

# Mono County Local Agency Formation Commission

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## AGENDA

Wednesday, May 3, 2017 – 3 p.m.  
Town/County Conference Room, Minaret Village Mall  
Mammoth Lakes, California

- 1. CALL TO ORDER**
- 2. PUBLIC COMMENT**
- 3. MINUTES:** Review and approve minutes from June 1, 2016
- 4. PUBLIC HEARING:** Consider adoption of 2017-18 Preliminary Budget
- 5. MEMBERSHIP REVIEW**
  - A. Update on current membership – welcome new commissioners
  - B. Election of officers
  - C. Initiation of special district election to fill vacant regular special district seat
- 6. SPECIAL DISTRICT STUDY UPDATE**
  - A. Fire Protection District Consolidation status report
  - B. Hospital District Study status
- 7. ADJOURN** to next meeting: June 7, 2017

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## DRAFT MINUTES

June 1, 2016

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**COMMISSIONERS PRESENT:** Fred Stump & Tim Alpers, Mono County; Shields Richardson, Town of Mammoth Lakes; Bruce Woodworth, public member (via video); Stephen Kalish, alternate public member.

**STAFF PRESENT:** Scott Burns, executive officer; CD Ritter, secretary

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**1. CALL TO ORDER:** Acting Chair Fred Stump called the meeting to order at 3:05 p.m. in the Town/County Conference Room, Minaret Village Mall, Mammoth Lakes and attendees recited the pledge of allegiance to the flag.

**2. PUBLIC COMMENT:** None.

### 3. MINUTES

Adopt minutes of May 4, 2016, as amended: 1) Item 5B: ... served on a California Public Utilities Commission **administrative committee**; and 2) P. 3, next to last comment by Kalish: CSD **assessments are not based on property valuation**; FPD **are**. (Richardson/Kalish. Ayes: 5-0. Absent: Henderson, Brown.)

### 4. PUBLIC HEARING: Adopt 2016-17 Final Budget

Scott Burns described the budget as: status quo, maintenance level; working in planning realms; General Plan links to Spheres of Influence/Municipal Services Reviews, grant planning efforts such as Sustainable Agriculture grant. Walker Lake water transfer study involves CEQA on lease/sale of water rights. Water transfer to lake involves irrigation district. Other items are FPD reorganization, healthcare, preservation of open space, and infrastructure needs of communities.

Woodward asked about bringing Sustainable Agriculture grant and water transfer to Walker Lake to Antelope Valley RPAC meeting. Burns indicated both grants are in the study process, maybe reconvene defunct agriculture group. With focus on agriculture, opportunities depend on adjacent federal land, sage grouse habitat protection. Policies need to involve public agencies on grazing allotments, transfer of development credits.

Stump met earlier today with LADWP on irrigation in Long Valley area. He also noted FPD consolidation discussion by Paradise/Wheeler Crest is deferred for now.

**OPEN PUBLIC HEARING:** No comments. **CLOSE PUBLIC HEARING.**

Alpers was pleased that water items will go to Antelope Valley RPAC, as controversies arise on water transfer across state lines. Maybe single agenda item for future meeting.

**MOTION:** Adopt Final 2016-17 budget as presented. (Alpers/Richardson. Ayes: 5-0. Absent: Henderson & Brown.)

**5. MEMBERSHIP UPDATE:** An election seeking Special District Alternate nominations from each Special District will end Aug. 1, when ballots will be sent. The vacancy term expires in 2018.

**6. HEALTH CARE REGIONALIZATION ISSUES:** Scott Burns referenced a memo from Inyo LAFCO's Josh Hart indicating that Inyo LAFCO had sued Southern Mono Healthcare District

(SMHD), but also was considering regional possibilities. Where do things stand? Hart was not forthcoming, just mentioned new county counsel.

Burns cited very little local public subsidy for the hospital to dissociate from the hospital district.

Kalish suggested starting with a preliminary community analysis to explore, ask questions on regionalization instead of hiring costly consultant.

