County of Los Angeles
Health and Mental Health Services

FESIA A. DAVENPORT
Chief Executive Officer

DATE: Wednesday, May 25, 2022
TIME: 10:30 a.m.

THIS MEETING WILL CONTINUE TO BE CONDUCTED VIRTUALLY TO ENSURE THE SAFETY OF MEMBERS OF THE PUBLIC AND EMPLOYEES AS PERMITTED UNDER STATE LAW.

TO PARTICIPATE IN THE MEETING, PLEASE CALL AS FOLLOWS:
DIAL-IN NUMBER: 1 (323) 776-6996
CONFERENCE ID: 322130288#
MS Teams link (Ctrl+Click to Follow Link)

AGENDA

Members of the Public may address the Health and Mental Health Services Meeting on any agenda item. Two (2) minutes are allowed for each item.

THIS TELECONFERENCE WILL BE MUTED FOR ALL CALLERS. PLEASE DIAL *6 TO UNMUTE YOUR PHONE WHEN IT IS YOUR TIME TO SPEAK.

I. Call to order

II. **Discussion Item(s):**

a. **DPH**: Update on Child Health and Disability Prevention Program and State Budget

III. **Information Item(s)** (Any Information Item is subject to discussion and/or presentation at the request of two or more Board offices)**:**

a. **DHS**: Request Approval to Amend the Transportation Overflow Services (TOS) Master Agreement to Increase Agreements' Various Transportation Rates and Available Bonuses/Supplemental Fees, and Introduce New Supplemental Fees for TOS Transports to, from, and within the Antelope Valley Area and for Department of Mental Health Transports

b. **DHS**: Request for approval of funding methodology and allocation of funding to non-County trauma centers for Fiscal Year 2021-22, and delegation of

authority to the Director of Health Services, or designee, to extend the term of the Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreements through June 30, 2023, which will contain the reimbursement provision for Fiscal Year 2021-2022, and approve an allocation of funds to County hospital

IV. **Presentation Item(s):**

a. DMH: Request Approval to Amend Four Legal Entity Contracts and Delegated Authority to Amend Existing Legal Entity Contracts Due to the Post Annual Cost Report Adjustments

V. **Items Continued from a Previous Meeting of the Board of Supervisors or from the Previous Agenda Review Meeting**

a. Discussion and consideration of necessary actions on issues related to the Harbor-UCLA Medical Center Replacement Program, and briefing by DPW, CEO and DHS, as needed, as requested at the Health and Mental Health Services Cluster meeting on May 18, 2022.

VI. Items not on the posted agenda for matters requiring immediate action because of an emergency situation, or where the need to take immediate action came to the attention of the Department subsequent to the posting of the agenda.

VII. Public Comment

VIII. Adjournment

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

MEGAN McCLAIRE , M.S.P.H.
Chief Deputy Director

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April 29, 2022

The Honorable Nancy Skinner
Chair, Senate Budget and Fiscal Review Committee
1021 O Street, Room 8630
Sacramento, CA 95814

The Honorable Phil Ting
Chair, Assembly Budget Committee
1021 O Street, Room 8230
Sacramento, CA 95814

RE: Los Angeles County Opposes the Administration's Budget Proposal to Sunset the Child Health and Disability Prevention (CHDP) Program

Thank you for your leadership and support of programs that optimize the well-being of our communities and families. We are writing to express our concern and opposition to the proposed elimination of the Child Health and Disability Prevention (CHDP) program by July 2023, as reflected in Governor Newsom's January proposed budget. We strongly encourage the Legislature to delay the planned sunset and offer a new proposal to improve and leverage CHDP proficiency to build and strengthen high-quality pediatric expertise across the State.

CHDP was established in 1973 to ensure access and quality of care for children enrolled in Medi-Cal and pivots on four central functions: ensuring pediatric provider site certification/re-certification, provider support activities, patient care coordination, and administrative management and support of the Health Care Program for Children in Foster Care (HCPCFC) program.

CHDP's elimination will create a gap in pediatric preventative care expertise and qualification that we fear may lead to lowered childhood health outcomes and increased childhood health condition chronicity, morbidity, and mortality. The Administration has contended that CHDP activities are redundant with Medi-Cal Managed Care (MMC) responsibilities and are unnecessary under CalAIM. However, there is no evidence that the MMCs have assumed the responsibility or have the capacity, resources, and incentives to support pediatric providers and ensure quality of service delivery.

As part of its sunset plans, the Department of Health Care Services (DHCS) has designed a new "Presumptive Eligibility" program that will automatically enroll children into MMC. However, this does not address continuing patient care coordination needs of non-MMC children and families including children who may continue receiving Medi-Cal fee-for-service care (e.g., foster children and youth), families that choose not to enroll in Medi-Cal for various reasons (e.g., fear of immigration status or public charge consequences), and children and families that need help accessing otherwise limited or scarce services.

CHDP ensures that quality care for these specialized populations is not overlooked. As we know, when it comes to health care, children are not "little adults." A practitioner providing care to a child needs to know, for example, how to examine the child and look for potential abnormalities, screen for and interpret results for childhood conditions, and detect and diagnose health factors and symptoms that differ significantly from how they manifest in adults. The level and proficiency of CHDP provider certifications are unmatched in the Medi-Cal system.

When providers fail to meet certification/re-certification requirements and cannot provide care to Medi-Cal-enrolled children/youth, CHDP partners with them to upgrade their pediatric skills, knowledge, and practices. CHDP provider support trainings are renowned for their effectiveness and have helped multitudes of pediatrician practices keep their skills and knowledge current and up-to-date, and the MMC and health plans consistently refer their pediatric providers to CHDP trainings and for CHDP technical assistance. For example, this past year, Los Angeles County's CHDP program created trainings on adverse childhood experiences (ACEs), toxic stress, developmental delay screenings, and the impact of environmental conditions—all consistent with State priorities. When a provider requires it, CHDP's Public Health Nurses provide technical assistance and direct instruction for the providers. These efforts ensure provider expertise and build a more expansive pool of practices and providers able to care for low-income children and youth.

We believe there is a better solution to eliminating CHDP and losing access to the 3:1 Federal matching revenues that it generates annually. We urge the Legislature to enhance CHDP's current public health role and extend its quality assurance and provider support activities to all providers who intend to care for California's children and youth—whether or not the children are enrolled in Medi-Cal. This effort—with no additional financial investment—would guarantee consistent, quality, and evidence-based pediatric preventive care to children and youth throughout the State.

We strongly encourage the Legislature to delay the planned sunset while DHCS and the State's child and health advocates work over the next year(s) on plans to improve the use of CHDP dollars and capitalize on CHDP proficiency to expand and build a more robust reservoir of high-quality pediatric expertise throughout the State.

As we work collaboratively with stakeholders around the State, our elected leaders and the families we serve, we hope that the Legislature will reconsider this proposal to unravel a true pediatric health care program success without fully weighing the costs and benefits and considering more positive solutions. We will be happy to engage as fully as needed with the Legislature and the Administration to steer this decision-making to a more fruitful and productive outcome that will enhance pediatric care throughout the State and that will greatly benefit millions of California's children, youth, and their families.

If you have any questions or need further information, please do not hesitate to contact me.

Sincerely,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

CC: Honorable Members, Senate Budget and Fiscal Review Committee
Honorable Members, Assembly Budget Committee
Marjorie Swartz, Office of the Senate President Pro Tempore
Agnes Lee, Office of the Assembly Speaker
Joe Stephenshaw, Staff Director, Senate Budget & Fiscal Review Committee
Scott Ogus, Consultant, Senate Committee on Budget and Fiscal Review Subcommittee No. 3
Christian Griffith, Chief Consultant, Assembly Budget Committee
Andrea Margolis, Consultant, Assembly Budget Committee


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CSAC


COUNTY OF LOS ANGELES
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California Dental Hygienists' Association
The Voice of Dental Hygiene

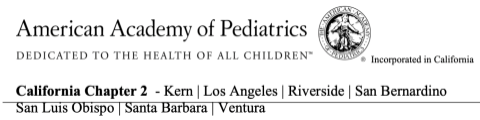

American
Academy of
Pediatrics
CALIFORNIA
Incorporated in California


CWDA
Advancing Human
Services for the Welfare
of All Californians


California
Children's
Trust


CALIFORNIA
CHILDREN'S
HOSPITAL
ASSOCIATION


cda
California
Dental
Association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UCP
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CALIFORNIA SOCIETY
OF PEDIATRIC DENTISTRY


ASIAN HEALTH SERVICES
HEALTH CARE FOR ALL. ADVOCACY FOR THE UNDERSERVED.


LOS ANGELES UNIFIED SCHOOL DISTRICT
OFFICE OF THE MEDICAL DIRECTOR


children's
defense fund
Leave No Child Behind


WESTERN CENTER
ON LAW & POVERTY


FIRST 5
VENTURA COUNTY


The Los Angeles Trust
for Children's Health


californiahealth+
advocates


CALIFORNIA
MEDICAL
ASSOCIATION


FIRST 5
SACRAMENTO


UCLA Dentistry
UCCOH
UCLA CENTER FOR CHILDRENS ORAL HEALTH

May 17, 2022

The Honorable Susan Eggman
Chair, Senate Budget Subcommittee No. 3 on Health and Human Services
1021 O Street, Suite 8530
Sacramento, CA 95814

The Honorable Dr. Joaquin Arambula
Chair, Assembly Budget Subcommittee No. 1 on Health and Human Services
1021 O Street, Suite 6240
Sacramento, CA 95814

RE: FY22-23 Budget Proposal to Sunset CHDP - OPPOSE

Dear Chairs Eggman and Arambula,

We the undersigned organizations write today on behalf of California's local health departments, county social services agencies, county supervisors, their workforce, and the children and families we serve are disappointed to see that the Administration's proposal to sunset the Children's Health and Disability Prevention Program (CHDP) continues to be reflected in the Governor's May Revision and we write to express our opposition. We appreciate the tremendous vision this Administration has brought to CalAIM and the Administration's commitment to Medi-Cal expansion. While the Administration proposes to sunset CHDP as a result of these commitments, we argue that premature elimination of CHDP will create gaps in care and reduce the quality of care for California's most vulnerable children.

We request the Legislature's leadership in prioritizing this matter. Specifically, we request that the Legislature:

- **Modify the sunset date to no sooner than July 1, 2024.**
- **Require robust stakeholder engagement that is inclusive of local health departments, health care delivery system, social services, labor, and consumer/family interests to inform a transition of CHDP, define new partnerships and roles that harness CHDP expertise, and ensure the commitment to pediatric excellence and quality assurance into the future.**
- **Ensure the children do not experience gaps in services or reductions in the quality of care.**
- **Ensure post-CHDP sunset commitment to fully fund the Health Care Program for Children in Foster Care.**
- **Minimize the loss of crucial local health department workforce.**

In the paragraphs below we explain our concerns with the Administration's proposed sunset of CHDP.

Premature Sunset

CHDP is a dynamic program that includes (1) providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening, including preventive health, vision, hearing and dental screening, follow-up services, and care coordination; (2) CHDP Gateway which serves as a presumptive eligibility entry point for children, to receive temporary preventive, primary and specialty health care coverage through the Medi-Cal Fee-For-Service (FFS) delivery system; (3) training and certifying pediatric providers for quality

assurance and AAP Bright Futures standards; and (4) Responsibility for local administration of the Health Care Program for Children in Foster Care (HCPCFC) and the Childhood Lead Poisoning Prevention (CLPP) program. With the exception of HCPCFC program, the current proposal will sunset all other program components by July 1, 2023. The CHDP's proposed sunset assumes other programmatic transitions being led by DHCS and delivery system partners are on schedule and without error. With the vast number of Medi-Cal programming and policy shifts happening now, we must leave open the possibility of programmatic delays and/or challenges that may need to be addressed.

Thinking about these transitions through the lens of critical health care for some of California's most complex children and families, there is no room for error. We recommend shifting the sunset date to no sooner than July 1, 2024, to allow for other program transitions to be fully implemented while also creating the stakeholder environment to inform the sunset process, define new partnerships and opportunities, and ensure no gaps in coverage or reductions in quality of service.

CHDP Gateway is More Than Just Enrollment

We recognize the Administration's interest in ensuring that children will be able to access care through expanding the number of Medi-Cal providers that can presumptively enroll children in Medi-Cal. However, currently CHDP programs help families find CHDP-certified providers who can enroll them in the CHDP Gateway. In addition, local health departments collaborate with partner agencies, such as social services, the Women, Infants and Children (WIC) Program, California Children's Services, Head Start, and child welfare services/foster care, to provide them with information and referrals to local CHDP providers. Under the proposed presumptive eligibility pathway for children, we are concerned that these linkages to services will be lost. Individuals and families may not only struggle to identify and access Medi-Cal providers given many of our current clients do not know how to navigate the Medi-Cal system and provider network, but they may also lose these critical navigation and lifelines to services that are at the heart of addressing social determinants of health. This concern is further exacerbated by the lack of current collaboration between Medi-Cal managed care and public health departments.

Gap in Services for Fee-for-service Beneficiaries

CHDP currently provides services to Medi-Cal fee-for-service children. While we understand care for the majority of Medi-Cal kids will be provided through Medi-Cal managed care, it is important to note that there will continue to be a residual population of children that will remain in fee-for-service, such as the foster care population. Should the sunset be implemented, children in fee-for-service will not receive the same coordination that they are provided today.

Quality Assurance and Provider Support

One of CHDP's greatest strengths is the role it plays ensuring quality of pediatric preventive care and excellence for the State's children and youth enrolled in Medi-Cal. In regular site certification visits and medical record reviews, CHDP monitors a practice's adherence to and compliance with Bright Futures (BF) guidelines from the American Academy of Pediatrics (AAP)—the gold standard in pediatric care. They conduct medical chart reviews to assure a pediatric focused history and physical exam, oral health screening, lab assessments, developmental, mental health, social determinants, and ACEs screening among a host of preventive and diagnostic assessments performed accurately on infants and children.

