

# HMHS Cluster Transcript

March 25, 2026, 7:11PM

□ **Kieu-Anh King** started transcription

KK

**Kieu-Anh King** 0:06

And the the mic on the owl is now live, as is the video and transcription should be starting in just a moment.

I think we're good to go. Yeah.

We're muted. Unmuted. Yes, there you go. Thank you everyone for your patience. I'll go ahead and call the meeting to order now. Please note that the meeting will be muted for all participants. You can unmute yourself using the Teams app or by dialing star 6 if you're calling into the meeting.

A quick change public comment will be limited to one minute. This is to ensure that we're consistent with every other cluster. So moving forward it'll it'll be one minute for public comment. We'll start now with introductions with board office going first.

Hi, everyone. Alexandra with the Board District.

Oh, Chloe Genie Rice with the 4th District. I'm Tyler Cash, Rosa Barker's Office, 5th District. Chris Cullen, 4th District. Jasmine Griselavio, 1st District. Victoria Gomez, 2nd District. Jared Ridman, 3rd District. Erin Fox, 3rd District. Angelica Yella, 3rd District. Yolanda Vera, 2nd District. Elizabeth Varasola, 2nd District.

Do we have representatives from the first district on the call?

We have representatives from the second district on the call.

Do we have representatives from the third district on the call?

Do we have representatives from the 4th District on the call?

Do we have representatives from the 5th District on the call?

OK, we'll move on to county staff representatives. Do we have any CEO staff in the room? Kiwan King, CEO, Rustaba Medrano, CEO. Do we have representatives from the County Council in the room? Brandy Moore, County Council, Blayne McPhillips, County Council.

Do we have representatives from Public Health in the room? Jacob Kramer, Public Health. Azar Tan, Public Health.

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Do we have representatives for mental health in the room? Bristol Kitty, David Parker.

Do we have representatives from health services in the room?

Do we have any CO staff on the call that would like to do themselves?

Do we have representatives from County Council on the call?

**RK Rachel Kleinberg 2:32**

Rachel Kleinberg for DMH.

**KK Kieu-Anh King 2:37**

Thank you. Do we have representatives from public health on the call?

So we have representatives from mental health on the call.

**SK Stella Krikorian 2:49**

Stellar Kerkorian, Contracts Division.

**KK Kieu-Anh King 2:54**

Do we have representatives from health services on the call?

**FL Ferris Ling 2:58**

Fairest Link DHS Finance.

**CS Connie Salgado-Sanchez 3:01**

Bonnie Salgado Sanchez, Government Relations.

**AG Allen Gomez 3:05**

Alan Gomez, Gome Relations.

**+13\*\*\*\*\*33 3:08**

Judith Millsab, WGLACO.

**KK Kieu-Anh King 3:10**

Great, thank you.

Do we have any other county representatives on the call?

**JC** **Joseph Ciccone** 3:21

I'm Joseph Chacone. I'm with CEO Lair. I missed my chance earlier, so thank you.

**KK** **Kieu-Anh King** 3:28

Thank you. All right. We'll proceed with today's agenda. As the agenda notes, we had one closed session item. We have two board motions and information item, a presentation item and a discussion item. We'll start with public comment for the closed session item at CS1 Conference with Legal Counsel and State Litigation from Department of Public Health. Do we have any?

public comment on this item.

Alright, we'll move on to item 2A. This is St. Vice Motion Mayor Smith Hall. Yes, thank you Madam Chair and hello colleagues, everyone. I did distribute to most of you a photo. I'll get you a copy here. There was a slight revision that was made by our office after submitting the motion, but essentially we're asking for there to be.

An awareness campaign that's kicked off with HR coming into May. We know May is a mental health month. There will be an additional promotion. I think actually handling that piece, that's the only change here. But this is enabling HR to distribute the materials, encourage support from within the county and encouraging our employees, you know, to take an active look at their mental health and making sure that.

That there are resources to support the county workforce. So it's a very straightforward motion. Uh, but happy to take any questions if anyone has any. Do you have any questions from board offices on this motion?

Do we have any public comment on this motion?

