

# Mono County Local Agency Formation Commission

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## AGENDA

Wednesday, June 1, 2016 – 3:00 p.m.  
Town/County Conference Room, Minaret Village Mall  
Mammoth Lakes, California  
Teleconference at CAO Conference Room, Bridgeport

1. **CALL TO ORDER**
2. **PUBLIC COMMENT**
3. **MINUTES:** Review and approve minutes of May 4, 2016
4. **PUBLIC HEARING:** Adopt 2016-17 Final Budget
5. **MEMBERSHIP UPDATE:** Special District Alternate status
6. **HEALTH CARE REGIONALIZATION ISSUES:** Review Inyo LAFCO memo and provide any desired direction to staff
7. **FIRE DISTRICT CONSOLIDATION:** Receive status report
8. **CALAFCO CONFERENCE:** Report on recent conference highlights
9. **ADJOURN**

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## DRAFT MINUTES

May 4, 2016

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**COMMISSIONERS PRESENT:** Fred Stump & Tim Alpers, Mono County; John Wentworth & Shields Richardson, Town of Mammoth Lakes; Earl Henderson & Hank Brown, special districts; Bruce Woodworth, alternate public member.

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

**GUESTS PRESENT:** Chris Lizza, Lee Vining; Stephen Kalish, Swall Meadows

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**1. CALL TO ORDER:** Chair Earl Henderson called the meeting to order at 3:06 p.m. in the Town/County Conference Room, Minaret Village Mall, Mammoth Lakes.

**2. PUBLIC COMMENT:** None

### 3. MINUTES

**MOTION:** Approve minutes of June 3, 2015 (*Brown/Alpers. Ayes: 6. Abstain due to absence: Wentworth.*)

**4. PUBLIC HEARING: 2016-17 Preliminary Budget.** Scott Burns introduced preliminary budget, as required by law, reflecting an increase in CALAFCO membership dues. LAFCO has been in a caretaker function, not a real aggressive work program of reorganization or consolidation. Staff integrated SOI (Spheres of Influence) and MSRs (Municipal Service Reviews) into Mono County policies, especially the General Plan, a major accomplishment. Daily review of items that may pertain: development projects, issues arising out of RPACs, Lee Vining PUD. Major work item was General Plan. Interest in Mono City/Lee Vining and Paradise/Wheeler Crest. Strong interest was shown with joint fund raising at Paradise/Wheeler Crest. Mono City/Lee Vining still has interest, but boards are not aligned yet. CWPP has BLM funding and LTC funding to look at emergency access routes. \$150,000 grant for hazard mitigation update. Interest in consolidation.

Typically, a LAFCO is equally funded by County, Town and Special Districts, but Mono's two well-off districts stepped up to share Special Districts' third.

Brown asked about status of hospital district study. Any conflicts? Burns will consult County Counsel.

Stump inquired about LAFCO involvement in CD-IV geothermal. Burns recalled nothing approached recently, but will check with County Counsel. Work tasks: Tri-Valley Groundwater Management District, which has had no funding since 1989, will need assistance in complying with state groundwater law. Mono tries to be a backstop entity. Examine for outside funding sources? \$11,000-\$12,000 from Mono for well monitoring. Current activity was a split from Inyo County. One comment was received from Owens Valley Committee regarding sustainability of fish slough; one or two basins? No well extraction, so technically didn't qualify. But due to environmental concern, analyzed anyway. Potential staff time is needed.

Tri-Valley is the only basin in Mono County involved. Burns stated Tri-Valley Groundwater is not subject to LAFCO purview. Maybe need to look at government assistance, possibly in irrigation. Mono has provided assistance through CDD and County Counsel.

Henderson asked about an irrigation district. Burns replied that so far, not subject of LAFCO.

Staff Brent Calloway attended LAFCO conference, and subsequently was offered better-paying position with Inyo-Mono agriculture commission. Burns hopes to seek Calloway's help with water-related issues.

Richardson asked about Inyo Forest Plan review. Burns indicated desire for USFS to be aware of needs of Special Districts.

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

**MOTION:** Adopt 2016-17 Preliminary Budget. (*Alpers/Richardson. Ayes: 7-0.*)

## 5. MEMBERSHIP REVIEW

**A. Alternate Special District member:** Alternate Maria King passed away, so need to fill position. Stump recalled Mono Supervisors sent condolence card. Brown indicated his FPD term expires this fall, will reapply; also Henderson at MCWD. LAFCO could convene Special District selection committee, but hard to do. Alternative is ballot by mail. Try for quorum on nomination.

**B. Alternate Public seat:** Burns provided follow-up from last meeting, where interest was shown by a June Lake resident. LAFCO preferred greater geographical representation. Stephen Kalish has been very active on scenic corridor, Stump commended Kalish's involvement in Digital 395 and indicated things would not be happening in Mono without his activities. The Swall Meadows resident also served on California Public Utilities Commission. Now LAFCO has representation from Walker in north to southern Mono line. Staff recommends appointment as alternate public member.

