Panel Addresses

ITUP convened leaders representing health plans, providers, and government agencies that play a key role in providing safety net care to the remaining uninsured and newly insured in Los Angeles. These leaders identified ways that the ACA has changed the safety net landscape, and what challenges and opportunities they currently face.

John Baackes – CEO, L.A. Care Health Plan

The ACA has significantly diversified and expanded L.A. Care's membership. The organization has significantly reorganized itself to ensure it can deliver quality care to its membership, which spans Medi-Cal, Medicare (via CCI and dual-eligibles), Covered California, and its SEIU-UHW plan. These subpopulations are now handled separately under different teams to make sure that their care is effectively coordinated and delivered to achieve desired health outcomes. Because of its wide reach, L.A. Care now has the ability to catalyze change in the healthcare delivery system.

L.A. Care works with a number of plan partners and contracted medical groups to deliver care. While it has had good success working with plan partners, its delegated entities still struggle to meet various standards of care. The organization is working to address these issues to ensure access to quality care.

Rapid expansion has greatly strained access to care. L.A. Care is working to reach untapped providers and directly contract with them to bring providers in-network in underserved areas such as the Antelope Valley. Medi-Cal's complexity unfortunately gets in the way of addressing access issues. Rates are still not actuarially sound, which will impede expansion, and the program's administrative complexity effectively penalizes the poor.

Tangerine Brigham – Director, Office of Managed Care, Los Angeles County Department of Health Services

The Department's Medi-Cal Managed Care insured population has skyrocketed following the ACA, more than tripling from under 100,000 to 350,000. In order to cope with the increased demand for care, the Los Angeles County Department of Health Services (DHS) has made improvements to ensure timely access to care while working with patients to shift their care-seeking behaviors towards in-network primary care instead of the emergency room. While most patients are quite satisfied with their doctors, wait times are still very long. DHS aims to improve in this area so it can have good patient retention, which is essential to effectively providing coordinated care. As delivery systems move towards value-based purchasing, DHS is stepping up data collection efforts to improve its ability to delivery high value care to its patients.

DHS is also responsible for providing care to the remaining uninsured, many of whom receive care through MyHealthLA. Currently, over 130,000 people are enrolled, and DHS has partnered with more clinics to maintain

capacity to ensure good quality and value care is available. Ultimately, the goal is to ensure that regardless of the payor, all patients under the department's purview will receive the same quality of care.

Hector Flores – Medical Director, Family Care Specialists Medical Group Qualified Essential Community Providers

White Memorial hospital serves a wide variety of patients under different payors, ranging from Medi-Cal (40%), commercial plan coverage (30%), Medicare (15%), and Covered California (10%), with the remaining patients uninsured (5%, down from 10% before the ACA). Despite $95 billion going into Medi-Cal, many Californians still struggle to access quality care.

Providing safety net care faces several challenges. Firstly, safety net care heavily depends on private physicians who work closely with FQHCs, even though these physicians are frequently left out of safety net discussions – in fact, the vast majority of Medi-Cal patients receive care from private physicians. Secondly, financing care to the uninsured is becoming more difficult, as cuts to Medi-Cal are eliminating the margins needed to cover the costs of uncompensated care.

Going forward, ways to better invest into Medi-Cal need to be identified. In additionally, more patients need to be moved away from seeking catastrophic care into consistent care.

Mark Gamble – Senior Vice President & Chief Operating Officer, Hospital Association of Southern California

Since the expansions, hospitals have seen their uncompensated charity care costs decrease from 15% to 9% while Medi-Cal volume increases. Many non-traditional Medi-Cal hospitals have since seen significant increases in their Medi-Cal populations – some of whom have never in the past handled any large Medi-Cal volume. The increase in volume has not been met with an appropriate adjustment to Medi-Cal reimbursement rates, which are 64 cents to the dollar. Additionally, many of these patients seek care through the emergency room instead of receiving regular coordinated primary care.

The ACA's passage has triggered a discussion on moving away from sick care towards health care. The transition will be challenging and involve growing pains. Care needs to be managed in a way where cost control does not simply cut rates, but instead provides care more efficiently.

Yunkyung Kim – Vice President & COO, Molina Healthcare of California

Molina Healthcare now covers 3.5 million patients across the country, with many based in California. Los Angeles County accounts for 140,000 of its members. Medi-Cal is Molina's largest program, which in Los Angeles is subcontracted through Health Net.

Molina has also expanded into the Covered California market, offering plans in 5 of the 6 counties where it already operates Medi-Cal plans, with the goal of serving individuals who are moving between its Medi-Cal plans

and commercial/private insurance. Many patients have demonstrated extreme price sensitivity, signing onto low-priced bronze plans as their income increases and they lose subsidies. More work is being done to educate potential enrollees about the value offered by differently tiered plans.

