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June 28, 2005

To: Supervisor Gloria Molina, Chair
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Office

HEALTH AUTHORITY BLUE PRINT – ADDITIONAL INFORMATION

On April 18, 2005, my office provided a report to the Board regarding the development of a draft Health Authority Blue Print for the possible implementation of a health authority to run the County's entire hospital system. This report provides an update on health authority legislation, information about alternative governance in other jurisdictions, responses to questions raised in the January 11, 2005 Board instruction to develop a Health Authority Blue Print, and information on transition costs.

Legislative Developments

Two bills were introduced in the Legislature that address the issue of Department of Health Services (DHS) governance.

AB 166 (Ridley-Thomas), as introduced on January 19, 2005, would have authorized the Los Angeles County Board of Supervisors to create a hospital authority patterned on a model created for Alameda County. On April 26, 2005, the Assembly Health Committee passed a significantly amended version of AB 166. The current version of the bill contains legislative intent language to "enact legislation relating to the governance, administration, and control of public hospitals and other medical facilities within the jurisdiction of the Board of Supervisors of the County of Los Angeles." It also calls for a comprehensive review of various models of governance, but no longer includes substantive provisions regarding the nature of a health authority. The bill was referred to the Assembly Local Government Committee and no hearing date has been set.

AB 201 (Dymally), as introduced on January 31, 2005, would have authorized Los Angeles County to establish a health authority by ordinance. On April 18, 2005, the bill was amended and no longer relates to County health governance. AB 201 now addresses Medi-Cal managed care enrollment and marketing, and has been referred to the Assembly Health Committee with no hearing date set.

Review of Other Jurisdictions

Our previous report provided summary information about the characteristics of alternative governance models in other jurisdictions namely, Alameda County, New York City, Denver, Miami-Dade County, Dallas, Cleveland, and Minneapolis (proposed). Staff from my office and the Department of Health Services conducted interviews and gathered information about these jurisdictions to increase our understanding of the operation of these models. A summary of the structure and experience of these models is included in Attachment I.

This information has been shared with the Governance Task Force of the LA Collaborative, and reveals several lessons that should be considered by the Board when contemplating alternative governance.

Roles and responsibilities. The clarity of the roles and responsibilities crafted between the health authority and the local government has a bearing on whether a health authority is viewed as a success. In Denver, a clear division of responsibilities has helped foster a healthy relationship between the authority and city government and has allowed for an effective transfer of operational oversight from the city to the authority. In jurisdictions where the lines of authority are not as clearly drawn, such as in Dallas or Miami-Dade County, the local government is more frequently involved in operational issues, which, at times, causes operational delays and administrative confusion.

Public accountability and transparency. Public confidence and investment in a safety-net health care system requires a strong working relationship between the authority and local government. This can be assured by statute, ordinance, and bylaws or by practice. For example, the enabling statute creating the New York City authority requires creation of a community advisory board for each hospital and regular public meetings across the city. In Denver, the health authority has recognized the value of transparency and voluntarily shares information with city government and relevant city managers, and has dedicated a staff person to handling city relations.

Link payments to specific health care services. The funding relationship between the local government and the health authority should be linked to a specific set of services to ensure adherence to the safety net mission over time. Jurisdictions pay their health authorities in different ways. The reimbursement can be made through a negotiated

lump sum payment (Cleveland), based on a negotiated percentage of uncompensated care costs (Denver), or tied to the number of indigent patients (Alameda County). The proposed model for Minneapolis recommends a volume-based formula with payments based on the lower of 90% to 99% of Medicaid or cost.

Ensuring a degree of financial flexibility. Granting the health authority greater financial flexibility, such as bonding or taxing authority, may help improve finances. Denver has been able to improve its financial situation through issuing revenue bonds whereas before the change in governance, the city had been reluctant to do so. The Dallas health authority has been able to take advantage of its taxing authority, with the approval of the county board, to cover a significant proportion of its uncompensated expenditures. On the other hand, in Alameda County, the authority has relatively little financial flexibility or independence.