Stump questioned: 1) EMS services are perfunctory. Hart referenced Mono paramedics, but they do not exist in all of Mono County, or response is delayed. The hospital acts as a mandatory base station. How would that be addressed if districts consolidated? 2) Inyo has two volunteer ambulance providers that do not extend to Mono; and 3) Southern Inyo Hospital District has its own money problems, and is managed by Kern County. Include SIHD in consolidations discussions? Combine three districts? Legal status of NIH (aggressor) vs. SMHD? Inyo LAFCO funded attorney, which was a concern. Stump thought nothing should be hidden if districts want to unify.

Burns summarized comments to Inyo: 1) tax contribution; 2) citizen options at less cost; and 3) volunteer ambulance providers (two in Mono).

Stump mentioned base station coverage in both counties, but Inyo is different from Mono. Forward when legal proceeding is underway.

Woodworth thought Josh Hart would want to know if information reflects the board's vote. Burns noted input by Mono was not a position, but a loose paper, not precise. Kalish saw no formal recommendations.

**7. FIRE PROTECTION DISTRICT CONSOLIDATION:** After May 4 LAFCO meeting, Wheeler Crest/Paradise expressed interest, but no consensus. Lee Vining/Mono City need to get boards aligned, which likely would not be a quick discussion, Stump thought. No further contact from either district. The FPDs usually meet monthly. Kalish suggested sharing any progress with other FPD.

**8. CALAFCO CONFERENCE:** Scott Burns reported former LAFCO staff Brent Calloway attended the CALAFCO conference to see how other LAFCOs handled FPD consolidations. The requirement often was an outcome of a Grand Jury report, not well received. A common controversy was wealthy district subsidizing less well off, resulting in a loss of power. Consolidations seem to be complicated, never fair. Smaller district interest should be covered. Disadvantaged communities were involved in annexation issues. Regarding staffing, the very few LAFCOs with adequate staff (12-15) could do more outreach to lesser-staffed LAFCOs.

**9. ADJOURN** at 3:45 p.m. Staff and Chair Henderson will set the next meeting. Also, a replacement will be needed for Supervisor Alpers, who is not running for reelection.

*Prepared by CD Ritter, LAFCO secretary*

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## STAFF REPORT

May 3, 2017

**TO:** Mono LAFCO  
**FROM:** Scott Burns, Executive Officer  
**RE:** 2017-18 PRELIMINARY BUDGET

### **RECOMMENDATION**

Following close of the public hearing, adopt the attached preliminary budget for fiscal year 2017-18.

### **BACKGROUND**

In accordance with the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 (CKH Act), a public hearing is scheduled today to adopt the Preliminary Budget for fiscal year 2017-18.

The LAFCO budget must be at least equal to the budget adopted for the previous fiscal year unless the Commission finds that reducing staffing or program costs will still allow the LAFCO to fulfill the purposes and requirements of the Act. The preliminary budget of \$11,582 is the same as last year and reflects a status-quo level of funding.

### **ALTERNATIVE APPORTIONMENT**

The CKH Act establishes methods for apportioning LAFCO staffing and program costs among the County, Town and special districts. The law allows alternative apportionment methods, which Mono LAFCO has used in the past to avoid impacting financially constrained special districts. Prior to using an alternative apportionment method, LAFCO costs were fully borne by the Town of Mammoth Lakes and Mono County. In recent years, the Commission applied an alternative apportionment method consisting of a third from Mono County; a third from the Town of Mammoth Lakes; and a third from special districts, with the special district share provided exclusively from the Southern Mono Healthcare District and the Mammoth Community Water District, rather than from all independent special districts.

The proposed preliminary budget reflects this same alternative budget apportionment method, which consists of a third (\$3,861) from Mono County; a third (\$3,861) from the Town of Mammoth Lakes; and a third (\$3,860) from the special districts. Instead of all independent special districts in Mono County contributing, this alternative apportionment consists of \$1,930 from Southern Mono Hospital District and \$1,930 from the Mammoth Community Water District.

