Health Services
LOS ANGELES COUNTY

March 19, 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 # 45, MARCH 19, 2013)**

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

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.

UPDATE

The Department of Health Services (DHS) is making steady progress in preparing for the challenges presented by the Affordable Care Act (ACA). ACA implementation will increase patient choice about where to seek care, change reimbursement to a per-member-per-month capitation rather than reimbursing the expenses of providing care, and will reduce federal funds for the care of the uninsured. Successfully addressing each of these challenges requires a variety of initiatives as well as concerted effort with our community and labor partners and our broader County family. With the assistance of the Board, the CEO's Health Care Reform Task Force, and our many partners, DHS is making key operational changes in our system of care as well as advocating for a legislative and regulatory implementation of Medicaid expansion that would optimize quality of care for patients and the financial security of the safety-net.

In this update, I will highlight recent policy developments related to Medicaid expansion in California, our ongoing progress with Healthy Way LA enrollment, efforts to increase revenue contracts for services we have additional capacity and expertise to provide, and initiatives we are undertaking to improve patient experience at DHS.

POLICY DEVELOPMENTS

Medicaid Expansion

The ACA provides our state a historic opportunity to expand access to Medicaid insurance to more than 1 million uninsured Californians. Beginning January 1, 2014, the ACA requires the federal government to pay 100% of the reimbursement for the Medicaid expansion population. The federal government will pay 100% of the reimbursement through January 1, 2017 and thereafter, will pay at least 90% of the reimbursement. This means that the State's share of reimbursement for Medicaid expansion is 0% through January 1, 2017 and will not ever increase beyond 10% of the reimbursement for Medicaid expansion enrollees.

With January 1, 2014 less than nine months from now and the need to begin the process of transitioning current Low Income Health Program (LIHP) enrollees into Medicaid expansion by October 2013, it is imperative that our State legislature and

Governor Brown's Administration move expeditiously to finalize legislation and write the regulations to implement Medicaid expansion. As you know, the State legislature took a big step forward on March 7, 2013 by passing companion bills in the Assembly and Senate that would expand Medicaid to individuals with incomes up to 138% of Federal Poverty Level (FPL) and simplify the Medi-Cal enrollment process. The next steps are for the Assembly and Senate to concur on one final version of the bill, for the Governor to sign it, and for his administration to develop the implementing rules and regulations for expansion in time to meet the January 1st deadline.

Unfortunately, recent Budget hearings in Sacramento suggest that the Governor is not yet ready to take-up the legislation in its current form. Governor Brown and Administration officials remain interested in exploring the creation of a new County-based Medicaid system for new enrollees, as opposed to allowing new enrollees to enter the already existing State-based Medicaid system. In addition, the Governor continues to express his desire to take back realignment monies that the State currently provides to Counties to pay the State share of cost for Medicaid under the ACA. As you know, these ongoing barriers to finalizing Medicaid expansion legislation threaten to derail implementation by January 2014, which would mean the loss of hundreds of millions of federal dollars to the California economy and the delay of health care coverage for more than a million uninsured Californians.

In a previous report to the Board, I described why the County-based expansion option is not viable. In brief, adding a new county Medicaid system for the expansion population would require a new and parallel bureaucracy that would co-exist with the current state-wide Medicaid system for traditionally eligible populations. This would cause confusion for patients and providers, since families could be split between the county and state-wide systems. In addition, since the ACA specifically prescribes a state-wide expansion approach, the federal Centers for Medicare & Medicaid Services (CMS) would need to provide special approval for a county-based expansion. CMS approval for a county-based expansion would require that all 58 counties provide a single benefit package. Achieving a single benefit package at the county level is a daunting task and would require costly and time-intensive administrative expenditures. I joined a group of Health Services Directors and public hospital Chief Executive Officers from Contra Costa, Orange, San Diego, San Francisco, San Joaquin, and San Mateo Counties in a letter to Health and Human Services Secretary Diana S. Dooley stating that the state-based Medicaid expansion model is the only viable option and urging that the state move forward with state-based expansion immediately to ensure that California is ready by the historic January 1st deadline.

Last week, Bill Fujioka and I met with California Director of Finance, Ana Matasantos, and Secretary Dooley regarding Medicaid expansion and the critical importance of meeting the January 1, 2014 start date for the expansion. Based on the Board's February 19th motion, we also expressed a willingness to enter into discussions regarding how the county might participate in using new Medicaid revenues to help the state with the costs of the expansion. As a result of this meeting, State and County staff will engage in ongoing discussions regarding the actual increased revenues to our county and the real expenses of the Medicaid expansion.