**KM** **Karen Morris** 4:55

Yes, Karen Morris from SEIU Local 721. Just thanking the supervisor for the motion.

**KK** **Kieu-Anh King** 5:03

Thank you.

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Thank you. All right. Next we have item 2B. This is SC Three's motion combating home health and Hospice fraud in LA County. Yes, thank you. So we know in recent years instances of fraudulent practices among home health and Hospice providers has increased.

And there are 3170 home health and 1623 Hospice agencies located at LA County. Historically, this businesses have been concentrated in Glendale and Burbank, but of late there have been significant increases in the number of operations located in the Van Nuys area in LA.

County The Department of Public Health Facility Inspection Division HFID is contracted by the California Department of Public Health CDPH to conduct licensing and certification work in the county on behalf of the state. So this includes conducting inspections on behalf of both the state and the US Centers of.

For Medicare and Medicaid Services, CMS related to home health Hospice operations, including investigation of fraud allocations. And then under federal law, home health and Hospice agencies can elect to be deemed by a private.

Accrediting organization to meet the CMS approved accrediting organizational standards. So deemed status allows providers to be surveyed by private accredited entities rather than CMS for surveyed confirm surveys to confirm the compliance with federal statutory requirements.

And over 60% of home health and Hospice agencies operating in the county have federal deemed status and fall outside the direct oversight of HVID. And while HVID does retain control over the investigation and complaints against the non deemed agencies, the investigation or complaints about a deemed provider.

Must be referred to CMS to obtain authorization to conduct a complaint validation survey, which they do follow up on. So this motion has two directives. The first it directs DPH to report back county DPH report back in writing in 60 days.

On recommendations to improve coordination of the federal and state government's investigation and enforcement against fraud in the home health and Hospice industries with HFID's inspection division and contracted enforcement activities. The second directive directs the Chief Executive Office, Legislative Affairs and Intergovernmental. Relations Branch to send A5 signature letter to the Director of the California Department of Public Health and the Administrator of CMS, urging greater coordination and

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investigation and enforcement of home health and health providers and straightened regulatory oversight for accrediting bodies in their.

Roles overseeing deemed Hospice and home health entities and are there any questions for my colleagues?

Yeah, I'll start. Thank you. This is it. It's a good motion. Just in the directive too, similar to the the clarifications that were brought about the.

Warner Brothers.

With the with the letter that we're sending and things like that, is that is this letter going to be sent after or are we doing it concurrently to the report? That's an excellent question. It I'm I'm open to suggestions if you don't not.

Committed one way or the other, OK.

Just in case they had recommendations that we want to, yeah, so we can definitely discuss that and figure out what makes the most sense, OK.

Any other questions?

Do we have any public comment on this item?

OK, great. We'll move on to to information item 3A. This is a DPWDHS board letter on the Harvard UCLA replacement program. Do we have any questions from board offices on this item?

Hey, do we have any public comment on this item?

Great. We'll move on to presentation item 4A. This is a presentation from CMH on the approval to execute a new contract with Universal Exemption Service Hospital PDA Allied Universal Security Services for Security Guard.

Hi, I'm Crystal Kidney, the DMH Board liaison and I'm here with Damien Parker on the head of the or Chief of MH support. So thank you for having us today. Currently the Sheriff's Department provides security services.

Services to DMH facilities. However, due to staffing shortages, they don't have the capacity to continue with these services effective at the end of this month. DMH conducted A solicitation for the provision of these security services and Universal Protection Service LPDBA.

Allied Universal Security Services was the selected entity. They were the most reasonable applicant and had the lowest bid.

The services will include the provision and supervision of trained and certified armed

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and unarmed security personnel who are professional, courteous, uniformed and properly equipped. Approval of recommendation one of this board letter will allow DMH to execute the new contract.

With Universal Protection Services effective upon board approval to June 30th, 2027 with an option to extend to June 30th, 2030. The total contract sum is about \$23.2 million for the two year period.

That's three and a half million dollars for the remaining of fiscal year 2526 and \$19.7 million for fiscal year 2627. They'll be funded by a mix of federal financial participation, 2011 realignment, MHSA and BHSA funding.

