Report on Health Reform Implementation

What Changes Are Needed to Enable the Safety Net to Become a Provider of Choice? And How Does It Get Done?

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Editor's note: The two essays in this issue's Report on Health Reform Implementation section emerged from a workshop, generously funded by the Robert Wood Johnson Foundation, that was held in Chicago, Illinois, in January 2014. The purpose of the workshop was threefold: first, to increase communication and learning between state-level policy practitioners and health policy researchers; second, to address key ACA implementation issues that states are currently grappling with; and third, in response to these issues, to identify useful policy instruments and strategies for dissemination across the states. With these goals in mind, we asked several policy practitioners in different states to submit questions on current implementation challenges that might benefit from the insights of a policy researcher. We then identified researchers with significant expertise in applicable areas to respond to a small selection of these important questions. Howard Kahn's question on how safety net clinics and hospitals will evolve in the wake of recent health care reform and the response by Julia Murphy et al. is an example of the work that came out of this productive process. This is the third and final set of essays to be published from the January 2014 workshop. We welcome any feedback on the process or the issues.
—Colleen M. Grogan

Abstract The safety net is the delivery system that provides health care to low-income and uninsured populations. Following the recent implementation of health care reform, hundreds of thousands of people in Los Angeles County gained or became eligible for health care coverage. The safety net now has the potential to remain a regular source of care for these newly covered patients who historically have been dependent

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on the safety net for their health care. Safety net providers may need to rethink current practices, operate more efficiently, document more consistently, and improve patient experience to keep and attract this newly insured population. Faced with an uncertain future, safety net clinics and hospitals will need to strategically plan for the coming years, with patient choice at the core of their decisions. Given the newly ensured Medicaid beneficiaries, the safety net will need to evolve and adapt to ensure its role in Los Angeles County.

Keywords safety net, L.A. Care Health Plan, Medicaid, public health care

Introduction

In 2014 Los Angeles (LA) County implemented one of the largest expansions of health coverage to the uninsured as part of the Affordable Care Act (ACA). During this time, hundreds of thousands of individuals became eligible for Medicaid or obtained coverage through the state of California's health benefit exchange. Many of LA County's uninsured residents, who traditionally had no other option than to be cared for by the safety net health care system, now have coverage and, correspondingly, their choice of provider. In the past, the safety net has never needed to be a competitive player in the health care system, since the uninsured had few provider options. This article aims to provide background on whether changes are necessary to enable the safety net to become an attractive provider of choice in this new postreform environment.

Background on L.A. Care

L.A. Care Health Plan is an independent local public agency created by the state of California and LA County to provide health coverage to low-income county residents. In April 1993 the California Department of Health Services (today known as the Department of Health Care Services) created the Two-Plan Model health care delivery system in which a locally developed public health plan competes against a commercial health plan in a specific county. The goals and objectives of the Two-Plan Model were to expand choices of coverage, physicians, and other medical providers; improve access to primary and preventive health care services; ensure quality of care; and preserve the health care safety net.

Since obtaining its license to become a full-service health plan in 1997, L.A. Care has grown to over 1.7 million enrolled members, making it the largest public health plan (and one of the largest Medicaid plans) in the

nation. It is not only a health plan but also a supporter of the safety net and advocate for the uninsured, underinsured, and low-income residents of LA County. It has become a go-to resource in the community, a grant maker, and a policy leader in local and national health policy. L.A. Care is governed by thirteen board members representing specific stakeholder groups, including consumers, community clinics, physicians, federally qualified health centers, children's health care providers, the LA County Department of Health Services, and local hospitals.

L.A. Care, as part of its mission, is committed to supporting the safety net. The plan advances individual and community health through targeted activities, including a Community Health Investment Fund that has awarded more than $132 million over the last decade to support practice transformation, increase capacity to serve seniors and people with disabilities, and expand health coverage.

L.A. Care Product Lines

L.A. Care is a Medicaid managed care plan with multiple product lines. In addition to offering a Medicaid product through a directly contracted network of providers, L.A. Care subcontracts with three fully licensed health plans to organize health care services to Medicaid members. These health plan partners are Anthem Blue Cross, Care 1st Health Plan, and Kaiser Permanente.

L.A. Care also offers several other non-Medicaid products, including Healthy Kids, for children ages five and younger up to 300 percent of the federal poverty level who do not qualify for Medicaid; Medicare Advantage Special Needs Plan that provides coordinated care for LA County seniors and people with disabilities who are dually eligible for Medicare and Medicaid; coverage for LA County's In Home Supportive Services workers, who provide services such as meal preparation and personal care to vulnerable members in the county; and L.A. Care Covered, an expansion of L.A. Care's Medicaid line of business in California's health benefit exchange, Covered California. L.A. Care is the only safety net health plan participating in Covered California.

The Safety Net

The safety net is the system that provides health care to low-income and uninsured populations. LA County has a robust safety net of public clinics

and hospitals, community clinics, and free clinics, in addition to traditional Medicaid doctors. There are also many private safety net hospitals or disproportionate share hospitals (DSH) that receive federal funds to provide a disproportionate share of cost to Medicaid patients and the uninsured. The LA County Department of Health Services operates a network of four public hospitals and nineteen freestanding clinics. During the 2012–13 fiscal year, the LA County system provided 2.9 million ambulatory care visits, 215,000 urgent care visits, almost 300,000 emergency room visits, and inpatient care to an average of 1,234 patients per day.

