California State Auditor

BUREAU OF STATE AUDITS

Los Angeles County Department of Health Services:

Current Proposals Will Not Resolve Its Budget Crisis, and Without Significant Additional Revenue It May Be Forced to Limit Services

May 2002
2001-119

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CALIFORNIA STATE AUDITOR

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May 30, 2002 2001-119

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As required by Chapter 195, Statutes of 2001, the Bureau of State Audits presents its audit report concerning Los Angeles County Department of Health Services' (Health Services) financial capacity to render health care services to county residents.

This report concludes that Health Services' projected budget deficit threatens its ability to continue providing the current level of health care services to low-income and medically indigent residents of the county. Health Services forecasts a budget deficit beginning in fiscal year 2003–04 of $365 million, and projects the shortfall will grow to $688 million by fiscal year 2005–06. However, Health Services' forecasts of revenue and expenses are optimistic. To address the deficit, it is developing a strategic plan to improve efficiency and seek new funding sources. If this effort is not successful in eliminating the projected deficit, Health Services plans to propose reducing the size and capacity of its health care system. These reductions would require a change in the historic definition of Health Services' mission and role as the county's safety net provider.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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Response to the Audit

SUMMARY

Audit Highlights . . .

Our review of the Los Angeles County Department of Health Services (Health Services) to evaluate its financial capacity to render necessary health care services to the residents of Los Angeles County revealed that:

- ☑ *Health Services' projected budget deficit of $688 million by fiscal year 2005–06 is likely to be larger than it has forecasted.*
- ☑ *Efforts to reduce costs and improve efficiencies are not likely to avert the forecasted budget deficit.*
- ☑ *To maintain current levels of service, additional sources of revenue are required.*
- ☑ *Health Services has identified four options for reducing the size of its system, but has not yet offered a specific proposal for accomplishing these reductions.*

RESULTS IN BRIEF

The Los Angeles County Department of Health Services (Health Services) currently forecasts a budget deficit beginning in fiscal year 2003–04 of $365 million, and it projects the shortfall will grow to $688 million by fiscal year 2005–06 of which $628 million is related to its enterprise units. The deficit threatens the department's ability to continue providing the current level of health care services to low-income and medically indigent residents of Los Angeles County.

To address the deficit, Health Services is developing a strategic plan to improve efficiency and seek new sources of funding. If this effort is not successful in eliminating the projected deficit, Health Services plans to propose reducing the size and capacity of the county's health care system. According to Health Services, these reductions will require a change in the historical definition of the department's mission and role as the safety net provider in the county.

In fiscal year 1995–96, facing a similar deficit of $655 million, the county and the State negotiated a special Waiver agreement with the federal government that provided $1.2 billion in federal funding over 5 years. The Waiver was intended to give the county time to restructure its health care system, reducing hospital-based services and increasing the volume of primary and preventive care delivered in less-expensive outpatient settings. Although progress was made in restructuring the delivery system, a continuing budget deficit led to a 5-year extension of the Waiver beginning in fiscal year 2000–01. The Waiver extension provides a total of $900 million in federal funding and requires Health Services to meet several operating objectives.

Health Services' baseline budget deficit, before considering the impact of initiatives that may result from the current strategic planning effort, will likely be larger than it has forecasted. In fiscal year 2005–06, Waiver funding will be eliminated, resulting in a loss of more than $230 million in revenue annually. Further, Health Services has identified, but has not yet incorporated into its baseline budget, additional losses in state and federal

funding totaling an estimated $67 million. Changes in the mix of payors, toward a greater proportion of uncompensated care, have exacerbated Health Services' revenue problems. The unbudgeted reductions in funding and the changing payor mix, combined with unfavorable pending, or as yet unimplemented, federal and state laws, suggest that Health Services' revenue forecast may be optimistic.

While important revenue streams are forecasted to remain flat or to decline, the cost of providing health care continues to grow. Employee salaries and benefits, predicted to grow at the rate of inflation, are expected to add more than $300 million to the deficit by fiscal year 2005–06. Overall, Health Services forecasts that its total costs will increase by 4.2 percent annually through fiscal year 2005–06, a rate less than the recent rate of increase in the hospital Consumer Price Index and also less than the rate of growth in Health Services' spending in the last five years. Like the department's revenue forecast, the expense forecast appears optimistic. Regulatory changes and other factors not reflected in the baseline budget, including new minimum nurse staffing ratios, the need to accommodate seismic retrofitting of hospitals, and the requirements of the Health Insurance Portability and Accountability Act, may increase Health Services' operating cost by approximately $103 million above the baseline forecast by fiscal year 2005–06.

We found that the accounting tools and procedures used by Health Services to track and report on the status of the budget deficit are sufficient for that purpose. However, the department lacks the clinical or financial information systems needed to effectively manage a multibillion-dollar health care system.

Past efforts to resolve the budget deficit have not succeeded in averting another crisis. With respect to revenue, Health Services has been innovative in finding new sources of funding to support its health care systems. Examples include the aggressive use of intergovernmental transfers to maximize federal matching contributions and negotiation of the Waiver and Waiver extension that together provided $2.1 billion in federal funding over 10 years. With respect to costs, labor productivity fell and operating expense rose somewhat more quickly at Health Services hospitals than at other public and teaching hospitals in California during the early 1990s. However, recent efforts to contain costs and improve operating efficiency have helped limit growth in spending. Health Services reports savings of $259 million annually from cost-reduction efforts initiated since

fiscal year 1996–97. Our comparison of Health Services hospitals with other benchmark hospitals supports Health Services' claims of improved efficiency at its hospitals.

Health Services is scheduled to present its plan to address the budget deficit to the County Board of Supervisors on June 18, 2002. As of the time we performed our work, this plan was not complete. Only a limited number of immediate opportunities to reduce costs and enhance revenue were sufficiently specified to allow potential fiscal benefits to be estimated. However, because Health Services' hospitals are already moderately efficient compared to the benchmark facilities we analyzed, cost reductions alone are not likely to eliminate the department's budget deficit. To maintain the current system and level of service, additional sources of funding will be required.

Although it has identified four options for reducing the size of the county health care system in the event that immediate cost-reduction efforts and revenue enhancements are not sufficient to balance the budget, Health Services has not yet offered a specific proposal for accomplishing these reductions. Each of the four options would require the county to focus its resources more narrowly on those residents that it is legally obligated to serve.

