County of Los Angeles
CIVIL GRAND JURY

222 South Hill Street • Sixth Floor • Suite 670 • Los Angeles, California 90012
Telephone (213) 893-0411 • Fax (213) 893-0425
www.grandjury.co.la.ca.us

September 10, 2025

Honorable Sergio C. Tapia II
Superior Court of California
County of Los Angeles
111 North Hill Street, Room 204
Los Angeles, CA 90012

Dear Judge Tapia,

Pursuant to California Penal Code 933 and 933.05, public agencies of Los Angeles County and all elected officials are required to respond to recommendations documented in the 2024-2025 Los Angeles County Civil Grand Jury interim report, published April 22, 2025.

The 2025-2026 Los Angeles County Civil Grand Jury received these responses, as requested.

Respectfully submitted,

Marvin Gordon Seyffert, Chairperson, Continuity Committee
2025-2026 Los Angeles County Civil Grand Jury

Dennis R. Martinez, Foreperson
2025-2026 Los Angeles County Civil Grand Jury

LOS ANGELES COUNTY
HOSPITALS AND HEALTHCARE DELIVERY COMMISSION
313 N. Figueroa Street, Room 433D Los Angeles, CA 90012
Phone: (213) 288-8104

May 14, 2025

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

Subject: Response to the 2024-2025 Los Angeles County Civil Grand Jury Interim Report - LA GENERAL IS POISED TO ENERGIZE CAL-AIM AND CREATE A HEALTHY LOS ANGELES (AND, WHILE WE'RE AT IT, LET'S ERADICATE HOMELESSNESS)

The Hospitals and Health Care Delivery Commission (Commission) is writing to respond to the 2024-2025 Los Angeles County Civil Grand Jury Interim Report titled, "LA GENERAL IS POISED TO ENERGIZE CAL-AIM AND CREATE A HEALTHY LOS ANGELES (AND, WHILE WE'RE AT IT, LET'S ERADICATE HOMELESSNESS." As requested, below is the Commission's response to Recommendation 4 and Recommendation 13.

Recommendation 4 - *The Board of Supervisors should direct the Hospitals and Health Care Delivery Commission to study and make recommendations regarding the proposed creation and operation of the Health Agency in order to further the coordination and integration of high-quality health and social services, especially services for the homeless, across all County Departments; and the Board of Supervisors should review and respond to such recommendations.*

Response to Recommendation 4: The Commission's role as an advisory body is to advise the Director of Health Services and the Board of Supervisors on matters pertaining to patient care policies and programs. If the Board of Supervisors were to request this action, the Commission would look into this matter and provide its recommendations on the proposed creation and operation of the Health Agency within the Commission's purview and within the scope of responsibilities.

Recommendation 13 - *The Board of Supervisors should direct the Hospitals and Health Care Delivery Commission to investigate the potential benefits and structural challenges of the LA County Restorative Care Villages, and make recommendations regarding their organization, management, coordination and operation for the purpose of maximizing high quality care for County patients, especially focusing on: (1) the importance of establishing centralized control and management over each Restorative Care Village, (2) the benefits of each Restorative Care Village effectively communicating and coordinating with its associated County Hospital, (3) the Restorative Care Village's effective participation in CalAIM, especially in coordination with providers of Community Supports, and (4) the apparent lack of a County-wide vision for the Restorative Care Villages; and the Board of Supervisors should review and respond to such recommendations.*

Response to Recommendation 13: As stated above, the Commission's role as an advisory body is to advise the Director of Health Services and the Board of Supervisors on matters pertaining to patient care policies and programs. If the Board of Supervisors were to ask the Commission to review and make recommendations regarding the organization, management, coordination and operations of the Restorative Care Villages it would do so within the Commission's purview and scope of recommendations.

Per California Penal Code 933.05, the Commission is providing the following responses:

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

Finding 1 – *LAHSA's coordination of housing, social and health services for the homeless (and those at risk of becoming homeless) in Los Angeles County has been siloed, fragmented and disjointed, generating limited results at a high cost.*

Response to Finding 1: The Commission does not have sufficient information to agree or disagree with this finding.

Finding 2 – *LAHSA's budget in 2024 was $875 million, with more than $300 million of that coming from LA County.*

Response to Finding 2: The Commission does not have sufficient information to agree or disagree with this finding.

Finding 3 – *LA County has decided to withdraw its contributions to LAHSA and redeploy them to provide homeless services directly (referred to herein as the Homeless Funds).*

Response to Finding 3: The Commission agrees that the County has decided to withdraw funds from LAHSA and redeploy funds to provide services directly.

Finding 4 – *LA County intends to merge the CEO Homeless Initiative (CEO-HI) and the DHS Housing for Health (DHS-HFH), creating a new County Department focused on the homeless (the Homeless Services Department).*

Response to Finding 4: The Commission agrees with this finding.

Finding 5 – *The currently proposed timeline for the Homeless Services Department initiatives is as follows: (1) merging the operation of CEO-HI and DHS-HFH by April 28, 2025, (2) creating the Homeless Services Department as of July 1, 2025, (3) Phase I implementation would then include the "integration of the CEO-HI and DHS-HFH core housing and supportive services," (4) Phase II would include "integration of County-funded programs and services administered by LAHSA" into the Homeless Services Department, (5) Phase III would "include the integration of programs and services administered by other County departments* ***as applicable,"*** *[emphasis added] and (6) County-sourced LAHSA funds and related staff would be transferred to the Homeless Department by July 1, 2026.*

Response to Finding 5: The Commission does not have sufficient information to agree or disagree with this finding.

Finding 6 – *The County's proposal for the "full" integration of County services for the homeless into one Homeless Services Department will have two major exceptions that will likely undermine the County's comprehensive approach to homelessness, possibly leading to the same "siloed, fragmented and disjointed services" that plagued LAHSA.*

Response to Finding 6: The Commission does not have sufficient information to agree or disagree with finding.

Finding 7 – *The first category of likely exceptions to the County's integration of homeless services will be certain specified homeless services provided and retained by other County Departments, each of which will be assessed for integration appropriateness "in partnership" with the relevant Department (with the history of County Departments asserting the importance of their independence likely being a major hindrance in achieving full integration).*

Response to Finding 7: The Commission does not have sufficient information to agree or disagree with finding.

Finding 8 – *The second category of exceptions includes those services that are "highly clinical and deeply integrated with DHS's core health provider and managed care functions for its empaneled population and financing," thereby keeping many of the County's major interactions with the homeless population within DHS.*

Response to Finding 8: The Commission does not have sufficient information to agree or disagree with finding.