Ensuring governing board appointments are based on qualifications and experience. The authority governing board should be independent and capable. The authorities in Denver and Cleveland have strong and relatively stable governing boards. In both cases, the authority recommends candidates for approval when there are vacancies. In contrast, some recent appointees to the Dallas health authority have had little relevant or applicable expertise, which, according to some, has weakened the effectiveness of the board. In 2004, a study commissioned by the Dallas County Commissioner's Court recommended formation of a civic nominating committee to help de-politicize the process.

Financial challenges will persist. Public health care systems across the country are struggling financially due to increases in the number of uninsured, cost pressures attributable to medical inflation, and decreases in Federal and State funding. All of the models examined from other jurisdictions continue to cope with these issues in the same way that county-operated systems do – by identifying new revenues or reducing services.

January 11, 2005 Board Motion Questions

The Board's January 11, 2005 Board motion posed a series of detailed questions about practical and operational aspects of a health authority. We have attempted to answer these questions for each of the four possible governance options – health commission (as defined by the 1995 Health Crisis Manager Report and the recently-established King/Drew Hospital Advisory Board), private non-profit public benefit corporation, health care district, and health authority (as defined by earlier versions of AB 166 and AB 201). The questions and answers can be found in Attachment II.

Transition Costs

We have updated our 2001 estimate of transition costs related to a change in governance for DHS. With the exception of a commission model, which has minimal costs, a change to an alternative governance model has potentially significant financial implications.

At present, the current DHS budget (FY 2004-05) reflects $163.9 million in appropriation in the hospital enterprise funds for services received from other County departments including Internal Services ($63.2 million), Office of Public Safety ($37.9 million), and Risk Management ($12.6 million). If a health authority model is established for the County health system, and it decides to purchase support services from entities other than County departments, the County will need to address the financial impact on these departments from revenue loss.

If you have any questions or need additional information, please let me know.

DEJ:GK
MAL:JF:ib

Attachments

c: Executive Officer, Board of Supervisors
County Counsel
Director of Health Services

ATTACHMENT I

SUMMARY OF THE EXPERIENCE OF OTHER HEALTH AUTHORITIES

	Alameda County (Oakland), CA	New York City, NY	Denver, CO	Miami-Dade County, FL	Dallas County, TX	Cuyahoga County (Cleveland), OH	Hennepin County (Minneapolis), MN
Background • Type of governance structure • Name • Date Established	• Separate public entity • Alameda County Medical Center • Established in 1998	• Public benefit corporation • New York City Health and Hospitals Corporation (HHC) • Created in 1970	• Separate public entity • Denver Health & Hospital Authority • Established in 1997	• Separate public entity • Jackson Health System (JHS) • The Public Health Trust is the governing body • Established in 1973	• Hospital District • Parkland Health & Hospital System • Established in 1954	• Separate public entity • The MetroHealth System • Established in 1989	• Public Benefit Corporation • Hennepin Healthcare System (HHS) – *proposed* • Proposed transfer in 2006; state statute not passed as of March 2005
State of the Authority (1) Finances	• (-) Significant deficits in 2001-2003 and poor financial outlook; although, financial situation has improved due to recent increase in tax revenue	• (-) Poor financial outlook; sustained deficit since 2001 – expected to reach $600 million for FY 2006	• (+) Positive	• (+/-) Relatively positive financial situation in recent years, although outlook is not positive due to increasing uncompensated care costs	• (+) Recent layoffs, but usually has a balanced budget; no major sustained deficits	• (+) Never has huge gains or losses; has strong bond rating	• Not applicable
(2) Safety net commitment and funding	• (-) Cost of uncompensated care increasing faster than local government subsidy	• (+/-) Uncompensated care is a relatively low percentage of total costs (12-15%); level of state/local funding has increased substantially overtime, but covers a relatively	• (+/-) Level of uncompensated care is increasing and represents a relatively high proportion of total costs (around 40% on average); local subsidy covers a small and decreasing	• (+) Provides average level of uncompensated care (25% of total costs); these costs have steadily increased since 1996; state/local government subsidy is high (in 2002, covered 90% of	• (+) High and increasing level of uncompensated care (40% of total costs); similarly high level of state/local subsidy that has more than doubled since 1996 (subsidy covered 87% of	• (-) Uncompensated care represents a low percentage of total costs (13% in 2002) and has decreased since 1996; state/local subsidy has remained relatively flat (although	• Not applicable

