County of Los Angeles
Health and Mental Health Services

FESIA A. DAVENPORT
Chief Executive Officer

DATE: Wednesday, December 15, 2021
TIME: 10:00 a.m.

THIS MEETING WILL CONTINUE TO BE CONDUCTED VIRTUALLY TO ENSURE THE SAFETY OF MEMBERS OF THE PUBLIC AND EMPLOYEES AS PERMITTED UNDER STATE LAW.

TO PARTICIPATE IN THE MEETING, PLEASE CALL AS FOLLOWS:
DIAL-IN NUMBER: 1 (323) 776-6996
CONFERENCE ID: 479494149#
MS Teams link (Ctrl+Click to Follow Link)

AGENDA

Members of the Public may address the Health and Mental Health Services Meeting on any agenda item. Two (2) minutes are allowed for each item.

THIS TELECONFERENCE WILL BE MUTED FOR ALL CALLERS. PLEASE DIAL *6 TO UNMUTE YOUR PHONE WHEN IT IS YOUR TIME TO SPEAK.

I. Call to order

II. **Presentation Item(s):**

- **a.** American Rescue Plan Departmental Updates
- **b.** **DHS:** DHS Fiscal Outlook

III. Items Continued from a Previous Meeting of the Board of Supervisors or from the Previous Agenda Review Meeting

IV. Items not on the posted agenda for matters requiring immediate action because of an emergency situation, or where the need to take immediate action came to the attention of the Department subsequent to the posting of the agenda

V. Public Comment

VI. Adjournment

Health Services
LOS ANGELES COUNTY

DRAFT

December 21, 2021

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TO: Supervisor Holly J. Mitchell, Chair
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES' (DHS) FISCAL OUTLOOK**

This is to provide an update to DHS' fiscal forecast for Fiscal Years (FY) 2021-22 through 2024-25 (Attachment I). DHS is forecasting a surplus of $1.57 billion in FY 2021-22 and decreasing surplus amounts in FYs 2022-23 and 2023-24. For FY 2024-25, DHS is estimating a deficit of ($454.1) million.

There are major programs, e.g., the 1115 Waiver Renewal Request (Waiver Renewal), the new California Advancing and Innovating Medi-Cal program (CalAIM) program, and other related issues that are pending, and the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid (CMS) are currently in negotiations.

There are many uncertainties regarding key elements of these programs, including program specifics, total available funding, and claiming protocols. The final agreements on program and funding details will dictate the impact, either positively or negatively, on DHS' budget. It is important to point out that, lacking specific details, the projections in this report are at a point in time and could significantly change as agreements between CMS and DHCS are reached. DHS is expecting that most of the programmatic and financial details of these major programs will be finalized by our next report to the Board. The fiscal outlook will be updated at that time to incorporate the estimated impacts to DHS.

DHS continues to have a structural budgetary deficit. To address this, we continue our collaboration with DHCS and our public hospital county partners to develop and pursue additional revenues through waivers and other potential avenues. As explained below, DHS is also focusing on reducing costs by implementing a cost accounting system, and automating processes for staff scheduling, recording time worked, etc., to promote improved use of staff resources.

Significant Updates Since Last Fiscal Outlook

Medi-Cal 2020 1115 Waiver One-Year Extension

CMS approved a one-year extension of the 1115 Medi-Cal 2020 Waiver through December 31, 2021, including Whole Person Care (WPC) and the Global Payment Program (GPP). GPP, a combination of Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) funds used for uninsured services, was originally approved by CMS for the extension period, but only for the DSH portion. Following requests from DHCS, CMS agreed to reinstate the SNCP portion retroactive to July 2020, and to continue GPP funding throughout the one-year extension period.

CalAIM

DHCS developed the CalAIM program under a 1915(b) waiver to implement broad delivery system and program changes in the Medi-Cal program. Under CalAIM, enhanced care management (ECM) and in-lieu-of-services (ILOS) (alternative non-medical services, e.g., housing transition, recuperative care, sobering centers, etc.) would be provided to address both the clinical and non-clinical needs of high-cost, high-utilizing Medi-Cal beneficiaries through a collaborative and interdisciplinary WPC approach. CalAIM will provide intensive care management services to ensure these beneficiaries receive the multiple types of care they need in a coordinated manner. CalAIM's goal is to improve overall health outcomes through intensely coordinated care management, mitigation of social determinants of health, and reduction of health disparities and inequities. DHCS is currently in negotiations with CMS on the financial details of CalAIM. We will update our forecast to account for the financial impact as the final details become available.

