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CHIEF EXECUTIVE OFFICER
Fesia A. Davenport

January 16, 2024

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

From: Fesia A. Davenport
Chief Executive Officer

REPORT BACK ON ENSURING THE ONGOING SUCCESS OF THE MARTIN LUTHER KING JR. COMMUNITY HOSPITAL (ITEM NO. 60-A, AGENDA OF NOVEMBER 21, 2023)

On November 21, 2023, the Board of Supervisors (Board) directed the Chief Executive Officer (CEO), in consultation with its Anti-Racism, Diversity and Inclusion Initiative (ARDI), its Center for Strategic Partnerships (The Center) and the Director of the Department of Health Services (DHS) to review Martin Luther King, Jr. Community Hospital's (MLKCH) short- and long-term one-time and ongoing financial needs and report back in writing in 30 days on options for Los Angeles County (County) to help stabilize the MLKCH financial position. The Board further directed that the CEO provide an array of additional information such as the County's bond obligations related to the hospital, as well as several clinical metrics, data and other trends.

Background

In 2010, the County embarked on a path towards establishing a public-private partnership (PPP) to open a new hospital on the campus of the previously County-operated King Drew Medical Center. The County entered into a Coordination Agreement, approved by your Board on July 13, 2010, that stated the County's commitment to open the new private MLKCH and included significant provisions, such as the County's commitment to provide financial investments to establish and support ongoing hospital operations. The County recognized that it was in the public's interest to establish a hospital due to the need for additional inpatient and emergency services in South Los Angeles. To this end, the County

supported legislation (California Statue Assembly Bill 2599) that entitles MLKCH to a one-of-a-kind inter-governmental transfer from the County, which then allows MLKCH to receive federal matching funds.

The MLKCH is situated on the MLK medical campus in a County-owned facility that meets the needs of the community through high-quality hospital services, serving a region that is underserved in many ways, as will be more fully described in the Attachment. On April 22, 2014, the County approved a 40-year lease agreement, with three 10-year optional renewal terms. The lease agreement includes the County's array of financial investment including a mix of State, federal, and County payments, as well as short-term and long-term loans. Additionally, the County funded MLKCH's electronic health record (EHR) system, acquiring it via a three-party contract with the vendor to leverage the County's price structure and to ensure that MLKCH's EHR was online prior to hospital opening. This unique arrangement via the PPP, led to the opening of the MLKCH in 2015.

The MLKCH was established by the County for the sole purpose of operating an inpatient hospital on the site of the former County-owned and operated MLK campus. The County's financial investments and commitments date back to 2010 and are memorialized in a reopener provision in the 2014 lease agreement. The provision notes that the financial assistance provided by the County is intended to help create a sustainable hospital. It further states that in light of the rapidly changing and unknown framework for future health care needs and funding, the County and MLKCH agree to meet and negotiate in good faith towards appropriate adjustments to MLKCH's financial obligations.

Strategies that MLKCH is Actively Pursuing

In order for the CEO to develop appropriate initial options for consideration to help stabilize the MLKCH's financial position, we worked with MLKCH to better understand their financial needs. MLKCH indicated that they are simultaneously working on various strategies for additional funding, some options are one-time in nature, some ongoing and the timing varies for each group of options. They are exploring, among other things, the possibility of State loans, additional new market tax credits, enhanced philanthropy efforts, increases in State and federal supplemental funding arrangements, health plan rate increases, increases in State and federal revenue resulting from the new Managed Care Organization tax, and an increase in the Hospital Fee Program. MLKCH is also exploring various cost reduction options to lower their annual operating costs. Lastly, The Center has previously partnered with MLKCH's philanthropic arm and the California Community Foundation (CCF) to discuss support for MLKCH at a CCF convening of its funders. The Center is available to continue to support in this manner by providing a platform for MLKCH to pull funders together again, as necessary.

