HEALTH CARE REFORM
MAKING IT WORK FOR LA COUNTY DEPARTMENT OF HEALTH SERVICES AND SAFETY NET SYSTEM

July 15, 2013

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DHS Ambulatory Care Network
Our Story

• Affordable Care Act (Obamacare) 101

• Safety net, politics and money.

• Healthcare Expansion
  • Healthy Way LA (HWLA)/Low Income Health Plan
  • Covered California/Health Exchange

• Residually Uninsured in LA

• LA County DHS Transformation

• Future Chapters
Photos from Google: “Supreme Court Decision Affordable Care Act Legislation”
Photos from Google: “Tree”
Affordable Care Act (ACA) STRATEGIES

- Insurance Reform
- Coverage Expansion
- Delivery System Redesign
- Payment Reform

Healthcare Reform
Safety Net System Snap Shot

- County of Los Angeles Department of Health Services (>2.3 million visits)
  - 19 community based clinics (primary, specialty care, diagnostics and urgent care)
  - 4 hospitals (2 are trauma centers)

- Federally Qualified Health Centers (>1 million visits)
  - ~50 non-profit agencies (~180 clinic sites)

- Disproportionate share hospitals
  - ~20+ hospitals

- “Some” private providers
We are less than 6 months away from the first year of the Medicaid and Commercial Insurance Expansion.

- **March 2013**: California State Legislature passed companion bills.
- **May 2013**: Governor agrees to implement Medicaid/Medi-Cal Expansion.
- **October 2014**: HWLA transition to Medi-Cal begins and Exchange goes live.
State Expansion Proposal, Realignment and Safety-Net Dollars

- Governor says that State will need Counties to contribute their realignment funds up-front to pay for State-based Medicaid expansion

- L.A. County’s Position:
  - With Federal government funding 100% of Medicaid expansion costs first 3 years, and 90% of costs 2020 onwards, *the State does not need realignment dollars up-front nor even half of realignment to cover expansion in later years*
Politics and Money:

• Brown Administration’s Goal.
  • Interested in County-based Medicaid option
  • Wanted Counties to contribute realignment monies to support State costs (FY 13-14 $300M; FY 14-15 $900M; FY 15-16 $1.3B)

• What if California miss the January 1\textsuperscript{st} 2014 Start Date?
  • Loss of hundreds of millions of federal dollars
  • Delay in coverage for uninsured

• Moving Forward.
  • LA County contributes around $88M to the State in 2 years.
  • In the future, there will be a mathematical formula to determine the money needed to redirect the realignment back to the State.
Covered California – Health Benefit Exchange

• New insurance market place begins January 2014
  • Subsidized health insurance for income over 138% Federal poverty level (FPL)
  • Affordability a concern for working poor

• Covered California Board seeking federal approval for Medicaid Bridge Plan
  • Lower price and maintains continuity of care for individuals with income 138 to 200% FPL
Coverage Expansion

• Commercial Insurance Expansion
  • Exchanges- Covered California
    • Individuals
    • Small Business

• Low Income Health Plan/Medicaid (Medi-Cal in California) Expansion

• Individual Mandate

• Patient Choice
• U.S. Citizenship or Legal Permanent Residence for at least 5 years
• Los Angeles County residency
• Age 19 to 64
• Monthly family income at or below 133 percent FPL
• Not currently pregnant
• Not eligible for Medi-cal or Healthy Families

**Healthy Way LA:** No-Cost Health Coverage | United Way of Greater
www.unitedwayla.org/2011/12/healthy-way-la/Cached

**Healthy Way LA - Wikipedia, the free encyclopedia**
en.wikipedia.org/wiki/Healthy_Way_LA/Cached

**Healthy Way LA Member Handbook - Department of Health Care ...**
www.dhcs.ca.gov/provgovpart/.../LIHP/.../LA/15.1MemberHandbook
Reaching our 300,000 HWLA Goal