1115 Waiver Five-Year Renewal Request

DHCS submitted its Waiver Renewal in combination with the CalAIM 1915(b) waiver to CMS. The Waiver Renewal period is January 1, 2022 through December 31, 2026. Among other things, the Waiver Renewal requests full funding for GPP, including both the DSH and SNCP portions. DHCS is also requesting an expansion of the categories of services eligible for reimbursement under GPP for uninsured patients, e.g., ECM and ILOS services.

Federal funding is also being requested to support delivery system reform through a proposed "Providing Access and Transforming Health" (PATH) initiative. PATH would include funding for: 1) transitioning existing WPC pilot services (e.g., ECM, ILOS, etc.), capacity, and infrastructure to managed care; 2) collaborative planning to identify capacity and infrastructure needs necessary to support readiness to expand services for ECM/ILOS eligible members; 3) capacity building to enable expansion and transition of ECM and ILOS services necessary to support CalAIM objectives; and 4) technical assistance to entities supporting and providing ECM and ILOS to expand their service capacity.

In addition, the Waiver Renewal includes proposed Medi-Cal coverage for certain services, (e.g., medication, telehealth visits, and mental health services) provided to county jail inmates 90 days prior to their release, beginning in January 2023. The 90-day pre-release proposal also includes providing the inmate with a 30-day supply of medications for use post-release. If approved, this proposal would provide additional reimbursement to DHS and enhance the County's ability to expand the scope of services available to those County jail inmates who have acute medical, mental, and social challenges. A response from CMS on the Waiver Renewal is currently pending. The Department has not included the potential fiscal impact of the Waiver Renewal as DHCS is still in discussions with CMS on the programs and funding details.

Disproportionate Share Hospital (DSH)

Under the ACA, reductions in DSH allotments were slated to begin in 2014. Since then, Congress has approved multiple delays and no reductions in DSH funding have occurred. Passed by Congress in December last year, the Consolidated Appropriations Act, 2021 eliminates Medicaid DSH reductions that were slated to begin in October 2020, and also mandates that no DSH cuts will occur before October 2023. As the end of the current delay period approaches, DHS will join other California counties and our legislative advocates to lobby against any future proposed DSH cuts.

Pending Issues

Medi-Cal Managed Care

Medi-Cal rules require that eligibility for beneficiaries must be redetermined on an annual basis. Many beneficiaries fall off the Medi-Cal rolls each year because they fail to comply with the redetermination requirements. In response to the COVID-19 pandemic, Governor Newsom issued an executive order on March 17, 2020 suspending the Medi-Cal redetermination requirement during the "State of Emergency" he declared on March 4, 2020. This action resulted in many more Medi-Cal beneficiaries retaining their eligible status.

Since the redetermination moratorium was put into place, there has been a significant increase in Medi-Cal managed care patients assigned to DHS. Specifically, in March 2020, DHS' assigned members were 259,186; as of November 2021, the number has risen to 339,828, an increase of 80,642 members. This increase has significantly enhanced DHS' Medi-Cal capitation revenues. While the State of Emergency order remains in effect, we expect these numbers to continue increasing. Once the executive order is lifted, however, the redetermination requirement will be reinstated. When this occurs, a decline in assigned members, along with the associated capitation revenues, is expected. DHS continues to process new Medi-Cal applications for eligible DHS patients and assist them with responding to a redetermination notice and/or reapplying for Medi-Cal if their coverage has been discontinued. We will update the Board if new developments occur.

Affordable Care Act (ACA) - U.S. Supreme Court Ruling

On June 7, 2021, by a 7-2 vote, the U.S. Supreme Court rejected a challenge to the ACA brought by Texas and a coalition of other states in *California v. Texas*. The Court concluded that the plaintiffs did not have "standing" which is a legal requirement. Because the plaintiffs did not meet the threshold issue of "standing", the Court vacated the lower court rulings and instructed the district court to dismiss the case. This case is the third time the ACA has survived a constitutional challenge since it was signed in 2010. Most legal experts believe that this Supreme Court ruling effectively ends the legal challenges to the ACA.

