Health Services
LOS ANGELES COUNTY

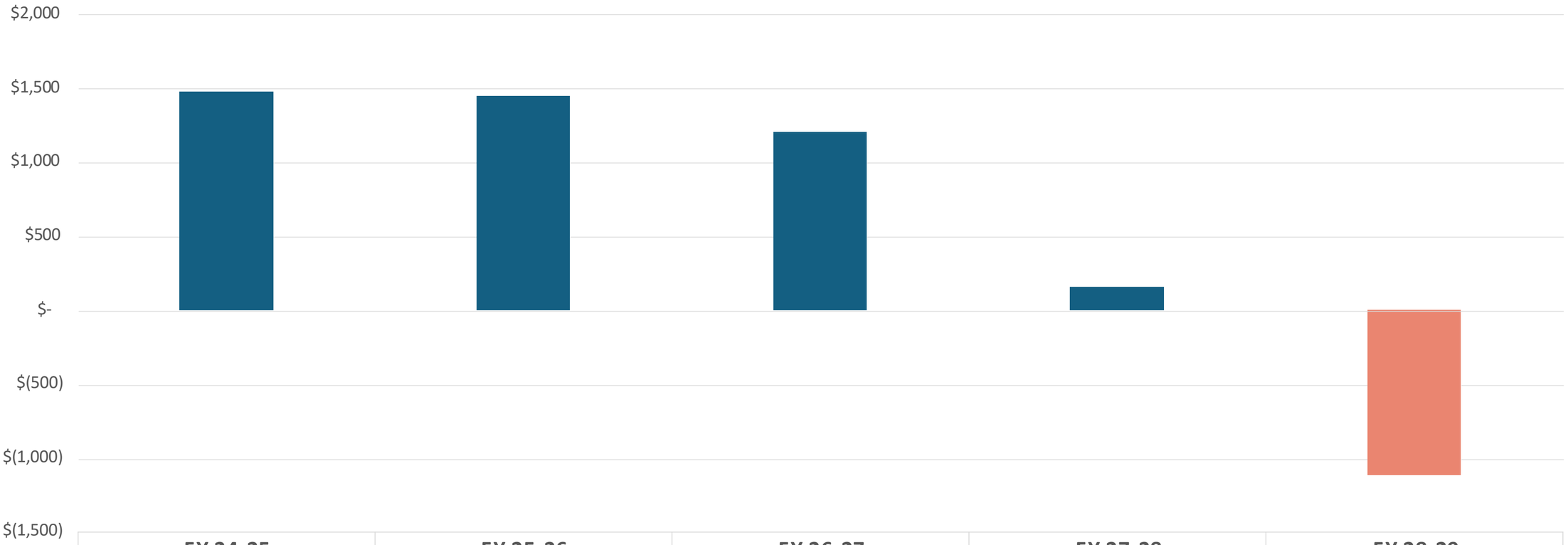
HEALTH SERVICES FINANCIAL UPDATE

JUNE 9, 2026

Forecast: FY 2025-2029

Driven by escalating costs and declining revenue

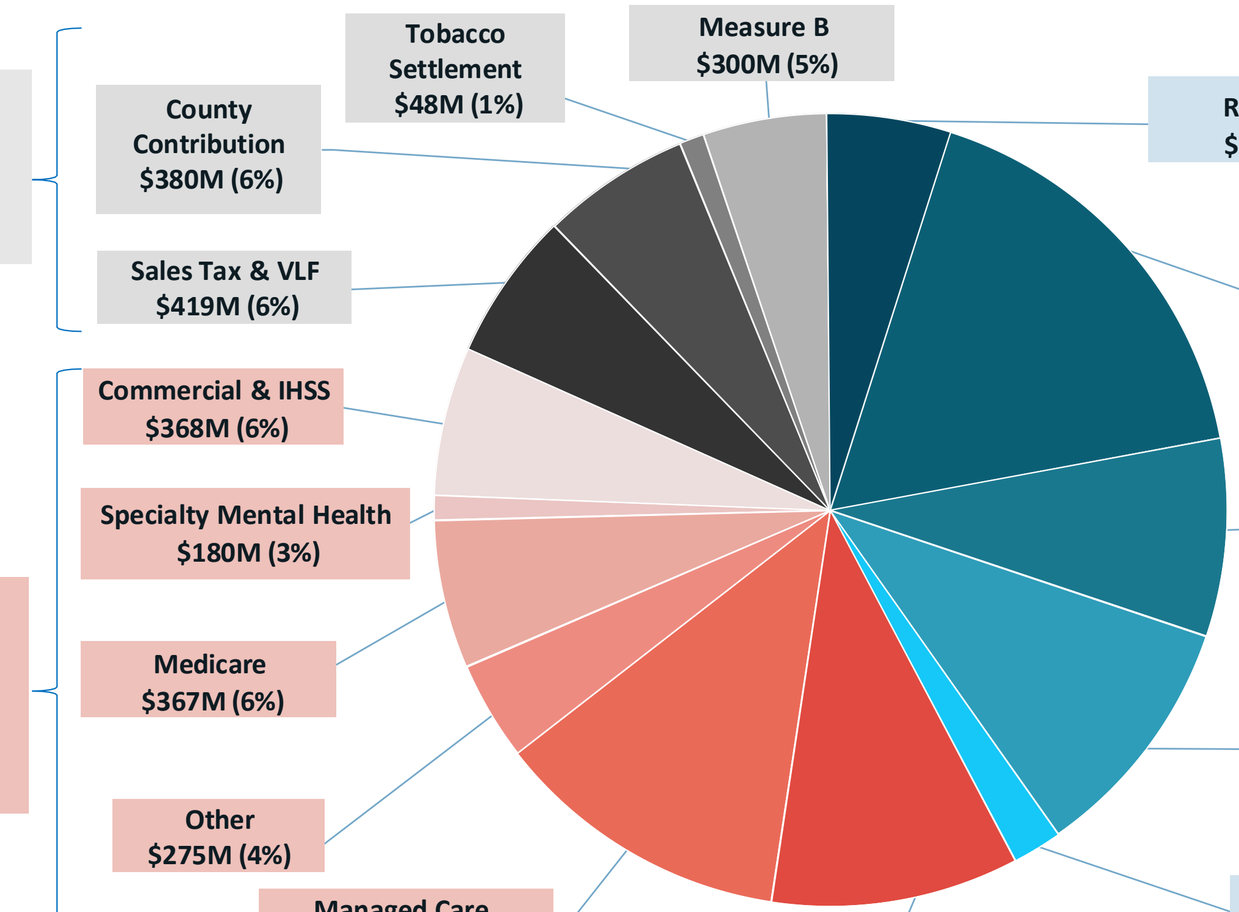
Fund Balance