The CHDP site certification process includes review of practice protocols, site and equipment specifications, and patient services to ensure that clinics meet acceptable standards for "child-centered" care. The certification/recertification reviews and audits performed in CHDP greatly improve the quality and expectation of pediatric and family practice care of children in our State. In some instances, these reviews have precluded a site provider from CHDP certification/recertification, despite having been certified by the health plan. When a provider does not meet CHDP-certification criteria, CHDP provides support in the form of corrective action plans, which includes resources, training, and technical assistance to help that provider elevate their standards and expertise for services to children and youth—therein building a more robust pool of qualified providers.

While the Administration's proposal notes the managed care requirements to follow such standards, the proposal lacks detail on how managed care plans will be required to carry out such trainings and facility and medical chart reviews. It is critical that this be addressed in detail to avoid significant gaps in the standard of care of services delivered to children.

EPSDT Requirements and Coordination to Medi-Cal Dental Services

CHDP has a significant and unique role in fulfilling the Early Periodic Screening Diagnosis and Treatment (EPSDT) components of the federal Medicaid mandate. We believe that a wholesale sunset of CHDP is premature and does not reflect well the complex role counties play in supporting children, their families, and providers, particularly as it relates to oral health care. Currently, CHDP is the vehicle for implementing the Early and Periodic Screening (EPS) components of the federal mandate, while the fee-for-service Medi-Cal Dental program provides the required dental Diagnosis and Treatment (DT) services. Despite recent guidance, enacted legislation, and new initiatives,[1] the Medi-Cal managed care medical plans (MCPs) do not provide EPSDT assurances with respect to dental care. In addition, although expectations of managed care plans have expanded, the outcomes for children in poor oral health have not improved. Local CHDP programs assure access to dental services by informing Medicaid beneficiaries and their families of both medical and dental benefits. For children, whose care is coordinated directly by CHDP programs, there is a high success rate of placement in a dental home, in some areas upwards of 90%. This is just one example of how CHDP is playing a critical role in connecting California's families to preventative services and, in doing so, setting our families on a path to a healthy future. This loss would go against California's commitment to health equity.

Decreasing Public Health Workforce

At a time when local health departments are working to bolster our workforce, the proposal to sunset the CHDP program would result in local health departments losing nearly 300 full-time equivalents (FTEs) across the state, including 68 public health nurse FTEs impacting over 80 nurse positions.

The COVID-19 pandemic served as a wake-up call and a reminder that underinvestment, and devaluing of public health, undermines the health of our communities and our resiliency as a state. At a time when

[1] See APL 19-010, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf; AB 2207 (chaptered in 2016), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2207; and CalAIM dental components, https://www.dhcs.ca.gov/services/Pages/DHCS-CalAIM-Dental.aspx.

federal and state leadership, including this legislature, are debating how to bring more investments to public health infrastructure and workforce we must not eliminate long-standing funding streams. And, in this case, eliminating state general fund investments also cuts off an opportunity for counties to draw down additional federal funding through Title XIX federal funding match.

Fully Funding the HCPCFC Program

We are grateful that the administration sees the value in maintaining the HCPCFC program at the county and appreciate that this is a recognition of the success our counties have had in supporting California's foster families. It is important to note how the elimination of CHDP positions will impact the HCPCFC program. Currently, CHDP supports HCPCFC program management, public health nurse supervision, and other administrative functions. In addition, the HCPCFC often funds partial public health nurse FTEs, which is inadequate in a standalone program. Our early estimates suggest that the HCPCFC would need to retain nearly 80 FTEs from CHDP to operate as a standalone program. This includes roughly 14 public health nurse supervisor FTEs and 30 public health nurse FTEs. Absent the continuation of these positions, services provided to foster youth under HCPCFC may be adversely impacted.

For these reasons, we respectfully urge the Legislature to reject the Administration's proposal to sunset the CHDP program. We look forward to working with the Legislature in the coming weeks to identify a path forward that reflects our shared commitment to the health and wellbeing of all Californians. And furthermore, we request robust stakeholder dialogue to ensure such a transition is handled delicately, is appropriately timed, and puts California's most vulnerable children first.

Sincerely,

Michelle Gibbons
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Beth Malinowski
Government Relations Advocate
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Executive Director
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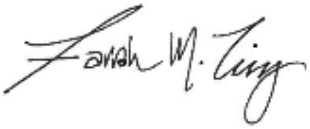

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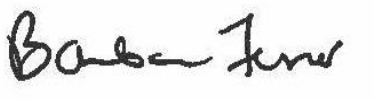

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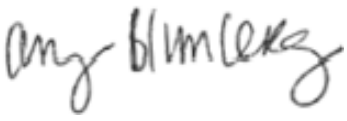

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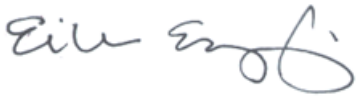

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Alex Briscoe
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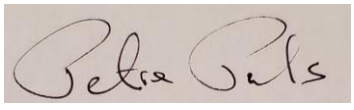

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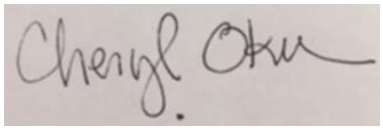

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Help Me Grow San Mateo County

Francisco Ramos-Gomez, DDS, MS, MPH
Executive Director
UCLA Center for Children's Oral Health

Julie Gallelo
Executive Director
First 5 Sacramento

cc: Honorable Members, Senate Budget & Fiscal Review Committee
Honorable Members, Assembly Budget Committee
Marjorie Swartz, Policy Consultant, Office of the Senate President Pro Tempore
Agnes Lee, Policy Consultant, Office of the Assembly Speaker
Elisa Wynne, Staff Director, Senate Budget and Fiscal Review Committee
Scott Ogus, Deputy Staff Director, Senate Budget and Fiscal Review Committee
Kirk Feely, Fiscal Director, Senate Republican Caucus
Anthony Archie, Consultant, Senate Republican Caucus
Christian Griffith, Chief Consultant, Assembly Budget Committee
Andrea Margolis, Consultant, Assembly Budget Subcommittee No. 1
Joe Shinstock, Fiscal Director, Assembly Republican Caucus
Eric Dietz, Consultant, Assembly Republican Caucus
Keely Bosler, Director, California Department of Finance
Dr. Mark Ghaly, Secretary, California Health and Human Services Agency
Michelle Baass, Director, California Department of Health Care Services
Dr. Tomás Aragón, Director and State Public Health Officer, California Department of Public Health
Richard Figueroa, Legislative Affairs Secretary, Office of Governor Gavin Newsom
Tam Ma, Deputy Legislative Secretary, Office of Governor Gavin Newsom
Sonja Petek, Principal Fiscal & Policy Analyst, Legislative Analyst's Office

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/25/2022	
BOARD MEETING DATE	6/14/2022	
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th	
DEPARTMENT(S)	Department of Health Services	
SUBJECT	Authorize the director of Health Services, or designee, to amend the transportation overflow services master agreement to increase and introduce new rates, expand the scope of services, and increase the estimated annual cost.	
PROGRAM	Emergency Medical Services (EMS) Agency	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No	
SOLE SOURCE CONTRACT	☐ Yes ☒ No	
	If Yes, please explain why:	
DEADLINES/ TIME CONSTRAINTS	Amendments to be executed by July 1, 2022.	
COST & FUNDING	Total cost: $10 million	Funding source: Departmental Budgets
	TERMS (if applicable): N/A	
	Explanation: DHS will be responsible for $5.5 million and DMH will be responsible for $4.5 million for a total of $10 million.	
PURPOSE OF REQUEST	The purpose of the request is to increase and introduce new supplemental rates. The rates for supplement fees have remained the same since the Board's approval on December 5, 2017 and while the original rates have helped, both DHS and DMH have experienced a delay in response times for non-emergency medical transportation services. Increasing and adding supplemental fees is necessary to incentivize ambulance contractors to respond to TOS requests from both Departments. Along with increasing and adding supplemental fees, the purpose of the request is to obtain delegated authority to allow the Director, or designee, to execute future amendments to TOS Master Agreements to revise base rates and/or supplemental fees. Allowing the Director, or designee, to execute amendments to the TOS Master Agreements, to increase the supplemental fee for County-wide Advanced Life Support (ALS) transportation services for the Department of Health Services (DHS) from $125 to $200 per transport, increase the supplemental fee for County-wide Critical Care Transport (CCT) services from $125 to $200 per transport, and add an Antelope Valley (AV) specific supplemental fee of $200	

	per transport, for ALS patient transports to, from and within the AV area. Approval of the first recommendation will also expand the scope of service to include Basic Life Support (BLS) transportation services for the Department of Mental Health patients, and introduce new supplemental fees for BLS transports for DMH patients of $200 per transport, at an estimated annual cost of $4.5 million. Last, approval for the first recommendation will increase the estimated annual cost from $5.5 million to $10 million for the period effective upon execution through December 31, 2024, subject to prior review and approval by County Counsel. Allowing the Director, or designee, to execute future amendments to TOS Master Agreements to revise base rates and/or supplemental fees, as deemed appropriate in order to remain competitive with market rates and increase the annual cost by up to ten (10) percent, subject to prior review and approval by County Counsel.
BACKGROUND (include internal/external issues that may exist including any related motions)	In July 2021, DHS' Emergency Medical Services Agency identified that the requests for non-emergency ALS transports for DHS patients in the AV area had extended response times. The average response times in May and June of 2021 for routine ALS transports was 3.5 hours for High Desert Urgent Care and 2.17 hours for South Valley Urgent Care, while the required response time for routine ALS transports under the TOS Master Agreement is 1.5 hours or less. There were also six canceled calls due to a lack of ALS resources in the AV area, and DHS urgent care centers were forced to call 9-1-1 to transport the patient to the emergency department. There are currently only two overflow ambulance contractors in the AV area that have ALS transport capabilities. One of the contractors responds primarily to 9-1-1 calls, which essentially leaves one ambulance contractor available to provide area residents with non-emergency ALS transportation. Although there are four overflow ambulance contractors located in San Fernando Valley, the cost to drive to the AV area, along with limited staff due to COVID-19, has forced these contractors to decline, delay, or cancel calls. In addition, DMH is also experiencing response time delays for non-emergency BLS. Unlike the delay in response times for DHS patients, which is primarily in the AV area, DMH patients have experienced County-wide delays in response times for BLS transports. DMH reported an estimated average wait time of four (4) hours, with the primary reason being contractor's cancelling and/or rejecting transportation requests. Although DMH had seven ambulance companies under contract for non-emergency medical transportation services, the decision was made to cancel the contracts due to a lack of response by contractors. In December of 2021, the EMS Agency assumed BLS transportation arrangements for DMH patients and has made it a goal to improve the response times for both DHS and DMH patients. The EMS Agency has begun a continuous evaluation of ambulance transportation market rates, and in the interim proposes to incentivize ambulance contractors, as deemed appropriate by the Director, or designee, in order to maintain appropriate levels of ALS and BLS transportation services for both DHS and DMH. Increasing and adding supplemental fees will provide an incentive for ambulance contractors to provide BLS transports for DMH patients, as well as

	an incentive to provide ALS transports to DHS patients in the AV area. Delegated authority to revise base rate and supplemental fees in the future may also encourage additional ambulance companies to apply for a TOS Master Agreement to fulfill the County's mission of transporting its residents in a timely and cost-effective manner.
EQUITY INDEX OR LENS WAS UTILIZED	☐ Yes ☒ No If Yes, please explain how:
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☐ Yes ☒ No If Yes, please state which one(s) and explain how:
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: (DHS) **Julio Alvarado**, Director Contracts & Grants, (213) 288-7819 JAlavarado@dhs.lacounty.gov (DHS) **Roel Amara**, Emergency Medical Services Assistant Director, (562) 378 – 1598 ramara@dhs.lacounty.gov

June 14, 2022

DRAFT
DHS Letterhead

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

DELEGATED AUTHORITY TO AMEND
TRANSPORTATION OVERFLOW SERVICES MASTER AGREEMENTS
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request for delegated authority to the Director of Health Services, or designee, to amend the Transportation Overflow Services Master Agreements to increase current supplemental fees and introduce new supplemental fees payable to ambulance contractors that provide ambulance/ambulette services; add the Department of Mental Health to the Master Agreements at an estimated annual cost of $4.5 million; and increase the estimated annual cost to $10 million for both Departments.

IT IS RECOMMENDED THAT THE BOARD:

1. Delegate authority to the Director of Health Services (Director), or designee, to execute amendments to the Transportation Overflow Services (TOS) Master Agreements, effective upon execution to: (a) increase the supplemental fee for County-wide Advanced Life Support (ALS) transportation services for the Department of Health Services (DHS), increase the supplemental fee for Countywide Critical Care Transport (CCT) services, and add an Antelope Valley (AV) specific supplemental fee for ALS patient transports to, from and within the AV area, at an estimated annual cost of $0.5 million; (b) expand the scope of services to include Basic Life Support (BLS) transportation services for patients of the Department of Mental Health (DMH), and introduce new supplemental fees for BLS transports for DMH patients, at an estimated annual cost of $4.5 million; and (c) increase the County's estimated annual cost for TOS from $5 million to $10 million, subject to prior review and approval by County Counsel.