Other

As previously reported, DHS received approximately $315.4 million from the U.S. Department of Health and Human Services' Provider Relief Fund to cover increased expenditures and lost revenues related to COVID-19 and placed these funds in a trust fund. Pending further clarification from CMS on allowable expenditures and lost revenues, only the partial amount of $155.1 million of the $315.4 million was placed in a restricted fund balance and recognized in FY 2020-21. Once final guidelines on allowable expenditures and lost revenues are received from CMS, the allowable amounts of the remaining balance will be moved from the trust fund to the DHS budget.

New Revenues under State's FY 2021-22 Budget

One-Time Only

Coronavirus Fiscal Recovery Fund

$300.0 million statewide was allocated for FY 2021-22 in one-time funding to assist county public hospitals and University of California hospitals with unanticipated increased costs for care provided to Medi-Cal fee-for-service and uninsured patients throughout the COVID-19 pandemic. DHS expects to receive approximately $80.0 million of these one-time funds during FY 2021-22.

Ongoing Statewide

Expanded Medi-Cal Coverage

An ongoing $1.0 billion statewide will provide Medi-Cal coverage to all income-eligible persons aged 50 and older, regardless of immigration status, starting no sooner than May 1, 2022. This new program is a State-only funded program (no federal funds). Those newly eligible under this program will have state-only funded Medi-Cal managed care and will be assigned to either L.A. Care or Health Net, who will receive capitation from the state. Since it is not yet clear how this new program may impact DHS, any potential fiscal impact is not included in the forecast.

Harbor-UCLA Medical Center Replacement Project (H-UCLA Replacement Project)

On November 10, 2020, the Board approved the H-UCLA Replacement Project. At an estimated cost of $1.7 billion, the H-UCLA Replacement Project consists of the construction of an acute care inpatient tower, an outpatient treatment building, and other supporting buildings and structures. The long-term debt service costs will be shared between DHS (90%), and the Department of Mental Health (10%) whose share will fund the construction of psychiatric emergency services and psychiatric inpatient beds. The H-UCLA Replacement Project is expected to be completed by the end of 2027.

In order to fund the equipment needed for the new hospital facility, DHS set up an Accumulated Capital Outlay (ACO) fund in the amount of $175.0 million during FY 2021-22. (DHS also used an ACO to set aside funds for equipment during the construction of the new LAC+USC Medical Center.) The estimated debt service payment for DHS upon completion of the project will be approximately $102.3 million annually for 30 years. DHS will include its portion of the debt service costs annually in future budgets.

In addition, DHS is paying planning, design, and construction costs as they occur, and so far this fiscal year, has covered approximately $80.0 million of these costs using fund balance (included in the forecast). DHS plans to continue to pay planning, design, and construction costs as they occur, and this will ultimately reduce the ongoing debt service in future fiscal years. For future fiscal years, the forecast reflects the projected debt service before DHS pays down any of these construction costs and it will be reduced downward to the degree DHS pays down any of these amounts.

Critical Care Unit (CCU) Nurse Staffing Plan

DHS has developed a standardized critical care nurse staffing model which it will present to the Board separately. Currently, in order to maintain the state-mandated minimum staffing ratios and staff by acuity in the CCUs, overtime is necessary and registry nurses are used to supplement DHS' CCU staff to ensure open ICU beds are maintained. The DHS Nursing Critical Care Staffing Plan estimates a total of an additional 189.0 Full-Time Equivalent CCU registered nurses at a projected net annual cost of $26.8 million.

DHS' Key Imperatives for Calendar Year 2022

Implementation of Cost Accounting System

DHS expects the first phase of the Cost Accounting Decision Support System (CADSS), which includes Cost Accounting and Management Reporting Modules, to be implemented in April 2022. Multiple activities are in progress related to data capture, data quality and ensuring data accuracy. These activities are labor intensive and include multi-level review and analysis of innumerable data details that reside in various systems. We need to ensure that all critical data elements are identified and included

and that the data feeding the new system is internally consistent, of high quality, and accurate. An ongoing review of data will be necessary as the initial steps of the implementation begin and will continue as the new system progresses. The second phase of CADSS will be implemented by the end of calendar year 2022. It will include Strategic Planning, Episode Analytics, and Operating Budgeting Modules. DHS anticipates being able to produce initial reports by May 2022. DHS will provide updates in future reports.