### **FY 2017-18 BUDGET**

The attached Preliminary Budget for fiscal year 2017-18 maintains a status-quo funding level. This level of funding has been sufficient for LAFCO activity this past year. Staff activity included:

- consideration of LAFCO policy in county General Plan annual update;

- coordinating with federal, state and local agencies, conservation entities and land owners in planning for open space and agricultural preservation via the ongoing implementation of the Bi-State Action Plan for Sage Grouse;
- based on local interest, continuing discussions on potential district consolidation processes with Lee Vining and Mono City Fire Protection District (FPD) representatives, and monitoring same with the Paradise and Wheeler Crest FPDs;
- assisting County Service Areas in Crowley and Bridgeport on capital programming and project planning;
- reviewing development projects and CEQA documents for potential LAFCO issues;
- considering LAFCO policies in adjusting Community Wildfire Protection Plan (CWPP) project list and in contracting for Hazard Mitigation Plan Update;
- providing staff assistance as needed to the Tri-Valley Groundwater Management District in responding to the Sustainable Groundwater Management Act;
- reviewing plans, such as the Inyo Forest Plan Update, for LAFCO- related issues;
- responding to occasional LAFCO inquiries, such as reviewing process for potential dissolution of the June Lake PUD, and current efforts to initiate an annexation to the Mammoth Community Water District (MCWD); and
- continuing coordination with Inyo LAFCO to examine hospital service issues between the Southern Mono and Northern Inyo healthcare districts.

Anticipated work tasks for 2017-18 include:

- Consider LAFCO policies in updating housing policies and mitigation requirements;
- review LAFCO agriculture preservation policies as a part of a Sustainable Agriculture grant;
- assess water service providers, including irrigation services, as a part of the Walker River Water Transfer Study and EIR;
- continue to provide staff assistance as warranted to the Tri-Valley Groundwater Management District in responding to the Sustainable Groundwater Management Act;
- monitor FPDs reorganization interest, including potential merger of supporting fire districts, as a part of grant-funded community wildfire protection planning and hazard mitigation plan update;
- respond to application activity, including application processing, such as MCWD annexation;
- work with Inyo LAFCO in coordinating health care district service review, if circumstances allow;
- transition supporting staff and work to strengthen coordination with the Agriculture Commissioner on agriculture preservation matters; and
- review plans, projects and environmental documents for LAFCO concerns.

This expected low level of activity, which is similar to last year, is reflected in the attached recommended FY 2017-18 Preliminary Budget.

#### **ATTACHMENT**

- Preliminary FY 2017-18 Budget

**FY 2017-18 PRELIMINARY BUDGET**

<b>Salary and Benefits</b>	<b>\$8,732</b>
<b>Memberships (CALAFCO)</b>	<b>\$850</b>
<b>Office Expense</b>	<b>\$200</b>
<b>Travel and Training</b>	<b>\$1,500</b>
<b>Legal Notices</b>	<b>\$300</b>
<b>TOTAL</b>	<b>\$ 11,582</b>

# MONO COUNTY

## LOCAL AGENCY FORMATION COMMISSION

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### **MAMMOTH LAKES, TOWN OF**

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### **PUBLIC MEMBER**

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**Inyo Local Agency Formation  
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August 24, 2016

Southern Mono Healthcare District Board  
PO Box 660  
Mammoth Lakes, CA 93546

Northern Inyo Healthcare District Board  
150 Pioneer Lane  
Bishop, CA 93514

Southern Inyo Healthcare District Board  
PO Box 1009  
Lone Pine, CA 93545

**Re: Healthcare Regionalization**

To Whom It May Concern:

As you may be aware, the Inyo Local Agency Formation Commission (LAFCO) is exploring healthcare regionalization issues. The attached report describes the findings of Inyo LAFCO staff's preliminary investigation into these topics. At its June 13, 2016 meeting at which it reviewed the draft report, Inyo LAFCO directed me to coordinate with your agencies to move forward with further discussing healthcare regionalization issues.