Covered California Board Seeks Federal Approval for a Medicaid Bridge Plan

Under the ACA, individuals with income over 138% FPL will be eligible to seek health insurance through a health benefit exchange. Covered California, our state's exchange, is charged with creating a new insurance marketplace in which individuals and small businesses can get access to subsidized health insurance, allowing many people who could not previously afford insurance to obtain coverage. Unfortunately, even with the subsidies provided through the exchange, coverage will still be too

expensive for those who hover just above the poverty line, particularly with income between 138%-200% FPL. In addition to affordability, another potential problem is churn between the Medicaid program and coverage through the exchange. Due to income fluctuations related to changes in employment and family structure, individuals within this income group are likely to find themselves cycling between Medicaid eligibility and eligibility for subsidies on the exchange, potentially resulting in disruptions in care.

In a previous report, I described the proposal for a Medicaid Bridge Plan, designed to improve the affordability of insurance on the exchange and maintain continuity of care for families who go in and out of eligibility for Medicaid. Last week, the Covered California Board announced it is seeking federal approval for Bridge Plans that will enable such families to purchase standard benefit plans through Covered California at a substantially reduced cost. If an individual must exit Medicaid, the Bridge Plan would provide enhanced financial support to help that person maintain his or her Medicaid managed care plan, and keep the same provider network. The Covered California Board also directed staff to explore expanding Bridge Plan eligibility to all persons whose income is at or below 200% FPL– including persons currently not in Medicaid.

HEALTHY WAY LA (HWLA) UPDATE

As of February 1, 2013, HWLA enrollment has reached 222,705 individuals. Our goal is to enroll over 300,000 individuals by the end of 2013. To achieve this goal, DHS is working hard with The Department of Public Social Services (DPSS), our Community Partners, and other community outreach organizations to streamline the redetermination (renewal) process, ensure timely processing of applications, and enhance outreach to potential enrollees in community-based settings.

Improving Redetermination Rate

As I indicated in a previous report, annual redetermination of HWLA eligibility proved challenging in 2012. As HWLA enrollees approached their one year tenure in the program, enrollees were required to appear in-person to complete the redetermination process. Many HWLA participants were unable or unwilling to return to their clinic to complete the in-person process. As a result, gains in HWLA enrollment since July 2012 were negated by the low redetermination rate, which averaged about 20%. To address this challenge, DHS and DPSS created a new HWLA Mail-In Redetermination unit, which enables enrollees to complete the redetermination process by mail, similar to the process that Medi-Cal utilizes for redetermination. The Mail-In Redetermination Unit began operations in the first week of January. In addition, working with County Counsel, the redetermination process was streamlined to enable use of existing data sources to validate client information, such as income verification and residency. These steps have helped to achieve a significantly improved redetermination rate of over 40% in the month of January.

Recently, we have also worked with County Counsel to enable HWLA enrollees receiving General Relief (GR) benefits to auto re-determine. This will ensure that coverage for eligible GR individuals will occur without any disruptions or extra work by the GR clients. It is estimated that at least 150,000 HWLA patients will be required to re-determine in 2013, however, the majority of these re-determinations (around 108,000) will occur in the key months of May, June, July and August 2013. DHS applied for a Blue Shield Foundation grant to hire a vendor to make personal calls to HWLA patients to confirm that they received their redetermination paperwork, make sure they understand why it is important to renew their coverage, and assist them in filling out and mailing back the form. Between these important process changes, including expanding our outreach efforts to improve redetermination and collaborating with DPSS, DHS has a target goal of accomplishing at least 66% successful re-determination paperwork return rate for patients. As with all target goals, DHS will work very hard to exceed this minimum threshold of success as much as possible.

Reducing HWLA Application Backlog

As you know, the HWLA program nearly quadrupled enrollment in our County's LIHP over the last 18 months. The large influx of applications, beginning with Operation Full Enrollment in July 2011 and followed by auto-enrollment of GR participants, resulted in a larger than expected workload of completing and processing applications. This large workload, coupled with the conversion of the IT system for processing applications in July 2012, resulted in a backlog of 71,044 applications requiring further processing.

