LA GENERAL IS POISED TO ENERGIZE CAL-AIM AND CREATE A HEALTHY LOS ANGELES (AND WHILE WE'RE AT IT, LET'S ERADICATE HOMELESSNESS)

"I MEAN MAN, THIS IS IT"

2024-2025

Los Angeles County

Civil Grand Jury

LA GENERAL IS POISED TO ENERGIZE CAL-AIM AND CREATE A HEALTHY LOS ANGELES (AND, WHILE WE'RE AT IT, LET'S ERADICATE HOMELESSNESS)

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EXECUTIVE SUMMARY

The 2024-2025 Los Angeles Civil Grand Jury (CGJ) is taking the unusual step of issuing this Report on an interim basis. The Board of Supervisors (BOS) voted on April 1, 2025 to embark on a major reorganization of the provision of services for the homeless by the County of Los Angeles (LA County or County), and, given the importance of this initiative, it is proceeding on a very aggressive timeline. The County's assessment of the problems of our current system of services for the homeless and its proposed solutions has been both thorough and thoughtful as reflected in the February 28, 2025 Memorandum from the Chief Executive Officer to the BOS entitled "Feasibility of Implementing the Blue Ribbon Commission on Homelessness Report Recommendations." [1] We believe, however, that the County's approach could be significantly improved if it addresses and incorporates two additional elements:

First, there are major obstacles to the integration of homeless services and related healthcare services within the County system. We believe these are not adequately addressed in the current plan, and, as a result, there is a substantial risk that many of the endemic issues of fragmentation and inefficiency at the Los Angeles Homeless Services Authority (LAHSA) will resurface.

[1] February 28, 2025 Memorandum from the Chief Executive Officer to the Board of Supervisors entitled "Feasibility of Implementing the Blue Ribbon Commission on Homelessness Report Recommendations.https://file.lacounty.gov/SDSInter/bos/bc/1178494_FesabilityofImplementingtheBRCHonHomelessnessRecommendationsNo1and3-SIGNEDBOARDMEMO.pdf (accessed March 21, 2025)

Second, the State CalAIM[2] program provides a powerful framework for addressing homelessness that should be (but apparently is not) a major focus of the County's restructuring. The County has both the experts and the opportunities (especially in connection with the County's Hospitals and Ambulatory Care Network) to utilize CalAIM as a major weapon in addressing homelessness, and this unique opportunity should not be squandered.

In that regard, it's important to note that many (but not all) of this Report's recommendations focus on an expanded use of the exceptional CalAIM program. We acknowledge that, unless renewed, the federal waiver for the CalAIM program expires on December 31, 2026.[3] Accordingly, there might be a question whether it's appropriate to invest heavily in a program that's possibly in danger of disappearing. In fact, in a presentation by Dr. Ghaly, the Director of the Department of Health Services (DHS), to the Hospitals and Health Care Delivery Commission at its February meeting, she specifically noted that "the CalAIM Waiver is sunsetting in 2026, and it is possible that it may not be renewed."

How is the federal government likely to assess CalAIM, especially since Medicaid is clearly in the cross-hairs, given the current government's desire to slash expensive programs? It's hard to know, but, notwithstanding the federal government's apparent targeting of Medicaid,[4] there are strong arguments that CalAIM should be spared and extended because of its promise to significantly reduce healthcare cost.

The County should avoid a weak-kneed abandonment of CalAIM, letting a fearful anticipation of CalAIM's demise become a self-fulfilling prophecy. To the contrary, the County should mount the strongest possible arguments that CalAIM should continue because it's the financially smart thing to do. Specifically, rather than lament CalAIM being a possible victim of federal funding reductions, the County, working with fellow CalAIM stakeholders, should spend the next year expanding CalAIM's transformative program and generating "outcome studies"

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[2] CalAIM is an acronym for California Advancing and Innovating Medi-Cal. The CalAIM program is a central component of California's Medi-Cal program, whose primary focus has historically been access to healthcare services for the poor, and, as such, the general perception has been that CalAIM is primarily a healthcare program. It is indeed an essential healthcare program that promises to promote the many benefits of integrated healthcare, but it is also a major weapon in the war against homelessness.

[3] CalAIM 1115 Demonstration & 1915(b) Waiver, Department of Health Care Services website https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx (accessed April 11, 2025)

[4] Williams, Elizabeth; Burns, Alice; Rudowitz, Robin, "Putting $880 Billion in Potential Federal Medicaid Cuts in Context of State Budgets and Coverage," KFF (March 24, 2025) (accessed April 11, 2025) https://www.kff.org/medicaid/issue-brief/putting-880-billion-in-potential-federal-medicaid-cuts-in-context-of-state-budgets-and-coverage/ https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx (accessed April 11, 2025)

that will compel the federal waiver renewal and a continuation of this essential program.

The County must decide now whether to "lie down" or "double down." This Report's most important recommendation to the County is simple: make the right choice.

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This investigation was initiated months ago based on a quite narrow (but important) concern expressed by the physician leadership at Los Angeles General Medical Center (LA General) [5] regarding the apparent inability to enroll LA General Emergency Department (ED) patients in the Enhanced Care Program (ECM) under CalAIM.

From LA General's perspective, CalAIM provides services that would greatly enhance the overall care for a variety of LA General's most vulnerable patients, and it was frankly frustrating that such services seemed, for unknown reasons, to be inaccessible. These CalAIM benefits include the following:

First, CalAIM's Enhanced Care Management program provides Lead Care Managers (Care Managers) for qualified beneficiaries[6] to assist them in identifying and accessing needed medical and social services, which is particularly valuable for patients with comorbidities and insecure living environments who truly need an integrated approach to their healthcare needs. LA General's ED patients have extremely high comorbidity rates, including chronic illnesses, mental health issues and addictions, and the impact of this is seen in the high number of return visits to the ED, with over 40% of the ED patients returning within 30 days and over 10% visiting the ED more than ten times over a 12 month period.[7]

Second, CalAIM's Community Supports program provides access to more than a dozen types of coordinated shelter and housing services for the

[5] This Report focuses on LA General and its participation in the CalAIM program. There are some aspects of LA General's operations, such as proximity to Skid Row, which make it a particularly valuable participant in CalAIM. However, we believe many of the proposals in this Report are equally applicable to the other LA County general acute care hospitals, Harbor-UCLA Medical Center (Harbor UCLA) and Olive View Medical Center (Olive View) (collectively referred to as County Hospitals), and we recommend that each of them also seriously consider active participation in CalAIM, especially as ECM providers.

[6] This Report will for the most part refer to the persons who are the focus of CalAIM as "beneficiaries." We are intentionally using the term "beneficiaries" rather than patients (except where the context requires otherwise), since many CalAIM services are not directly related to patient care.

[7] LA General ED-ECM Table (See Methodology Documents # 9)

homeless.[8] Given LA General's location within a few miles of Skid Row, the largest concentration of homeless in the country, it's not surprising that almost 15% of its ED patients are homeless.[9]

LA General's ED patients could clearly benefit substantially from access to CalAIM's unique services, so why are they unavailable?

We solved that mystery in short order (See Part 4), and the simple answer is funding. Basically, the payments available under the Medi-Cal program for ECM and Community Supports services fall far short of the costs incurred by the County (specifically, DHS) in providing those services,[10] and, as a result, DHS had decided to limit its CalAIM services and associated subsidies, with some minor exceptions, to those patients who are empaneled with DHS under a managed care relationship.[11]

DHS's position is certainly rational and fiscally prudent, but it seems tragic that highly vulnerable LA General patients who qualify for potentially transformative services are unable to access them. Accordingly, we considered various justifications for providing those services as well as potential funding sources. We concluded that DHS's approach is too narrowly focused, and that DHS should seriously consider expanding ECM and Community Supports services to LA General ED patients for two reasons:

First, given the immense potential value of CalAIM services for patients, we believe the County should consider absorbing related costs in connection with its general obligation to provide healthcare services for the medically indigent. We believe these CalAIM services are as essential to the well-being of our citizens as many of the healthcare services the County already provides. And, whether or not it's statutorily required, it's the right thing to do.

Second, providing such services is also the economically smart thing to do. The effective use of CalAIM services with these vulnerable patients should greatly decrease their healthcare utilization and costs, directly reducing the future costs incurred by the County healthcare system, including LA General. (The State estimates that approximately 50% of Medi-Cal costs are generated by just

[8] Transformation of Medi-Cal: Community Supports, DHCS webpage https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf (accessed April 11, 2025)
[9] ibid
[10] Interview with DHS Leadership
[11] ibid

5% of Medi-Cal beneficiaries, most of whom qualify for CalAIM.[12] And, 20% of Medi-Cal costs are generated by just 1% of Medi-Cal beneficiaries.)[13]

It would of course be even better if sources of direct funding could be identified. In that regard, we have the BOS's recent decision to begin retaining the $300 million in annual funding it has provided to LAHSA, which the County intends to use to provide services directly for the County's homeless.[14]

In addition, the benefits of reduced healthcare costs under CalAIM will accrue not only to the County, but also the State (by reducing overall Medi-Cal expenditures), and the relevant managed care plans, such as LA Care, [15] which incur significant financial risk for the care of enrolled patients. Accordingly, we believe DHS would likely have significant opportunities to coordinate with both the State and managed care plans.

Regardless of the funding source, we have concluded that the County Hospitals' expanded participation in CalAIM would benefit its most vulnerable patients; accordingly, we have investigated how the County can improve its processes to most effectively participate in CalAIM.

Although our investigation started with a narrow focus on the specific enrollment of LA General ED patients in CalAIM, we came to the exciting realization, as a result of thoughtful and inspiring conversations with LA General's leadership, that, with a major commitment to CalAIM, it would be possible to achieve two major, long-term goals of the BOS as reflected in the 2024-2030 County Strategic Plan:

> (1) Creating a fully integrated healthcare system for the general benefit of patients, and
>
> (2) Using that integrated healthcare system to effectively address homelessness.

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[12] Medi-Cal Transformation: Enhanced Managed Care. DHCS website https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdfState ECM report (accessed February 13, 2024)

[13] Petek, Gabriel, "The 2025-26 Budget: CalAIM Enhanced Care Management and Community Supports Implementation Update," Legislative Analyst's Office (March 2025) https://lao.ca.gov/Publications/Report/5003 (accessed March 14, 2025)

[14] Zahniser, David; Ellis, Rebecca, "County supervisors create new homeless agency, despite warnings from LA mayor," Los Angeles Times (April 1, 2025) https://www.latimes.com/california/story/2025-04-01/county-votes-to-pull-money-from-homeless-agency-despite-mayors-opposition (accessed April 11, 2025)

[15] In this Report, we focus on LA Care as the managed care plan that enrolls the most Medi-Cal beneficiaries in LA County. But many of our recommendations regarding LA Care also apply to the other Medi-Cal managed care plans operating in LA County, especially HealthNet and also more recent participants such as Molina Healthcare (which commenced participation in 2024).

The 2024-2030 Strategic Plan contains nine BOS "Directed Priorities," with "each of these Priorities representing the Board's responsive action to a complex issue that can negatively impact the health, safety, and well-being of individuals who reside in LA County."[16] One of those Priorities is "Health Integration," with the BOS stating that "this priority seeks to streamline and integrate access to high-quality services across the departments of Health Services, Mental Health, and Public Health";[17] and another Priority is "Homelessness," with the BOS stating that its "Homeless Initiative is the central coordinating body for Los Angeles County's ongoing effort - unprecedented in scale – to expand and enhance services for people experiencing homelessness or at risk of losing their homes."[18]

Let's briefly summarize the scope of our inquiry accordingly:

Healthcare Integration

LA County has established an exceptional array of hospital, non-hospital clinical and social services for the benefit of its citizens, especially those who are most vulnerable, but it has not been able to link these various services into an integrated healthcare system that provides, on the one hand, high quality medical care, and, on the other, effective social services that reduce as much as possible the need for that medical care, especially inpatient services. Simply put, LA County has created an amazing variety of health and social services that includes substantially all of the essential pieces for integrated care, but it has failed to provide the integration of those pieces necessary to enhance overall care and well-being. We have concluded that the CalAIM program, and the ECM benefit in particular, provides a catalyst to achieve that integration.

Addressing Homelessness

Homelessness is one of the foremost social (and political) issues in Los Angeles County, and we seem to be unable to identify effective solutions. We believe CalAIM is that solution, having been created "to provide robust, statewide housing services for Medi-Cal members who are affected by homelessness and housing instability." [19]

We have investigated LA County's processes regarding healthcare integration and, as detailed in this Report, identified many examples where the County's processes seem to run counter to the BOS's Priority to "streamline and integrate

[16] "Read the 2024-2030 Los Angeles County Strategic Plan," Los Angeles County Chief Executive Office websitte https://file.lacounty.gov/SDSInter/bos/bc/1178715_2.06.25HHCDMeetingMinutes-APPROVED.pdf (accessed April 2, 2025)
[17] ibid
[18] ibid
[19] "CalAIM's Commitment to Addressing California's Homelessness Crisis, California Department of Health Care Services (with cover letter from Jacey Cooper, State Medicaid Director (April 9, 2021)) https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Role-in-Addressing-Homelessness-Fact-Sheet-%26-Letter-4-9-21.pdf (accessed March 21, 2025)

access to high-quality services across" all healthcare related Departments. In order to address those procedural deficiencies, we are making one major recommendation in this Report: utilize a consolidated Health Agency (a la Mitch Katz)[20] which establishes procedures that "streamline and integrate" services in order to achieve the extraordinary benefits of healthcare integration, and then use that Health Agency to combine the tools of CalAIM and healthcare integration to defeat homelessness.

We know we are recommending extraordinary and massive changes in governmental operations in order to foster essential County policies, but the County, with its impending withdrawal from LAHSA, recognizes the need for bold action, and the times are indeed ripe for a bureaucratic revolution. [21]

[20]Mitchell H. Katz, M.D., Memorandum to Board of Supervisors entitled "Proposal to Integrate the Departments of Health Services, Mental Health, and Public Health (January 2, 2015) https://californiahealthline.org/wp-content/uploads/sites/3/2016/01/la-health-services-memo.pdf (accessed March 5, 2025)

[21] "The revolution is not an apple that falls when it is ripe. You have to make it fall." CG

BACKGROUND

LA County is responsible for ensuring that those who are medically indigent receive necessary and appropriate care,[22] and there have been long-running questions how to accomplish this in the most caring, effective and comprehensive way possible. As described in the Global Executive Summary preceding the CGJ's series of reports focused on LA General, the history of LA County's provision of services for the medically indigent has evolved over the years into a relatively new system of managed care that is substantially funded by the Medi-Cal program. Under this system, most payments for services are made pursuant to contracts between managed care plans (MCPs) and healthcare providers, especially hospitals, with those providers assuming financial risk in the form of capitation payments for assigned beneficiaries. The theory has been that managed care incentives would compel providers to rationalize their services through integrated healthcare systems, thereby expanding a narrow focus on treating sick individuals to fostering the community's overall health. We've had fifty years of stumbles and false starts in meeting that promise, but we contend that LA General, using the tools of CalAIM, is on the road to making that long-ago promise a reality.

A. The Optimistic Hope and Delayed Promise of Managed Care

Dr. Paul Ellwood coined the phrase Health Maintenance Organization (HMO) in a 1970 article in Fortune magazine, in which he advocated a new system of managed care that provides financial incentives to keep citizens healthy, encouraging the provision of basic nutrition and housing needs, ensuring effective public health initiatives, and recognizing the importance of both mental health and traditional medical services.[23] Dr. Ellwood's proposals got political traction, and only two years later, Congress passed the Health Maintenance Act of 1973.[24]

What went wrong? Health maintenance organizations and managed care are pervasively present in our current healthcare system, but we have not seen the anticipated increases in overall community health and well-being envisioned by Dr. Ellwood. In a 2010 interview, Dr. Ellwood continued to

[22] LA County's obligation to care for the medically indigent is established in Section 17000 of the California Welfare & Institutions Code, which reads as follows: "Every county … shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."
[23] Ellwood, Paul, M.D., "Our Ailing Medical System: It's Time to Operate," Fortune Magazine (January 1970); McFadden, Robert D., "Dr. Paul M. Ellwood, Jr., Architect of the HMO, Is Dead at 95," New York Times (June 29, 2022) https://www.nytimes.com/2022/06/20/us/dr-paul-m-ellwood-jr-dead.html (accessed February 14, 2025)
[24] 42 USC, Section 300e

be optimistic about the potential of managed care, but identified three mistakes that undermined the potential of managed care that would need to be corrected before that potential could be fully realized: "Political expediency in the initial plan designed for HMO growth led to the inclusion of three mistakes: for profit plans, independent practice associations, and the failure to include outcome accountability."[25]

As discussed in this Report, LA General and LA Care, working together to implement the CalAIM program, promise to address all three of those problems, with LA General being instrumental in providing a framework for "outcome accountability" and putting us on the path to realizing Dr. Ellwood's original vision of an integrated system that effectively promotes "healthy citizens."

B. A Brief History of LA County's Involvement With Managed Care

We contend that CalAIM is the culmination of LA County's commitment to the ideals of managed care, and this Section is a brief description of the managed care foundations that have been laid for CalAIM.

1. LA County made an early commitment to managed care, creating the Community Health Plan in 1983, one of the very first public health plans in the nation.[26]

2. The Local Initiative Health Authority for Los Angeles County, commonly referred to as LA Care, was established as a public health plan in 1997 in response to the State's desire to manage burgeoning healthcare costs through the promotion of managed care for Medi-Cal beneficiaries.[27] The State created a number of options for California counties, and LA County adopted the so-called Two Plan Option to ensure some competition among plans and choice for Medi-Cal beneficiaries.[28] In addition to LA

[25]. Kovner, Anthony R., "Paul M. Ellwood, Jr., M.D., in the First Person: An Oral History," American Hospital Association Center, page 16 (September 16, 2010) https://www.aha.org/system/files/2018-03/Ellwood-FINAL-050211.pdf (accessed February 13, 2025)

[26] Memorandum regarding Community Health Plan from Thomas Garthwaite, M.D., to the LA County Board of Supervisors (March 11, 2003) https://file.lacounty.gov/SDSInter/bos/bc/005444_breport031103.pdf (accessed February 13, 2025)

[27] Fact Sheet, LA Care Health Plan website https://www.lacare.org/news/fact-sheet (accessed February 13, 2025)

[28] Tartar, Margaret, "Medi-Cal Managed Care: And Overview and Key Issues," KFF (March2, 2016) https://www.kff.org/report-section/medi-cal-managed-care-an-overview-and-key-issues-issue-brief/ (accessed April 11, 2025)

Care, the other major Medi-Cal health plan in LA County is HealthNet

3. LA County's Community Health Plan was absorbed into LA Care in 2012.[29] (As a result, representatives of LA General, including its Chief Executive Officer, participate as LA Care board members, closely linking the two institutions.)

4. The passage and implementation of the Affordable Care Act in 2014 ("Obamacare") substantially expanded Medi-Cal coverage, which had a significant impact on the managed care landscape in LA County. In particular, there was significant concern that the "county would lose patients en mass to the private healthcare system under Obamacare,"[30] jeopardizing its stability; but the DHS Director at the time, Dr. Mitch Katz, has been credited with taking two actions to stabilize the County Hospital system by fully committing the County to managed care. Specifically, Dr. "Katz set about strengthening the county's outpatient care system and preemptively enrolling roughly 300,000 people in the county medical care program to the run-up to the launch of" Obamacare.[31] The substantial expansion of the County ambulatory care network allowed the County to better serve and manage the medical needs of the Medi-Cal beneficiaries newly enrolled in managed care; and the significant influx of Medi-Cal beneficiaries into the County managed care system meant the County Hospitals had a stabilizing flow of capitation revenues with a concomitant long-term commitment to creatively manage the medical needs of those beneficiaries. This is the true "ground zero" of managed care in LA County, when LA County and the County Hospitals irreversibly shifted from a narrow focus on treating the sick to an expansive commitment to community health.