In light of the current litigation between Southern Mono Healthcare District (SMHD), Northern Inyo Health Care District (NIHD), and Inyo LAFCO, I understand that there may be reluctance to participate in such discussions unless or until the litigation is concluded. However, I believe that the current disagreements between SMHD and NIHD are rooted in statutory interpretation issues that are legally distinct from the topic of regionalization. Thus, there is no reason why the parties couldn't investigate and discuss regionalization options without prejudicing their positions vis-à-vis the litigation. For good measure, they could even stipulate that anything said by party representatives in such regionalization discussions would be inadmissible in the litigation.

As we all know, litigation can be a slow, time-consuming process – which could also be the case with a regionalization discussion. Given the unknown amount of time remaining before the pending litigation is concluded, and the unknown but potentially considerable amount of time that would be involved in a regionalization discussion, it would seemingly be in everyone's interests to commence the regionalization discussion sooner rather than later.



*Correspondence from Inyo LAFCO to SMHD, NIHD, and SIHD  
August 24, 2016*

Delaying the regionalization discussion could effectively delay the parties' and public's receipt of any benefits that might come from any resulting regionalization.

I hope that we can find a way to work together to bridge these differences and work in a cooperative manner to benefit all of the citizens of the Eastern Sierra. I believe that an excellent point to move forward in a positive and productive manner would be to convene in a neutral forum to discuss the opportunities and constraints we face.

Thank you for your attention. Please contact me at (760) 878-0263 or [jhart@inyocounty.us](mailto:jhart@inyocounty.us) at your earliest convenience to discuss the next steps.

Sincerely,



Joshua Hart, AICP  
Inyo LAFCO Executive Officer

cc: Inyo LAFCO  
Mono LAFCO

Attachment

# Health Care Regionalization Report

Prepared by Inyo Local Agency Formation Commission

July 2016



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On June 29, 2015 the Inyo Local Agency Formation Commission (LAFCO) directed staff to investigate regionalization opportunities for health care. This document reports the outcome of that investigation, including inventorying available health services in the region, discussing current trends, exploring opportunities and constraints, and presenting recommendations for moving forward. The Inyo LAFCO reviewed the draft report on June 13, 2016, entertained public comment, and provided input, which has been incorporated.

## **Background**

Health care provision in the Eastern Sierra has been stressed due to regulatory burdens, implementation of the Affordable Care Act (ACA), and general disincentives for services in rural areas. The Eastern Sierra is not alone; many health care entities throughout the State and the nation face similar difficulties, and many of their experiences enlighten and provide lessons for others.

Health care is provided in northern Inyo County by the Northern Inyo Healthcare District (NIH), in southern Inyo County by the Southern Inyo Healthcare District (SIH), and in southern Mono County by the Southern Mono Healthcare District (SMHD). Health care is provided in the Ridgecrest area by Ridgecrest Hospital, which is not a healthcare district but a non-profit corporation. Other health care providers in the region include the Toiyabe Indian Health project, Inyo and Mono counties, and numerous other entities. The following summarizes many of the health services provided in the region. Although not described herein, numerous other entities provide health services, such as school districts, Cerro Coso Community College, convalescent care, and private providers.

### ***Northern Inyo Healthcare District***

NIH was formed in 1946 and is governed by Health and Safety Code Section 3200 et seq. (known as the Local Health Care District Law). A five-member elected board (by zones) serves the District, which encompasses lands in northern Inyo County, roughly from Aberdeen north. NIH provides hospital services; its primary facility is located in West Bishop, which is a 25-bed critical access hospital accredited by The Joint Commission. Services provided include 24-hour emergency, imaging, child birth, laboratory, surgery, hospitalist services, and many others. The Hospital includes a new facility (which opened in 2013), and also operates a rural health clinic. Of particular note the Hospital offers comprehensive diagnostic imaging, including advanced breast imaging; a comprehensive orthopedic service, including two full-time specialty trained Orthopedics surgeons and a rehabilitation center; a women's health clinic (which delivers over 200 newborns per year), and; two full-time general surgeons, one who specializes in colorectal surgery.

