KK
FYI

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

ADMINISTRATIVE AND FINANCIAL SERVICES

FAX TRANSMITTAL

PHONE # (213) 240-7882 - **FAX #** (213) 977-0954

April 26, 1996

Process Extenders

Did they commit to something new?

TO: BRUCE VLADECK

FROM: GARY W. WELLS

SUBJECT: LOS ANGELES COUNTY MEDICAID DEMONSTRATION PROJECT -- REVISED PHASE II FINANCING PROPOSAL

NUMBER OF PAGES: 10 (Including Cover)

If you do not receive all pages or if some pages are illegible, please call Alice Guerrero at (213) 240-7884.

COMMENTS:

Fillcare - dep of/hosps - new positions, lost 400,000? +50% of visits to get @50%

Repl of LAC - smaller than 1,700 - consol IP

Workforce + diversity - part of demo - elig for

7/1-9/1 - convert re. clinic to prov.

Bd giving him leeway; Come to system, not be led by it

Real partnership or program does - Both MF + BV want

Sups focused on extenders/45 days

MARK FINUCANE, Director

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

April 25, 1996

Bruce C. Vladeck, Ph.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314G
Washington, D.C. 20201

Dear Dr. Vladeck:

LOS ANGELES COUNTY MEDICAID DEMONSTRATION PROJECT –
REVISED PHASE II FINANCING PROPOSAL

As agreed in our March 1996 meetings, we have developed the following revised Phase II financing proposal for your consideration. Our initial proposal was included in the demonstration project application dated February 29, 1996.

As indicated on Attachment A, our most current estimates indicate that our need for federal Medicaid funds to achieve ongoing fiscal stability and the goals of the Project is below the budget neutrality limit over the five-year Project period. This estimated funding level is necessary to maintain a minimal funding level for the Los Angeles County Department of Health Services given:

1. Reductions during the current fiscal year of (a) 307 budgeted beds from the Fiscal Year 1994-95 budgeted level (2,595), (b) nearly half a million outpatient visits, (c) over 3,600 budgeted positions, and (d) more than half of our central office administrative costs; and

2. A further reduction during the term of the Project of budgeted beds to 1,719, for a total one-third curtailment from the Fiscal Year 1994-95 budgeted level. Included in this reduction are the privatization of Rancho Los Amigos Medical Center and High Desert Hospital or the equivalent, by June 30, 1997.

We are currently developing a request for concept papers on Rancho privatization, which we hope to release to the public in 45 days. We are involving High Desert representatives in this effort as a precursor to preparation and release of a similar request for that hospital as well.

It is important to note that our current estimate of need does not take into account the Project goal of a 50 percent increase in ambulatory care without further downsizing our remaining operations. Therefore, the County's fiscal need may increase toward the $5.225 billion budget neutrality limit. Such would be the case if some of our 22 Health Centers, originally scheduled for privatization by June 30, 1996, are retained by the County, or if the County must incur additional cost under contracts with private providers to ensure the increase in ambulatory care. Given that reasonable bids for privatization of only two of the 22 health centers without County funding have been received, we are reassessing the disposition of these facilities and considering funding some of our private sector partners no later than September 1, 1996

Attachment B shows that existing non-Waiver Medicaid reimbursement mechanisms and other funding sources are projected to fall $1.628 billion below our overall operating needs of $11.024 billion during the Project period. About $804 million of the $1.628 billion gap can be addressed by means of the funding elements recognized in the Fiscal Year 1995-96 Fiscal Relief Package (FRP), as follows:

1. The federally-approved FRP provides $285 million of benefits for the County applicable to the current fiscal year (the remaining $79 million of the $364 million total benefits apply to Fiscal Year 1994-95); and

2. Certain elements recognized in the FRP could be extended to the remaining four years of the Project, generating an additional $519 million in benefits for the County (Attachments B and C).

The solution to the remaining balance of $823 million is less clear. Under HCFA's current interpretation of the OBRA 1993 Limit, the County's hospitals appear to be unable to receive any additional Medicaid revenue beyond that assumed in the attached. Moreover, the upper payment limit computation regarding non-hospital clinic services provided by your staff indicates that there is only $50 million of available room left for additional gross Medicaid payments, statewide, that could be used for increases in the Supplemental Project Pool (SPP) in the future

(Attachment D). Therefore, our ability to realize additional Medicaid revenues up to the budget neutrality limit appears to be substantially frustrated.

In view of these factors, our proposal for financing under Phase II includes the extension of the following elements that exist under Phase I:

1. Continuation of federal financial participation for indigent care costs in the non-hospital, ambulatory care setting, including the County Department of Mental Health;

2. Continued recognition of the County's intergovernmental transfer (IGT) as an expense for purposes of calculating the OBRA 1993 Limits, to the extent that the IGT represents the non-federal share of disproportionate share hospital payments to private hospitals; and

3. Possible continuation of SPP payments at the current level of $125 million annually for the five-year Project period. (The State has some reservations about this element without a waiver of the upper payment limit, since this element otherwise might limit Medicaid amounts available to other counties in California.)

In addition, we have the following proposals for your consideration regarding additional funding under Phase II:

1. Project facilitation payments based on the difference between (a) the County's federal Medicaid revenues and (b) the budget neutrality limit. These payments would be made on an estimated basis in conjunction with the Project reporting schedule, with a reconciliation to the budget neutrality limit at the end of the five-year period;

2. An increase in the federal medical assistance percentage with respect to expenditures under the Project that results in such amounts necessary to meet the County's estimated need (Additional federal payments would be made pursuant to Section 1115(a)(2) of the Social Security Act.);

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

1115 WAIVER EFFECT

FISCAL YEARS 1995-96 THROUGH 1999-2000

($ In Millions)

	95-96	96-97	97-98	98-99	99-00	TOTAL
NEW						
SB 1255	$125.00	$0.00	($125.00)	$0.00	$0.00	$0.00
Indigent Care Clinic Match	34.00	28.12 (1)*	28.12 *	28.12 *	28.12 *	146.48
Supplemental Pool	62.50	62.50 *	62.50 *	62.50 *	62.50 *	312.50
Public Health Services Grant	17.50	0.00	0.00	0.00	0.00	17.50
Mental Health	18.00	18.90 *	19.85 *	20.84 *	21.88 *	99.46
IGT Expense	28.00	44.08 (2)*	52.22 (3)*	52.07 *	51.92 *	228.29
TOTAL	$285.00	$153.60	$37.88	$163.53	$164.42	$804.23

(1) Assumes health centers privatized in Fiscal Year 1996-97.

(2) SB 855 returns to a "Full Program".

(3) Includes additional IGT from Rancho and High Desert privatization.

* Assumes these elements are extended: without extension of these elements, the total net benefit of $804.23 million is reduced to $160 million.

ATTACHMENT C

3. A substantial increase in the SPP annually. This approach would be of limited benefit, and may not be feasible, without a recomputation or waiver of the upper payment limit;

4. Increased, or newly created, capitation or case management payments to the County, with non-federal matching funds provided through IGT;

5. Approval of the February 29, 1996 proposal calling for pre-determined OBRA 1993 Limits and supplemental payments to the County; and

6. Federal payments to the County through other programs falling within the scope of Section 1115, other demonstration project authority, or Public Health Service grants.

Our situation has been reviewed by some of the nation's most prominent Medicaid experts, and, given HCFA's interpretation of various limitations on hospital and administrative payments under the Medicaid program, they have not been able to identify other significant opportunities that could be reasonably implemented in the context of the Project.

Accordingly, we would like to proceed as follows:

1. Initiate the 45 day review cycle upon your receipt of this document.

2. Establish a goal to reach closure as quickly as possible on extending the identified components of the Fiscal Year 1995-96 FRP for the full Project term, as displayed on Attachment C. Our Chief Administrative Officer's proposed budget for Fiscal Year 1996-97 relies on the full extension of these benefits for next fiscal year. Absent such extension, major service reductions and corresponding employee layoffs are likely by early summer.