Alpers recalled wanting diversity. In past, it was hard to interest southern residents.

**MOTION:** Appoint Stephen Kalish as Alternate Public Member (*Alpers/Stump. Ayes: 7-0.*)

Kalish was introduced and joined commissioners at the table.

## 6. SPECIAL DISTRICT STUDY UPDATE

**A. Fire Protection District Consolidation Status:** Burns cited mostly dialog with FPDs. Chris Lizza serves on Lee Vining FPD and Planning Commission. Inquiry two months ago from Paradise/Wheeler Crest FPD boards to look at consolidation. No prop tax revenues. Take up under grant-funded studies.

Lizza laid out issues for FPD, where he is captain but not representing the district. FPD would be stronger with one department than two separate. Now need financial and legal analysis, which neither district is capable of doing. Aftermath of revenues. Provincial paranoia exists regarding assessments to new combined district – restricted to spending in one community or other, board membership restricted, and fear of absconding with funds.

Henderson cited major function of LAFCO is staff helping resolve issues to ensure service to communities. Burns: Part of hazard plan update. At the CALAFCO conference Brent Calloway asked about other FPDs that merged. Meet with financial and legal staff to establish Zone of Benefit, preserve assets into system. Tools to resolve issues, who serves on board. LAFCO could place conditions on merger to satisfy concerns.

Lizza thought the issue is possibly stymied by financial concerns, but budget analysis indicated funding for a study. Burns explained that two entities deposit money with LAFCO. Look at different approach too. Maybe just application for merger/consolidation. Sphere of Influence/Municipal Service Review amendment to process concurrently. Examine issues in greater depth.

Brown asked about fee if one submits application. Maybe waive? Burns indicated provisions to do that.

Stump cited precedent with Bridgeport PUD. Expanded district boundaries, fee waived by LAFCO. Usually \$500. How to answers to questions in both potential mergers? Same issues. Not specific but generic. Even White Mountain & Chalfant split. Nearly identical districts.

Burns recalled that Brent Calloway had initiated questionnaire with FPDs to update CWPP, planned to do it in-house. Recent outreach from EMS to update hazard mitigation plan with equipment inventory, location, capacity, emergency access, and wildland fire characteristics. Focused review. Mono City/Lee Vining has prop tax revenue, but not Paradise/Wheeler Crest.

Stump mentioned different percentage is allocated to districts. Lee Vining is disparate from Mono City. Prop 13 implications? Staffing and capacity just diminished, so might not be immediate.

Burns suggested addressing needs through grants. Guidance is to pursue consolidation if desired by boards. LAFCO is not aggressive, especially with volunteers. Lizza stated board can't support till gets answers to questions.

Brown noted others have consolidated, so database exists on how it was done. Does CALAFCO have that information? Burns indicated Calloway got insight at conference.

Brown: Hearing that issue brought to LAFCO, nothing done. Maybe progress on mentioned today?

Stump noted LAFCO doesn't have spare staff capacity or time, and didn't see money to fund a consultant. Chicken/egg analogy. Willing to commit to Lee Vining/Mono City and Paradise/Wheeler Crest that if grant revenue is received, will get answers to questions.

Burns indicated as move on to other studies, other districts would have to pay. Small rural districts do the best they can.

Stump cited less than \$40,000 at Lee Vining, just no capacity to contribute. Grant funding first task would be answers to questions posed.

Burns stated Mono would bear cost, going beyond hazard mitigation required. Maybe want overview of financial health of FPDs. Work with County Counsel, finance director (on next BOS agenda).

Woodworth noted reluctance on commitment until provincialism is resolved. Representation and credit to resources must be resolved by two districts. No point in doing analysis if two tribes say they can't make it work.

Henderson suggested that FPDs get together, not make LAFCO the referee. Can't move forward till keep personal issues out.

Kalish indicated Paradise/Wheeler Crest had annual fundraiser, split proceeds 50/50, maybe started conversation. **CSD not tax base, FPD not.**

Stump recalled a vote to create parcel fee at Wheeler Crest. Tax rate areas list out entities, neither Paradise nor Wheeler Crest included. Not collected by Mono as property tax. Collected differently. Paradise copied in 2014 election.

**B. Hospital District Study Status:** Hot topic last year when Southern Mono Healthcare District (SMHD) operated outside its sphere. SMHD thought it was complying with MSR/SOI to pursue regional approach to healthcare. Conflicts took a legal turn. Inyo LAFCO participated, but Mono stayed out. Recent memo from Inyo LAFCO indicated potential regional healthcare approach. Awaiting final version for next meeting. LAFCO remains an impartial entity. Maybe more collaborative approach could work with Inyo LAFCO.

**7. SPHERES OF INFLUENCE & MUNICIPAL SERVICE REVIEW STATUS:** Burns touted one of big accomplishments as General Plan Update/RTP, with LAFCO principles integrated into General Plan and GHG (Greenhouse Gas) information. He introduced Wendy Sugimura, project lead on General Plan update.