Finding 9 – *There is no evidence that LA County has any plans to use the homeless Funds to expand the County's CalAIM services (either ECM or Community Supports), including in connection with the County Hospitals' interactions with the homeless, especially regarding the significant opportunities for increased ECM enrollment by the County Hospitals (although the County does acknowledge the importance of CalAIM funding with respect to current DHS-HFH functions).*

Response to Finding 9: The Commission does not have sufficient information to agree or disagree with finding.

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

Finding 10 – *The County Departments of Health Services, Public Health and Mental Health have strongly preferred voluntary, non-binding consultations rather than centralized decision-making regarding their operations, which has created major challenges for the ongoing efforts to coordinate and integrate the County's health and social services.*

Response to Finding 10: The Commission does not have sufficient information to agree or disagree with finding.

Finding 11 – *The County Departments are inclined to coordinate their roles as ECM providers solely on a voluntary basis, including the enrollment of Medi-Cal beneficiaries, assignment of Lead Care Managers and accessing Community Supports networks.*

Response to Finding 11: The Commission does not have sufficient information to agree or disagree with finding.

Finding 12 – *LA County is creating a Restorative Care Village on the LA General campus, which promises to give patients, especially the homeless, expanded*

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

Response to Finding 12: The Commission agrees in part, that LA County is creating a Restorative Care Village on the LA General Campus, but lacks sufficient information to opine on the rest of the statement.

Finding 13 – *Although there are "Restorative Care Villages" located (or being built) on the campuses of each of the County Hospitals as well as MLK Community Hospital, there appears to be no County-wide strategic plan regarding the potential and purpose of the Restorative Care Villages and little if any communication among the Restorative Care Villages or the entities associated with them.*

Response to Finding 13: The Commission agrees in part that Restorative Care Villages are located or are being built on the campuses of each of the County Hospitals and MLK Community Hospital. The Commission does not have sufficient information to agree or disagree with the rest of the finding.

Section III. Findings Regarding CalAIM

Finding 14 – *There have been no systematic analyses of the CalAIM program's overall impact on reducing homelessness, improving healthcare or reducing costs.*

Response to Finding 14: To the best of the Commission's knowledge, we agree that there has been no systematic analysis of CalAIM.

Finding 15 – *There are major impediments to ECM and Community Supports provider participation in CalAIM based on associated costs, non-standardization of compliance processes, burdensome reporting requirements, and inadequate compensation.*

Response to Finding 15: The Commission agrees with this finding.

Finding 16 – *The enrollment of Medi-Cal beneficiaries in ECM has been lower than anticipated for ECM's target populations*

Response to Finding 16: The Commission agrees with this finding.

Finding 17 – *The State estimates that only 30% of Medi-Cal beneficiaries who are identified as eligible for ECM will likely enroll in ECM, but no studies have been conducted to determine why that percentage is so low.*

Response to Finding 17: The Commission does not have sufficient information to agree or disagree with this finding.

Finding 18 – *DHS, as an ECM provider, only enrolls Medi-Cal beneficiaries in ECM who are empaneled with DHS, a relatively limited population compared with all ECM eligible beneficiaries in LA County.*

Response to Finding 18: The Commission does not have sufficient information to agree or disagree with this finding.

Finding 19 – *Communication and coordination between ECM providers and the Community Supports providers to whom ECM beneficiaries are referred could be improved,*

Response to Finding 19: The Commission agrees with this finding.

Finding 20 – *Children's Hospital of Los Angeles patients include a high percentage of ECM eligible Medi-Cal beneficiaries; and, by enrolling as an ECM provider, CHLA provides an exemplary example of the opportunities under CalAIM to support Medi-Cal beneficiaries, especially regarding the needs of discharged patients.*

Response to Finding 20: The Commission does not have sufficient information to agree or disagree with this finding.

Finding 21 – *Providing Access and Transforming Health (PATH) has provided and continues to provide substantial funding for participants in the CalAIM initiatives, especially for infrastructure and start-up costs.*

Response to Finding 21: The Commission agrees in part that PATH has provided funding to CalAIM participants and does not have sufficient information to agree or disagree with the rest of the finding.

On behalf of the Hospitals and Health Care Delivery Commission, these responses were vetted and approved during a special meeting held on May 13, 2025.

Sincerely,

David Marshall, RN

David Marshall, JD, DNP, RN
Chair

cc: Executive Office, Board of Supervisors
Department of Health Services

Chief Executive Office.

COUNTY OF LOS ANGELES
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, CA 90012
(213) 974-1101 ceo.lacounty.gov

CHIEF EXECUTIVE OFFICER
Fesia A. Davenport

July 15, 2025

To: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Janice Hahn

From: Fesia A. Davenport
Chief Executive Officer

RESPONSES TO THE 2024-2025 LOS ANGELES COUNTY CIVIL GRAND JURY INTERIM REPORT

Attached are the responses to the 2024-2025 Civil Grand Jury (CGJ) Interim Report. We are responding to specific recommendations dealing with the following section:

- LA General is Poised to Energize Cal-AIM and Create a Healthy Los Angeles (and While We're at it, Let's Eradicate Homelessness) "I Mean Man, This is it"

The Attachment represents Los Angeles County's (County) combined responses to the recommendations specified by the 2024-2025 CGJ. California Penal Code Sections 933(c) and 933.05 require a written response to specified recommendations contained in the CGJ Interim Report.

The following is the list of County departments and entities that were required to provide responses to specific recommendations designated by the 2024-2025 CGJ:

- Board of Supervisors
- Chief Executive Office
- Health Services
- Hospital and Health Care Delivery Commission

The responses received from the departments were consolidated to provide a unified County response to each recommendation that at least one County department or entity was required to provide a response for. Additionally, the responses to the recommendations from this investigative report are preceded by a summary of what was covered in the report, incorporating language from the original report.

The County's written responses to the designated recommendations follow the standard set forth in California Penal Code Section 933.05. This includes an indication of whether the respondent agrees, disagrees, or partially disagrees, as well as reporting whether each recommendation being responded to has been implemented, has not yet been implemented (but will be implemented in the future), requires further analysis, or will not be implemented (because it is not warranted or is not reasonable).

Should you have any questions regarding our responses, please contact me or Carrie Miller, at (213) 262-7823 or cmiller@ceo.lacounty.gov.