3. Begin direct negotiations among Federal, State and County representatives during early May to further explore approaches to achieving the needed $5.144 billion federal Medicaid funding level.

Once we have settled the financial arrangements for Phase II, we can then begin preparing the detailed programmatic restructuring plan. Interim steps being taken include (a) consulting with a wide variety of health care experts, (b) recruiting an Associate Director of Clinical and Medical Staff Affairs to assist in the process, (c) initiating an internal staff retreat to focus on restructuring, with a later session involving individuals in the industry, (d) finalizing a revised capital construction plan which limits inpatient census to a maximum of 1,719, (e) developing a series of internal managed care initiatives, and (f) pursuing a Kaiser Family Foundation sponsored and funded County-wide ambulatory care needs study.

This letter has been reviewed by the California Department of Health Services (State DHS), and State DHS has concluded that the proposals set forth in this letter can appropriately form the basis for advancing the Phase II process. We will be calling you shortly to pursue discussions regarding these matters and to agree upon the next steps.

Very truly yours,

Mark Finucane
Director of Health Services

MF:dpc

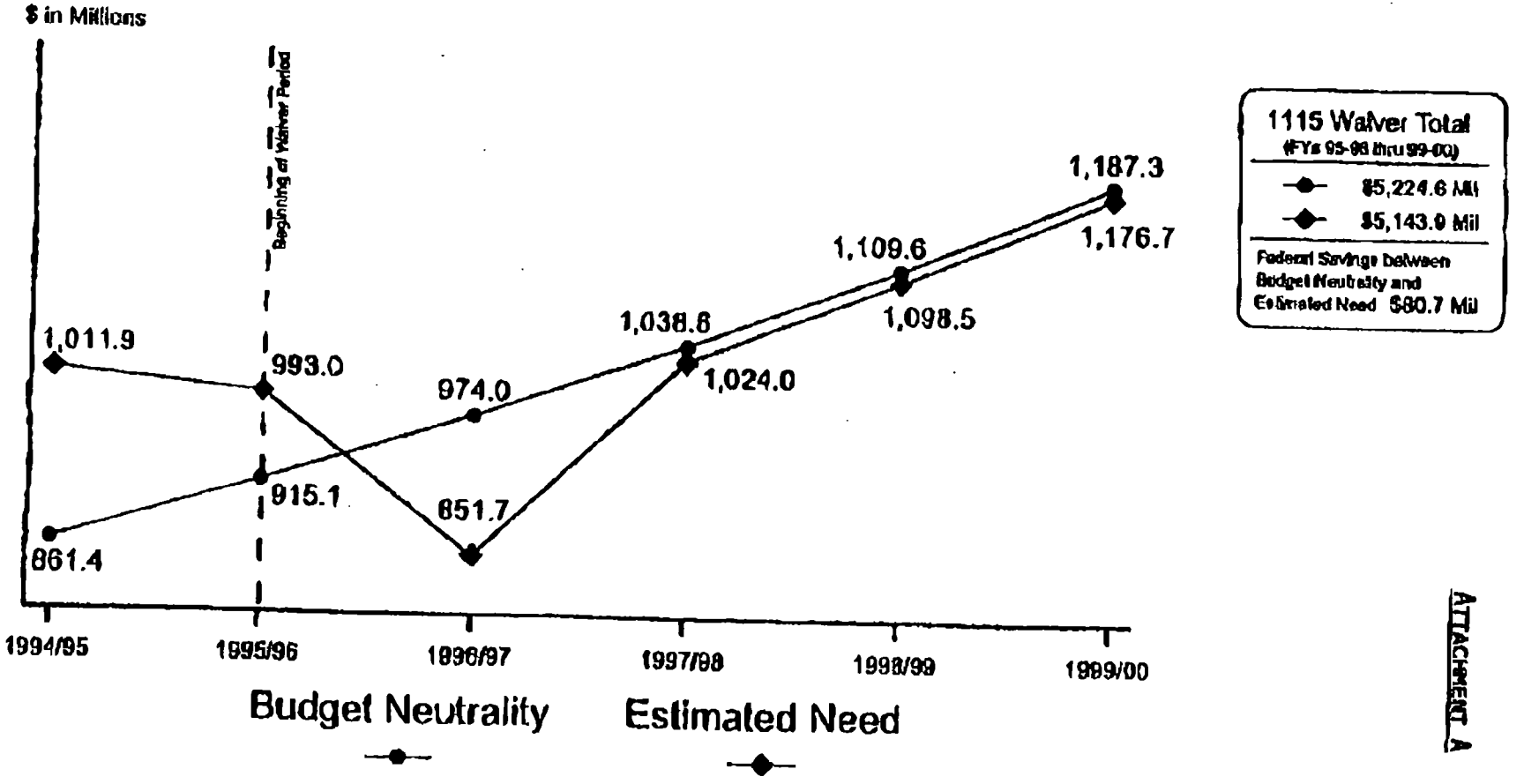
Attachments

c: Each Supervisor
Chief Administrative Officer
Executive Officer, Board of Supervisors
County Legislative Strategist
John Emerson
John Monahan
John L. Rodriguez

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

BUDGET NEUTRALITY vs. ESTIMATED NEED

1115 WAIVER / BUDGET NEUTRALITY



(Bud_Nevpro) 04/18/96 RLA & HD - O

ATTACHMENT A

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

FINANCIAL FORECAST

1115 WAIVER

($ in Millions)

	FISCAL YEARS					TOTAL
	95-96	96-97	97-98	98-99	99-00	
DHS Operating Needs (Appropriation)	2,248.78	2,143.82	2,110.59	2,208.80	2,311.93	11,023.92
Projected Funding Available - No 1115 Waiver	2,128.11	1,827.56	1,758.57	1,812.71	1,869.41	9,396.36
Surplus(Deficit)	(120.67)	(316.26)	(352.02)	(396.09)	(442.52)	(1,627.56)
1115 Waiver - FFP Increases plus PHS Grants (PHASE I Fiscal Relief Package plus "Extension" of 4 Elements) (Attachment C)	285.00 *	153.60	37.68	163.53	164.42	804.23 *
Adjusted Surplus(Deficit)	164.33	(162.66)	(314.34)	(232.56)	(278.10)	(823.33)
Budget Neutrality "Room" (Potential Delivery Mechanism to be defined under Phase II)	(77.90)	120.60	328.90	243.70	288.70	804.00
Remaining Budget Neutrality Beyond Operating Needs	86.43	(42.06)	14.56	11.14	10.69	80.67

* Assumes four elements in FY 95-96 Federal Restructuring Plan are extended and these are worth $142.5 million in FY 95-96.

ATTACHMENT B

Statewide Medicare / Medicaid Outpatient Upper Payment Limit Analysis CY 1994				
	Total Payments	Total Units Of service	Average cost Per Service	Federal Share Amounts
Medicare Medi-Cal	$1,912,380,635 $330,361,067	48,813,784 14,338,241	$39.18 $23.04	
Average Cost Differential Medicare to Medicaid			$16.14	
CY 94 Medi-Cal Statewide Units of Service CY 95 Medi-Cal Statewide Units of Service (CY 94 With 5% Growth Rate Applied)		14,338,241	15,055,153	
CY 95 Room Under the Upper Limit			$242,937,542	$121,468,771
Less: Amount Applicable to Indigent Care			$68,000,000	$34,000,000
CY 95 Room Remaining Under the Upper Limit			$174,937,542	$87,468,771
Amount Applicable to LA County Restructuring Pool			$125,000,000	$62,500,000

NOTES:

1. Medicare data from Blue Shield CA and T/A Occidental payment records.
2. Medi-Cal data from CA DHS expenditure records.
3. Medicare & Medi-Cal Payments for Physician Services Only.
4. Medicare payments based upon allowed services and charges.
5. This methodology should include a case mix adjustment in Phase II.