5. In 2016, just two years later, LA County initiated the Whole Person Care program, a County-wide initiative that laid the groundwork for integrated managed care, focusing on "breaking down silos in physical health, behavioral health, justice, and social services systems, and addressing health equity through

[29] "New Health Plan, Same Doctor," Communication from Community Health Plan and LA Care Health Plan (January 1, 2012) https://www.lacare.org/sites/default/files/files/CHP-LAC%20Medi-Cal_Same%20PCP_Joint.pdf (accessed February 13, 2025)
[30] Sewell, Abby, "Mitch Katz poised to lead L.A. County's consolidated healthcare agency," Los Angeles Times, page 5 (September 9, 2015 https://www.latimes.com/local/countygovernment/la-me-mitch-katz-20150929-story.html (accessed February 13, 2025)
[31] ibid

holistic, person-centered programming."[32] The Whole Person Care program continued in operation until superseded by its first cousin, CalAIM.[33] The Whole Person Care interventions are directly visible in many of the CalAIM initiatives, including an emphasis on recuperative care and various enhanced payments for supports and services, to keep people with higher needs in the community.[34]

C. CalAIM – A Transformational Experiment that Energizes Medi-Cal Managed Care in Order to Improve Community Health and Aggressively Address Homelessness

This Report will discuss in detail the various components of the revolutionary CalAIM program being deployed to address the overall health and well-being of at-risk Medi-Cal beneficiaries, especially the homeless, but from a high-level perspective there are two words that sum it up: "comprehensive" and "transforming."

> "CalAIM is a **comprehensive**, multi-year initiative launched by the California Department of Health Care Services (DHCS). Its goal is to enhance the quality of life and health outcomes for Medi-Cal members through extensive reforms in delivery systems, programs and payment structures within the Medi-Cal Program."[35]

> "Bigger Picture: DHCS is **transforming** Medi-Cal to ensure Californians can get comprehensive care to improve their health and well-being."[36] [Emphasis added]

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[32] Whole Person Care Los Angeles - Impact Report June 2022 https://file.lacounty.gov/SDSInter/dhs/1126196_WPC-LAImpactReport6.15.22_FINAL.pdf (accessed February 13, 2025)

[33] Given the close alignment between the Los Angeles Whole Person Care program and CalAIM, the State allowed the more than 7000 participants in the Whole Person Care program to automatically enroll in CalAIM. (Interview with DHS leadership.)

[34] Diaz, Dalma, "Knitting Together Health and Social Services in Los Angeles: An interview with Dr. Clemens Hong at the Department of Health Services," California Health Care Foundation (January 25, 2023) https://www.chcf.org/blog/knitting-together-health-and-social-services-in-los-angeles/ (accessed February 13, 2025)

[35] Los Angeles County Hospitals and Health Care Delivery Commission – Annual Report June 2023 – May 2024, page 5 https://file.lacounty.gov/SDSInter/dhs/1167404_2024HospitalsandHealthCareDeliveryAnnualReport_V03.pdf (accessed February 13, 2025)

[36] State Department of Health Care Services News Release, "Success of Medi-Cal Transformation Continues as Latest Enhanced Care Management and Community Supports Data Report Shows Progress," (August 2, 2024) https://file.lacounty.gov/SDSInter/dhs/1167404_2024HospitalsandHealthCareDeliveryAnnualReport_V03.pdf (accessed February 13, 2025)

CalAIM's transformative role in addressing the homelessness crisis is nicely summarized in a memorandum from the State Department of Health Care Services entitled "CalAIM's Commitment to Addressing California's Homeless Crisis":

> "CalAIM is designed to provide robust, statewide housing services for Medi-Cal members who are affected by homelessness and housing instability"[37] by "meaningfully and sustainably address[ing] California's housing crisis."[38]

D. A Brief History Regarding the Independence and Coordination of the County Departments

The promise of CalAIM is dependent on the ability of the County Departments primarily focused on healthcare – DHS, the Department of Mental Health (DMH) and the Department of Public Health (DPH) – to coordinate and even integrate their services, which has not been their natural tendency. In fact, in the past DMH and DPH have objected vehemently to giving DHS a strong leadership role for purposes of mandating healthcare integration. As background, we provide the following history of the coordination and integration of these County Departments, which has been marked by unfortunate backsliding over the past decade.

Historically, there have usually been three County Departments that focus on healthcare related services: DHS, DMH and DPH. Relatively recently, the new Department of Aging and Disabilities was created, which will also presumably be directly involved with County healthcare related issues.

The County has frequently and creatively addressed the relationships among the three healthcare-related County Departments, balancing often conflicting needs for coordination and independence. Before 1972, DHS, DMH and DPH were separate Departments, ensuring their individual independence while encouraging coordination.[39] Between 1972 and 1978, the County went in the opposite direction, consolidating all three Departments into one Department of Health Services.[40] Then in 1978,

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[37] State Department of Health Care Services, "CalAIM's Commitment to Addressing California's Homeless Crisis" https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Role-in-Addressing-Homelessness-Fact-Sheet-%26-Letter-4-9-21.pdf (accessed March 21, 2025)

[38] ibid

[39] Li, Alexander, Deputy Director, Linkages and Systems Integration, LA County Health Agency – PowerPoint (April 20, 2016) https://file.lacounty.gov/SDSInter/bos/supdocs/103090.pdf (accessed February 6, 2025)

[40] ibid

addressing concerns that mental health deserved increased attention, DMH was carved out as an independent Department.[41] Then in 2006, with an increased emphasis on preventive care, DPH became independent from DHS (although some existing clinics were aligned with DHS and others with DPH).[42]

There were ongoing discussions regarding how best to balance the coordination and independence of the County Departments, and in September 2015 the BOS unanimously approved a compromise that retained the Departments' independent identities and budgets, but embedded them into a new Health Agency that had ultimate control, especially for purposes of coordinating and integrating healthcare services. Dr. Mitch Katz, who outlined the new structure and its justifications in a foundational Memorandum to the Board of Supervisors (see Exhibit A),[43] became the Director of the Health Agency.

Dr. Katz was committed to integrating the activities of the health-related Departments, and made significant strides in that regard, but he unfortunately left the Department just two years later in September 2017.[44]

The consolidation of the Departments into the Health Agency was controversial, especially among those who feared it would deemphasize both public and mental health services, and, in the absence of Dr. Katz's championing of healthcare integration, there was an apparent push to reassert the Departments' independence. This resulted in the Board of Supervisors replacing the consolidated Health Agency with the Alliance for Health Integration (AHI) in November 2019.[45] Rather than having one person with ultimate authority over the healthcare-related Departments, the Directors of those Departments "propose[d] that they, as a shared governance team (consensus decision-making) […] assume primary responsibility and accountability […]."[46] The Directors indicated they would "strive for consensus on all decisions related to issues that involve or

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[41] ibid
[42] ibid
[43] Dr. Katz Memo (N 20)
[44]Nina Agrawal, "Head of L.A. County's health system, one of the largest in the country, announced departure," Los Angeles Times (September 23, 2017) https://www.latimes.com/local/lanow/la-me-ln-health-agency-director-20170923-story.html (accessed March 5, 2025)
[45] County of Los Angeles 2024-2030 Strategic Plan, Attachment III "County of Los Angeles Board Directed Priority Report – 2023 (March 6, 2024) https://file.lacounty.gov/SDSInter/bos/supdocs/189036.pdf#page=60 (accessed April 11, 2025)
[46] "The Los Angeles County Alliance for Health Integration: A Proposal with Sample Objectives and Metrics" (February 12, 2020) (https://file.lacounty.gov/SDSInter/bos/supdocs/144099.pdf (accessed March 5, 2025)

impact more than one Department."[47] And, to further the commitment to consensus, the Directors agreed to "annually rotate an Alliance chair" among them.[48]

In 2020, AHI hired its first Chief Operating Officer, and by 2021 AHI had a staff of five. It was, however, quickly concluded that the voluntary commitment to integration was ineffective,[49] and, presumably in recognition of this fact, the Board of Supervisors transferred AHI's entire staff to DMH in March 2023, leaving AHI an empty shell.[50] Notwithstanding the dismantlement of AHI, the Board of Supervisors has voiced an ongoing commitment to integration, although it has provided few if any tools to convert principle into reality.[51]

[47] ibid
[48] ibid
[49] In our interviews with DHS leadership, it was acknowledged in two separate conversations that AHI's lack of authority resulted in its ineffectiveness.
[50] See "Alliance for Health Integration," Board Directed Priority Report – County of Los Angeles, page 9 (2023) (Attachment III to the Strategic Plan – Los Angeles County (2024-2030) https://file.lacounty.gov/SDSInter/lac/1156577_Strat.Plan.Jan.2024.final.pdf (Accessed February 6, 2025)
[51] 2024-2030 LAC Strategic Plan (n 16)

METHODOLOGY

The focus of this Report is on using the CalAIM program to foster an integrated healthcare system that can effectively address homelessness, with a specific focus on enhancing LA General's interaction with the CalAIM program. In this regard, our research has focused on (1) understanding the basics of the CalAIM program and its potential for promoting an integrated healthcare system that effectively addresses homelessness, (2) understanding the current interaction of LA General with LA Care in connection with CalAIM, and (3) identifying and reviewing the experience that other hospitals have had with CalAIM that might be informative (with Children's Hospital of Los Angeles (CHLA) being identified as the hospital with the most relevant experience).

We also identified the Restorative Care Village located on the LA General campus as a potentially powerful CalAIM partner, and accordingly researched its organization, structure and connections with CalAIM.

The following are the core documents and interviews that contributed to this Report:

DOCUMENTS

1. The State Department of Health Care Services (DHCS) has created detailed outlines of the CalAIM program and its various services, including ECM and Community Supports, which are referenced throughout this Report, with the DHCS Implementation Report being especially informative.[52]
2. The Standing Committee on CalAIM of the County Hospitals and Health Care Delivery Commission has generated annual reports as well as minutes of discussions that have been helpful in identifying CalAIM's implementation challenges. The Commission's June 2023 – May 2024 Annual Report is particularly helpful.[53]
3. The Los Angeles County Department of Health Services, Whole Person Care Los Angeles – Impact Report (June 2022)[54] provides an excellent summary of this important precursor to CalAIM.

[52] ECM and Community Supports Quarterly Implementation Report – Data from January 1, 2022 – June 30, 2024/updated December 2024, State Department of Health Care Services website https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117 (accessed February 13, 2025)
[53] Hospitals Commission (n 35)
[54] Whole Person Care (n 32)

4. The “Final Evaluation of California’s Whole Person Care (WPC) Program,” UCLA Center for Health Policy Research, (December 2022)[55] provides a helpful supplement to the Whole Person Care Impact Report.
5. The Blue Ribbon Commission on Homelessness Governance Report (March 20, 2022) [56] provided valuable insights regarding potential improvements to the County’s management of services for the homeless.
6. The “CalAIM Enhanced Care Management and Community Supports Implementation Update” published by the Legislative Analyst’s Office in March 2025[57] provides an exceptional overview of the current state of the CalAIM program.
7. The Chief Executive Officer’s Memorandum to the BOS entitled “Feasibility of Implementing the Blue Ribbon Commission on Homelessness Report Recommendations” provides an excellent roadmap for the implementation of the Homeless Services Department recently approved by the BOS.[58]
8. The 2023 survey regarding homelessness in California entitled “Toward a New Understanding – the California Statewide Study of People Experiencing Homelessness,” provides a good description of the challenges faced by our homeless population. [59]
9. LA General prepared a table regarding 2023-2024 emergency department visits by beneficiaries sorted by both ECM criteria and the responsible managed care plan (the “LA General ED-ECM Table”), which Table highlights LA General’s potential as an active participant in CalAIM.

INTERVIEWS

We had one or more interviews with each of the following:

1. LA General leadership
2. LA Care executives responsible for CalAIM implementation and operation

[55] “Final Evaluation of California’s Whole Person Care (WPC) Program” UCLA Center for Health Policy Research (December 2022) https://healthpolicy.ucla.edu/sites/default/files/2024-03/whole-person-care-final-evaluation-report-approved-with-signature_03_11_24.pdf (accessed February 13, 2025)
[56] Blue Ribbon Commission on Homelessness Governance Report (March 20, 2022) https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/c15b378d-d10e-46aa-a6cc-7102043aa708/BRCH%20Homelessness%20Report%20%28033022%20Adopted%29%20%28Final%29.pdf (accessed March 20, 2025)
[57] Legislative Analyst (n 13)
[58] CEO Report (n 1)
[59]Toward a New Understanding – The California Statewide Study of People Experiencing Homelessness, Benioff Homelessness and Housing Initiative, University of California San Francisco (June 2023) https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf (accessed March 13, 2025)

3. Representatives of the Standing Committee on CalAIM under the County Hospitals and Health Care Delivery Commission
4. Representatives of the Integrative Delivery Services Department responsible for CalAIM coordination at Children's Hospital of Los Angeles
5. Members of Supervisor Hilda Solis's office responsible for overseeing the Restorative Care Village located on the LA General campus
6. Representatives of DHS responsible for the oversight of Population Health, Enhanced Care Management and Community Supports

DISCUSSION

In our background discussion, we briefly outlined the evolution of managed care in LA County as it ultimately culminated in CalAIM. And we will now address how CalAIM can be harnessed to integrate the full array of health and social services for our most vulnerable population, and then be expanded to address homelessness. We develop and address the promises and challenges of using CalAIM to achieve healthcare integration and address homelessness in Nine Parts, as follows:

Part 1: The Promise of "Healthcare Integration" and CalAIM's Role in Keeping That Promise

This Part reviews the three essential pieces of an integrated healthcare system: comprehensive **services**, a regulatory **framework** that integrates those services, and, finally, effective vehicles to **empower individuals** to access necessary health and social services. Many of the necessary pieces have already been put in place by LA County, and CalAIM is now available to provide the finishing touches.

Part 2: CalAIM and the Homeless

This Part describes CalAIM's important role in establishing integrated care as the essential solution for homelessness.

Part 3: Where Is CalAIM Falling Short?

We have highlighted the exceptional promise of CalAIM, but it's also important to acknowledge its current deficiencies. The success of CalAIM is dependent on both enrolling ECM eligible beneficiaries and then creating a stable network of Community Supports for those who are enrolled, and there continue to be major shortfalls on both counts.

Part 4: DHS and CalAIM: Thinking Small (but Brilliantly)

In this Part, we focus on DHS's successful commitment to creating and stabilizing a strong Community Supports network, which is a major achievement. DHS, however, is not pursuing a solution for inadequate ECM enrollment, but rather has limited its focus to Medi-Cal beneficiaries who are empaneled with DHS.

Part 5: LA General and CalAIM: THINKING BIG!

In this Part, we turn to LA General as the source of potential solutions for many of the remaining CalAIM deficiencies, especially inadequate ECM enrollment. In addition to being a potential vehicle to substantially increase ECM enrollment, we describe how LA General is positioned to address two other major issues under CalAIM: (1) reducing overall healthcare costs, and (2) facilitating "outcome assessments" of the CalAIM program.

Part 6: Thinking Together – Finding Funding for the Comprehensive CalAIM Solution

In this Part, we note that current CalAIM funding is inadequate and acknowledge that achieving CalAIM's far reaching goals will require a major investment. There are a number of potential solutions in this regard. First, we emphasize the County's recent decision to recapture the $300 million it annually provides to LAHSA for homeless services, Second, it's also important to recognize that a major investment in CalAIM should generate substantial financial returns because of reduced healthcare costs. Therefore, a potentially important funding avenue would be to link these cost-savings with the benefitted parties and consider working with those parties to develop a mutually acceptable plan of coordination.

Part 7: Thinking Collectively - Integrating the County Departments' Healthcare and Homeless Initiatives

In this Part, we describe the lack of coordination among the County's Departments regarding certain essential healthcare related services. We then argue that the promise of an integrated healthcare system can only be achieved if the County Departments' relevant health and social services are also appropriately integrated, and, accordingly, we recommend a major but necessary restructuring of the healthcare-related County Departments to achieve that integration by consolidating them into a new Health Agency. (As noted above, the County has actually had a history of exceptional success with this model during the period from 2015-2017.)

Part 8: Thinking Creatively – Replacing the Proposed "Homeless Services Department" with a "Health Agency" that has "Full" Authority to Lead on Homeless Policy

This Part investigates the County's current plans to restructure the provision of homeless services. We address the inherent problems with the currently contemplated plan, and strongly advocate that the County refocus on the use of

a rejuvenated Health Agency to provide a fully integrated approach to homeless services in accordance with the principles of CalAIM.

Part 9: Children's Hospital of Los Angeles – Thinking Big with Small People

For the purposes of inspiration, we conclude with a description of Children's Hospital of Los Angeles's extraordinary experience with CalAIM, which has enabled it to vastly improve the well-being of its equally vulnerable population.

PART 1

THE PROMISE OF "HEALTHCARE INTEGRATION" AND CalAIM'S ROLE IN KEEPING THAT PROMISE

As we discussed above, the "holy grail" of health care delivery has been an integrated healthcare system where there is both:

(1) a comprehensive network of healthcare and social service providers addressing acute inpatient care, ambulatory care, mental health, substance addiction, and the so-called social determinants of health, including such things as housing and nutrition, and

(2) a payment system that rewards (and thereby incentivizes) providers and others who address immediate medical needs and take actions to prevent illness and generally improve individual and community health.[60]

Achieving this "holy grail" of integrated care is especially important for the medically indigent, many of whom have unique needs arising from challenging living conditions, including homelessness, that seriously compromise their health.

The many opportunities under CalAIM to improve health and reduce costs all hinge on the creation of an integrated health system, which, as discussed below, has three essential components – Services, Framework and Activation – all of which, thanks to essential players like LA General and LA Care, are on the verge of coming together in LA County.

SERVICES (thanks to LA County). On the positive side, LA County has created a vast array of services that potentially address the full continuum of both immediate and preventive care needs. In this regard, it's important to note that LA County provides the three layers of services necessary for integrated care: (1) hospitals, where the most serious medical issues are addressed, (2) other essential clinical services, including primary care (which LA County largely addresses through its Ambulatory Care Network) and substance abuse and

[60] Paul Ellwood HMO Architect (n 23)

mental health services (for which LA County has embarked on the creation of unique service hubs in its Restorative Care Villages), and (3) supportive services addressing the social determinants of health, which are a focus of Community Supports under the CalAIM program.

LA County has established an exceptional collection of health and social services for the benefit of its citizens, especially those who are most vulnerable. It has not,, however, been able to link these various services into an integrated healthcare system that provides, on the one hand, high quality medical care, and, on the other, effective social services that reduce as much as possible the need for that medical care, especially expensive inpatient services. Simply put, LA County has created a comprehensive array of health and social services that includes substantially all of the pieces essential for integrated care, but it has failed to provide the necessary integration of those pieces.

FRAMEWORK (thanks to the State and LA Care). There have been understandable challenges in fully deploying and coordinating the three layers of care; and, historically, there has never been a comprehensive payment mechanism that rewards (and thereby incentivizes) the long-term public benefits of collectively coordinated healthcare delivery. It was hoped by many that the integrated healthcare puzzle would be solved with the implementation of a managed care system using capitation payments to create incentives to coordinate the many services necessary for a healthy population. This hope was justified in theory, but, for a variety of reasons, it did not play out in reality.

However, CalAIM now provides that link between theory and reality. Specifically, the State and managed care plans (especially LA Care) provide an architectural framework for CalAIM, connecting individual services into an integrated system. This CalAIM framework has two essential components: First, and most important, an ECM program, under which a Lead Care Manager (Care Manager) is assigned to each ECM beneficiary in order to coordinate all health and social service needs.[61] Second, a Community Supports program that provides funding for defined services to address the social needs of those ECM beneficiaries, with a special focus on homelessness.[62]

There are a number of players required to populate the CalAIM framework. The State is of course needed to provide funding (although there are significant issues, as discussed below, regarding the adequacy of current funding); MCPs, such as LA Care, are needed to establish a network of ECM and Community Supports providers; and, most important, specific ECM providers are needed to enroll at-risk Medi-Cal beneficiaries and provide effective Care Managers and

[61] "Enhanced Care Management Providers," LA Care Health Plan website https://www.lacare.org/providers/ecm/providers (accessed February 13, 2025)
[62] Transformation of Medi-Cal: Community Supports, DHCS webpage https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf (accessed April 11, 2025)

Community Health Workers[63] to assist those beneficiaries in accessing health and social services.

