

**LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES
HOSPITALS AND HEALTHCARE DELIVERY COMMISSION
March 5, 2026**

<u>Commissioners</u>	Present	Absent
David Marshall, D.N.P., Chair	X	
William McCloud, M.H.A., F.A.C.H.E., Vice Chair	X	
Christopher Bui, M.D.		X
Mark Marat Hay, Ph.D.	X	
Laura LaCorte, J.D.	X	
Patrick Ogawa	X	
Elisa Nicholas, M.D.		
Margaret Farwell Smith	X	
Stanley Toy, M.D.		X
Rosemary C. Veniegas, Ph.D.	X	
Tia Delaney-Stewart	X	
Jennifer Sudarsky	X	
Brad Selby	X	
<u>DHS Staff</u>		
Allen Gomez	X	
Connie Salgado-Sanchez	X	
<u>County Counsel</u>		
Lynette Clyde	X	
<u>Members of the Public</u>		
Jarrold Erdman		

1. Call to Order

The meeting was called to order at 10:30 by Commission Chair David Marshall. Quorum was not met, and a fifteen-minute recess was called.

2. Roll Call

Allen Gomez, Commission staff, called the roll at 10:32. Quorum was met.

3. Welcome

Commission Chair Marshall welcomed all members of the commission, staff, and guests.

4. Action Item:

- Approval of February 4, 2025 Minutes: Minutes approved unanimously.

5. Presentation – General Discussion with Dr. Christina Ghaly, Director of DHS

Revenue Threats

- There were COVID-era flexibilities in Medi-Cal eligibility and determination rules that expired in July 2025, and we did not anticipate the drop of Medi-Cal enrollment that has happened countywide.

- The drop in Medi-Cal lives adversely impacts the County financially. It also affects the overall health of patients who lose coverage and are unable to access care.
 - It has been 5-7% drop since July
- Still working with the State on renewal of 1115 waiver
 - Biggest component of the waiver is the need for renewal of the global payment program, which offers flexibility on the disproportionate share hospital program (DSH)
 - Renewal of the waiver is key; without it we will have a difficult time as of 2027
- Waiting for the implementation of HR1, which will get phased in and includes redetermination of Medicaid eligibility every six months
- More frequent eligibility requirements are expected to result in significant declines in Medicaid enrollment.
 - State directed payment declines will go into effect in 2027-28 resulting in a minimum of 3/4 billion dollars in losses to DHS
 - New rule under review offers additional guidance on implementation of HR 1 on state directed payment declines, it may make things worse than what was in the legislation

DHS/County Response to Threats

- The State implemented \$30 per month premium, which goes into effect next year for individuals who are undocumented, who are on State-only full-scope Medi-Cal
- DHS has been advocating to the State Legislature to put State General Fund into the budget for \$500M payment of which DHS would earn approximately \$100M for the nonfederal share for fee-for-service inpatients and hospitalizations
- Approximately 20 years ago, the State withdrew all of State general funds from the fee-for-service program for public hospitals
 - They maintained the State general funds for private hospitals, creating a disparity between how public and private hospitals are paid
 - DHS is seeking to get that funding back
- The proposed ballot item in June regarding a tax for healthcare, if passed, would bring in funds for DHS over 5 years, which would help stabilize, but not solve cost increases facing the department
 - It would implement a coverage program for low-income uninsured individuals similar to My Health LA
- The Project Monarch Revenue cycle implementation will take time, and the department will need to work on third-party payer planning and billing functions

Costs

- Looking to control costs without making service cuts
- Have not implemented service cuts because cutting services cuts revenue
- For every \$100M gap between revenue and gap, we would have to cut \$600M-\$700M worth of services
- If we need to do service reductions, we will initiate planning in early 2027
- Paid a \$5000 bonus to labor that cost \$100M and was unfunded by the county
- Will pay a \$2000 bonus this year, plus a 2% COLA that is unfunded by the County
 - For every percent, it's at least \$50M
- COLAs will come from fund balance

- Cost increase will expedite the timing of which we will need to do layoffs and service reductions

Budget Initiatives

- Hiring freeze since July
 - Not hiring management positions, several senior management items are being left vacant, creating shared roles, dual roles
- Trying to get 340B pricing access for ACN clinics
- Curbing capital project expenditures as much as possible
 - Implemented utilization management protocols for high-cost pharmaceuticals, lab tests, imaging and the like
- Considering consolidation of services
 - We will close 3 small, low-volume clinics with no service reductions and transfer providers and staff to larger clinics
- Looking at volume and data to ensure the use of human and technological services are used most efficiently
- Even if all the revenue efforts came through, our costs are still higher than our revenue
- Biggest cost is labor
 - California has mandatory ratios and mandatory minimum wages
- It is not sustainable with the revenue streams that exist for a provider like us which depends on Medicaid and serves the uninsured
- Will not reduce access to services, even though this will not balance or cut costs

Q – Regarding Medi-Cal reassessment, what initiatives are in place to ensure people are aware of how important it is to renew? What about folks without an address and unable to get a notification in the mail?

