Preparing for Launch:

Views on the Implementation of Federal Health Reform in Los Angeles County

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Executive Summary

It would be difficult to overstate the profound changes coming to the health care safety net in Los Angeles County under the new Patient Protection and Affordable Care Act (ACA). With an expansion of insurance coverage, as well as efforts to reform service delivery and payment systems, the ACA has the potential to change the decades-old safety net financing paradigm based on uncompensated care and cost-shifting. It is critical for policymakers and leaders to understand just what these health system changes will mean for Los Angeles County and to be ready to respond.

To help raise the curtain on the road ahead, LA Health Action (LAHA) has worked to bring to light opinions on the ACA through almost 15 hours of interviews with more than 20 county-level health care thought leaders. While the ACA will ultimately affect almost every health care provider, these findings focus on medical care provided by the Los Angeles County Department of Health Care Services (DHS) and other safety net providers.

The leaders discussed five key areas of focus for the safety net in response to the ACA, including:

- *Defining the Roles of Provider Groups: Coordination versus Competition.* It was clear that a critical issue for the safety net is deciding who will deliver what care and when. There was significant discussion over the current system configuration among various providers (government, non-profit, and for-profit) and how that system should evolve.

- *Transforming to a Patient-Centered System.* To be fully successful moving forward, leaders discussed the need for public safety net providers to focus on patient satisfaction and to develop a "culture of excellence."

- *Improving Integration of the Delivery System.* The safety net continues to deliver care in silos. Leaders talked about the need to develop: a medical home model; Accountable Care Organizations (ACOs); better coordination between specialty and primary care; and, an integrated care model between medical, mental, and behavioral health.

- *Promoting ACA Outreach and Education.* According to several leaders, such sweeping change calls for sweeping education efforts to business, the health care workforce, the uninsured, and the public more broadly.

- *Preparing for the Ongoing Un-Met Need.* Under the ACA, there will still be a need for an organized system of care for those who will remain uninsured—many of whom will be undocumented.

While most leaders felt that both the pending state 1115 Medi-Cal waiver and the work being done to implement the March 2010 Health Management Associates report are the two crucial first steps on health reform, there was discussion about other work that is needed to just get out of the starting gate, with steps such as:

- *Appointing a Permanent Director for DHS.* There was a shared belief that there needs to be a permanent director as a means of reducing the uncertainty about the future of DHS.

- *Creating a Table for Stakeholder Interaction.* There was a sense that there needs to be an entity that can facilitate the interaction of stakeholders, with LA Care, LAHA, The California Endowment, and DHS all mentioned as possible tables for that work.

- *Defining a Shared Vision.* Many leaders felt that there needs to be a greater effort in developing a broadly shared vision for the future of the safety net that is endorsed by the Los Angeles County Board of Supervisors.

- *Paying Close Attention to Federal Funding Opportunities.* Several leaders commented that there should be a central clearinghouse on the opportunities to bring more federal resources to Los Angeles County.

- *Conducting Other Needed Research.* Leaders articulated a range of areas that need additional research, including a county-wide health information technology assessment, an analysis of how the pending Medi-Cal waiver will affect service delivery, and a review future workforce needs.

Introduction

The Patient Protection and Affordable Care Act (ACA) contains the most sweeping changes to health care in American history. The new law promises to expand coverage to 30 million more Americans, improve the service delivery system, and reform payment systems to increase quality. As the implementation of the ACA will require many new federal regulations, the easy part of health reform may well have been passing the legislation. To achieve real change, it will take a strong effort at all levels of government—federal, state, and county.

To implement the ACA, state and federal officials have already begun to take aggressive steps. Every week, there are headlines discussing the federal effort, including the launch of healthcare.gov and new regulations holding private insurance companies more accountable. At the state level, for example, California's Assembly Bill 1602 (Pérez) to create a state exchange has already passed through committee.