ACTIVATION (anticipated thanks to LA General and other ECM providers). With the State, MCPs, and ECM providers supporting CalAIM, we have the essential pieces in place for an integrated health system, but one additional piece is required to complete the integrated healthcare puzzle: patient agency. In order for the system to work, you need to educate and empower patients so they can identify and access healthcare and other services that best meet their needs, and thereby pursue and achieve long-term health benefits. Patients of course have the desire to increase their overall health, but the challenge (for all of us) is understanding, accessing and fully utilizing an extraordinarily complex healthcare system and related social services; and this is especially true for those plagued with comorbidities and social challenges, such as homelessness and addiction. In order to become both knowledgeable and empowered, patients need guides to help them navigate the healthcare maze, and CalAIM's ECM initiative provides those guides in the form of Care Managers and Community Health Workers.

In order to activate an integrated healthcare system, you specifically need beneficiaries who are empowered to make informed healthcare decisions; and CalAIM operates on the common sense assumption that if ECM Care Managers provide at-risk beneficiaries with education, guidance and encouragement regarding available health and social services, those beneficiaries will have the motivation and new-found ability to access appropriate care. They will, accordingly, make linkages that benefit their personal health, and, over time, collectively transform healthcare delivery for the overall community.

Let's now turn to CalAIM's specific functions, goals and aspirations regarding healthcare integration.

A. A Brief Summary of Medi-Cal and CalAIM

> "Medi-Cal provides health care coverage to almost 40 percent of Californians, but the program's complexity makes it difficult for some individuals to access appropriate care. The state received federal approval for […] funding two new benefits: Enhanced Care Management (ECM) and Community Supports. These benefits are provided by managed care plans (MCPs) and are intended to provide cost-effective services to high-cost, high need Medi-Cal members to improve health outcomes and reduce reliance on more costly medical services. The ECM benefit provides personalized care management to eligible members and Community Supports services – largely of a social services nature – are substitutes to traditional, often more costly medical services."[64]

[63] ECM Providers (n 61)
[64] Legislative Analyst (n 13) page 1

B. The Special Needs of Medi-Cal Beneficiaries and the CalAIM Tools That Have Been Created to Address Those Needs

The State recognizes that "Medi-Cal members typically have **several complex health conditions** involving physical, behavioral, and social needs, [and that] members with complex needs must often engage **several delivery systems to access care**, including primary and specialty care, dental, mental health, substance use disorder treatment, and long-term services and supports."[65] In order to address these complex needs effectively, "CalAIM has several initiatives […]. Two of the prominent and early implemented initiatives are: Enhanced Case Management (ECM) and Community Supports (CS). ECM is designed to assist people who have complex and special needs to get additional services in support of resolving or better managing their health problems […]."[66] Under ECM, "enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health-related care […]."[67]

C. What are the Social Goals under CalAIM? CalAIM's broad goals are those common to all integrated care systems: substantially better health accompanied by reduced costs:

1. Enhancing the Health and Well-Being of Medi-Cal Beneficiaries

The primary goal of CalAIM is very simple: enhancing the well-being of Medi-Cal beneficiaries, especially those high-risk persons qualifying for ECM**:** "[CalAIM's] goal is to enhance the quality of life and health outcomes for Medi-Cal members." [68]

2. Reducing Healthcare Costs

There are major concerns that Medi-Cal funding by the federal government may, in the near future, be substantially reduced,[69] especially since "Federal funds typically make up one-third of the state budget. Medi-Cal relies on $107.5 billion in federal funds in the current budget year, nearly two-thirds of all federal dollars received by the state.".[70]

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[65] ECM Transformation (n 12)
[66] Hospitals Commission (n 35) page 5
[67] ECM Transformation (n 12)
[68] Hospitals Commission (n 35) page 5
[69] Luna, Taryn, "Newsom to ask California legislature for another $2.8 billion to cover Medi-Cal cost overruns" Los Angeles Times (March 17, 2025) https://www.latimes.com/california/story/2025-03-17/newsom-to-ask-california-legislature-for-another-2-8b-to-cover-medi-cal-cost-overruns (accessed March 21, 2025)
[70] Luna, Taryn, "Cost of undocumented healthcare in California is billions over estimates, pressuring Democrats to consider cuts," Los Angeles Times (March 13, 2025).

The State will almost certainly face Medi-Cal funding cuts, undoubtedly requiring it to respond by substantially reducing costs or slashing services; and it's of course to everyone's benefit to focus on cost reductions to the extent possible.

CalAIM focuses on healthcare costs, recognizing that **"**[m]ore than half of Medi-Cal spending is attributed to 5 percent of members with the highest-cost needs."[71] And the State rightfully assumes that those qualifying for ECM encompass a substantial portion of that medically challenged five percent:

> "[T]he highest cost enrollees typically are being treated for multiple chronic conditions … and often have mental health or substance abuse disorders. Costs for this population often are driven by frequent hospitalizations and high prescription drug costs. In some cases, social factors like homelessness play a role in the high health care utilization of these enrollees."[72]

Although detailed studies have not yet been conducted to confirm how significantly CalAIM will reduce healthcare costs, precursors to the CalAIM program support its cost benefits:

> "Patients who received services under WPC [i.e., Whole Person Care] or HHP generally saw a reduction in emergency department visits and hospitalizations, along with overall lower health care costs due to lower utilization of certain services."[73]

3. **Combatting Homelessness.** CalAIM recognizes that in order to embrace the well-being of Medi-Cal beneficiaries and reduce overall healthcare costs, a central focus must be the elimination of homelessness,[74] which is discussed in detail in the next Chapter. By focusing on those Medi-Cal beneficiaries most at risk of homelessness, one simultaneously has a huge impact on personal health while substantially reducing overall healthcare costs.

D. What is the Promise of CalAim? The promise of CalAIM is both simple and profound: "The goal of CalAIM is to transform Medi-Cal to be a "more

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https://www.latimes.com/california/story/2025-03-13/3b-above-estimates-democrats-in-california-face-pressured to-cut-medi-cal-for-undocumented-immigrants (accessed March 21, 2025)

[71] ECM Transformation (n 12)

[72] Legislative Analyst (n 13) page 3

[73] ibid

[74] CalAIM and Homelessness (n 19)

coordinated, person-centered, and equitable health system that works for all Californians."[75] [76]

PART 2

CalAIM AND THE HOMELESS

In CalAIM, the State has created one of the most powerful weapons in the war against homelessness, and we argue that LA County should put CalAIM front and center in addressing this major social challenge. We specifically argue that DHS and LA General are positioned to implement CalAIM in a manner that could have a huge impact on the homeless; not by hiding them away, but by directly addressing their health and social needs so that they have the best possible chance to find shelter and reintegrate into society.

The following is a short summary of CalAIM's specific potential regarding homelessness

A. CalAIM was Created to Address Housing

Medi-Cal is generally perceived by the public as a health insurance program, but CalAIM transforms it into a major weapon against homelessness. In fact, at the launch of the CalAIM program, the Department of Health Care Services created a Fact Sheet to describe how CalAIM was specifically structured to attack homelessness, emphasizing that "CalAIM reflects a long-term commitment to addressing California homelessness crisis through strategic use of Medi-Cal and other resources."[77] In a letter to homeless advocates accompanying the Fact Sheet, Jacey Cooper, the State Medicaid Director, emphasized that "CalAIM is designed to provide robust, statewide housing services for Medi-Cal members who are affected by homelessness and housing instability."[78]

B. ECM: Both Preventing and Addressing Homelessness

One of CalAIM's essential features is the assignment of an individual Care Manager to assist each beneficiary in both finding shelter and addressing related social and health issues. CalAIM ensures that each beneficiary has this singular point of contact, a personal bureaucracy "whisperer," to assist in

[75] Hospitals Commission (note 35) page 5

[76] This Report's primary focus is on improving healthcare for a very narrow population of at-risk Medi-Cal beneficiaries estimated at from 3% to 5% of the managed Medi-Cal population**.** (See ECM Transformation (n 12).) We contend, however, that by creating the infrastructure for an integrated health system to address this narrow population, we will establish a template for healthcare integration that has the potential to promote health and social services for the benefit of all County residents.

[77] CalAIM and Homelessness (n 19)

[78] ibid

stitching together the many social and health services needed for personal well-being, including associated housing:

> "Depending on which services beneficiaries require, they may need to navigate multiple delivery systems, which can make it difficult for beneficiaries to receive all the services that their conditions would indicate are needed. Difficulties navigating Medi-Cal's multiple systems can be particularly pronounced for individuals with multiple complex conditions."[79]

In order to qualify for CalAIM, one needs to both participate in managed Medi-Cal and qualify as a member of a Population of Focus (POF); and there are four POFs that are directly relevant to homelessness. First, those who are homeless constitute a specific POF, so CalAIM is immediately available to anyone who needs assistance in finding and maintaining shelter. However, there are three other POFs that are equally important regarding services for those who are homeless or at risk of becoming so: Mental Health, Substance Abuse and Prior Incarceration.[80]

Many of the homeless have social comorbidities. For example, "31% substance abuse disorder and 24% serious mental illness [was] reported by unsheltered homeless people in the most recent count" in LA County. Further, in a recent Statewide survey of the homeless, 66% of those surveyed indicated serious mental health symptoms in the prior 30 days,[81] and 35% were active users of harmful substances at least three times a week (with most of that use involving amphetamines).[82]

These mental health and substance abuse comorbidities often afflict the homeless, but, of equal importance, they are also frequent precursors to homelessness. Accordingly, CalAIM, by independently focusing on mental health and substance abuse, is not only a powerful means to alleviate homelessness, but to prevent it as well.

CalAIM's focus on prevention is also an essential aspect of a fourth POF that encompasses those who have recently been incarcerated. Nineteen percent of the homeless actually entered homelessness directly from a jail setting; and 30% of the homeless experienced a jail stay during their period of homelessness.[83]

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[79] Legislative Analyst (n 13) pages 2-3

[80] The three most common POFs that members have qualified under are individuals experiencing "homelessness, individuals at risk for hospitalization, and individuals with a serious mental illness or substance abuse disorder." Each of these categories recently had about 50,000 enrollees, with all of the others in the aggregate having only 25,000 enrollees. (Legislative Analyst (n 13) page 10.)

[81] Homeless survey (n 59) page 59

[82] ibid page 61

[83] ibid

C. Community Supports – Focusing on Housing Assistance

The focus of CalAIM on housing and shelter for the homeless is highlighted by the fact that virtually all of the Community Supports are housing related. Specifically, Community Supports "are a set of 14 community services (mostly housing related) in which communities can use existing funds to pay for community benefits. [84] These included housing, food support, transportation and more." (LA Care currently makes all 14 Community Supports available for ECM beneficiaries.)[85]

In the Legislative Analyst's recent report on CalAIM, these supports are separated into three categories:[86]

1. "Housing–related services" (the "housing trio"), including housing transition/navigation services; housing deposits; and housing tenancy and sustaining services; [87]
2. "Recuperative Services," including recuperative care (medical respite),[88] respite services and sobering centers; and
3. A variety of services to enable members to remain in a homelike setting, such as medically tailored meals, assisting with daily living activities and home modifications.[89]

D. Qualifying for CalAIM – Facilitating Medi-Cal Enrollment

In order to participate in CalAIM, it's necessary to enroll in Medi-Cal and participate in a Medi-Cal managed care program. This is not, however, a barrier for the homeless, since the vast majority of the homeless are either Medi-Cal beneficiaries or Medi-Cal eligible. In fact, one of the benefits of CalAIM is that it's a vehicle to identify those who are Medi-Cal eligible but have not yet enrolled, opening an opportunity to assist them in obtaining MediCal coverage.

Based on a 2023 Statewide homeless survey, 75% of the homeless participate in Medi-Cal, with 17% having no insurance coverage, including

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[84] Transformation of Medi-Cal: Community Supports, HCS https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf (accessed February 13, 2025)

[85] CalAIM Community Supports – Managed Care Plan Elections https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf (accessed February 13, 2025)

[86] Legislative Analyst (n 13) page 5

[87] ibid

[88] Recuperative care is recognized as one of the most important CalAIM benefits to avoid homelessness, addressing members with unstable housing who no longer require hospitalization, but still need to heal from an injury or illness. With "recuperative care," beneficiaries receive short-term residential care, including housing, meals, ongoing monitoring of the member's condition and coordination of transportation to appointments. Legislative Analyst (n 13)

[89] Legislative Analyst (n 13) page 5

Medi-Cal.[90] Of the homeless between the ages of 18 and 24, a much smaller percentage, 54%, participate in Medi-Cal, with 35% of them having no insurance coverage, including Medi-Cal.[91] It seems likely in both cases that most of those without insurance would be eligible to enroll in Medi-Cal, with CalAIM providing an opportunity to identify those who need assistance in obtaining such coverage.

(There certainly might be some small percentage of the homeless who would be ineligible for Medi-Cal, but are nonetheless deserving of housing assistance. The County could of course provide them with that assistance using the CalAIM framework, albeit without the supplemental Medi-Cal funding.)

E. Using Healthcare System Interactions to Access and Recruit CalAIM Participants

In considering the sufficiency of CalAIM to recruit those needing and desiring housing assistance, it's important to be flexible:

1. The County is in a unique position to use a variety of mechanisms to identify homeless persons who are accessing care at County health facilities (recognizing that the County, as discussed in Part 4, is not yet fully taking full advantage of this unique opportunity). Focusing on healthcare interactions will identify and access a surprising percentage of the homeless, including many with the greatest needs. According to the referenced 2023 homeless survey, 38% of the homeless visited an ED at least once in the prior six months (and 9% visited an ED three or more times during that period) [92] Twenty-one percent reported an inpatient stay during that period (which is substantially higher than the general population)**.**[93] In the case of 18 to 24 year olds, the percentage with at least one inpatient stay increased surprisingly to 29%.[94] Clearly, focusing on healthcare services should capture a large number of the homeless having the greatest need for CalAIM services.

2. We are not suggesting, however, that interactions of the homeless with the healthcare system should be the exclusive means of recruiting homeless beneficiaries into the CalAIM program. Certainly, successful outreach programs to connect with the homeless in the community, whether on Skid Row or in homeless encampments, should continue.

3. It's also important to recognize that the County may connect with homeless individuals who need and desire housing assistance, but are

[90] Homeless Survey (n 59)
[91] ibid at page 58
[92] ibid at page 58
[93] ibid
[94] ibid

not eligible for CalAIM because they are either not interested or able to enroll in the Medi-Cal program. Although CalAIM participation should be seen as an opportunity, it should not, as noted above, be a condition to receiving necessary assistance.

F. Ancillary Benefits of Using CalAIM as a Framework for Addressing Homelessness

In addition to the direct benefits of using CalAIM to address homelessness, there are four major ancillary benefits. First, as discussed above, CalAIM provides a vehicle and incentive to enroll eligible beneficiaries in Medi-Cal, thereby giving them access to health insurance. Second, CalAIM is a vehicle to obtain enhanced Medi-Cal funds to address homelessness. Third, CalAIM provides a strategic framework for addressing homelessness, which should help to avoid the apparent lack of strategic focus under LHASA's historical management of homeless initiatives. Fourth, a major challenge for any social services program is to assess its actual benefits, achievements and success, and, as discussed below, CalAIM provides a framework for generating "outcome assessments" regarding both beneficiary health and program costs.

G. Respecting the Homeless Through Integrated Care (and Avoiding the Pitfalls of "Housing First")

Let's be honest:

When addressing homelessness, there is often political pressure to give housing itself the highest priority, not because that is necessarily the most effective way to address homelessness, but because the public is frequently most concerned with reducing the impact of the homeless on their communities. As such, it is often argued that the focus should be on aggressively addressing housing, with social and health issues being follow-up issues of secondary concern.

Sadly, when it comes to homelessness, the public's primary focus often seems to be on the inconvenience and unpleasant aesthetics of dealing with the homeless; in most cases, the public is happy if the homeless disappear into any available shelter, caring little about where they've gone or their ultimate well-being.[95] We see this perspective often embedded in "Housing

[95] How cities deal with the homeless in the context of mega-events such as the Olympics is a good example of the public focusing on aesthetics over care. "Displacing people experiencing homelessness from a mega-event host city allows attendees to ignore that city's housing and homelessness crises ahead of large global events and only serves to exacerbate social inequities." Holly, Edward, "Hiding a City's Homelessness Crisis Through Displacement: What the Olympics Remind Us about Harmful Practices," National Alliance to End Homelessness (August 6, 2024) https://endhomelessness.org/blog/hiding-a-citys-homelessness-crisis-through-displacement-what-the-olympics-remind-us-about-harmful-practices/ (accessed March 21, 2025)

First" policies, which have been increasingly criticized for taking an ineffective and even callous approach to the homeless, accepting homelessness as a problem to be deferred rather than cured:

> **"**We've all heard the statement, "Housing First does not mean housing only," and it is true. To be effective, there needs to be both housing and supportive services (i.e., health care, behavioral health services, substance use disorder treatment, employment/education supports, etc.) that meets the needs and choices of the people being served. If both are not available and accessible, then a program is not actually using a Housing First approach."[96]

> **"**Experience shows us that this [housing first] approach, in effect since 2016, is more of a cover-up than a solution. It doesn't treat the root causes of homelessness, which for many are addiction or mental illness. It simply institutionalizes the homeless."[97]

CalAIM recognizes that access to housing and healthcare services interact to create a virtuous cycle (and the absence of either can create a death spiral). Homelessness is a major contributor to adverse health issues, and, if you can reduce homelessness, you will significantly increase the health and well-being of beneficiaries. And, conversely, if you address the health and well-being of beneficiaries, it will significantly reduce the likelihood of future homelessness. Accordingly, CalAIM is simultaneously focused on getting people off the street into shelter and aggressively working with them to manage their social and health needs.

CalAIM requires that we actively engage with the homeless rather than hide them away, providing them with both care and respect

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[96] Thompson, Marcy, "The Truth About Housing First," National Alliance to End Homelessness," page 5 September 22, 2023) https://endhomelessness.org/blog/the-truth-about-housing-first/ (accessed March 21, 2025)

[97] Winegarden, Wayne; Jackson, Kerry, "Housing First Programs aren't Working" Pacific Research Institute, page 2 (August 20, 2022) https://www.pacificresearch.org/housing-first-programs-arent-working/#:~:text=It%20doesn't%20treat%20the,%2C%E2%80%9D%20says%20the%20Cicero%20Institute. (accessed March 21, 2025)

PART 3

WHERE IS CalAIM FALLING SHORT?

CalAIM's promise currently falls short in three broad areas. First, there are many ongoing impediments to the enrollment of Community Supports providers, which makes it challenging to develop a robust Community Supports network that coordinates and communicates effectively. Second, the CalAIM program's success rate in enrolling ECM eligible beneficiaries is far below reasonable expectations. Third, there seems to be little focus on generating the outcome metrics that are necessary to justify the substantial, ongoing investment in CalAIM required for its success.

A. Compensation Issues for Providers of ECM and Community Supports

The basic question is whether ECM and Community Supports providers are receiving adequate compensation that, at minimum, meets their costs. In a recent survey of CalAIM providers (both ECM and Community Supports) in Southern California, 83% said the payment rates are not covering the cost of services, [98] and DHS has adamantly agreed.[99] Forty-seven percent of ECM providers and 41% of Community Supports providers also indicated that the inadequate compensation arrangements are "very challenging."[100] (The percentage of providers expressing concern would have undoubtedly been higher in the absence of DHS subsidies (discussed below), Providing Access and Transforming Health (PATH) grants (also discussed below) and other funds that have made up some portion of the overall shortfall.)[101]

The County Departments participating as ECM providers uniformly note "low reimbursement rates" as a major challenge. [102] In fact, DMH, in considering (and tending toward rejecting) the feasibility of expanding its ECM program, notes as a major negative that its "break even analysis results show that reimbursement […] does not cover the majority of program costs."[103]

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[98] Goodwin Simon Strategic Research, "CalAIM Experiences: Implementation Views in Year Three of Reforms,: California Health Care Foundation," California Health Care Foundation, page 32 (December 16, 2024) https://www.chcf.org/wp-content/uploads/2024/12/CalAIMExperiencesImplementerViewsinYearThreeofReforms12132024.pdf (accessed February 13, 2025)
[99] Interview with DHS leadership
[100] CalAIM Survey (n 99) pages 28 and 30
[101] ibid at page 32
[102] "Enhanced Care Management (ECM) Updates: Board Informational Briefing," PowerPoint presented by DHS, DMH, DPH, DCFS and JCOD (December 1, 2024)
[103] ibid

CalAIM providers also note issues with "delays in receiving reimbursements," with 30% of ECM providers and 41% of Community Supports providers stating that such delays are "very challenging."[104]

Finally, in connection with payment denials, "DHS has reported that many CS [Community Supports] service referrals were initially denied. Although this situation has reportedly improved, particularly for recuperative care, [the Hospitals and Health Care Delivery Commission recommends] this situation should be closely monitored going forward."[105]

B. Lack of Standardization by Managed Care Plans and Additional Bureaucratic Burdens for ECM and Community Supports Providers.