	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29
Fund Balance	$1,475	$1,443	$1,208	$157	$(1,111)

$ in millions

FY 2025-26 Funding Sources – $6.5 Billion[1]



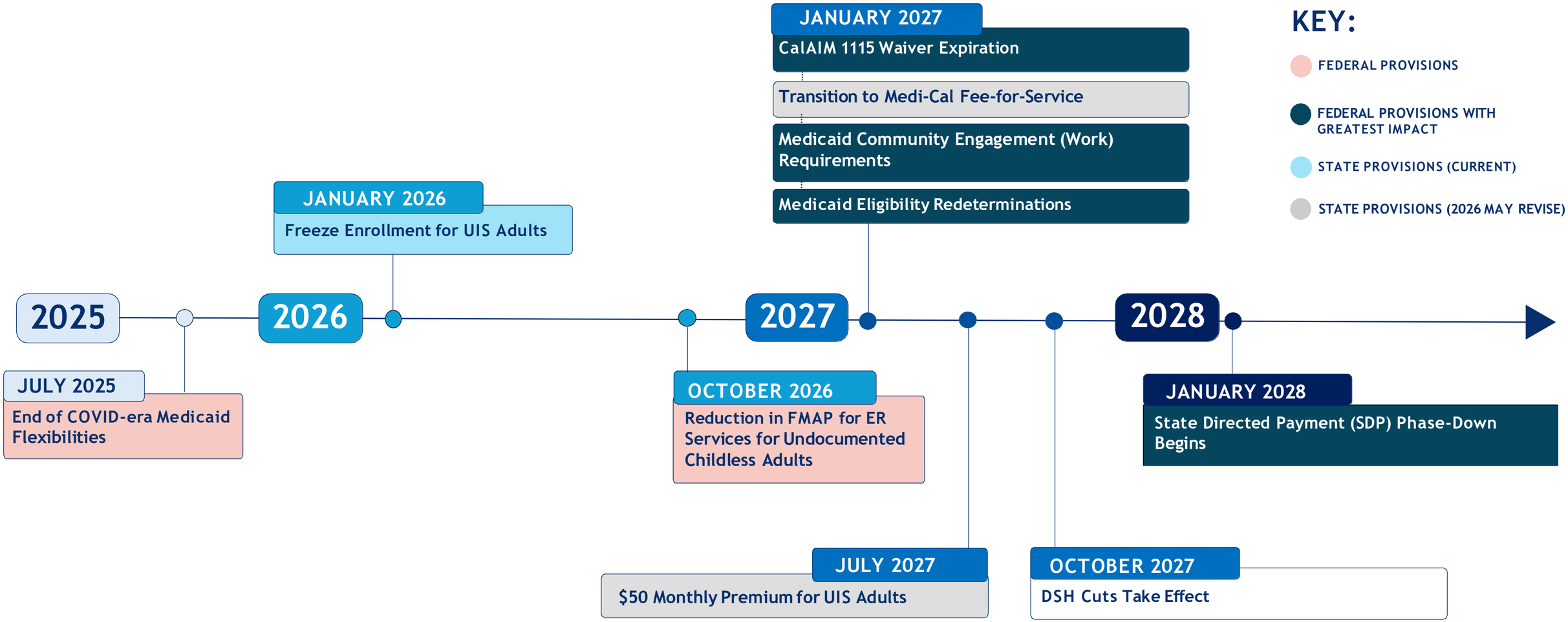
County and State Contributions
$1.1B (18%)