At the same time, there is less clarity on the work that is taking place in Los Angeles County on ACA implementation, particularly as that work relates to the safety net. There are important efforts taking place to gain approval of the statewide Medi-Cal 1115 waiver and to implement the recommendations made in a March 2010 report by Health Management Associates—with both efforts laying the foundation for the future of reform in Los Angeles County.[1] And even prior to the passage of the ACA, The California Endowment released "Achieving the Vision" as one direction for the future of health care services in Los Angeles County. At the same time, there is at least a perception that the Los Angeles County Department of Health Services (DHS) has limited resources for long-range planning, beyond the difficult tasks of addressing the future Martin Luther King, Jr. Hospital Medical Facility and reconciling the substantial budget deficit.

Yet, it would be difficult to overstate the profound change that the ACA holds for the health care safety net in Los Angeles County. With an expansion of insurance coverage, as well as efforts to reform service delivery and payment systems, the ACA has the potential to change the decades-old safety net financing paradigm based on uncompensated care and cost-shifting. It is critical for policymakers and leaders to understand just what these health system changes will mean for Los Angeles County and to be ready to respond.

This report is designed to help raise the curtain on ACA implementation in Los Angeles County. Through almost 15 hours of interviews with more than 20 health care thought leaders, LA Health

[1] For information on the 1115 waiver proposal, please see: the California Department of Health Care Services at http://www.dhcs.ca.gov/Pages/SACMeetings.aspx. For information on the HMA report, please see: Health Management Associates, Evaluation of the Office of Managed Care, March 2010 at http://www.healthmanagement.com/files/LA%20County%20Report%20March%202010.pdf .

Action (LAHA) has worked to bring to light the opinions of key thought leaders on a series of critical issues, such as:

- *The key challenges posed by the ACA for Los Angeles County.*
- *The opportunities for Los Angeles County under the ACA.*
- *The needed first steps for ACA implementation.*

The findings, based completely on the interview process, paint a picture of the work that needs to be done and of the critical role county-level leaders will play in reform. (Appendix A lists the leaders interviewed, although no quotes in the report are attributed to the source in order to promote a free flow of ideas.) The interviews were conducted in a semi-structured manner with a careful focus on allowing the leader to speak their mind and to take the conversation in the direction they desired. The focus here is on issues related to DHS, even though the impact of reform will also affect services delivered by the Department of Mental Health (DMH) and Department of Public Health (DPH).

The paper has two primary sections. Following a brief discussion of the state and federal context for reform, the report explores key areas of focus for ACA implementation in Los Angeles County. The report then concludes with a list of key first steps identified by the leaders that should be taken in order to successfully move forward on implementation of the ACA.

The State and Federal Context of Reform

The most consistently discussed aspect of the state and federal context for implementation is uncertainty. Given that the interviews occurred prior to the ACA's six month anniversary, this isn't much of a surprise. At the federal level, health reform is a vast and sweeping piece of legislation that will require more than 40 separate federal regulations to be promulgated.[2] There are many more questions than answers about the future. At the state level, the Schwarzenegger administration and the legislature are moving forward faster than perhaps any other state on ACA implementation. At the same time, there is a sense that uncertainty at the state level could slow progress at the county level, with sources of uncertainty including the:

- *Serious weakness in the state budget.*

[2] Jennifer Haberkorn and Sarah Kliff, "AMA Lobby Strategy Criticized," *Politico*, July 12, 2010.

- *State leadership changes to be determined by the November 2010 election.*

- *Ongoing negotiation of the pending 1115 Medi-Cal waiver and the pending statewide hospital provider fee, with billions at stake for the California health care system.*

The second most consistent theme on context is the certainty of the vast new commitment of federal funds to health care. For all intents and purposes, the federal government has bought out the majority of the county's requirement under state law to provide health care to those who have no other alternative.[3] Under the ACA, approximately 1.2 million uninsured people in Los Angeles County will have chance for some type of subsidized coverage.[4] This will bring significant positive change to Los Angeles County.

Areas of Focus

We asked leaders to discuss the issues that would need the most focus in Los Angeles County on the ACA. We found several themes that, on some level, have long been discussed. But the ACA creates new urgency since the health care system is going to substantially change in a set timeframe. The momentum in the system seems to be shifting from favoring the status quo to favoring change, with leaders expressing an eagerness to address issues in the following five areas.