While there are a variety of options being explored by MLKCH, the work is ongoing and there are many uncertainties around if or when any of these approaches will materialize and what their potential fiscal outlook impact might be. Due to the time allotted to respond to the Board's motion, we have not conducted a comprehensive assessment of MLKCH's lines of business, revenue streams, and cost drivers to assess its longer-term financial outlook to determine the amount of financial support that MLKCH may need in the future. Notwithstanding, based on the information received from MLKCH to-date, including data related to their explosive growth in emergency room visits over the years, coupled with the State's recent award of a State distressed hospital loan, and their patient-payor mix, the CEO has concluded that MLKCH's is likely in need of immediate assistance. Our assessment is based on a point-in-time, is subject to change as circumstances change, and should be re-evaluated at least annually to allow MLKCH to provide updates on their revenue-generating and cost-saving approaches. This would also allow time for the County to determine if any additional ongoing financial support is required once the impact of the various possibilities described above are known.

Options for Board Consideration to Support MLKCH

Below is a listing of various options for the Board's consideration made up of one-time and ongoing funding approaches. These options primarily focus on funding that could be deployed relatively quickly and would have the least impact on the County's limited resources. It should be noted that the County and DHS do not have revenue sources to support private hospital operations and the options presented here are being presented based on the unique relationship MLKCH has with the County as previously described in this memo:

1. **Provide one-time Measure B funding:** Measure B is a special property tax assessment that was passed by the voters of the County on November 5, 2002. This assessment provides funding for the Countywide System of Trauma Centers, Emergency Medical Services, and Bioterrorism Response. Ongoing Measure B funding is allocated through the annual Budget process. In 2017, the Board directed the creation of the Measure B Advisory Board (MBAB) to provide advice to the Board on options for future spending of unallocated funds. However, actual allocation of funding is solely at the discretion of the Board and contingent upon Board approval.

   Earlier in the year, $28.0 million in unallocated one-time Measure B funding was identified for consideration through the MBAB process. After MBAB completed its project ranking process, and after DHS' year-ending book closing activities concluded, DHS advised that an additional $20.0 million in one-time funding was available. The additional funding was caused by refunds and underspending of various Measure B funded projects. The CEO recommends that the MBAB process proceed with the original amount of $28.0 million.

The County currently only provides Measure B funding to private hospitals that have trauma centers, but given the urgent and emergent needs at MLKCH which serves a woefully underserved patient population which exceeds nearly every indicator of high unmet needs, and the unique contractual relationship MLKCH has with the County, the Board could consider using up to $20.0 million of newly identified one-time Measure B funding to provide additional support to MLKCH over several fiscal years. These funds could be deployed shortly after approval from the Board. Finally, there is no new net County cost (NCC) impact associated with this option.

2. **Provide new ongoing Measure B funding:** The Board has the option to approve Measure B rate increases that would generate additional ongoing Measure B funding annually. This action would generate additional ongoing revenue at an amount to be determined based on need and available room within the consumer price index-allowable amount. This option has a timing impact associated with it and if deemed viable, requires approval of a rate increase via Board action by August 2024, to take effect for Fiscal Year (FY) 2024-25. There is no new NCC impact associated with this option.

3. **Refinance the MLKCH loans that are currently outstanding:**

   a) **$20.0 million line of credit**. This line of credit was approved by the Board in April 2014 and allows MLKCH access to a revolving line of credit to support MLKCH cash flow issues. MLKCH received the latest draw on the line of credit in the amount of $20.0 million in May 2023. They are required to make interest-only payments in May and November each year and the first interest payment was due and paid in November 2023 in the amount of $0.351 million. MLKCH has the option of making installment principal payments, but final repayment of the entire outstanding principal is due in May 2025. The County could change the due date for payment in full, from May 2025 to a later date; could consider delaying the interest payments for a period of time; or consolidate this debt with the long-term loan discussed below to avoid the need to make a single balloon payment in May 2025. These options could be structured in a flexible manner based on MLKCH's cash flow needs. As the funding for this loan was established in 2014 and approved in a prior year's budget, there would be no new NCC impact associated with this option.

   b) **$50.0 million long-term loan**. This loan was approved by the Board in April of 2014 and was intended to allow MLKCH to fund anticipated pre-hospital opening activities. As of June 30, 2023, MLKCH's outstanding balance on the long-term loan is $37.5 million. An interest only payment is due in May of each year and a principal and interest payment is due in November of each year. Their last installment was due and paid in November 2023 in the amount of $2.5 million, comprised of $1.8 million in

principal and $0.700 million in interest. The County could consider delaying these payments for a period of time, or as indicated above, consolidate this loan with the line of credit and develop a new payment term that reduces MLKCH's debt burden in the future. As the funding for this loan was established in 2014, and approved in a prior year's budget, there is no new NCC impact associated with this option.

