

September 14, 1999

State Department of Health Services  
Attn: Hearing Officer  
Los Angeles County Section 1115 Waiver  
714 P Street, Room 1550  
Sacramento, CA 95814

Dear Hearing Officer:

The National Health Law Program (NHeLP) is a non-profit consumer advocacy organization, which for the past 30 years has worked with California advocates to gain access to health care for low-income individuals in Los Angeles and throughout the state. NHeLP testified at the public hearing on the extension of the Medicaid Demonstration Project for Los Angeles County on Thursday, September 9, 1999. This written statement is an expanded version of the testimony which we presented and we request that it be included with the transcript of the public hearing on the Los Angeles County 1115 Waiver Extension.

We would like to commend the county and the state for the progress it has made to increase access to health care for Los Angeles' low-income residents. We see the waiver extension proposal as an opportunity to fully achieve this goal and believe the following points should be addressed in the waiver.

**I. The County Should Eliminate Barriers to Health Care Services By Simplifying the Financial Screening Process**

The Ability to Pay (ATP) program is meant to assist individuals who are uninsured to cover costs of health care services. Yet financial barriers continue to be a major problem, for patients inside and outside the system, because the application process is overly burdensome and difficult.

The county itself estimates that at least 80% of those who have gone through the extensive and time consuming financial outpatient screening process have been determined to have no

financial liability for the ATP program. This is based on inpatient data that, at some hospitals, result in more than 90-95% of patients having no financial liability.

In addition, many more individuals are prevented from applying because of the process barriers which include:

- long wait lines and the requirement for separate, often multiple trips to complete the process;
- the limited capacity for screening and resulting limits on the number of applications accepted per day at sites and the limited hours of availability of screening;
- the lack of access to timely Medi-Cal screening and establishment of eligibility, which is a prerequisite to ATP for those who are potentially eligible, and
- the lack of patient-accessible information about the ATP program.

We have anecdotal information of people who are missing work days and sometimes getting fired, because of the number of days that they have to spend getting through this process.

The county has devised a pilot project strategy to simplify the ATP application process, called the Outpatient Reduced-Cost Simplified Application (ORSA). We support this or a similar strategy and the county should implement or address this serious problem.

## **II. The 1115 Waiver Extension Is An Opportunity to Align and Facilitate Access To All Needs-Based Programs**

In addition to simplifying the ATP process, the county, working with the state and with HCFA, should take this opportunity to simplify access to all need-based programs. Assistance should be provided to patients to identify sources of coverage and to access these sources appropriately. These are federal state, and local programs, including Medi-Cal, Healthy Families, ATP, AIM, CHDP, Family PACT and other programs.

Further, this is an opportunity to align program eligibility requirements, consolidate funding sources, and to eliminate the fragmentation of these programs. Individuals could potentially

have a single point of entry, eliminating the need to apply for separate programs.

### **III. The County Should Maximize Billing to Existing State and Federal Programs**

To ensure that scarce county resources are available to those who truly have no other means of coverage, the county should implement a policy and practice of billing existing programs (such as Family PACT) for patients who qualify for these programs. The state should work with the county to simplify and facilitate this process for county providers. By maximizing revenue from these coverage sources, more patients can be served.

### **IV. The County Should Eliminate Fragmentation of Services and Ensure Access to the Women's Health Services**

We commend the county for creating the Office of Women's Health and support the recommendations from the Women's Health Summit, such as the recommendation to implement a multi-tiered strategy to reduce the incidence of cervical cancer.

We also urge the county in this restructuring to maintain a focus on women's health throughout the system. Ensuring access to reproductive health services is especially important, since women access most of their preventive health care (including pap smears and mammograms) through family planning. Access to reproductive health services should be an integral part of services provided throughout the system - from the primary care sites, including the PPPs, the outpatient surgical sites, the specialty care sites, and the county's acute care hospitals.

In addition, access to reproductive health services should be part of the monitoring and planning strategies, including the 2001 LA Health Survey, patient satisfaction surveys, the annual Ambulatory Care Plan, and the community needs assessment and planning process.

Finally, the health needs of special groups, such as non-contracepting women, older women, women with disabilities, immigrant women, and adolescents, needs special attention. We know,

for example, that adolescents notoriously are not getting preventive health screens. The Healthy Student Partnership is an opportunity through both school-based AND school-linked services to ensure that adolescents have access to CHDP screens and to minor consent services.