The District's boundary and sphere of influence are coterminous. According to the 2007 Municipal Service Review (MSR), interest was expressed to expand services to Chalfant Valley and communities of Paradise and Swall Meadows in Mono County.

### ***Southern Inyo Health Care District***

SIH was formed in 1949 and provides hospital services pursuant to the Local Health Care District Law. SIH historically was governed by a five-member board elected by zone, and encompassed much of central Inyo County, including Lone Pine to the County's southern border and much of Death Valley. SIH's primary facility is located in east Lone Pine, which provides four acute care beds and 33 skilled nursing beds for a total of 37 licensed beds. SIH provides emergency, acute care, a rural health clinic, laboratory, radiology, skilled nursing, physical therapy, hospice, and other services, and has been designated a Critical Access Hospital. The District has been experiencing fiscal challenges, and filed for bankruptcy while re-structuring. The Hospital shut down late in 2015, but has been providing services recently with the assistance of Healthcare Conglomerate Associates.

The District's boundary and sphere of influence are coterminous. The 2007 MSR does not identify any opportunities for service changes.

### ***Southern Mono Healthcare District***

SMHD, better known as Mammoth Hospital, was created in 1968. The District's boundaries encompass lands from north of the Town of Mammoth Lakes to the southern Mono County boundary along the County's western side, and is governed by a five-member board. The District provides numerous services, including orthopedics, family medicine, pediatrics, surgery, women's health, and urology. Mammoth Hospital operates a 17-bed Critical Access facility in the Town on the east side that was recently expanded in 2007, as well as 12 out-patient clinics, including in Bishop and Bridgeport. SMHD is working to affiliate with Loma Linda University Medical Center.

The SMHD sphere of influence was coterminous with the boundaries of the District, but the sphere was expanded in 2009 to include all of Mono County. According to the 2009 Mono LAFCO MSR, the sphere should include those areas in Wheeler Crest and Paradise that were then excluded, and the District intends to collaborate with NIH to form a regional healthcare system for the Eastern Sierra. The SMHD believes there is a need to develop an effective regional approach to healthcare delivery for the Eastern Sierra, in order to reduce duplication of expensive facilities, technology, and staff, lower costs, and make the provision of additional specialty services feasible.

### ***Toiyabe Indian Health Project***

In 1968 the Tri-County Indian Health Project was established under leadership of nine Tribal Governments in the Eastern Sierra, which has evolved into the Toiyabe Indian Health Project, a consortium of seven federally recognized Tribes and two Indian communities:

- Antelope Valley Indian Community,
- Big Pine Paiute Tribe of the Owens Valley,
- Bishop Paiute Tribe,
- Bridgeport Indian Reservation,

- Fort Independence Indian Reservation,
- Kutzad Ka Paiute Tribe (Lee Vining),
- Lone Pine Paiute-Shoshone Reservation,
- Utu Utu Gwaitu Tribe (Benton), and
- Timbisha Shoshone Tribe (Death Valley).

The Project operates three clinics in Bishop, Coleville, and Lone Pine providing a variety of services, including dental, medical, dialysis, family services, optical, public health, preventive medicine, and an elders program. A significant expansion to the Bishop facility is currently under construction. Services are provided broadly to both Native American and other populations, with some restrictions. The project is governed by Federal laws, and a Board consisting of representatives of seven of the participating federally recognized Tribes oversees its programs. The Project has relationships with Mammoth and Northern Inyo Hospitals for shared services, and is working with SIH. Staff reports interest in participating in further regionalization discussions.

### ***Mountain Warfare Training Center Clinic***

The Marine Corps operates a clinic at the Mountain Warfare Training Center Clinic north of Bridgeport. Services provided include family practice/military medicine, and basic pharmacy, laboratory, and radiology.