4. **Allocate one-time Tobacco Settlement Funds:** As bridge funding over several years based on MLKCH's cash flow needs. There is no new NCC impact associated with this option, however, these funds have historically been limited to various County health department obligations and have not been used to support non-County entities.

5. **One-time or ongoing NCC as part of the FY 2024-25 budget process:** Funding to support MLKCH's needs can be included in the FY 2024-25 budget process for consideration. However, there is a new NCC impact associated with this option and any requests for new NCC will need to be considered in a future budget phase to allow recommendations to be made within the context of the overall budget and numerous competing funding priorities and requests.

As noted above, the motion further directed that the CEO provide and consider an array of additional information such as the County's bond obligations, as well as several clinical metrics, data, and other trends. This information is contained in the Attachment.

Recommendation

In order to meet the urgent needs of MLKCH, the CEO recommends the Board consider Option 1 to use up to $20.0 million in one-time unallocated Measure B funding over several years. This option could be deployed shortly after Board approval and would not impact other County operations or require any NCC. This option also provides an expedited, short-term solution over the next few fiscal years while the CEO continues to work with MLKCH to determine the outcome of MLKCH's revenue generating strategies and cost-saving options.

The other options listed above would require a longer-term approach that would add time and complexity to the process. Each of the options included above, including option 1, require distinct Board action and authorities, some of which may need to occur within certain timeframes in order to be implemented. Additionally, any option(s) contemplated for consideration by the Board may require further discussion with County Counsel to identify appropriate next steps, necessary agreements and/or authorities needed, and clarity on timing.

Should you have any questions concerning this matter, please contact me or Mason Matthews at (213) 974-2395 or mmatthews@ceo.lacounty.gov.

FAD:JMN:MM
MM:EB:JA:yjf

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services

On November 21, 2023, the Board of Supervisors (Board) directed the Chief Executive Officer (CEO), in consultation with its Anti-Racism, Diversity and Inclusion Initiative (ARDI), its Center for Strategic Partnerships and the Director of the Department of Health Services (DHS) to review Martin Luther King, Jr. Community Hospital's (MLKCH) short and longer-term one-time and ongoing financial needs and report back in writing in 30-days on options for Los Angeles County (County) to help stabilize the MLKCH financial position recognizing approaches such as the County's bond obligations related to the hospital, as well as several clinical metrics, data and other trends.

The options related to funding are found in the body of the memo and this attachment specifically addresses Directives 1 through 7 regarding bond obligations, as well as several clinical metrics, data, and other trends.

Directive 1: The County's bond obligations (Los Angeles County Public Works Financing Authority Lease Revenue Bond, 2016 Series D) to ensure that a hospital operates on the site.

Based on a review of the Los Angeles County Public Works Financing Authority Lease Revenue Bonds, 2016 Series D bond documents, the County is required to ensure that the tenant maintains its status as a federal tax-exempt organization as described in § 501(c)(3) of the Internal Revenue Code (IRC). Factors for tax-exempt healthcare facilities such as compliance with Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010) and IRS reporting requirements applicable to tax-exempt organizations can affect maintenance of tax-exempt status.

The operation of the current hospital, as configured, meets these requirements. Although the bonds do not require that the site of the MLK Hospital be used only for hospital purposes, changing the use of the facility that would maintain the tax-exempt status of the bonds would be a laborious process. The County may use the site for other governmental or approved § 501(c)(3) purposes, subject to procedures (such as a Tax Equity and Fiscal Responsibility Act (TEFRA) hearing if another § 501(c)(3) entity is to use the property), amendments and notices to evidence such change.