- DHS works closely with health plans and DPSS to remind patients about renewals every 6 months; folks without an address have always been a challenge
 - Ensuring that those who interface with patients are aware of when renewal may be coming up to help them through the process
- DPSS will be moving to electronic enrollment
- Will no longer require wet signatures for the applications allowing more work to be done online and over the phone

Q – Collaboration with other organizations who provide prevention and screening services, i.e. mammogram – can DHS refer community members to other resources for those services?

- We should look to that further to allow for prevention services to occur as people lose their insurance and the uninsured population grows
- FQHCs are also ramping up

Q – In the past you have mentioned a role for philanthropy, i.e. creating a foundation. What is the status of that?

- An existing staff member will lead this effort over the next year
- County Counsel is being tapped for perspective on how to approach this from a government standpoint
- Thinking about the right structure for a DHS-specific or facility-specific foundation
- Looking at governance structure models – figuring out where to invest efforts

Q. What is impact of Public Health cuts? Any discussion around merger?

- No discussion around possible merger
- DHS and DPH do different things; DPH handles population health, DHS handles patients in managed care
- The sales tax will provide 10% of its funding to DPH to help build up additional program

The Commissioners thanked Dr. Ghaly for her presentation and for her continued efforts.

6. Presentation – Discussion on Project Monarch with Dr. Phillip Gruber, Chief Health Medical Information Officer, Kevin Lynch, Chief Information Officer and Chris Rodriguez, Enterprise Health Information Management (EHIM) Director

Dr. Phillip Gruber introduced the group.

Provided visual overview of Project Monarch –

1. Provider Documentation Experience (PDX)
2. Clinical Documentation Improvement System (CDIS)
 - Physician visit followed by documentation in electronic medical record (EMR) reflects clinical care and guides future clinical care
 - Clinical documentation improvement specialists (CDI Specialists) conduct a concurrent review to look for opportunities to improve documentation to accurately reflect patient acuity and the services being delivered
 - CDI Specialists are trained nurses and coders and can query providers through the system when there are questions regarding the documentation
 - Health Information Management (HIM) is the medical records part of the organization, and the coders handle coding
 - The coding goes to revenue cycle analytics

Q. How do you itemize professional billing fees?

- The revenue cycle is the end of the receiving system for this workflow
- The providers most appreciate the voice recognition feature in Monarch, which reduces the need to type
- Real time Documentation Improvement (RDPI) is a tool used for voice recognition, that algorithmically identifies opportunities to improve documentation
- CDIS replaces manual processes – it's a software product designed to facilitate the work of CDI

Q. What is the underlying software providing the assistive documentation and the documentation decision support?

- The vendor is Nuance, now owned by Microsoft. The coding product is from Dolby Fusion.

Q. Have they been tested? Are you in the process of beta testing?

- Yes, they have been tested for coding accuracy. This is commercially available software used in the coding industry
- As part of implementation, we go through a rigorous design, build, test, train, implementation and ongoing support process
- Testing is part of implementation process
- The documentation tools do not use artificial intelligence – they are algorithmic, based on rules from CMS

Q. Does the algorithm draw from other information like labs and other diagnostic testing information?

- The algorithm is very conservative to avoid potential upcoding of claims; it looks for some structured data, but is ultimately reviewed and decided on by humans
- The voice recognition tool is one step removed from typing, and providers can see what is captured in real time, enabling providers to assess accuracy
- CDI specialists review data for patients that are still in the hospital so the coders or nurses can do concurrent review – it's the middle step before final coding
- It's a tool to help facilitate the work of the providers without substituting for their judgement and training
- CDI specialists and coders send queries to providers, which are addressed promptly over 90% of the time
- The system tracks queries between the coding specialists and providers and the resolution
- The system does not automatically escalate a query, but facilitates the process to do so, if needed
- The CDI queries have been licensed since July/August and the products have been implemented as of early December
- These tools can capture more of the thinking and reasoning that goes into documentation, this is critical information for clinical care
- PDX is the optimization of the EMR that's paired with the software described, which enables providers to access one consolidated view to review the needed data for effective documentation

Q. When you present reports for budget review, what is presented to Dr. Ghaly? What are the metrics that get reported to leadership in terms of the quality of documentation?

- Diagnostic capture and case mix index
- Documentation time and turnaround time for radiology are being tracked
- Coders can review the data in real time to ensure accuracy, rather than going through a retrospective audit to find information

Q. When will DHS be able to drop bills from the system?

- Negotiating with the vendors to create an integrated platform that will transfer clinical data into the revenue cycle
- The integrated platform will allow communication with health plans
- Good documentation will yield better reimbursement for services rendered
- When negotiations are complete, the letter will go to the Board for approval

- It is generally a one-year design, build implementation process, which is implemented in phases – starting with Harbor, LA General, and Ambulatory Care Network (ACN) facilities that are in close proximity
- Expect to be able to issue bills in 2027

A Commissioner requested that the speakers come back when implementation has been completed.