Defining the Roles of Provider Groups: Coordination versus Competition

With one leader calling it an out-dated "romantic notion" that the safety net is the exclusive purview of public providers, virtually all of the leaders discussed the need to better define the relationship between public and private health care providers in Los Angeles County. Indeed, leaders consistently referred to the need to address a fundamental question on the structure of the safety net: are public and private facilities competitors or teammates?

Conversations with leaders revealed a range of possible answers, with at least a few leaders saying that the two provider groups have to learn to accept each other as *competitive teammates*. Ultimately, the issue seems to be one of finding the right balance in the system. At one end of a

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[3] California State Welfare and Institutions Code Section 17000 states that: "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

[4] Shana Alex Lavarreda and E. Richard Brown, "National Health Care Reform Will Help Four Million Uninsured Adults and Children in California," UCLA Center for Health Policy Studies, October 2009.

continuum, there is concern that the DHS' challenges (real and perceived) on delivering high-quality customer service means that there is a potential for the "mass exodus" of newly-insured patients from the public safety net system. By choosing to take their new insurance coverage provided by the ACA and leaving the DHS system to see other providers (non-profit and for-profit), patients could create instability in the DHS system—jeopardizing its ability to serve anyone.

At the other end of the continuum in thinking about service delivery, there was a separate concern that the DHS system doesn't have sufficient capacity today and will always be under-resourced, such that DHS has no choice but to reduce the scope of its current mission as compared to non-profit and private providers. Certainly, the DHS system will continue to play a very critical role in providing health care access to all, with a skilled and culturally competent workforce of 22,000 people serving the entire county in a series of hospitals, clinics, and teaching programs. Yet, some leaders see a need to limit the current DHS mission.

Regardless of their overall position, the basic question from the leaders on this point was the same, "who should be doing what"?

Improved Coordination

Several leaders offered a critique that, historically, DHS has kept itself "walled off" from the rest of the system, with private hospitals seeking greater collaboration only to be "rebuffed." The fact that the county is "finally" willing to move away from the Community Health Plan, the county-sponsored managed care plan, and transfer those functions to LA Care is a sign to some that maybe there is growing interest in the walls coming down.

In any event, the need for greater coordination is self-evident to many. As an example, one leader highlighted the proximity of private hospitals to public facilities as a defining need for coordination, pointing both to White Memorial Medical Center which is less than a mile from LAC+USC Medical Center and to St. Francis Hospital which is less than three miles from the Martin Luther King Jr. Multi-Ambulatory Care Center (MACC). Another leader asserted that DHS does not have strong coverage in all parts of the county; and as a result, greater coordination is needed by definition with private providers, particularly in Long Beach, on the Westside, and in portions of the San Fernando Valley (with the latter being cited as an area with weak clinic coverage). The stitching together of the facilities so that there is greater coordination of services will be a critical step in making the ACA successful.

Managing Increased Competition

In a sign of the tension between public and private providers, one leader derisively volunteered that, "the private side will also do better at making money" under the ACA. In fact, more than

one leader pointed to lessons from the increase in Medi-Cal obstetric rates, and the subsequent loss of such patients from the DHS system to the private system, as evidence of how a nimble private sector competitor can weaken the public system. One leader even took this a step further and talked about the "unscrupulous" practices of a few private doctors who actively recruit patients for birthing from non-profit clinics, only to drop the patient when the enhanced Medi-Cal obstetrics rate runs out.

Most every health leaders interviewed commented in some way on the need for the public system to ready itself for this new competition. Broadly speaking, leaders believe that the expansion of insurance and the creation of the exchange will result in roughly half of the DHS patients obtaining coverage, being given greater choice, and then ultimately choosing against county providers. The exchange will increase availability of cost and quality data. And the county will need to compete for customers in a way that it has not had to do previously.

California's 2007 health reform effort called for locking certain newly covered populations into the DHS system for a period of time. A few health leaders commented that this may be needed as part of ACA implementation. As part of this work, one leader also commented on the need for public safety net providers to strengthen their connection to Medicare and private care.