A TEFRA hearing is a public inquiry required by the Internal Revenue Service (IRS) of non-profit borrowers that intend to issue tax-exempt debt. The TEFRA hearing provides the public an opportunity to comment on the use of tax-exempt bond proceeds by the specific borrowing institution to finance their capital needs. Following the public hearing, the Treasurer executes an approval certificate for the financing under the TEFRA rules.

So long as the County continues to have "use and consideration" of the site and the improvements thereon, and the County maintains the lease-lease back structure (County's lease of the site to a financing authority followed by the County's lease back) by continuing to make debt service payments on the 2016 Series D Bonds (e.g., payments from the County to the authority), it upholds its commitments undertaken

under the deal structure and, as a result, can continue to service the 2016 Series D Bond debt.

Directive 2: Martin Luther King Jr. Community Hospital's historic current and projected patient population trends for its Emergency Department (ED), in light of its location on a growing County-owned and operated medical campus.

According to MLKCH, their historical, current, and projected ED visits since 2016 have been on a consistent rise, except for the 2020-2021 dip in volume due to the COVID-19 pandemic. At that time, there were nationwide decreases in hospital and emergency room visits as patients were actively avoiding hospitals due to the fear of contracting the highly contagious COVID-19 virus, including at MLKCH.

MLKCH reports that their volume is substantially more than what was originally projected before the hospital opened, which was a volume of 25,000-30,000 annually, for years 2016-2018. MLKCH also reported that their current volume exceeds the run rate projected in their upcoming budget as they anticipate year-over-year increases in the ED volume going forward.

Year	**Volume *(Rounded)***	***% Change over prior period***
2016	62,000	*n/a*
2017	90,000	*45.2%*
2018	104,000	*15.6%*
2019	111,700	*7.4%*
2020	84,800	*-24.1%*
2021	89,900	*6.0%*
2022	112,000	*24.6%*
2023	120,000	*7.1%*

The data is presented as provided directly from MLKCH since we do not have access to the underlying details.

Directive 3: Martin Luther King Jr. Community Hospital's patient payer mix, especially relative to services provided in its emergency department.

According to the Department of Health Care Access and Information site for Martin Luther King, Jr. Community Hospital - HCAI, as of the most current reporting period covering July 1, 2020 through June 30, 2021, the Hospital's overall patient payer mix is dominated by Medi-Cal Managed Care and Medi-Cal Fee-for-service patients, followed by County Indigent Program-Fee-for-service payer mix.

The historical data in the Hospital Financial Data Interactive Series: Hospital Utilization - HCAI tool for 2016-2019 further supports the payer mix composition. Payer mix is an important metric for hospitals and healthcare practices because it impacts revenue

and cash flow. When payer mix is heavily weighted towards government programs, the reimbursement rates are relatively lower compared to commercial insurance. Thus, MLK-CH is faced with the challenges of revenue and cash flow issues given its heavily concentrated government payer mix composition.

Directive 4: Patient quality of care performance metrics.

According to latest data for MLKCH on Medicare's website, MLKCH has an overall 5-star rating based on how well the hospital performs across different areas of quality for its Medicare payer mix which represented approximately 25.7% of inpatient and 10.7% outpatient patients as of June 30, 2022 per HCAI data. The quality areas covered categories such as treating heart attacks and pneumonia, re-admission rates, and safety of care. MLKCH has received ratings of at or above national averages for care provided to Medicare patients in the following areas:

- **Mortality** measures examine death rates in the 30-days following hospitalization.

- **Safety of Care** measures examine potentially preventable injury and complications due to care provided during hospitalization.

- **Re-admission** measures examine returns to the hospital following a hospitalization.

- **Patient Experience** The Overall Star Ratings' Patient Experience measure group is based on results from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care. This group is based on the HCAHPS measures. Hospitals must have at least 100 completed HCAHPS surveys in the reporting period to be eligible for this measure group.

- **Timely and Effective Care** measures examine how often or how quickly hospitals provide care that research shows get the best results for patients.