Total Enrolled = 232,000

*Total Enrolled = 257,009 (May 1, 2013)
So Far, DHS has enrolled 66% of LIHP-Eligible LA County Individuals

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<tr>
<td>Sacramento</td>
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<td>7,661</td>
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<tr>
<td>Central Coast</td>
<td>70,000</td>
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<td>93,452</td>
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<tr>
<td>Los Angeles</td>
<td>390,000</td>
<td>205,172</td>
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Now: 232,000 Now: ~60%
L.A. County
Residually Uninsured and
The Importance of the Safety Net System
Residually Uninsured in LA County

TODAY:
2.2 million uninsured (under age 65)

Full Medicaid Expansion by State Covered California Exchange

2019:
1.1 million ‘Residually’ uninsured

Not eligible: Immigrant status
Eligible, but not enrolled: Medi-Cal
Eligible, but not enrolled: Exchange

Increased Revenue from Expansion

In Context

• Disproportionate Share Hospital (DSH) revenue fund care for uninsured
  • ACA mandates decreases in DSH payments

• Although DHS and safety net clinics will have increased expansion revenue, realignment revenue is still needed for uninsured care (primary and specialty care)
  • Individuals who are undocumented or unable to afford coverage on Exchange
ACA Provisions Affecting DHS

- Patient choice
  - Newly insured Medicaid patients will have greater choice of where to seek care

- Reduced State and federal funds for care of the uninsured

- Reimbursement based on capitation
  - Move towards ‘managed care’
  - Per member per month rate *instead of* payment based on expenses
Our Overall Strategy for ACA: DHS Triple Aim

More Care

Same or Better Quality

Same or Lower Budget
U.S. Health Care System
(Hospital Focused, Episodic Care System)

• Primary care is not emphasized
  • No single provider is the “quarterback for care”

• Care is often uncoordinated
  • Care provided in the clinic and in the hospital is not in sync

• Diseases are often treated at a late stage
  • First care for a problem is often in urgent care or in the ER

• Unsustainable under the ACA
  • Poor outcomes for patients and high costs to the system
Residually Uninsured

• Estimate around 1.1 Million uninsured after 2014.

• DHS and Community Partners actively see over 200 to 300K uninsured in primary care settings.

• Planning around primary care capacity between DHS and Community Partners that has a healthy mix of uninsured and Medi-Cal patients.
Photo: LA Times: April 2009
U.S. Health Care System
(Hospital Focused, Episodic Care System)

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ACA
Delivery System Redesign

• Building Patient Centered Medical Homes (Care Management)

• Improve primary and specialty interaction (Care Coordination and Management)

• Reduce Hospital and Emergency Room Use (Care Coordination)

• Expansion of Health Information Technology (Communication)
Diabetic Patient with an Infected Diabetic Foot

Hospital-focused, episodic care

- Late Stage
- Hospital and ER $$$
- Urgent Care $$
- Primary Care Clinic $

* Diagnosis/Treatment
* Referral to primary care provider?
* No follow-up.
* Admitted to Hospital.
* Amputation.
* No follow-up.

* Diagnosis.
* Some initial treatment.
* Maybe referral?
* No follow-up

* Diagnosis/treatment.
* Referral to podiatry?
* Follow-up?
DHS Integrated Care for Diabetic with Foot Problem

- Preventative Treatment
- Early diagnosis
- Follow-up assured
- Referral system
- Electronic Health Records and Health Information Exchange to connect primary care providers, specialists and hospitals

If patient needs hospital care

Consult

Primary Care Provider & Medical Home Team

Podiatrist

If patient needs hospital care
Patient Centered Medical Neighborhood

- Fragmented
- Duplicative
- Discoordinated

BARRIERS
- Lack of Dialogue
- Visit-based care
- Misalignment of incentives

SOLUTIONS
- Create dialogue
- Abolish visits as care measure
- Align incentives

- Coordinated
- Integrated
- Effective

OBJECTIVES
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

ACCESS ≠ VISIT

Hal Yee, 2013
Maria

• Maria’s Story
  • 42 year old female with early Rheumatoid Arthritis
    • The right treatment could make all the difference for her