	Alameda County (Oakland), CA	New York City, NY	Denver, CO	Miami-Dade County, FL	Dallas County, TX	Cuyahoga County (Cleveland), OH	Hennepin County (Minneapolis), MN
		small and variable proportion of uncompensated costs	proportion of uncompensated care costs	uncompensated costs)	uncompensated costs in 2002)	modestly increased this year)	
(3) Governance	• (-) High level of board and CEO turnover; lack of trust; poor communication	• (+/-) Mixed	• (+) Strong relationship with city government; high level of communication and information sharing	• (-) Poor relationship with County Commission; lack of trust and transparency (although improving)	• (-) Recent political problems related to board appointments; poor relationship between governance board and CEO	• (+) Independent governing board; no recent removals or major political battles	• Not applicable
Experience • Successes	• (+) New management has led to improved quality of care • (+) Indigent care formula has decreased the county's financial risk for indigent care expenditures (per-capita payment)	• (+) Statute sets minimum level of indigent care subsidy (although floor has not been appropriately adjusted for increased costs) • (+) Relatively high level of transparency and public accountability	• (+) Strong/stable leadership with commitment to safety net mission • (+) Fairly high level of autonomy from city; clearly defined statutory responsibilities • (+) High level of financial flexibility: bonding authority and participation in purchasing consortiums have contributed to good financial condition	• (+) Dedicated tax plus county maintenance-of-effort requirements have led to a relatively high level of local funding for indigent care • (+/-) Having commissioners on the board has increased county involvement/ interest in the authority, but has also politicized governance to some degree	• (+) Dedicated tax has helped stabilize revenues • (+) Vocal and public participation in the governance process by members of business, civic, and advocacy communities	• (+) High level of financial independence • (+) Committed and experienced governing board; relatively long terms, low turnover	• (+) Implemented a stakeholder and expert driven process to examine alternative governance models and to make recommendations to the County Board
• Challenges	• (-) Unrealistic expectation by Board of Supervisors that change in governance would eliminate underlying	• (-) City controls may be too stringent, especially with regards to personnel and property	• (-) Declining local government investment in indigent care; based on ability to pay rather than volume	• (-) Lack of accountability and financial transparency, despite statutory reporting requirements (this has changed with	• (-) Roles/ responsibilities between County Commissioner's Court and authority governing board are not clearly	• (-) Relatively weak reporting requirements; little public oversight, control, or investment • (-) Indigent care subsidy not	• Not applicable

	Alameda County (Oakland), CA	New York City, NY	Denver, CO	Miami-Dade County, FL	Dallas County, TX	Cuyahoga County (Cleveland), OH	Hennepin County (Minneapolis), MN
	financial problems • (-) Unrealistic expectation by Board of Trustees that "county will always pay" • (-) Inadequate level of financial independence from County • (-) Amount of indigent care subsidy not reliable; tied to the financial condition of the County			new CEO) • (-) Large size of the board (and potential conflicts of interest) have led to ineffective governance (board membership has recently been reduced from 21 to 16 members) • (-) Lack of controls against county cost-shifting to the authority (when authority had significant reserves, county shifted new responsibilities to the authority)	defined • (-) Politicized appointment process (recent study recommends forming a civic nominating committee that would present a list for approval) • (-) Lack of governing board authority over CEO; may be due to short tenure and lack of expertise of board members • (-) Governance structure has not reduced/stabilized dependence on tax dollars (largely due to increasing uncompensated care costs)	formula driven	