The Hospitals and Health Care Delivery Commission notes that "providers across LA County […] manage significant administrative burdens and reporting requirements when participating in ECM and CS [Community Supports] programs. The lack of standardization across Health Plans in reporting requirements and, authorization processes and data sharing, necessitates compliance with multiple data systems and approaches."[106] The Commission further notes that the "lack of standardization across Health Plans […] has created significant administrative burdens and added costs, leading some providers to question the feasibility and cost-effectiveness of participating in CalAIM's ECM and CS programs."[107] Further, the State Legislative Analyst's Office notes that "[e]ven three years into the program, unfamiliarity with the ECM and Community Supports benefits and how to provide them as a Medi-Cal benefit are major challenges for providers to enter MCP networks."[108]

According to the Hospitals and Health Care Delivery Commission, regulatory changes and proposed legislation in 2024 were expected to promote better alignment of the Health Plan data systems, [109] although it appears that may be wishful thinking. In fact, DHS notes that there are "[i]ncreasing changes and less standardization across all MCPs."[110] In support of that conclusion, a survey of CalAIM providers indicates that lack of standardization continues to be a problem, with 47% of ECM providers and 40% of CS implementers indicating this issue is "very challenging."[111] CalAIM providers also noted the continuing burdens of complying with reporting and documentation requirements under CalAIM (most of which, according to LA Care, are mandated by the State), with

[104] CalAIM Survey (n 99) pages 28 and 30
[105] Hospitals Commission (n 35) page 8
[106] ibid at page 7
[107] ibid at pages 7-8
[108] Legislative Analyst (n 13) page 13
[109] ibid page 8
[110] ECM Board Briefing (n 103)
[111] CalAIM Survey (n 99)

27% of ECM providers and 22% of Community Supports providers indicating these requirements are "very challenging."[112] DHS, as both an ECM and Community Supports provider, confirmed that these requirements are extremely onerous, even for an organization with the resources of DHS,[113] and specifically noted the "[c]omplex and time-consuming processes for reauthorization."[114]

C. Fragility and Isolation of Community Supports Providers

As described above, Community Supports providers face many challenges, including burdensome reports, non-standardized compliance requirements, billing and collection challenges, and inadequate compensation. If these concerns aren't adequately addressed, it's reasonable to fear that valuable providers of Community Supports, especially Community Based Organizations, will leave the program, reducing important beneficiary access to services. For example, DMH has questioned the feasibility of expanding its important participation in CalAIM based on inadequate compensation and administrative demands.[115]

D. Lack of Optimal Communication Among ECM and Community Supports Providers

Another issue is a lack of ongoing connections between ECM and Community Supports providers. This is especially a problem with ECM providers affiliated with healthcare entities, such as hospitals, that have an independent provider relationship with their ECM eligible beneficiaries. In those cases, the fact that ECM beneficiaries will likely have recurring needs for hospital care means that ongoing coordination between the ECM Care Manager and Community Supports providers is essential to maximize the well-being of the beneficiaries. (LA Care indicated it was unaware of major communication issues between ECM and Community Supports providers, but at the same time recognized the importance of those communications and indicated it would support their strengthening.)

Community Supports for a beneficiary can be initiated by various sources, although approval by the MCP is required in all cases. Based on a recent survey, nearly two-thirds of all requests come from the MCP itself, another provider of Community Supports, or through self-referral or another caregiver.[116] Surprisingly, only five percent of referrals for Community Supports come from ECM providers.[117] This fact is consistent with what appears to be a frequent disconnect between ECM Care Managers and

[112] ibid
[113] Interview with DHS leadership
[114] ECM Board Briefing (n 103)
[115] ECM Board Briefing (n 103)
[116] CalAIM Survey (n 99)
[117] ibid

Community Supports providers, especially regarding inadequate follow-up by a Community Supports provider to the responsible ECM Care Manager. At least one ECM provider has indicated that, as a result of this lack of ongoing communication with the providers of Community Supports, it is seriously considering providing essential Community Supports itself in order to close that communication gap.

E. Low Enrollment of Medi-Cal Beneficiaries in ECM.

"Participation and utilization of CalAIM have been lower than anticipated, particularly for the ECM's program's target populations[118] and this trend is evident both statewide and in Los Angeles County."[119]

"The Department of Health Care Services (DHCS) has estimated that between 3 percent and 5 percent of all MCP members statewide are potentially eligible for ECM, " but that "[t]he percent of MCP members statewide utilizing ECM […] in 2022 was [only] 0.6 percent […] increasing to [just] 0.9 percent in 2024."[120] In the specific case of the homeless, "[o]nly about one-fifth of all MCP members that identified as homeless … were receiving ECM services in 2023."[121][122]

In order to create enrollment goals and measure success, it's necessary to estimate what would constitute full enrollment. In this regard, LA Care uses a simple formula to determine a "ballpark" figure for the number of ECM eligible beneficiaries likely to be recruited. LA Care assumes, based on State estimates, that, as noted above, between 3% to 5% of Medi-Cal beneficiaries are eligible for ECM. It also assumes, based on general enrollment experience, that only 30% of Medi-Cal beneficiaries identified as ECM eligible will actually enroll, either because of difficulty in making personal contact or because they affirmatively reject participation.[123] (A low enrollment success rate is both confirmed and elaborated by DHS based on its ECM enrollment experience, discussed in more detail, below.)

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[118] LA Care representatives noted that the slow start for ECM enrollment was likely due in part because its commencement on January 1, 2022 occurred during the Covid pandemic, making personal contacts, which is essential for enrollment, challenging if not impossible.

[119] Hospitals Commission (note 35) at page 6

[120] Legislative Analyst (n 13) page 1

[121] ibid

[122] Although participation has not reached anticipated levels, DHCS notes that "the number of members served by Enhanced Care Management quarter over quarter continues to rise; in Q4 2023 approximately 96,000 members received Enhanced Care Management [Statewide], a 40 percent increase from Q4 2022." Success of Transformation (n 36)

[123] Interview with LA Care representatives

In LA County, there are approximately 4.7 million persons who are covered by Medi-Cal, with 2.7 million of those enrolled with LA Care.[124] Based on LA Care's assumptions, there would be an estimated 108,000 Medi-Cal beneficiaries in LA County who are enrolled with LA Care and ECM eligible,[125] but, considering the estimated 30% enrollment success rate, only 32,000 of those are likely to be enrolled in ECM based on beneficiary access and interest.

LA Care indicated that approximately 20,000 of its 2.7 million enrollees are enrolled in ECM. Is this a satisfactory number? If you accept the validity of the 30% enrollment success rate, the comparison is between 20,000 actual enrollees and 32,000 potential enrollees, which seems like a positive start given LA Care's ongoing ECM enrollment initiatives. However, if you compare it with the 108,000 beneficiaries enrolled with LA Care who are likely eligible for ECM, 20,000 enrollees seems to fall far short of acceptable goals.

In evaluating current ECM enrollment success in LA County, it's crucial to consider the validity of the assumed 30% success rate; and, as discussed below, we believe LA General's participation as an ECM provider will allow us to test this validity.

F. Lack of Data Collection and Evaluation of Desired Health and Cost Outcomes.

The Hospitals and Health Care Delivery Commission notes "[t]here is a lack of data reporting on outcomes, including process measures that define intermediate outcomes […]. Without this data it is difficult to evaluate the effectiveness of CalAIM initiatives and determine their success."[126]

LA Care informed us that the MCPs participating in CalAIM were initially accumulating data for the purpose of evaluating the effectiveness of the program, but, in mid-2023, the State directed the MCPs to cease such activities, since the responsibility for such data collection and evaluation was being assumed by the State.[127] However, LA Care is unaware of any State activities or pending reports in this regard.

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[124] Reyes, Emily Alpert, "Tens of thousands of L.A. County residents could soon lose Medi-Cal coverage, Here's why," Los Angeles Times (July 1, 2023) https://www.latimes.com/california/story/2023-07-01/tens-of-thousands-la-county-could-lose-medi-cal-coverage#:~:text=L.A.%20Care%20projects%20that%2013,Cal%20obtain%20other%20health%20coverage. (accessed March 21, 2025)

[125] We assume 4% of Medi-Cal beneficiaries are ECM eligible in our computational approximations

[126] Hospitals Commission (n 35) page 7

[127] Interview with LA Care representatives

Although CalAIM's potential to substantially reduce healthcare costs is logically indisputable, it's essential to generate data and studies to support that conclusion in order to justify an appropriate expansion of the program. The State's Legislative Analyst's Office in its recent report on CalAIM emphasized the importance of such studies:

> "More information is needed to assess cost-effectiveness and improvements in health outcomes […]. [T]he Legislature may wish to direct ongoing evaluations to determine whether ECM and Community Supports result in net savings to the state and/or improved health outcomes to beneficiaries."[128]

> "We recommend the Legislature consider requesting additional information from DHCS to enable it to […] ensure that a system is in place to allow for robust, ongoing evaluation of the cost-effectiveness of the benefits and their impact on health outcomes."[129]

PART 4

DHS AND CalAIM: THINKING SMALL[130] (BUT BRILLIANTLY)

DHS has made a major commitment to CalAIM, and has specifically made a major financial investment in the creation of a robust Community Supports network. In this Part, we describe the nature of DHS's participation in CalAIM and specific actions it has taken to create an effective Community Supports network. We also note that DHS's chosen role in CalAIM limits its potential impact on ECM enrollment, and that we need to look elsewhere (we suggest LA General) for solutions regarding increased enrollment.

A. The Nature of DHS's Participation in CalAIM

As an ECM provider, DHS focuses exclusively on Medi-Cal beneficiaries who are enrolled in one of the 30 Primary Care Medical Homes (Medical Homes) operated by DHS (each of the County Hospitals being included as a component of one of those Medical Homes).[131] From that population, DHS identifies potentially eligible ECM enrollees by applying an algorithm to the medical record data base covering medical and related services provided to those assigned beneficiaries.[132] Once the algorithm identifies a potential ECM beneficiary, a DHS Community Health Worker attempts to contact the

[128] Legislative Analyst (n 13) page 16
[129] ibid at page 1
[130] "Small" is of course a relative term. DHS, as an ECM provider, focuses on its empaneled population, which it estimates at approximately 500,000. (Interview with DHS leadership.) This is a small number only in comparison with the 4.7 million Medi-Cal beneficiaries who live in LA County. (Medi-Cal Coverage n 124)
[131] Interview with DHS Leadership
[132] DHS implemented the ECM algorithm relatively recently in July 2024. ECM Board Briefing (n 103)

beneficiary (making up to five attempts) to discuss ECM enrollment. In addition to using the algorithm, a DHS healthcare worker (e.g., an LA General physician) who believes a patient potentially qualifies for ECM may also contact the DHS ECM unit with a request to evaluate the patient for ECM eligibility. In that case, the DHS ECM unit will first determine whether the patient is empaneled with DHS, and then assess the beneficiary's potential eligibility under the algorithm. This review process typically takes from 24 to 48 hours.[133]

B. DHS's Partial Solution to Deficiencies in the Community Supports Network.

LA Care acknowledges that DHS is one of its most important providers of Community Supports, especially in the housing category, with over 15,000 beneficiaries having received housing navigator and tenancy support services from DHS.[134] DHS's success in this regard is attributable to its creative solutions to many of the hurdles in establishing effective Community Supports under CalAIM.

DHS understands the importance and challenge of supporting individual providers of Community Supports.

> "Community-based organizations (CBOs) are a critical part of our delivery system […]. [Recognizing] the challenge that we have of coordinating our programs with thousands of services organizations that work with us […]. [S]uccess […] requires an upfront investment in building capacity in community-based entities that deliver the full suite of services we know are needed for these populations."[135]

DHS has in fact created a robust Community Supports Network through creative solutions to inadequate compensation and coverage, onerous bureaucratic procedures, and individual isolation and fragility. Specifically, DHS's solution has been to assume the role of a primary contractor with

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[133] This ECM evaluation process would be ineffective for LA General ED patients, since approval of the beneficiary typically won't occur for 24 or more hours, probably long after the beneficiary has left the ED, thereby losing the benefits of personal contact. .

[134] Interview with LA Care leadership

[135] Hong Interview (n 34)

the MCPs, and then subcontract with Community Supports providers[136] (in most but not all cases).[137] This approach has the following benefits:

1. DHS takes on the regulatory responsibilities of being a Medi-Cal provider, which means a subcontractor doesn't need to enroll as a Medi-Cal provider, substantially expanding the universe of available Community Supports providers.[138]

2. DHS assumes many of the burdens of being a contracting provider, such as billing, which means Community Supports providers don't need to deal directly with MCP contracting hassles.

3. DHS supplements MCP compensation to address insufficient payments.

4. DHS fronts payment when MCP payments are delayed.

5. DHS expands coverage and payment beyond what's approved by MCPs when appropriate, e.g., Community Supports coverage for recuperative care is generally limited to three months, but DHS may expand that up to eight months if medically appropriate. Another example of expanded coverage is the availability of certain rental subsidies not covered by CalAIM.

6. DHS also provides certain operational support, such as IT support.

As a general matter, DHS is also in a better position to negotiate MCP rates (as compared with individual Community Supports providers) and, similarly, is in a better position to lobby for the collective interests of the Community Supports providers, both with MCPs and the State.

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[136] The Justice Care and Opportunities Department (JCOD), which is in the process of enrolling as an ECM provider, has also expressed a commitment to this "ECM Hub-and-Spoke Model" under which it subcontracts with Community Based Organizations that may not be directly contracted with MCPs, but "who are trusted in their community and have experience serving the [Justice Involved] Population." ECM Board Briefing (n 103)

[137] DHS does not subcontract with all providers of Community Supports in its network, e.g., it does not subcontract with sobering centers and providers of home modifications. Interview with DHS Leadership.

[138] "While many CBOs are not government contractors, some are the best equipped to engage the populations they serve. We're missing an opportunity if we don't partner with them and take advantage of their deep ties to people right there in that community." Hong Interview (n 34)

C. What DHS's Partial Solution Fails to Address

While DHS brilliantly addresses the challenge of adequate Community Supports under CalAIM, it fails to address ECM recruitment, since DHS has limited its ECM population to those beneficiaries already empaneled with DHS. While this decision is understandable given the fact that DHS's compensation under CalAIM falls substantially short of DHS's costs, especially given its decision to subsidize many of the Community Supports providers in its network, it means there is a significantly missed opportunity to increase ECM enrollment in LA County.

DHS leadership estimates the number of its empaneled beneficiaries at approximately 500,000 out of more than 4 million Medi-Cal beneficiaries in LA County. DHS, as an ECM provider, enrolled 5,531 unique ECM beneficiaries from its empaneled beneficiaries during 2024, and it indicates that at any one time it has approximately 3000 active ECM enrollees, with an average length of enrollment being approximately 11 months.[139] As discussed in the next Chapter, this compares with an estimated 26,000 ECM eligible beneficiaries seen in the LA General Emergency Department during a recent twelve month period (approximately 15,000 enrolled with LA Care and 8,000 enrolled with HealthNet).[140]

There is clearly a missed opportunity here that, as discussed in the next Part, LA General is poised to exploit.

PART 5

LA GENERAL AND CalAIM – THINKING BIG!

While DHS has creatively addressed many of the major problems for Community Supports under CalAIM, LA General is positioned to address several of the current deficiencies in the overall implementation of CalAIM:

Increasing Enrollment. LA General could contribute to the CalAIM program in many ways, but its most crucial contribution will likely be its exceptional ability to increase ECM enrollment. There have been huge challenges in enrolling at-risk beneficiaries into the CalAIM program so that their medical and social needs can be effectively managed*. LA General has special access to those beneficiaries and the relationships to facilitate and accelerate their enrollment.* We evaluate

[139] DHS is required by the State to evaluate continuing ECM eligibility once every six months. Interview with DHS leadership

[140] We discussed with DHS leadership the possibility of expanding ECM enrollment to County Hospital EDs. They noted that, given the inherent nature of an ED, they would likely identify many potentially ECM eligible patients who are not empaneled with DHS, and that it's a time-consuming process to determine with whom an individual beneficiary is empaneled. Therefore, given its focus in DHS empaneled patients, ECM enrollment in County Hospital EDs would not be cost effective from their perspective.

the specific numbers in detail below, but it appears that LA General itself could likely meet and perhaps substantially exceed the ultimate ECM enrollment goals for LA County

Reducing Costs. There are huge opportunities to reduce overall healthcare costs by effectively managing the care of high-cost Medi-Cal beneficiaries. *LA General has the knowledge, motivation and experience in reducing its own costs, and is strategically positioned to substantially reduce those costs further using the tools of CalAIM.* Further, because of inadequate State funding, those costs reductions are a potentially important financial engine for CalAIM, as discussed in detail, below.

Enhancing Health. The success of CalAIM depends on keeping beneficiaries healthy by aggressively providing preventive care to avoid hospitalization as well as post-discharge care to avoid readmissions. *LA General has valuable experience with its patient discharge protocols for the purpose of stabilizing patients following discharge, and additional CalAIM tools would provide substantial enhancements*

Creating a Network of Community Supports. ECM is the enrollment and management feature of CalAIM, but the funding of Community Supports is also important, since it ensures the availability of essential social services, especially those focused on homelessness, necessary for the overall well-being of eligible beneficiaries. *As noted above, DHS has already created a robust network of Community Supports that could be supplemented by the many relationships LA General has with various organizations providing post-discharge support for patients. LA General is also strategically connected with the new Restorative Care Village on its campus, which has the potential to be a valuable hub for non-hospital clinical services, especially recuperative care and associated Community Supports.*

Outcome Studies. The long-term success of CalAIM will depend on developing "outcome" studies that "prove" that CalAIM initiatives actually enhance the health of our most vulnerable residents while reducing costs. *LA General is uniquely positioned to generate, access and evaluate data regarding the impact of CalAIM initiatives on the number and type of hospital admissions, which is highly correlated with well-being and healthcare costs.*

The following is a more detailed discussion of LA General's potential contributions to three of the most critical areas necessary for CalAIM's success: (1) ECM enrollment, (2) cost reduction, and (3) outcome metrics "proving" CalAIM's success.

A. ECM Enrollment: LA General has the potential to have a profound impact on ECM enrollment under CalAIM. As we discuss, this is for two reasons: LA General is a major contact point for ECM eligible patients, especially in its Emergency Department, and, further, its unique access to and

relationship with those patients has the potential to significantly increase the usual enrollment success rate. It's important to emphasize that we are not recommending that LA General replace DHS as an ECM provider, but rather that their different approaches be recognized and managed as complementary.

1. LA General Is a Major Contact Point for ECM Eligible Patients

In comparing ECM eligibility requirements and LA General demographics, there is remarkable overlap.

In order to be eligible for ECM, a beneficiary has to be enrolled in a Medi-Cal managed care program, such as LA Care, and have certain characteristics that put the beneficiary into a "Population of Focus," specifically including: (1) homelessness, (2) high avoidable use of hospital or emergency department care, (3) serious mental health and/or substance use disorder needs, (4) at risk for long-term care institutionalization, and (5) transitioning from incarceration.[141]

LA General's patient population is strongly aligned with these ECM target populations:

As an initial matter, 74% percent of LA General's patients are covered by Medi-Cal, with 88% of those being enrolled in managed care, meaning that 65% of the LA General patient population meets the first hurdle of ECM participation.[142] (Although 12% of LA General's Medi-Cal patients are not currently enrolled in managed care, if it's determined they have medical or social conditions that warrant ECM, they presumably would have an opportunity to enroll in order to become eligible.)