• The Challenge
  • Wait lists of greater than 9 months for uninsured patients referred to the county system for care.
  • No straightforward means for community based physicians to communicate with specialists about possible consults or patients needing expedited attention.
The challenge

• How does DHS, a large, historically fragmented health care system address the issues of:
  • 350,000+ referrals to specialty care annually (not including paper, fax or patient self-referrals.
  • Long wait times for specialty services
  • Lack of coordinated care between DHS specialists and DHS and Community Primary Care Providers
    – High no-show rates to specialty clinics
    – Large variation in care delivery processes
  – System that predominately sees uninsured patients
Disruptive Innovation

- Investment in Patient Centered Medical Neighborhood (PCPs and Specialists).
  - Specialty Primary Care Workgroups
  - eConsult – in partnership with L.A. Care, local public health plan and FQHCs

- Investment in Patient Centered Specialty Scheduling
  - Reduction in process variation
  - Reduction in no-show rates
  - Improved patient experience
-2.1 days = Average Specialty Reviewer response time
-97 sites (40 DHS and 57 Community Partner)
-950+ Primary Care Providers using eConsult System
-7,100+ patients scheduled via Patient Centered Specialty Scheduling
-84% of all patients needing an appointment have been reached and scheduled.

*Those who could not be contacted have been mailed a notice to call the CRU and a message has been sent to the PCP via eConsult

**Data from June 2014
Ralph

• Ralph’s Story
  • 62 year old male with 50 lbs unintentional weight loss

• Booked into colonoscopy within 2 weeks of receiving an approved eConsult
  • On day of procedure, staff nurse was surprised at the fact that the patient was in for procedure within less than a month
  • A cancerous growth was detected.

*Had this patient been put through the standard referral process, it is unclear how long it would have taken the referral to get a colonoscopy.
Feedback

Community Partner Medical Director — “eConsult has been a blessing and the providers are thoroughly enjoying the opportunity to learn new patient management strategies from the specialty providers. The best part is our patients aren’t waiting over 6 months for consultations!”

DHS Medical Director—
“One of the providers from our team sent eConsult to neurology service the day before yesterday and we received the response within 24 hours which was a great experience and was very helpful for the patient and the provider for ongoing care. Patient was contacted regarding the neurology input once the response was received and does not have to wait several months for appointment to get the same result. Thank you.”

Health Plan Medical Director—
“The safety net can do creative things (eConsul)...with necessity is the mother of invention.”
Improving Patient Experience at DHS

Improving Care Delivery Processes

- Integrated care delivery system
  - System wide electronic health record (ORCHID)
- Telephone system upgrade
- eConsult
- Patient-centered scheduling
- Patient-centered medical home
- New DHS website
Payment Reform
(Strategic New Partnerships and Relationship)

• Integrated Delivery System
  • Kaiser (Plan and Delivery System) like
  • Work with DPSS, L.A. Care, Community Clinics (Community Partners)

• County Strength
  • DHS, DMH, DPSS and DPH and L.A. Care Health Plan
  • Public Private Partnership
    • Non-Profit Community Clinics (Federally Qualified Health Plan),
Payment Reform

• Reimbursement based on capitation
  • Per member per month rate *instead of* payment based on expenses

• Reduced federal funds for care of the uninsured

• (DHS) Payment of out of network services
County Delivery System
Health Reform Efforts:

1. Maximize Coverage Expansion through Outreach, Enrollment and Retention (Low Income Health Plan or Healthy Way LA)

2. Transform and bolster support for outpatient care and services

3. Greater integration and synergy between County Departments

4. Greater synergy with local public health plan (L.A. Care and engage with external payors)

4. Maintain and support a Safety Net for residual uninsured
Future Chapters

- Low Income Health Plan Transition
- Patient choice
- DHS Customer service
- Length of time for delivery system transformation
- Residually uninsured
- Payment reform and changes
- New partnership
QUESTIONS?