Implementation of Acuity, Scheduling and Time Employee Resource (ASTER) System

The ASTER project seeks to automate manual processes for creating work schedules and recording time worked. Implementation of the new ASTER system will provide enterprise-wide staff scheduling tools to monitor patient progress against established benchmarks, provide ability to make patient assignments, and determine patient acuity leaves from clinical documentation in ORCHID. Implementation of this system will provide accurate and timely data to the cost accounting system as well. This gives DHS the opportunity to better assess clinical service lines, manage and assign staff appropriately, e.g., during a surge in patient admissions, and enhance revenue opportunities related to managed care contracts, billing, and cost reports.

Phase One of the ASTER system has been successfully implemented at six Intensive Care Units (involving 400+ nurses) at LAC+USC Medical Center (LAC+USC MC). LAC+USC MC was selected for initial implementation because the facility had the largest number of COVID-19 patients during the COVID-19 surge. In that critical need environment, identifying nurses with specific skills to care for complex COVID-19 patients and redeploying them from other DHS sites to LAC+USC MC was a time-consuming manual process.

The ASTER system will support agile scheduling, accurately capture staff time and attendance (via web clocks), reconcile attendance against staff schedules (interface between web clocks and scheduling system), and enable adjustments in staffing levels in real time. The ASTER system will also enable DHS to predict nursing care requirements and determine how to effectively allocate staff resources to replace the 12-24 hour acuity delay currently in place. Phase Two has kicked off with a Wave 1 go-live date in Fall 2022 for the rest of LAC+USC MC, followed by Waves 2-4 to implement ASTER at all DHS hospitals and the Ambulatory Care Network.

Concluding Statement

DHS continues to focus on community health needs, improving and enhancing service delivery, strengthening core clinical services, and providing quality services that advance the health of the neediest and most vulnerable in our community, in keeping with our mission.

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

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Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

ATTACHMENT I

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

FORECAST *

FISCAL YEARS 2021-22 THROUGH 2024-25

($ IN MILLIONS)