AGENCY COMMENTS

Health Services generally agrees with the findings contained in our report. ■

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INTRODUCTION

BACKGROUND

The mission of the Los Angeles County Department of Health Services (Health Services) is to protect, maintain, and improve the health of one of the largest and most diverse populations in the nation. Health Services is the health care safety net provider for Los Angeles County's low-income and indigent residents. The largest department within the Los Angeles County government and the second-largest public health care system in the country, it includes 6 hospitals, 6 comprehensive health centers, 33 health centers/clinics, 2 residential rehabilitation centers, and more than 100 public-private partnership sites. Its 3 trauma centers provide approximately 50 percent of all trauma care in the county, while its 4 emergency rooms handle nearly 20 percent of all emergency medical service visits in the county—and 41 percent of the visits by patients categorized as indigent, charity, or self-pay. It also provides public health services for the county, with responsibilities that include operating AIDS prevention and treatment programs, providing restaurant inspections, and administering alcohol and drug treatment programs.

For budgeting purposes, Health Services is organized into 6 enterprise units and 7 general fund units. The enterprise units include the hospitals, regional units for reporting by the comprehensive and community health centers, and 1 unit for the Antelope Valley Rehabilitation Clinic. The 7 general fund units include AIDS programs, alcohol and drug programs, children's medical services, juvenile court health services, public health services, health services administration, and the office of managed care. In this evaluation, we have focused on Health Services' enterprise units only, which account for approximately 74 percent of its operating budget. Additionally, as we explain further in the Scope and Methodology section, we have redefined the enterprise units to include health services administration and the office of managed care.

Over the past decade, Health Services has struggled in its efforts to provide services for a variety of reasons, including Los Angeles County's large and growing population of uninsured residents, declining Medi-Cal revenues, and a delivery system that relies

on hospital-based services within an aging infrastructure. Its enterprise units received an operating subsidy of nearly $581 million in fiscal year 2001–02, and it anticipates the need for an additional $682 million by fiscal year 2005–06 if it is to continue providing health care at current service levels. Health Services projects that its general fund units will also require an operating subsidy of $226 million by fiscal year 2005–06.

On January 29, 2002, Health Services presented to the County Board of Supervisors (board) a document that summarized the "strategic and operational planning process" in which it was engaged in the hope of addressing the forecasted deficit. Delays in developing concrete strategic recommendations have left Health Services with little time to implement potentially significant changes before the start of fiscal year 2003–04, at which time it has forecasted that its enterprise deficit will reach nearly $333 million.[1] If the deficit grows as predicted, it will threaten the ability of Health Services to continue serving as the safety net provider for the county.

THE 1115 MEDICAID DEMONSTRATION PROJECT

Medicaid is a federal program that provides health care coverage for low-income families and certain individuals who lack health insurance. For those who qualify in California, the federal government contributes approximately 50 percent toward the cost of health care, while the State generally pays the difference. Changes to the Medicaid program can be made by applying to the Centers for Medicare and Medicaid Services (CMS) for a waiver under Section 1115 of the Social Security Act (Waiver). The purpose of the Waiver is to allow experimental, pilot, or demonstration projects that are likely to assist in promoting Medicaid's objectives.

Los Angeles County, with participation from the State, first applied for a Waiver in 1996, after Health Services' increasing costs and flat or declining revenues had led to a $655 million deficit. Recognizing that Health Services could no longer maintain the financial viability of its system, the county negotiated with the State and CMS to obtain a Waiver that would provide financial assistance and give Health Services time to restructure away from delivering expensive hospital

[1] Contributing to the delay has been the lack of a permanent director of Health Services from March 2001 until February 2002.

services to delivering primary care and preventive services in an outpatient setting. The Waiver provided $1.2 billion in federal funding over a 5-year period from July 1, 1995, through June 30, 2000, during which time Health Services significantly increased access to county-funded outpatient care services while reducing hospital capacity and the number of inpatients treated in county hospitals.

Despite these restructuring efforts, Health Services was unable to secure adequate ongoing funding to ensure its long-term financial viability. As a result, CMS agreed to grant it an extension of the Waiver beginning July 1, 2000. The 5-year Waiver extension provides $900 million in federal funding and requires Health Services to meet several objectives, including providing a minimum number of outpatient visits each year, implementing clinical resource management practices, applying for Federally Qualified Health Center (or look-alike) status for county and public-private partnership clinics, simplifying the process for determining an uninsured patient's ability to pay, increasing the number of individuals in the county that are certified as eligible for Medi-Cal, and updating coding systems to comply with the Health Insurance Portability and Accountability Act. The Waiver extension was intended to further assist Health Services in restructuring its health care delivery system to ensure its long-term viability and reduce its reliance on federal revenue. Health Services' funding under the Waiver extension is more than $231 million in fiscal year 2001–02 and will be phased out to nothing by fiscal year 2005–06.

HEALTH SERVICES' OTHER SOURCES OF FUNDING

In addition to the Waiver extension, Health Services relies on a number of sources of funding, many of which involve federal or state programs. One of these is Medi-Cal, California's Medicaid program, the primary source of health care coverage for low-income individuals who lack medical insurance. Generally, Medi-Cal covers low-income children and their families and adults who are blind or disabled. Medi-Cal pays Health Services a fixed amount per day for inpatient services, and it reimburses it for outpatient services based on costs, subject to the terms of the Waiver. That is, Health Services receives a fixed amount per day for each hospitalized Medi-Cal patient, while the amount it receives for outpatient visits varies based on the services the patient received.

A second program, the Acute Inpatient Disproportionate Share Hospital (DSH, also known as SB 855) Program, allows public agencies such as Health Services to contribute funds to the State in the form of intergovernmental transfers. After retaining an administrative fee, the State transfers the funds back to the agencies along with federal matching funds—which in fiscal year 2001–02 equaled 51.4 percent—from CMS. The total dollar amount that the federal government will contribute is defined in the Balanced Budget Act of 1997. The allocation of state and federal DSH funds to hospitals is based on the number of inpatient days for both Medi-Cal and indigent patients. The allocation formula, however, gives more weight to Medi-Cal inpatient days than to indigent inpatient days.[2]

The Emergency Services and Supplemental Payment Fund (Emergency Services Fund, also known as SB 1255) is a supplemental reimbursement program that is available to DSH-qualified hospitals. The California Medical Assistance Commission (medical commission), which is jointly appointed by the governor and the Legislature, establishes contracts with California hospitals that meet the DSH criteria and provide emergency medical services. Through these contracts, the program contributes funding for services provided to Medi-Cal patients. While the medical commission determines the funding amounts, Health Services administers and distributes the funds to ensure that the federal government matches them. Health Services allocates funds from this program across its inpatient system.