Transforming to a Patient-Focused Model

The discussion around competition generally turned to the reasons why DHS facilities specifically, and non-profit facilities broadly, might find themselves at a disadvantage in competition with for-profit facilities: a need to increase customer service quality. Leaders talked about many DHS providers delivering high quality medical services, but that the system could struggle to maintain patients due to real or perceived challenges around long wait times, unresponsiveness to customers, and a lack-of patient focused care. "People kept waiting for care are not going to stay in the system," as one leader succinctly explained.

Many leaders said that poor customer service within DHS could be traced back to understaffing, underfunding, and lack of basic delivery innovations (such as nurse call lines and urgent care) that lead to unnecessary use (and overcrowding) of safety net Emergency Departments (EDs). One leader made the observation that DHS provider facilities primarily have a teaching focus, which can lead to a focus on pathology and not the patient. And that, overall, the entire system suffers from a "welfare stigma" that could be very difficult to overcome in a competitive market place, especially given county government budget constraints.

Although the interviews were conducted independently, several leaders used the exact same phrase to convey that DHS must go from being the "provider of last resort to a provider of choice." A series of suggestions were offered on how the system could move forward.

- *Developing a "Culture of Excellence."* The need to develop the workforce was a common theme. There was discussion about how all hospital staff, both related to patient care and in the administrative functions-- affect the patient experience and how all staff must strive for excellence in their work. As part of this, there should be appropriate recruiting and staffing at all levels of the workforce, including physicians and nurses.

- *Quality Transparency for All Providers.* Several leaders touched on the need to have broadly understood and shared quality measures for care delivery. One leader in particular talked about the need for such information to be transparent for all providers, lest provider groups attempt to leverage available information to disadvantage a group over another.

- *Patient-Centered Effort*. As part of system transformation, several leaders expressed concern that the current system appears designed around keeping institutions going, not supporting individuals. There was discussion about the need to think carefully about what is needed in the community and then delivering that. For example, culturally competent *Promotores* programs can deliver care where it is needed in the Spanish-speaking community.

- *Develop and Strengthen Social Service Efforts.* By offering a package of non-medical services, it is felt that county and non-profit facilities can have a competitive advantage with patients. The non-profit system is perceived to have an advantage because it has successfully bundled the delivery of social services through health care facilities—including social work, case management, behavioral health, and dental. It was also suggested that all clinics all need to achieve Federally Qualified Health Center and National Committee for Quality Assurance (NCQA) approved status.

- *Developing Stronger Health Information Technology Systems.* Several health leaders commented on the need to develop health information record systems as a means of improving both care delivery and patient experience. Some examples included improving appointment systems and registries. There is a feeling that the safety net broadly, and public facilities specifically, are behind in this area.

- *Enrollment Processes.* At least one health leader expressed concern about the Medi-Cal enrollment process in Los Angeles and whether or not it could keep pace with the significant new number of enrollments under an expanded Medi-Cal program. The concern here is that people are unlikely to differentiate their experience in applying for Medi-Cal with their care experience in the DHS health system.

Improving Integration the Delivery System

The need for "better integration" is a common refrain among health care leaders nationally, and this interview process was no different. Every leader interviewed, to one degree or another, commented that the development of an integrated health care system is a critical step in health reform. There was clearly a feeling that, while Washington and Sacramento will set broad policy and allocate resources, the control of the delivery system rests with leaders in Los Angeles County. As one leader said, the delivery system "is where rubber meets the road" of implementation.

As previously stated, there was broad agreement that DHS and non-profit facilities can provide high quality health care services. Yet, leaders clearly feel that there is both a need and an opportunity to: build a stronger network of services; deliver a higher level of care; and, find ways to achieve a more efficient system to contain costs. In particular, leaders talked about developing the following concepts.

- *Development of a Medical Home.* Leaders expressed support for implementing a medical home concept. However, as at the national level, there was no consistent operational definition given beyond the broad notion of a medical home as a usual source of care offering primary care (and other services) that is coordinated with system of specialty care.