2. Delegate authority to the Director, or designee, to execute future amendments to the TOS Master Agreements to: (a) revise the base rates and supplemental fees for TOS contractors no more than once a year, to remain competitive with market rates; and (b) increase the County's cost, by no more than 10 percent of the estimated annual

cost of $10 million until the TOS Master Agreements terminate on December 31, 2024, subject to prior review and approval by County Counsel, and with notice to the Board and Chief Executive Office.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Background

The County has an ambulance fleet to provide non-emergent BLS transport of County patients between County hospitals; health, custody or court facilities; State mental and other governmental hospital or health facilities; psychiatric wards; private hospitals/facilities; and patients' homes. However, the Emergency Medical Services (EMS) Agency does not employ paramedics, nor does it operate its own ALS equipped ambulances, nor does DHS own or operate a sufficient number of vehicles (e.g. ambulances, ambulettes, station wagons, or vans) to meet the transportation needs of its patients at all times. In order to meet the additional growing need to provide BLS ambulance transportation, and paramedic or nurse-staffed ambulance transportation, DHS also utilizes contracted services under the TOS Master Agreements. The TOS Master Agreements also help to meet the BLS and ALS transportation needs of the Los Angeles County Sheriff's Department (LASD).

The Board approved the TOS Master Agreements on November 13, 2012. Since that time, the base rates have increased only to accommodate Cost of Living Adjustments (COLAs). With the Board's approval on December 5, 2017, the Statement of Work (SOW) to the TOS Master Agreement was amended to implement service standards and to add performance bonuses/supplemental fees to incentivize TOS contractors to provide more timely and reliable transportation services. The rates associated with these performance bonuses/supplement fees have remained the same since the Board's approval on December 5, 2017.

In July 2021, DHS' EMS Agency ascertained that requests for non-emergency ALS transports for DHS patients in the AV area experienced prolonged response times. The required response time for routine ALS transports under the TOS Master Agreements is 1.5 hours or less. However, average response times for routine ALS transports in May and June of 2021 from the High Desert Urgent Care was 3.5 hours, and 2.17 hours from South Valley Urgent Care. Additionally, six calls were cancelled due to a lack of ALS resources in the AV area. As a result, DHS urgent care centers were forced to call 9-1-1 to transport patients to hospital emergency departments.

Delayed and cancelled transports are primarily due to a low number of ambulance contractors that service the AV area, and exacerbated by the costs to outside AV area contractors to travel to that area. Currently, there are only two overflow ambulance

contractors in the AV area that are ALS-capable. One of these contractors responds primarily to 9-1-1 calls for emergency transport, which essentially leaves only one ambulance contractor available to provide area residents with non-emergency ALS transportation. Although there are four overflow ambulance contractors located in the San Fernando Valley, the cost of driving vehicles to the AV area and the effect of COVID-19 that limited staff, has forced these contractors to decline, delay, or cancel calls. Increasing and adding supplemental fees would incentivize ambulance contractors to timely respond to TOS requests.

DMH also experienced delayed response times in this same time period for non-emergency BLS transports, but on a Countywide scale. DMH reported an average wait time of approximately four (4) hours, primarily because contractors cancelled and/or rejected transportation requests. This lack of responsiveness by contractors caused DMH to cancel the seven contracts it had with ambulance companies for non-emergency medical transportation services. In December of 2021, the EMS Agency assumed BLS transportation arrangements for DMH patients and has made it a goal to improve the response times for both DHS and DMH patients.

The EMS Agency has begun a continuous evaluation of ambulance transportation market rates. As an interim measure until the current TOS Master Agreements terminate on December 31, 2024, it proposes to incentivize ambulance contractors with increased and/or new supplemental fees, as deemed appropriate by the Director, or designee, in order to maintain appropriate levels of ALS and BLS transportation services for both DHS and DMH. Delegating authority to revise the base rates and supplemental fees in the future may also encourage additional ambulance companies to apply for a TOS Master Agreements and fulfill the County's mission of transporting its residents in a timely and cost-effective manner.

Recommendations

Approval of the first recommendation will allow the Director, or designee, to execute amendments to the TOS Master Agreements, to: (a) increase the supplemental fee for County-wide ALS transportation services for DHS from $125 to $200 per transport, increase the supplemental fee for Countywide CCT services from $125 to $200 per transport, and add an AV specific supplemental fee of $200 per transport, for ALS patient transports to, from and within the AV area, all at an estimated annual cost of $0.5 million; (b) expand the scope to include BLS transportation services for DMH patients, and introduce new supplemental fees for BLS transports for DMH patients of $200 per transport, at an estimated annual cost of $4.5 million; and (c) increase the estimated annual cost from $5 million to $10 million for the period effective upon execution through December 31, 2024, subject to prior review and approval by County Counsel.

Approval of the second recommendation will allow the Director, or designee, to execute future amendments to TOS Master Agreements to revise base rates and/or supplemental fees no more than once per year, to remain competitive with market rates and increase the cost by up to ten (10) percent of the estimated annual cost of $10 million until the TOS Master Agreements terminate on December 31, 2024, subject to prior review and approval by County Counsel, and with notice to the Board and CEO.

Implementation of Strategic Plan Goals

The recommended actions support Strategy II.2, "Supporting the Wellness of Our Communities" and III.3, "Striving for Operational Effectiveness, Fiscal Responsibility and Accountability," of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Expenditures under the TOS Master Agreements vary from year to year, but are estimated at an annual cost of $10 million. Of the estimated $10 million, DMH will be responsible for financing $4.5 million and DHS will be responsible for financing the remaining $5.5 million. DHS will use existing resources to support this cost and any increase pursuant to the use of the delegated authority in the second Recommendation.

Funding is included in the DHS FY 2021-22 Final Budget and will be requested in future fiscal years, and will not result in new Net County Cost.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On November 13, 2012, the Board approved the current TOS Master Agreements for the provision of patient transportation services on an as-needed basis when County vehicles are unavailable to provide transport of County-responsible patients. On December 5, 2017, the Board approved an amendment to add service response/minimum call requirements, to meet the growing transportation needs of the Department until December 31, 2024.

It has been determined that the provision of services provided by the Contractors for TOS is not subject to Prop A guidelines, which include the Living Wage Program set forth in Los Angeles County Code Chapter 2.201.

The recommended Amendments will be reviewed and approved as to form by County Counsel.

CONTRACTING PROCESS

On April 12, 2012, DHS released a Request for Statement of Qualifications (RFSQ) to identify and qualify ambulance contractors to provide ALS services on an as-needed basis. Notice of the RFSQ was posted on the DHS and EMS Agency websites. The approved ambulance contractors submitted their Statement of Qualifications (SOQ) which met the requirements outlined in the RFSQ by the submission deadlines; TOS Master Agreements were awarded to these companies. The RFSQ solicitation remains open on the DHS and EMS Agency websites to attract new qualified ambulance/ambulette companies, inasmuch as the volume of TOS remains high in Los Angeles County.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will ensure that DHS can provide safe and timely medical transportation services to DHS and DMH patients. Delays in providing medical transportation can negatively impact our patients' health and disrupt the delivery of healthcare services within our County.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:JCA:sr

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/25/2022
BOARD MEETING DATE	6/14/2022
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Health Services
SUBJECT	Request for approval of funding methodology and allocation of funding to non-County trauma centers for Fiscal Year 2021-22, and delegation of authority to the Director of Health Services, or designee, to extend the term of the Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreements through June 30, 2023, which will contain the reimbursement provision for Fiscal Year 2021-2022, and approve an allocation of funds to County hospitals.
PROGRAM	Emergency Medical Services
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No
	If Yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	Dept. of Health Care Services (DHCS) requires County to complete IGT by July 29, 2022; TCPR MOU's expire June 30, 2022.
COST & FUNDING	Total cost: $55.40 million / Funding source: Measure B (Maddy's Fund) and (Richie's Fund)
	TERMS (if applicable): Allocation and funding for FY 2021-22 and extend TCPR MOA's through June 30, 2023.
	Explanation: The total maximum payment for FY 2021-22 is approximately $95.65 million, including $55.42 million of County funds (Measure B: $53.91 million; Maddy Fund: $0.85 million; Richie's Fund: $0.66 million which includes $20,000 in funds for the two County pediatric trauma hospitals) and $40.23 million of federal matching funds, which was calculated based on a federal matching rate of 50%. Funding for the County responsible portion of the TCPR MOAs is included in DHS' FY 2021-22 Final Budget. There is no net County cost; the MOAs are fully funded by Measure B, Maddy and Richie funds.
PURPOSE OF REQUEST	Approval of Recommendations will ratify the funding methodology and delegate authority to the Director, or designee, to execute the amendments to the TCPR MOAs, to include financial terms for FY 2021-22, extend the term of the MOAs for an additional one (1) year period, process payments for FY 2021-22, and submit an IGT to draw down federal matching funds for those portions of the payments that are to be made as Medi-Cal supplements to ensure emergency room access to Medi-Cal beneficiaries. The recommended amendments to the TCPR MOAs permit the continued provision of Measure B funding to trauma centers which help secure emergency care access for Medi-Cal beneficiaries, stabilize trauma care system in Los Angeles County, and allow sufficient time for development of a funding methodology for FY 2022-23.

BACKGROUND (include internal/external issues that may exist including any related motions)	Measure B, passed by the voters on November 5, 2002, authorized the County to levy a tax on structural improvements within the County, in part, to provide funding to strengthen the Los Angeles County trauma network, particularly those trauma centers operated by the County, and expand it if possible; and to fund emergency medical services and bioterrorism preparedness. Subsequent to Measure B's passage, the Board approved multiple proposals to allocate Measure B funds among the non-County trauma centers. The Board also approved payments to reimburse trauma centers for costs associated with serving as a base hospital in the Emergency Medical Services system. The County receives funds derived from penalties assessed on fines and bail forfeitures that the Superior Court collects for certain criminal offenses and motor vehicle violations. As permitted by California Government Code Section 76000.5 and H&S Code Section 1797.98a, these funds are placed in the County's Maddy Fund and used by DHS for trauma and emergency services. A portion of the Maddy Fund is designated by statute for support of pediatric trauma programs and is segregated as the Richie's Fund. The remaining Maddy Fund dollars are available to support trauma and emergency services provided by hospitals and physicians.
EQUITY INDEX OR LENS WAS UTILIZED	☐ Yes ☒ No If Yes, please explain how:
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☐ Yes ☒ No If Yes, please state which one(s) and explain how:
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Manal Dudar, Chief, Financial Management (626) 525-6426 Mdudar@dhs.lacounty.gov Richard Tadeo, Emergency Medical Services, Director (562) 378-1610 Rtadeo@dhs.lacounty.gov

June 14, 2022

DRAFT
DHS LETTERHEAD

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF FUNDING METHODOLOGY AND AMENDMENTS TO THE MEMORANDUM OF AGREEMENTS FOR NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request for approval of funding methodology and allocation of funding to non-County trauma centers for Fiscal Year 2021-22, and delegation of authority to the Director of Health Services, or designee, to extend the term of the Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreements through June 30, 2023, which will contain the reimbursement provision for Fiscal Year 2021-2022, and approve an allocation of funds to County hospitals.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve the funding methodology and allocation of Trauma Center Provisions for Reimbursement (TCPR) funding for Fiscal Year (FY) 2021-22, and authorize the Director of Health Services (Director), or designee, to execute amendments to the TCPR Memorandum of Agreement (MOA), substantially similar to Exhibit I, with 13 non-County trauma centers to extend the term for the period July 1, 2022 through June 30, 2023, and include the funding terms for the period July 1, 2021 through June 30, 2022, for a total County obligation of approximately $55.40 million (comprised of $53.91 million from the Measure B funds, $0.85 million from the Maddy Emergency Medical Services Fund (Maddy Fund), and $0.64 million from the Richie's Fund), as set forth in Attachment A and described below.

2. Approve and authorize the Director, or designee, to allocate up to a maximum of $40.23 million of the Measure B funds to be used as an Intergovernmental Transfer (IGT) to the California Department of Health Care Services to draw down federal matching dollars for supplemental Medi-Cal payments to eligible non-County trauma centers.

3. Approve and authorize the Director, or designee, to allocate the amount of $20,000 from Richie's Fund to the two County Pediatric Trauma Centers listed in Attachment A.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Funding Methodology Background

Prior to the implementation of the Affordable Care Act (ACA) in January 2014, the methodology used to distribute trauma funding to non-County trauma centers was largely based on trauma claims for the uninsured population. After the ACA was implemented and its impact became more widespread, there was a significant reduction in the volume of uninsured trauma claims. Beginning in FY 2014-15, the number of uninsured trauma claims was too minimal to allow the full allocation of Measure B funds. In light of the significant and continuing decrease in the number of uninsured, the non-County trauma centers expressed concerns and wanted to ensure they would continue to receive the same level of trauma funding as in years prior to the ACA. Therefore, on May 3, 2016, the Board approved an amendment to the Trauma Centers Agreements for FY 2014-15 which continued trauma funding to the non-County trauma centers for the same funding amounts received by the trauma centers in FY 2013-14.

Given the significant and continuing impact of the ACA, and to ensure prior funding levels would be maintained, the non-County trauma centers deemed it necessary to develop a new basis for distributing trauma funds. Pursuant to discussions between the non-County trauma centers and DHS, a new funding methodology for FY 2015-16 was developed that incorporated new categories for reimbursement, and which was approved by the Board on November 1, 2016.