Reimbursement for Patient Services
$2.6B (40%)

Supplemental Payments Medi-Cal Programs[2]
$2.8 B (42%)

Notes:
(1) Numbers exclude Correctional Health and Community Programs
(2) Includes full funding for all programs

Timeline of Changes



Anticipated Revenue Impact of Federal/State Actions

Driver	Changes	Effective Date	Degree of $ Impact to DHS when fully implemented
Federal	End of Medicaid Flexibilities	July 2025	$30M
State	Enrollment Freeze for UIS Adults 19+	Jan 2026	$65M Annually
Federal	FMAP Reduction for UIS ER Services	Oct 2026	$40-60M Annually
Federal	6-month Eligibility Redetermination	Jan 2027	$130M Annually
Federal	Work Requirements for Adults 19-64	Jan 2027	
State	UIS Transition to Medi-Cal FFS	Jan 2027	$150-200M Annually
State	$50 Monthly Premium for UIS 19-59	July 2027	
Federal	Changes to State Directed Payments	Jan 2028	$200-275M Annually

New Major Revenue Initiatives

	Structure & Recipients	Total Value	Expected Allocation to LA Health Services	Decision Point
Sales Tax	Los Angeles County; Recipients Per Spending Plan	$1B Annually for Five Years	$220M a Year for Five Years	June 2026 Primary Election
Medi-Cal FFS Inpatient	Public Hospitals Statewide	$500M One-time	$75-100M One-time	June 2026
Incentive Band	Public Hospitals Statewide	$500M Annually Ongoing	$100M a Year	January 2028
Revenue Cycle System / Billing	Health Services from Third Party Payers	n/a	$10-12M Annually Pre and $50-75M Post Implementation of Patient Accounting System (PAS)	Pre-PAS Efforts Ongoing; Post-PAS Efforts 2028+
Billionaire Tax	Statewide Allocation for Health Care (90%), Education, Food Assistance	$100B One-time	Unknown	November 2026 General Election
FQHC Conversion	Ambulatory Care Network	n/a	$20-50M Annually	In progress

General Approach to Cost Containment

Cost reduction without workforce or service reductions (i.e., "efficiencies")

Well underway (see next slide)

- Hiring freeze
- Registry & Overtime reduction
- Reduction in IT, medical supply, pharmaceutical, & capital project spend
- Service hour/site changes and elimination of unused capacity

Workforce reductions without service reductions

Focus on staff not directly responsible for completing a patient encounter, e.g.,

- Management
- Administrative / non-clinical staff
- Clinical support staff

Workforce and service reductions that do not result in revenue cuts

In initiating service reductions, where feasible, focus would first be on services that bring in little or no additional revenue and / or help to avoid new costs

Workforce and service reductions that result in revenue cuts

As a last resort, DHS will need to reduce revenue-generating services. Depending on the how highly leveraged the revenue is, service reductions may generate little savings

Major Cost Reduction Initiatives

	Activities	FY Impact to Date
S&EB	Hiring freeze 36% overtime reduction (1)	$77M $48M
Registry Staffing	30% registry reduction (1)	$69M
Supply Chain	Standardization of high-cost implants	$3.5M+
Pharmaceutical Expenditures	Referral of infusion drugs to specialty pharmacies	$20M
Information Technology	Elimination and optimization of existing contracts, services, and equipment	$10M+
IHSS Line of Business	Reduce out-of-network use through coordinated repatriation procedures, enforcement of UM requests, and stricter management of pharmacy benefit	$7-10M
Utilization Management	Network repatriation	$3.5M+

(1) Based on FY 25-26 full year estimate

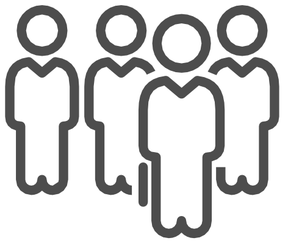
Key Considerations for Future Service Reductions

Regulatory mandate

- Is the service legally or administratively required?

Fiscal impact

- Is the service revenue-generating?
- Does reduction help avoid future expenditures?
- What net savings are achievable with ending the service?



Workforce impact

- What magnitude of layoffs would be involved?

Patient/community impact

- What is the magnitude of impact on patients & communities and overall access to services?
- What are equity-related considerations of the reductions?
- How do the reductions differentially impact vulnerable communities?

QUESTIONS?