The community clinics are another important facet of the safety net. The Community Clinic Association of LA County represents most community clinics in the county that serve over 1 million patients per year. These clinics are oftentimes federally qualified health centers (FQHC), which include organizations receiving grants under Section 330 of the Public Health Service Act. They must also serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Community clinics also include FQHC look-alikes (those that do not receive 330 funding but do receive the Medicaid prospective payment system wrap-around payment) and free clinics. That said, despite the size of the safety net, the vast majority of care to LA County's over 2 million Medicaid patients is provided by private doctors and hospitals.

The Affordable Care Act

The Affordable Care Act (ACA) was signed into law in 2010 with the promise of major change for the health care system. California was an innovator in many ways, leading the way in state health benefit exchanges and rolling out the largest Medicaid expansion in the nation. L.A. Care also had the unique opportunity to contribute to the historic changes that resulted from health care reform.

Health Insurance/Benefits Exchange

In accordance with the ACA, California opted to set up a health benefit exchange for people to buy health insurance. This virtual marketplace, Covered California, allows consumers to research equitable health plan offerings to compare benefits and costs. This was an opportunity for California residents who previously had not had health coverage to gain

access to insurance prior to the deadline for the individual mandate. L.A. Care, in an effort to stay true to its mission to provide health coverage for low-income LA County residents, made the decision to participate in Covered California as a qualified health plan and create its first commercial product, L.A. Care Covered. By the end of open enrollment in April 2014, over 1 million Californians had selected insurance through Covered California, with approximately 400,000 signing up in LA County.

Medicaid Expansion

In June 2013 the California legislature authorized the California Department of Health Care Services to expand Medicaid eligibility to low-income childless adults ages nineteen to sixty-four, as well as improve coordination of the existing behavioral health benefit and services to support vulnerable individuals to stay longer in the comfort and security of their homes (long-term supports and services). Covered California was pivotal in identifying new eligibles by screening customers seeking coverage for Medicaid eligibility. As reported by Covered California, California's Medicaid program enrolled approximately 1.9 million people through the end of March 2014, including 1.1 million through the Covered California portal and county offices.

For LA County, this translated to 300,000 uninsured adults who were enrolled in a pre-ACA coverage program operated by the LA County Department of Health Services, known as Healthy Way LA, and who were automatically transitioned into Medicaid on January 1, 2014. L.A. Care received over 160,000 new Medicaid members, many of whom already had ties to the safety net.

Impact of Health Care Reform on the Safety Net

This newly insured population, which historically has been dependent on the safety net for health care, poses a challenge and an opportunity for the safety net. The safety net has been the provider of last resort for this population, which had no other choices for health care. Safety net providers now have the potential to become a regular source of care for patients who have gained coverage. However, the newly insured also now have a choice of providers and the ability to "vote with their feet." A 2011 study commissioned by the Blue Shield Foundation on the health care preferences of low-income people, *On the Cusp of Change: The Healthcare Preferences*

of Low Income Californians, indicated that about 44 percent of low-income people in California had no choice of where to go for care, and an equivalent number lacked a regular primary care doctor. These are prime factors in patient satisfaction and also a driving force behind the desire to change facilities. Other factors that predict patient satisfaction included (but were not limited to) courtesy of staff, cleanliness of the facility, and the amount of time a doctor spends with a patient. It was the authors' conclusion that facilities that fail in these areas will be at risk for losing their patients.

Safety net providers will need to compete to keep and attract newly insured patients. These providers will need to rethink current practices, operate more efficiently, and increase the importance of the quality of the patient experience to ensure that these newly insured patients do not switch to other providers. Also, many safety net providers have operated with the more traditional fee-for-service Medicaid model (providers are reimbursed directly by the state for services rendered), but an increasing number of low-income patients are being enrolled in managed care. Providing high-quality health services for these patients requires a different model of care, one that manages a patient's care as a whole, not as separate incidents.

To compound the concern, decreased DSH funds may not be supplanted by seeing an increased proportion of insured patients. Public hospitals in California could face a $1.5 billion shortfall in 2019, when federal funding cuts go into effect. According to the UCLA Center for Health Policy Research, those cuts could undermine the financial stability of the state's safety net hospital system. Health care reform confronts the safety net with a new challenge of being responsive to consumer demands.

Given this uncertain future, safety net clinics and hospitals will need to modify their strategic planning in the near term to place the factors affecting patient choice at the core of their decisions. The safety net will need to choose to (1) compete with the private sector and become a traditional commercial/Medicaid provider; (2) shrink with decreased demand and remain a provider for the uninsured; or (3) use its policy influence to increase financial support for underutilized infrastructure. Most likely, we will see a combination of all three. L.A. Care will also need to determine how to continue supporting a possibly shrinking safety net and stay true to the organization's mission. With the newly ensured Medicaid beneficiaries, will the safety net need to evolve and adapt to ensure that it will maintain its role in health care in LA County?

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Howard A. Kahn was CEO of L.A. Care Health Plan for thirteen years; he left the organization at the end of 2014. L.A. Care, the nation's largest publicly operated health plan, has more than 1.7 million enrolled members in Los Angeles County. He is widely recognized as an expert in government health care programs, health care disparities, and the safety net. He has more than twenty-five years of experience in national and international health care. He serves as a board member for the Charles Drew University School of Medicine, Insure the Uninsured Project, the Latino Coalition for a Healthy California, and the RAND Health Advisory Board. He also chairs the Association for Community Affiliated Plans Board of Directors. Kahn pursued undergraduate studies at Harvard and received his bachelor's degree in development studies from UC Berkeley and his master's degree in public affairs from the University of Minnesota's Humphrey Institute.