Quality data is not broadly publicly available for performance among Medi-Cal patients.

Directive 5: Any impact on the hospital's emergency department volume due to the proximity of DHS' Urgent Care Center (UCC) operated on the same campus.

DHS operates a UCC on the MLK campus. The UCC is located next door to the MLKCH and is open daily from 7:30 a.m. to 11:00 p.m. The DHS UCC accepts all Medi-Cal patients (regardless of network affiliation) and uninsured patients. For those hours during which the DHS UCC is open, the presence of the UCC helps to divert volume from patients that would otherwise be likely to go to the MLKCH ED.

Over the past few years, DHS has increased staffing at the UCC in an effort to help decompress the MLKCH ED; this additional staff has resulted in an increase in patient visits compared to pre-pandemic volumes. It is likely that this additional capacity helped to avoid even larger increases in ED visit volume at MLKCH; overall the increase in both UCC and MLKCH ED capacity indicates large demand and preference for UCC and ED services in the Willowbrook community and surrounding areas.

While the MLK OPC UCC has likely helped avoid even larger volume increases at MLKCH ED, it is not realistic to expect that the UCC will receive all clinically suitable patients. Hospitals are limited in the extent to which they can direct patients who present to their EDs to other sites for care, including urgent care centers because in the United States hospitals are bound by the federal Emergency Medical Treatment and Labor Act (EMTALA).

EMTALA requires hospitals with dedicated emergency departments to provide a Medical Screening Examination (MSE) to any individual who comes to the emergency department and requests such an examination and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition or from directing them to other facilities (including urgent cares) prior to the MSE.

The provisions of EMTALA apply to all individuals who attempt to gain access to a hospital for emergency care. MLKCH and DHS' MLK Outpatient Center have worked collaboratively to provide signage and messaging that makes patients aware of the availability of urgent care services on the campus while still maintaining full compliance with EMTALA.

The impact of high demand for emergency and urgent care is well known and includes issues such as ED crowding, increased costs, longer waiting times and overstretched services. A variety of factors can help to explain people's preferences for ED and UCC-based services.

One such study "*Why do People Choose Emergency and Urgent Care Services? A Rapid Review Utilizing a Systematic Literature Search and Narrative Synthesis*" provides some insights. The results identified six broad themes that summarized reasons why patients chose to utilize ED or urgent care. These were a) access to and confidence in primary care; b) perceived urgency, anxiety, and the value of reassurance from emergency-based services; c) views of family, friends, or healthcare professionals; d) convenience (location, not having to make appointment, and open hours); e) individual patient factors (e.g., cost); and f) perceived need for emergency medical services or hospital care, treatment, or investigations.

Further, on January 20, 2022, the U.S. Census Bureau issued a report identifying a clear correlation between income level and the frequency of preventable emergency care visits nationally. Individuals in lower-income households, on average, visited emergency rooms for preventable reasons, roughly 2.5 times as often as those with higher incomes. Among factors affecting the rate of preventable ED visits were:

income, education, employment, health insurance coverage, transportation access, and internet access.

Published literature also suggests that a relatively large portion of ED utilization is for conditions that do not require the high level of care offered in emergency department settings and that could be appropriately managed in non-ED settings. The Emergency Severity Index (ESI) is one indicator of the clinical severity of patients presenting to EDs based on initial nurse triage.

The ESI is a five-level scoring system, with level 1 and 2 requiring the types of interventions and evaluation capabilities most readily available in ED-settings: Level 1 indicating immediate life-saving interventions are needed and Level 2 indicating the presence of a high-risk situation, presence of confusion/disorientation, or an individual in significant pain or distress. Patients triaged as ESI scores of 3-5 are not considered at initial evaluation to be high acuity, but require variable level of resources (e.g., imaging, laboratory studies, medication administration) for appropriate management, with ESI score 3 requiring two or more hospital resources, ESI score 4 requiring one hospital resource, and ESI score 5 expected to require no resources.