Approval of recommendations two and three will allow DMH to make amendments to the contract to revise the language to revise the total contract sum not to exceed 20% of the Board approved amount.

To extend the term if necessary and modify the statement of work or service exhibits without any interruptions to services, and also terminate the contract in accordance with the contracts termination provisions. The contract will be evaluated by DMH on an annual basis to ensure the contractors come.

Compliance with all of the contract terms and performance standards as per board mandate. We are here if you have any questions. We also have contracts and County Council on the line. Questions.

Can you say a little bit more about why there's what triggers the decision to put our guards in a particular location and not and?

I'm also just mindful about there are some providers, for example, on the MLK campus, I talked to the Community Hospital and talked to Exodus. They've affirmatively chosen not to do armed guards because of the message it sends to the patients in the community.

And because of anxiety around accidental shootings, there was a situation in Fresno where a patient grabbed an armed guard's gun and and shot himself in the head in front of everybody. And so I.

I'm wondering if you could say more about the decision on where they're host. So in in every clinic we do an assessment and we do it with the program staff to understand what the program needs and it's it's ultimately a decision on the program and what they felt they need in that space.

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Some spaces we don't have off guard, some spaces we do. And with this contract, unlike the sheriff contract, every guard understands and he takes a course which is we call mental health first aid. So they understand where they're going into instead of just placing a guard off the streets.

And put them into a mental health clinic where they don't understand exactly where there are or how to de-escalate or how to do those things. These guards that are now in this contract will go before they go into one of our clinics, have to do this training and have to understand where they're at and and.

The situation and and be able to deescalate or understand when the situation is getting out of hand and how to deescalate at this time. The sheriff don't have to go to that train. Do they? I mean, are they placed inside the clinics? No. So, so the guards, like at the at the gates where people come in, so the patients will all see them. So they're placed in inside for weapon screening. There's always weapon screening within that.

And that's just to make sure staff and to themselves. There are many times whether it's at the BAC that that there are weapons confiscated and we just take them so they're not a harm to themselves or anyone else. So it it really depends on each and the individual. It's not a catch all for every single fight.

It all depends on on that site and how they feel and their clientele. When you say they feel, so it's a staff driven, it's a staff driven. Are the patients or clients views taken into consideration? We've never had, not before. That's something that we can think about in the first day 101.

To bring the clients in and see how they feel about what guards and and maybe it's strategic of where the guards are armed and where they're not armed. And also with this contract, it's a difference between a the sheriff's, sheriff's guards are really a an observing report, right? So if something is happening.

They are not to engage and that is the main reason why we went to our own, our own contract, especially when you take SSOS. Now we don't have that authority in that room anymore, right? We don't staff were not only safe understanding that the SSOS were going to be gone.

So we had to do our own contract because the share contract doesn't allow them to engage in the clientele. Two more questions. One is.

Just with anxiety around ICE presence, I'm wondering if you can share information about

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the uniforms that they'll be wearing and how we're dealing with any anxiety that some clients might have.

And I know people come in plain clothes, but if you can, so the thought process is is doing it some kind of the concierge that we have at the BHC where they're not security guard uniforms are more polo shirts where you feel more comfortable where it's not a uniform as as a security guard.

As a normal security guard with a patch on it and and you know it's more of someone that you you will see there have their their stand their belt on and things like that but they'll be they'll be in in Apollo and playing clothes and stuff and the concierge at the BHC when I when you walk in they're not armed right by the front they're not.

So, but these, this will change it. They will make them armed. It would be strategic of where we put them. No, right, right now. So the BHC is completely different than a normal clinic, right? In a normal clinic, your first initial contact is with the security guard. Right. Because you're doing the web screening, you're doing those things before you're put into the clinic and to make sure everyone's sick. So your first initial would be that person, but they will be in and not a security guard uniform, but in a polo. And so your first initial reaction is someone isn't OK, this security. You would know it's a security guard, but you won't feel that he's in.

And uniform, I guess is the best way to say it. My last question is, can DMH share incidents of violence across its clinics over the last couple of years, where they occurred? Thanks.