FAD:JMN:CDM
PN:kdm

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Mental Health
Public Health
Hospital and Health Care Delivery Commission

County of Los Angeles Responses

RESPONSE TO THE CIVIL GRAND JURY INTERIM REPORT

COUNTY OF LOS ANGELES
CHIEF EXECUTIVE OFFICE FOR THE BOARD OF SUPERVISORS; CHIEF EXECUTIVE OFFICE; DEPARTMENT OF HEALTH SERVICES; DEPARTMENT OF MENTAL HEALTH; DEPARTMENT OF PUBLIC HEALTH; HOSPITAL AND HEALTH CARE DELIVERY COMMISSION

2024-2025 CIVIL GRAND JURY RECOMMENDATIONS FOR
LA GENERAL IS POISED TO ENERGIZE CAL-AIM AND CREATE A HEALTHY LOS ANGELES (AND WHILE WE'RE AT IT, LET'S ERADICATE HOMELESSNESS) "I MEAN MAN, THIS IS IT"

SUMMARY
"This report reviews and evaluates the current system of services for the homeless population in the County of Los Angeles (County) and the proposed solutions. Two primary focus areas are healthcare integration and addressing homelessness. In terms of healthcare integration, there is an evaluation of the efforts to achieve this outcome and a focus on the CalAIM program to achieve such integration. In terms of addressing homelessness, the analysis of the report proposes that a consolidated Health Agency could be combined with the tools of CalAIM and healthcare integration to effectively address homelessness."

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

FINDING NO. 1
The Los Angeles Homeless Service Authority's (LASHA) coordination of housing, social and health services for the homeless (and those at risk of becoming homeless) in the County has been siloed, fragmented and disjointed, generating limited results at a high cost.

RESPONSE
Agree.

FINDING NO. 2
LAHSA's budget in 2024 was $875 million, with more than $300 million of that coming from the County.

RESPONSE
Agree.

FINDING NO. 3
The County has decided to withdraw its contributions to LAHSA and redeploy them to provide homeless services directly (referred to herein as the Homeless Funds).

RESPONSE
Partially disagree. The County is not planning to withdraw all funds.

FINDING NO. 4
The County intends to merge the Chief Executive Office (CEO) Homeless Initiative (HI) and the Department of Health Services (DHS) Housing for Health (HFH), creating a new County department focused on the homeless (the Homeless Services Department).

RESPONSE
Agree.

FINDING NO. 5
The currently proposed timeline for the Homeless Services Department initiatives is as follows: 1) merging the operation of CEO-HI and DHS-HFH by April 28, 2025, 2) creating the Homeless Services Department as of July 1, 2025, 3) Phase I implementation would then include the "integration of the CEO-HI and DHS-HFH core housing and supportive services," 4) Phase II would include "integration of County-funded programs and services administered by LAHSA" into the Homeless Services Department, 5) Phase III would "include the integration of programs and services administered by other County departments **as applicable,**" [emphasis added] and 6) County-sourced LAHSA funds and related staff would be transferred to the Homeless Services Department by July 1, 2026.

RESPONSE
Partially disagree. The timeline of the new County department on homelessness is as follows: DHS and the CEO with participation from other County departments supported DHS-HFH and CEO-HI in establishing a joint administrative team by April 28, 2025; in Phase I, CEO-HI and DHS-HFH will work closely together to align and integrate work by July 1, 2025, with the goal of complete transition to the new County department effective January 1, 2026; Phase II there will be the transition of specified County funded programs and services currently administered by LAHSA to the new County department by July 1, 2026; and Phase III includes the integration of programs and services administered by other County departments into the new County department, as applicable.

FINDING NO. 6
The County's proposal for the "full" integration of County services for the homeless into one Homeless Services Department will have two major exceptions that will likely undermine the County's comprehensive approach to homelessness, possibly leading to the same "siloed, fragmented and disjointed services" that plagued LAHSA.

RESPONSE
Disagree. Certain departments are uniquely qualified to administer certain funds serving people experiencing homelessness (PEH), such as Public Defender for criminal record clearing and the Department of Economic Opportunity (DEO) for employment services. It is expected that the new department will administer funds from other departments that had previously gone to LAHSA, such as Department of Public Social Services' (DPSS) Housing Support Program (HSP) funding.

It is anticipated that the new department will become a Medi-Cal biller and will draw down Medi-Cal funds, as appropriate, and will also become a Full Service

Partnership (FSP) provider under the Department of Mental Health (DMH) and will thus be able to provide an integrated service package to PEH and others.

While DHS will maintain select core clinical services, the vast majority of DHS-Housing for Health's programs, budget, and staffing will transfer to the new homeless department. What will remain at DHS is a small subset of DHS-HFH's work, which are the recuperative care centers on DHS' hospital campuses, Enriched Residential Care for DHS patients, and the Star and Mobile Clinics; all these support DHS hospitals and are deeply integrated with DHS' functions for its empaneled population. Most of the housing and supportive housing engagements (including clinical encounters) with clients will transfer to the new department.

FINDING NO. 7
The first category of likely exceptions to the County's integration of homeless services will be certain specified homeless services provided and retained by other County departments, each of which will be assessed for integration appropriateness "in partnership" with the relevant department (with the history of County departments asserting the importance of their independence likely being a major hindrance in achieving full integration).

RESPONSE
Disagree. Certain departments are uniquely qualified to administer certain funds serving PEH, such as Public Defender for criminal record clearing and the DEO for employment services. It is expected that the new department will administer funds from other departments that had previously gone to LAHSA, such as DPSS HSP funding.

It is anticipated that the new department will become a Medi-Cal biller and will draw down Medi-Cal funds, as appropriate, and will also become a FSP provider under DMH and will thus be able to provide an integrated service package to PEH and others.

FINDING NO. 8
The second category of exceptions includes those services that are "highly clinical and deeply integrated with DHS's core health provider and managed care functions for its empaneled population and financing," thereby keeping many of the County's major interactions with the homeless population within DHS.

RESPONSE
Partially disagree. While DHS will maintain select core clinical services, the vast majority of DHS-Housing for Health's programs, budget, and staffing will transfer to the new homeless department. What will remain at DHS is a small subset of HFH's work, which are the recuperative care centers on DHS' hospital campuses, Enriched Residential Care for DHS patients, and the Star and Mobile Clinics; all these support DHS hospitals and are deeply integrated with DHS' functions for its empaneled population. Most of the housing and supportive housing engagements (including clinical encounters) with clients will transfer to the new department.

FINDING NO. 9

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

RESPONSE

Disagree. In the April 1, 2025, motion to create a new County homeless department, the Board of Supervisors (Board) directed the implementation of a workplan and timelines that included building the administrative infrastructure necessary to maximize claiming of CalAIM revenue for rental subsidies, housing supportive services, and clinical services, including expertise in navigating Medicaid policy and managed care requirements. The new County department will leverage DHS-Housing for Health's experience in braiding CalAIM funding with Measure H and other funding streams.