During FY 2016-17, the non-County trauma centers advised that funding levels should be maintained at levels similar to prior fiscal years, despite the severe decline in uninsured trauma patients. As such, the funding methodology that was approved for the fiscal year was based on the following: the level of indigent services, the provision of base station services, and a flat amount to support infrastructure. In addition, and recognizing the continuing ACA impact, the non-County trauma centers identified other add-on factors to be used as a basis for the distribution of the FY 2016-17 trauma funds at levels similar to prior years. The add-ons selected by the non-County trauma centers and approved by DHS were as follows: 1) an adjustment for the volume of trauma patients; 2) an adjustment for the level of acuity of trauma patients; and 3) an adjustment for the number of Medi-

Cal days and visits, which serves as a proxy for the underinsured population. Lastly, to address concerns that the application of the proposed FY 2016-17 formula would impact each trauma center to a greater or lesser degree, a parity adjustment was made in proportion to the degree of positive or negative impact to assure that no trauma center would be affected disproportionately. The FY 2016-17 methodology was approved by the Board on May 16, 2017.

For FY 2017-18, in conjunction with all 13 non-County trauma centers, DHS reached a consensus for utilizing the basic methodology components from FY 2016-17, but with the following modifications: 1) Including a parity adjustment to reduce the decrease in funding received by a trauma center in comparison to the prior fiscal year; 2) Information about services was included with the Medi-Cal information given to patients who were brought in by law enforcement to determine the component related to underinsured populations; and 3) The allocation of pediatric trauma payments to each pediatric trauma center from Richie Funds for pediatric trauma services was based on the facility type. Since Northridge Hospital Medical Center is the only pediatric trauma center in Los Angeles County operating as a community hospital, it was given a larger allocation than the remaining pediatric trauma centers, which are tertiary trauma centers.

DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2017-18 methodology for FY 2018-19. FY 2018-19 funding also included a one-time allocation of unspent Measure B funds from FY 2017-18 for the trauma centers as recommended by the Measure B Advisory Board (MBAB), which was presented by the Chief Executive Office (CEO) to the Board on March 12, 2019.

For FY 2019-20, DHS again reached consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, including a recommendation by the MBAB for a one-time allocation of unspent Measure B funds from FY 2018-19, which was presented by the CEO to the Board on February 11, 2020.

For FY 2020-21, DHS again reached consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, but without the one-time allocation of unspent and unallocated Measure B funds, as recommended by the MBAB.

FY 2021-22 Distribution Methodology

DHS and all 13 non-County trauma centers have reached a consensus for utilizing the same components used in the FY 2020-21 methodology for FY 2021-22. FY 2021-22 funding also included a one-time allocation of unspent Measure B funds for the trauma centers as recommended by the MBAB, which was presented by the CEO to the Board on February 7, 2022.

The proposed FY 2021-22 payments to each non-County trauma center are summarized in Attachment A.

Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreement (MOA) Background

Prior to June 30, 2021, the trauma center designation process, requirements and provisions for reimbursement were covered under a Trauma Center Services Agreement as a means to provide supplemental funding to offset operating expenses related to trauma center operations. On June 22, 2021, DHS split the two actions and executed TCPR MOAs for the continued implementation of reimbursement provisions for designated trauma centers. The trauma center designation for each hospital was added, by way of an amendment, and under delegated authority by the Board, to the Specialty Care Center Designations Master Agreement, which was approved by the Board on June 11, 2019.

Summary of Recommendations

Approval of Recommendations 1 through 3 will ratify the funding methodology and delegate authority to the Director, or designee, to execute the amendments to the TCPR MOAs, substantially similar to Exhibit I, to include financial terms for FY 2021-22, extend the term of the MOAs for an additional one (1) year period, process payments for FY 2021-22, and submit an IGT to draw down federal matching funds for those portions of the payments that are to be made as Medi-Cal supplements to ensure emergency room access to Medi-Cal beneficiaries.

The recommended amendments to the TCPR MOAs permit the continued provision of Measure B funding to trauma centers which help secure emergency care access for Medi-Cal beneficiaries, stabilize trauma care system in Los Angeles County, and allow sufficient time for development of a funding methodology for FY 2022-23.

Implementation of Strategic Plan Goals

The recommended actions support Strategy III.3, “Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability”, of the County’s Strategic Plan.

FISCAL IMPACT/FINANCING

The total maximum payment for the above recommended actions under the MOAs for FY 2021-22 is approximately $95.65 million, including $55.42 million of County funds (Measure B: $53.91 million; Maddy Fund: $0.85 million; Richie's Fund: $0.66 million which includes $0.02 million in funds for the two County pediatric trauma hospitals) and $40.23 million of federal matching funds, which was calculated based on a federal matching rate of 50%. Funding for the County responsible portion of

the TCPR MOAs is included in DHS' FY 2021-22 Final Budget. There is no net County cost; the MOAs are fully funded by Measure B, Maddy and Richie funds.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Pursuant to the authority under California Health and Safety (H&S) Code Section 1798.160, the County maintains trauma facilities as part of the regional trauma care system for the treatment of potentially seriously injured persons. Division 2.5 of the H&S Code authorizes the local Emergency Medical Services Agency to designate trauma centers as part of the regional trauma care system. Since March 1, 2017, there have been 13 non-County and two County-operated trauma centers.

The TCPR MOAs are designed to provide supplemental funding to offset the significant expenses related to maintaining trauma designation and treating trauma patients. The FY 2021-22 TCPR MOAs are funded by Measure B, Maddy Fund and Richie Fund, and contemplate the State making IGT-funded supplemental Medi-Cal payments to non-public trauma centers in Los Angeles County.

Measure B Funds

Measure B, passed by the voters on November 5, 2002, authorized the County to levy a tax on structural improvements within the County, in part, to provide funding to strengthen the Los Angeles County trauma network, particularly those trauma centers operated by the County, and expand it if possible; and to fund emergency medical services and bioterrorism preparedness. Subsequent to Measure B's passage, the Board approved multiple proposals to allocate Measure B funds among the non-County trauma centers. The Board also approved payments to reimburse trauma centers for costs associated with serving as a base hospital in the Emergency Medical Services system.

Maddy and Richie Funds

The County receives funds derived from penalties assessed on fines and bail forfeitures that the Superior Court collects for certain criminal offenses and motor vehicle violations. As permitted by California Government Code Section 76000.5 and H&S Code Section 1797.98a, these funds are placed in the County's Maddy Fund and used by DHS for trauma and emergency services. A portion of the Maddy Fund is designated by statute for support of pediatric trauma programs and is segregated as the Richie's Fund. The remaining Maddy Fund dollars are available to support trauma and emergency services provided by hospitals and physicians.

Medi-Cal Payments

The California State Plan, starting at page 51 of Attachment 4.19B, permits the California Department of Health Care Services to make supplemental Medi-Cal payments to non-public trauma centers in Los Angeles County. The County makes

recommendations regarding the amount of the supplemental payments and provides the funding for the non-federal share of such payments through an IGT.

County Counsel has reviewed and approved Exhibit I as to form.

CONTRACTING PROCESS

N/A.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will assure continued participation of non-County trauma centers in the County's trauma network and provide trauma funding for FY 2021-22.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:KF:MD

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

LOS ANGELES COUNTY TRAUMA CARE SYSTEM

PROPOSED PAYMENTS TO NON-COUNTY TRAUMA HOSPITALS
FISCAL YEAR 2021-22

	Patient-Based	Pediatric	Designation Support		Add-Ons				MBAB Projects					Total Payment (1) thru (13)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	
	UNINSURED	PEDIATRIC TRAUMA	BASE STATION	INFRASTRUCTURE	TRAUMA	ACUITY	UNDERINSURED	PARITY	MBAB	MBAB	MBAB	MBAB	MBAB	
Hospitals	(Volume)	(Fixed Rate)	(Fixed Rate)	(Fixed Rate)	(Volume)	(Adjustment)	(Adjustment)	(Adjustment)	(Physcian Call)	(Data Collection/Analysis)	(Education-Trauma Ctr)	(Stop the Bleed)	(Injury Prevention)	
Antelope Valley Hospital	$ 689,629	$ -	$ 700,000	$ 1,200,000	$ 1,405,470	$ 535,635	$ 2,024,419	$ (453,159)	$ 506,360	$ 300,000	$ 20,000	$ 40,000	$ 20,000	$ 6,988,354
California Hospital Medical Center	2,077,635	-	700,000	1,200,000	1,819,036	736,572	3,972,900	144,938	883,855	300,000	20,000	40,000	20,000	11,914,936
Cedars-Sinai Medical Center	553,797	10,884	700,000	1,200,000	1,622,620	917,642	2,952,554	(146,743)	647,254	300,000	20,000	40,000	20,000	8,838,008
Children's Hospital Los Angeles	-	10,884	-	1,200,000	625,260	160,822	857,018	89,745	243,375	300,000	20,000	40,000	20,000	3,567,104
Henry Mayo Newhall Memorial	59,298	-	700,000	1,200,000	778,028	269,215	655,722	128,041	314,529	300,000	20,000	40,000	20,000	4,484,833
Huntington Memorial Hospital	181,954	-	700,000	1,200,000	1,209,053	465,052	1,066,150	100,003	408,458	300,000	20,000	40,000	20,000	5,710,670
Long Beach Memorial Medical Center	88,364	10,884	700,000	1,200,000	1,339,998	560,829	1,815,287	319,151	499,857	300,000	20,000	40,000	20,000	6,914,370
Northridge Hospital Medical Center	1,474,426	600,000	700,000	1,200,000	1,175,226	481,506	1,455,484	(75,358)	532,025	300,000	20,000	40,000	20,000	7,923,309
Pomona Valley Hosp. Medical Center	231,173	-	700,000	1,200,000	1,738,287	778,723	2,501,746	25,897	595,469	300,000	20,000	40,000	20,000	8,151,295
Providence Holy Cross Medical Center	2,060,147	-	700,000	1,200,000	1,254,884	590,337	2,459,558	(18,289)	684,328	300,000	20,000	40,000	20,000	9,310,965
Ronald Reagan UCLA Medical Center	167,427	10,884	700,000	1,200,000	1,248,337	604,203	1,816,493	(56,844)	471,309	300,000	20,000	40,000	20,000	6,541,809
St. Francis Medical Center	237,185	-	700,000	1,200,000	1,795,029	793,252	3,925,890	302,474	743,012	300,000	20,000	40,000	20,000	10,076,842
St. Mary Medical Center	419,138	-	700,000	1,200,000	724,559	312,435	1,464,525	(359,856)	370,169	300,000	20,000	40,000	20,000	5,210,970
Subtotal	**$ 8,240,173**	**$ 643,536**	**$ 8,400,000**	**$ 15,600,000**	**$ 16,735,787**	**$ 7,206,223**	**$ 26,967,746**	**$ 0**	**$ 6,900,000**	**$ 3,900,000**	**$ 260,000**	**$ 520,000**	**$ 260,000**	**$ 95,633,465**
County Hospitals														
LAC+USC Medical Center	$ -	$ 10,884	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,884
Harbor-UCLA Medical Center	-	10,884	-	-	-	-	-	-	-	-	-	-	-	10,884
Subtotal	**$ -**	**$ 21,768**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 21,768**
Grand Total	**$ 8,240,173**	**$ 665,304**	**$ 8,400,000**	**$ 15,600,000**	**$ 16,735,787**	**$ 7,206,223**	**$ 26,967,746**	**$ 0**	**$ 6,900,000**	**$ 3,900,000**	**$ 260,000**	**$ 520,000**	**$ 260,000**	**$ 95,655,233**

Notes:

Col (1) - Payment is based on each hospital's share in the total value of the FY 20-21 indigent claims submitted by non-County trauma hospitals to the County (net of FY 19-20 disallowed claims), multiplied by the total funding allocated for this category.

Col (2) - Payment is based on facility type. Northridge Hospital Medical Center receives a larger allocation due to its State-designated status as a Pediatric Community Hospital.

Col (3) - Fixed payment for each hospital that provides base hospital service meeting the requirement of County's Emergency Medical Services Agency.

Col (4) - Infrastructure is a fixed payment for each trauma hospital to defray the trauma call panel, specialist physicians and trauma program costs.

Col (5) - Trauma payment is based on each hospital's percentage in the total trauma patient volume of non-County trauma hospitals (reported by County's TEMIS for CY 2020) multiplied by the total funding allocated for this category.

Col (6) - Acuity payment is based on each hospital's percentage in the total patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2020) that are adjusted for severity factors, multiplied by the total funding allocated for this category.

Col (7) - Under-insured payment is based on each hospital's percentage in the total Medi-Cal and In-Custody patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2020), multiplied by the total funding allocated for this category.

Col (8) - Parity adjustment is to redistribute a portion of the surplus of payments received by some hospitals, to mitigate the loss of payments experienced by other hospitals. Each hospital's surplus or loss is determined by the difference between its current year and prior year payments.

Col (9) - One-time funding recommended by the Measure B Advisory Board (MBAB) to cover trauma program costs associated with operating a trauma center, specifically the cost of physcian call coverage.

Col (10) - One-time funding recommended by the MBAB to cover truama program costs associated with operating a trauma center, specifically the cost to support timely data collection, analysis , and performance improvement patient safety (PIPS).

Col (11) - One-time funding recommended by the MBAB to cover trauma program costs associated with operating a trauma center, specifically the cost for up-to-date education for credentialing of trauma center staff that support clinical patient care, data and performance improvement.

Col (12) - One-time funding recommended by the MBAB to cover the cost of doing Stop the Bleed community outreach.

Col (13) - One-time funding recommended by the MBAB to cover the cost to deliver injury prenvention programs within each trauma centers' community.