Any other questions? No. I just wanted to echo Yolanda's points and I had similar questions regarding the armed security where they will be placed. I mean, we all know and especially as mental health conditions, you're experts at this that that just can be in and of itself seeing someone triggering. So I.

I understand that you're, you know, talking to staff would be really great to see if there could be more incorporation of the the folks that are actually receiving the services and then also if you can share where the armed securities are actually going to be placed.

Yes, you want it perfect. So you're gonna get 56 different. So every clinic's absolutely different, right, of how we set it up. So if you want it for every single clinic of how they're going to be be, that'll be, I can give that to you.

Yeah. Oh, OK. Thank you. We'd like to receive that too. Thank you, Larry. I appreciate it. I

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have another question going off of sort of the additional trainings that the county might mandate for the contractor.

I know there's been just recent like changes on how we ask if there's ice presence for verified identification or ask them to step out in areas. Is that also training that they are receiving? That's part of the the mental health.

Oh, God.

I have a quick question, just curious, is this going to like increase the number of facilities that the Sheriff Department was like? Is it gonna expand services? It's gonna be the same amount of services covered, same amount of services, but with the understanding that we're growing.

Um, it. It'll expand at some point in time, got it? But it's the same exact services that share.

Questions.

Do we have any public comment on this item?

Great. We'll move on to discussion item 5A. Thank you. This is the DHS fiscal outlook for March 2026.

**FL** Ferris Ling 19:59

Hi, this is. Hi, this is first link. Can you guys hear me OK?

**KK** Kieu-Anh King 20:00

And I think, yeah, there is, yeah.

Yeah, we can hear you.

**FL** Ferris Ling 20:06

Great. Thank you so much. Um, so um, we are doing this, uh, physical out of presentation. We do it every six months. Uh, the last one was September. Uh, the format is the same. We have to write up for our forecast, uh, in the first few pages.

Attachment one has to do with our multi year forecast starting fiscal year 2526. This time we decided to add another attachment, attachment 2 to illustrate the.

Factors that we have to monitor in the next 9 to 12 months because of various changes affecting our forecast. Some of that we're gonna.

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Talk about that in in this discussion, but the impact is yet to be determined. We are being conservative in our forecasts as a result, but we will touch on some of that as we go on.

So our current year forecast right now for 2526, we are forecasting a deficit of 257 million, which is an improvement from the last forecast that was presented to the board. It was around \$410 million. We continue to expect uncertainties. We were hoping to get some of the clarities from some of the pending regulations and rules, but we haven't got the final.

Versions so that is still to be determined. So once we receive the those updates then we'll modify our forecasts and then present to the board next time when we do the physical outlook.

Um, there are uncertainties for sure. Um, you know, we didn't expect our managed care lives to drop, uh, over the past. Um.

Eight months I would say starting uh July of 25. Um, so it has been dropping for about like 10% Uh from July. Um that is kind of before the Uh state only Uh implementation that they the the the state applies starting January of 20.

Six, they are freezing the enrollment for the state only program and also because of that we expect a a a worse than expected number from and that's it that's included in our forecast.

In our forecast, but because of the pending rules that hasn't been finalized, we also expect some one time delay of those rules impacting our forecast. So the mix of the two that's in slight improvement from our forecast.

As of 410 to now 257 deficit. So we have fund balance right now that we are able to use to balance our budget for 2526272627.

And 2728, we do expect a small amount to to continue in 2829. Obviously as we hear more and more updates from the federal regulations and policies, we will continue to update.

Our forecast, the number could be better than anticipated. We tend to do a a conservative forecast, but at this time we don't know. So, so let's go over some of the uncertainties that we have and if someone is putting.

This the document on the screen, maybe you can go to attachment to the last page because most of the items are listed there, the ones that I'm gonna talk about on at the

state level.

Because of the state budget, they are as I mentioned earlier, they freeze the state only program starting January of 26 and we also expect them to to add and a premium.

To the state only program starting January of 27. So for the freeze that has already begun January of 26, we do see a accelerated or higher reduction in in.

Our assigned lives, it used to be about 1 to 2% going down every month. Now it's like about, I think about 3% every month. So it's still fresh, it's still kind of new. We have to continue to monitor the process. I don't know if this reduction is going.