Further, LA General is located in an area where many in the ECM target populations reside. For example, LA General is 2.5 kilometers from Skid Row, the largest concentration of homeless individuals in the United States, many of whom also have significant mental health and substance use disorders.[143] Based on data prepared by LA General, it's clear that many in that population utilize LA General for hospital care.[144]

LA General has generated data that summarizes its Emergency Department (ED) visits for most of 2023-2024, identifying patients

[141] ECM Transformation (n 12)
[142] PowerPoint presentation for CGJ tour of LA General on October 6, 2024
[143] ibid
[144] ibid

potentially in the ECM target populations.[145] During the time covered, there were 20,199 ED visits by patients enrolled in LA Care, and an amazing 15,476 (over 75%) had strong indications of ECM eligibility Specific categories included: homeless flag (13.8%); high utilizer, i.e., more than 10 visits in 12 months (10.3%); primary diagnosis of mental health or substance abuse (9.5%), and thirty day "bounce backs" (43%).[146] (According to LA General personnel, there have been few if any initiatives to enroll these patients in ECM.)[147]

LA General also generated data regarding patients enrolled in HealthNet, with similar results. Specifically, out of 10,029 ED visits by patients enrolled with HealthNet, 7,959 (or 79%) had strong indications of ECM eligibility.[148]

As described below, LA General estimates that more than 15,000 patients enrolled in LA Care seen in its ED during 2023- 2024 appeared likely to be ECM eligible; and, even using the conservative 30% enrollment success rate, this would mean an additional 4000 new ECM enrollees for LA Care. (It's also important to note that this number is solely focused on the LA General ED, so it doesn't include regularly admitted and discharged patients, who are also a likely source of ECM eligible patients given LA General's patient demographics.)

Clearly, there is a significant opportunity to expand ECM enrollment by focusing on ED visits at LA General, and in fact the Hospitals and Health Care Delivery Commission specifically suggests this strategy in connection with patient discharges from all of the County hospitals:

> "To improve the identification of individuals eligible for CalAIM, the Committee recommends exploring additional methods, such as focusing on unhoused individuals being discharged from the four county hospitals."[149]

2. LA General and that 30% ECM Enrollment Success Rate

According to LA Care, the State estimates a 30% enrollment success rate for beneficiaries identified as ECM eligible. We believe this assumed 30% enrollment success rate is significantly lower than what's reasonably achievable, and that LA General is the ideal context in which to test this assumption.

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[145] ED-ECM Table (n 8). As mentioned above, the State estimates that 3% to 5% of Medi-Cal beneficiaries are likely eligible for ECM. In contrast, it's truly extraordinary that over 75% of LA General's emergency department patients have strong indications of eligibility.
[146] ibid
[147] Meeting with LA General leadership
[148] ED-ECM Table (n 8)
[149] Hospitals Commission (note 35) page 7

An eligible beneficiary's failure to enroll in ECM is likely based on two factors. The first reason ECM eligible beneficiaries are not enrolled is that it can be difficult if not impossible to connect with them; for example, it can be extremely challenging to contact a beneficiary who is homeless and without regular contact information. DHS acknowledges that "ECM-eligible patients are generally hard to reach, resulting in high effort to engage and lower than anticipated enrollment volumes."[150] DPH also acknowledges "[e]xtremely low outreach yield rate [based in part on] poor quality health plan referrals and contact information."[151] In concrete terms, DPH notes that "[o]utreach attempts to 477 referrals […] yielded […] 2 enrollments [and] 2 pending enrollments."[152]

The challenge of contacting beneficiaries is of course eliminated if they are already being seen as an LA General patient. This is an important reason to use ED contacts for ECM enrollment, since all other strategies for making contact are so challenging. (We of course recognize it will still be important to utilize standard outreach approaches for ECM eligible persons who would not be captured by focusing exclusively on the hospital.)

The second reason ECM eligible beneficiaries are not enrolled is that enrollment is not automatic; rather, beneficiaries are given an option whether or not to enroll in ECM. There will certainly be some beneficiaries who will reject participation in any event, but we believe in many cases such rejections occur because there is no foundation of trust between the beneficiary and the ECM provider. However, in the case of LA General, the beneficiary usually develops a relationship with the beneficiary's specific healthcare providers that generates trust, which presumably should increase the enrollment percentage.

LA Care itself notes that enrollment is far more successful if there is a personal contact with a patient rather than indirect contact through a phone call or mail, and if you combine that personal contact with a relationship of trust, as should usually be the case in a hospital environment, it seems likely the expected enrollment percentage would increase, perhaps substantially.

DHS's more detailed data regarding its current ECM enrollment program suggests a 40% ECM enrollment success rate[153] (compared

[150] ECM Board Briefing (n 103)
[151] ibid
[152] ibid
[153] DHS's estimated 40% success rate is based on a review of data from September through November, 2024. See ECM Board Briefing (n 103). This success rate is higher than the State's estimated 30%, probably because of DHS's direct connection with its empaneled patients, but it's surprising the percentage isn't even higher given that connection.

with the State's 30% rate reported by LA Care), and also highlights where LA General's interactions with patients would likely enhance such success. Specifically, DHS has found that it is only able to make contact with ECM eligible beneficiaries 69% of the time.[154] (DHS generally requires five attempts at making contact.) Further, DHS has found that, of those contacted, only 58% agree to participate. In the case of LA General's ED patients, you should be able to connect with patients almost 100% of the time (barring occasional premature departures). It's also reasonable to assume that, with the special relationship between caregiver and patient, there should be an increase in the patients' decisions to enroll.

For the purpose of comparison, we assume in the context of LA General a connection rate of 95% and a decision to enroll in ECM at 70% (rather than the DHS's 58%). Using these conservative adjustments, the percentage comparisons reveal the substantial impact that LA General could have on the ECM enrollment success rate:

i. The State: 30%
ii. DHS: 40% (58% of 69)
iii. LA General: 66% (70% of 95).

It is clearly important to test the assumptions behind the State's presumed 30% enrollment success rate for ECM eligible beneficiaries, since they are the basis for crucial ECM strategies and goals, and LA General's participation in ECM will enable those assumptions to be effectively tested.

3. Coordinating Both DHS and LA General as ECM Providers

Despite various inquiries, LA General has not (until now) identified a strategy to facilitate the ECM enrollment of LA General's ED patients, notwithstanding the fact that LA General's internal data indicates a substantial percentage of such patients are likely ECM eligible.[155]

We believe LA General's best strategy to address this situation is to enroll as an ECM provider itself, a strategy that, as discussed below, has already been effectively pursued by Children's Hospital of Los Angeles (CHLA), another hospital with a high percentage of ECM eligible patients. LA General's enrollment would not only directly benefit LA General's patients, but should substantially contribute to the overall success of CalAIM because of LA General's incentive (1) to enroll substantial numbers of beneficiaries in ECM, (2) to generate data and outcome

[154] Interview with DHS Leadership
[155] Interview with LA General leadership.

assessments for beneficiaries enrolled in ECM, and (3) to facilitate an enhanced network of Community Supports providers as LA General manages its ECM responsibilities.

a. **Addressing DHS's Reservations in Providing ECM for Beneficiaries Not Empaneled With DHS**

DHS has decided to provide ECM and related Community Supports only for Medi-Cal beneficiaries who are empaneled with DHS, which makes economic sense from the County's narrow perspective, since there are significant costs in providing ECM Care Managers and associated Community Health Workers for which there is apparently inadequate compensation.

If LA General aggressively enrolls all ECM eligible beneficiaries identified in its ED, it will need to consider the costs of providing ECM and associated Community Supports for those beneficiaries. Presumably, as with DHS, the direct payments for those services will be inadequate to cover its costs, and it will be necessary to evaluate how much of those costs can be absorbed and if there are additional revenue sources that can be pursued to offset costs. In that regard, there should be a fourfold evaluation: (1) what is the County's general commitment to provide care for the medically indigent in this case, (2) to what extent is the County benefitted by any resulting reductions in healthcare costs, (3) are there additional opportunities for the County with respect to beneficiaries that should be considered, and (4) are there opportunities to negotiate cost sharing with stakeholders vested in CalAIM's success (which is the focus of the next Part entitled "Thinking Together: Finding Funding for the Comprehensive CalAIM Solution").

County's Commitment to the Indigent

LA County has an obligation under Section 17000 of the California Welfare and Institutions Code to provide care for the medically indigent. From a patient-care perspective, it seems grossly uncaring and certainly callous to identify a beneficiary who clearly qualifies for and needs ECM benefits, but deny that beneficiary an opportunity to access the ECM program. The County should therefore consider whether it should assume responsibility for ECM benefits as part of its obligations under Section 17000 (whether or not there's a legally enforceable claim in that regard).

The County's Economic Benefit

As noted, the County has an obligation to provide care for the medically indigent, and therefore it is financially benefitted if it can

reduce the costs of providing that care. One of the primary benefits of ECM and associated Community Supports is reduced healthcare costs for ECM beneficiaries, especially in connection with unnecessary hospitalizations. With many of LA General's ED patients being "frequent fliers," regularly returning to the ED, the County's investment in ECM and associated Community Supports could significantly reduce the overall use of the ED and associated costs.

Discrete Strategies based on a Beneficiary's Specific Situation

We have not been able to access a detailed breakdown of the demographics of those who are receiving LA General ED services and identified as ECM eligible, but we suspect that such information would generate strategies that could make ECM enrollment in the ED appropriate and even advisable. Specifically:

1. DHS indicated that some percentage of the LA General ED patients are likely empaneled with DHS and would benefit from ECM enrollment (if the time and cost of culling them from the general ED population was reasonable).
2. DMH is also an ECM provider focused on beneficiaries who need significant mental health services, and during a recent annual period, 2,109 of those seen in the LA General ED had a primary mental health diagnosis, many of whom would likely be ECM eligible.
3. DPH is also an ECM provider focused on beneficiaries who need significant services regarding substance abuse, and during a recent annual period, 1,021 of those seen in the LA General ED had a primary substance abuse diagnosis.
4. Twelve percent of LA General's population are Medi-Cal fee-for service beneficiaries[156] (although we were not able to determine if that percentage holds for ED patients). To the extent Medi-Cal fee-for-service beneficiaries would be ECM eligible if enrolled in Medi-Cal managed care, this presents a potential opportunity to enroll with an MCP and empanel with DHS, thereby getting access to additional capitation revenue for both the MCP and DHS.[157]
5. There may be situations where an ED patient is already empaneled with another provider, and it may be possible

[156] LA General PowerPoint (n 143)

[157] DHS indicated it does not currently have any strategy or process to identify and pursued opportunities to convert Medi-Cal beneficiaries from fee-for-service to managed care. Interview with DHS leadership

for LA General to coordinate enrollment with that provider. For example, Kaiser enrolls its eligible patients in ECM, and there are undoubtedly Kaiser patients who occasionally present at the LA General ED.

In summary, there are clear benefits for LA General to enroll as an ECM provider with a focus on its ED, and, at the same time, it should be possible to manage the demographics of its ED patients in a manner that minimizes the challenges for LA General and greatly benefits many of those patients.

b. Should LA General Be an Independent ECM Provider or Utilize DHS for ECM Enrollment of LA General Patients

LA General's enrollment as an ECM provider would need to be coordinated with DHS, especially since DHS already functions as an ECM provider in its own right[158] (as does DMH and DPH). In fact, DHS is an important ECM provider for LA Care, having enrolled 2000 LA Care beneficiaries for ECM, or 10% of LA Care's total ECM enrollees.

One major question is whether DHS and LA General should operate as one consolidated ECM provider, or, to the contrary, if LA General should operate as an independent ECM provider that closely coordinates its activities with DHS. Given the completely different approaches that are likely to be utilized by DHS and LA General as ECM providers, we strongly recommend that LA General be designated an independent ECM provider, but, at the same time, the parties should be attuned to inefficiencies based on overlapping and redundant services and work closely to make their aggregate operations as efficient as possible.

There are three reasons for this recommendation: (1) the very different approaches used by DHS and LA General are likely to become muddled if they are consolidated in one unit, (2) LA General has a committed and sophisticated staff of social workers and others who already effectively manage hospital patient discharge functions, which should serve as a foundation for LA General's expanded group of outreach workers, and (3) by maintaining the independence of the two complementary approaches it will be easier to do follow-up research on the relative effectiveness of each, thereby helping to improve both.

[158] DHS has made a major commitment to ECM as evidenced by the 350 DHS personnel working on ECM operations, with more than 100 serving as Care Managers. [Interview with DHS Leadership.]

The benefit of LA General's approach is its ability to interact directly with potential ECM enrollees in the context of a strong, presumably trusting relationship, making ECM enrollment more likely. The complementary benefit of DHS's approach is that it identifies potential enrollees receiving an array of medical and social services that otherwise might not be identified by the entities providing the services. It seems likely these two approaches would address different populations with minimal overlap, ensuring an overall increase in ECM enrollment.

B. LA General's Role in Reducing Healthcare Costs

1. General Discussion

As previously noted, a major purpose of the CalAIM program is to reduce overall healthcare costs by focusing on the substantial "Medi-Cal spending that is attributable to **5 percent of members with the highest-cost needs."**[159] Where is health care spending focused in the United States, and where are the best opportunities to reduce that spending? In short, "[m]ost health spending in the U.S. and peer countries is on hospital and physician care […]."[160]

Although hospital care is a major driver of health care costs in all wealthy countries, it constitutes a much higher percentage of costs in the United States, with international comparisons suggesting that reductions in unnecessary hospitalizations is where most cost savings can be found: "In comparison to other large and wealthy countries, the U.S.'s higher spending on inpatient and outpatient care explains the vast majority of higher spending overall."[161] "In 2021, inpatient and outpatient care represented **approximately 62% of total health care spending in the U.S. and 46% of spending in comparable countries,** on average."[162] [Emphasis added.]

Clearly, in the current healthcare environment, the most effective means to reduce health care costs is to avoid unnecessary hospitalizations and readmissions; and LA General has already shown immense creativity in pursuing innovative programs to reduce hospital admissions and associated costs with millions of dollars in savings, such as the Safer at

[159] ECM Transformation (n 12)
[160] Cox Cynthia et al, "Health Care Costs and Affordability – What Factors Contribute to Health Care Spending?" KFF (Kaiser Family Foundation) (May 28, 2024) https://www.kff.org/h ealth-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-introduction (accessed February 19, 2025)
[161] ibid
[162] Wagner, Emma et al, "What drives health spending in the U.S. compared to other countries?" KFF (Kaiser Family Foundation) (August 2, 2024) https://www.kff.org/health-costs/issue-brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/ (accessed February, 19, 2025)

Home program, addressed below."[163]CalAIM promises to further unleash that creativity.

2. Reducing Costs: Using LA General's Robust Discharge Planning Process

One of the primary vehicles to reduce healthcare costs is effective discharge planning that maximizes the stability and well-being of discharged patients, thereby minimizing unnecessary readmissions. LA General is required to manage patient discharges in order to ensure appropriate follow-up care, and this is especially true regarding homeless patients. Under California law, there are specific requirements for hospital discharge policies regarding the homeless,[164] including a "written homeless patient discharge planning policy and process," specific inquiry "about a patient's housing status during the discharge planning process," and "an individual discharge plan for a homeless patient that helps prepare the homeless patient for return to the community."[165]

LA General, given its substantial volume of homeless patients, has significant experience in complying with these legal requirements. However, with the lack of housing options for the homeless, hospital compliance with discharge requirements can be challenging, and, notwithstanding the commitment of hospital social workers to address patient needs, they are, as a practical matter, largely limited to providing support at the point of discharge, having neither the ability nor bandwidth to provide the ongoing health management truly needed by these patients. LA General is committed to using all available resources to meet its patients' needs upon discharge; and, with the additional resources made available by ECM Care Managers and associated Community Supports, it would be able to address its patients' well-being far beyond the hospital door.

Children's Hospital of Los Angeles, for example, recognized the potential value of Community Supports following patient discharge, which was a major justification for its substantial investment in ECM:

> "Prior to the creation of Enhanced Care Management, if a family had health-related social needs, such as being without housing or suffering from food insecurity, CHLA's social workers would come to their aid, directing them to resources that could help, but they

[163] Banerjee, Josh et al, Virtual Home Care for Patients With Acute Illness, JAMA Network Open (November 26, 2024). https://www.calhealthplans.org/wp-content/uploads/2024/05/KaplanPres.pdf (accessed February 13, 2025). LA General leadership estimates that its "Safer at Home" initiative generated almost $4.8 Million in cost savings over seven and a half months.
[164] California Health & Safety Code, Section 1262.5(n).
[165] ibid

> didn't have enough staff to reach families outside the hospital. "We haven't had the bandwidth to follow up," Dr. Patel says…. "Nor have we had the depth of trust or community expertise.""[166]

With ECM, CHLA is now able to continue its engagement with these patients and ensure they receive essential Community Supports following discharges; and LA General, as an ECM provider, would be able to do the same.

3. Reducing Costs: LA General and the Restorative Care Villages

As referenced above, a healthcare ecosystem has three essential elements. At its core is the ultra-expensive acute care hospital, which should be used as seldom as possible and only when necessary. Beyond the hospital you have other clinical services to address the immediate healthcare needs of patients, typically in a manner that should reduce the need for hospitalization. This includes primary care and other clinical services, especially mental health and substance abuse services. Finally, you have social services, especially focused on housing and nutrition, that are the underpinning of health and stability, and which are the focus of Community Supports.

Too often, these three components of the healthcare ecosystem function independently without the full integration necessary to obtain maximum benefits, but we now have the potential of a unique alignment of all three elements on the campuses of the County Hospitals. First, the County Hospitals are the coordinating entity at the center of these campuses; second, the County, in its great wisdom, is creating Restorative Care Villages on each campus, which have the potential to become the hubs of non-hospital clinical services, especially recuperative care and mental health services; and, third, with LA General becoming an ECM provider, it has the incentive to create a robust network of Community Supports for both itself and the Restorative Care Village, building on a strong base already constructed by DHS.

By using LA General to coordinate these three components of the healthcare ecosystem, you both maximize the health of patients and minimize associated healthcare costs. In essence, LA General, with its ECM Care Managers, is able not only to expand the scope of the patient discharge process beyond the hospital door, but to access virtually all necessary clinical and social services required for a patient's immediate well-being.

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[166] Jeff Weinstock, "Community Health Workers Offer Hands-on Help to Medi-Cal Families,: CHLA Blog, page 3 (July 16, 2024) https://www.chla.org/blog/serving-community/community-health-workers-offer-hands-help-medi-cal-families#:~:text=By%20the%20program's%20definition%2C%20community,on%20support%20outside%20the%20hospital (accessed February 13, 2025)

The Restorative Care Villages are crucial participants in the healthcare ecosystem centered on the County Hospitals, since (1) each is located on the campus of a major County Hospital that is a likely source of a significant number of ECM beneficiaries, (2) each provides a significant range of clinical services, including recuperative, psychiatric and addiction services that are essential in creating a continuum of care for discharged patients, and (3) each has the opportunity, often in conjunction with the aligned County Hospital, to coordinate and collaborate with Community Based Organizations to build out necessary Community Supports.[167]

LA General, by coordinating with s Restorative Care Village, will have greatly enhanced opportunities to improve health services and reduce overall healthcare costs. However, those opportunities will depend in large part on the various County Departments involved with the Restorative Care Village operating in a coordinated, even integrated manner, and we address the associated challenges in Part 7.

C. LA General Is a Potential Source of Ouittcome Metrics With Which to Assess the Efficacy of CalAIM

As noted above, there is "[n]o systematic method to monitor and report on the […] outcomes of various CalAIM programs and activities,"[168] which is rightly deemed essential for the ongoing evaluation and improvement of the various CalAIM initiatives. It's worth repeating that Paul Ellwood, the "father of managed care," pointed to a lack of "outcome accountability" as one of the primary reasons that managed care has not lived up to its promise.

Hospitals are required to generate and maintain detailed historical data regarding patient demographics and health outcomes for a variety of purposes, especially in connection with their participation in the Medicare and Medi-Cal programs. As a result, hospitals are a rich source of comparative data regarding health outcomes, and this is particularly true for at-risk populations, such as the ECM target populations, that are likely to have a high incidence of hospital encounters.

For example, hospitals maintain records as to whether a patient is homeless upon discharge along with detailed information regarding follow-up visits to the emergency department and readmissions. Accordingly, hospitals can generate historical baselines for certain patient populations,

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[167] This is especially the case of the LA General Restorative Care Village where the Health Innovation Community Partnership (sponsored by the LAC+USC Medical Center Foundation, Inc.) has been an important source of community guidance regarding connections with Community Based Organizations, presumably including those providing Community Supports. https://www.hicpla.org/about-us (accessed March 21, 2025)

[168] Hospitals Commission (n 35) page 7

such as the homeless, that can then be compared with similar populations who receive the benefit of specified CalAIM initiatives, such as access to an ECM Care Manager or specific Community Supports. For example, one could generate data regarding the timing and nature of hospital readmissions for homeless patients in the recent past, and compare that with comparable data for homeless patients who are enrolled in ECM. Through such analysis, one could determine if ECM enrollment results in fewer readmissions, which is indicative of better healthcare status; and, further, one could quantify the reduction in overall hospital costs associated with the reduced readmissions.