DRAFT

MEMORANDUM OF AGREEMENT (MOA) EXHIBIT A-1
PROVISIONS FOR REIMBURSEMENT

TABLE OF CONTENTS

LISTING OF ATTACHMENTS

ATTACHMENT	ATTACHMENT NAME
1	PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM
2	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE - ENGLISH
3	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE - SPANISH
4	TRAUMA SERVICES COUNTY ELIGIBILITY
5	HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE
6	INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION
7	TRAUMA CENTER PAYMENT SURRENDER

TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT

I. ELIGIBLE PATIENT-BASED FUNDING

A. BUDGET ALLOCATION

1. Patient-Based Allocation Amounts

This Section I is applicable to the Non-County Trauma Hospitals with the exception of Children's Hospital Los Angeles. For the Contract Period, the County has established a budget allocation (the "Budget Allocation") for each such Non-County Trauma Hospital providing medical care to Eligible Patients (as defined below) during the Contract Period. The budget allocations are as follows:

Antelope Valley Hospital	$ 689,629
California Hospital Medical Center	$2,077,635
Cedars-Sinai Medical Center	$ 553,797
Henry Mayo Newhall Memorial Med. Ctr.	$ 59,298
Huntington Memorial Hospital	$ 181,954
Long Beach Memorial Medical Center	$ 88,364
Northridge Hospital Medical Center	$1,474,426
Pomona Valley Hospital Medical Center	$ 231,173
Providence Holy Cross Medical Center	$2,060,147
Ronald Reagan UCLA Medical Center	$ 167,427
St. Francis Medical Center	$ 237,185
St. Mary Medical Center	$ 419,138
Total Patient Based Funding	**$8,240,173**

The above amounts for each hospital were determined based on each Non-County Trauma Hospital's share of the total value of the Fiscal Year (FY) 2020-21 indigent claims submitted by all the Non-County Trauma Hospitals to the County, net of any FY 2019-20 disallowed claims, multiplied by the total funding allocated for this category (which include Measure B, Maddy

and Federal matching funds). The value of the indigent claims was computed by applying the emergency department (ED) visit or per diem rates described in the paragraph below. The final value of all the claims was adjusted upwards by an escalation factor of 53.82%, in order to fully distribute the entire funding available for this category. Payments to Non-County Trauma Hospitals listed in this section will be made directly by the County (inclusive of the Maddy Fund as defined below), and/or by the California Department of Health Care Services (CDHCS) as enhanced Medi-Cal payments to eligible private hospitals as set forth in this Exhibit.

$ 6,425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$12,471	for the first inpatient day; and
$ 5,417	for the second inpatient day; and
$ 4,283	for the third inpatient day; and
$ 4,283	for the fourth inpatient day; and
$ 3,023	for each day thereafter.

Accordingly, the Patient-Based Allocations will be taken into account in the amounts that the County recommends be paid by CDHS as enhanced Medi-Cal payments taking into account direct payments the County has made or will make to the hospitals for such allocations.

2. Maddy Fund

Certain funding known as “Maddy Emergency Medical Services Fund” (Maddy Fund) is available for hospital care rendered to Eligible Patients (as defined in I.B below) by the Non-County Trauma Hospitals. As described in I.D of this Exhibit, Contractor is required to submit a claim (an "Eligible Claim") to the County for the hospital care rendered to Eligible Patients within the Contract Period. Based on claims for patient visits and days from July 1, 2020 to June 30, 2021, County will determine the Maddy Fund payment amount for ED visits and inpatient stays up to three (3) days, using

the rates below plus an escalation adjustment factor of 53.82%, due to each hospital for this Contract Period. The amount of Maddy Fund payments is included in determining the total funding for the Patient/Hospital-Based Allocation amount.

$ 6,425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$12,471	for the first inpatient day; and
$ 5,417	for the second inpatient day; and
$ 4,283	for the third inpatient day; and
$ 4,283	for the fourth inpatient day; and
$ 3,023	for each day thereafter.

B. GENERAL CONDITIONS

Contractor shall provide Trauma Services, as defined below to Eligible Patients. For purposes of this Exhibit, an "Eligible Patient" is a patient receiving Trauma Services from Contractor meeting the following criteria: (1) the Contractor believes that the patient is unable to pay for the Trauma Services so provided; (2) the patient has no third-party coverage, in part or in whole for the Trauma Services provided by Contractor and (3) the patient's annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

For purposes of this Exhibit, "third-party coverage" or "third-party payers" includes, but is not limited to commercial insurance or any program funded in whole or in part by local, state or the federal government. "Trauma Services" refers to all hospital services furnished by the Contractor to a patient who presents to the Contractor, or is classified subsequently during the patient's stay as a Trauma Patient from the time the patient presents at or is admitted to the Contractor's hospital until the patient is discharged. The term "Trauma Patient" for purposes of this Contract is defined in the Specialty Care Center Designation Master Agreement Exhibit A, Sub Exhibit - TC Trauma Center, Attachment 5, *Patient*

Inclusion in the Trauma Data System and incorporated in this Exhibit as Attachment 1.

A claim (a “Patient-Based Claim”) shall not be submitted to the County hereunder for an Eligible Patient if: (a) the patient has the ability to pay for the service, but refuses or fails to pay the service; or (b) Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s); or (c) for any Trauma Services which is covered in, or the subject of reimbursement in, any other contract between Contractor and County. Subject to the County’s review and verification, Contractor will determine and document persons who are Eligible Patients as described in Section I.C below.

County claim is accepted from Non-County Trauma Hospitals for patient care provided to Trauma Patients who do not have the ability to pay for the services, under the following conditions: (1) Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, in accordance with Section I.C below; (2) Contractor either determines that there is no source of payment; or there is a potential source of payment but the Contractor is unable to obtain payment after making reasonable efforts to pursue such revenue and (3) the patient’s annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

During the term of this Agreement, as required by Section 16818 of the Welfare and Institutions Code (W&IC), Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, individual notice of the availability of reduced cost hospital care. Additionally, Contractor shall post, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced cost hospital care. The approved "Notice" language is reflected in English in Attachment 2 and in Spanish in Attachment 3.

C. PATIENT ELIGIBILITY

For a patient to be an Eligible Patient, Contractor must document that the person cannot afford to pay for the services provided by the Contractor. Contractor must also document that payment for the services will not be covered by third-party coverage, including any program funded in whole or in part by the federal government; and that Contractor has not received payment for any portion of the amount billed.

The documentation that the person cannot afford to pay must show that the patient's annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

Contractor shall utilize Attachment 4, *Trauma Service County Eligibility* ("TSCE") *Agreement* form as the sole means for determining whether the patient is at or below the 200% of the current year FPL and therefore meets patient's eligibility criteria for trauma care claiming during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s) at the time it is determined there is not a responsible private or public third-party source of payment and that the patient meets the eligibility requirements. The completed form must be signed and dated by the hospital representative who obtained the information, verifying that the information was obtained from the patient or the patient's responsible relative(s).

If a TSCE Agreement form cannot be secured because the patient's condition prevents the patient from providing the necessary financial information, and there is not a responsible relative(s) available then Attachment 5, *Hospital Certification of Inability to Cooperate* form must be completed. A hospital representative will complete the form, sign and date it and a second hospital representative will verify the information by also signing and dating the form. The original (or electronic scan) of either the *TSCE* or *Inability to Cooperate* form must be maintained by Contractor as part of its financial records. Contractor shall submit a copy of the applicable form to the County Emergency Medical Services (EMS) Agency when

submitting a claim to be included in the patient-based claims total as stated in Attachment 6, *Instructions for Submission of Claims and Data Collection*.

Contractor must document that it has made reasonable efforts to secure payment from the patient by billing upon discharge and two (2) subsequent billings at least a month apart with a minimum of three (3) billings. Financial notes must clearly indicate that the patient was billed at least three (3) times.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request, to authorized County or State representatives for inspection, audit, and photocopying.

D. CLAIMS SUBMISSION:

Contractor shall submit all Patient-based Claims to the County for Trauma Services to Eligible Patients, for the Contract Period. These claims, subject to the following conditions and subsequent agreements of the parties, will be used to determine the amount of the patient-based Budget Allocation for Contractor. Claims from the prior fiscal year will be used to determine the patient-based funding for the contract period.

1. A valid claim shall include a completed Trauma Patient Summary ("TPS") form, for each Eligible Patient receiving Trauma Services.
2. In addition to the TPS form, Contractor shall submit the required claim form, (UB04) as well as all required reports as set forth in Attachment 6, *Instructions for Submission of Claims and Data Collection*, attached hereto and incorporated herein by reference, to County's Emergency Medical Services Agency, 10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, California 90670, for Trauma Services provided to Eligible Patients under the terms of this Agreement. This information shall be used in determining the next (and possibly subsequent) year's Budget Allocation.
3. Claims submitted to the County shall be limited to the hospital

component of Trauma Services provided to Eligible Patients during the term of this Agreement. Inclusion of the claims in the determination of a Contractor's Budget Allocation or funding under this Agreement shall be limited to the claims for which all required data has been included in the Trauma and Emergency Medicine Information System (TEMIS) and which has been submitted as required by reporting procedures reflected in Attachment 6.

4. Claims shall be submitted to County's EMS Agency on an on-going basis once all eligibility requirements have been met and the Contractor has determined that no other source of funding is likely to be available. All Contractor claims for services provided during a County Fiscal Year (FY) (July 1 – June 30) must be received by County no later than the last working day of the first December following the close of the FY. Only claims for which the Contractor has ascertained that no payment will be received should be submitted.

5. To the extent permitted by law, upon submission of claim by Contractor to County for a trauma patient's care, and unless and until the claim is rejected by the County, Contractor assigns and subrogates to County any and all rights to collection as set forth herein, and Contractor shall cease all current and waive all future collection efforts, by itself and by its contractors/agents, to obtain any payment from the patient. At its sole discretion, County and/or County's Contractor may proceed independently against any parties responsible for payment for the Trauma Services to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees (including, for example, billed charges) for patient care and services regardless of any amount the Contractor has received under the TCSA, but only to the extent permitted by law. In the event Contractor is contacted by a third party's representative (e.g., insurance claim adjuster) or a patient's

attorney regarding pending litigation concerning a claim that has been assigned to the County hereunder, Contractor shall indicate that the claim is assigned and subrogated to the County and refer such representative to the designated County contact. Contractor shall reasonably cooperate with County in its collection efforts.

6. Contractor shall notify the County, and update the financial status of patient in TEMIS, if Contractor becomes aware of any third-party coverage such as Medi-Cal, Medicare, other government programs**,** or other health insurance for any claim that the Contractor submitted to be included for purposes of calculating the Budget Allocation. The County has all rights to work with the identified third-party payers to receive any payment due with respect to claims that Contractor has assigned to County, but only to the extent permitted by law.

7. Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment that was received within sixty (60) days of receipt of such payment, and must complete and submit Attachment 7, TRAUMA CENTER PAYMENT SURRENDER FORM with each surrendered payment.

8. For Trauma Patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement, and remaining in the hospital after that date, reports and claim submission to County shall be made only after the patient has been discharged; the Contractor shall not submit partial or interim billings.

9. All reports and claims shall be completed in such detail and with such attachments as are in accordance with procedures prescribed in writing in Attachment 6. Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Contractor and County

agree that County may revise such forms, and such procedures and instructions without using a formal amendment to this Agreement. Such revised forms, procedures and instructions shall be effective at least fifteen (15) calendar days after written notice to Contractor. In the event Contractor submits a timely written objection, Contractor and County will promptly meet and confer in good faith in an effort to resolve their differences. In the event the parties are not able to resolve their differences, Contractor may send a written notice to County within (30) days of the meet and confer session terminating this Agreement. This Agreement shall terminate fifteen (15) days after the date of the written notice, on such other days as the parties shall agree in writing.

E. AUDITING OF RECORDS

Contractor shall maintain and, upon request, make available to State or County representatives, records containing the financial information referenced in this Section, including records of patient and third-party payer payments, all in accordance with Section I B. General Conditions of this Exhibit.

1. County may periodically conduct an audit of the Contractor's records pertaining to the Patient-Based Claims for Eligible Patients that are required under this Exhibit. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of submitted claims for a fiscal year, provided the sampling methodology is statistically valid. The scope of the audit shall include an examination of patient medical and financial records, patient and/or insurance billing records, and collection agency reports associated with the sampled claims.
2. Audited claims that do not comply with requirements in this Agreement shall result in a reduction in the total value of patient-based claims that will be used to determine each trauma hospital's patient-based Budget Allocation for the next fiscal year.

For example, if two patient-based claims for the prior fiscal year with a total value of $12,850 were audited and determined not to be in compliance with the program requirements and the Contractor's total value of submitted claims for that prior fiscal year was $150,000, $12,850 would be subtracted from the total value, reducing it to $137,150 which would then be the amount used to determine the Contractor's patient-based Budget Allocation for the next fiscal year. The County will notify Contractor of any audit findings. Audit results may be appealed to the EMS Agency Director, or his/her designee.

II. FUNDING FOR PEDIATRIC TRAUMA CENTERS

The parties acknowledge that Chapter 841 of the Statutes of 2006, authorized the County Board of Supervisors (Board), until December 31, 2008, to elect to levy an additional penalty in the amount of two dollars ($2) for every ten dollars ($10), upon fines, penalties, and forfeitures collected for specific criminal offenses. This authority was subsequently extended to December 31, 2013 by Chapter 288 of the Statutes of 2008. New legislation (SB 191) was chaptered October 5, 2013 and Section 76000.5 of the Government Code was amended extending these provisions through January 1, 2017. In 2016, legislation (SB 867) was again passed amending Section 76000.5 of the Government Code, extending these provisions through January 1, 2027.

The legislation further authorized the Board to utilize fifteen percent (15%) of the funds collected pursuant to the provisions of Health and Safety Code section 1797.98a, subdivision (e) (known as Richie's Fund) to provide funding to enhance pediatric trauma services by both publicly and privately owned and operated Pediatric Trauma Centers (PTCs) throughout the County.