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

FINDING NO. 10

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

RESPONSE

Disagree. DHS, DMH, and DPH collaborate extensively on joint efforts and are committed to coordination of services where possible, within the constraints of California's Medi-Cal model in which behavioral health services (substance use disorder and mental health services) are carved and in which physical health services follow a managed care model coordinated at the plan level. Services for patients and clients are coordinated as appropriate while also respecting each department's unique and distinct regulatory mandates and responsibilities.

One example of active coordination is the provision of ECM services for the justice-involved population of focus. DHS, DMH, and DPH meet regularly to ensure these complex clients - many of whom might fall into multiple eligibility categories for ECM services - are enrolled into the program that best meets their unique health needs. The same coordination takes place between DMH and DHS to improve service for patients in the Serious Mental Illness (SMI) population.

There is also disagreement with the CGJ Interim Report's description of the authority and role of the Health Agency (as directed by the Board, the departments maintained independent reporting relationships to the Board and did not follow a typical "Agency" model) and the characterization of the Board's motivation for the

creation of the Alliance for Health Integration (AHI) and its role and contributions, as well as the reason for the later transition of AHI staff to DMH.

FINDING NO. 11
The County departments are inclined to coordinate their roles as ECM providers solely on a voluntary basis, including the enrollment of Medi-Cal beneficiaries, assignment of Lead Care Managers and accessing Community Supports networks.

RESPONSE
Disagree. DHS, DPH, and DMH closely coordinate their roles as ECM providers in respect to their unique roles within the Medicaid managed care system in California, and in partnership with the health plans.

FINDING NO. 12
The County is creating a Restorative Care Village on the LA General campus, which promises to give patients, especially the homeless, expanded access to a broad continuum of social and health services; however, the various providers participating in the Restorative Care Village are not subject to any centralized management or control, and therefore there is little if any coordination, much less integration, of the various Restorative Care Village services. (There do, however, appear to be tentative plans to create an advisory "Care Coordination Committee" with representatives from DHS, DMH and DPH to provide voluntary guidance regarding effective coordination.)

RESPONSE
Partially disagree. While there is agreement with the first statement in the finding (i.e., "The County is creating a Restorative Care Village on the LA General campus, which promises to give patients, especially the homeless, expanded access to a broad continuum of social and health services"), there is disagreement with the second statement in the finding (i.e., "there is little if any coordination, much less integration, of the various Restorative Care Village services.")

The County's health departments (DHS, DMH, and DPH) regularly coordinate on areas of overlap, including client hand-offs, care coordination, campus issues (e.g., security), communications, and other related issues.

FINDING NO. 13
Although there are "Restorative Care Villages" located (or being built) on the campuses of each of the County Hospitals, as well as Martin Luther King Community Hospital, there appears to be no County-wide strategic plan regarding the potential and purpose of the Restorative Care Villages and little if any communication among the Restorative Care Villages or the entities associated with them.

RESPONSE
Partially disagree. While there is no written "strategic plan regarding the potential and purpose of the Restorative Care Villages," as presented in this finding, there is regular communication among DHS, DMH, and DPH to coordinate resources and services where relevant.

III. Findings Regarding CalAIM

FINDING NO. 14
There have been no systematic analyses of the CalAIM program's overall impact on reducing homelessness, improving healthcare or reducing costs.

RESPONSE
Agree. We are not aware that the State of California or other entities have performed State-wide or County-specific analyses of the CalAIM program on these topics.

FINDING NO. 15
There are major impediments to ECM and Community Supports provider participation in CalAIM based on associated costs, non-standardization of compliance processes, burdensome reporting requirements, and inadequate compensation.

RESPONSE
Agree.

FINDING NO. 16
The enrollment of Medi-Cal beneficiaries in ECM has been lower than anticipated for ECM's target populations.

RESPONSE
Agree. However, it is important to note that this finding is not unique to the County and DHS. The "ECM Penetration Rates" (i.e., the percentage of health plan members receiving ECM in the last 12 months) can be found on the Department of Health Care Services (DHCS) website under ECM Quarterly Implementation Report (https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=4) with the footnote that "While DHCS expects that 3-5% of the Medi-Cal membership will be eligible for ECM, this will vary based off of local demographics and not all eligible members may want to participate in the program, so penetration rates are expected to be significantly lower than 3-5%."

FINDING NO. 17
The State estimates that only 30% of Medi-Cal beneficiaries who are identified as eligible for ECM will likely enroll in ECM, but no studies have been conducted to determine why that percentage is so low.

RESPONSE
Agree.

FINDING NO. 18
DHS, as an ECM provider, only enrolls Medi-Cal beneficiaries in ECM who are empaneled with DHS, a relatively limited population compared with all ECM eligible beneficiaries in the County.

RESPONSE
Partially disagree. DHS intentionally contracted with the health plans to be the ECM provider for DHS-empaneled patients. This approach is in alignment with DHCS guidance that states:

> "Medi-Cal health plans will assign an ECM provider to a member based on their needs. If a member's primary care provider or behavioral health provider is affiliated with an ECM provider organization, the member will most likely be assigned to that ECM provider."

Non-DHS patients may be eligible to receive or already receiving ECM services from their non-DHS primary care provider (PCP) or another ECM Provider assigned by the health plans.

Contrary to the CGJ report findings, DHS did not decide "to limit its CalAIM services and associated subsidies, with some minor exceptions, to those patients who are empaneled with DHS under a managed care relationship." The decision was made because DHS is not well-positioned to provide ECM services to patients who belong to a managed care network outside of DHS. Changing the contractual ECM model to care for non-DHS patients could lead to disruptions in the therapeutic relationship with that patient's existing care team, as well as significant coordination and data integration challenges.

FINDING NO. 19
Communication and coordination between ECM providers and the Community Supports providers to whom ECM beneficiaries are referred could be improved.

RESPONSE
Agree. While communication could be improved, it would require ECM and Community Supports (CS) providers to have increased data visibility into whether their patients are cross-enrolled.

Currently, this information is held at the health plan level, and there is no central database or health information exchange approach for a provider to look up this information. DHS has an internal approach for patients cared for within DHS, but some ECM patients receive CS services from non-DHS CS providers and vice versa. This issue requires resolution at the health plan level.

FINDING NO. 20
Children's Hospital of Los Angeles patients include a high percentage of ECM eligible Medi-Cal beneficiaries; and, by enrolling as an ECM provider, CHLA provides an exemplary example of the opportunities under CalAIM to support Medi-Cal beneficiaries, especially regarding the needs of discharged patients.

RESPONSE
Agree.

FINDING NO. 21
Providing Access and Transforming Health (PATH) has provided and continues to provide substantial funding for participants in the CalAIM initiatives, especially for infrastructure and start-up costs.

RESPONSE
Agree.