- *Coordination of Specialty Care.* In many interviews, there were references to DHS struggling with the interaction between primary and specialty care providers—with leaders citing difficulties in both making referrals from primary to specialty care and then coordination of care between specialists and primary care physicians. There was also recognition that it can be difficult for Medi-Cal patients to obtain specialty care at all.

- *Utilization of Accountable Care Organizations (ACOs).* As a new concept offered under the ACA, ACOs promise to better integrate care delivery across hospitals and physicians by helping to align their incentives. At least one leader thought that ACOs could be critical for aligning hospital and physician incentives, especially in California where there is a ban on the corporate practice of medicine. While there was significant interest in exploring the concept, another leader was concerned that ACOs could have an unintended consequence of focusing on higher paying providers (Medicare and commercial products) to the detriment of Medi-Cal beneficiaries and the uninsured.

- *Increased Integration of Mental and Behavioral Health Services.* Leaders spoke of the need to, and value of, better integrating physical and other health services. This would include not only the need for improved care delivery but for better coordination of county

government organizations as well, including DHS, DMH, and DPH. There was widespread feeling that the ACA would be most successful if the existing organizational silos could be broken down and better coordinated. There was also a mention of integrating other services, such as those delivered to veterans.

Promoting ACA Outreach and Education

Several leaders commented on the need for better education around ACA implementation. There was a sense that health reform is only going to be effective if there is a widespread understanding of the changes that are coming—both in terms of preparing the public for those changes and maintaining the political pressure that will be needed to achieve those changes. Generally speaking, there was a call for a well-funded and well-designed education and outreach effort--culturally and linguistically appropriate--for the public at large on the ACA. Leaders also discussed the value of directing outreach and education efforts at specific populations, including:

- *Local Businesses.* Businesses will face many changes under the ACA. At least one leader commented that educating business owners will be critical so that they have a clear picture of the benefits and challenges.

- *Health Care Workforce.* Another leader commented that there needs to be a major effort to help the workforce understand the changed that are coming, including physicians, nurses, and technicians, both inside and outside the public sector. An educated workforce will be better able, and more willing, to participate in the new system.

- *The Public and Accessing the System.* Several leaders talked about the need to better educate those accessing the health system as to when a clinic might be better than the ED. At least one leader talked about overuse of the ED as an individual "choice" in many cases that could be better informed by a discussion on the role of the ED – and alternative sources of care.

- *The Uninsured.* The uninsured are going to need to understand their new options and the benefits of the new system and how to use the exchange and other new programs. For example, initial reports from states with the new federal pre-existing conditions pool is that enrollment has been slower than expected, which is a reminder that new public programs typically need aggressive outreach campaigns.

In reaching out to these communities, it was noted that communication networks already exist and that the most efficient approach could be to work through those networks. Many of these communities have their own leadership that could serve as a basis for outreach. Information should be as specific and as actionable as possible, with implementation dates and cost analysis.

Preparing for the Ongoing Un-Met Need

There was a consistent level of concern from leaders regarding the 900,000 people living in Los Angeles County who will likely remain uninsured under ACA implementation.[5] Many of those interviewed said that careful planning was going to be needed to develop the delivery system needed for this population in particular. Several leaders lamented what it could mean for county DHS facilities to become the only source of care for this population, saying that it could be a major burden on the county, especially given planned reductions in federal funds to support the uninsured.

Getting Started: Critical First Steps

While work by Los Angeles County health leaders on the ACA may not be front page news, it was clear that work has already begun. As mentioned, several leaders referred to implementation of the March 2010 Health Management Associates report on health care in Los Angeles County as the first concrete step towards preparing the system for change. The development of the Medi-Cal 1115 waiver was also cited as a critical early step, along with the implementation of statewide hospital provider fee.

Despite the established challenges in the safety net, there was a sense of optimism from the leaders in facing the work that's ahead. An obvious reason for that is simply the possibility for a better future as a result of the ACA coverage expansion and new federal resources. More than that, leaders also gave a sense that "we are all in this together," with two factors consistently raised as reasons for confidence:

- *Well-Developed Policy and Provider Community Relationships.* Many of the leaders commented on the strong relationships that exist between stakeholders as an important reason ACA implementation could be successful. As part of this, the Board of Supervisors was cited as having the resources to help focus state and federal attention on key policy and budget issues.