Health Services also receives government funding from Medicare, the federal program that provides health insurance to most persons over 65 years old and to certain disabled persons. Medicare reimburses Health Services on a fee-for-service basis for both inpatient and outpatient services to Medicare recipients.[3] In addition, it derives a small amount of revenue from private health insurers and out-of-pocket payments made directly by patients. These revenues are primarily fee-for-service.

[2] The Omnibus Budget Reconciliation Act of 1993 defined unreimbursed costs as Medi-Cal/indigent-related operating expenses less Medi-Cal/indigent-related revenues. The Medi-Cal/indigent operating expenses, however, are estimated by applying the proportion of revenues from Medi-Cal and indigent patients to total operating expenses, rather than applying the actual patient day mix. As a result, Medi-Cal patients are more heavily weighted because this group has the largest revenue per day. Thus, if Health Services loses revenue from one Medi-Cal patient day and gains revenue from one indigent patient day, the Medi-Cal/indigent patient mix will fall, and so will the DSH reimbursement.

[3] When Medicare patients are seen through graduate and indirect medical programs, Health Services is reimbursed based on its costs rather than on a fixed basis.

Finally, because revenues from traditional health care sources are not sufficient to fund its operations, Health Services has required subsidies from the State and county. Funds derived from the State include allocations from sales tax, vehicle license fees, and tobacco taxes. As a requirement of the Waiver extension, the county must contribute $60 million each year during the Waiver extension from tobacco settlement funds and a total of $100 million over 5 years from its own general fund.

THE SCORECARD

Health Services tracks its projected financial position in an internal document called the scorecard. The scorecard tracks variances from the current year's budget and identifies changes that are expected to affect subsequent years (up to a 5-year period). For example, scorecard adjustments include projected increases in costs such as salaries and employee benefits, and services and supplies. Also reflected are projected revenue adjustments related to Medi-Cal and Medicare reimbursements, as well as changes to Waiver revenues. The scorecard also reflects estimated changes to operating subsidies such as tobacco settlement funds and vehicle license fees.

Health Services also identifies other potential needs and developments that may affect its budget. However, because these events are less certain or their impact is unknown, they are not reflected in the scorecard forecast. For instance, the scorecard does not incorporate any projected cost savings or revenue enhancements related to the January 2002 strategic plan. The enterprise units' baseline budget for fiscal year 2001–02 is shown in Appendix A, as are the related scorecard adjustments.

SCOPE AND METHODOLOGY

Chapter 195, Statutes of 2001, required the Bureau of State Audits to evaluate the financial capacity of Health Services to render necessary health care services to the residents of Los Angeles County. In particular, we were asked to do the following:

- List and describe each of the proposals put forward to reduce Health Services' expenditures or increase its revenues, including the current status of each.

- Review projections of budgetary shortfalls to determine whether the assumptions that underlie Health Services' baseline revenue and expenditure estimates for fiscal years 2001–02 through 2004–05 are reasonable, and adjust the projections as necessary.

- Determine whether Health Services has accounting tools adequate to track its budget deficit.

- List and explain how Waiver extension requirements and other existing or potential laws, regulations, or administrative rules affect the deficit.

- Evaluate Health Services' timeliness and effectiveness in addressing the deficit.

- Determine the extent to which Health Services' proposals to address the deficit are complete and likely to be effective.

To assist in our review, we hired a health care economics and strategy consulting firm, Analysis Group/Economics.

For the purposes of this audit, we have focused on Health Services' enterprise units, since these units are directly involved in the delivery of traditional health care services. The 12 enterprise units are Los Angeles County–University of Southern California Medical Center (LAC/USC), northeast comprehensive health centers and health clinics, Martin Luther King Jr./Drew Medical Center (MLK/Drew), southwest comprehensive health centers and health clinics, Los Angeles County Harbor–University of California Los Angeles Medical Center (Harbor/UCLA), coastal comprehensive health centers and health clinics, Los Angeles County Olive View–University of California Los Angeles Medical Center (Olive View/UCLA), San Fernando Valley comprehensive health centers and health clinics, Rancho Los Amigos National Rehabilitation Center (Rancho Los Amigos), High Desert Hospital (High Desert), Antelope Valley comprehensive health centers and health clinics, and Antelope Valley Rehabilitation Center. We included two of the general fund budget units, health services administration and the office of managed care, in our analysis of the total enterprise funds. We included the office of managed care largely because the funding and expense for public-private partnership clinics and for the Community Health Plan are included in its budget, and these two functions are an important part of Health Services' delivery of traditional

health care services.[4] We included health services administration because it performs the administrative functions for all of Health Services' budget units. Although it also serves the general fund units, we have included it in the total enterprise budget to be conservative.

To assess the assumptions of the budget forecasts, Analysis Group/Economics reviewed detailed financial data and interviewed Health Services' administrative and medical staff. To assess the adequacy of Health Services' accounting tools, our consultants reconstructed the scorecard that Health Services uses to track its deficit. For the purposes of this audit, our consultants disaggregated the scorecard to identify a separate enterprise unit scorecard. To isolate the enterprise unit activity, our consultants also reorganized the fiscal year 2001–02 budget to include only the enterprise units defined above.

Our consultants evaluated the past strategic initiatives by analyzing savings estimates and assessed the current strategic initiatives by developing a "report card" for each initiative to determine whether it included sufficient detail to ensure that the proposed changes can and will take place. Additionally, our consultants conducted interviews with Health Services staff to determine the impact of the Waiver requirements on the deficit. They also analyzed the hospital data compiled by California's Office of Statewide Health Planning and Development to assess Health Services' operating performance relative to comparable benchmarks. We did not audit the Health Services financial data contained in our report, nor did our consultants. ■

[4] On September 4, 2001, responsibility for the public-private partnership program was transferred to the office of ambulatory care, which is part of health services administration.

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CHAPTER 1

Los Angeles County Department of Health Services' Budget Deficit Is Likely to Be Larger Than It Has Forecasted

CHAPTER SUMMARY

The Los Angeles County Department of Health Services (Health Services) has estimated that it will receive a subsidy of $581 million to fund its enterprise operations during fiscal year 2001–02. It believes that it will require an additional $682.5 million in fiscal year 2005–06, at which time it estimates that it will require a total enterprise subsidy of more than $1.2 billion to continue providing health care at current service levels. The reasons for this substantial projected increase involve a combination of reduced revenues and rising costs.