## **V. The County Should Adopt and Monitor Standards for Ambulatory Care Visits**

We support the county's objective to increase ambulatory care visits, and by doing so, defining and developing performance indicators and standards. (Extension Proposal at 43). In this regard, we would like to underscore the fact that there are existing standards that should be incorporated. These include the CHDP; the Medi-Cal managed care Adult Preventive Health and Immunizations policy; the American College of Obstetrics and Gynecology standards for prenatal care and women's health screens, and CPSP. We understand that JCAHO also has ambulatory care standards that may be useful. While these standards may need to be modified to ensure that they are appropriate for indigent patients, they are a place to start.

A piece that often is missing from this is making sure that providers are adequately resourced to provide the components of the ambulatory care visits to meet these standards. Providers need to have the staff, training, and financial resources to meet the standards.

We understand that the county also plans to develop evidence-based standards for monitoring. We support the use of standards. However, we would like to caution the county about using evidence-based standards that may not adequately fit the needs and experience of an indigent-based population. Collective experience in delivering care to indigent patients must also be taken into account.

## **VI. The County Can Look to Existing Disease Management Performance Measures That Have Been Designed for Managed Care**

We support the county's objective to implement disease management programs. (Extension Proposal at 39). Reducing the incidences of diseases that are prevalent in the county's low-income population is an important public health function.

In implementing these strategies, the county should ensure that the diseases identified correspond to the conditions that are most prevalent among indigent individuals in the county. For example, among those diseases identified, the county should consider rheumatoid arthritis. In addition, the county should ensure that the disease management is appropriate for both men and women. The way these diseases manifest themselves in women is often different than in men, as we have seen with HIV/AIDS. Thus, disease management should be gender specific when appropriate. [\(1\)](#)

## **VII. The Country Should Ensure that Specialty Care Services Are Appropriately Available Throughout the County**

We support the county's goal to make specialty care services, including outpatient surgery, more accessible to patients, including by relocating specialty care sites where it makes sense and by adding specialty care services in other sites. The utilization of specialty care referral centers also has made a difference in increasing and coordinating referrals.

However, we continue to see barriers that are insurmountable for many people in gaining access to specialty care once they have been screened or given a diagnosis indicating needed follow-up care. First, there is the problem of geographic access. For example, while it may be appropriate to have pediatric cardiology at Children's Hospital with transportation assistance, it is not appropriate to have basic orthopaedics unavailable to a child in the San Fernando Valley who needs to have a broken wrist set. Basic orthopaedics and other types of specialty care services should be geographically available throughout the county.

Second, while we support the county's general goal of decreasing the appointment waiting times for specialty care services, we recommend that instead of setting a generic goal of no less than 21 days for 80 percent of the specialty care clinics, that the wait times be more tailored to the needs of the patients. For some diagnoses, it is imperative that individuals be seen right away. In other cases, it is appropriate to wait 21 days or perhaps longer. There must be a correlation mechanism to insure *timely* access to appropriate medical treatment and follow-up, depending on the type of diagnosis.

Third, there appears to be no uniform system to follow-up with patients who are given referrals

to specialty services by the primary care provider to ensure that the patient actually seeks and receives such services. Thus, monitoring of follow-up care needs to be instituted by the health care providers to insure patient access to specialty care services.

### **VIII. The County Should Ensure Inpatient Capacity for Individuals Who Need Hospital-Based Care**

We support the waiver's goal to increase ambulatory care capacity and getting services out into the community. However, with the increase in preventive health screens, the county will be diagnosing an increasing number of people who will need inpatient care. The county needs to make sure that there is sufficient inpatient capacity for individuals who need hospital-based care. For example, a woman who is diagnosed with breast cancer via a mammogram screen must be able to obtain the inpatient surgery that she needs.

### **IX. The County Should Ensure that Patients Not Receiving Care in the ER Obtain Care in Ambulatory Care Settings**

The county proposes to continue to reduce the inappropriate use of emergency rooms by an additional 10 percent. (Extension Proposal at xiv, 40). While this is a formidable goal, it is important to somehow track what is happening to individuals who are not receiving care in the emergency room to make sure that they are accessing other appropriate sources of care.

The Extension proposal states that "[e]mpirical data to determine a cause and effect relationship between increased ambulatory care access and reduced [inappropriate] emergency room utilization is not available, and may not be possible to establish." This certainly may be the case. However, we cannot assume that the decrease in emergency room visits is due to the increase in ambulatory care -- this may not be the same group of people and the decrease in the ER access may be due to new barriers.