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

RECOMMENDATION NO. 7-1
The Board should rejuvenate the Health Agency originally approved by the Board in 2015, empowering it to make binding decisions regarding collaboration and integration projects involving health-related County departments, including the DHS, DPH, DMH and Aging and Disabilities, especially including CalAIM participation and the operation of the Restorative Care Villages. (In implementing this Recommendation, the Board should read Dr. Katz's memorandum, attached as Exhibit A.)

RESPONSE
Disagree. On May 21, 2024, the Board directed the Chief Executive Officer, in collaboration with the Directors of DHS, DPH, and DMH, to retain a consultant to conduct an evaluation of the AHI to determine best practices and areas for improvement and provide recommended options for the Board's consideration for supporting the collaboration between the three health departments that improve access to comprehensive health care.

The CEO procured TurningWest, Inc. (Consultant) through a competitive solicitation process to complete the evaluation. The Consultant facilitated 39 individual and group interviews with the Board's health deputies; former AHI staff; DHS, DMH, and DPH leadership and staff; other County departments; and external stakeholders, including representatives from labor and community-based organizations.

The Consultant developed comprehensive criteria for analyzing eight organizational design options, considering future Measure G changes. The options fell across a continuum from the least restrictive to the most formal structure, and were scored using a Decision Matrix Scale (ranging from 0 – 20 points):

- Option A: **Implement No Change** (7 points)
- Option B: **Increase Communication** (16 points)
- Option C: **Create Collaborative Forum** (18 points)
- Option D: **Establish Collaborative Units within the Health Depts** (11 points)
- Option E: **Reinstate AHI as Independent Unit** (10 points)
- Option F: **Reinstate AHI Reporting to the CEO** (9 points)
- Option G: **Create Supra-Ordinate Structure Over the Health Depts** (9 points)
- Option H: **Merge the Health Departments** (10 points)

The Consultant's report recommended that, in lieu of a formal AHI structure or Health Agency model, the three County health departments implement a two-tiered approach for improving coordination that:

1. Increase Communication (Option B)
Enhance the communication teams within each health department by designating one or two communication professionals who would be responsible for creating and maintaining regular, structured communication both within and across departments, ensuring collaborative efforts are effectively communicated to stakeholders. The role of these professionals would include:

- Creating intra-departmental newsletters and other communications;
- Producing an inter-departmental communication vehicle that would spotlight various collaborative priorities and projects;
- Establishing a public-facing communication medium to help inform partner organizations and the public on coordinated efforts;
- Developing structures, networks, and information-gathering practices to share information on current collaboration; and
- Discerning how to simply communicate efforts in ways that are understandable and useful to a variety of audiences.

2. Create Collaborative Forum (Option C)
Create a new collaborative forum where the three health department directors and key staff come together monthly, facilitated by a contracted outside expert in meeting facilitation. The forum's design would support ongoing strategic planning, and allow health departments to present updates, discuss emerging challenges, and negotiate priorities with each other.

This collaborative pathway would establish a formal process for discovery, discussion, and debate between experts in healthcare delivery that is currently being done on an ad hoc basis. Such a structured forum would facilitate ongoing conversations about current and potential areas of collaboration and offer a place to seek agreement and buy-in where needed.

This option would not require a set of dedicated staff be in place to support it, which would help it maintain the level of adaptability needed to be successful. However, the consultants recommend that an outside facilitator be responsible for regular meeting facilitation and follow-up.

The recommendations were vetted by leadership from the three departments and key stakeholders, and all agreed that they would support joint decision-making, shared accountability, and increased visibility of inter-departmental collaboration.

While the Consultant's report did analyze the option of implementing a Health Agency structure (Option H: Merge the Health Departments), the arguments against this structure outweighed the arguments for it.

The Consultant's report highlighted several reasons against this option, including: 1) the sheer complexity of the three County health departments deems it an impossible option and would most likely require legislative mandates to adjust policies and requirements currently guiding the separate departments; and 2) the unique missions of the three health departments would be at risk of getting lost.

Historically, when the three departments were all under one large health department, the tremendous needs of DHS tended to drain resources away from the needs of mental health and public health. The size of the bureaucracy did little to meet the complex healthcare needs of County residents, and, therefore, it was found that the tradeoff of specialization here was not worth the outlined benefits.

Based on the findings of this detailed study, no further action relating to this recommendation will be taken.

RECOMMENDATION NO. 7-2
The Board should direct the Chief Executive Officer, in consultation with DHS, to conduct a detailed study of the opportunity, ability, and available budget for a rejuvenated Health Agency to assume responsibility for all County initiatives regarding the homeless.

RESPONSE
Disagree. As discussed above, this detailed study has already been completed and as such, no further action will be taken.

On May 21, 2024, the Board directed the Chief Executive Officer, in collaboration with DHS, DPH, and DMH, to retain a consultant to conduct an evaluation of the AHI to determine best practices and areas for improvement and provide recommended options for the Board's consideration for supporting the collaboration between the three health departments that improve access to comprehensive health care.

The CEO procured TurningWest, Inc. (Consultant) through a competitive solicitation process to complete the evaluation. The Consultant facilitated 39 individual and group interviews with the Board's health deputies; former AHI staff; DHS, DMH, and DPH leadership and staff; other County departments; and external

stakeholders, including representatives from labor and community-based organizations.

The Consultant developed comprehensive criteria for analyzing eight organizational design options, considering future Measure G changes. The options fell across a continuum from the least restrictive to the most formal structure, and were scored using a Decision Matrix Scale (ranging from 0 – 20 points):

- Option A: **Implement No Change** (7 points)
- Option B: **Increase Communication** (16 points)
- Option C: **Create Collaborative Forum** (18 points)
- Option D: **Establish Collaborative Units within the Health Depts** (11 points)
- Option E: **Reinstate AHI as Independent Unit** (10 points)
- Option F: **Reinstate AHI Reporting to the CEO** (9 points)
- Option G: **Create Supra-Ordinate Structure Over the Health Depts** (9 points)
- Option H: **Merge the Health Departments** (10 points)

The Consultant's report recommended that, in lieu of a formal AHI structure or Health Agency model, the three County health departments implement a two-tiered approach for improving coordination that:

1. Increase Communication (Option B)
Enhance the communication teams within each health department by designating one or two communication professionals who would be responsible for creating and maintaining regular, structured communication both within and across departments, ensuring collaborative efforts are effectively communicated to stakeholders. The role of these professionals would include:

- Creating intra-departmental newsletters and other communications;
- Producing an inter-departmental communication vehicle that would spotlight various collaborative priorities and projects;
- Establishing a public-facing communication medium to help inform partner organizations and the public on coordinated efforts;
- Developing structures, networks, and information-gathering practices to share information on current collaboration; and
- Discerning how to simply communicate efforts in ways that are understandable and useful to a variety of audiences.