LA General has already been active with such comparative research, most recently with its "Safer at Home" initiative developed during the Covid pandemic.[169] In that case, LA General developed a program where patients who had traditionally been hospitalized for certain conditions were now treated at home with significant oversight by registered nurses and other healthcare providers. LA General's research compared these patients treated at home with comparable patients who continued to receive inpatient care in terms of (1) relative health status, (2) impact on hospital and related healthcare costs, and (3) financial impact on the patient. Very briefly, this analysis concluded that (1) there were no adverse health impacts for the participating patients, (2) each patient was, on average, financially benefitted in an approximate amount of $13,300 with respect to out-of-pocket costs and lost wages for both the patient and care-giver, and (3) the hospital saved almost $4.8 million over seven and half months.[170] (The report notes that the evaluation did not include patient satisfaction scores, which would also be an important data point if available, but it seems fair to speculate that patients on average would prefer to be effectively treated at home and avoid the disruption of hospitalization.)

The overall point is that LA General routinely generates patient data that could be used to assess "outcomes" for CalAIM patients who receive hospital services; that these outcome assessments would provide a relatively comprehensive view of the benefits of CalAIM, since a significant percentage of the CalAIM target populations have multiple hospital encounters; and, finally, that LA General is experienced and competent to evaluate that data in terms of the overall impact on both health and costs.

Through LA General's active participation in CalAIM and the aggressive recruitment of ECM eligible beneficiaries who receive hospital services, LA General would be in a position to generate data and assess outcomes that are essential for the ongoing monitoring and improvement of the CalAIM program, and, most important, to justify CalAIM's continued expansion.

[169] Safer at Home (n 164)
[170] ibid

PART 6

THINKING TOGETHER: FINDING FUNDING FOR THE COMPREHENSIVE CalAIM SOLUTION

The necessary pieces are in place to energize and expand CalAIM in LA County:

(1) LA General (and the other County Hospitals) are positioned to vastly increase the enrollment of ECM eligible beneficiaries, subject to having adequate Care Leaders and Community Support providers to address their needs,

(2) DHS has created a robust network of Community Supports, which, with additional funding, could become the foundation and framework for a comprehensive Community Supports system able to address the needs of ECM beneficiaries far beyond those currently empaneled with DHS, and

(3) The County has created Restorative Care Villages on the campuses of County Hospitals that should be valuable sources of clinical services to reduce overall healthcare costs, especially by preventing unnecessary readmissions for discharged patients.

Although all of the pieces are in place, there continue to be questions regarding adequate funding. The extraordinary potential of CalAIM in LA County is within reach if the County, for example, redeploys a significant portion of the funds it is recouping from LAHSA to CalAIM initiatives However, in the absence of such financial commitments, there is a serious risk that this exceptional opportunity to transform the LA County healthcare delivery system will stall out.

A. Inadequate Funding is a Common Problem. The Civil Grand Jury frequently identifies County operations where there are opportunities, interest, expertise and competence to make substantial improvements in the services for County citizens, but they are impeded by a lack of funding. That can be frustrating, especially for committed County personnel, but there's of course a recognition that funding is limited and there are many competing priorities. In the case of funding an expansion of CalAIM, we are fortunate to have a number of potential funding sources.

B. The Four Potential Sources of CalAIM Funding

There are at least four potential sources of funding for an expansion of the County's participation in CalAIM:

Redirecting Funds Traditionally Appropriated To Address Homelessness. It is generally agreed that LAHSA, despite the best of

intentions, has not effectively addressed homelessness in LA County, and, accordingly, the County will be retaining the amounts it has historically transferred to LAHSA (approximately $300 million annually) in order to provide homeless services directly. As discussed in detail in Part 8, we strongly advocate that a substantial portion of those funds be used for CalAIM initiatives.

Additional Self-funding: In addition to direct County funding of homeless services, LA Care, DHS, and LA General may identify opportunities to self-fund some of the CalAIM investment through anticipated cost savings (as DHS has already done in creating and subsidizing its Community Supports network).

The State: The State substantially benefits from the cost-savings of a successful CalAIM program, and a good portion of those benefits will depend on its success in LA County. LA Care, DHS and LA General should be able to mount strong arguments for increased funding by the State, in the absence of which all of the opportunities under CalAIM to improve health and reduce costs (to the substantial benefit of the State) will likely falter and disappear.

Potential Funding under "Providing Access and Transforming Health" (PATH Funds):

PATH is a "five year, $1.85 billion initiative to build up the capacity and infrastructure of on-the-ground partners, **such as … hospitals, county agencies** … and others, to successfully participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management and Community Supports….PATH funding will address the gaps in local organizational capacity and infrastructure…; enabling these local partners to scale up services they provide to Medi-Cal beneficiaries. With resources funded by PATH … community partners will successfully contract with managed care organizations, bringing their wealth of expertise in community needs to the Medi-Cal delivery system."[171] [Emphasis added]

In a recent survey of CalAIM providers in LA County, 46% indicated they had received grants from PATH,[172] and over 80% of those receiving a PATH grant found it "very helpful."[173] CHLA has also informed us that PATH has provided major grants for CHLA that substantially funded the creation of its ECM program, and that CHLA will be pursuing additional

[171] "CalAIM Providing Access and Transforming Health (PATH) Initiative," pages 1-2, DHCS website https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM-PATH.aspx (accessed February 13, 2025)
[172] CalAIM Survey (n 99) page 20
[173] ibid page 21

grants as it seeks to expand its participation in CalAIM.[174] And DMH noted that it had received major PATH funding for "IT infrastructure and administrative support."[175]

As LA Care, DHS and LA General explore their collective participation in CalAIM, especially LA General's role as an ECM provider, PATH appears to be a promising funding source, at least for initial infrastructure investments.

C. Cost Savings as a Source of Indirect Funding?

1. In General.

As discussed, the State notes that 50% of Medi-Cal costs are associated with 5% of Medi-Cal beneficiaries, with the assumption that, by effectively managing the care of that 5%, the State's associated health care costs will be substantially reduced. In this regard, there are three questions:

> Is the assumption correct that CalAIM, if fully implemented, will in fact substantially reduce overall healthcare costs?
>
> How much investment in CalAIM, especially ECM and Community Supports provider services, is necessary to achieve those cost savings, and would those cost savings be a reasonable return on investment?
>
> Who would be the primary beneficiary of those cost savings, and therefore a potential source of funding?

LA Care and LA General should work together to assess CalAIM's likely impact on overall healthcare costs, and the funding necessary to achieve those cost reductions. Assuming the results of that assessment are positive, there are three potential beneficiaries of the cost savings generated by CalAIM. The State itself is certainly the major beneficiary, since it's the primary source of funding for the Medi-Cal program. However, LA Care (and other MCPs), as the direct contracting entities, and LA County as a major provider of Medi-Cal services, especially through its Hospitals and Ambulatory Care Network, are also likely to be benefitted. Specifically, by participating in Medi-Cal managed care, both LA Care and LA County assume significant financial risk for healthcare services required for assigned beneficiaries, and to the extent they can reduce that financial risk by decreasing needed healthcare services, through CalAIM or otherwise, they will directly benefit from those cost savings.

[174] Meeting with CHLA leadership
[175] ECM Board Briefing (n 103)

2. LA Care, DHS and LA General Working Together To Identify and Develop Strategic CalAIM Initiatives and Funding Options From Future Cost Savings

The success of CalAIM is based on having appropriate financial incentives to ensure the effective integration and deployment of medical and social services to address the healthcare and related needs of County residents. There are a number of different participants in Medi-Cal managed care whose various financial incentives must be aligned in order to ensure they will actively pursue and promote CalAIM, but we believe the financial alignments are by far the strongest between LA Care, DHS and LA General, justifying the creation of a powerful strategic partnership to jointly pursue the maximal implementation of CalAIM.

LA Care as a Medi-Cal MCP is mandated by the State to participate in CalAIM and specifically receives funds from the State for the purpose of establishing and operating the CalAIM initiatives. In addition, since LA Care receives capitation payments from the State for enrolled Medi-Cal beneficiaries, it benefits financially if the CalAIM program decreases the healthcare costs of patients enrolled with LA Care.[176] DHS, being generally compensated on a capitated basis regarding hospital and other healthcare services for assigned Medi-Cal beneficiaries, is also financially motivated to eliminate unnecessary costs, especially limiting avoidable hospitalizations and reducing the length of stay of admitted patients. However, not only is DHS motivated to reduce healthcare costs, it has, with LA General, the management control and patient relationship necessary to achieve substantial reductions in overall costs for the financial benefit of both DHS and LA Care.[177]

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[176] "The state pays MCPs a monthly rate for each enrollee based on plans' past expenditures. The ECM and Community Supports benefits are included in this … calculation, and it is up to MCPs to arrange for ECM and Community Supports services for their enrolled members through the plans' network of providers." Legislative Analyst (n 13) page 8. LA Care also has the opportunity to receive a portion of the savings it generates as a result of its participation in CalAIM: "DHCS is also developing specific fiscal incentives for plans to seamlessly launch ECM and provide the pre-approved [Community Supports], **including … offering shared savings** through the effective use of pre-approved [Community Supports] and the new ECM benefit to avoid unnecessary hospitalizations, nursing home stays , and emergency department visits," [Emphasis added.] CalAIM and Homelessness (n 19).

[177] Clearly, if LA Care and LA General work together strategically to maximize the impact of CalAIM through appropriate investments in personnel and processes, the financial benefits for each could be substantial (while at the same time significantly improving the well-being of patients). It's also probably worth noting that both LA Care and LA General might have additional opportunities for revenue generation to the extent fee-for-service Medi-Cal beneficiaries are identified as ECM eligible and converted to managed care in order to participate in ECM (and then also enroll with LA Care and DHS). It's difficult to predict how significant this opportunity might be, but it's worth considering since 12% of LA General's Medi-Cal population is fee-for-service. LA General PowerPoint (n 143)

LA Care, DHS and LA General should create a working partnership to discuss and agree on:

a. The mutual benefits of enrolling additional ECM eligible beneficiaries, and the most effective strategies to achieve that, especially considering patient interactions at LA General and other County Hospitals.

b. The specific subsidies currently provided by DHS to maintain its network of Community Supports providers, the need for an expanded Community Supports network, and the additional financial support needed for that expanded network.

c. The projected increased enrollment of ECM eligible beneficiaries in using the enrollment strategies identified and agreed upon by the partnership

d. The projected increased cost for Care Leaders, Community Health Workers and Community Supports providers in order to support the projected increased ECM enrollment

e. The estimated overall increased cost savings resulting from the projected expansion in ECM enrollment and Community Supports, and how much the State, LA Care and DHS are likely to benefit respectively from such cost savings.

f. And, most important, how to connect those cost savings with the funding of CalAIM's expansion in LA County

PART 7

THINKING COLLECTIVELY: INTEGRATING THE COUNTY DEPARTMENTS' HEALTHCARE AND HOMELESSNESS INITIATIVES

We believe the County must be able to mandate collaboration among the various County Departments so that CalAIM can be utilized to create a County-wide integrated healthcare system. As described below, we are specifically recommending the resurrection of the Health Agency advocated by Dr. Katz and approved by the BOS in 2015, which, in essence, established DHS as the controlling entity over both its own functions and those of DMH and DPH to the extent necessary to create an integrated healthcare system.

The County has experimented with voluntary collaboration among the County Departments over the last decade, and it has proven to be ineffective in creating the integrated networks necessary for CalAIM's success. This was

an interesting experiment, but the County should acknowledge its failure and return to the Health Agency's success.[178]

In arguing for the resurrection of the Health Agency, we first investigate some of the major issues the County is already encountering as a result of the County Departments' assertions of independence. We then briefly revisit the history of the Health Agency's creation and promise, and the loss of that promise upon the Health Agency's demise and dismantlement following the departure of Dr. Katz.

Multiple County Department are involved in organizing and operating the components of an integrated healthcare system essential for the successful implementation of CalAIM, including the operation of the Restorative Care Villages, the coordination of ECM provider functions, and the operation of overlapping Community Supports Networks. We describe the challenges associated with each of those in turn, and then consider possible solutions, generally concluding that a centralized decision-making authority, although historically anathema to the individual Departments, will be essential in order to ensure the County's successful implementation of CalAIM.

A. Integration Challenges

1. Restorative Care Villages

The Restorative Care Village on the campus of LA General will have a psychiatric unit run by DMH, an addiction unit run by DPH, and a recuperative care unit run by DHS. (And those units will be managed and operated by a variety of providers under contract with the County Departments.) The current plan appears to contemplate representatives of each of the Departments forming a "Coordination Committee" that would regularly consult regarding the operation of the Restorative Care Village.[179] (A similar structure and approach is apparently already being used in connection with the service providers on the MLK Hospital campus. [180]) A

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[178] If the BOS finds the history and logic insufficient to warrant the creation of a Health Agency, and succumbs again to the arguments for voluntary collaboration among County Departments, we strongly recommend that it pursue an audit to evaluate the efficiency and effectiveness of the healthcare related County services provided under the current scheme of Department independence. We suspect the results of that audit will be similar to the negative findings of the recent audit of LAHSA and its coordination of independent homelessness services in LA County.

[179] Interview with representatives from Supervisor Solis's office

[180] "[T]he County built and opened other facilities on the MLKCH campus [including] the Department of Mental Health's busiest psychiatric urgent care center,… DHS' busiest urgent care center,… the County's first medical campus sobering center,…nearly 100 unlocked substance abuse and recovery beds,….[and soon] nearly 32 psychiatric health facility beds,…and 50 locked justice-involved and general population mental health beds for seriously mentally ill County patients." See "Ensuring the Ongoing Success of Martin Luther King, Jr. Community Hospital,

Coordination Committee would certainly be helpful to avoid conflicts and stumbles, but it's completely inadequate to create a vehicle for the integrated healthcare services necessary to achieve the full potential of CalAIM. The County's history with voluntary coordination, discussed below, highlights the inadequacy of that approach.

Unfortunately, the County's current approach to the Restorative Care Villages seems to prioritize the independence of the County's Departments, significantly discounting the many benefits of healthcare integration that could otherwise be achieved. With all the progress that has been made under CalAIM to further healthcare integration, we encourage the County to empower comprehensive leadership over the Restorative Care Villages in order to achieve CalAIM's enlightened vision of integration.

Specifically, we have concluded that, in order for a Restorative Care Village to be effective, it needs a ringmaster who can speak on behalf of the Network, be a source of reliable information, and initiate policies fostering integration, for example active coordination with Community Based Organizations. Crucially, we believe it specifically needs an entity that is empowered to speak and strategize on behalf of the Restorative Care Village and its constituents in discussions with MCPs such as LA Care, in order to address essential coordination with the CalAIM vision.

2. **County ECM Providers.** Three County departments - DHS, DMH and DPH - are already enrolled as ECM providers, and the Justice, Care and Opportunities Department (JCOD) is in the process of enrolling. In addition, we are strongly suggesting that LA General should enroll as an ECM provider. If our recommendation regarding LA General is accepted, there will be at least five County ECM providers actively enrolling ECM eligible beneficiaries.[181] The following is a brief summary of each County ECM provider and its targeted population

   DHS: Limited to beneficiaries empaneled with DHS

   DMH: Primary diagnoses regarding Mental Health

Motion by Supervisor Holly Mitchell (November 21, 2023) https://dhs.lacounty.gov/health-care-centers/who-we-are/ (Accessed February 6, 2025)

[181] The Star Clinic, operating as a component of the County's Housing for Health program, is also enrolled as an ECM provider, with 282 ECM beneficiaries. Housing for Health website https://dhs.lacounty.gov/housing-for-health/our-services/housing-for-health/programs/#1607638463393-e469ab41-6efe (accessed March 21, 2025)

DPH: Primary diagnosis regarding substance abuse as well as birth equity (regarding pregnancy and post-partum care)

JCOD:[182] Focused on those recently released from incarceration[183]

LA General: Beneficiaries with exceptional hospitalization risk.

Having five independent ECM providers obviously creates opportunities for inconsistencies and confusion, especially since the ECM population is known for its comorbidities.[184] In that regard, the State specifically recognizes that ECM beneficiaries "typically have several complex health conditions involving physical, behavioral, and social needs, [and that] members with complex needs must often engage several delivery systems of care […]." Since Medi-Cal beneficiaries will not fit neatly into five siloes corresponding with the County departments, how will ECM beneficiaries be assigned and best managed? [185] For example, should someone recently released from incarceration who requires focused mental health assistance be managed by JCOD or DMH; should someone empaneled with DHS with serious substance abuse issues be managed by DHS or DPH; and should someone

[182] The Justice Care and Opportunities Department (JCOD) is still in the process of applying to be an ECM provider with a focus on the recently incarcerated (referred to as the Justice Involved Population). ECM Board Briefing (n 103)

[183] It's worth noting that LA General is only three kilometers from Men's Central Jail, one of the largest jails in the world, and LA General has a secure inpatient floor where those incarcerated at Men's Central Jail are typically treated when necessary. [LA General PowerPoint (n 143)]. As noted above, the ECM target populations include those transitioning from incarceration; and DHS has been designated to support the implementation of Justice Involved ECM requirements for these adult detainees (whereas DMH oversees ECM regarding juvenile detention). [Interview with DHS Leadership] For those who have received care at LA General during incarceration, LA General should work with relevant Care Managers to ensure appropriate continuity of care.

[184] Based on discussions with DHS personnel, there seems to be little coordination between DHS, DMH and DPH in their ECM provider roles. The justification for DMH to be an ECM provider along with DHS is unclear, and, given the fact that ECM eligible beneficiaries typically have multiple comorbidities, there would seem to be a risk that the DMH ECM provider might be unduly focused on mental health issues to the exclusion of other needs. Although this concern is speculative, as LA General and DHS investigate how best to coordinate their ECM provider functions, it would probably be worthwhile to discuss coordination with the DMH and DPH ECM providers as well.

[185] JCOD is recommending collaboration among all the County Departments participating as ECM providers in order to address the effective care of ECM beneficiaries who require "services from multiple service delivery systems." Specifically, JCOD recommends "launching an Interdepartmental Workgoup (i.e., JCOD, DMH, DPH and DHS) to develop workflows across and between these departments that will facilitate coordination of care and eliminate duplication of care/services when a Medi-Cal Beneficiary presents with multiple needs that require receipt of services from multiple service delivery systems." See ECM Board Briefing (n 103)

managed by DMH because of mental health issues who has a challenging pregnancy be shifted to DPH?

3. **Community Supports Networks**

What does it mean for the County to be committed to the benefits of a network of Community Supports providers? First, it means ensuring the participation of all providers essential for the network, including the various County Departments, independent Community Based Organizations that directly contract with an MCP, and other Community Based Organizations that, even if they're not eligible to contract directly with MCPs, can provide services indirectly under a subcontract with the County ECM provider. Second, it means establishing an organizational structure for the network that facilitates the coordination of services rather than isolated relationships.

Having five separate County ECM providers creates issues regarding the Community Supports networks that can be accessed by those providers. Will each County ECM provider create its own Community Supports network? Will the robust Community Supports network created and subsidized by DHS be available to all? Similarly, will DHS ECM beneficiaries with mental health issues be able to access the DMH Community Supports network?

There are a multitude of potential questions, and we, again strongly suggest that there should be a centralized decision-making authority to resolve those issues in the best interest of beneficiaries.

B. Big Solutions to Big Challenges (Think like Mitch Katz)

The lack of County Department coordination is a major impediment to achieving the full promise of CalAIM, but there are solutions if the County is willing to consider its own history of struggles in balancing the independence and integration of its healthcare-related Departments.

The County has indeed struggled with the appropriate coordination and possible integration of its Departments, but found an elegant solution with the creation of a new Health Agency in 2015 that had ultimate authority over DHS, DMH and DPH, while allowing the individual Departments to retain their identity and separate budgets. In his January 2, 2015 memorandum to the BOS advocating for a Health Agency, Dr. Katz describes the many benefits of healthcare integration that would be made possible by the Health Agency:[186] (1) better care for patients, (2) a full package of physical and behavioral healthcare services, (3) improved

[186] Dr. Katz Memo (n 20)

linkages between prevention and health services delivery activity, and (4) better control over costs. Many expressed concerns that this approach would create problems for the effective operation of DMH and DPH, but those problems did not materialize, and Dr. Katz made significant strides in achieving the benefits of healthcare integration during the two years following the creation of the Health Agency:[187]

> **"**I think everyone would agree the formation of the Health Agency has been successful and has not caused any of those problems," Katz said. "It hasn't done everything as people would like it to, but that's because it takes time."