During the last 10 years, Health Services has become increasingly reliant on state and federal funding programs to meet the demands of serving a growing indigent population. The current legislative environment suggests that federal and state support for Health Services may be eroding, and in fiscal year 2005–06 Health Services will lose more than $231 million in revenues annually when the Waiver extension it received from the federal government expires.

Moreover, Health Services' estimates do not take into account a number of factors that may further weaken its financial situation by fiscal year 2005–06. While not incorporated into its budget forecast, Health Services has estimated that increases in the administrative fee it pays the State for the Acute Inpatient Disproportionate Share Hospital Program (DSH) and the federal reduction of the Medicaid upper payment limit may reduce its cumulative revenues by more than $67 million at that time. In addition, the proportion of uncompensated care that Health Services provides is rising, which may further reduce its revenues. Regulatory changes and other factors, such as mandatory minimum nurse staffing ratios, the need to accommodate the seismic retrofitting of hospitals, and the requirements of the Health Insurance Portability and Accountability Act, may increase Health Services' operating cost by approximately $103 million. Thus, with revenues likely lower and costs higher than presented in the baseline forecast,

Health Services' budget deficit is likely to be larger in fiscal year 2005–06 than its current projections, possibly by as much as $170 million. The result may be a total enterprise deficit of $798 million.[1]

In general, we found that the accounting tools used by Health Services to report on the status of its budget deficit are sufficient. The scorecard, the primary tool it uses to track its deficit, provides reliable estimates of its financial position on a monthly basis. The current cost accounting system is oriented toward evaluating broad cost analyses on an annual basis. However, Health Services lacks the information technology systems and corresponding accounting tools to provide a detailed breakdown of the costs of the services it provides, by facility, in a timely manner. Thus, the system lacks the information necessary for management to make proactive decisions regarding cost control and resource allocation.

HEALTH SERVICES HAS BECOME INCREASINGLY RELIANT ON FEDERAL FUNDING, WHICH WILL DECREASE SIGNIFICANTLY IN FISCAL YEAR 2005–06

Federal funding has increased from 23.2 percent of Health Services' revenue in fiscal year 1980–81 to more than 47 percent in fiscal year 2000–01.

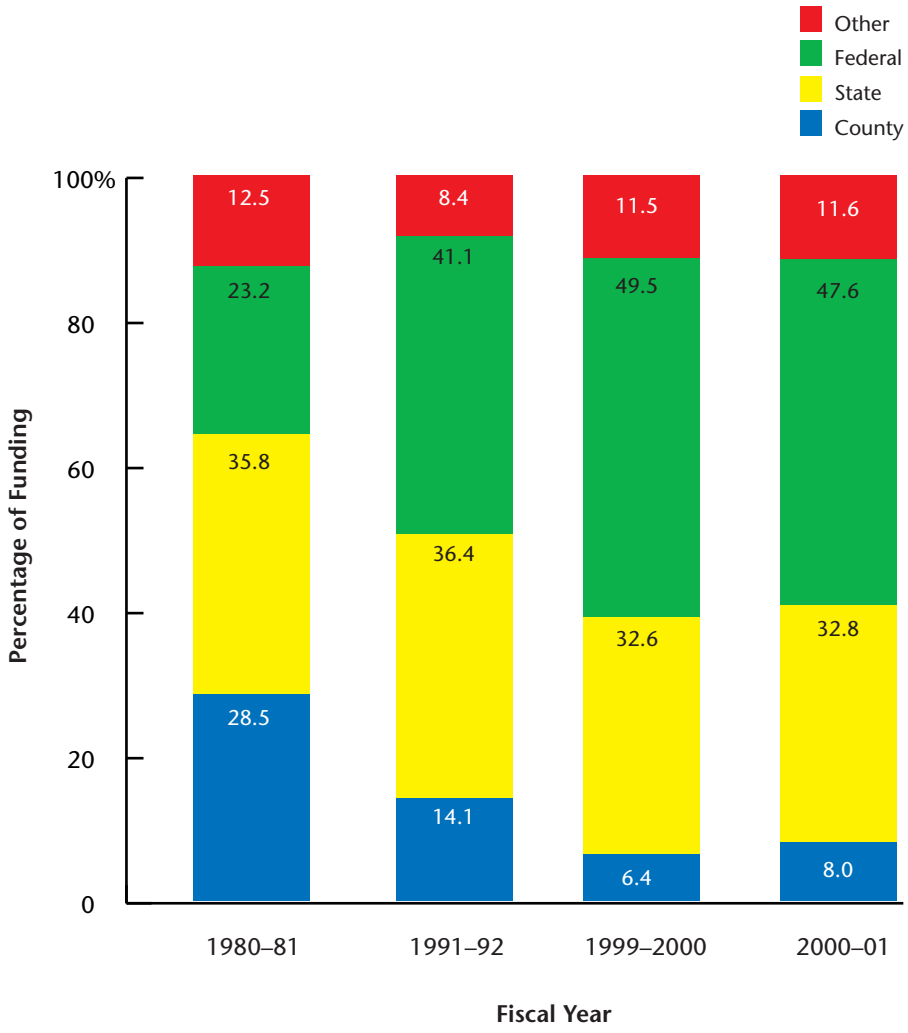
As we discussed in the Introduction, Health Services uses a variety of sources of revenue to pay for its operations.[2] However, over the past 20 years, it has increasingly come to rely upon federal funding. As shown in Figure 1, federal funds have risen from 23.2 percent of Health Services' revenue in fiscal year 1980–81 to more than 47 percent in fiscal year 2000–01. Conversely, the county's contributions have fallen dramatically during the same period, from 28.5 percent in fiscal year 1980–81 to just 8 percent in fiscal year 2000–01. The size of Health Services' overall budget has more than tripled during this time, increasing from $882 million in fiscal year 1980–81 to more than $2.7 billion in fiscal year 2000–01.

[1] Health Services is currently implementing a new strategic plan intended to both increase revenues and decrease costs. However, because it did not provide estimates of the impact of that strategic plan in its forecast, we have not included it in our budget evaluation. We present details and an analysis of the plan in Chapter 3.

[2] Throughout this chapter, our analysis focuses exclusively on the enterprise units. For a discussion of which units we have included specifically, see the Scope and Methodology section in the Introduction.