The FY 2020-21 Richie's Fund collections available for FY 2021-2022 allocation to the non-County PTCs and County PTCs are $665,304. This amount is allocated to PTCs for expansion of pediatric trauma care services as follows:

Cedars-Sinai Medical Center	$ 10,884
Children's Hospital Los Angeles	$ 10,884
Long Beach Memorial Medical Center	$ 10,884
Northridge Hospital Medical Center	$ 600,000
Ronald Reagan UCLA Medical Center	$ 10,884
Total	**$ 643,536**

III. DESIGNATION SUPPORT FUNDING

The funding described in this Section III is in addition to the funding described in Section I and II of this Exhibit.

A. BASE HOSPITAL SERVICES AND INFRASTRUCTURE

To account for the special costs incurred for those private trauma hospitals providing base and trauma hospital services and to ensure the continued access by Medi-Cal beneficiaries to emergency rooms and emergency room care in the County by maintaining efficient prehospital transport of all patients to the most appropriate emergency room, the County will recommend to the State that it make an aggregate supplemental payment in the amount of $700,000 for base station and $1,200,000 for infrastructure to each private Non-County Trauma Hospital pursuant to the Trauma SPA, with the exception of Children's Hospital Los Angeles. Children's Hospital Los Angeles will receive a supplemental infrastructure payment in the amount of $1,200,000 but will not receive a supplemental base station payment because it does not provide base hospital services.

As public hospitals, Ronald Reagan UCLA Medical Center ("UCLA") and Antelope Valley Hospital ("Antelope") may not receive these supplemental Medi-Cal payments under the State Plan. Accordingly, the County will directly pay each of those hospitals the amount of $700,000 for base station support and $1,200,000 for infrastructure support at or about the same time as County makes its IGT payment to the State. In the event the County

makes its IGT payment to the State in multiple installments, the County will make the base station and infrastructure supplemental payments to UCLA and Antelope in the same number of installments.

IV. ADD-ONS PAYMENTS

The funding described in this Section IV is in addition to the funding described in Sections I, II and III of this Exhibit. The total payment amounts below were designed to reflect the following: a) trauma patient volume; b) trauma patient acuity; c) the levels of underinsured trauma patients treated; and d) a parity adjustment to mitigate the negative financial impact among various hospitals.

Antelope Valley Hospital	$ 3,512,365
California Hospital Medical Center	$ 6,673,446
Cedars-Sinai Medical Center	$ 5,346,073
Children's Hospital Los Angeles	$ 1,732,845
Henry Mayo Newhall Mem. Med. Ctr.	$ 1,831,006
Huntington Memorial Hospital	$ 2,840,258
Long Beach Memorial Medical Center	$ 4,035,265
Northridge Hospital Medical Center	$ 3,036,858
Pomona Valley Hospital Medical Center	$ 5,044,653
Providence Holy Cross Medical Center	$ 4,286,490
Ronald Reagan UCLA Medical Center	$ 3,612,189
St. Francis Medical Center	$ 6,816,645
St. Mary Medical Center	$ 2,141,663
Total	**$50,909,756**

Except for UCLA and Antelope, it is the intent of the County to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to UCLA and Antelope as grants to support their provision of trauma services.

V. MEASURE B ADVISORY BOARD FUNDING

The Measure B Advisory Board (MBAB) recommended that the Board of Supervisors use unallocated and unspent Measure B funds from prior periods for the following one-time purposes in FY 2021-22: (1) to fund an IGT to CDHCS to draw down federal matching dollars to pay for the costs of physician call coverage and the costs to support timely data collection, analysis, and performance improvement-patient safety for the eleven (11) Non-County Trauma Hospitals that are classified as private hospitals and identified in Sections V.1 and V.2; (2) to issue direct payments to two (2) Public Non-County Trauma Hospitals that are ineligible for federal matching dollars as identified in Sections V.1 and V.2; (3) to issue direct payments to all thirteen (13) Non-County Hospitals to cover the costs of (i) up-to-date education for credentialing of trauma center staff; (ii) Stop the Bleed community outreach; and (iii) Injury Prevention Programs within each trauma centers' community as identified in Sections V.3, V.4, and V.5.

The payments to the thirteen (13) Non-County Trauma Hospitals are as follows:

1. Trauma Program Services (Physician Call Coverage)

Antelope Valley Hospital	$ 506,360
California Hospital Medical Center	$ 883,855
Cedars-Sinai Medical Center	$ 647,254
Children's Hospital Los Angeles	$ 243,375
Henry Mayo Newhall Mem. Med. Ctr.	$ 314,529
Huntington Memorial Hospital	$ 408,458
Long Beach Memorial Medical Center	$ 499,857
Northridge Hospital Medical Center	$ 532,025
Pomona Valley Hospital Medical Center	$ 595,469
Providence Holy Cross Medical Center	$ 684,328
Ronald Reagan UCLA Medical Center	$ 471,309
St. Francis Medical Center	$ 743,012

St. Mary Medical Center	$ 370,169
Total	**$ 6,900,000**

2. Trauma Program Services (Data Collection/Analysis)

Antelope Valley Hospital	$ 300,000
California Hospital Medical Center	$ 300,000
Cedars-Sinai Medical Center	$ 300,000
Children's Hospital Los Angeles	$ 300,000
Henry Mayo Newhall Mem. Med. Ctr.	$ 300,000
Huntington Memorial Hospital	$ 300,000
Long Beach Memorial Medical Center	$ 300,000
Northridge Hospital Medical Center	$ 300,000
Pomona Valley Hospital Medical Center	$ 300,000
Providence Holy Cross Medical Center	$ 300,000
Ronald Reagan UCLA Medical Center	$ 300,000
St. Francis Medical Center	$ 300,000
St. Mary Medical Center	$ 300,000
Total	**$ 3,900,000**

3. Trauma Program Costs (Education for Credentialing of staff)

Antelope Valley Hospital	$ 20,000
California Hospital Medical Center	$ 20,000
Cedars-Sinai Medical Center	$ 20,000
Children's Hospital Los Angeles	$ 20,000
Henry Mayo Newhall Mem. Med. Ctr.	$ 20,000
Huntington Memorial Hospital	$ 20,000
Long Beach Memorial Medical Center	$ 20,000
Northridge Hospital Medical Center	$ 20,000
Pomona Valley Hospital Medical Center	$ 20,000

Providence Holy Cross Medical Center	$ 20,000
Ronald Reagan UCLA Medical Center	$ 20,000
St. Francis Medical Center	$ 20,000
St. Mary Medical Center	$ 20,000
Total	**$ 260,000**

4. Stop the Bleed Program:

Antelope Valley Hospital	$ 40,000
California Hospital Medical Center	$ 40,000
Cedars-Sinai Medical Center	$ 40,000
Children's Hospital Los Angeles	$ 40,000
Henry Mayo Newhall Mem. Med. Ctr.	$ 40,000
Huntington Memorial Hospital	$ 40,000
Long Beach Memorial Medical Center	$ 40,000
Northridge Hospital Medical Center	$ 40,000
Pomona Valley Hospital Medical Center	$ 40,000
Providence Holy Cross Medical Center	$ 40,000
Ronald Reagan UCLA Medical Center	$ 40,000
St. Francis Medical Center	$ 40,000
St. Mary Medical Center	$ 40,000
Total	**$ 520,000**

5. Trauma Program Costs (Injury Prevention)

Antelope Valley Hospital	$ 20,000
California Hospital Medical Center	$ 20,000
Cedars-Sinai Medical Center	$ 20,000
Children's Hospital Los Angeles	$ 20,000
Henry Mayo Newhall Mem. Med. Ctr.	$ 20,000
Huntington Memorial Hospital	$ 20,000
Long Beach Memorial Medical Center	$ 20,000

Northridge Hospital Medical Center	$ 20,000
Pomona Valley Hospital Medical Center	$ 20,000
Providence Holy Cross Medical Center	$ 20,000
Ronald Reagan UCLA Medical Center	$ 20,000
St. Francis Medical Center	$ 20,000
St. Mary Medical Center	$ 20,000
Total	**$ 260,000**

VI. PAYMENT LIMIT

Contractor acknowledges that the amounts payable under Attachment A ("the Trauma SPA") are limited to the uncompensated costs of providing outpatient hospital services of all eligible private trauma hospitals in Los Angeles County and are also limited by the State's upper payment limit, as established in 42 C.F.R. Section 447.321. To the extent that either or both limits preclude the State from paying all the aggregate amounts set forth below, the amount to be recommended by the County for each private trauma hospital shall be reduced by the same percentage as the percentage of total allowable supplemental payments under the Trauma SPA is to total recommended supplemental Medi-Cal payments under the Trauma SPA to all private trauma hospitals.

VII. POTENTIAL IGT FOR FEDERAL MATCHING FUNDS

As discussed in Section III, the County intends that the Designation Support payments, Add-On Payments, a portion of the Patient-Based payments and any MBAB payments, should they be allocated, to the private Non-County Trauma Hospitals be made as additional Medi-Cal payments in accordance with the Trauma SPA. Unless CDHCS rejects this payment approach, the County will transfer the non-federal share of such funds to CDHCS in one or more IGTs. The amount of the additional Medi-Cal payments to the private Non-County Trauma Hospitals will be included in the amounts set forth in Sections IA.1, III, IV and V above.

The parties acknowledge and agree that some or all of the IGT, which the County intends to make to effectuate the provisions of this Agreement may not be capable of drawing down federal matching funds under the Trauma SPA. To the extent that is true, the parties agree that the County shall have no obligation to make an IGT of such amounts and shall instead provide such IGT funds directly to the private Non-County Trauma Hospitals in proportion to the payments that would have been made to each hospital relating to such IGT funds if the funds had been accepted as a permissible IGT for which federal matching funds would be available under the Trauma SPA. To the extent that Non-County Trauma Hospitals receive the full amounts set forth in Section VIII, County has no obligation to make further direct payments, even if not all of the funds set aside for use as an IGT are ultimately used for that purpose.

The total amount of the IGT that the County intends to make shall be $40.23 million.

VIII. TOTAL MAXIMUM PAYMENTS

The total maximum payments that each Non-County Trauma Hospital may receive, either directly from the County, or from the State of California as additional Medi-Cal payments under the Trauma SPA (which includes the amounts of IGTs made by the County and federal matching funds), and subject to the limitations and conditions as described in this Agreement, shall be as follows:

Antelope Valley Hospital	$ 6,988,354
California Hospital Medical Center	$ 11,914,936
Cedars-Sinai Medical Center	$ 8,838,008
Children's Hospital Los Angeles	$ 3,567,104
Henry Mayo Newhall Memorial Med. Ctr.	$ 4,484,833
Huntington Memorial Medical Center	$ 5,710,670
Long Beach Memorial Medical Center	$ 6,914,370
Northridge Hospital Medical Center	$ 7,923,309

Pomona Valley Hospital Medical Center	$ 8,151,295
Providence Holy Cross Medical Center	$ 9,310,965
Ronald Reagan UCLA Medical Center	$ 6,541,809
St. Francis Medical Center	$ 10,076,842
St. Mary Medical Center	$ 5,210,970
Total	**$ 95,633,465**

Each non-County Trauma Hospital will be paid the above amounts through a combination of direct payments by the County or additional Medi-Cal payments under the Trauma SPA, except for UCLA and Antelope which shall receive only funds from the County. Payments may be reduced to the extent that the amounts anticipated to be paid as Medi-Cal funds through the Trauma SPA cannot be paid in that manner, in which case the County will make direct payments of the non-federal share of such payments, up to, but not exceeding the amount of the IGT set forth above, less the amount used to fund the Medi-Cal payments which were actually made.

IX. EFFECTIVE DATES

The provisions of this Exhibit shall only apply to trauma services provided on or after July 1, 2021 and before July 1, 2022.

BOARD LETTER – EXHIBIT 1

Agreement No.: _____

NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT

Amendment No. 1

THIS AMENDMENT is made and entered into this _____ day of June, 2022,

By and between — COUNTY OF LOS ANGELES (hereinafter "County"),

And — HOSPITAL (hereinafter "Hospital").

Business Address:

1600 West Avenue J
Lancaster, CA 93534

WHEREAS, reference is made to that certain document entitled " MEMORANDUM OF AGREEMENT FOR NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT" dated on _____, and further identified as Agreement No.:_____ , including any amendments and any other modifications thereto (cumulatively hereafter referred to as "MOA"); and

WHEREAS, _____the Board of Supervisors approved reimbursement to the Non-County Trauma Hospitals using funding provided by Measure B, the EMS Maddy Fund, and Richie's Fund.

WHEREAS, on ____, 2022 the County's Board of Supervisors delegated authority to the Director of Health Services, or authorized designee, to, among other delegations, to execute amendments to the MOA to extend the term of the MOA for the period July 1, 2021 through June 30, 2022, for a total County obligation of approximately $55.40 million comprised of various amounts from Measure B, The EMS Maddy Fund, and Richie's Fund.

_____

NOW THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall be effective upon execution.

2. The MOA is hereby incorporated by reference, and all of its terms and conditions, including capitalized terms defined herein, shall be given full force and effect as if fully set forth herein.

3. The MOA, Paragraph 1.0 – SCOPE is deleted in its entirety and replaced to read as follows:

"1.0 SCOPE

1.1 This MOA addresses funding for the fiscal year ending June 30, 2022 (the "Contract Period") for the Los Angeles County private and non-County public hospitals having trauma centers ("Non-County Trauma Hospitals"). Non-County Trauma Hospitals are hospitals that are not owned nor operated by County of Los Angeles (the "County"). The County's funding to Non-County Trauma Hospitals for this contract period assures the continuance of emergency care access for Medi-Cal beneficiaries and stabilizes the provision of trauma care services in Los Angeles County.