- *Strong Philanthropy Community.* As an offset to weak government budgets, Los Angeles County continues to have resources made available by foundations for planning and implementation of change. Philanthropy is clearly seen as being a key part of achieving success in ACA implementation.

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[5] Shana Alex Lavarreda and E. Richard Brown, "National Health Care Reform Will Help Four Million Uninsured Adults and Children in California," UCLA Center for Health Policy Studies, October 2009.

With such a daunting task ahead, we asked leaders to talk about the immediate steps that they would take in order to help make sure implementation would be successful. There were five themes that became clear.

Appointing a Permanent Director for DHS

"The lack of permanent leadership is hurting in a big way," is how one leader summarized a widely shared belief—that Los Angeles County needs to establish a permanent head for DHS. While focus on the concern ranged from a brief mention in one interview to one leader spending almost their entire interview on the negative impact there being no permanent director, virtually every interview contained a spontaneous call for a permanent head of DHS. At the same time, leaders were also complimentary and supportive of the ongoing efforts by the current interim director and other county leadership. The concern here has more to do with the uncertainty caused by having a long-term interim leader and the challenge of lacking a permanent leader that can partner with DMH and DPH to move forward. There was a clear feeling that ACA implementation would suffer so long as there is no permanent head of DHS.

A related concern was one of overall governance of DHS. Historically, questions have been raised about whether or not the current system of governance constituted the most "nimble" or "efficient" means of governing the health care system, with some leaders calling for a special board to oversee DHS. While a few leaders raised governance as an "important" question, it was clearly secondary to the need to appoint a permanent head of DHS.

Creating the Table for Stakeholder Coordination

The leaders consistently called for an organized effort to improve communication and organization of decisions across health care stakeholders in Los Angeles County. However, there was less consistency among leaders in talking about who should host that table, with two entities receiving the bulk of the comments as a possible convener.

- *LA Care*. There is a sense that LA Care already touches on all the critical aspects of the health care system, and that the LA Care leadership is well positioned to bring stakeholders together. It is worth mentioning that there was an articulated concern that LA Care could be a stronger friend to the safety net, with specific references to some of LA Care's plan partners being uncommitted to supporting the safety net.

- *LAHA*. Many leaders commented that this paper was a needed and appropriate role for LAHA and expressed hope that there would be more such work. However, concerns over long-term LAHA funding created some uncertainty. Several leaders commented that, if LAHA was not able to serve as a convener in the long run, then there would be a need for a "LAHA-like" entity with "no self-interest" in the system and that is "neutral".

There was certainly a sense that DHS could serve the role as a facilitator, but it was difficult for leaders to engage in that conversation given that there is no permanent director. The California Endowment was also mentioned as a possible convener.

Defining a Shared Vision

For the most part, leaders focused on the positive and reflected an understanding that a vision will "take time to develop," especially in a safety net where patients are already "lined up out the door." Leaders regularly mentioned the need for a vision, including that it should not be overly complex and county leaders cannot be afraid to try something that may fail. While a few leaders were critical of the policy community as a whole, with one calling it "unimaginative" and another making reference to a "broken" political system that is not "nimble" enough to respond to changing environment, most were more optimistic.

In developing a vision, it becomes critical acknowledge some of the unknowns that must be accounted for in planning. For example, how does the weak Los Angeles County budget affect the future of DHS? How should (will) the role of DHS and other providers be defined by leaders? Regardless of the desired definition of roles by leaders, how will patients vote on system design with their feet? Given the uncertainty, one approach to future planning would be to define a vision under various scenarios, as articulated by the leaders.