The Commissioners thanked the speakers.

3. Items for discussion and possible action:

	DISCUSSION/FINDINGS	RECOMMENDATIONS, ACTIONS, FOLLOW-UP
a. Discussion – Commission Site Visits	<p>Commission site visit on 2/19 to MLK, Jr. Outpatient Center</p> <ul style="list-style-type: none"> ● Elaine Batchelor discussed this time as an opportunity for improvement ● CMO led discussion on their scheduling <ul style="list-style-type: none"> ○ Implementing precision scheduling, which has reduced the incidence of late shows to less than 5% ● They account for 25% of ACN population ● Push for patient centered medical home model ● Good use of shared use building on campus ● They are budget and space constrained ● The space is nice – good use of art and architecture ● Operational efficiency is very good ● The community is engaged with the health center ● The commitment to do more with less efficiently and not affecting patient experience is evident ● They are changing their security from the Sheriff's department to armed private security, which may be more cost effective ● Surgical network adequacy pilot project that started 10 years ago and is now showing results ● Commissioner Veniegas noted that some of the long-term efforts and assessments are now coming to fruition and some are not <ul style="list-style-type: none"> ○ Dr. Soni, a previous Commissioner predicted poor health outcomes due to a drop in cervical cancer and breast cancer screening, as a result of 	<p>Future locations:</p> <ul style="list-style-type: none"> - Rancho Los Amigos in May or June - High Desert - Olive View-UCLA Medical Center - Children's Hospital site visit possibility. Could we hold a meeting there and get a tour? <p>Are we using the newest version of the site visit form? Should not have the Covid questions.</p>

	<p>COVID-19 and reduced access to preventive care, which did not happen</p> <ul style="list-style-type: none"> ○ Some ACN facilities were concerned about the centralization of surgeries at LA General, which is now well ordered ● The Sheriff security issue has been in discussion for a long time ● They intend to do training with trauma-informed approaches to effectively deal with people with mental health issues ● When the security team is vetted, they are looking to ensure the teams have experience with the population they are serving 	
<p>b. Discussion – Commission Guest Speakers</p>	<p>January – Canceled February – Caroline Balfour March – Dr. Phillip Gruber, Kevin Lynch, Christopher Rodriguez (Project Monarch) April – Dr. Lisa Wong (DMH) May – June – Dr. Timothy Belavich (Correctional Health) July – meeting dark August – Dr. Jackie Contreras (DPSS) September – Dr. Barbara Ferrer (DPH) October – November – December –</p>	<p>(Tentative) October – Sara Mahin November - Louise McCarthy (CCLAC) December – Dr. Wei-An (Andy) Lee December - Jessica Kuo/Shari Doi</p> <p>Others: Dr. Nina Park LA Care Director</p>
<p>c. Discussion – 2026 Strategic Priorities</p>	<p>Commission staff provided the DHS strategic priorities and Commission Chair Marshall asked the group to think about how the Commission can align its strategic priorities with DHS strategic priorities:</p> <ol style="list-style-type: none"> 1) Population Health 2) Service Excellence 3) Workforce Enrichment 4) Fiscal Sustainability <p>Given the financial headwinds, which of the DHS priorities are at greatest risk? Consolidation, but not the reduction of services is a challenge. Where can the Commission provide most value?</p>	<p>Commission Chair asked the Commissioners to look at the priorities and be prepared to discuss at next meeting to identify areas of focus for Commission’s work going forward.</p>
<p>d. Discussion – Department of Health Services Dashboard</p>	<p>The Commissioners reviewed the DHS Dashboard.</p> <p>DHS Data Analytics and Dr. Ghaly are reviewing current metrics and determining what should be included in the dashboard.</p> <p>Dr. Ghaly mentioned that a concern is the folks who are no longer insured. That will likely be a metric that should be tracked.</p>	

	<p>At the state level, DPSS is working with DCHS to implement a way to identify and automatically renew certain individuals for Medi-Cal through the <i>ex parte</i> process used during the Covid pandemic.</p> <p>50% of people who purchase insurance independently are opting out of buying insurance because they cannot afford it.</p> <p>Exemption for individuals who are in foster care, coming out of incarceration and “medically frail,” would automatically qualify, although the term has not yet been defined by the federal government.</p> <p>Commissioner Veniegas suggested that the Commission review Medi-Cal enrollment data to determine the number of individuals who are dropped from coverage.</p>	
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7. Items not on the posted agenda for matters requiring immediate action because of an emergency, or where the need to take immediate action came to the attention of the Commission.

8. Public Comment – No public Comment received.

9. Adjournment

The meeting adjourned at 12:22 p.m. next regular meeting is scheduled for April 2, 2026.