### ***Ridgecrest Regional Hospital***

Ridgecrest Regional Hospital (RRH) is an acute care hospital certified by the State Department of Health Services and the California Medical Association as well as DNV Healthcare Accredited. RRH is a nonprofit community organization governed by a Board of Directors providing a wide spectrum of services, including emergency, cardiology/cardiac rehab, hospice, maternity and obstetrics, radiology, rehab, a rural health clinic, sleep lab, and surgery. The Hospital was first constructed in 1945; the primary facilities are located in southern Ridgecrest in Kern County, with a new clinic in Trona in San Bernardino County. RRH staff has indicated an interest in discussion regionalization opportunities, particularly in southern Inyo County.

### ***Inyo County Health and Human Services***

Inyo County provides very limited primary health care services pursuant to its health and safety mandate, predominantly to the uninsured and/or those without access to a primary provider. Numerous additional programs are administered through behavioral health and social services, with targeted health care issues addressed. The Bishop Public Health Clinic provides women's health screenings, family planning, and sexually transmitted disease screening and treatment. A Behavioral Health Wellness Center is operated in the City of Bishop, as well as a part time Wellness Center operated in Lone Pine.

### ***Mono County Services***

Mono County operates numerous health services, including one of the most comprehensive publicly financed advanced life support ambulance coverages in the State. The Public Health Department provides immunizations, communicable disease prevention and surveillance, services for women and children, safety programs, and others. Mono County Behavioral Health provides a wide variety of mental health services. Two Wellness Centers are operated, one in Mammoth Lakes and the other in Walker.

### ***Tonopah Hospital***

Nye County Regional Medical Center (known as Tonopah Hospital), a 10-bed facility and the only hospital within a 100-mile radius of Tonopah, ceased operations in 2015. Some emergency cases have been treated at NIH whereby ambulances transport patients from Tonopah to Bishop.

### ***Emergency Medical Services***

Emergency medical services (EMS) are provided throughout the region through a Joint Powers Agreement between Inyo, Mono and San Bernardino Counties, with oversight by San Bernardino County Board of Supervisors through their staff in the Inland Counties Emergency Medical Authority (ICEMA). ICEMA regulates and monitors EMS services provided by local volunteer ambulance providers, one for-profit ambulance provider, and one air flight provider (Sierra Life Flight). EMS is also provided out of local emergency rooms in all the local hospitals. Federal entities, such as Death Valley National Park and Bureau of Land Management provide EMS on their lands. Land areas not designated as “exclusive operating areas” by ICEMA receive EMS services through mutual aid provided by adjacent EMS jurisdictions, including Mono County EMS, Nye County, Nevada, Liberty Ambulance in Ridgecrest, etc.

### ***Critical Access Hospitals***

Critical Access Hospitals (CAHs) and other small, rural hospitals provide vital services in rural areas and often serve as the foundations of rural health care delivery systems. Residents of rural areas face barriers to accessing health care services that include traveling long distances to seek care. Since rural hospitals are often the sole local source for patient care in rural communities, they are more likely to offer additional services that otherwise would not be accessible to residents.

The Medicare Rural Hospital Flexibility (Flex) Program was authorized by section 4201 of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. The Flex Program provides funding to states for the designation of CAHs in rural communities, allowing the hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare patients. The Flex Program Grant provides funding to state governments, or designated entities, to spur quality and performance improvement activities, stabilize rural

hospital finance and integrate EMS into their health care systems. NIH, SIH, RRH, and Mammoth Hospital are designated CAHs.

Flex funding encourages the development of cooperative systems of care in rural areas, joining together CAHs, EMS providers, clinics, and health practitioners to increase efficiencies and quality of care. The Flex Program requires states to develop rural health plans and funds their efforts to implement community-level outreach. The core areas of the Flex Program include support for the following four core areas:

1. Quality Improvement
2. Operational and Financial Improvement
3. Health System Development and Community Engagement
4. Conversion to CAH status

### **Affordable Care Act**

The Patient Protection and Affordable Care Act (PPACA) 2010 HR3590, or ACA, is the new health care reform law known as Obamacare. The ACA is made up of the Affordable Health Care for America Act, the Patient Protection Act, and the health care related sections of the Health Care and Education Reconciliation Act and the Student Aid and Fiscal Responsibility Act. It also includes amendments to other laws like the Food, Drug and Cosmetics Act and the Health and Public Services Act.