ATTACHMENT II

OPERATIONAL ASPECTS OF ALTERNATIVE HEALTH GOVERNANCE OPTIONS

	HEALTH GOVERNANCE OPTIONS					
	Commission				Health Authority	
January 11, 2005 Board Motion Questions	**Commission Recommended by Health Crisis Manager**	**King/Drew Hospital Advisory Board**	**Private Non-Profit Public Benefit Corporation**	**Health Care District**	**AB 166 (Ridley-Thomas)** 1-19-05 version	**AB 201 (Dymally)** 1-31-05 version
What existing County operations will be shifted to the Authority?	None	None	Hospitals & clinics	Hospitals & clinics	Hospitals & clinics	Hospitals, clinics, and possibly other health programs
How will this be phased?	Created by ordinance	Created by Board motion	Could be incorporated by the County, or another existing or newly created non-County group	Established pursuant to procedures in State Health and Safety Code	Created by ordinance after passage of authorizing legislation	Created by ordinance after passage of authorizing legislation
What will the new Authority be called?	Subject to County determination	Hospital Advisory Board	Subject to determination by County or non-County group	Health Care District	Subject to County determination	Subject to County determination
How many people will be on the Board?	Seven	Thirteen to fifteen	Subject to determination by non-profit corporation	Five to seven	Subject to County determination	Thirteen

January 11, 2005 Board Motion Questions	HEALTH GOVERNANCE OPTIONS					
	Commission		Private Non-Profit Public Benefit Corporation	Health Care District	Health Authority	
	Commission Recommended by Health Crisis Manager	King/Drew Hospital Advisory Board			AB 166 (Ridley-Thomas) 1-19-05 version	AB 201 (Dymally) 1-31-05 version
What will be their qualifications be?	Must be recognized experts in health	Must have expertise/experience in a variety of areas including academic medicine, community medicine, health care and/ or business administration, financial management, nursing, and public health	Subject to determination by non-profit corporation	Must be registered voter in District	Subject to County determination	Subject to County determination
How will they be selected?	Slate developed by nominating committee, approved by 4/5 majority of Board of Supervisors	All members appointed by the Board of Supervisors with Initial slate of nominees recommended by CAO, with future nominees recommended by Advisory Board	Subject to determination by non-profit corporation	Elected by registered voters in District	Subject to County determination	Subject to County determination
How long will they serve?	Members assigned staggered non-recurring 3, 4, or 5 years terms	Members assigned to staggered 3 year terms with no member serving more than two consecutive terms	Subject to determination by non-profit corporation	Staggered four-year terms	Subject to County determination	Subject to County determination
How many hours a year will they work and how much will they be paid?	Meetings bi-weekly Members receive minimal compensation	Meetings monthly No compensation	Subject to determination by non-profit corporation	District may provide $100 per meeting up to five meetings per month	Subject to County determination	Subject to County determination
How and under what circumstances will they be removed?	By 4/5 majority vote of Board of Supervisors	By majority vote of Board of Supervisors	Subject to determination by non-profit corporation	Specified by State Government Code provisions related to elected officials	Subject to County determination	Subject to County determination
What effect will the transfer of an	None	None	County employees could transfer to non-	County employees could transfer to	Would allow transfer of County employees to	Would allow transfer of County employees to

	HEALTH GOVERNANCE OPTIONS					
	Commission				Health Authority	
January 11, 2005 Board Motion Questions	**Commission Recommended by Health Crisis Manager**	**King/Drew Hospital Advisory Board**	**Private Non-Profit Public Benefit Corporation**	**Health Care District**	**AB 166 (Ridley-Thomas)** 1-19-05 version	**AB 201 (Dymally)** 1-31-05 version
operation from the County to the Authority have on the civil service status of existing employees?			profit corporation but would not be considered public employees	district and would be considered public employees; however, they would likely not be subject to same civil service rules as County employees	Authority and consider them public employees however, they would likely not be subject to same civil service rules as County employees	Authority and consider them public employees however, they would likely not be subject to same civil service rules as County employees
What will the status of new employees?	Unchanged	Unchanged	Employed by non-profit corporation	Employed by district	Employed by the Authority	Employed by the Authority
What effect will the transfer have on existing bargaining agreements, and how will this be addressed?	Unchanged	Unchanged	Agreements could expire or labor organization could be recognized and the existing agreement renegotiated by the corporation	Agreements could expire or labor could be recognized and the existing agreement subject to renegotiation by the district	Requires Authority to recognize represented employees and organizations under Myers-Milias-Brown Act and public retirement laws Also, requires personnel transition plan for employees, and that the Authority abide by the County's contracts with labor organizations until expiration, when successor agreements would be solely negotiated by the Authority	Requires personnel transition plan for employees, and that the Authority abide by the County's contracts with labor organizations until expiration, when successor agreements would be solely negotiated by the Authority
How will the Authority be held accountable for quality of care and financial performance?	The Commission would provide oversight and recommendations to the Board on quality of care and financial	Responsibility for quality of care and financial performance continues to rest with Board and Department	Through contract with County for indigent care or through lease or transfer agreement	Through contract with County for indigent care or through transfer agreement.	Through contract with County for indigent care	Through contract with County for indigent care