FIGURE 1

Trends in Health Services' Sources of Funding

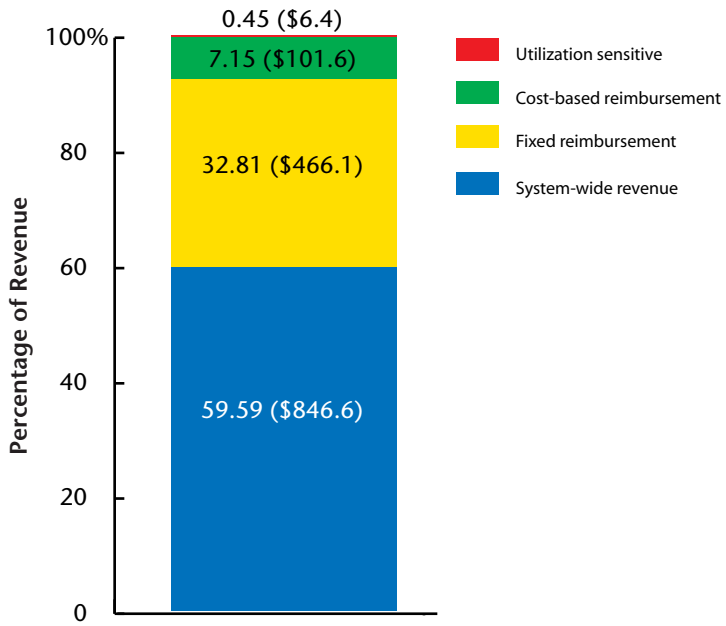


Source: Health Services, *Five-Year Strategic Plan*, October 21, 2000.

As shown in Figure 2, nearly 60 percent of Health Services' operating revenues come from system-wide revenue sources. It particularly relies on the special payments under the Emergency Services and Supplemental Payment Fund (Emergency Services Fund) and Waiver programs. In fiscal year 2001–02, it estimated that these two programs would account for 32 percent of its direct revenues. Payments from the Emergency Services Fund program were an estimated $344 million in fiscal year 2001–02. Waiver funds accounted for more than an estimated $231 million in fiscal year 2001–02, as shown in Table 1. The Waiver, however, will expire at the end of fiscal year 2004–05. Unless additional funding sources are found, the loss of Waiver funds will significantly affect Health Services' ability to provide its current levels of care.

FIGURE 2

Health Services' Sources of Operating Revenues
Fiscal Year 2001–02
(In Millions of Dollars)



Source: Health Services.

TABLE 1

Scorecard Summary for Enterprise Units
Fiscal Years 2001–02 Through 2005–06
(In Millions of Dollars)

	2001–02	2002–03	2003–04	2004–05	2005–06	Totals
Revenue						
Reimbursement	$1,264.57	$1,220.11	$1,230.96	$1,242.23	$1,253.77	$6,211.64
Waiver	231.41	174.92	129.40	83.88	0.00	619.61
Other	282.41	235.17	235.58	236.01	236.43	1,225.60
Totals	**1,778.39**	**1,630.20**	**1,595.94**	**1,562.12**	**1,490.20**	**8,056.85**
Expense	2,339.53	2,504.58	2,576.94	2,662.54	2,753.50	12,837.09
Revenue less expense	(561.14)	(874.38)	(981.00)	(1,100.42)	(1,263.30)	(4,780.24)
Identified operating subsidy	580.79	874.38	648.41	626.18	634.90	3,364.66
Unidentified operating subsidy	**19.65**	**0.00**	**(332.59)**	**(474.24)**	**(628.40)**	**(1,415.58)**

Source: The figures are a compilation of the board adopted budget for fiscal year 2001–02 and adjustments reflected in the scorecard. See Appendix A for details.

Note: Health Services' required subsidy for fiscal year 2001–02 is the portion of expenses not covered by revenues, or $561 million.

Seven percent of Health Services' revenues come from cost-based reimbursements, which it receives primarily for Medi-Cal outpatient visits. The other 33 percent come from the fixed-rate (per diem) fees it is paid for Medi-Cal inpatient visits and Medicare patients.

Health Services has been faced, however, with decreasing reimbursements from base Medi-Cal and DSH. Base Medi-Cal reimbursement rates have been essentially flat for the last 10 years, and DSH funds have been limited as a result of Congress enacting the Omnibus Budget Reconciliation Act of 1993 and the Balanced Budget Act of 1997. Under the Omnibus Budget Reconciliation Act, DSH payments to a single hospital are limited to 175 percent of the unreimbursed costs of providing care to Medi-Cal and indigent patients.[3] Under the Balanced Budget Act, Congress reduced gross Medicaid expenditures by approximately $17 billion through 2002 and capped the funding for the DSH program. As a result, Health Services' DSH revenues have fallen from $387 million in fiscal year 1991–92 to $207 million in fiscal year 2000–01.

[3] Subsequently, California was granted a two-year exemption, raising the rate to 200 percent of unreimbursed costs.