The ACA attempts to reform the healthcare system by providing health insurance and curbing the growth in healthcare spending, including new benefits, rights and protections, rules for insurance companies, taxes, tax breaks, funding, spending, the creation of committees, education, etc. Since being instituted, additional rules and regulations have expanded upon the law, which is expected to continue. It appears that market forces have resulted in a wave of consolidations in healthcare providers and insurers since adoption of the ACA.

In conjunction with other industry trends, the concept of a Patient Centered Medical Home is being emphasized: this concept works to personalize medical care. Teams help manage care, all services are coordinated, and patients are included in decision-making, all to improve care delivery, result in better outcomes, and reduce costs. Also, patient population health is emphasized, focusing on larger populations as a whole. Health care providers are held accountable for overall population health. These concepts may be difficult to implement due to healthcare portability in modern society.

Of relevance to this report, the ACA addresses rural healthcare issues and encourages performance standards, electronic medical records, and healthcare regionalization. The ACA also emphasizes several rural healthcare issues. Of note, the ACA provides for demonstration projects and extends certain provisions of previous programs.

### ***Performance Standards***

The health care system now emerging is based on value, as defined by quality, satisfaction, cost, and population health: better care, lower cost, and better health. The emerging new delivery models are based on maximizing efficiencies, coordinating care, teamwork and partnerships, and more effective transitions of care. The ACA works to improving payment accuracy and enhancing the health care work force as well, thereby reducing costs.

The ACA begins to transform healthcare pricing in Medicare and Medicaid. Hospital payments are being tied to performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers are being established. Payment adjustments for conditions acquired in hospitals are specified. Funding is identified for the development of quality measures, with the Health and Human Services Secretary collecting consistent data on quality and resource use measures from information systems supporting healthcare delivery to implement the public reporting of performance information. The ACA establishes a Center for Medicare and Medicaid Innovation to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program, rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time, and establishes programs for payment bundling, hospital readmissions reduction, and community-based care transitions. The ACO in the region includes Mammoth Hospital, RRH, and SIH.

### ***Medical Records***

Participation in the new value-based models will require sophisticated electronic health records, such as a regional health information exchange. The population health management and quality improvement activities will also require the development and management of complex databases, enabling providers to determine the best treatment protocols as well as progress toward wellness, chronic illness management, and population health management goals. Rural hospitals have the option of participating in large health system databases, or coming together in networks to pool their data and manage and analyze the data cooperatively. Access to research and analytical expertise will also become important in translating the data to be used as information for quality and population health improvement.

The ACA accelerates adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (such as benefit eligibility verification, prior authorization, and electronic funds transfer payments). It also establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary in order to make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.



## **Case Study – Northern California Health Care Authority**

The Northern California Health Care Authority was formed in 2007; its five members are the Palm Drive Healthcare District, Sonoma Valley Health Care District, North Sonoma County Healthcare District, Mendocino Coast Healthcare District, and South Humboldt Community Healthcare District. Each agency has two members on the Joint Powers Authority (JPA), which was formed out of a non-profit organization to address operational feasibility issues for the member rural healthcare districts. Similar to many others, the districts face difficulties with providing care to small populations, managing financing, addressing regulatory burdens, and adapting to the ACA and other modern health care trends. Under the JPA, the districts coordinate human resource functions, share procurement and medical practitioners, and operate a telemedicine program.

### **Opportunities**

Health care in the Eastern Sierra represents numerous opportunities. There is a long history of providing health care in the isolated environment and sharing services, and thus local health care delivery is resilient and strong. While the region's remoteness can be seen as a detriment in the face of the ACA, it may conversely be one of its greatest strengths. Social trends towards quality of life may result in more resources and demand for certain health care delivery.