However, upon the departure of Dr. Katz in 2017, the individual Departments unfortunately reasserted themselves, replacing the integrative functions of the Health Agency in February 2020 with a new Alliance for Health Integration (AHI), which was directed by the BOS to coordinate integration projects involving the Departments.[188] However, since the AHI made decisions on a consensus basis among the Departments, hard questions involving healthcare integration were seldom addressed and rarely resolved.[189] Apparently recognizing that AHI was largely toothless, the BOS transferred all Alliance personnel to DMH in March 2023,[190] leaving AHI an empty shell.

This Report recommends the County learn from its history and rejuvenate the County's Health Agency with appropriate centralized authority to take a leading role in promoting CalAIM and establishing effective healthcare integration.

PART 8

THINKING CREATIVELY: REPLACING THE PROPOSED "HOMELESS SERVICES DEPARTMENT" WITH A HEALTH AGENCY THAT HAS THE "FULL" AUTHORITY TO LEAD ON HOMELESS POLICY

[187] Katz Departure (n 44) page 3.

[188] Memorandum from Baucum, Jaclyn, Chief Operating Officer, Alliance for Health Integration, LA County Board of Supervisors (March 23, 2023) https://file.lacounty.gov/SDSInter/bos/supdocs/144161.pdf (accessed February 13, 2025)

[189] In conversations with DHS leadership, there was consensus that, in the absence of a central authority, the AHI was not an effective vehicle to pursue healthcare integration among the County's healthcare services.

[190] Baucum Memorandum (n 189)

LA County has provided massive funding to address homelessness, and it's generally accepted that the current LAHSA bureaucracy, although well-intentioned, has been largely ineffective and wasteful, which has created a ground-swell for bureaucratic restructuring. The County's commitment to CalAIM should be central to that restructuring.

We concur with the need for a bureaucratic restructuring and recommend that the new Health Agency described in the preceding Part assume responsibility for the County's war on homelessness. DHS, as the central component of the Health Agency, has both expertise and experience with CalAIM, the powerful program specifically created to address homelessness, and it is therefore best-positioned to lead and manage the County's new commitment to directly address homelessness.

The BOS has in fact concluded that a restructuring of the homelessness bureaucracy is necessary, and, accordingly, decided on April 1, 2025 that it would cease its historical funding of LAHSA in the amount of approximately $300 million per year, and use those funds to directly address homelessness in LA County. However, rather than using a rejuvenated Health Agency for this purpose, it is recommending the creation of a new County Department.

In taking this action, the BOS indicated it is generally following the recommendations of the Blue Ribbon Commission on Homelessness in its Report on Homelessness Governance, dated March 30, 2022. That Report recognized that "[t]here is no single County department or sub-department dedicated to driving policy, operational improvements, and systems change with respect to homelessness. Consequently, the machinery of the County is not operating optimally in its efforts to address homelessness."[191] Given this conclusion, the Blue Ribbon Commission concluded there was a need for a County Department with the full authority to lead on homelessness policy, specifically "an appropriately resourced lead County entity on homelessness, directly accountable to the Board of Supervisors, **with the ability to cut across County departments and take charge** to ensure that all system partners are working together."[192] [Emphasis added.]

The importance of this "take charge" authority was emphasized in public statements by the members of the Blue Ribbon Commission:

> "The new leader would report directly to the Board of Supervisors and have the authority to "cut across" agencies such as the county's departments of Public Social Services, Mental Health and Health Services, said Sarah Dusseault, co-chair of the commission." **[193]**

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[191] Blue Ribbon Commission (n 56)
[192] Ibid
[193] Ding, Jaimie, and Smith, Doug, "County commission backs creating a leadership post on homelessness," Los Angeles Times (March 18, 2022) https://www.yahoo.com/news/county-commission-backs-creating-leadership-120032550.html (Accessed March 14, 2025)

> "There wasn't an entity, a coordinated entity, a take-charge entity at the county that can ensure all the spokes of the wheel were moving together," said Commissioner Wendy Greuel, "And that is on areas of health and substance abuse, diversion, all those things that would help ensure we can keep people off the streets."[194]

Given the Commission's conclusions and the statements of its individual members regarding the importance of strong governance, it's essential to monitor the County's proposed implementation of this recommendation to ensure this essential feature is retained, and, as described below, there are legitimate and serious concerns in this regard.

A. The Problems With the Current Structure for Addressing Homelessness Under LAHSA

The various reviews of LAHSA over the years have identified significant problems, many of them structural, which have made it virtually impossible to provide an effective solution to homelessness.[195] First, LAHSA notwithstanding public perceptions to the contrary, simply doesn't actually "control many of the tools" necessary to address homelessness:

> "Given its name, it's not surprising that many view the Los Angeles Homeless Services Authority as a one-stop shop for solving the county's homelessness crisis. Yet it's the Los Angeles County Department of Health Services that tends to assist people on the streets with physical ailments and the Department of Mental Health that serves mentally ill homeless people. And it's the city that has taken the responsibility of building permanent supportive housing, and it's the county that funds the services." [196]
>
> "The reality is, the agency known as LAHSA doesn't control many of the tools that help people get off the streets and into housing."[197]

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[194] ibid

[195] Although there have been longstanding concerns about LAHSA as an institution, there have generally been few complaints about the vast majority of LAHSA employees who are truly committed to assisting the homeless, and, in fact, LA County seems inclined to hire many of them to staff its new Department, indicating that both "LAHSA funds and **related staff** would be transferred to the Homeless Department by July 1, 2026." [Emphasis added.] CEO Memorandum (n 1)

[196] Smith, Doug and Oreskes, Benjamin, "L.A. officials are getting serious about overhauling this top homeless services agency," Los Angeles Times (March 2, 2020) https://www.latimes.com/homeless-housing/story/2020-03-02/homeless-authority-los-angeles-restructure (accessed March 14, 2025)

[197] ibid

Second, in those areas where LAHSA did have authority, its governance structure was simultaneously rigid and fractured (a very bad combination):

> "[LAHSA] remains steeped in a rigid culture of federal compliance and saddled with a structure that gives it little power to guide local policy. Internally, LAHSA's governance is fractured with multiple commissions and boards and councils in charge of various and sometimes competing tasks."[198]

As a result of litigation brought by the LA Alliance for Human Rights against the City of Los Angeles, the presiding judge ordered an independent review of City-funded services for the homeless.[199] That review was released on March 6, 2025, and in great detail supported the County's concerns regarding LAHSA's inadequacies. Its findings included:

> **"Poor Data Quality and Integration…**.Fragmented data systems across LAHSA, the City, and the County and inconsistent reporting formats made it challenging to verify spending and the number of beds or units reported by the City and LAHSA, track participant outcomes, and align financial data with performance metrics."[200]
>
> **"Disjointed Continuum-of-Care System:** Multiple siloed referral processes and disparate data systems, along with differing prioritization and matching processes to connect people experiencing homelessness to services, impeded the establishment of a uniform coordinated entry system."[201]

In response to this review, LAHSA itself acknowledged its many failings:

> "LAHSA issued a statement acknowledging the "siloed and fragmented nature of our regions' homeless response for driving poor quality and integration, lack of contractual clarity, and disjointed services as major impediments to success and oversight."[202]

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[198] ibid

[199] Alvarez & Marsal Public Section Services, LLC, "Independent Assessment of City-Funded Homelessness Assistance Programs." https://www.cacd.uscourts.gov/sites/default/files/Dkt%20870%20AM%20Draft.pdf (Accessed March 14, 2025)
Although the audit focuses on City of Los Angeles programs, it addresses LAHSA's operations generally since LAHSA coordinates those programs, and therefore also addresses LA County programs embedded in LAHSA.

[200] ibid

[201] ibid

[202] Smith, Doug, "Court-ordered audit finds major flaws in L.A.'s homeless services," Los Angeles Times (March 6, 2025) https://www.latimes.com/california/story/2025-03-06/court-ordered-audit-finds-flaws-in-l-a-citys-homeless-services (accessed March 21, 2025)

The findings of the recent review provided strong support for the BOS initiative to remove the County's funds from LAHSA and restructure the County's services for the homeless, and "Supervisor Lindsey Horvath said she saw the audit as an endorsement of her proposal to create a new county department that would take over LAHSA's contracting duties. "No more waste through duplicated resources," Horvath said in a statement."[203]

B. The County's Proposed Restructuring of the County's Homeless Services

1. Summary of Proposed Restructuring

LA County has decided to withdraw its contributions to LAHSA and redeploy them to provide homeless services directly (referred to as the Homeless Funds). What does this mean from a financial perspective? LAHSA's budget in 2024 was $875 million, with more than $300 million of that coming from LA County (with other sources of funding being $306 million from the City, $145 million from the State, and $73 million from the federal government). **[204]**

(It's worth noting that, with the withdrawal of County funds, LAHSA will continue to function, albeit at a much reduced level, focused primarily on those activities mandated by federal law.[205])

LA County intends to deploy those retained funds in connection with a merger of the CEO Homeless Initiative (CEO-HI) and the DHS Housing for Health (DHS-HFH), creating a new County Department focused on the homeless (the "Homeless Services Department").

The currently proposed timeline for the Homeless Services Department initiatives is as follows: (1) merging the operation of CEO-HI and DHS-HFH by April 28, 2025,[206] (2) creating the Homeless Department as of July 1, 2025, (3) Phase I implementation would then include the "integration of

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[203] ibid

[204] Smith, Doug, "A radical reshaping of L.A. County's homeless services system is proposed,: Los Angeles Times (November 26, 2024) https://www.latimes.com/california/story/2024-11-26/a-radical-reshaping-of-l-a-countys-homeless-services-system-is-Aproposed#:~:text=The%20intent%20of%20the%20proposal,recently%20expanded%20into%20a%20year%2D (Accessed March 14, 2025)

[205] "The intent of the [County] proposal is to reduce the functions of the city-county joint authority to those mandated by the federal government: maintain a homeless database, conducting the annual point-in-time count and providing related services, including the winter shelter program that was recently expanded into a year-round emergency response effort." ibid

[206] Supervisor Horvath's press release assumes the "[m]erging [of] the County's Housing for Health program in the Department of Health Services with the Homeless Initiative in the Chief Executive Office by April 28, 2025." https://lindseyhorvath.lacounty.gov/consolidate-homeless-services/ (accessed March 21, 2025)

the CEO-HI and DHS-HFH core housing and supportive services," (4) Phase II would include "integration of County-funded programs and services administered by LAHSA" into the Homeless Department, (5) Phase III would "include the integration of programs and services administered by other County departments as applicable," and (6) County-sourced LAHSA funds and related staff would be transferred to the Homeless Department by July 1, 2026.[207]

2. **The County's Exceptions to the "Full Authority" of the new Homeless Services Department**

The County's proposal for the "full" integration of County services for the homeless into one Homeless Services Department will have two major exceptions that will undermine the County's comprehensive approach to homelessness, likely leading to a version of the "siloed, fragmented and disjointed" services that plagued LAHSA. It would certainly be ironic if the County assumes responsibility for its funded homeless initiatives because of the lack of operational "streamlining" at LAHSA, and then stumbles itself because of a failure to address its own lack of operational streamlining.

The first exception to the full integration of all homeless services under the County plan is with respect to homeless services provided by other County Departments, which will be assessed for integration appropriateness "in partnership" with those other Departments (and the history of County Departments asserting the importance of their own independence will likely be a major negative factor in achieving full integration).

> "Phase III would be the integration of programs and services administered by other County departments beyond the CEO and DHS into the new County department **as applicable**."[208] [Emphasis added.]

The second exception are those services that are "highly clinical and deeply integrated with DHS's core … functions," and will therefore remain

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[207] The timeline is summarized by the CEO as follows: **"**It is envisioned that CEO-HI [CEO Homeless Initiative] and DHS-HFH [DHS Housing for Health] employees would merge to create the core of the new department. It is envisioned that CEO-HI and DHS-HFH will work closely together to align and integrate work beginning July 1, 2025, while concurrently developing the implementation plans for the administrative functions of the new County department with a goal of a complete transition to the new County department effective January 1, 2026." CEO Memorandum (n 1) page 7

[208] The proposal includes "a list of other county agencies that have assumed responsibility for homelessness. It includes the Department of Mental Health, the Department of Health Services, the Department of Public Health, the Department of Children and Family Services, and the Department of Public Social Services." Radical Reshaping (n 205)

within DHS, thereby excluding many of the County's major interactions with the homeless population:

> "Core clinical services outside of [certain limited situations][209] are highly clinical and deeply integrated with DHS' core health care and provider and managed care functions for its empaneled population and financing mechanisms and would remain within DHS."

3. **The County's Silence on CalAIM's Importance in the War Against Homelessness**

There is no evidence that LA County has any plans to use the Homeless Funds to expand CalAIM services (either ECM or Community Supports) in connection with the County Hospital's interactions with the homeless, especially regarding the significant opportunities for increased ECM enrollment.[210]

4. **The Flaws in the County's Proposed Restructuring**

In order for the new Homeless Services Department, as the coordinating entity for the County's homeless services to be successful, it's essential, as recognized by the Blue Ribbon Commission, that it have the ability to "cut across County Departments and take charge." However, the County has concluded that the proposed entity shouldn't interfere with DHS's direct provision of services for its empaneled patients. We agree this makes sense, given the integrated nature of those services, but this excludes a huge array of opportunities to address homelessness, and that doesn't make sense. Further, the County has concluded that other Departments involved with homelessness should have the opportunity to discuss their coordinated independence in providing homeless services, which sounds wonderful in theory but has been the source of regular inconsistencies and inefficiencies in the context of healthcare services and promises to be equally dysfunctional regarding homeless services.

In this Report we have focused on the importance of fully utilizing the framework and services of CalAIM in successfully addressing homelessness, and, therefore we believe it is crucial that the County's CalAIM experts be at the helm of any new homeless initiatives, which is not the case with the County's proposal.[211]

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[209] The specified situations involving DHS that will be shifted to the new Homeless Services Department include "supportive housing sites (e.g., STAR clinic and mobile clinics), DHS recuperative centers, and Enriched Residential Care beds funded by DHS to offload DHS hospitals." CEO Memorandum (n 1) page 3

[210] The County does, however, acknowledge the importance of CalAIM funding in subsidizing DHS-HFH's existing functions: "[T]he new County department will need to invest in the administrative infrastructure necessary to maximize claiming of CalAIM revenue for rental subsidies, housing support services, and clinical services, including expertise in navigating Medicaid policy and managed care requirements." CEO Memorandum (n 1) page 8

[211] The CalAIM experts at DHS are primarily involved with the direct provision of services for empaneled patients, which is excluded from the scope of the Homeless Services Department.

An Alternative Restructuring Focused on the Proposed New Health Agency

1.**The Proposal.** We believe the County's decision to assume primary responsibility for the provision of homeless services in LA County is completely justified in light of the history of LAHSA's challenges over the last thirty years; and the County's overall vision and strategy to empower a coordinating entity to "take charge" is the right decision. We strongly believe, however, that a successful coordination of County homeless services should be focused on the powerful engine of CalAIM, and accordingly the rejuvenated Health Agency is the ideal and necessary coordinating entity.

In making this recommendation, we should emphasize that we are not at all criticizing the CEO Homeless Initiative or DHS Housing for Health, both of which programs are making major contributions to the alleviation of homelessness, and we assume the leadership of those initiatives should be actively involved with the new Health Agency.

2. The Benefits of an Alternative Restructuring Focused on the New Health Agency

The benefit of the rejuvenated Health Agency is that it forcefully corrects the flaws inherent in the County's current proposal:

First, the use of the Health Agency avoids each of the exceptions to the "full authority" of the governing entity which would otherwise hobble the Homeless Services Department. Under this alternative approach, there is no reason to exempt DHS's provision of managed care services to its empaneled patients, since DHS would itself be at the helm of the new Health Agency. Further, the Health Agency would operate (as it was operated from 2015-2017) with the understanding that regarding issues of healthcare integration, now expanded to cover homelessness services, the Health Agency would be empowered to "cut across County Departments and take charge," as forcefully advocated by the Blue Ribbon Commission.

Second, and equally important, DHS (being at the center of the new Health Agency) is the primary source of County expertise on CalAIM. DHS has been truly innovative and uniquely successful in creating a robust Community Services network, and it has the expertise to use LA General's patient connections to vastly increase ECM enrollment. With access to the additional funds the County redirects from LAHSA, the promises of CalAIM's impact on the homeless would finally be within reach.

3.A Recipe for Success: Think Like Mitch Katz

We believe the history and logic of a Health Agency is sufficient to conclude that it is the necessary vehicle for the effective implementation of CalAIM, integrated healthcare and the crusade against homelessness.[212] If there are any remaining doubts, please read Dr. Katz's memorandum, attached as Exhibit A.

PART 9

CHILDREN'S HOSPITAL OF LOS ANGELES: THINKING BIG WITH SMALL PEOPLE

LA General is uniquely situated to transform the care of our most medically vulnerable citizens by enrolling them in ECM. And one reason to be confident about its likely success is the guidance, insight and inspiration provided by Children's Hospital of Los Angeles (CHLA), since CHLA is already participating as an ECM provider for its unique and equally vulnerable patient population, showing what a hospital can accomplish when actively interacting with patients to facilitate their health and well-being.

Like LA General, close to 75% of CHLA patient families are Medi-Cal beneficiaries,[213] which creates a wonderful opportunity for CHLA to use ECM to access necessary Community Supports for its patients, such as nutritional support for a patient population where 28% have food access challenges.[214]

CHLA concluded that, given its strong connections with patients, especially in the case of CHLA social workers who were already actively addressing their social service needs, it made sense for CHLA to provide complementary ECM services. And "in spring 2023, CHLA created the Integrated Delivery Services Department to administer the [ECM] benefit, and Dr. Patel was named Chief of the Department."[215]

As of January 2025, CHLA employs 19 community health workers, and is hoping to increase that number as CHLA actively expands its ECM program. Specifically, as of January 2025, it screens approximately one-third of its patients for ECM eligibility, and intends to expand that to 100% during the current year.[216] The ECM program at CHLA is rapidly expanding, and, as of July 2024, with the

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[212] The rejuvenation of the Health Agency contemplates a significantly expanded role for DHS, with it becoming responsible for the various function of LHASA as well as a number of County Departments. DHS is already a huge department with a multitude of responsibilities, and it's a fair question whether adding overall responsibility for homelessness may simply be too much for one Department. One answer to that question is for the BOS to implement the Health Authority as recommended in the 2024-2025 Civil Grand Jury Report entitled "What They Said," which would shift a substantial bureaucratic burden from DHS to that Health Authority.

[213] CHLA (n 167) page 3

[214] Interview with CHLA leadership.

[215] CHLA (n 167) page 3

[216] Interview with CHLA leadership

program only about a year old, CHLA Community Health Workers had already had 2000 encounters (what CHLA refers to as “individual family touches”). [217]

Although we are unaware of any systematic study at this early stage regarding the impact of the ECM program at CHLA, there is an abundance of stories of individual patients whose lives have been transformed. Dr. Patel enthusiastically sums up the impact of the program at CHLA as follows:

> “I think it’s such a beautiful way to deliver care. It’s deep social impact, in that it’s really lifting a population. And if you think about reducing health disparities, **I mean, man, this is it**.”[218]

[217] CHLA (n 167) page 6
[218] ibid at page 7

ATTACHMENTS

Exhibit A

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January 2, 2015

CONFIDENTIAL

TO: Each Supervisor

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **PROPOSAL TO INTEGRATE THE DEPARTMENTS OF HEALTH SERVICES, MENTAL HEALTH, AND PUBLIC HEALTH**

In response to your request, please find a proposal for integrating the Departments of Health Services, Mental Health, and Public Health. I look forward to discussing with you on January 6th, January 13th, or whenever you choose.