ATTACHMENT D

TOTAL P.11

COUNTY OF LOS ANGELES - HEALTH CRISIS MANAGER

January 12, 1996

TO: Kathy King

FROM: Burt Margolin

SUBJECT: DRAFT RESTRUCTURING DOCUMENT

Per our discussion, here is a draft restructuring plan elaborating on the concepts outlined in the proposed Medicaid Demonstration Project for Los Angeles County.

Our comments on DSH will follow on Tuesday or Wednesday of next week.

Please contact me at (213) 974-2469 if you have any question.

bm

c: John Monahan

The project will provide a national testing ground for the transformation of a large, decentralized public health care system into an integrated system that will focus on the provision of comprehensive ambulatory and preventive health care to Medicaid and indigent populations through both public and private providers. The project seeks to realign resources from inpatient to outpatient services within DHS, allowing the County to maintain its role as a safety net provider, without great loss of Medicaid funds.

A restructured system will assure the effective and efficient use of resources and improve access through an emphasis on managed care principles. At the end of the project, it is intended that the County will have increased access to community-based primary care services, a more controlled demand for inpatient services, and reductions in inappropriate emergency room use.

System Overview

For decades, DHS has provided medical care for medically indigent patients, offered clinical preventive services, and performed core public health functions. DHS' role has ranged from direct provider, to contractor, to coordinator of health services.

The DHS system includes clinical prevention and primary care, specialty services, emergency and trauma services, acute and intensive inpatient care, rehabilitation, sub-acute and nursing care, and home health services. A full range of diagnostic, ancillary, and supportive services are integral to the system.

Today, the changes occuring in practice and delievery of health care from episodic disease care to overall personal health and wellness, as well as market forces, are dictating the restructuring of the DHS delivery system. These forces are catalyzing a move toward a more cost-effective and community-driven system.

A major step moving DHS in this direction was accomplished in 1993 with a Departmental reorganization of DHS toward client-centered personal health services according to five geographical cluster areas.

The DHS cluster areas are comprised of 26 health districts which are the basis for data collection and analysis, health assessment, and planning. The need to divide into clusters of regionally integrated systems stems from the unique characteristics of the County. The geography, population size, natural terrain, and diverse communities are reasons for a regional approach to organizing health services.

The reorganization provided DHS with the ability to integrate fragmented inpatient and outpatient services, and positioned it to deliver community-level primary care. DHS has initiated the following actions to integrate services in the clusters:

- Integration of hospital, CHC and HC patient care staff within each cluster.
- Integration of ancillary support services (lab, radiology, pharmacy) within each cluster.
- Expansion of DHS facilities as Community Health Plan sites.
- Standardization of intake and referral procedures within each cluster.
- Increased availability of specialty consultative services at CHCs.
- Increased availability of primary care and walk-up services at CHCs and HCs.

The restructured DHS system will have a greater orientation toward wellness and health improvement through a community-based primary care service networks. This strategy is important because the barriers the DHS patient population face are significant. DHS has traditionally provided health care to populations that are underserved and are disenfranchised from the health care system. These individuals are generally unable to access mainstream providers, and when they do are inadequately served. Such individuals typically rely on the DHS for their source of health care.

Nevertheless, individuals who use the DHS system also face physical, knowledge and attitude, and system barriers. Such barriers include:

- Geographic inaccessibility and poor transportation.
- Client lack of knowledge regarding availability of services, when to access services, self care, and financial policies.
- Client attitudes about importance of health care and preventive services, and beliefs/non-beliefs regarding health and health care.
- Waiting times, inconvenient hours of operation, and staff lack of knowledge about culture and language of clients, .

DHS must work further to create a fully integrated community-based primary care service network.

Development of Community-Based Primary Care

DHS seeks to have a community-based primary care provider serve as the access point for basic non-emergency health services and coordinate necessary specialty care. The primary care provider will work within a system of care providing a full range of outpatient and inpatient services. This system, or network, will be comprised of DHS facilities and private community providers based on a managed care service model.

DHS also seeks to have "enabling services" to assist vulnerable, high risk populations in obtaining health care early in the course of illness or disability. Services will include outreach to provide education about available services; individual care coordination to ensure linkage to other services; transportation; translation and other means to ensure culturally and linguistically competent services; and referral linkages to mental health, alcohol and drug programs, and social services.

DHS needs to further integrate caregivers and increase flexibility of staff skills to improve continuity of care; improve administrative functions such as appointment systems and intake procedures; expand and improve Community Health Plan sites into cluster operations to achieve a uniform model of care and practice; expand and integrate contractual relationships for primary care; and more effectively link personal health and public health services.

Project Phase I -- Stabilization

During the first year of the Project, DHS will focus on stabilizing the service configuration remaining after the 1995-96 curtailments and implementation of public-private partnerships in some of the health centers. Both inpatient and outpatient services will consolidate services and space where feasible. For example, services will be restructured into an integrated medical group practice model where sub-specialists will share a series of multi-specialty clinics and supporting a primary care core.

Key components of the stabilization are:

- **Partial restoration of outpatient services.** Restore 90% of capacity of Comprehensive Health Centers and 75% capcity of 22 DHS Health Centers, and partially restore hospital outpatient services

- **PPP Contracts.** Implement an initial 6 public/private partnership agreements, and release an request for proposals for additional sites to ensure continuing availability of primary and preventive care and public health services.

- **Federal fiscal relief.** The one-time infusion of federal funds only buys time for the County to avoid a massive shut-down of public hospitals and clinics.

- **Address the 1996-97 Budget Deficit.** Address a projected shortfall of an additional $190 million in the Department of Health Services budget for FY 1996-97.

Service Configuration for Stabilization Period

- **Inpatient Services.** Maximize intensive care beds, retain unique and regional services (jail, burn, HIV), eliminiate costly medical/surgical beds, and services which can be absorbed by other County facilities or private hospitals.

- **Outpatient Services.** Preserve women's and children's services where possible, re-locate hospital-based primary care and specialty care clinics to CHCs where feasible, restructure remaining sub-specialties into consolidated clinics and reconfigure specialty access and patient flow, and offer extended service hours where possible.

Project Phase II -- Restructuring

The long term vision of a coordinated system of comprehensive care with an emphasis on prevention and primary care can only be realized by solving the severe structural and financial problems that precipitated the current crisis. The County's Health Crisis Manager's October 5, 1995 report summarizes the challenge: "We need to reduce the system's current reliance on inpatient care and dramatically expand outpatient services with an emphasis on primary care and prevention. We need to strengthen the County's ability to provide core public health services to ensure the health and safety of the community. We need to stabilize and expand the funding base for the County's health care safety net."

The following assumptions, designed to reduce utilization of hospital services, improve public health and increase access to primary and preventive care, will guide the restructuring phase:

- DHS will provide a **core of health care services** which includes:

  Assurance of adequate outpatient and inpatient services County-wide, through direct service or contract and advocacy for resources
  Trauma services
  Emergency services

Services to special populations, including children with special health needs, General Relief recipients, and the alcohol/drug dependent
Restructured relationships with medical schools to increase emphasis on training of primary care physicians and physician extenders.

- DHS will conduct **core public health functions** to protect and promote health, and prevent disease. This includes the following services:

  Public Health Clinics
  Environmental Health Services
  Disease surveillance, investigation, and control
  Health needs assessment in the general population
  Community health promotion
  Community alliances to advocate public health policies and to provide public health programs
  Set priorities for health needs based on epidemiological and other data

- DHS **secondary services** will be provided through a combination of DHS and private providers.

- Primary and preventive care services will be **community based** to ensure access, and will be offered through a network including:

  Federally Qualified Health Centers
  Community and Free Clinics
  Public-Private Partnership Health Centers
  Community-based medical school programs

Those actions, along with the shift in financial incentives sought through the Project and implementation of the State's Medi-Cal Managed Care Two-Plan Model, will: 1) begin improveing health care access for the populations most at risk, and 2) protect the health of the entire community. Under the five-year term of the Project, the County is committed to the following to move the DHS system toward community-based primary care services:

1. Expanding access to community-based primary care services.

2. Reducing County-operated inpatient beds.

3. Expanding access to outpatient specialty services.

Project Initiatives

Initiative 1: Expanding access to community-based primary care services

DHS has for some time recognized the need to shift its resources toward comprehensive primary care and position itself in the growing managed care environment. There are a number of efforts underway within DHS to promote the shift toward primary care. However, the current fiscal crisis forces DHS to accelerate the process to achieve cost savings needed to stabilize the budget.