2. Create Collaborative Forum (Option C)
Create a new collaborative forum where the three health department directors and key staff come together monthly, facilitated by a contracted outside expert in meeting facilitation. The forum's design would support ongoing strategic planning, and allow health departments to present updates, discuss emerging challenges, and negotiate priorities with each other.

This collaborative pathway would establish a formal process for discovery, discussion, and debate between experts in healthcare delivery that is currently being done on an ad hoc basis. Such a structured forum would facilitate ongoing conversations about current and potential areas of collaboration and offer a place to seek agreement and buy-in where needed.

This option would not require a set of dedicated staff be in place to support it, which would help it maintain the level of adaptability needed to be successful. However, the consultants recommend that an outside facilitator be responsible for regular meeting facilitation and follow-up.

The recommendations were vetted by leadership from the three departments and key stakeholders, and all agreed that they would support joint decision-making, shared accountability, and increased visibility of inter-departmental collaboration.

While the Consultant's report did analyze the option of implementing a Health Agency structure (Option H: Merge the Health Departments), the arguments against this structure outweighed the arguments for it.

The Consultant's report highlighted several reasons against this option, including: 1) the sheer complexity of the three County health departments deems it an impossible option and would most likely require legislative mandates to adjust policies and requirements currently guiding the separate departments; and 2) the unique missions of the three health departments would be at risk of getting lost.

Historically, when the three departments were all under one large health department, the tremendous needs of DHS tended to drain resources away from the needs of mental health and public health. The size of the bureaucracy did little to meet the complex healthcare needs of County residents, and, therefore, it was found that the tradeoff of specialization here was not worth the outlined benefits.

Based on the findings of this detailed study, no further action relating to this recommendation will be taken.

RECOMMENDATION NO. 7-3
The Board should direct the Chief Executive Officer, in consultation with DHS, to conduct a detailed study of the comparative benefits of the new Homeless Services Department to address homelessness as compared with a rejuvenated Health Agency serving the same function, as proposed under Recommendation 1.

RESPONSE
Agree. This recommendation has already been implemented.

On April 1, 2025, the Board adopted a motion to establish a new County department focused on homelessness. This decision was informed by extensive studies, analyses, and stakeholder input (listed below) conducted over a significant period. Given this comprehensive foundation, additional analysis comparing alternative models (such as a rejuvenated Health Agency serving the same function) is not necessary and will not be pursued at this time.

Please see the following documents for further information:

- Feasibility of Implementing the Blue Ribbon Commission on Homelessness Report Recommendations No. 1 (Establish a County Entity Dedicated to Homeless Service Delivery) and No. 3 (Streamlined LAHSA)

- Feasibility of Implementing the Blue Ribbon Commission on Homelessness Report Recommendations No. 1 (Establish County Entity Dedicated to Homeless Service Delivery) and No. 3 (Streamlined LAHSA) (Item no. 90D, Agenda of November 26, 2024)

- Implementing the Blue Ribbon Commission on Homelessness Report Recommendation No. 1 (Establish a County Entity Dedicated to Homeless Service Delivery) and No. 3 (Streamlined LAHSA)

Some of the summary points from these documents are as follows:

Benefits of establishing a new department:
Creating a new County department on homelessness provides an opportunity to align our countywide response to homelessness. This transition provides an opportunity for new collaboration between service providers, people with lived experience, County departments, local jurisdictions, unincorporated areas, and elected officials to create positive change in our communities. The driving force behind this new department is increasing accountability, streamlining services for people experiencing homelessness, and reducing the barriers on the providers who serve them every day. We have an opportunity to use what we know is effective to create even more impact and touch even more lives, while at the same time creating more accountability and support for the providers on the front line.

The new department aims to provide:

- More effective braiding and leveraging of different homelessness funding streams administered by the County to provide more comprehensive and integrated services to people experiencing homelessness.

- Reduced administrative burden for homeless services providers through aligned programs with a common philosophical framework, consolidated contracting and use of standardized agreements, invoice processing, and payment systems.

- Opportunities to serve and stabilize clients sooner and more effectively through greater integration of mainstream services provided by County departments with programs and services focused on people experiencing homelessness.

- Increased authority for the County to directly oversee policies, procedures, service delivery models, data collection, evaluation, etc., for County funded programs and services.

- Increased accountability and transparency associated with County funding being administered by a County department that will publish budgets, expenditure reports, audits, evaluations, and dashboards with outcomes and metrics, and will make them available in one location in a public facing website.

RECOMMENDATION NO. 7-4
The Board should direct the Hospitals and Health Care Delivery Commission to study and make recommendations regarding the proposed creation and operation of the Health Agency in order to further the coordination and integration of high-quality health and social services, especially services for the homeless, across all County departments; and the Board should review and respond to such recommendations.

RESPONSE
Disagree. As previously discussed, the CEO hired an independent consultant to analyze the feasibility of creating a Health Agency (amongst other options) that has already been completed. Based on the findings from that study, it was determined that it is not feasible to create a Health Agency, relative to the other options that were evaluated. As such, no further action related to this recommendation will be taken.

The role of the County Commission on Hospitals and Health Care Delivery, as an advisory body, is to advise the Director of DHS and the Board on matters pertaining to patient care policies and programs. The Commission can study and provide its recommendations on the proposed creation and operation of the Health Agency, within the Commission's purview and within the scope of responsibilities. However, in this case, the study has already been completed, and this study does not recommend the creation of such a Health Agency.

Recommendations Regarding the County's Commitment to the CalAIM Program

RECOMMENDATION NO. 7-5
LA Care, DHS, and LA General should create a working partnership to fully implement CalAIM in the County, addressing, among other things 1) effective strategies to maximize ECM enrollment, 2) the expected increase in cost saving resulting from expanded ECM enrollment, and how to connect those cost savings to the funding of CalAIM activities, and 3) effective lobbying of the State for increased funding of CalAIM.

RESPONSE
Agree. The related activities of this partnership are ongoing. DHS, which includes LA General, is contracted with three health plans (i.e., LA Care, HealthNet, Molina) to be the ECM Provider for DHS-assigned patients.

Since 2021 (prior to the launch of ECM in 2022), DHS has been involved in numerous joint ECM implementation, operational, and clinical workgroups with the health plans that are ongoing.

In terms of the first suggestion ("effective strategies to maximize ECM enrollment"), DHS presented data in a December 2024 Board Informational Briefing that approximately 42% of DHS' ECM-eligible patients decline enrollment and staff are unable to engage another 31% despite a robust outreach protocol that spans time and modalities.