In the past, Molina was solely a family health plan. As it transitions towards delivering a full spectrum of services to seniors, the disabled, and chronically ill adults, it has transformed its staff appropriately, and begun working more closely with providers and contracted groups to ensure care coordination. Managing care and leveraging good data is essential to continued success.

Louise McCarthy – President & CEO, Community Clinic Association of Los Angeles County

CCALAC works with all non-profit clinics in Los Angeles County. In the past few years, many of these clinics have transitioned to FQHC status, with 56 FQHCs now in Los Angeles online, 10 of which acquired FQHC status in the past year. The number of patients and services delivered sharply increased in the past year, though many patients also acquired coverage from Medi-Cal.

Community clinics currently face a need for increased staff to meet the need for expanded coverage. Additionally, there is a major lack of dental care, with many covered patients unable to find a dental provider. Additionally, plan administration remains complex, posing significant challenges for the community clinic population, many of whom lack familiarity with the healthcare system and may not be fluent in English.

Sean O'Brien – Director of Medicaid Expansion and Ancillary Programs, Health Net

The ACA is the most significant source of change in Medi-Cal in the past two decades. Health Net, originally a commercial plan that participated in government plans, now primarily works with government-sponsored lines of business, with only a few ventures into commercial markets. Currently Health Net covers nearly one million patients, including a Medi-Cal Managed Care dental plan in Los Angeles that covers 250,000 patients that continues to rapidly grow.

Coordination is critical to success. Organizations need to move away from silos towards internally and externally coordinated care efforts. Data sharing is necessary for coordination to be successful; ways to synthesize and centralize large dispersed datasets need to be developed to support increased coordination.

Roderick Shaner – Chief Medical Officer, Los Angeles County Department of Mental Health

Since the ACA's expansion, 85% of patients under the Los Angeles Department of Mental Health (DMH) are now covered under Medi-Cal, with the majority of the remainder uninsured. Because county mental health is carved out, it faces unique and complex funding challenges compared to other health services. Although originally a mental health services provider, Medi-Cal realignment tran-

sitioned DMH into the additional role of fiscal intermediary. Consolidation has since effectively made it a managed care plan.

As the health system further integrates, DMH faces new challenges. The new Medi-Cal population has distinct needs compared to the severely mentally ill that DMH used to exclusively oversee. More infrastructure and capacity must also be developed while maintaining existing safety net functions (emergency services, involuntary treatment, disaster response). Patient confidentiality rules also pose a barrier to data exchange needed for coordination. DMH must also now manage interfacing with a large number of payors and entities.

Discussion

Panelists responded to questions posed by the moderator and the audience. The remarks below are a summarized version of their remarks.

How should groups transition from the existing fee-for-service paradigm towards fee-for-value when the two have very different operational approaches and workforces?

Louise McCarthy: Transitioning from volume to value is part of the recently passed payment reform pilots. Even so, many clinics are already fluent in managed care, and the workforce for value is not all that different from the one for visits – in either case, you are aiming to deliver care efficiently, which leads to good outcomes and good value.

Mark Gamble: Limited scope of practice reduces efficiency – many practitioners are fully competent to deliver forms of care they are legally blocked from providing (e.g. MFTs cannot provide services in an FQHC).

John Baackes: The jump between the two is not that far apart. A value-based system focuses on identifying an appropriate intervention and delivering it in a timely fashion.

Doctors are not always the best equipped to provide care to a population in poverty, as is the case for much of the Medi-Cal population. Integrated care that utilizes community health workers as part of a care team has been demonstrated repeatedly to be effective, so it's time to start implementing it in a widespread fashion. The system is largely in place to do so, but key adjustments must be made.

Hector Flores: The things done to coordinate care are important. They don't all have to be in the hospital setting, nor do they all have to be done by a physician.

As the delivery system is transformed, there will likely be winners and losers. Hospitals depend on the ER to fill their beds, but managed care aims to prevent that from happening. Entities that fail to transform could become the 'dinosaur in the room.'

An aging population will get sicker. Since patients play a key role in managing their chronic health conditions, how do we equip them to manage their own conditions?

John Baackes: A more educational approach that emphasizes patients' goals for their own health is needed. Care teams need to have patient advocates who represent a

patient's interests while educating and informing them about their options. Patients may be more willing to follow the lead of a trusted partner, such as a social worker.

Admittedly, case decisions get more complicated if finances come into the picture. This will become more of an issue as high deductible health plans become increasingly prevalent.