- Since the early 1990s, DHS has been engaged in an active strategic planning process aimed at educating its professional and administrative staff in the goals of managed care and enlisting them in the transition to a more integrated and comprehensive primary care delivery system.

- DHS' has an increased commitment toward the improvement of the public's health through alliances with community groups and agencies.

- Through its federally-qualified HMO, the Community Health Plan, DHS has demonstrated its ability to provide comprehensive managed care to the Medi-Cal population.

- In November 1992, DHS issued a policy which states that "the recruitment, development, training, and retention of primary care physicians and mid-level practitioners represents a high departmental priority."

- The State's program to move Medi-Cal recipients into managed care, and the County's active participation in the formation of the Local Initiative, has promoted an awareness in DHS of the coming shift to primary and managed care delivery systems.

- The Department of Family Medicine residency program at Harbor/UCLA Medical Center has received national recognition for its development of a model primary care infrastructure and delivery system which recruits and trains family physicians to meet the needs of an underserved population.

- DHS' recent contracts for the provision of primary care to the County's General Relief population have not only defined the role of primary care providers, but have also enlisted essential community providers through public-private partnerships.

DHS' ability to move more quickly toward the ideal environment of comprehensive integrated primary care has been constrained by financial incentives which reward emergency and inpatient utilization. **The current fiscal crisis provides a strong impetus to change, and the Project seeks financial incentives which reward primary care in free-standing ambulatory settings. It is only then that DHS will be in a position to implement meaningful service restructuring.**

Definition of Primary Care. The Project embraces the definition of primary care proposed by the Institute of Medicine, as published in the Journal of the American Medical Association, January 18, 1995, V 273, N 3:

> Primary care is the provision of integrated, accessible health care services by clinicians capable of addressing a large majority of health care needs, developing a sustained partnerships with patients, and practicing in the context of the patient's family and community.

Additionally, DHS defines primary care as inclusive of health promotion, disease prevention, health maintenance, counseling, patient education, emphasis on the biopsychosocial approach to patient care, and diagnosis of acute and chronic illnesses in an office or clinic environment.

Although DHS currently provides services to a large number of individuals through a significant output of outpatient visits, such visits are typically single purpose and disease-related, and not representative of client-centered primary care. Numerous studies and reports have documented the overall shortage of primary care units of service for the County's Medi-Cal, General Relief and uninsured populations.

The County will seek to assign an increasing proportion of its patient population to a primary care provider from a baseline of 12,000 in fiscal year 1995-96 to 250,000 in fiscal year 1999-2000.

Access to primary care for the indigent population of the County must include coordination, cultural and linguistic appropriateness, and availability both in time and distance. The Project will provide at least a 50% increase in access to primary care services throught the following elements:

- Coordination. The primary care provider (which may consist of an individual or health care team at a primary care site) will provide initial and follow-up care to patients with the goal of establishing an ongoing relationship. DHS recognizes that primary care relationships will influence and move patient behavior toward a health maintenance and

preventive care mode, which will minimize inappropriate use of emergency and inpatient services.

The primary care provider will coordinate referrals for specialty care and have responsibility for the continuity of the patient's health care. It is expected that primary care providers will be able to provide approximately 90% of the care required by their patients.

- Extended Hours. DHS will provide extended and weekend hours for the community, and use flexible staff scheduling to provide services at times of peak demand.

- Telephone Access. DHS will provide telephone triage services staffed by registered nurses who are able to provide advice after hours. DHS will also provide numbers to patients and encourage telephone use for questions after hours.

- Cultural and Linguistic Appropriateness. DHS will 1) use existing traditional community providers already serving special populations, 2) recruit from underserved communities, as in the Harbor Family Medicine residency program, 3) contract with services like the ATT Language Line for translation services, especially during extended hours and after hours telephone coverage, 4) build on relationships with the Medi-Cal Local Initiative in the County which is also required to provide culturally and linguistically sensitive services, and 5) assess and meet the language requirements by area, such as Russian and Spanish in the San Fernando Valley, Spanish and Chinese in East Los Angeles, etc...

- Accessibility of Care in Local Communities. Through the term of the project, DHS will expand access to primary care, by geographic area, in its directly operated clinics and through the development of public-private partnerships. Additionally, DHS will seek to recover lost access as a result of budgetary reductions in 1995-96.

  The development of public-private partnerships with community providers sharing the County's commitment to the indigent and Medi-Cal populations will be central to expanding access to primary care. Through public-private partnerships, there will be an increase in both the number of clients receiving primary care services and the number of service sites. Collaboration has already begun with the establishment and implementation of public-private partnership agreements for the operation of six DHS Health Centers.

The County is seeking additional public-private partnerships through a Request for Proposals released on December 14, 1995, and a projected implementation to occur on or before July 1, 1996. Public-private partnerships are intended to achieve strategic alliances between DHS and local consortiums/networks of physicians, community clinics, and private hospitals for the provision of primary care services in geographic areas of the County.

Expanded access to primary care will not necessarily result in an increase in outpatient visits. Transformation of single-purpose, disease-related visits into primary care based on managed care principles will be essential. Thus, there will be an increase in the provision of services by primary care providers who will have ongoing relationships with clients.

DHS will encourage patients seeking care, especially pregnant women, families with young children, patients with ambulatory sensitive conditions (ASC), and other special populations, such as HIV-positive patients, to form ongoing relationships with primary care providers. DHS will also provide health education in waiting rooms which promotes awareness of and support for healthy lifestyles and referrals to such resources as weight-loss and smoking cessation programs.

In addition to the assignment of clients to primary care providers and the development of public-private partnerships, improvement in primary care access will also be measured by:

- Proximity of DHS facilities and its public-private partners to the patient population according to State managed care standards (Knox-Keene).
- An increase in the number of DHS facilities providing services during extended hours (evenings and weekends).
- Development of 24-hour telephone triage and referral services in each cluster.
- Reduction in clinic waiting times, and waiting times for an appointment.

Initiative 2: Reducing County-operated inpatient beds

Over the term of the Project, DHS will make a minimum one-third reduction of inpatient beds.

In 1994-95, the County budgeted for the operation of 2,595 inpatient beds at the six DHS hospitals. During 1994-95, the

average daily census of the beds actually filled was 2,475. This census rate of over 95% was far higher than generally experienced by private hospitals throughout Southern California. Nevertheless, budgetary demands in 1995-96 required the County to make major inpatient and outpatient reductions.

A primary objective of the project will be to test whether demand for inpatient services can be reduced or controlled. This will be possible through the management of patients in a primary care setting based on managed care principles. The goal of the project to expand access to primary care will allow the County to continue to serve the needs of the indigent and Medi-Cal population while experiencing a significant reduction in the inpatient beds it maintains. Further, additional reductions in inpatient beds may allow the County to address a projected budgetary shortfall in 1996-97.

In recognition of this effort, the County will, by the end of the first year of the project, have a census 307 beds below the budget total of 2,595 in 1995-96 to 2,288. In addition, by the end of the project, the County will have eliminated direct operation of 75 beds at High Desert Hospital, and 299 beds at Rancho Los Amigos Medical Center.

The reduction of 299 beds at Rancho Los Amigos Medical Center reflects the facility being divested from the County system. Rancho has a national reputation as a high quality, innovative rehabilitation hospital. Divestiture will be accomplished through sale or operation via public-private partnership.

Finally, it is projected that with the implementation of expanded access to primary care and an managed care approach to services, 200 additional inpatient beds within the County system can be eliminated by the end of the project. Thus, over the term of the project County-operated inpatient beds will be reduced by one-third from 2,595 to 1,719.