### ***Coordination***

Due to the pressures of the ACA to agglomerate, cooperation between health care providers is an optimal path to better provide services at lower costs. It has been reported that larger health care providers in urban California are interested in entering smaller markets elsewhere in the State through cooperative relationships to provide an umbrella service structure whereby highly advanced specialized services are provided through the larger network with acute care and other more traditional services provided locally. Affiliations of this type can reduce costs by optimizing service delivery through structured arrangements, rather than the more haphazard approach as may occur presently. Health care providers in the Eastern Sierra can also coordinate services through specialization as discussed below, either in tandem with external organizations, or on their own initiative.

### ***Specialization***

Many of the local healthcare providers offer similar services. Eliminating these duplicative amenities can reduce costs region-wide, while focusing on the strengths of the individual providers. The low-hanging fruit is in the realm of administration; personnel, payroll, billing, marketing, procurement, and other administrative functions could be consolidated to reduce overhead costs. Agglomeration of these services could be phased to minimize job losses, taking advantage of attrition and opportunities as they arise. Equity in where the administrative services are housed would most likely be a sensitive topic, and care would need to be taken to account for each individual entity's peculiarities.

In the professional realm, the service providers already specialize, a trend that could be focused based on each organization's strengths and weaknesses. Obstetrics, orthopedics, urology, women's health, and convalescent care are just a few of the services that could be considered. Health transportation services are also opportunity areas, particularly in the dispersed context of the Eastern Sierra.

### ***Rural Health Incentives***

Numerous programs are available to assist rural communities in healthcare delivery. Congress has recognized the economic disadvantage in rural health care by establishing programs and policies to ensure and protect access to a broad range of health care services for the elderly and others living in rural America. These resources could be tapped and/or leveraged to assist with any regionalization initiatives.

Grants are available for rural health care districts in particular to evolve to the modern delivery system under the ACA, such as for technological and organizational advancements. Programs are offered to induce medical specialists to practice in rural areas, such as visa and pay incentives, and loan repayment/forgiveness. New funding for districts is being offered, such as Whole Person Care pilots.

### **Constraints**

As to be expected, numerous factors work to constrain regionalization. Individual personality frictions, cultural differences between the organizations, and competition amongst the providers are to be expected and are present. The great distances between facilities raises costs and limits interactions, thereby exacerbating these factors.

Uncertainty due to implementation of the ACA and how it may be amended in the future also works to limit innovation. Lower patient volumes in particular make it difficult for rural providers in the region to bear significant risk.

### **Recommendations**

Numerous challenges face health care providers in the Eastern Sierra. The shifting paradigm resulting from the ACA's implementation and uncertainty regarding its future are impediments to organizational change. However, healthcare providers in the Eastern Sierra already cooperate in many realms, and a multitude of opportunities present themselves to be exploited for cost reduction and efficiency enhancements.

Staff recommends that if there is commitment from the providers to investigate such opportunities, that a Regionalization Study be prepared by an entity or entities that have expertise in health care provision to pinpoint more precise alternative paths forwards. It may be wise to structure the study to provide information to update MSRs in the future as well. Alternatively, a citizens committee could begin the process, although any comprehensive study would be better informed by expert analysis.

## **Conclusion**

The ACA and evolving trends in health care are working towards encouraging agglomeration of health care providers. In the Eastern Sierra, efforts should be made by health care providers to expand their cooperative activities and break down institutional barriers. Potential areas to be explored include affiliation, sharing administrative costs, and specialization. A more detailed study is recommended moving forward to identify specific actions to achieve these goals. Given the unique expertise that would be required in health care institutions and trends, it is recommended that knowledgeable professionals be retained to prepare the study. Staff preliminarily estimates that such a study prepared by a consultant would cost about \$100,000 plus about \$20,000 in LAFCO resources.

## **Resources**

<http://www.flexmonitoring.org/>

<http://www.hrsa.gov/ruralhealth/index.html>

<https://www.ruralcenter.org/tasc>

<http://healthit.gov/>

<http://www.hhs.gov/healthcare/rights/>

<http://obamacarefacts.com/>

<http://www.hhs.gov/healthcare/index.html>

National Rural Health Association Policy Brief. The Future of Rural Health. 2013.