DHS, DPSS and our Community Partners have developed a new end-to-end business process that will reduce the current backlog of pending HWLA applications and more expeditiously process new applications moving forward. The large majority of backlog applications is either missing pertinent information such as income verification, proof of residency, date of birth, and social security number or is duplicate applications. By marshaling data from multiple sources, the new process is designed to identify and fill-in the missing information to complete the application process. Since December, this new process has reduced the backlog applications from 71,044 to 45,557. In addition to clearing 25,487 applications, an additional 4,126 applications were found not have the applicant's e-Signature, and therefore are not valid applications. DPSS is currently paying eligibility workers to work through the weekend to process all pending applications and get through the backlog, with the goal of being current by April 2013. I look forward to reporting on our ongoing progress in further reducing the application backlog over the next couple of months.

It is important to address the issue of medical expenses incurred by patients awaiting HWLA application processing. It has come to DHS' attention that some patients who have a pending HWLA application and who received services at a DHS, Community Partner clinics, or non-DHS hospitals may have received a bill. HWLA pending patients should not receive a bill for health care services and they do not need to pay it. However, we know that it has happened to some patients and we are working to direct all HWLA pending or existing patients with a bill to contact HWLA member services to resolve the issue for them. HWLA member services will review the patient's application to see if there is missing information that is preventing the application from being processed. Once the application is complete, it is quickly approved and member services will give the bill to the HWLA claims department to make payment to the community clinic or hospital. The patient is then informed that the issue is resolved with an official notice. We recognize that the receipt of a bill may be upsetting or confusing to patients and we have made clear in our flyers and HWLA website that HWLA health care services are free and to contact member services with any questions or issues.

If the HWLA application is denied for lack of eligibility, patients receiving services at DHS may still qualify for one of the other DHS no- or low-cost programs. At Community Partner clinics, patients may still qualify for the HWLA unmatched program and at non-DHS hospitals, the service may be considered as the customary charity care for the uninsured.

HWLA Transition to Medicaid Expansion

As you know, our HWLA patient population will transition into Medicaid expansion under the ACA. Ensuring a safe and effective transition of our HWLA patients will require careful coordination between the State, health plans, and DHS. We are awaiting important guidance from Sacramento regarding the rules and processes for the transition. In the meantime, DHS, the Community Partner clinics, and L.A. Care have together created a HWLA Early Transition Workgroup. The aims of the Workgroup are to a) identify policy priorities for the transition that we will communicate to the State and our advocates in Sacramento and b) plan operational activities that will optimize a smooth transition of HWLA members

that preserves continuity of care. Once State rules for the transition are finalized, DHS and DPSS will initiate training programs to educate staff about the enrollment rules and processes for Medicaid expansion and the health benefit exchange. In addition, DHS and L.A. Care are jointly developing a communication and outreach strategy for HWLA patients to help mitigate any potential confusion and anxiety about the transition period.

REVENUE CONTRACTS IN A MANAGED CARE ENVIRONMENT

Under health reform, reimbursement based on capitation rather than expenses presents a major change in the way care is delivered in the safety-net. In a capitated payment model, a provider group receives a per-member-per-month payment for the patients assigned to them by the health plan. In most instances, it is up to the provider group to meet the health care needs of their assigned patients, including specialty and hospital care.

Some provider groups, such as DHS, have both primary care and specialty and hospital care services that are made available to their assigned patients. Other provider groups, such as Community Partner clinics, have mainly primary care services and rely on DHS and other providers for delivering specialty and hospital care services to their patients. In today's world, DHS serves as the main specialty and hospital referral center for the CPs because of our relatively large specialty care capacity as compared to our primary care capacity. Under the ACA, with the move to Medicaid expansion and a capitation payment model, provider groups such as the CPs may have options other than DHS for specialty care referral. It is important that DHS develop contracts with CPs and their associated Independent Practice Associations (IPAs) for continued referral of their managed Medicaid patients to DHS specialty care services. With funding support from the Blue Shield Foundation, DHS is currently receiving technical assistance to implement all necessary contractual, fiscal, operational, and technical support goals required to integrate DHS's specialty healthcare providers into the Health Care LA IPA (and potentially the Altamed IPA) by January 1, 2014.