At DHS, significant resources are devoted to patient engagement. Lower-than-expected ECM enrollment rates may be inherently related to the characteristics of the ECM Populations of Focus. Some of the risk factors that make patients eligible for ECM (e.g., homelessness, mental illness) may also be associated with barriers to engagement. The State Department of Health Care Services (DHCS) acknowledges that not all individuals eligible for ECM will want to participate, as seen in ECM Penetration Rates noted above.

In terms of the second suggestion ("addressing...the expected increase in cost saving resulting from expanded ECM enrollment, and how to connect those cost savings to the funding of CalAIM activities"), DHS has already undertaken detailed ECM financial analyses to examine actual costs, reimbursement, and projected revenue. Unfortunately, the rates from the State and health plans are so low that even increased enrollment projections would not fully offset DHS costs (i.e., expanded ECM enrollment would not lead to cost savings).

In terms of the third suggestion ("effective lobbying of the State for increased funding of CalAIM"), the County has shared concerns about the low rates with the contracted health plans and with the State.

RECOMMENDATION NO. 7-6
LA General, in coordination with DHS, should seek ECM provider status from LA Care, and LA Care should expedite LA General's ECM provider status.

RESPONSE
Disagree. DHS does not need to seek ECM provider status for LA General as it is already a contracted ECM Provider with LA Care, as well as with other health plans. LA General Hospital is part of DHS, and as such, is already a contracted ECM provider.

DHS is a large organization with 4 acute care hospitals, 23 standalone outpatient clinics, Community Programs (including Housing for Health), and many other divisions.

RECOMMENDATION NO. 7-7
LA General and LA Care, in consultation with DHS, should work together to develop a written plan that maximizes LA General's impact in qualifying eligible Medi-Cal beneficiaries for ECM.

RESPONSE
Disagree. Efforts to enhance beneficiary enrollment should not be focused on any one provider. Quality improvement efforts related to ECM enrollment already occur across DHS, in addition to activities at the health plan level (including but not

limited to LA Care) and by other non-DHS providers. These efforts are not and should not be specific to LA General.

RECOMMENDATION NO. 7-8
LA General, as an ECM provider, should work with LA Care to generate a study on the effective recruitment of ECM eligible beneficiaries for the purpose of increasing the current 30% success rate in enrolling ECM eligible beneficiaries.

RESPONSE
Partially disagree. DHS (which includes LA General) has already embarked upon numerous structured efforts to increase ECM enrollment rates but continue to see high rates of declination. These challenges have been and will continue to be shared with the health plans, including but not limited to LA Care. These efforts are not specific to LA General or LA Care.

RECOMMENDATION NO. 7-9
The Board should direct DHS to conduct a detailed study of the incremental costs of DHS's current and anticipated participation in CalAIM as an ECM provider, and the resulting financial benefits to the County and the State.

RESPONSE
Disagree. DHS has already undertaken detailed ECM financial analyses to examine actual costs, reimbursement, and projected revenue.

Unfortunately, per beneficiary rates are far exceeded by per beneficiary costs of providing care under the ECM program. The rates are so low that increased enrollment would not be sufficient to offset DHS' costs. Conversely, it would likely create a larger financial deficit as DHS would have to add staff to care for a larger ECM-enrolled population.

RECOMMENDATION NO. 7-10
The Board should direct DHS to conduct a detailed study of the incremental costs of LA General's anticipated participation in CalAIM as an ECM provider, and the resulting financial and operational benefits to both the County and the State.

RESPONSE
Disagree. As previously discussed, DHS (which includes LA General) has already undertaken detailed ECM financial analyses to examine actual costs, reimbursement, and projected revenue.

Unfortunately, per beneficiary rates are far exceeded by per beneficiary costs of providing care under the ECM program. The rates are so low that increased enrollment would not be sufficient to offset DHS' costs. Conversely, it would likely create a larger financial deficit as DHS (which includes LA General) would have to add staff to care for a larger ECM-enrolled population.

RECOMMENDATION NO. 7-11
LA General and LA Care, in consultation with DHS, should work together to develop strategies to obtain and analyze available data, including data generated by LA General's ECM patients, for the purpose of evaluating the impact of the CalAIM program on beneficiary well-being and cost reduction.

RESPONSE
Agree. This work is currently ongoing. DHS, which includes LA General is already working with a team at UCLA to perform an ECM evaluation to understand the overall impacts of the program.

Such evaluations are ongoing, both within the next six months and beyond, and any pertinent findings regarding beneficiary well-being and cost reduction will be considered for implementation, where feasible.

RECOMMENDATION NO. 7-12
DHS and LA General should seek grants from PATH to fund LA General's infrastructure and associated costs in connection with its participation as an ECM provider.

RESPONSE
Agree. This work is currently ongoing, both within the next six months and beyond. DHS, which includes LA General, has already applied for and received PATH funding. These grants fund DHS' ECM infrastructure overall, beyond funding just LA General specifically.

Recommendation Regarding the Restorative Care Village

RECOMMENDATION NO. 7-13
The Board should direct the Hospitals and Health Delivery Commission to investigate the potential benefits and structural challenges of the County Restorative Care Villages, and make recommendations regarding their organization, management, coordination and operation for the purposes of maximizing high quality care for County patients, especially focusing on: 1) the importance of establishing centralized control and management over each Restorative Care Village, 2) the benefits of each Restorative Care Village effectively communicating and coordinating with its associated County Hospital, 3) the Restorative Care Village's effective participation in CalAIM, especially in coordination with providers of Community Supports, and 4) the apparent lack of a County-wide vision for the Restorative Care Villages; and the Board should review and respond to such recommendations.

RESPONSE
Partially disagree. The analysis of such issues could be considered through the County's efforts to implement the findings of the Consultant's report (as referenced in the responses to Recommendations 7-1 and 7-2), both within the next six months and beyond, as necessary. The improvement of communications and the creation of a collaborative forum amongst the County's health departments, as recommended in the Consultant's report, will provide the arena for such an analysis, as further data from the operations of the Restorative Care Villages

becomes available. This includes data about the organization, management, coordination, and operations of the Restorative Care Villages.

The role of the County Commission on Hospitals and Health Care Delivery, as an advisory body, is to advise the Director of DHS and the Board on matters pertaining to patient care policies and programs. If the Board were to ask the Commission to review and make recommendations regarding the organization, management, coordination, and operations of the Restorative Care Villages, at some point in the future, the Commission would do so within the Commission's purview and scope of the recommendations.

L.A. Care HEALTH PLAN

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

July 22, 2025

Re: L.A. Care Response to 2024-2025 LA County Civil Grand Jury Report

Dear Presiding Judge:

Attached to this letter you will find L.A. Care's response to the 2024-2025 Los Angeles County Civil Grand Jury Report, titled "LA General Is Poised to Energize CAL- AIM and Create a Healthy Los Angeles (and, While We're at It, Let's Eradicate Homelessness)."

