulcerative colitis, a chronic inflammatory disease of the colon. For the last few years, his PCP at a local Community Partner (CP) clinic was successfully treating him with anti-inflammatories. Over the last month or two, however, Mario's inflammation has flared up and his PCP would like the input of a Gastroenterology (GI) Specialist to help address the flare. Unfortunately, using the traditional referral system, the wait-time for specialty visits in GI after referral is often several months. If Mario's PCP is unable to obtain GI Specialist advice for Mario's condition, Mario's condition may worsen by the time he gets into the GI Specialty clinic or his condition may worsen to the point that Mario visits the emergency room for further care.

How eConsult addresses the problem

eConsult is a web-based platform that allows DHS/CP PCPs and DHS specialists to securely share health information and discuss care options for individual patients. The goal of eConsult is to provide timely and coordinated specialty care services for patients with specialty care needs. In Mario's case, this is how eConsult works:

1. Mario's PCP would initiate an eConsult with DHS Gastroenterology. In the secure eConsult message, the PCP would describe Mario's disease, the medications he has been taking so far and his new and worsening symptoms. His PCP could also attach Mario's latest blood test results. Mario would finish with a question like: How should I further manage Mario's flare?
2. ***Within 72 hours***, a DHS Gastroenterologist would review the eConsult for Mario's problem and provide a response to the PCP. The Gastroenterologist may a) ask Mario's PCP for more information, b) recommend a specific treatment that the PCP could start right away, c) request the PCP to schedule a face-to-face visit with DHS Gastroenterology through the DHS Central Referral Unit, or d) ask that Mario be directly scheduled for a diagnostic colonoscopy. The set-aside slots for face-to-face visits or directly scheduled procedures enables patients identified as urgent by specialist reviewers in eConsult to obtain expedited appointments as needed.
3. If it is a) or b) above, the PCP and DHS Gastroenterologist would communicate back and forth over the eConsult platform until Mario's flare is sufficiently addressed. The specific treatment that the GI Specialist recommends to the PCP and gives to Mario may successfully treat the flare and resolve his symptoms. In this scenario, Mario would not need to see the Gastroenterologist in the specialty clinic, but he has benefited from specialty care in a timely and effective manner.
4. If it is c) or d) above, the eConsult case is closed once Mario's care plan is set.

Advantages of eConsult

In the safety-net today, health care is too often fragmented and chaotic. It is difficult for primary and specialty care providers to coordinate care for patients, there are long wait times for specialty services, and there are high no-show rates for specialty clinics because appointments are often scheduled months in advance. eConsult enables dialogue between PCPs and specialists around the needs of a specific patient, reduces avoidable specialist visits

by allowing co-management of complicated patients, optimizes quality of the first specialist visit by ensuring all of the necessary diagnostic testing is done ahead of time, and cuts no show rates and cancellations. Importantly, eConsult is patient-centered by tending to keep patient care local within the medical home and reducing unneeded visits to the hospital.

Our progress in implementing eConsult at DHS and with our partners

DHS has collaborated closely with L.A. Care, Health Care L.A. IPA, MedPOINT Management, and the Community Clinic Association of Los Angeles County to implement eConsult in the safety-net. I am pleased to report that we are making progress in scaling up eConsult use among PCPs, as well increasing the number of DHS specialties participating. Here are some highlights:

- On average, PCPs and their patients have received a response from the specialty reviewer in less than 48 hours.
- Over 950 PCPs are actively using the system at 97 sites (40 DHS sites, 57 CP sites).
- Patients have received care by eConsult from 75 specialty reviewers in 10 specialties: Cardiology, Dermatology, Gastroenterology, Gynecology, Nephrology, Neurology, Obstetrics, Ophthalmology, Podiatry, and Urology.
- Over 15,000 eConsults have been submitted to date.
- The Central Referral Unit has scheduled over 6,000 patients by directly calling them.
- As LA Care Health Plan's sponsorship of the first phase of eConsult draws to a close, DHS is moving to directly own use of the eConsult platform and add more specialties and users. Vendor negotiations are currently underway and are expected to be concluded in the next few weeks.

We expect that, upon conclusion of the eConsult implementation, every outpatient request for specialty assistance will begin in eConsult.

CONCLUSION

I look forward to updating you in future memos on our continuing negotiation effort in Sacramento and on our on-going progress in transforming DHS into an integrated care delivery system.

If you have any questions or need additional information, please contact me or Anish Mahajan, Director of System Planning, at (213) 240-8416.

MHK:jp

c: Chief Executive Office
County Counsel
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