This reduction can be summarized as follows:

FY 1994-95 Budget (Baseline)		2,595
FY 1995-96 Budget (Project Year 1)	2,288	
Additional Reductions (Project Years 2-5)		
Rancho Los Amigos	299	
High Desert Hospital	75	
Additional Reduction	195	
Revised Capacity (end of Project Year 5)		1,719
Net Reduction		876

Percent Reduction 33.1%

Initiative 3: Expanding access to outpatient specialty services

Consistent with the development of community-based primary care, DHS will initiate actions to expand access to outpatient specialty care services.

Some of the increased access to outpatient specialty care will result from re-locating services from hospitals to CHCs. Moving specialty services out of the hospitals may potentially decrease costs due to lower overhead, and decrease hospitalization (length of stay) by allowing certain procedures to be done on an outpatient basis.

However, it is unrealistic to expect all specialty clinic services to be re-located, as some services require high-tech equipment and hospital back-up, and are closely linked with the training programs in DHS hospitals. Consultative outpatient specialty services are the most easily moved from the hospital to CHC settings, and efforts are underway in DHS to move in this direction.

Overall, DHS will restructure its traditional, teaching-hospital approach to patient care (i.e. one the heavily emphasizes inefficient inpatient and subspecialty care) toward a managed care/medical group practice model emphasizing high quality, efficient community and hospital-based primary care, and problem oriented, time limited secondary care in conjunction with strong, university-linked hospitals providing tertiary care. This will be accomplished through:

- Promotion of better understanding of primary care providers' abilities by the specialists.
- Assessment of patients being followed in specialty clinics for referral to primary care providers for ongoing care.
- Creation of additional, timely, specialty appointment slots for new referrals. As restructuring unfolds, most specialty care will become time-limited, as the specialists learn to return patients to the primary care providers thereby, increasing efficiency of the specialty clinics.
- Development of specific guidelines for appropriate referrals to specialty clinics.
- Provision of specialty secondary care at the community-based health centers on a regular, pre-arranged basis. Patients

will be able to receive specialty consultations and remain under the care of their primary care physicians.

- Establishment of primary care physician training programs in the community health centers similar to the Harbor-UCLA Family Medicine/Wilmington Health Center model.

- Supplement secondary services through a combination of DHS and private providers, such as:

  Financially self-supporting hospital services at Rancho Los Amigos Medical Center and High Desert Hospital.

  Partnerships between DHS and community based organizations such as FQHCs and non-profit hospitals.

- Expand current electronic information systems while developing and implementing new information technology to manage large amounts of clinical data. Adequate information systems will be critical to the long term success of the transformation of our health care delivery system.

- Collaborate with the medical schools and other training programs to increase emphasis on training of primary care physicians and physician extenders.

  Increase residency training positions in primary care while reducing numbers of specialty training slots.

  Increase the ratio of primary care to specialist faculty through redistribution of faculty positions.

- Develop marketing strategies and programs to facilitate communication of restructured services to both patients and public.

- Develop financial information systems to provide necessary cost and revenue data needed to manage the system at both a local and department-wide basis.

Special Outcomes: Reducing inappropriate use of inpatient services and emergency services

While most patients admitted to DHS hospitals are acutely ill, some patients, who have chronic illnesses that can be treated in an outpatient setting coordinated by a primary care provider, may be able to avoid or reduce hospitalization. The range of medical and surgical activities which may be reduced is somewhat narrow, as demonstrated by the attached data tables comparing DHS hosptials to area private hospitals by major diagnostic group.

The types of diagnoses for which inpatient utilization can be controlled are known as ambulatory sensitive conditions (ASC). Such conditions are known to be responsive to ambulatory care, which if provided in a timely and effective manner can help reduce the risk of hosptialization by preventing the onset of an illness or condition, controlling an acute episode, illness or condition, or managing a chronic disease or condition. DHS will undertake activities to aggressively identify and treat patients with the following conditions through primary care.

Asthma
Uncontrolled Diabetes
Bacterial Pneumonia
Congestive Heart Failure
Cellulitis
Kidney Infection
Hypertension

It is expected that utilization of emergency room resources for these conditions will decrease for those patients provided access to primary care.

DHS will use sub-acute beds, increase outpatient diagnostic services for elective admissions, and monitor Medi-Cal denied days as a measure of inappropriate inpatient use.

WHile many patients seen in DHS emergency rooms are acutely ill, some patients can and should be treated in a less intensive outpatient setting coordinated with a primary care provider. Extended service hours, 24-hour telephone triage, and transportation services are key components in providing alternative access to care and health-related information. DHS will undertake education activities to inform users of the appropriate way to access services.

Overall, fundamental reductions in DHS inappropriate inpatient and emergency room use, along with previously discussed outcomes of the Project, will come via expanded access to primary care services, as comtemplated in Initiative 1.

# # #

KK

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

ADMINISTRATIVE AND FINANCIAL SERVICES

FAX TRANSMITTAL

PHONE # (213) 240-7882 - FAX # (213) 977-0954

May 3, 1996

TO: BRUCE C. VLADECK, Ph.D.

FROM: GARY W. WELLS

SUBJECT: FOLLOW-UP TO OUR PHASE II FINANCING PROPOSAL

NUMBER OF PAGES: 3 (Including Cover)

If you do not receive all pages or if some pages are illegible, pleaso call Alice Guerrero at (213) 240-7884.

COMMENTS:

MARK FINUCANE, Director

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

May 3, 1996

Need budget assumes extension

w/ 6/14 8/10-8/Ca Thurs off?

Bruce C. Vladeck, Ph.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314G
Washington, D.C. 20201

Dear Dr. Vladeck:

FOLLOW-UP TO OUR PHASE II FINANCING PROPOSAL

As you may know, members of our Board of Supervisors and other County representatives, including myself, were in Washington, D.C. the past two days, meeting with the Administration and members of Congress on a variety of issues of County interest. During these meetings, we discussed the need to rapidly move forward with efforts to finalize the financing for Phase II of our Medicaid Demonstration Project. We were particularly encouraged with respect to the apparent commitment to extending certain elements of the Fiscal Year 95-96 Fiscal Relief Package (FRP) beyond the initial year of the Waiver term.

As I indicated in our April 25, 1996 Proposal to you, the Chief Administrative Officer's Proposed Budget for next fiscal year, which begins July 1, 1996, relies on over $150 million from extending certain FRP elements as summarized in Attachment C of our Proposal. Accordingly, we would like to reach closure on this component of our Proposal during the coming week. I would be happy to work with you and your staff to accomplish this end. It will also be necessary to involve the California Department of Health Services, especially with respect to the extension of the Supplemental Project Pool for the nonhospital health clinics and its relation to the Statewide upper payment limit.

We look forward to continuing our work with you and your staff.

I will call you the first of next week to discuss how we might best proceed.

Very truly yours,

Mark Finucane
Director of Health Services

MF:sp
(ALICE\VLADECK)

c: Each Supervisor
Chief Administrative Officer
Executive Officer, Board of Supervisors
County Legislative Strategist
John Emerson
John Monahan
John Rodriguez

Diana F: Did you ever see this?

SECURE AGREEMENT ON PHASE II FUNDING FOR THE COUNTY'S MEDICAID SECTION 1115 WAIVER

The Los Angeles County Section 1115 Medicaid Waiver, developed in response to the worst funding crisis in the history of the Department of Health Services (DHS), has two phases.

Phase I is devoted to stabilizing a system that was on the brink of collapse.

Phase II, set to begin July 1, 1996, is intended to give the County the capacity to restructure by moving away from an emphasis on expensive hospital in-patient care to a system that stresses cost-effective primary and preventive care delivered in an outpatient setting.

The Health Care Financing Administration (HCFA), the State and the County have not yet reached agreement on the financial issues that are key to Phase II. Without agreement on Phase II rules, the restructuring of the County health care system will come to an abrupt halt and the County will once again face catastrophic service reductions.