AN INCREASE IN ITS NUMBER OF INDIGENT PATIENTS HAS EXACERBATED HEALTH SERVICES' REVENUE PROBLEMS

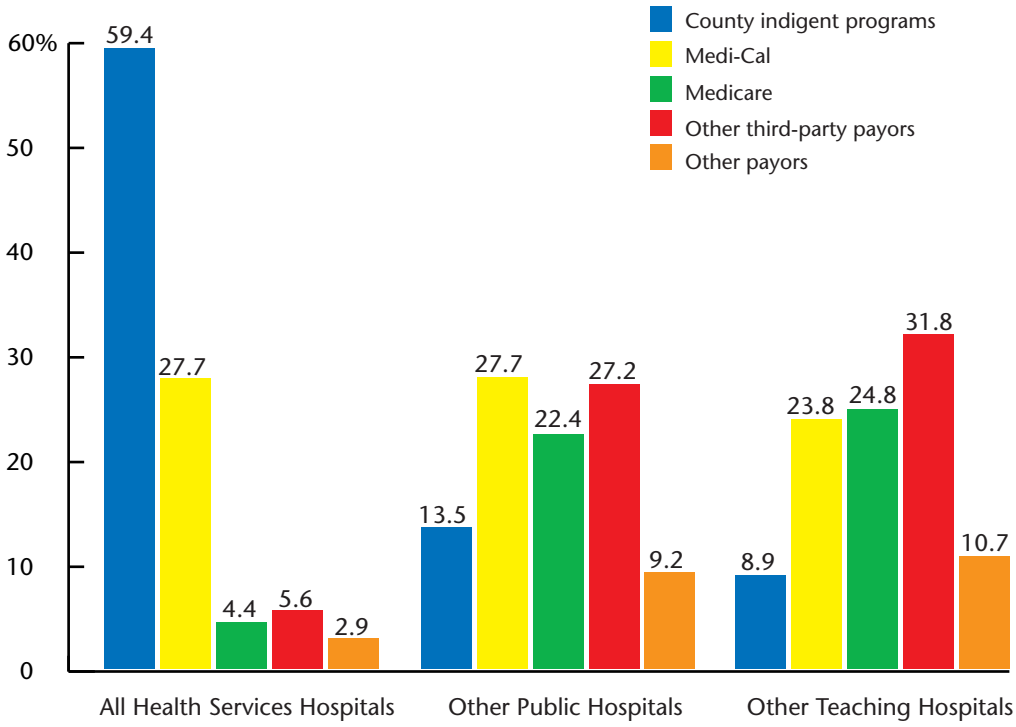
Changes in the types of patients using Health Services' facilities have exacerbated the problem of capped and declining federal funding programs. During fiscal year 1999–2000, more than 85 percent of Health Services' inpatient days and outpatient visits involved county indigent and Medi-Cal patients, as shown in Figures 3 and 4 on the following pages. The proportion of Medi-Cal inpatient days has fallen from 61 percent to 55 percent since 1993, while the proportion of indigent inpatient days has risen from 25 percent to 31 percent. These changes were caused in part by an increase in patients covered under Medi-Cal managed care. Under managed care, Health Services sees more patients in outpatient settings than it does as inpatients. Because DSH funds mainly target Medi-Cal-eligible inpatient stays, revenues from that source have fallen commensurate with the decline in inpatient services. Moreover, as Medi-Cal patients are moved into managed care plans outside of the Health Services network, base Medi-Cal revenues decline.

Two other factors have also contributed to changes in the sorts of patients Health Services treats. First, because the health care market has become increasingly competitive, Medi-Cal patients are more attractive to providers. Hospitals that did not historically compete for these patients now look to Medi-Cal reimbursements to support their own delivery systems. Second, the indigent population in Los Angeles County has grown in recent years.

To illustrate the implications of serving the indigent population, we estimated the impact a more favorable patient mix might have on Health Services' revenues. In fiscal year 1999–2000, Health Services' mix of inpatient days by payor type consisted of 55 percent Medi-Cal, 31 percent county indigent programs, 7 percent Medicare, 5 percent other third-party payors, and 2 percent other payors. Health Services received $208 per day for serving indigents, compared to

FIGURE 3

Types of Outpatient Payor:
A Comparison of Health Services' Hospitals to Other Hospitals
Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

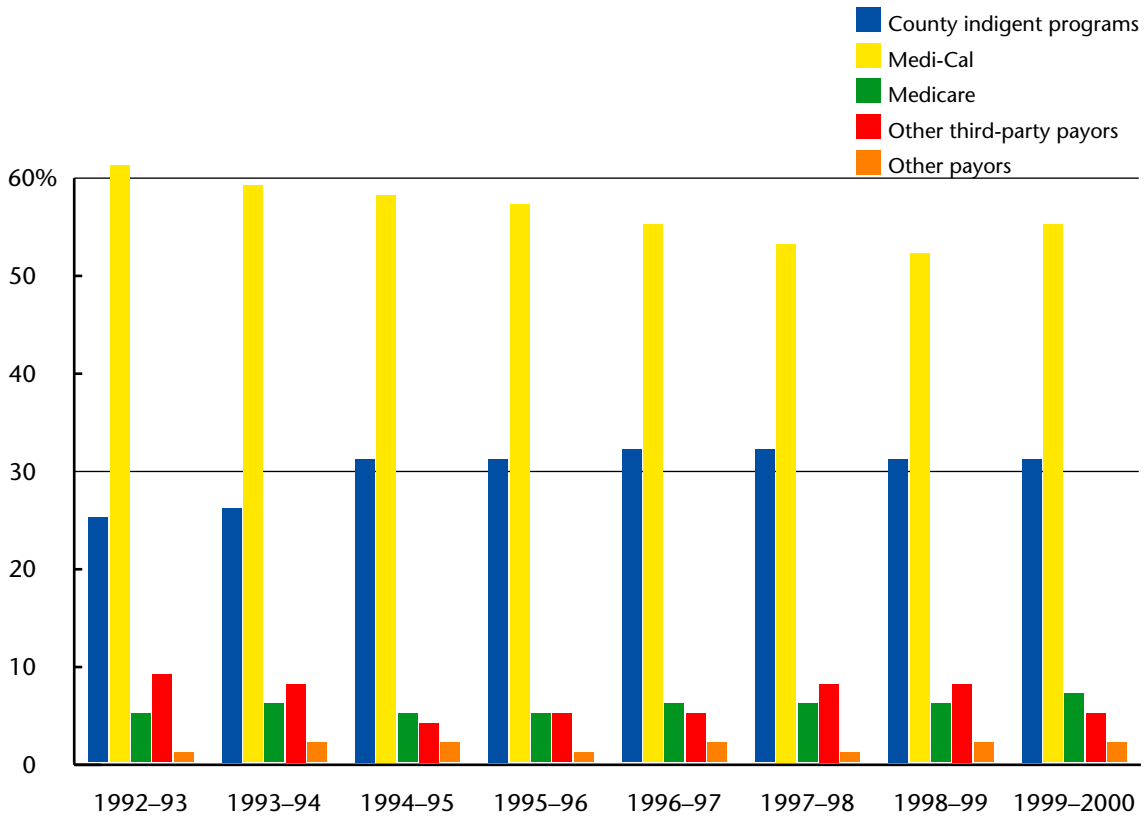
Note: Hospitals that are classified as both teaching and public appear in both teaching hospitals and public hospitals.

$1,548 per day for all other payor categories. Figure 5 on page 21 shows that if Health Services had the same mix of payors as public hospitals, where inpatient days for county indigent programs account for only 8 percent of total inpatient days, its revenues would increase from $984 million to $1.12 billion, a difference of $136 million.[4]

[4] This estimate is only an approximation to illustrate the impact of serving the indigent. Because much of Health Services' revenues are systemwide (for example, funds from the Emergency Services Fund), the actual impact cannot be precisely estimated.