January 11, 2005 Board Motion Questions	HEALTH GOVERNANCE OPTIONS					
	Commission		Private Non-Profit Public Benefit Corporation	Health Care District	Health Authority	
	Commission Recommended by Health Crisis Manager	King/Drew Hospital Advisory Board			AB 166 (Ridley-Thomas) 1-19-05 version	AB 201 (Dymally) 1-31-05 version
	performance issues					
What will be the relationship between the Authority and the County?	Would meet to receive budget and policy recommendations from DHS Authority would recommend to Board of Supervisors which would ratify by yes/no vote	Reports periodically to the Board. Has modest independent authority to act; must request Board action to implement many of its policies and recommendations	Defined in contract with County for indigent care or through lease or transfer agreement	Defined in contract with County for indigent care or through transfer agreement	Defined in contract with County for indigent care	Defined in contract with County for indigent care
What will be the County's funding obligation?	Unchanged	Unchanged	Specified through contract for indigent care	Specified through contract for indigent care	Specified through contract for indigent care	Specified through contract for indigent care
What will be the Authority's and County's Section 17000 obligation?	Obligation remains with the County	Obligation remains with the County	Obligation remains with the County	Obligation remains with the County	Obligation remains with the County	Obligation remains with the County
Who will own the transferred facilities?	Unchanged	Unchanged	County or non-profit	Health Care District	County or Authority	County (not specified if Authority could own)
How will capital development be funded?	Unchanged	Unchanged	Though traditional private sector debt financing practices	Revenue or general obligation bonds	Not specified	Not specified
How will the levels of Medi-Cal reimbursement be protected and maintained through and after the transfer?	Unchanged	Unchanged	Not clear that protection can be achieved because cannot make certified public expenditures	Unknown	Would ensure revenues to the County are maintained under an authority; however, may have problems achieving that under	Unknown

January 11, 2005 Board Motion Questions	HEALTH GOVERNANCE OPTIONS					
	Commission		Private Non-Profit Public Benefit Corporation	Health Care District	Health Authority	
	Commission Recommended by Health Crisis Manager	King/Drew Hospital Advisory Board			AB 166 (Ridley-Thomas) 1-19-05 version	AB 201 (Dymally) 1-31-05 version
					federal law as currently being interpreted	
What County controls will the Authority be subject to in the areas of personnel management, employee relations, purchasing, contracting, capital financing, and legal representation?	Authority would have delegated power to approve contracts up to a set amount, without Board of Supervisors approval All other areas unchanged	Has no direct authority in these areas; can only make recommendations to Health Department or Board	Legally, not required to have any of these controls; however non-profit corporation could voluntarily adopt them or could be forced to apply them by indigent care contract or the lease or transfer agreement	Controlled by Health Care District, but could be specified in transfer agreement	Authority would not be governed or subject to County rules and policies	Authority would not be governed or subject to County rules and policies
Will the Authority be able to use the County's resources in these areas?	Unchanged	Unchanged	No	Potentially	Potentially	Potentially
What are the estimated one-time transitions costs?	Minimal	Minimal	Potentially significant	Potentially significant	Potentially significant	Potentially significant
What are the potential long-term savings?	Indeterminate	Indeterminate	Indeterminate	Indeterminate	Indeterminate	Indeterminate