County Position

- **Seek HCFA approval, prior to July 1, 1996, of a Phase II financing plan which provides the County with the Medicaid funding flexibility it needs to implement its plan to downsize its hospital capacity and to expand outpatient services.**

Background/Impact

- Phase I of the Waiver, which began July 1, 1995, provides the County with $364 million in immediate fiscal relief to avert sudden hospital closures and the meltdown of Countywide trauma and emergency services, and to preserve vital community clinic capacity for the 2.6 million uninsured residents and 1.6 million Medicaid beneficiaries in the County.

- Phase II restructuring will move the County health care system, over time, away from expensive hospital services toward community-based primary and preventive care services. The objectives for restructuring include:

  - A reduction of County DHS hospitals' budgeted census by one-third from 2,595 to 1,719.

  - Relocation of hospital ambulatory care services to community-based freestanding clinics.

  - An increase by 50 percent of ambulatory care access to reduce the inappropriate use of hospital-based services, particularly emergency room services.

-- Development of additional public-private partnerships for community-based primary care.

- Under Phase II, which is to begin on July 1, 1996, the County will accelerate restructuring of its health care system through additional inpatient reductions and expanded access to community-based primary care services. Over the five-year life of the Waiver, the County will provide at least a 50 percent increase in access to primary care services.

- In order to allow the County to move ahead with its restructuring, HCFA has agreed to an expedited process for deciding Phase II issues. HCFA has advised the County and the State that, at minimum, it will decide on the initial rules for Phase II within 45 days of receiving a revised financing proposal from the County.

Status

- The County, with the clearance of the State, submitted its revised financing plan on April 29, 1996.

FOR FURTHER INFORMATION, PLEASE CONTACT MARK FINUCANE, DIRECTOR OF HEALTH SERVICES, AT (213) 240-8101.

REINSTATE THE 200% DISPROPORTIONATE SHARE HOSPITAL (DSH) CAP FOR PUBLIC HOSPITALS

The Medicaid Disproportionate Share Hospital (DSH) program was established to provide supplemental funding to hospitals that treat high numbers of Medicaid and uninsured patients.

Because of program abuse by some states (Medicaid dollars were used to support non-health spending), Congress, in the Omnibus Budget and Reconciliation Act of 1993, capped the amount of DSH payments that a hospital can receive.

In order to avoid damaging the fragile funding balance that maintains most public hospitals, Congress approved special DSH cap rules that allowed these hospitals to be capped at 200 percent of unreimbursed costs, rather than the 100 percent standard applied to other hospitals.

The reduction in 1995 to the 100 percent standard for public hospitals has had the unintended impact of making it significantly more difficult for counties throughout California to fund their public hospitals.

County Position

- **Support legislation to reinstate the DSH payment cap for California public hospitals at the 200 percent level for two years beginning July 1, 1996.**

Background/Impact

- DSH payments represent supplemental Federal Medicaid reimbursements to hospitals which serve a disproportionate share of Medicaid and uninsured patients.
- The DSH cap was never intended to destabilize the health care safety net. This is why the Congress established the 200 percent factor for public hospitals.
- Reinstating the 200 percent factor for two additional years would give counties the flexibility they need to restructure their health care delivery systems.
- This provision would not affect the statutory Statewide cap on DSH payments.

Status

- This proposal was considered, but not included, in the recently enacted FFY 1996 omnibus appropriations bill (H.R. 3019). Another legislative vehicle must be found for the amendment.

FOR FURTHER INFORMATION, PLEASE CONTACT MARK FINUCANE, DIRECTOR OF HEALTH SERVICES, AT (213) 240-8101.

NYLCARE CONFERENCE POSITIONS ON H.R. 3103

ISSUE	NYLCARE POSITION	EXPLANATION
Long Term Care Treatment	prefer Senate language	Senate language matches I.R.C. tax treatment of reserves with the NAIC minimum reserving requirements.
Deductibility for Self-Employed	prefer Senate language	Senate increases the deductibility for the self-employed to 80%, over only 50% in the House.
MEWAs	prefer Senate language (there are no MEWA provisions)	Small employers and individuals should be allowed to form private, voluntary cooperatives to buy health insurance, but they should not be exempt from state rating laws and mandated benefits. The House MEWA provisions exacerbate problems in the small group market and create an unlevel playing field in the small group market.
Mental Health Parity	prefer House language (no language on this issue)	Requiring plans to provide "equivalent" mental health coverage ignores that there often are no set protocols for treating mental illness. Health plans and providers should be able to provide the best treatment possible for each individual case, without being required to meet artificial and expensive coverage requirements. If the mandate applies to Medicare and Medicaid, the 7 year cost to Medicare would be about $80 billion, and for Medicaid, about $35 billion.

REIMBURSE EMERGENCY MEDICAL COSTS FOR UNDOCUMENTED IMMIGRANTS

Hospitals with emergency rooms, such as the County's, are legally required to provide emergency medical care to all persons regardless of ability to pay, including undocumented immigrants.

Under current Federal law, undocumented immigrants must meet all income and categorical eligibility requirements to qualify for emergency medical services under Medicaid. Therefore, for medically indigent adults who are categorically ineligible for Medicaid, the County does not receive Medicaid reimbursement for services provided to these individuals. The County incurs an estimated $100 million annually in emergency medical costs for undocumented immigrants.

The Federal government should reimburse the County, which has more undocumented immigrants than any single state, for its unreimbursed costs of emergency medical care provided to undocumented immigrants who are in the country because of the Federal government's inability to control illegal immigration.

County Position

- **Support legislation which would provide direct Federal reimbursement of local as well as state costs of emergency medical care provided to undocumented immigrants, including those who are ineligible for Medicaid.**

- **Support appropriations of at least $3.5 billion over the next five years to reimburse state and local costs of emergency medical care provided to undocumented immigrants.**

Background/Impact

- The County would qualify for Federal funding under County-supported language in pending immigration reform legislation (H.R. 2202 and S. 1664), which would authorize Federal reimbursement of state and local costs of emergency medical care provided to undocumented immigrants, not limited to Medicaid beneficiaries.

- The County would not have qualified for funding under the approach used in the vetoed 1996 budget reconciliation bill which would have reimbursed only the non-Federal share of emergency Medicaid services to undocumented immigrants. In California, counties do not finance the non-Federal share of Medicaid costs.

- The President's and Republicans' balanced budget plans both include $3.5 billion over five years for reimbursement of undocumented immigrant emergency medical costs.

Status

H.R. 2202 (L. Smith), immigration reform legislation which would authorize Federal reimbursement of state and local undocumented immigrant emergency medical costs (not limited to Medicaid), passed the House on March 21, 1996. A similar provision is included in a Senate immigration bill, S. 1664 (Simpson), which is currently on the Senate floor.

In addition to the enactment of the authorizing legislation, funding must be included in the FFY 1997 Labor, Health and Human Services, and Education appropriations bill. Committee action has not begun on any of the FFY 1997 appropriations bills.

FOR FURTHER INFORMATION, PLEASE CONTACT MARK FINUCANE, DIRECTOR OF HEALTH SERVICES, AT (213) 240-8101.

PRESERVE ELIGIBILITY OF LEGAL IMMIGRANTS FOR FEDERAL PROGRAMS

Proposals to deny Federal-funded public assistance benefits to legal immigrants would hurt the County of Los Angeles more than any other unit of state or local government. This is because the County not only has more immigrants than any other state, but also would bear the entire cost of general assistance (GA) and medical assistance provided to legal immigrants denied Federal benefits. In New York, which has the second biggest immigrant population of any state, such GA and medical costs would be shared equally between State and county governments.

Under H.R. 4, welfare reform legislation which was vetoed, the County would have experienced an estimated $236 million increase in annual GA costs alone due to the loss of SSI benefits by legal immigrants. The County would also have experienced dramatic increases in unreimbursed medical care costs for legal immigrants who would have been made ineligible for Medicaid.