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		Year 1		Year 2		Year 3		Year 4
		A	B	C	D	E	F	G
		FY 2021-22 Forecast	Adjustments	FY 2022-23 Forecast	Adjustments	FY 2023-24 Forecast	Adjustments	FY 2024-25 Forecast
(1)	**Expenses**							
(2)	Salaries & Employee Benefits	$ 3,649.539	$ 175.740	$ 3,825.279	$ 138.485	$ 3,963.764	$ 147.573	$ 4,111.337
(3)	Net Services & Supplies	3,115.187	(218.151)	2,897.036	(24.630)	2,872.406	29.322	2,901.728
(4)	Debt Service - Harbor Master Plan	-	-	-	54.182	54.182	7.438	61.620
(5)	Debt Service - Other	69.542	5.306	74.848	0.337	75.185	0.177	75.362
(6)	Other Charges - Other (Net of IGTs)	267.562	(161.102)	106.460	(0.134)	106.326	-	106.326
(7)	Capital Assets	46.520	(12.994)	33.526	-	33.526	-	33.526
(8)	Capital Projects & Deferred Maintenance	57.892	41.721	99.613	(50.713)	48.900	(1.900)	47.000
(9)	Operating Transfers Out	28.200	0.982	29.182	1.016	30.198	1.052	31.250
(10)	Intrafund Transfer	(582.610)	194.608	(388.002)	(5.117)	(393.119)	(5.272)	(398.391)
(11)	**Total Expenses**	$ 6,651.832	$ 26.110	$ 6,677.942	$ 113.426	$ 6,791.368	$ 178.390	$ 6,969.758
(12)	**Revenues**							
(13)	Medi-Cal Inpatient	428.202	6.778	434.980	11.375	446.355	11.680	458.035
(14)	Global Payment Program (GPP)	553.788	(14.055)	539.733	17.358	557.091	18.054	575.145
(15)	Enhanced Payment Program (EPP)	657.406	21.454	678.860	27.203	706.063	28.320	734.383
(16)	Quality Incentive Program (QIP) **	289.071	26.292	315.363	5.418	320.781	5.636	326.417
(17)	Managed Care ***	954.282	(23.617)	930.665	(51.791)	878.874	(11.570)	867.304
(18)	Mental Health	52.139	-	52.139	-	52.139	-	52.139
(19)	Whole-Person Care (WPC) ***	74.766	(74.766)	-	-	-	-	-
(20)	Medi-Cal Outpatient - E/R	83.242	1.108	84.350	1.077	85.427	1.109	86.536
(21)	Medi-Cal CBRC	211.803	1.582	213.385	5.741	219.126	5.897	225.023
(22)	Medi-Cal SB 1732	11.131	-	11.131	-	11.131	-	11.131
(23)	Hospital Provider Fee	27.296	0.537	27.833	-	27.833	0.584	28.417
(24)	Federal & State - Other	230.521	(148.833)	81.688	(1.756)	79.932	(0.802)	79.130
(25)	OCD	436.507	0.148	436.655	-	436.655	-	436.655
(26)	Other	93.368	(0.508)	92.860	(5.597)	87.263	0.003	87.266
(27)	Measure H	191.293	(4.011)	187.282	(1.500)	185.782	(6.750)	179.032
(28)	Self-Pay	6.370	-	6.370	-	6.370	-	6.370
(29)	Medi-Cal Managed Care GME	66.919	-	66.919	-	66.919	-	66.919
(30)	Medicare	268.477	0.128	268.605	-	268.605	-	268.605
(31)	Hospital Insurance Collection	111.735	(0.003)	111.732	-	111.732	-	111.732
(32)	In-Home Supportive Services (IHSS)	112.338	23.303	135.641	5.736	141.377	5.666	147.043
(33)	Grant Funded COVID	125.562	(125.562)	-	-	-	-	-
(34)	**Total Revenues**	$ 4,986.216	$ (310.025)	$ 4,676.191	$ 13.264	$ 4,689.455	$ 57.827	$ 4,747.282
(35)	**Net Cost - Before PY**	$ 1,665.616	$ 336.135	$ 2,001.751	$ 100.162	$ 2,101.913	$ 120.563	$ 2,222.476
(36)	AB 85 Redirection	(161.115)	161.115	-	-	-	-	-
(37)	Prior-Year Surplus / (Deficit)	590.636	(590.636)	-	-	-	-	-
(38)	**Net Cost - After PY & AB 85 Redirection**	$ 1,236.095	$ 765.656	$ 2,001.751	$ 100.162	$ 2,101.913	$ 120.563	$ 2,222.476
(39)	**Operating Subsidies**							
(40)	Sales Tax & VLF	379.101	-	379.101	-	379.101	-	379.101
(41)	County Contribution	734.812	15.135	749.947	17.571	767.518	18.645	786.163
(42)	Tobacco Settlement	73.503	-	73.503	-	73.503	-	73.503
(43)	Measure B	211.410	-	211.410	-	211.410	-	211.410
(44)	**Total Operating Subsidies**	$ 1,398.826	$ 15.135	$ 1,413.961	$ 17.571	$ 1,431.532	$ 18.645	$ 1,450.177
(45)	**Surplus / (Deficit) = (44) - (38)**	**$ 162.731**	$ (750.521)	**$ (587.790)**	$ (82.591)	**$ (670.381)**	$ (101.918)	**$ (772.299)**
(46)	**Beginning Fund Balance**	**$ 1,588.646**	$ (12.269)	**$ 1,576.377**	$ (587.790)	**$ 988.587**	$ (670.381)	**$ 318.205**
(47)	Surplus / (Deficit)	162.731	(750.521)	(587.790)	(82.591)	(670.381)	(101.918)	(772.299)
(48)	H-UCLA MC Master Plan - ACO Fund	(175.000)	175.000	-	-	-	-	-
(49)	**Ending Fund Balance**	**$ 1,576.377**	$ (587.790)	**$ 988.587**	$ (670.381)	**$ 318.205**	$ (772.299)	**$ (454.094)**

* The forecast is net of IGTs and other double-counts such as internal transfers, and includes Correctional Health and Office of Diversion and Re-Entry.

** For FY 2021-22 forward, PRIME is incorporated into QIP.

*** For FY 2021-22, 6 months of WPC and the annual amount going forward are included in Managed Care.