FIGURE 4

Percentage of Inpatient Days by Payor at Health Services' Hospitals
Fiscal Years 1992–93 Through 1999–2000



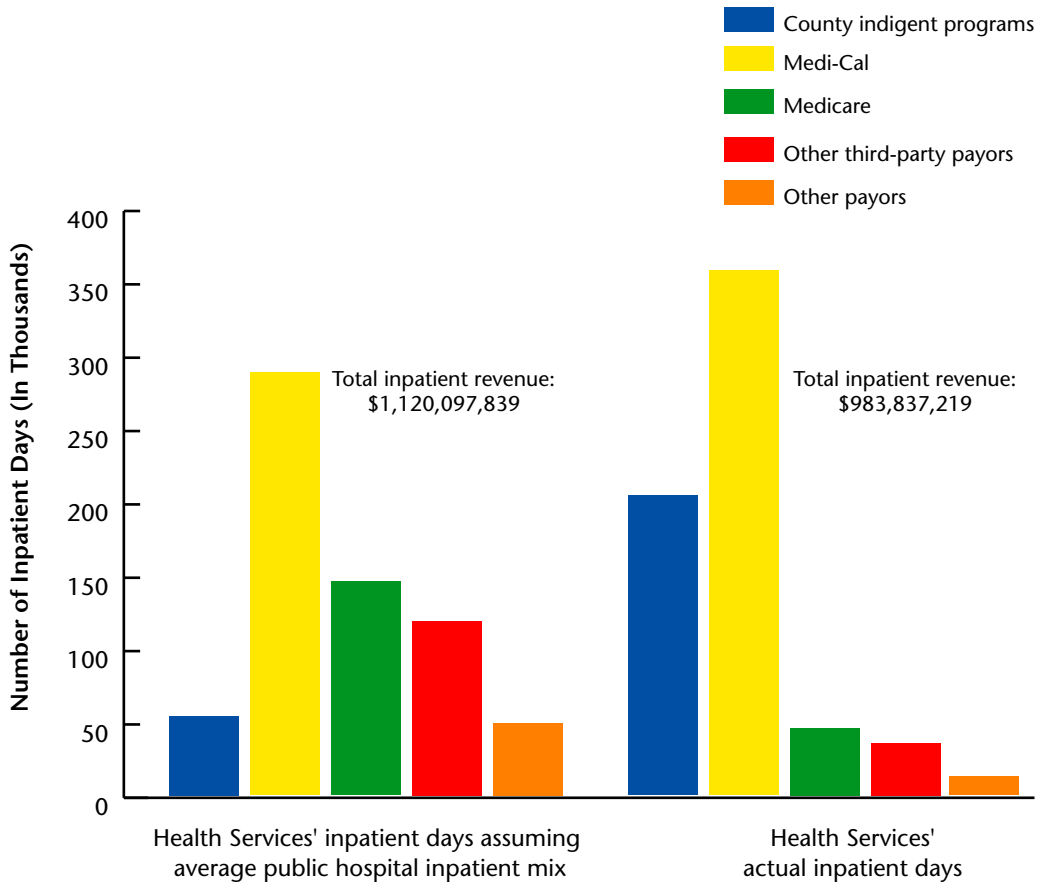
Source: Office of Statewide Health Planning and Development.

A CHANGING PAYOR MIX AND THE CURRENT LEGISLATIVE ENVIRONMENT SUGGEST THAT REVENUE FORECASTS MAY BE OPTIMISTIC

When Health Services estimated its future revenues, it assumed that its service levels—that is, the volume of service it provides—and payor mix would remain constant through fiscal year 2005–06. Figure 6 on page 22 presents actual and forecasted outpatient visits and inpatient days at its facilities from fiscal years 1991–92 through 2004–05. Outpatient visits have increased from nearly 2.1 million per year in fiscal year 1996–97 to approximately 3 million per year in fiscal year 2001–02, while inpatient admissions have declined from 716,000 to 661,000. During the last 4 years, however, patient workload at

FIGURE 5

A Comparison of Health Services' Actual Inpatient Revenue to Its Projected Revenue, Assuming an Average Public Hospital Inpatient Mix Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

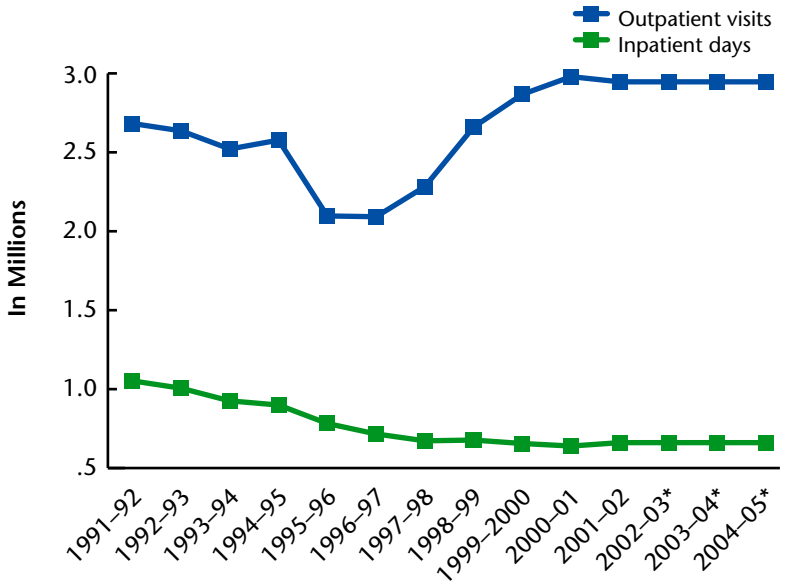
Health Services has fluctuated only slightly, which is consistent with the constant service level it has forecasted.[5] However, as we discussed previously, Health Services has experienced unfavorable changes in the payor mix during the last several

[5] It is difficult to precisely measure the volume of health care services delivered because there is no standardized unit of output. Between fiscal years 1996–97 and 2000–01, Health Services' number of outpatient visits increased by 10.6 percent per year while the number of inpatient days declined by 2.7 percent per year. It has forecasted that the number of both its outpatient and inpatient visits will remain constant from fiscal years 2001–02 through 2004–05.

years. To the extent that the trend toward serving more indigent patients and fewer Medi-Cal patients continues, Health Services' actual revenues are likely to fall short of its forecasted revenues.

FIGURE 6

Health Services' Actual and Projected Outpatient Visits and Inpatient Days Fiscal Years 1991–92 Through 2004–05



Source: Health Services.

* Projected by Health Services.