At the very least the county should track those individuals who have contact with the emergency rooms and who are referred to ambulatory care sites. It is necessary to monitor how many of those individuals are reaching those alternative sources of care.

In an attempt to track individuals who never reach the emergency room, appropriate questions should be incorporated into the LA Health Survey. While this information may not be as timely as we would like, it at least provides us with one potential source of information.

## **X. The County Should Improve Its Data Collection and Monitoring Procedures**

The waiver application describes many system improvements which we support. In addition, this is an opportunity to build on existing data collection efforts to ensure that HCFA, the state, the county and the public can monitor the progress and effectiveness of these structural changes. In doing so, it is important to ensure that the data collection provide information that is timely and publically available so that appropriate action can be taken where improvements are lacking.

We support the county's plans to create a system in which there are unique patient numbers that facilitates, for example, encounter data reporting, monitoring of quality of care, and identification of patterns of care. (Extension Proposal at 49-55). However, systems also should be in place to protect patient confidentiality. An individual's medical and/or financial records should not be accessed without his or her permission. Data should be released in other circumstances (e.g., to identify county-wide health service patterns and/or disease) only in a manner in which individual, identifiable information is redacted.

To ensure that data is collected at the appropriate time and place (e.g, at the point of accessing care), it is also important to ensure that resources are allocated to help provider sites adequately prepare for data reporting. In the Medi-Cal managed care system, it has been difficult to obtain data on some of the most basic services, including prenatal care and well child care. There needs to be technical and financial support for sites to report accurate data.

## **A. Grievance and Complaints**

Complaint and grievance data is an important tool for monitoring quality and access. However, the manner in which complaint data is recorded can be a problem. Inconsistent data collection

across facilities can make this information meaningless (e.g., what is an inquiry in one site can be a complaint in another). Consistent standards on how to define patient complaints and how to report and resolve them is critical. Even more critical, patients have to *know* about the availability of the procedure, and have access to a process to actually *resolve*

their problems and to insure adequate follow-up on both individual and systemic problems which have been identified. We support the county's efforts to develop a standardized reporting form to summarize complaints received by DHS facilities. This same form should be used by those receiving complaints on the Health Services Information Unit's toll-free number.

More than monitoring of complaints, [\(2\)](#) however, there needs to be independent consumer assistance for those patients who are having trouble accessing care. Such an independent ombuds system is a way for ensuring quality. Most people who are having trouble accessing care will not file complaints. However, they will contact an entity that is providing direct assistance. Data collection can and should be an integral part of this function as well.

## **B. Patient Satisfaction Surveys**

Patient satisfaction surveys can be potentially helpful in identifying what works and what does not work for consumers. However, the usefulness of these instruments can be limited if not done appropriately. [\(3\)](#) For example, surveying only those individuals who have been successful at accessing the system will not provide any information on what barriers prevent others from getting through the front door. Without distinguishing the subgroups that are being surveyed (e.g., women, men, adolescents, people with disabilities), the problems faced by some will be masked by lumping the responses together. Thus, the survey has to be carefully designed to capture and report the experiences of different groups, such as women, immigrants, limited English proficient clients, disabled patients, and adolescents.

We believe the recently completed draft of the Patient Assessment Survey is a critical piece of information, examining not only patient satisfaction, but quality and access issues, albeit self-reported. However, it will be equally, critically important to independently validate the survey results through other means, such as population-based surveys and other means that do not rely on self-reporting (e.g., medical records, encounter data reporting).

## **XI. Conclusion**

While we wholeheartedly support the extension of the Los Angeles County 1115 waiver, we



would like the county and state to incorporate the above recommendations in the waiver program, as well as the many excellent recommendations submitted by San Fernando Valley Neighborhood Legal Services and the California Women's Law Center. We believe that Los Angeles County can lead other counties in the next millenium by showing that its waiver program can achieve its goal of improving health care access for all of its residents, including its low income individuals.

Sincerely,

Lourdes Rivera  
Staff Attorney

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Staff Attorney

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One resource that the county can look to is the Foundation for Accountability (FACCT) which has developed performance measure protocols that are disease-specific, e.g., for diabetes care. FACCT's website can be found at [www.facct.org](http://www.facct.org).

See Lourdes A. Rivera, et al., National Health Law Program, Center for Health Care Rights, Making Sense of Managed Care Quality Information at 5.7-5.10 (Nov. 1998) (discussing the limitations of complaint and grievance data).

See Id. at 6.7-6.10 (discussing the limitations of consumer surveys).