1.2 The funding identified in this MOA for Non-County Trauma Hospitals is described in Exhibit A-1, Provisions For Reimbursement, covers the following four components:

1.2.1. Patient/Hospital-Based Payments
This component includes uninsured trauma claims and pediatric trauma services as described in Exhibit A-1, Sections I and II.

1.2.2 Designation Support Payments
This component includes payments for Non-County Trauma Hospitals that serve as base stations, and funding for trauma hospitals' infrastructure as described in Exhibit A-1, Section III A.

1.2.3 Add-On Payments
This component includes payments for: a) trauma patient volume; b) patient acuity; c) the volume of underinsured patients (i.e., Medi-Cal and In-Custody patients); and d) a parity adjustment to mitigate the negative financial impact among various hospitals as described in Exhibit A-1, Section IV.

1.2.4 Measure B Advisory Board Funding (if available)
This component includes one-time payments, as applicable, if funding is available and recommended by the Measure B Advisory Board (MBAB), and approved by the County Board of Supervisors, to distribute prior year unspent and unallocated Measure B funds as described in Exhibit A-1, Section V.

1.3 The County intends to provide funding to Hospital for one or more of the four components described in Section 1.2 from the following fund sources under this MOA: Measure B, The EMS Maddy Fund, and Richie's Fund. In addition, the County will utilize Measure B funds, to the extent possible, to make an inter-governmental transfer (IGT) of funds to the California Department of Health Care Services (CDHCS) to draw down Federal matching dollars for enhanced Medi-Cal payments to Eligible Trauma Hospitals, pursuant to California's Medicaid State Plan (Title XIX), Attachment 4.19B (Enhanced Payments to Private Trauma Hospitals), pp. 51-51c (TN-03-032, app. Mar. 31, 2005; eff. Jul. 1, 2003), attached hereto as Attachment A.

1.4 The Non-County Trauma Hospitals entering into this MOA acknowledge that Attachment A, was approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Attachment A enables private trauma hospitals in Los Angeles County to receive additional Medi-Cal payments, under Section 14087.3 of the Welfare and Institutions Code. Pursuant to Medicaid State Plan and a related interagency agreement between the County and the CDHCS, these additional Medi-Cal payments are distributed to the County-designated private trauma hospitals, in a lump-sum amount to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County."

4. The MOA, Paragraph 2.0 – TERM is deleted in its entirety and replaced to read as follows:

"2.0 TERM

1.5 The term of this MOA is effective upon the date of execution by the Director of Health Services (Director), or designee. This MOA shall expire on June 30, 2023 unless sooner extended or terminated, in whole or in part, as provided herein.

1.6 In any event, this MOA may be terminated for any reason at any time by either party by giving at least thirty (30) calendar days advance written notice to the other party."

5. The MOA, Paragraph 3.0 – PAYMENT AND INVOICES is deleted in its entirety and replaced to read as follows:

"3.0 PAYMENT AND INVOICES

1.7 County's maximum reimbursement amount to the private Non-County Trauma Hospitals for the delivery of trauma services for fiscal years

2020-21 and 2021-22 shall not exceed the amounts identified in Exhibit A-1."

6. The MOA, Exhibit A- Provisions For Reimbursement is modified to add Exhibit A-1, attached hereto and incorporated herein by reference. Any reference to Exhibit A in the MOA shall include Exhibit A-1.

7. Except for the changes set forth hereinabove, the MOA shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services, or authorized designee, and Hospital has caused this Amendment to be executed on its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By: _____
Christina R. Ghaly, M.D.
Director of Health Services

HOSPITAL

_____

By_____
Signature

_____
Printed Name

_____
Title

APPROVED AS TO FORM:

DAWYN R. HARRISON
Acting County Counsel

By: _____
Brian T. Chu
Principal Deputy County Counsel

BOARD LETTER/MEMO
CLUSTER FACT SHEET

X Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	5/25/2022
BOARD MEETING DATE	6/14/2022
SUPERVISORIAL DISTRICT AFFECTED	☐ All X 1st ☐ 2nd X 3rd X 4th X 5th
DEPARTMENT(S)	Mental Health
SUBJECT	Request delegated authority to amend four Department of Mental Health Legal Entity Contracts for Fiscal Year 2020-21 and request delegated authority to amend Legal Entity contracts in the future, due to the post Annual Cost Report adjustments and realigning of the funded programs with actual costs, as necessary.
PROGRAM	Medi-Cal
AUTHORIZES DELEGATED AUTHORITY TO DEPT	X Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes X No If Yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	June 14, 2022
COST & FUNDING	Total cost: $1,843,355 | Funding source: fully funded by federal and State revenues TERMS (if applicable): N/A Explanation: There is not a term associated with these four contracts as they have expired and this requested increase is due to post Annual Cost Report adjustments which is consistent with the State Department of Health Care Services' (DHCS) reimbursement methodology for Specialty Mental Health Services (SMHS).
PURPOSE OF REQUEST	To allow DMH to amend four LE Contracts, as listed in Attachment I, for FY 2020-21 by making a post Annual Cost Report adjustment which resulted in an increase in their MCAs beyond the original 25 percent delegated authority granted by the Board for FY 2020-21.
BACKGROUND (include internal/external issues that may exist including any related motions)	There are no known issues related to this action nor related motions. This action is in line with the DHCS' reimbursement methodology for SMHS. Each LE Contractor is required to submit an Annual Cost Report to DMH for the applicable fiscal year two months after the fiscal year end, if the due date is not extended by the State. Additionally, under the LE Contract Financial Exhibit A, LE Contractors are allowed to shift funds within contracted funded programs in the applicable fiscal year to align contracted funded program amounts to actual and allowable costs based on their submitted Annual Cost Report. This adjustment gives DMH and the LE Contractors the flexibility to maximize the use of federal and State funding for Medi-Cal services and minimize State disallowances at the time of the State reconciliation process.
EQUITY INDEX OR LENS WAS UTILIZED	☐ Yes X No If Yes, please explain how:
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☐ Yes X No If Yes, please state which one(s) and explain how:
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: DMH: Kimberly Nall, Finance Manager III, (213) 738-4625, knall@dmh.lacounty.gov Deputy County Counsel: Emily Issa, (213) 974-1827, eissa@counsel.lacounty.gov

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

June 14, 2022

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

REQUEST APPROVAL TO AMEND FOUR LEGAL ENTITY CONTRACTS AND DELGATED AUTHORITY TO AMEND EXISTING LEGAL ENTITY CONTRACTS DUE TO THE POST ANNUAL COST REPORT ADJUSTMENTS

(SUPERVISORIAL DISTRICTS 1, 3, 4, AND 5)
(3 VOTES)

SUBJECT

Request delegated authority to amend four Department of Mental Health Legal Entity Contracts for Fiscal Year 2020-21 and request delegated authority to amend Legal Entity contracts in the future, due to the post Annual Cost Report adjustments and realigning of the funded programs with actual costs, as necessary.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or his designee, to prepare, sign, and execute an amendment (Attachment I) to four Department of Mental Health (DMH) Legal Entity (LE) Contracts, as identified on Attachment II. These amendments are necessary to make post Annual Cost Report adjustments which will result in an increase to the four LE Contracts' Maximum Contract Amounts (MCA), beyond the original 25 percent of the previously Board-approved MCAs for Fiscal Year (FY) 2020-21. The aggregate amount of the increase for these four LE Contracts is $1,843,355, fully funded by federal and State revenues.

2. Delegate authority to the Director, or his designee, to prepare, sign, and execute an amendment, substantially similar to Attachment I, as necessary, to DMH's existing LE Contracts as the result of the post Annual Cost Report adjustments, subject to the prior review and approval of County Counsel, with notification to the Board and Chief Executive Office.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Board approval of Recommendation 1 will allow DMH to amend four LE Contracts, as listed in Attachment I, for FY 2020-21 by making a post Annual Cost Report adjustment which resulted in an increase in their MCAs beyond the original 25 percent delegated authority granted by the Board for FY 2020-21. Each LE Contractor is required to submit an Annual Cost Report to DMH for the applicable fiscal year two months after the fiscal year end, if the due date is not extended by the State. Additionally, under the LE Contract Financial Exhibit A, LE Contractors are allowed to shift funds within contracted funded programs in the applicable fiscal year to align contracted funded program amounts to actual and allowable costs based on their submitted Annual Cost Report. This adjustment gives DMH and the LE Contractors the flexibility to maximize the use of federal and State funding for Medi-Cal services and minimize State disallowances at the time of the State reconciliation process.

In this instance, such post Annual Cost Report adjustment made by the four LE Contracts caused the MCA to increase beyond the 25 percent delegated authority granted by the Board for FY 2020-21. In accordance with the LE Contract's Financial Exhibit A, DMH reviewed and analyzed the four LE Contractors' requests to determine the appropriateness of the adjustment. DMH determined that the adjustment was appropriate to reimburse the four LE Contractors for the specialty mental health services (SMHS) already rendered and to ensure Medi-Cal reimbursement is received for allowable costs.

Board approval of Recommendation 2 will allow DMH to amend the existing LE Contracts, by making an adjustment after the submission of the post Annual Cost Report, which may result in an increase of the MCA beyond the original 25 percent delegated authority granted by the Board, and in every case, based on actual and allowable costs based on the submitted Annual Cost Reports.

Implementation of Strategic Plan Goals

The recommended actions are consistent with the County's Strategic Plan III, Realize Tomorrow's Government Today, specifically Strategy III.3 - Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability.

FISCAL IMPACT/FINANCING

The cost associated with Recommendation 1 was determined upon receipt of the post Annual Cost Report adjustment request submitted by the four LE Contractors. The total aggregate for these LE Contracts for FY 2020-21 is $1,843,355, fully funded by federal and State revenues. DMH has sufficient FY 2021-22 budgeted appropriation for this recommended action.

There is no net County cost impact with the recommended actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On June 6, 2018, your Board authorized the Director to enter into a contract with 133 LE Contractors for FYs 2018-19 through 2020-21, which included the LE Contracts listed in Attachment I.

LE Contractors are reimbursed for services based on their negotiated provisional rate during a given fiscal year and are subject to a Cost Report settlement process. This practice is consistent with the State Department of Health Care Services' reimbursement methodology for SMHS, as specified in Exhibit A of the LE Contracts. Therefore, in order for LE Contractors to have the flexibility to adjust their Medi-Cal funded amounts, within a given number of days after submission of their Annual Cost Report to DMH, LE Contractors may submit a written request to shift funds as specified in the Financial Exhibit A (Paragraph X titled "Survival: Amendments to Maximum Contract Amount and Financial Summary"). In some cases, the final DMH approved shift amounts may also require an increase to the corresponding gross contract amounts to allow for the flow of federal or State Medi-Cal funds, thus increasing the MCA. In some circumstances, the increase in the MCA goes beyond the Board-approved delegated authority for the fiscal year. Such amendment may need to be executed during the First and/or Second Optional Extension Period within the term of the LE Contract as described in the LE Contract, Paragraph 4 (Term) and/or after the LE Contract has expired or terminated. As a result, the four Contractors' 2020-21 LE Contracts would not be reconciled until well after the fiscal year in question.

According to the April 2020 Retroactive Contracts Review Committee Procedures, retroactive contracts are defined as contracts authorizing payment for services provided during a period when there was no valid contract in place or there was a valid contract in place and the vendor provided goods/services beyond the contract sum. The retroactive policy does not apply to this situation because the four LE Contracts provided services within the contract term and the LE Contract allows the Contractor to submit a post Annual Cost Report adjustment for the applicable fiscal year due to the nature of Short-Doyle/Medi-Cal reimbursement methodology.

Under Board Policy No. 5.100 (Sole Source Contracts), DMH is required to notify your Board six months in advance of amendments to existing contracts when DMH does not have delegated authority to increase the maximum amount of the current contract. On July 14, 2020, DMH requested an exemption to Board Policy No. 5.100 (Sole Source Contracts), from your Board for the six month notification requirement for DMH LE Contracts, and in accordance with the Board Policy, DMH considers this request approved, as we did not hear otherwise.

The amendment format (Attachment I) has been approved as to form by County Counsel.

Attachment II lists the LE Contractors and includes their headquarters addresses, Supervisorial District(s) served, Service Area(s) covered, and the MCA.

As mandated by your Board, the performance of all contractors is evaluated by DMH on an annual basis to ensure compliance with all Contract terms and performance standards.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

This settlement process allows DMH and the LE Contractors to maximize the use of federal and State funding for provided Medi-Cal services and minimize State disallowances at the time of the State reconciliation process.

Respectfully submitted,

JONATHAN E. SHERIN, M.D., Ph.D.
Director

JES:GCP:SK
RLR:MM:mm

Enclosures

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Chairperson, Mental Health Commission

CONTRACT NO. MH122xxx

AMENDMENT NO. x

THIS AMENDMENT is made and entered into this xx day of June, 2022, by and between the COUNTY OF LOS ANGELES (hereafter “County”) and _____ (hereafter “Contractor”).

WHEREAS, reference is made to that certain document entitled "Department of Mental Health Legal Entity Contract," dated July 1, 2018, and further identified as County Contract No. MH122xxx, and any amendments thereto (hereafter collectively “Contract”); and

WHEREAS, on June xx, 2022, the County Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute an amendment to the Contract necessary to make post Annual Cost Report adjustments to revise the annual Maximum Contract Amount (MCA) in an amount that exceeds the original 25% Board-approved MCA for Fiscal Year (FY) 2020-21; and

WHEREAS, said Contract provides that changes may be made in the form of a written amendment which is formally approved and executed by the parties; and

WHEREAS, for FY 2020-21, County and Contractor intend to amend the Contract due to the post Annual Cost Report adjustment to increase DMH Mental Health Services Medi-Cal (MC), or increase Mental Health Service Act (MHSA) Outpatient Care Services MC, or increase MHSA Prevention & Early Intervention (PEI) MC (whichever is applicable) Funded Program funds, and make other hereinafter designated changes; and

WHEREAS, for FY 2020-21, as a result of the above change in Funded Program funds, the MCA will increase; and

NOW, THEREFORE, County and Contractor agree as follows:

1. This amendment is effective upon execution for FY 2020-21 to settle funds after the Annual Cost Report settlement process.