- *Scenario 1: Patients exit DHS facilities post-ACA.*
    - Given the reduction in need, how could DHS be downsized appropriately, while protecting needed services? Does it make sense to reconfigure the DHS system to minimize in-patient care? To reconfigure DHS to focus on specialty care and minimize primary care?
    - What are the financial ramifications of DHS caring for an entirely uninsured, but smaller, population?
    - Is the system weaker for losing the accountability and transparency that comes from a public system of care (versus an entirely private system)?
    - What is the burden on the rest of the system caused by absorbing former DHS patients? Do system-wide capacity limits mean that some newly covered patients will be unable to find needed care outside of the DHS system?

- *Scenario 2: Patients stay with existing DHS providers, thereby creating a need to develop stronger systems of care.*
    - What are the opportunities to create a system that will offer better coordinated patient care?

- What are the options for bending the cost curve and improving quality care delivery?
- How can the distribution of resources available from government programs and private insurance be done in a way that "makes sense," including defining the population of patients that the county should care for?
- What are the organizational, political, and financial ramifications of DHS transitioning from a hospital-centered system with a strong medical teaching mission to a patient-centered system driven by the managed care imperatives of prevention and early intervention?

- *Scenario 3: More patients utilize DHS as a provider of choice that retains current patients and attracts new one.*
  - What are the structural and cultural barriers that would have to be overcome for DHS to become a provider of choice? What are the specific quality and customer service challenges?
  - Do private hospitals have an incentive to negotiate their role for the uninsured absent the existence of a competitive DHS that could claim Medi-Cal and Medicare market share?
  - How can the patient experience be improved to draw in more patients, including greater utilization of DHS services by DHS employees?
  - What is the cost of an action plan to achieve change and are the stakeholders prepared to "leave their hats at the door" for such a planning effort? How could that cost be financed? Are the right DHS relationships, particularly with unions, in place for such an effort?

As part of embracing a single vision, it is important to understand existing funding streams. One leader who is an expert on hospital funding commented that the lack of transparency in existing streams is a significant disadvantage to the whole system in that it limits the ability of leaders to coordinate the rational use of resources. While much of this paper has discussed the competition of public and private hospitals, there is also competition with physicians, clinics, and within the various divisions of private hospitals. As made clear in the interviews, disparate levels of policy expertise and political skill can be used as a means to increases the financial standing of one division. Given that, it would seem that effective scenario planning would include an effort to educate leaders on various funding streams as well as an effort for leaders to step beyond their traditional advocacy roles and see the needs of the system as a whole.

A few leaders discussed the effort by The California Endowment in releasing "Achieving the Vision," as a path forward for Los Angeles County health care. But the interviews failed to find a widespread understanding of what was included in that extensive work. One idea could be to

use that effort as the starting point for future conversations. As the bottom line, several leaders made it clear that, without agreement of the Board of Supervisors, “no vision will stick.”

Paying Close Attention to Federal Funding Opportunities

ACA implementation is a mammoth undertaking. There are numerous opportunities for states and stakeholders to apply for federal resources for implementation—and many funds are still without an application process.

Leaders lamented that there is no one clearinghouse for all of the federal funding opportunities that might be helpful to Los Angeles County. While individual stakeholders will always have the best information regarding changes under their area of purview, there is a need to coordinate those opportunities and respond in an organized manner. This activity could be well-suited for the Insured the Uninsured Project and/or LAHA.

Completing Critical Analyses for Future Planning

In addition to the issues discussed above, the leaders identified additional areas that would benefit from a greater research and planning effort.

- *Understanding the Impact of Pending Federal Funding.* Several leaders talked about a need to develop a stronger shared sense of what the funds made available by the pending Medi-Cal 1115 waiver, pending hospital fee, and the potential federal Medicaid matching rate increase (or lack thereof), could mean to Los Angeles health care providers. As part of this, there was at least some interest in the Medi-Cal 1115 waiver’s proposed County Alternative Model as a means to maintain county funding.

- *Health Information Technology Assessment.* There was a suggestion that there needs to be a safety net-wide assessment of the information systems used across the county. This effort could include, for example, a DHS/DMH/DPH planning effort to develop a single patient number for all county clients and to improve data sharing across departments.