County Position

- **Support retention of the current eligibility of legal immigrants for Federal programs, including Medicaid, Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Foster Care and Food Stamps.**

Background/Impact

- Legal immigrants are currently eligible for all Federal-funded public assistance benefits. Denial of Federal benefits to legal immigrants would result in a major shift in costs to state and local governments because legal immigrants would remain eligible for state and local assistance programs. The courts have ruled that the Federal government may restrict Federal-funded assistance to legal immigrants, but states cannot deny public assistance because it would violate the Fourteenth Amendment's equal protection clause.

- It would be particularly unfair to shift immigration costs to states and localities given that the Federal government, which has sole authority over immigration, receives most of the taxes paid by immigrants while states and localities bear most of the costs of services provided to them.

- In Los Angeles County, an estimated two-thirds (or $2.6 billion) of all taxes paid by immigrants in 1991-92 went to the Federal government.

- H.R. 4 would bar SSI and Food Stamps to most legal immigrants (including current recipients), bar most other Federal means-tested benefits to most future immigrants during their first five years in the country, and authorize states to bar AFDC, Title XX Social Services, and all Medicaid benefits to most legal immigrants (including current recipients).

- Another approach to reducing Federal spending on immigrants would be to extend the time period for deeming immigrants' sponsors' incomes in determining eligibility for AFDC, SSI, and Food Stamps which currently have deeming requirements. However, deeming sponsors' incomes under Medicaid would result in a major cost shift to the County which would have to bear the costs of medical care provided to immigrants who would lose Medicaid eligibility. Deeming under non-cash programs, such as job training and social services, also would impose major new administrative costs on the County which would be required to collect information on sponsors' incomes.

Status

- The Congressional leadership is undecided on how to proceed on welfare reform legislation. Two major immigration reform bills, H.R. 2202 (L. Smith), which passed the House on March 21, 1996, and S. 1664 (Simpson), which is on the Senate floor, include deeming provisions which would affect the eligibility of sponsored immigrants for Federal means-tested programs, including SSI, AFDC, Food Stamps, and Medicaid.

FOR FURTHER INFORMATION, PLEASE CONTACT EDDY TANAKA, DIRECTOR OF PUBLIC SOCIAL SERVICES, AT (310) 908-8383.

LA County Waiver - Phase 2

HHS FACT SHEET DRAFT

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

Contact: HHS Press Office
(202) 690-6343

HHS APPROVES AMENDMENT TO CALIFORNIA'S 1115 MEDICAID DEMONSTRATION FOR LOS ANGELES COUNTY

Overview: HHS has approved an amendment to California's 1115 Medicaid Demonstration Project for Los Angeles County. By extending several provisions of the demonstration for an additional year, this amendment will ensure that the state and county have sufficient time for the restructuring of the County's health care delivery system that was begun in the original demonstration project. The focus of the demonstration project is to provide fiscal relief to the County, stabilize the public health system, and assist the process of restructuring the County's health care delivery system to rely more on primary and outpatient care. It is the result of a partnership effort by federal, state and county governments.

Background

Under the terms of the original agreement, an additional $364 million was made available to Los Angeles County for the first year of the demonstration. Extension of the financial provisions will provide an additional $172 million for the second year. Like all other Section 1115 Medicaid Demonstration Projects, this plan will be budget neutral over five years.

The amendment will provide Federal financial participation for the following components:

- Administrative cost categories associated with the administration of the project;
- Federally reimbursable ambulatory service costs incurred by the County in rendering services to Medi-Cal and eligible indigent patients in the County health system; and
- Expenditures made as State disbursements from a Supplemental Project Pool that has been established for use in outpatient clinics.

Section 1115 demonstrations allow states to test new approaches to benefits, services, eligibility, program payments, and service delivery. These approaches are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people.

- More -

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Since Jan. 1, 1993, comprehensive health care demonstration waivers have been approved for 12 states and eight have already been implemented. When all 12 are implemented, 2.2 million previously uninsured individuals are expected to receive health coverage.

Federal representatives will work with the county and state to provide technical assistance in the development of their restructuring plan. The Health Care Financing Administration remains committed to considering ~~new proposals~~ submitted by the county and to participating in an expedited review process. further refinements to their plan

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DRAFT

LOS ANGELES COUNTY
DEPARTMENT OF HEALTH SERVICES

Contact: Public Information Office
(213) 240-7707

DRAFT

FOR IMMEDIATE RELEASE

The federal Health Care Financing Administration (HCFA) today announced additional fiscal relief for the 1996-97 budget for the Los Angeles County Department of Health Services as well as technical assistance in helping the county further develop the restructuring required under its Medicaid Demonstration Project (1115 Waiver).

"The announcement is good news for the county in that it looks like we'll have a stable budget next fiscal year and be able to continue our restructuring efforts such as the expansion of ambulatory care including the development of public/private partnerships," said Mark Finucane, director of Health Services.

"About $172 million has been obtained for the second year of the waiver. This is in addition to the $364 million fiscal relief package announced by President Clinton last September," said Finucane. "We got exactly what we expected to get financially for 1996-97 and, perhaps most important, we got a strong commitment from HCFA to work closely with us over the coming months on our restructuring effort."

The county still needs additional flexibility in federal Medicaid reimbursement rules for years 3-5 of the 1115 Waiver to fund continued expansion of ambulatory care and not suffer financial losses resulting from planned hospital downsizing. The county seeks to have these financing issues resolved by the end of 1996.

The announcement comes at the close of a 45-day review by federal officials of county proposals for financing future years of the 1115 Wavier and it follows a series of federal, state and county meetings in Washington, D.C., in March and May

-more-

HCFA add 1-1-1-1-1

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of this year.

"The Board of Supervisors' leadership in securing the 1115 Waiver has been outstanding and we look forward to continuing our productive work with HCFA Administrator Dr. Bruce Vladeck and State Medi-Cal Deputy Director John Rodriguez and their respective staffs," said Finucane.

The five-year demonstration project, which runs from July 1, 1995 through June 30, 2000, is designed to fiscally stabilize the county health care system and, overtime, move it away from expensive hospital services toward community-based primary and preventive care services.

# # # # #

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6/96

DRAFT

CALIFORNIA SECTION 1115 MEDICAID DEMONSTRATION
LOS ANGELES COUNTY PROJECT
AMENDMENT
--QUESTIONS AND ANSWERS--
FOR INTERNAL USE ONLY

Q. What does the amendment do?

A. This amendment will extend several financial provisions of the demonstration through June 30, 1997, providing the County with an additional $172 million in Federal funds.

Under the amendment provisions, Federal matching funds will be available for:

1) Ambulatory service costs (as defined in the terms and conditions) incurred by the County in rendering services to Medi-Cal and eligible indigent patients in the County health system;
2) Expenditures made to County outpatient clinics from a Supplemental Project Pool;
3) Administrative costs associated with the demonstration.
4) Expenditures made as part of the County's obligation to meet the non-Federal share of certain disproportionate share payments to private hospitals.

Q. How is this amendment different from what HCFA approved in April?

A. With the exception of the extension of the above provisions, the demonstration remains as approved on April 15, 1996.

Q. Were any new proposals submitted by the County?

A. In April, the County and State indicated they would submit a revised proposal to HCFA that would permit the County to restructure its health care system and achieve long-term financial stability. On April 26, the State submitted a draft financial proposal. The proposal contained several funding mechanisms that Federal representatives had previously informed County and State officials would not be approved because they violated Federal policy regarding Medicaid waivers. In May, Federal representatives met with State and County representatives to discuss this draft proposal and agreed that more time would be required to develop a proposal that achieved the restructuring goals, while complying with Federal policy regarding waivers and budget neutrality. HCFA agreed to extend several provisions of the approved demonstration for one additional year in order to give the County and State the required time to develop a detailed restructuring plan. Further, Federal representatives committed to a process for providing technical assistance to the County and State in the development of their restructuring plan. The amendment we are approving reflects this agreement.

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Q. Did HCFA complete its review of the proposal within 45 days of submission as promised?