It's gonna be, you know, gradually stabilize or it's gonna intensify. So we're gonna have to monitor this new development. Also for the premium that they're gonna add to in January of 27, we have no way to.

Predict how that's gonna affect the lives. So but we do expect and a negative impact to the managed care. So that's that's at the state level. At the federal level, there are a few. Factors affecting our forecasts. So one has to do with the reimbursement of F for the emergency services FMEP for our managed care population. The expectation is that it's going to be effective October of 26.

For that population, we used to get 809010 match from the federal. The expectation is that it's going to drop to 50%. That's one expectation and our current forecast is about 40 million for the first nine months and then annually it's going to be over 50 million.

Another change has to do with work requirement and also redetermination. The work requirement and redetermination both are expected to take place January of 27. Again, we have no historical trend to kind of.

Predict how that is gonna affect the lives, but we do again expect negative impact to our lives and at that time we're gonna have to monitor the new trending and update our forecast accordingly. Um, and then the last.

Expectation is that the federal government is gonna face down our directive payment beginning January of 28. So right now they are looking at how our payments.

Comparing to the Medicare rates, they our understanding is that they don't expect the eventually our payments should be over the Medicare payments. So they are doing a phase down of 10% on an annual basis.

Until we reach the Uh Medicare Uh payment level. So those are the highlights. Um, obviously there are other developments coming up. Uh, those are the big highlights I I

want to kind of touch on. Um, that is Uh.

What we expecting to monitor in the in the next 12 months. So and then another thing I wanted to also touch on is that in January of 27 our our actually our new our current waiver is scheduled to expire December.

About 26. So right now we are working with the state to hopefully extend the our current waiver program. If not, it will convert back to the oldish program which we're gonna.

Have to work with the state to make sure that we have a smooth transition. Usually for a new program being implemented, it takes some time to to finish all the negotiations and things like that. So we expect to be very busy in the next few months depending on. You know how they are looking at the current waiver and what they want to do. You know CMS wants to do either to extend the program or to, uh, make it converted back to the oldish program. So that's one.

Another update is that the dish cut is again eliminated for two more years. So originally the dish cut is expected to have to to cross 10 years. 9 out of the 10 years are eliminated now is.

So it's only one left to be to be done if the Congress decided to do it. Right now our expectation is that we don't get the this cut and that's the reason why based on historical.

Trend and we don't forecast this in our numbers. So those are the ones that we have in the pipeline to make sure that you know what we work with the state, the state stakeholders and other hospital systems to make sure that.

We are able to react and respond accordingly. In the meantime, the department has done a number of initiatives to preserve our fund balance, but the plan is to use the fund balance to breach us to over this.

Tough time period hopefully to the next administration. One has to do with we are setting up expenditure targets for all the hospitals, ACN and HSA so that we are able to promote efficiency.

And cost reductions examples would be like we implemented a hiring fee starting July of 25 and also controlling the use of overtime and registries. So just to name a few for on the revenue side.

Uh, we have some initiatives such as Um, the Um increasing the the sales tax Uh for five

years. Uh also asking for Um one time state Um funding to fund the Um.

The for 100 I think the at the state level is a \$500 million one one time for LADHS is estimated to be 100 million. So that would be.

Very helpful on our forecast if that gets approved and then another item we are working with is on the incentive fund. We are trying to design a new program to get additional fund. Right now the work is still in the works. We are working closely with CPH and State to design something that can be advanced to the CMS for consideration. So more to come on that one, but the expectation is that we will get something to the CMS in the next few.

Months. So um, obviously as I mentioned, uh, there are a lot of uncertainties, a lot of moving parts in the next few months that we have to monitor. But our plan is to continue our initiatives to preserve our fund balance and use it to bridge it to the Um. When we have the clarity, so I'll stop here um and see if you guys have any uh questions.

**KK** **Kieu-Anh King** 32:28

Do you have any questions from board offices?

Question. Yeah, go ahead, Aaron. Thanks for the presentation. I just have a question about CMS 1115 waiver approvals. Do is it an all or nothing approval or denial or?

Can CMS approve certain parts of the submission, the waiver submission by the state?