Mark Gamble: Currently, there is a sick care system that takes care of people at the end of life at high cost. Patients should be receiving more outpatient care, instead of intensive inpatient care. Person-centered care tries to keep people from needing such intensive and expensive care in the first place. This requires a transition that may involve some major losers – like hospitals, which are built around those lines of business.

Roderick Shaner: Patients who are not capable of directing their own care, such as the mentally impaired and geriatric patients, are prone to excessive and inappropriate use. The needs of these patients must be considered in the shift to person-centered care.

Hector Flores: Advances in technology provide more opportunities for care teams to engage with their patients. As more and more patients have access to the internet and cell phones, it becomes easier to engage patients earlier, which can be key to helping aging patients to age healthily. Healthcare needs to transform to work better with patients and connect them to the available services.

Incentive alignment is also important to push these changes. Capitation may be helpful in encouraging these transformations.

What is the role private practices will play in the evolving safety net landscape? Do they have a future?

Louise McCarthy: Los Angeles' safety net depends on the scarce resources that are available, including private practices. Losing them would severely harm access, as they play a key role in providing care.

Hector Flores: While there are no "haves" in the safety net, private practices do admittedly face unique challenges. While private practices do not receive as high reimbursement rates, FQHCs are subject to very stringent requirements. These private practices need investments similar to those being made in hospitals and FQHCs so they can transform to continue to play a role in the evolving safety net.

How do we ensure that undocumented youth have a smooth transition into Medi-Cal when SB75 goes into effect in the May?

Sean O'Brien: The LIHP transition demonstrated the safety net can handle a large influx of patients. Access to existing sources of care for SB75-eligibles must be maintained to ensure continuity of care when Medi-Cal eligibility kicks in.

Roderick Shaner: DMH has a major opportunity, as it already handles and will continue to handle these patients, now under a Medi-Cal like payor. In the past, it was difficult to

link these patients to a primary care provider. That will change.

Tangerine Brigham: The transition will be different for children known to DHS and those who aren't. DHS is currently working with its partners to move undocumented children into coverage, and has the data needed to oversee that.

Community outreach and engagement will be key to encouraging individuals who have had no prior contact with DHS to seek out coverage. Families need to be secure in their belief that seeking care will not result in an immigration raid.

Louise McCarthy: While it's true that any child on restricted scope Medi-Cal will automatically be redetermined into full-scope, the fact that everything is a workaround and nothing works simply is problematic in itself. Enrollment should not seem like a hazing process.

Who can push necessary simplification reforms to the Medi-Cal system?

Lucien Wulsin: While Secretary Dooley holds some of the necessary keys, stakeholders have an important role to play. In some cases, stakeholders have actually contributed to the complexity as well. Stakeholders have to be willing to put their piece of the system on the table for reform.

There are also obvious areas to tackle, such as how different MMC plans may place distinct and quite different obligations on a single practitioner, leading to a single practitioner splitting their time between multiple hospitals when they could better serve their patients by spending their time at one facility.

Sean O'Brien: As the state moves closer toward managed care, MCOs gain more responsibility, and will have increased power to make improvements and lead reform efforts with stakeholder support.

Roderick Shaner: There has been progress in establishing a universal consent system that will allow better communication between mental health and primary care providers in Los Angeles County. County counsel is close to an agreement on a system that will allow providers to share information to all necessary parties with a single authorization.

Hector Flores: The electorate also plays a key role by electing politicians who will champion system reform. Change requires a crisis, compulsion, and cash.

How do we improve professional education to better prepare practitioners to take part in care teams that provide patient-centered care?

Hector Flores: This is a time of great disruption – more education is necessary. Kaiser Permanente recently announced its intention to open medical schools that will have a managed care emphasis.

Roderick Shaner: DMH has been able to buy residency positions and embed those residents in real world contexts that require them to engage with and become fluent in managed care systems.

Louise McCarthy: We need to look more into systems that train students to understand the specific systems that they will work in lat-

er. One possible approach is to expose more people to public health through their education, perhaps by pairing residencies with MPH coursework.

What role does the Health Agency merger play in improving the safety net? Does it?

Roderick Shaner: Barring hopeless incompetence, administrative consolidation will help drive a better-integrated system, allowing all the necessary components to operate under a single umbrella.

Louise McCarthy: Although consolidation is unpopular, it could address the many issues arising from different departments handling different aspects of care. Work being done by many entities can be centralized under a single roof, and meaningful integration may become easier.

Tangerine Brigham: Each department has a good idea of how it can more efficiently serve a population. Integration that focuses on serving high-risk populations enables the departments to know what they need to do and what they need to deliver.

Is workforce development the next statewide priority?

Lousie McCarthy: Everyone needs more workforce, inclusive of all aspects of a care team ranging from physicians to coding experts. The critically needed elements of the workforce need to be identified so concrete solutions can be developed.

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