Background

Historically, the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) existed as a single organization within Los Angeles County. In response to a variety of external factors and the need to establish distinct identities, the Departments separated over time to become three separate entities. While these decisions to separate were appropriate at the time, evolving trends in health care delivery, policy, and reimbursement have changed things. In the present and expected future health care environment, it would be better for the County to operate a single unified health department that encompasses all aspects of population and personal health.

Benefits of integration

By integrating DHS, DMH, and DPH, the County will be better positioned to provide high-quality, comprehensive health-related services and programs to LA County residents within a fixed level of financial County resources. Specifically, integration of physical and mental health programs with population health within a single County department will:

1) Provide better care for LA County patients by integrating physical health care, mental health care, and substance abuse treatment.
2) Be better able to respond to health plans' expectation that providers deliver a full package of physical and behavioral health care services.
3) Improve prevention and early intervention strategies for physical and behavioral health by more closely linking them to clinical service delivery.
4) Better control costs by improving coordination of services, leveraging economies of scale, and decreasing administrative costs.
5) Increase revenue by taking greater advantage of available local, state, and federal funding streams.

Rationale

Provide better care for patients

Health care clinicians and policy makers agree that patients should receive integrated physical health, mental health, and substance abuse treatment. In fact, when patients present with symptoms (e.g., headaches, abdominal pain, palpitations) it is often not clear whether their illness reflects a physical health problem, a mental health problem, a substance abuse problem, or some combination of the three.

Individuals with serious mental illness die 25 years earlier than non-affected peers; 30 years earlier if they have a concomitant substance abuse disorder. To achieve better results among this most challenging of patient populations, physical health, mental health, and substance abuse providers must operate within a single, seamless system of care.

Consolidation of services within a single, unified department will enhance the ability of the County to:

- Bi-directionally co-locate primary care and mental health services
- Consult and refer select patients for services between physical and behavioral health settings
- Case-manage care for individuals who are high utilizers of County health services
- Target high-cost, finite resources to those patients who stand to benefit the most
- Ensure patients are cared for in the least costly setting that is appropriate for their clinical condition
- Improve coordination of care for persons under the County's supervision: jail inmates, juvenile detainees, and foster care youth

Although more coordinated care can be achieved through closer collaboration of the Departments, it will always be harder to achieve when the Departments have separate supervisory structures, locations, policies, and strategic plans. Today, patients requiring services from more than one County health department must navigate a complicated web of eligibility and enrollment procedures, referral protocols, and programs. Patients fall through the cracks too often and, even when they do get the services they need, they are often not provided in a timely, efficient, or coordinated manner. A single, combined health department is best positioned organizationally to break down the bureaucratic barriers facing our patients, identify synergies between programs, streamline operations, optimize finances, and align incentives so that all County staff work toward the same goal: the provision of high-quality, patient-centered, cost-effective health services, across the full continuum of health services, for LA County residents.

Recent work with the Department of Children and Family Services (DCFS) illustrates the potential benefit of this consolidation. The services that DCFS needs for its children are currently provided by the three separate Departments (DHS administers the medical/forensic HUBS; DMH provides services directly and through contractors at the HUBS; children and caregivers needing substance abuse services are referred to DPH).

Deliver a full package of physical and behavioral health care services

Under managed care, health plans prefer delivery systems that can provide the full spectrum of services including physical, mental health, and substance abuse treatment. For example, under our contracts with LA Care and Health Net for the Medicaid expansion population, DHS is required to provide treatment for mild to moderate mental health disorders and perform Screening, Brief Intervention, and

Referral to Treatment (SBIRT) services for individuals with potential alcohol misuse. Medi-Cal managed care plans must also ensure that individuals receiving specialty mental health services under a County's Mental Health Plan, receive coordinated physical health services within their regular Medi-Cal provider network: both the physical health and behavioral health sides are expected to ensure patients receive the entirety of their health needs. This emphasis on integrated physical and behavioral health care is similarly seen in the ACA's Health Home option which California is now exploring, as well as in California's Coordinated Care Initiative in which up to 200,000 dually-eligible (Medicare and Medicaid) beneficiaries in Los Angeles County could shift to Medicaid managed care, with the health plan and ultimately their providers bearing greater responsibility for coordinating physical and behavioral health services.

Improve linkage between prevention and health services delivery activity

As currently structured, prevention and population health activities largely reside within DPH whereas the majority of personal health services reside within DHS; DMH possesses both types, operating though in silo from DPH and DHS. It is widely accepted that health services is only one determinant of a person's health. Social behavioral determinants, including poverty, education, literacy, diet, exercise, life stress have a far larger effect on health. Separating prevention programs and the funding streams supporting them, from direct patient care services, complicates efforts to closely link and merge interventions that could ultimately improve health outcomes. For example, the county funds nutrition and exercise programs in the community through public health, but often the patients most in need of these services are in the DHS system. Getting these patients to needed community programs would benefit both the individual and the program. A combined health department would offer opportunities to adopt new approaches to such areas as chronic disease prevention, environmental health, and community-based interventions and to ensure there is synergy and non-duplication between available funding streams.

Better control costs

Consolidation will enable the County to coordinate services for patients with complex needs. Patients with mental health issues who can be cared for in a non-locked residential setting should be promptly moved from restrictive, costly emergency or inpatient settings. Patients who frequent emergency rooms and psychiatric urgent cares may reduce their visit rate if they had a safe place to live and store their medicines.

Similarly, the three health departments could realize budgetary savings if they shared costly capital or administrative resources, while yielding tangible benefits for patients in terms of service delivery enhancements. Buildings currently used to offer a limited array of STD and tuberculosis services could shift to providing a full set of primary care services, expanding geographic access for patients. Over time, administrative overhead could be reduced through greater collaboration among departmental personnel in such areas as contracting, supply chain, etc. A combined department would also be able to achieve economies of scale in the areas of drug formulary management, ancillary services (e.g., laboratory studies), and have the potential for better use of 340b drug pricing. These and other initiatives would ensure the County is making the most cost-effective use of all available resources.

Achieving these savings in practice requires close collaboration and communication between administrative staff and clinical personnel who work in very different parts of the health care system. While the County has encouraged and supported inter-departmental collaboration, such as with the Housing for Health initiative and the psychiatric emergency services decompression plan, results are complicated by the different ways in which each department chooses to prioritize its time and funding. A more integrated approach is needed if we want to achieve better results across a broader scale.

Increase revenue by taking better advantage of existing funding streams

A combined department would enhance budget flexibility and increase the likelihood that the County can draw down the maximum Disproportionate Share Hospital (DSH) payments, available Measure B funding, and other revenue sources. An integrated behavioral and physical health program will also help the County maximize opportunities to support whole person care which will likely be a prominent part of the next Section 1115 Medicaid waiver. For example, the Centers for Medicare and Medicaid Services (CMS) has expressed that they would like the goals of the next 1115 waiver to include population health goals, such as decreasing the prevalence of smoking in a community. By combining our efforts, Los Angeles would be in a better position to respond to these demands. We would also be in a better position to apply for competitive grants that are focused on integrated delivery systems.

Proposed implementation and practical considerations:

Although the greatest benefits in care integration and financial savings through efficiencies would come from a full integration of the three Departments, this would be a large undertaking that would be time consuming and disruptive of current activities. Instead, I propose the three Departments operate as an agency, with the current Director of Health Services serving as the Director of this new unified health department.

In this model, DPH and DMH would remain as distinct individual divisions with separate finance structures, just as each of the hospitals within the current DHS operates as its own division with its own financial reporting. The Directors of DPH and DMH would report to the Director of Health Services and would serve on the Health Services Executive Team. If the new permanent Director of Public health is a physician she or he will be the County Health Officer. The Director of Mental Health will remain the County Mental Health Director.

The permanent Director of Public Health would be selected by the Board of Supervisors in consultation with the Director of Health Services, or by the Director of Health Services in consultation with the Board of Supervisors, as preferred by the Board.

Over time, as potential synergies are identified, administrative and back-office functions (e.g., finance, contracting, procurement) currently residing within each Department would be combined.

This proposal is consistent with the State of California's decision to transition the California Department of Mental Health into the California Department of Health Care Services in 2011, as well as how most counties organize their county physical and mental health services and public health activities. Although it is worth checking with County Counsel, this organization is the same as that of the majority of counties in California, including San Francisco, where I was the Director of a combined department for 13 years. Our Department included a traditional public health department with restaurant inspections, categorical STD and TB clinics, a clinical laboratory, and broad population health activities, two hospitals and an ambulatory care division, and a county mental health and substance abuse division which were combined into Behavioral Health.

If the Board wishes to go forward, the next steps would be:

– Private discussion with Interim CEO and the leadership of DPH and DMH to assure them that this consolidation is being done to enhance our joint missions, not to weaken the individual programs, and to be open to feedback on how best to accomplish this goal.

– Motion by the Board consolidating the Departments of Health, Public Health, and Mental Health into a single Department under the Director of Health Services with maintenance of separate financial accounting of the three Departments.

If you have any questions or need additional information, please contact me at (213) 240-8101.

MHK:jp

c: Sachi A. Hamai, Interim Chief Executive Officer

FINDINGS

I. Findings Regarding Los Angeles County's Restructuring of its Homeless Services

FINDING #1

LAHSA's coordination of housing, social and health services for the homeless (and those at risk of becoming homeless) in Los Angeles County has been siloed, fragmented and disjointed, generating limited results at a high cost.

FINDING #2

LAHSA's budget in 2024 was $875 million, with more than $300 million of that coming from LA County.

FINDING #3

LA County has decided to withdraw its contributions to LAHSA and redeploy them to provide homeless services directly (referred to herein as the Homeless Funds).

FINDING #4

LA County intends to merge the CEO Homeless Initiative (CEO-HI) and the DHS Housing for Health (DHS-HFH), creating a new County Department focused on the homeless (the Homeless Services Department).

FINDING #5

The currently proposed timeline for the Homeless Services Department initiatives is as follows: (1) merging the operation of CEO-HI and DHS-HFH by April 28, 2025, (2) creating the Homeless Services Department as of July 1, 2025, (3) Phase I implementation would then include the "integration of the CEO-HI and DHS-HFH core housing and supportive services," (4) Phase II would include "integration of County-funded programs and services administered by LAHSA" into the Homeless Services Department, (5) Phase III would "include the integration of programs and services administered by other County departments

as applicable," [emphasis added] and (6) County-sourced LAHSA funds and related staff would be transferred to the Homeless Department by July 1, 2026.

FINDING #6

The County's proposal for the "full" integration of County services for the homeless into one Homeless Services Department will have two major exceptions that will likely undermine the County's comprehensive approach to homelessness, possibly leading to the same "siloed, fragmented and disjointed services" that plagued LAHSA.

FINDING #7

The first category of likely exceptions to the County's integration of homeless services will be certain specified homeless services provided and retained by other County Departments, each of which will be assessed for integration appropriateness "in partnership" with the relevant Department (with the history of County Departments asserting the importance of their independence likely being a major hindrance in achieving full integration).

FINDING #8

The second category of exceptions includes those services that are "highly clinical and deeply integrated with DHS's core health provider and managed care functions for its empaneled population and financing," thereby keeping many of the County's major interactions with the homeless population within DHS.

FINDING # 9

There is no evidence that LA County has any plans to use the Homeless Funds to expand the County's CalAIM services (either ECM or Community Supports), including in connection with the County Hospitals' interactions with the homeless, especially regarding the significant opportunities for increased ECM enrollment by the County Hospitals (although the County does acknowledge the importance of CalAIM funding with respect to current DHS-HFH functions).

II. Findings Regarding the Coordination of Los Angeles County's Health Related Departments

FINDING #10

The County Departments of Health Services, Public Health and Mental Health have strongly preferred voluntary, non-binding consultations rather than centralized decision-making regarding their operations, which has created major challenges for the ongoing efforts to coordinate and integrate the County's health and social services.

FINDING #11

The County Departments are inclined to coordinate their roles as ECM providers solely on a voluntary basis, including the enrollment of Medi-Cal beneficiaries, assignment of Lead Care Managers and accessing Community Supports networks.

FINDING #12

LA County is creating a Restorative Care Village on the LA General campus, which promises to give patients, especially the homeless, expanded access to a broad continuum of social and health services; however, the various providers participating in the Restorative Care Village are not subject to any centralized management or control, and therefore there is little if any coordination, much less integration, of the various Restorative Care Village services. (There do, however, appear to be tentative plans to create an advisory "Care Coordination Committee" with representatives from DHS, DMH and DPH to provide voluntary guidance regarding effective coordination.)

FINDING #13

Although there are "Restorative Care Villages" located (or being built) on the campuses of each of the County Hospitals as well as MLK Community Hospital, there appears to be no County-wide strategic plan regarding the potential and purpose of the Restorative Care Villages and little if any communication among the Restorative Care Villages or the entities associated with them.

III. Findings Regarding CalAIM

FINDING #14

There have been no systematic analyses of the CalAIM program's overall impact on reducing homelessness, improving healthcare or reducing costs.

FINDING #15

There are major impediments to ECM and Community Supports provider participation in CalAIM based on associated costs, non-standardization of compliance processes, burdensome reporting requirements, and inadequate compensation.

FINDING #16

The enrollment of Medi-Cal beneficiaries in ECM has been lower than anticipated for ECM's target populations.

FINDING #17

The State estimates that only 30% of Medi-Cal beneficiaries who are identified as eligible for ECM will likely enroll in ECM, but no studies have been conducted to determine why that percentage is so low.

FINDING #18

DHS, as an ECM provider, only enrolls Medi-Cal beneficiaries in ECM who are empaneled with DHS, a relatively limited population compared with all ECM eligible beneficiaries in LA County.

FINDING #19

Communication and coordination between ECM providers and the Community Supports providers to whom ECM beneficiaries are referred could be improved,

FINDING #20

Children's Hospital of Los Angeles patients include a high percentage of ECM eligible Medi-Cal beneficiaries; and, by enrolling as an ECM provider, CHLA provides an exemplary example of the opportunities under CalAIM to support Medi-Cal beneficiaries, especially regarding the needs of discharged patients

FINDING #21

Providing Access and Transforming Health (PATH) has provided and continues to provide substantial funding for participants in the CalAIM initiatives, especially for infrastructure and start-up costs.

RECOMMENDATIONS SECTION

Recommendations Regarding the Restructuring of County Departments Providing Healthcare-related Services

RECOMMENDATION #7-1

The Board of Supervisors should rejuvenate the Health Agency originally approved by the BOS in 2015, empowering it to make binding decisions regarding collaboration and integration projects involving health-related County Departments, including the Departments of Health Services, Public Health, Mental Health and Aging and Disabilities, especially including CalAIM participation and the operation of the Restorative Care Villages. (In implementing this Recommendation, the BOS should read Dr. Katz's memorandum, attached as Exhibit A.)

RECOMMENDATION #7-2

The Board of Supervisors should direct the Chief Executive Officer, in consultation with DHS, to conduct a detailed study of the opportunity, ability and available budget for a rejuvenated Health Agency to assume responsibility for all LA County initiatives regarding the homeless.

Recommendation #7-3

The Board of Supervisors should direct the Chief Executive Officer, in consultation with DHS, to conduct a detailed study of the comparative benefits of the new Homeless Services Department to address homelessness as compared with a rejuvenated Health Agency serving the same function, as proposed under Recommendation 1.

RECOMMENDATION #7-4

The Board of Supervisors should direct the Hospitals and Health Care Delivery Commission to study and make recommendations regarding the proposed creation and operation of the Health Agency in order to further the coordination and integration of high quality health and social services, especially services for the homeless, across all County Departments; and the Board of Supervisors should review and respond to such recommendations.

Recommendations Regarding the County's Commitment to the CalAIM Program

RECOMMENDATION #7-5

LA Care, DHS and LA General should create a working partnership to fully implement CalAIM in LA County, addressing, among other things (1) effective strategies to maximize ECM enrollment, (2) the expected increase in cost saving resulting from expanded ECM enrollment, and how to connect those cost savings to the funding of CalAIM activities, and (3) effective lobbying of the State for increased funding of CalAIM.

RECOMMENDATION #7-6

LA General, in coordination with DHS, should seek ECM provider status from LA Care, and LA Care should expedite LA General's ECM provider status.

RECOMMENDATION #7-7

LA General and LA Care, in consultation with DHS, should work together to develop a written plan that maximizes LA General's impact in qualifying eligible Medi-Cal beneficiaries for ECM.

RECOMMENDATION #7-8

LA General, as an ECM provider, should work with LA Care to generate a study on the effective recruitment of ECM eligible beneficiaries for the purpose of increasing the current 30% success rate in enrolling ECM eligible beneficiaries.

RECOMMENDATION #7-9

The Board of Supervisors should direct DHS to conduct a detailed study of the incremental costs of DHS's current and anticipated participation in CalAIM as an ECM provider, and the resulting financial benefits to the County and the State.

RECOMMENDATION #7-10

The Board of Supervisors should direct DHS to conduct a detailed study of the incremental costs of LA General's anticipated participation in CalAIM as an ECM provider, and the resulting financial and operational benefits to both the County and the State.

RECOMMENDATION #7-11

LA General and LA Care, in consultation with DHS, should work together to develop strategies to obtain and analyze available data, including data generated by LA General's ECM patients, for the purpose of evaluating the impact of the CalAIM program on beneficiary well-being and cost reduction.

RECOMMENDATION #7-12

DHS and LA Genera; should seek grants from PATH to fund LA General's infrastructure and associated costs in connection with its participation as an ECM provider.

Recommendation Regarding the Restorative Care Village

RECOMMENDATION #7-13

The Board of Supervisors should direct the Hospitals and Health Delivery Commission to investigate the potential benefits and structural challenges of the LA County Restorative Care Villages, and make recommendations regarding their organization, management, coordination and operation for the purposes of maximizing high quality care for County patients, especially focusing on: (1) the importance of establishing centralized control and management over each Restorative Care Village, (2) the benefits of each Restorative Care Village effectively communicating and coordinating with its associated County Hospital, (3) the Restorative Care Village's effective participation in CalAIM, especially in coordination with providers of Community Supports, and (4) the apparent lack of

a County-wide vision for the Restorative Care Villages; and the Board of Supervisors should review and respond to such recommendations.

REQUIRED RESPONSES

California Penal Code Sections 933(c) and 933.05 require a written response to all recommendations contained in this report. Responses by elected County officials and agency heads shall be made no later than sixty (60 days) after the CGJ published its report and files with the Clerk of the Court. Responses by the governing body of public agencies shall be made ninety (90) days after the CGJ published its report and files with Clerk of the Court. Responses shall be made in accord with Penal Code Section 933.05(a) and (b).

All responses to the recommendations of the 2024-2025 Los Angeles Civil Grand Jury must be submitted to:

Presiding Judge
Los Angeles County Superior Court
Clara Shortridge Foltz Criminal Justice Center
Los Angeles County Grand Jury
210 West Temple Street, 13t Floor, Room 13-303
Los Angeles, CA 90012

REQUIRED RESPONSES – CHART

Agencies	**Recommendations**
LA Care Health Plan	5, 6, 7, 8, 11
Los Angeles General Medical Center	5, 6, 7, 8, 11,12
Los Angeles County Department of Health Services	2, 3, 5, 6, 7, 9, 10, 11, 12

Agencies	Recommendations
Los Angeles County Commission on Hospitals and Health Care Delivery	4, 13
County of Los Angeles Board of Supervisors	1, 2, 3, 4, 9, 10, 13
Los Angeles County Chief Executive Office	2, 3

ACRONYMS

AHI	Alliance for Health Integration
BOS	Los Angeles County Board of Supervisors
CalAIM	California Advancing and Innovating Medi-Cal
CEO-HI	Chief Executive Office Homeless Initiative
CGJ	2024-2025 Los Angeles County Civil Grand Jury
CHLA	Children's Hospital of Los Angeles
DHS	County Department of Health Services
DHS-HFH	Department of Health Services - Housing for Health
DHCS	California Department of Health Care Services
DMH	County Department of Mental Health
DPH	County Department of Public Health
ECM	Enhanced Care Management
ED	Emergency Department
LA	Los Angeles
LAHSA	Los Angeles Homeless Services Authority
JCOD	County Justice, Care and Opportunities Department
MCP	Managed Care Plan
PATH	Providing Access and Transforming Health
POF	Population of Focus

COMMITTEE MEMBERS

Committee Co-chair: Rick Ellingsen
Committee Co-chair: Victor Lesley
Committee Co-chair: Linda Esparza
Committee Member: George Davis
Committee Member, Margaret Hatfield