In addition to our effort with Health Care LA IPA, a review of our current portfolio of revenue contracts shows that DHS already has contracts with large commercial and managed care Medi-Cal health plans such as Aetna, Blue Shield, Cigna, HealthNet, Kaiser, L.A. Care and others. For a variety of reasons, referrals of commercial patients have been low to DHS services where capacity exist. We intend to systematically explore the issues with the health plans so that patients can access DHS services and navigate between DHS and non-DHS care settings. The following are a few of the findings and solutions resulting from the review process:

- Engage and educate health plan and medical group referral staff: There is a general perception that all DHS specialty services are overwhelmed and that there is no capacity anywhere in our system. This is not actually the case. There are certain specialty care services that currently do have capacity to take on patients and that can be marketed to contracted health plans and IPAs. In addition, with further roll-out of eConsult, we are seeing a more efficient use of our existing specialty care capacity, which is freeing up capacity to see more patients in some specialties. We are working with our specialty services to compile a priority list for marketing.

- Define a clear and simple referral process: With the heavy managed care presence in Southern California, DHS needs to have a clear and simple process for health plans and IPAs to refer patients into our system. As we work with health plans and IPAs, we need to have an easy process that can be understood and executed by both DHS and referring staff.

- Stream line contract process and county contract terms: We are working with the health care task force to review DHS contracts to see if there are processes that can be stream-lined or County contractual terms that may need to be modified in order to expedite and facilitate contracts with health plans and IPAs.

PATIENT EXPERIENCE

Patients generally consider many factors when deciding where to seek medical care. Distance of the clinic from their home, their relationship with their provider, the provider's reputation, their satisfaction with the care they received, and whether a provider accepts their insurance plan are just a few of those factors. Today, about 70% of the patients DHS cares for are either uninsured or in the HWLA program. Due to their lack of insurance, these patients have few choices beyond safety-net providers for care. Under the ACA, patients gaining health insurance will have greater choice of where to seek care. To continue to serve this population as a provider of choice, DHS must improve the experience our patients have receiving care in our facilities.

There are many different ways to define patient experience, as well as related measures such as customer service and patient satisfaction. There are also many dimensions through which patients experience the care they receive in a health system. Patient experience is largely determined by 1) the care delivery processes they are exposed to (i.e. the ease of scheduling a specialty care appointment over the phone) and 2) the knowledge, capability, and empathy of the staff they interact with in our facilities.

Improving Care Delivery Processes

In my previous ACA report, I focused on a few of the operational changes we are making to improve our care delivery processes. I described our ongoing transformation from an episodic, hospital-focused system to an integrated care delivery system designed to provide access to timely primary and specialty care services, enabling early intervention and outpatient management of complex conditions. By providing the right care at the right time in the right setting, integrated care delivery improves clinical outcomes and patient experience of care. Our development of patient-centered medical homes will strengthen the doctor-patient relationship. I also described a number of other system-wide improvement initiatives such as patient-centered scheduling, telephone system upgrades, and eConsult, all of which will contribute to improved patient experience. In addition to these, there are numerous facility-specific operational and performance improvement initiatives, ranging from reducing the time it takes for a patient to go through the steps of registration and financial screening, to creating additional disabled person parking spots and improving hallway signage so that patients can more readily find their way around our facilities.

New DHS Website

We are looking forward in the coming months to launching a redesigned web site that is patient-centered, consumer friendly, and easy to use. The site will provide patients and the newly insured with information about DHS' community-based care and encourage patients to make DHS their medical home. It also will highlight the primary and specialty care available through DHS' integrated system of award-winning hospitals, outpatient health centers, community clinics, rehabilitation services and emergency services. The website redesign and initial content development is being conducted by Harbage Consulting, ID Media and Ziegler Associates, and is funded by a grant from the Blue Shield of California Foundation. The site will be built and launched by DHS IT staff.

Staff Engagement Initiatives

DHS' greatest resource is its mission-driven and compassionate staff. We are working closely with our labor union partners to provide our staff with a variety of opportunities to prepare for the new challenges that our system transformation and the ACA bring to their roles.

Care Improvement Teams (CITs)

Over the past year and a half, we have been working in partnership with SEIU 721 to improve patient experience by empowering small teams of frontline workers and managers to implement their own solutions and process changes. Patterned after Kaiser's Unit Based Teams - whose trainers have helped us adapt our own program - our teams are called "Care Improvement Teams" or CITs.