2. For FY 2020-21, DMH Mental Health Services MC Funded Program funds are increased by $_____, from $_____to $_____. OR

3. For FY 2020-21, MHSA Outpatient Care Services MC Funded Program funds are increased by $_____, from $_____to $_____. OR

4. For FY 2020-21, MHSA PEI MC Funded Program Funds are increased by $_____, from $_____to $_____. (whichever is applicable)

5. For FY 2020-21, the MCA is increased by $_____, from $_____ to $_____.

6. Financial Exhibit A (FINANCIAL PROVISIONS), Paragraph D (REIMBURSEMENT IF CONTRACT IS AUTOMATICALLY RENEWED), subparagraph (2) shall be deleted in its entirety and replaced to read as follows:

"(2) Reimbursement For Second Automatic Renewal Period: The MCA for the Second Automatic Renewal Period of this Contract as described in Paragraph 4 (TERM) of the DMH Legal Entity Contract shall not exceed _____ ($_____) and shall consist of Funded Programs as shown on the Financial Summary."

7. Financial Summary (Exhibit B) – xx for FY 2020-21, shall be deleted in its entirety and replaced with Financial Summary (Exhibit B) – xx for FY 2020-21, attached

hereto and incorporated by reference. All references in the Contract to Financial Summary (Exhibit B) – xx for FY 2020-21, shall be deemed amended to state "Financial Summary (Exhibit B) – xx for FY 2020-21".

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this amendment to be subscribed by County's Director of Mental Health or designee, and Contractor has caused this amendment to be subscribed on its behalf by its duly authorized officer, on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By_____
JONATHAN E. SHERIN, M.D., Ph.D.
Director of Mental Health

_____
CONTRACTOR

By _____

Name _____

Title _____
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: Emily D. Issa
Deputy County Counsel

mm: Four Legal Entities for FY 2020-21

Attachment II

LOS ANGELES COUNTY
Department of Mental Health
Increase of Maximum Contract Amounts due to the Annual Cost Report Adjustment
For FY 2020-21

Legal Entity Name	Headquarters Address	Supervisorial District Service Location	Service Area(s)	Current MCA for FY 2020-21	Increase for FY 2020-21	Revised MCA for FY 2020-21
Behavioral Health Services, Inc.	15519 Crenshaw Boulevard Gardena, CA 90249	1,3	4	$1,862,195	$11,326	$1,873,521
Step Up on Second Street, Inc.	1328 Second St. Santa Monica, CA 90401	3	4,5	$12,361,978	$611,962	$12,973,940
Tarzana Treatment Centers, Inc.	18646 Oxnard St. Tarzana, CA 91356	3,4,5	1,2,8	$14,863,471	$39,388	$14,902,859
Topanga-Roscoe Corporation dba Topanga West Guest Home	22115 Roscoe Blvd. Canoga Park, CA 91304	5	2	$1,084,746	$1,180,679	$2,265,425
TOTAL AGGREGATED AMOUNT AMENDED FOR FY 2020-21					**$1,843,355**	

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program

Health and Mental Health Services Briefing

May 25, 2022

Harbor-UCLA Replacement Program

Agenda:

- Program Overview
- Status of Key Activities
- Schedule Milestones
- Program Budget
- Upcoming Board Actions

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program

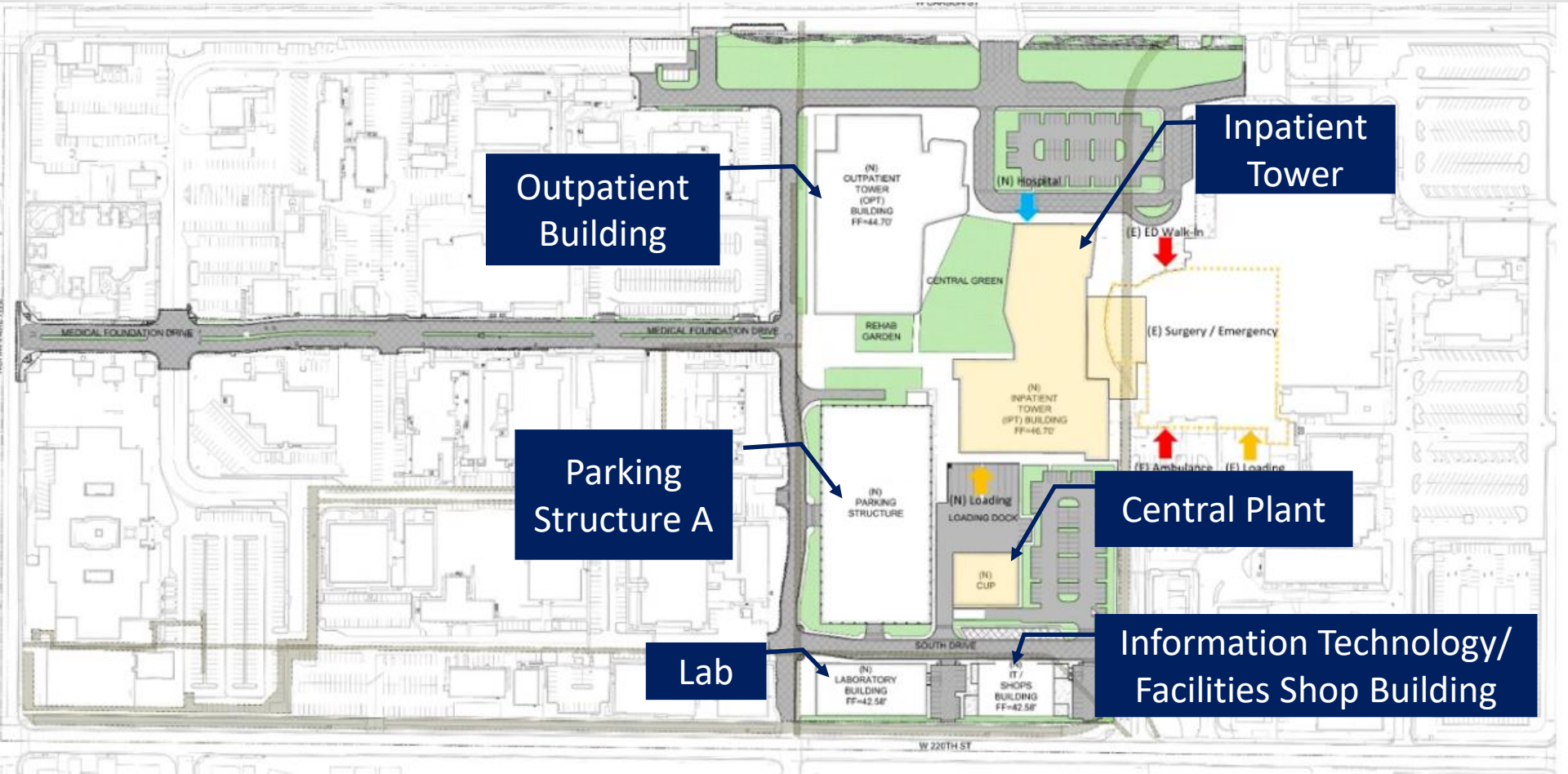
Program Overview

Design-Build Scope:

- Inpatient Tower
- Outpatient Building
- Parking Structure A
- Central Plant, Information Technology/Shops & Laboratory Buildings

- Make-Ready Scope:
  - Site Utilities
  - Interim Facilities (DHS/DMH), Helistop
  - Demolition of Unoccupied Buildings

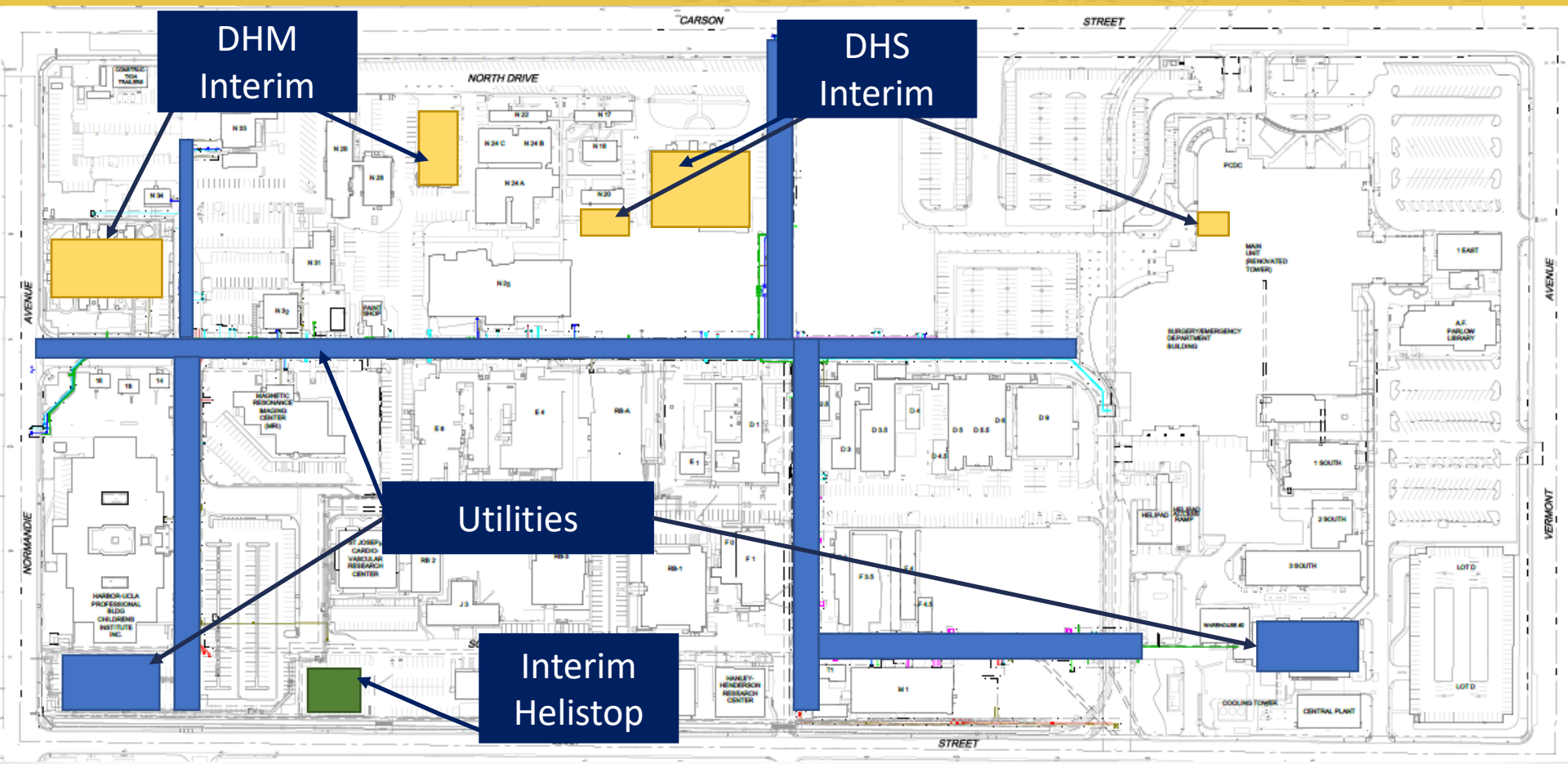
Harbor-UCLA Replacement Program



Design-Build

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program



Make-Ready

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program

Key Activities

- The Board approved the project and awarded a Design-Build contract on February 8, 2022
- User group meetings, design development, and coordination with jurisdictional agencies for all project components began in February 2022
- Civic Arts – The RFSQ to establish prequalified artists list was issued in March 2022, and artist selection will be completed in June 2022
- Outreach & Labor Compliance - Hensel Phelps continues to hold outreach events to engage local businesses and labor workforce; their 2nd event at the H-UCLA campus is scheduled for June 14th, 2022
- Community Workforce Agreement kick-off meetings with relevant stakeholders are being held in May 2022

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program

Key Activities

- Construction of make-ready work, including site utilities, interim facilities, and demolition, is ongoing
  - The Utility Ductbank is anticipated to be completed in November 2022
  - The construction of the Interim Helistop is scheduled to begin in January 2023
  - The DMH Interim Facilities are anticipated to be completed in March 2023
- Construction of Parking Structure A and the Information Technology/Facilities Shops Building is scheduled to begin in September 2022

Harbor-UCLA Replacement Program

Progress Photos- Utility Ductbank

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program

Progress Photos- Electrical Utilities

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program

Schedule Milestones

Project Component	Board Approved Completion Dates*	Contractual Completion Dates
Parking Structure A	6/30/24	3/15/24
Outpatient/Support Building	6/30/26	N/A
Central Plant Building	5/31/27	N/A
Inpatient Tower	8/31/27	6/8/27

*Per 2/8/22 Board action.

Note: The Design-Builder's baseline schedule will be available in late June 2022.

Harbor-UCLA Replacement Program

Program Budget

The project is within the previous Board-approved budget of $1,695,000,000

Public Works
LOS ANGELES COUNTY

Harbor-UCLA Replacement Program

Upcoming Board Actions

- June 14, 2022- Approval of change orders to Hensel Phelps for make-ready scope transfers
- July 12, 2022- Approval of a Community Workforce Agreement administration consultant services agreement
- August 9, 2022- Adopt, Advertise, and Award for Interim Helistop