L.A. Care thanks the Grand Jury for its service and for this opportunity to continue to improve our partnership with LA County to implement Cal-AIM programs effectively for the communities we serve.

Should there be any additional inquiries, please do not hesitate to reach out to me or my colleague, William Seldeen, wseldeen@lacare.org.

Sincerely,

Augustavia J. Haydel
General Counsel
L.A. Care Health Plan

Cc:
Martha Santana-Chin, CEO, L.A. Care Health Plan;
Sameer Amin, M.D., CMO, L.A. Care Health Plan;

L.A. Care
HEALTH PLAN®

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

2024-2025 Los Angeles Civil Grand Jury: Responses from Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan, a local public agency (L.A. Care)

RECOMMENDATION #5:
LA Care, DHS and LA General should create a working partnership to fully implement CalAIM in LA County, addressing, among other things (1) effective strategies to maximize ECM enrollment, (2) the expected increase in cost saving resulting from expanded ECM enrollment, and how to connect those cost savings to the funding of CalAIM activities, and (3) effective lobbying of the State for increased funding of CalAIM.

The above recommendation is fully aligned with L.A. Care's priorities and operational planning related to CalAIM.

1.) L.A. Care has been aggressively pursuing strategies to increase enrollment in ECM. We have seen a 75% year-over-year increase in enrollment since early 2024, driven by shifting to an in-person, community-based outreach model, rather than relying solely on data and telephonic outreach. Increasing enrollment in ECM services for individuals who receive care at L.A. General can also be achieved through focused coordination with ECM providers in L.A. Care's network who are well suited to the needs of L.A. General's population and have capacity to increase enrollment. L.A. Care recommends three complimentary approaches:
    a. Embedded solution: L.A. Care identifies key ECM partner organizations to embed staff at L.A. General for enrollment and engagement upon discharge. This solution would be beneficial for housed individuals and individuals experiencing homelessness.
    b. Field-based solution: L.A. Care provides information to L.A. General discharge planners for coordination with ECM/Field Medicine Primary Care providers for engagement in the field based on discharge location/region within the County. This solution is for individuals experiencing homelessness.
    c. DHS direct delivery solution: L.A. Care welcomes the opportunity to support DHS in expanding its current ECM program by providing on-site, integrated

1200 W. 7th Street, Los Angeles, CA 90017 : lacare.org
A Public Entity Serving Los Angeles County

ECM services at L.A. General through a dedicated ECM team based at the facility. (See RECOMMENDATION #6)

2.) L.A. Care is currently conducting an impact assessment to evaluate the effects of ECM on cost savings by reducing adverse utilization, while also identifying opportunities to enhance the program and improve health outcomes for our members.

L.A. Care welcomes collaboration with DHS as well as the new County housing agency on State level advocacy related to CalAIM and believes that increased funding from the State to support ECM services is an important way to bolster enrollment and service delivery. In addition to ECM services, L.A. Care also contributes tens of millions of dollars each year to DHS Housing for Health, soon to be transitioned to the new County housing agency, to support Intensive Case Management Services (ICMS) through CalAIM Housing Navigation, Housing Deposits, and Tenancy Sustaining Services Community Supports. Unlike ECM, the Medi-Cal program does not fully fund Community Supports services as these services are intended to be self-sustaining through improvements in total cost of care. Initial analyses suggest that the cost savings associated with these housing services are far lower than the costs to deliver the services and may not be sustainable without additional funding. The availability of housing stock is a primary barrier to achieving cost of care savings from these housing programs since savings are only achieved when an individual exits homelessness. While these services may not be self-sustaining at the Managed Care Plan level, these Medi-Cal supported services are critical to the overall housing services system since, in the absence of this funding from the Medi-Cal program, the County would need to dedicate additional Measure A and other local funds to cover the costs of these services. This would leave fewer resources to develop additional housing supply which is the principal solution to L.A. County's housing crisis.

RECOMMENDATION #6
LA General, in coordination with DHS, should seek ECM provider status from LA Care, and LA Care should expedite LA General's ECM provider status.

L.A. Care fully supports partnering with L.A. General to expand ECM services. This could include expanding the existing ECM contract with DHS to integrate an on-site ECM program at L.A. General, establishing a direct contract with L.A. General to develop a stand-alone ECM program, or expanding the use of L.A. Care's broader non-DHS ECM network in coordination with L.A. General.

1200 W. 7th Street, Los Angeles, CA 90017 | lacare.org
A Public Entity Serving Los Angeles County

RECOMMENDATION #7
LA General and LA Care, in consultation with DHS, should work together to develop a written plan that maximizes LA General's impact in qualifying eligible Medi-Cal beneficiaries for ECM.

L.A. Care is already working in partnership with L.A. General to advance this recommendation. Together, and in consultation with DHS, our teams have established a joint workgroup focused on streamlining post-ED care coordination—including identifying high-need ED utilizers and initiating ECM outreach and enrollment efforts. The workgroup will also develop a written plan to maximize L.A. General's impact in qualifying eligible Medi-Cal beneficiaries for ECM. As outlined above, L.A. Care recommends three avenues for ECM engagement: 1) Embedded non-DHS ECM providers, 2) Connection to field-based ECM providers and 3) if possible, integrate the DHS ECM program at L.A. General by establishing a dedicated, on-site ECM team based at the facility.

RECOMMENDATION #8
LA General, as an ECM provider, should work with LA Care to generate a study on the effective recruitment of ECM eligible beneficiaries for the purpose of increasing the current 30% success rate in enrolling ECM eligible beneficiaries.

L.A. Care has already initiated an analysis to assess the effectiveness of different ECM outreach modalities, including those used at DHS. Analysis is looking at factors such as outreach setting (e.g., in-person vs. telephonic), staffing models, referral pathways, and the timing and frequency of outreach attempts to identify strategies that may improve enrollment beyond the current 30% success rate.

RECOMMENDATION #11
LA General and LA Care, in consultation with DHS, should work together to develop strategies to obtain and analyze available data, including data generated by LA General's ECM patients, for the purpose of evaluating the impact of the CalAIM program on beneficiary well-being and cost reduction.

L.A. Care is actively conducting an impact assessment to evaluate the effects of ECM, with a focus on cost reduction and service utilization. We're working closely with partners—including LA General and DHS—to align data sources and strategies. Once complete, we'll share our findings to help inform ongoing improvements to the ECM program.

1200 W. 7th Street, Los Angeles, CA 90017 · lacare.org
A Public Entity Serving Los Angeles County