A. Yes, HCFA completed its review within 45 days of submission.

Q. Is the demonstration project still budget neutral?

A. Yes, the demonstration remains budget neutral.

Q. How will this amendment help Los Angeles County restructure its health care system?

A. Approval of this amendment will give the State and County the necessary time and resources to develop a detailed restructuring plan that relies more on primary and outpatient care. In addition, Federal representatives have agreed to provide the State and County with technical assistance in the development of this restructuring plan.

Q. Has any other county submitted a proposal similar to the one for Los Angeles County?

A. No other county has submitted a proposal for an 1115 demonstration; however, on May 21, HCFA sent a letter to Governor Wilson informing him that any county proposal that the State submitted would be considered if the county:

1) had a public hospital or hospitals;
2) was committed to a fundamental restructuring of its health care system to move more toward outpatient care;
3) meet the same budget neutrality requirements as other section 1115 demonstration projects; and
4) complied with the standards set forth in the public notice requirements published in the Federal Register on September 27, 1994.

For counties which do not meet the criteria, but for which the State wishes to pursue a demonstration project appropriate for the county, the Governor was informed that HCFA would consider the merits of the proposal in the ordinary section 1115 demonstration review process.

DRAFT

Mr. John Rodriguez
Deputy Director
Medical Care Services
Department of Health Services
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320

Dear Mr. Rodriguez:

We are pleased to inform you that your Amendment to the demonstration, entitled "Demonstration Project for Los Angeles County," has been approved as project No. 11-W-00076/9 for the period of July 1, 1996, through June 30, 2000. The approval is under the authority of section 1115 of the Social Security Act (SSA).

Our approval of the amendment and the waivers and Federal matching provided for thereunder is contingent upon compliance with the enclosed special terms and conditions that incorporate the changes required by the amendment. These terms and conditions, and the attached process letter submitted by you on June 4, set forth in detail the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acceptance of the award within 30 days of the date of this letter.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the Los Angeles County Medicaid Demonstration.

With this amendment, the waivers under section 1115(a)(1) and Federal matching under section 1115(a)(2) described below are approved for the first two years of the demonstration beginning July 1, 1995.

1. Statewideness — Section 1902(a)(1)

   To enable the State to implement the demonstration project in only certain delivery sites in Los Angeles County alone.

Under the authority of section 1115(a)(2) of the SSA, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903 of the SSA) shall, for the period of this demonstration project, be regarded as expenditures under the State's Title XIX plan.

1. Expenditures made by the State and/or County under paragraphs 1 and 2 of Attachment A of the Special Terms and Conditions.

Your project officer for this project is Ms. Gina Clemons. Ms. Clemons is available to answer any questions concerning the scope and implementation of the project described in your application. She can be reached at (410)786-9644. Correspondence to Ms. Clemons should be sent to: Health Care Financing Administration, Office of Research and Demonstrations, Mail Stop C-3-18-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Communications regarding program matters should be submitted simultaneously to Mr. Richard Chambers, Associate Regional Administrator for Medicaid, Health Care Financing Administration, 75 Hawthorne Street, 4th Floor, San Francisco, California 94105-3903.

We extend our congratulations to you on this award, and look forward to working with you during the course of the project.

Sincerely,

DRAFT

Bruce C. Vladeck
Administrator

Enclosure

TALKING POINTS FOR CALLS TO HILL STAFF
RE LA COUNTY WAIVER AMENDMENT APPROVAL

- This call is to update you on the most recent action HHS has taken on California's section 1115 Medicaid demonstration project for Los Angeles County.

- Since approving the demonstration this past April, the Department has worked with the State and the County on mutually acceptable options for restructuring the Los Angeles County health care system.

- We are pleased to advise you that today the HCFA Administrator approved an amendment to the State's project which will provide Los Angeles County with additional fiscal assistance to stabilize its system during state fiscal year 1996-1997. The project remains budget neutral over its five-year duration.

- Approval of the amendment will give the State and the County time to focus their efforts on developing a plan for restructuring the health care system throughout the remainder of the five-year project period. Federal representatives have committed to providing technical assistance to the State and the County in the development of this restructuring plan.

- If you'd like more detailed information about the amendment, I would be pleased to send you the waiver approval letter, a fact sheet, and the press release.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

FAX

Date: 6/12/96

Number of pages including cover sheet: 11

To: Alicia Fortuna
WH/Domestic Policy

Phone: 456-5570
Fax phone: 456-7028
CC:

From:
Pat Woods

Phone: (202) 401-5879
Fax phone: (202) 690-5672

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

Enclosed is 1.) L&Ctf's draft press release; 2.) HHS's draft press release + fact sheet and 3.) Qs + As for internal (4.) ltr to Rodriguez; 5.) talking points. Use. Please review + give John or me your comments/clearance ASAP. Thx

Pat

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

The Administrator
Washington, D.C. 20201

March 11, 1996

For copying to
Diane Fortner +
John Emmons +
return

Byron Chell, J.D.
Executive Director
California Medical Assistance Commission
1300 I Street
Suite 1040
Sacramento, California 95814

Dear Mr. Chell:

As you know, we reached an agreement in principle last September with officials from Los Angeles County and the State of California that would provide the county with an additional $364 million for State fiscal year 1995-96. These funds would be made available under a five-year Section 1115 Medicaid demonstration waiver. Since September, we have had a number of productive meetings with the State and the County to work on implementing our agreement. The State submitted a formal waiver proposal on behalf of Los Angeles County on February 29, 1996.

I am pleased to report that we are very close to concluding the terms and conditions of a waiver that will provide the county with $364 million for State fiscal year 1995 -1996. Resolution of a few remaining issues, including budget neutrality, should be accomplished without difficulty in the next few days. The Health Care Financing Administration (HCFA) would then be prepared to issue formal approval of the waiver shortly after March 29, 1996, at the conclusion of the thirty-day waiting period required after submission of a waiver proposal.

Sincerely,

Bruce C. Vladeck

LA County Waiver Notes; Plan 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 20 1996

Copy to:
John Fanelli
Diana Fortuna
Crawford Johnson
Pat Woods
FILE / LA county

The Honorable Pete Wilson
Governor of California
State Capitol
First Floor
Sacramento, California 95814

Dear Governor Wilson:

As you know, we recently approved California's Section 1115 demonstration project for Los Angeles County. We are extremely pleased that we were able to help Los Angles County avert a crisis and begin restructuring its health care system toward more primary and outpatient-based care. We look forward to working with you and the county as its restructuring plans progress.

We understand that California law required the state to notify all counties about the demonstration for Los Angeles County and offer them an opportunity to participate. Our records indicate that 28 counties have expressed an interest in participating in this demonstration. As you know, we do not enter into agreements or demonstration projects directly with counties. As with Los Angeles County, any proposal or application for a demonstration must be made by the state on behalf of a county; the state must also participate actively with the county and the federal government in the review process.

In order to guide decisions regarding how to proceed, we have identified the key components of the Los Angeles County demonstration. To be considered on the same basis as the Los Angeles County demonstration, a county must: (1) have a public hospital or hospitals; (2) be committed to a fundamental restructuring of its health care system to move more toward outpatient care; (3) meet the same budget neutrality requirements as other Section 1115 demonstration projects; and (4) comply with the standards set forth in the public notice requirements published in the Federal Register on September 27, 1994.

In the case of counties meeting these criteria and with which the state has agreed to support a demonstration project identical, or nearly identical, to Los Angeles County's, we will begin working with your staff and the county's staff on their proposals. As part of this process, a county will need to submit county-specific budget data and meet the public notice requirements established for Section 1115 demonstrations.

For counties which do not meet the criteria, but on behalf of which the state wishes to pursue a demonstration project appropriate for that county, we would be pleased to meet with the state to consider the merits of these proposals in the ordinary waiver process. The proposals would also require submission of county-specific budget data and compliance with applicable public notice requirements.

We look forward to working with you to provide greater access to health care for Medicaid beneficiaries and other indigent people.

Sincerely,

Bruce C. Vladeck
Administrator