Sugimura cited main point is General Plan encouraged compact communities, dependent on infrastructure to serve them. LAFCO is responsible agency in environmental documents, can use General Plan environmental information to tier off. Built in several means to comply with CEQA and GHG. Tool for LAFCO.

**8. ADJOURN** at 4:05 p.m. to next meeting June 1, 2016, for final budget.

*Prepared by CD Ritter, LAFCO secretary*

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## **STAFF REPORT**

June 1, 2016

**TO:** Mono LAFCO  
**FROM:** Scott Burns, Executive Officer  
**RE:** 2016-17 FINAL BUDGET

### **RECOMMENDATION**

Following close of the public hearing, adopt the attached final budget for fiscal year 2016-17.

### **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 Final Budget for fiscal year 2016-17.

As reviewed at the May meeting, 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 final budget of \$11,582 essentially reflects a status-quo level of funding, with a small increase of \$50 to accommodate a slight increase in CALAFCO membership dues.

### **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. The past several 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 2016-17 BUDGET**

The attached Final Budget for fiscal year 2016-17 maintains a status-quo funding level. This level of funding has been sufficient for LAFCO activity this past year. Staff activity included:

- reflecting LAFCO policies in the Mono County General Plan update;
- limited reviews/updates of agency Spheres of Influence/Municipal Service Reviews, in concert with the Mono County General Plan Update and Environmental Impact Report,

and in so doing sharing grant funds for coordination of the SOI/MSR updates with the county General Plan and Regional Transportation Plan updates;

- coordinating with federal, state and local agencies, conservation entities and land owners in planning for open space and agricultural preservation via the Bi-State Action Plan for Sage Grouse;
- reviewing the accuracy of district maps with the Assessor and GIS Coordinator as a part of the above reviews, making technical map corrections and converting to a GIS format;
- conducting initial discussions on potential district consolidation processes with Lee Vining and Mono City Fire Protection District (FPD) representatives, and more recently 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;
- investigating potential grant funding for reorganization study for Lee Vining and Mono City FPDs;
- responding to occasional LAFCO inquiries;
- coordinating with Inyo LAFCO to examine hospital service issues between the Southern Mono and Northern Inyo healthcare districts; and
- attending CALAFCO staff conference.

Anticipated work tasks for 2016-17 include:

- conclude digital versions of Sphere of Influence/Municipal Service Reviews, with integrated on-line links, in concert with the General Plan and Regional Transportation Plan update posting
- review LAFCO agriculture preservation policies as a part of a Sustainable Agriculture grant
- review water service providers, including irrigation, as a part of the Walker River Water Transfer Study;
- provide staff assistance as needed to the Tri-Valley Groundwater Management District in responding to the Sustainable Groundwater Management Act;
- assist FPDs with reorganization review, including potential merger of 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 FPD merger;
- work with Inyo LAFCO in coordinating health care district service review;
- transition supporting staff to replace departing Associate Analyst, and work to strengthen coordination with the Agriculture Commissioner on agriculture preservation matters; and
- review plans, projects and environmental documents for LAFCO concerns, including the Inyo Forest Plan update

This expected low level of activity, which is similar to last year, is reflected in the attached recommended FY 2016-17 Final Budget.

#### **ATTACHMENT**

- FY 2016-17 Final Budget

**FY 2016-17 FINAL BUDGET**

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

## Scott Burns

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**From:** Joshua Hart <jhart@inyocounty.us>  
**Sent:** Friday, May 13, 2016 1:20 PM  
**To:** Scott Burns  
**Subject:** LAFCO Healthcare Regionalization Study  
**Attachments:** MemoLAFCOHealthCareRegionalization.pdf

Hi Scott. As discussed, attached is the draft Health Care Regionalization Study. Please share with Mono LAFCO and anyone else you think might be interested – I will need any input prior to June 13 to share with Inyo LAFCO. Thank you.

Joshua Hart, AICP  
Inyo LAFCO EO  
(760) 878-0263





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**MEMO**

**DATE:** June 13, 2016  
**TO:** Inyo LAFCO  
**CC:** Local Health Service Providers, Mono LAFCO  
**FROM:** Joshua Hart, AICP, Executive Officer *JAH*  
**RE:** Health Care Regionalization Issues

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On June 29, 2015 the Inyo Local Agency Formation Commission (LAFCO) directed staff to investigate regionalization opportunities for health care. Staff has been working to investigate the possibilities of regionalization, the results of which are summarized below. Staff intends to present this Memorandum to Inyo LAFCO on June 13, 2016, and update the report based on feedback provided prior to and during the Commission's meeting. Please contact me at (760) 878-0263 or [jhart@inyocounty.us](mailto:jhart@inyocounty.us) if you have any questions.

**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 County Local Hospital 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 County Local Hospital 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 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 provided four acute care beds and 33 skilled nursing beds for a total of 37 licensed beds. In the recent past SIH provided 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 limited 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 are 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 address 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 determine 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.



## **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.

## **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/>

Memo from Inyo LAFCO staff to Inyo LAFCO  
June 13, 2016

<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.