- *Responding to the Ongoing Un-Met Need.* Leaders talked about the need for analyses of: how the size and composition of the uninsured will evolve under the ACA; the financing that will be available to care for the population; and, the system capacity that will be needed, as well as any system changes that could be needed, such as school-based clinics, to care for the population.

- *Impact of the Waiver on Service Delivery.* Aside from the positive financial impact of the pending Medi-Cal 1115 waiver, several leaders wondered out loud about their understanding of the waiver as a “bridge to health reform.” While a few commented on

what they called a "closed" development process, other leaders took a more positive tone and commented on the need to develop a broad understanding of the specific impact of the waiver on ACA implementation in Los Angeles County. This kind of research could also help address concerns by at least one leader regarding the ability of county facilities to treat greater numbers of seniors and persons with disabilities. No leader indicated any opposition to the waiver going forward.

- *Future Workforce Issues.* A few leaders expressed concern that the aging DHS workforce coupled with a County hiring freeze creates a recipe for long-term limits on capacity. There were calls for careful workforce planning to determine what is needed under the ACA, including an evaluation of the needs for physicians, nurses, and technicians.

Conclusion

The safety net health care delivery system in Los Angeles County is one of the largest and most complex in the United States. The changes that will take place within that system over the next 10 years will be profound and will require significant planning preparation. Today, the questions and challenges revolving around implementation are more obvious than the solutions. By beginning the planning process now, the Los Angeles County safety net has the best chance at being able to move beyond "just surviving" to a future where the system can achieve meaningful change.

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Harbage Consulting LLC is a health policy consultancy based in Washington, DC that seeks to help expand health care coverage and create a more efficient health care system. Peter Harbage, who has worked for almost 15 years at the federal and state level on health care issues, served as principle author of this report. Ingrid Aguirre Happoldt, an independent consultant based in Oakland, California, completed many of the leader interviews and edited the text of the report.

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Methodology

Interviews were conducted in June and July 2010. Lasting approximately 30 to 45 minutes, the interview approach was semi-structured and designed as a free response by the individual. Broadly, the questions focused on asking leaders to talk about the opportunities, challenges, and needed first steps for ACA implementation. The prompting of specific issues by the interviewer was eschewed in favor of exploring those ideas raised by the interviewee. Careful notes of the interviews were kept, although confidentiality of the interviewee was promised in the hopes of having a more open conversation.

Appendix A

Leaders Consulted

Harbage Consulting LLC interviewed the following leaders for this report.

Name	Title	Organization
Frank Binch	Emergency Medical Service Commissioner	Los Angeles County
Rick Brown	Director	UCLA Center for Health Policy Research
Ashley Cohen	Regional Workgroup Director	Insure the Uninsured Project
Michael Cousineau	Director	University of Southern California Center for Community Health Studies
Dr. Hector Flores	Co-Director	White Memorial Medical Center Family Practice Residency Program
Jonathan Freedman	Chief Deputy Director	Los Angeles County Department of Public Health
Lark Galloway Gilliam	Executive Director	Community Health Councils
Neelam Gupta	Deputy Director	LA Health Action
Ron Hansen	Principal Consultant	Leverage Health and Human Services
Howard Kahn	CEO	L.A. Care Health Plan
Jim Lott	Senior Vice-President	Hospital Association of Southern California
Jim Mangia	President & CEO	St. John's Well Child and Family Center
Barbara Masters	Principal	MastersPolicyConsulting
Kathy Ochoa	Director	SEIU Local 721
Mary Rainwater	Project Director	Integrated Behavioral Health Project
Gloria Rodriguez	CEO	Community Clinic Association of Los Angeles County
Dr. Robert Ross	President & CEO	The California Endowment
John Schunhoff	Interim Director	Los Angeles County Department of Health Services
Beatriz Solis	Director	The California Endowment
Gary Toebben	President & CEO	Los Angeles Chamber of Commerce
Yolanda Vera	Senior Deputy	Office of Supervisor Mark Ridley-Thomas
Dr. Keith Wilson	Medical Director	Healthcare Partners, Region 6
Lucien Wulsin	Project Director	Insure the Uninsured Project