We currently have 26 CITs, largely in primary and specialty care, and the results have been tremendous:

- In registration at a large south LA clinic, clerks and managers were able to streamline the registration process, decreasing patient wait time, and more than tripling the number of patients who are beginning their medical appointment within five minutes of their appointment time.
- In a rehabilitation clinic, staff nearly doubled the number of patients efficiently setting return appointments, with now more than 70% of the patients scheduling within five minutes of completing their appointment.
- In Radiology, the team doubled the number of patients prepared for their visit, which meant patients experienced less time to complete their visit, and fewer had to reschedule.

In addition to the strong, measurable improvements these teams are making, the partnership-based teams are giving a huge boost to number of creative solutions we are able to implement, as frontline workers have a real voice in leading change. Slowly, but surely, we are transforming the culture within DHS towards a more cooperative, improvement-driven, patient-centered teams of workers.

Currently we are working with SEIU 721 to strengthen our partnership, including strategically growing CITs to transform key areas within the ACN. Next up is to spread the positive results of our south LA registration team throughout County clinics, to improve registration, financial enrollment, and scheduling. DHS and SEIU 721 are grateful to the California Endowment for supporting the development of CITs.

Patient Experience and Communication Workshops

The Worker Education & Resource Center (WERC), a 501(c)(3) non-profit organization, is helping us prepare our DHS workforce to meet the challenges of the ACA. WERC developed a patient experience and communication workshop that is designed for DHS employees aimed at a) educating them about the need for system transformation, b) enabling them to elevate the health literacy of the patients they interact with, and c) developing improved patient communication skills emphasizing active listening, cultural sensitivity, empathy, and de-escalation. As of last month, over 6,600 clinical and non-clinical DHS employees who have direct patient interaction have completed this training. Additional trainings are planned in the spring.

ACA and Eligibility Workers Workshops

WERC is also in the process of developing a workshop designed for DPSS eligibility workers. This workshop will provide DPSS employees with a) critical information and training around how the ACA will affect eligibility and enrollment and b) skill development in communicating with patients about how best to navigate the new health insurance marketplace and select the appropriate plan. The funding to conduct 143 workshops for approximately 7,150 eligibility and clerical workers is currently in place and workshops are expected to begin in April.

Employee Relations and Performance Management Training

DHS Human Resources has developed a training for managers and supervisors regarding employee relations and performance management. The training will be offered on-site at various DHS facilities in April 2013, with each class limited to 30 participants to ensure interaction among the supervisors and trainers. The goal of the Performance Management training is to give managers/supervisors tools to assess employee performance in the workplace, articulate possible causes for corrective action, understand the discipline referral/review process, and identify corrective action tools and resources.

DHS Innovation Awards

In June 2012, DHS announced a competition for teams made up of labor and management for the Innovation Awards. Selectees could receive up to $5,000 to improve patient outcomes, reduce costs, improve safety, promote quality, and boost employee morale. Over 260 projects were submitted from throughout the county. The Innovation Project has led to collaboration on the frontlines of our system to improve DHS facilities and the delivery of care.

A joint SEIU 721-Management team selected 16 projects, which were funded by $50,000 from the Blue Shield of California Foundation. Another six projects were approved at the facility-level that require no budget. Teams have until April 12, 2013 to submit final reports detailing the impacts their projects have made on their facility. In May, teams whose projects demonstrated outstanding outcomes will be recognized. DHS is grateful to The California Endowment for supporting the grant award and management process.

Examples of projects include: creating a child and family friendly environment (Coastal Health Centers); increasing medication adherence through the use of pill organizers and small totes (Mid Valley Comprehensive Health Center); providing an easy-to-update patient information board that will serve as a communication tool between patients, family members, and hospital providers (LAC+USC Medical Center); developing a Diabetes Mentorship Program to train future diabetes educators (Rancho Los Amigos National Rehabilitation Center); and, creating a new program that will enhance the current services offered in Occupational Therapy Vocational Services by creating real life work opportunities (Rancho Los Amigos National Rehabilitation Center).

CONCLUSION

It is a pleasure to provide this update on our progress. Partnering closely with our community and labor partners as well as the broader County family, you can see that DHS is working very hard to transform our system of care and improve patient experience. With less than nine months until January 1, 2014, we still have a great deal more progress to make in order to be successful under the ACA. I look forward to updating you in the future on our continued efforts.

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

MHK:jp

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