**FL** **Ferris Ling** 32:56

So currently we have our waiver that applies to California. It's a point system is promoting non-emergent services. It's a great program. We all believe in it. The only thing is that.

This program is subject to consideration for CMS and if they decide that this is something they don't want to continue and we they want to revert back to the oldish program which is similar to every other state, then they won't be able to keep the GPP.

**EM** **Edward Morrissey** 33:16

Uh.

**FL Ferris Ling** 33:32

and we'll have to convert it back to the Vish program.

**KK Kieu-Anh King** 33:37

And is and is the GPP wrapped up in the overall 11:15 waiver that has Cal aim in it?

**FL Ferris Ling** 33:44

Yes.

**KK Kieu-Anh King** 33:46

OK, so they could say the feds could.

**FL Ferris Ling** 33:47

The big part for us is, yeah, the big part for us is the GPP program, yes.

**KK Kieu-Anh King** 33:52

OK, so the feds couldn't, could or could not say, well, Calam, we don't really like Calame and he needs to go back to like traditional Medic Medicaid services, but we're OK with keeping like the GPP.

**FL Ferris Ling** 34:07

Yeah, there could be situations like that. They could consider the different parts of it. So GPP is 1, tail aim is another. They could certainly do one and without another.

**KK Kieu-Anh King** 34:21

OK. Thanks.

Any other questions? Yeah, I had more of a request for us. Thank you and thanks for all the detail on this. It's really helpful. I was asking really more for something that's missing that I was surprised when I went through the document. I didn't see anything that gave an overall projection of how much DHS anticipates it might lose because of.

HR1 and as well as a projection of how soon we will run out of the reserves knowing what we know unless we get more something changes.

**FL Ferris Ling** 34:56

Yeah. So um, maybe not the breakdown per SE, but you know, if you look at attachment, um, one, you do see that in the green session, um, that uh, currently, uh, actually we close um.

2425 with about 1.5 billion in our fund balance. So when you look at year three you will see that after 2728 then we are expecting to have an A \$157 million left in the fund balance to be carried over to 2829 obviously.

**KK Kieu-Anh King** 35:30

OK.

**FL Ferris Ling** 35:32

These are based on assumptions that we are making without knowing all the final regulations and policies, but this is what we currently have as far as expecting how long we have the fund balance to bridge us to the.

Um, the new phase of our budget.

**KK Kieu-Anh King** 35:53

Thanks, Ferris. And so DHS is still saying rough that you're anticipating once HR1 is fully implemented a loss of what was it 725 million a year or so?

**FL Ferris Ling** 36:06

Yeah, HR run and also you know if they did, if they do convert the the waiver back to the oldish program.

**KK Kieu-Anh King** 36:17

And is that is that expressed somewhere in the document? I just didn't see it.

**FL Ferris Ling** 36:22

Yeah. So they are different lines and you know one has to do with you know on the HR one is really as an example really dealing with managed care. So you will see on the managed care line.

**KK** **Kieu-Anh King** 36:40

I'm sorry, Ferris, there it is on line 12. Okay.

**FL** **Ferris Ling** 36:43

Yeah, 920.

**KK** **Kieu-Anh King** 36:47

Yeah. And Yolanda, I would add in last week's budget presentation on DHS for 2627, there was a transaction. I think it was the 2nd to the last change on revenue adjustments and the revenue figure that DHS included in the recommended.

Budget was 660 million and so that's the amount I think from GPP, EPP and \*\*\*. And I think most of those changes are probably HR1 related. Ferris would know better than I would, but 660 is the number that we have plugged into the budget for 2627 today. And as as Ferris said, um, you know, moving forward, um, the the numbers may shift from year to year, OK. But for now we know 660 is um one number but may include more than just HR one.

**FL** **Ferris Ling** 37:38

Correct.

Any other questions?

**KK** **Kieu-Anh King** 37:57

We'll move on to public comment on this item. So we have meet public comment.

We'll move on to general public comment. Quick reminder that it will be limited to one minute. Do we have any general public comment on today's agenda?

Great. We'll go ahead and adjourn. Thank you all.

Hello.

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- **Viktoria Rama** stopped transcription