While MLKCH has a high overall volume of ED visits which impose a high degree of stress on hospital staffing and budget (due to EMTALA requirements), the acuity of patients seen at MLKCH is lower than at EDs countywide. See table below for distribution of patient volume by ESI.

ESI Score	All LA County ED Volume (2022)	MLK Community Hospital (2022)
1 (most acute)	1%	0% (0.1% rounded to 0)
2	17%	7%
3	52%	59%
4	26%	31%
5 (least acute)	4%	2%

Note: numbers may not total 100% due to rounding
Source: LA County, EMS Agency

Based on the above data, while several factors impact an individual's choice to seek care within emergency department settings, it is conceivable that a reasonable portion of patients currently seen in the MLKCH ED could safely seek care in alternative settings.

One challenge in achieving this redistribution in patient volume is the high Medi-Cal rates in the MLKCH population. In addition to EMTALA requiring hospitals to provide an MSE to all patients who present for care, Medi-Cal does not permit hospitals to attempt to dissuade such utilization through cost-sharing or network management. Patients with Medi-Cal coverage may seek care in any emergency department regardless of their managed care network. Patients with Medicare managed care or

commercial managed care patients are dissuaded from such utilization through cost-sharing requirements and are incentivized to seek care in urgent care or primary care/specialty care outpatient settings where appropriate. Additionally, EDs are open 24 hours a day and 7 days a week, making it more accessible without any financial impact to the patient.

Directive 6: Emergency department strain, considering the number of daily visits compared to the number of licensed emergency room beds and licensed hospital beds.

In 2021, HCAI published data relating to Emergency Department (ED) Volume and Capacity by Facility, Health Category and Health Professional Shortage Area. According to the data, the Statewide median number of ED visits per ED treatment station was 1,270. Hospitals located in areas designated as Health Professional Shortage Areas for both Primary Care and Mental Health had a higher median ED burden of 1,310 visits per station. An emergency department treatment station is defined as a specific space within the emergency department adequate to treat one patient at a time. Holding or observation beds are not included.

ED burden is an important measure of hospital and health system utilization. The ED Volume and Capacity by Facility visualization illustrates the ratio between the number of ED visits and the number of ED treatment stations as reported by each hospital. Smaller ratios indicate fewer ED visits per available treatment station and less burden. Larger ratios of ED visits per available treatment station which indicate greater burden.

The key findings noted that for California hospitals, the ED visits-to-treatment station ratio ranges between 482 visits per station and 3,548 visits per station in 2021. The Statewide median is 1,270 visits per station. Teaching hospitals had a considerably lower median ED burden ratio of 977 visits per station, when compared to non-teaching hospitals, which had a median ratio of 1,306 visits per station. In calendar year 2022, MLKCH self-reported an ED burden rate of 3,542 per station. This measure does not indicate the burden resulting from the acuity of patients visiting the ED, but it does reflect a high volume and relative burden on the ED due to the high volume.

Directive 7: Equity factors related to the relative need of the surrounding patient population (e.g., poverty rates and other factors).

The CEO's Anti-Racism, Diversity, & Inclusion (ARDI) Initiative conducted an analysis of equity factors to assess the need of patient populations served by Martin Luther King, Jr. Community Hospital (MLKCH) per the Board's directives. This analysis included the evaluation of health equity-related indices including, but not limited to, concentrated disadvantage, the federal poverty level (FPL), the California Healthy Places Index, and the Centers for Disease Control and Prevention's Social Vulnerability Index (SVI). Additionally, ARDI considered factors that are important to understand hospitals that serve low-income and historically marginalized populations, including diversity of revenue streams, transportation access, insurance status of residents, local legacy of redlining, and regional provider shortages.

Martin Luther King Jr. Community Hospital, located in Willowbrook, operates in areas where residents are living in concentrated disadvantage and face economic, societal, and transportation barriers to health care access. MLKCH hospital operates in communities designated by the U.S. Health Resources and Services Administration as Health Professional Shortage Areas (HPSAs), underscoring the importance of their current services. Martin Luther King, Jr Community Hospital's role in serving high need populations ensures equitable hospital access in Los Angeles County.