Health Services' revenue forecast assumes that Medi-Cal reimbursement rates will remain constant, which is reasonable considering the current legislative environment, and that DSH payments will fall slightly, which is consistent with the federal budget limits under the Balanced Budget Act. However, as discussed in the Introduction, under the DSH program, public entities send funds to the State that the federal government then matches. Before these funds are returned to individual public entities, the State charges an administrative fee. The governor's fiscal year 2002–03 budget proposes increasing this fee from $29.8 million to $85 million. This would affect Health Services because a larger fee would translate to a smaller net portion of DSH funding available for hospitals. According

to Health Services, its share of the DSH revenues after federal matching is approximately 20 percent, and so the increased fee would reduce its DSH revenues by an estimated $11 million. If the State continues to increase the DSH administrative fee—and in fiscal year 1996–97, the State charged a fee of more than $200 million—DSH revenues will fall further.

Similar problems may exist with Health Services' estimates of its payments from the Emergency Services Fund. Forecasts of these payments are held constant at fiscal year 2001–02 levels through 2005–06. The federal government, however, has recently established regulations to lower the Medicaid upper payment limit for public hospitals, which would reduce the payments Health Services receives under the Emergency Services Fund. Specifically, the new rule reduces the aggregate Medicaid reimbursements from 150 percent of the Medicare reimbursement levels to 100 percent.[6] Health Services estimates that the changes to the Medicaid upper payment limit will result in a loss of $56 million annually by fiscal year 2005–06 and of more than $125 million annually by fiscal year 2007–08, the end of the period over which the new rule is expected to be phased in. This potential reduction is not included in the forecast. Health Services is working with legislative strategists and public hospital organizations to seek relief from this rule.[7] It estimates that the change in the Medicaid upper payment limit, combined with the increased DSH administrative fee, could cause its revenues to fall by $67 million annually, or approximately 4 percent, of its enterprise revenues for fiscal year 2001–02. This represents an 11 percent increase in its $628 million enterprise deficit for fiscal year 2005–06.

Changes to the Medicaid upper payment limit will result in an estimated loss of $56 million annually by fiscal year 2005–06 and of more than $125 million annually by fiscal year 2007–08.

Finally, Health Services forecasted in its estimate that it would receive complete funding under the Waiver until fiscal year 2005–06, when Waiver funding is phased out. Funding is explicit under the Waiver, and we expect Health Services to meet the Waiver terms (see Appendix C), meaning that it is likely to receive full funding.

[6] See Appendix D for a more detailed definition of the upper payment limit.

[7] On April 20, 2002, an Arkansas federal district judge issued a ruling that delays the reduction in the Medicaid upper payment limit. The ruling, which prohibits the Department of Health and Human Services (HHS) from implementing the final rule before May 14, is a result of a lawsuit filed by the Association of American Medical Colleges, American Hospital Association, National Association of Children's Hospitals and Related Institutions, and National Association of Public Hospitals. The judge ruled that HHS failed to deliver the final upper payment limit rules to the Senate in a timely manner, which did not allow for a 60-day review. The judge was to rule on additional case motions before May 14, 2002.

HEALTH SERVICES MAY HAVE UNDERESTIMATED ITS FUTURE COSTS

Health Services has forecasted that expenses in its three major cost categories—salaries and employee benefits, services and supplies, and other costs—will continue to grow over the next 5 years at approximately the same levels that they have in the past, as shown in Figure 7. During fiscal years 1996–97 to 2000–01, Health Services' total spending grew by $103 million per year, from $1.807 billion to $2.240 billion, representing a compound annual growth rate of 5.5 percent. From fiscal year 2001–02 to 2005–06, it has forecasted that its spending will grow by $102.6 million per year to $2.754 billion, representing a compound annual growth rate of 4.2 percent. However, during the last 3 years, the hospital Consumer Price Index has increased from 3.7 percent annual growth in fiscal year 1998–99 to 6 percent annual growth in fiscal year 2000–01. If this trend continues, Health Services' forecast may prove overly optimistic.[8] Moreover, the cost of responding to regulatory changes related to minimum nurse staffing ratios and the need to accommodate seismic retrofitting may increase Health Services' costs above its forecast.

Health Services Has Forecasted That Its Personnel Costs Will Grow With Inflation but That the Number of Its Employees Will Remain Constant

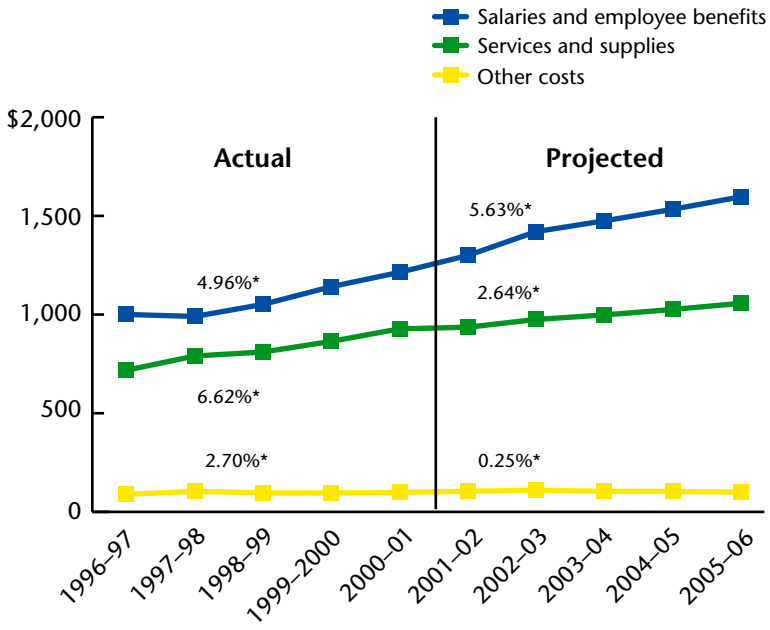
Personnel-related expenditures associated with Health Services' roughly 19,000 full-time equivalent employees (FTEs) constitute the majority of its annual costs,[9] with salaries and employee benefits representing 54 percent of its costs in fiscal year 2000–01. As shown in Table 2 on page 26, actual FTEs declined by 433 between fiscal years 1996–97 and 1997–98 but have risen each year since. Health Services' projections assume that the recent growth in the number of FTEs will stop and that FTEs will remain constant throughout the forecast period.

[8] A further discussion of Health Services' costs and medical cost benchmarks is presented in Chapter 2.

[9] This figure includes enterprise units only.

FIGURE 7

Actual and Projected Growth of Health Services' Three Major Cost Categories Fiscal Years 1996–97 Through 2005–06



Source: Health Services.

Note: Historical compound annual growth rates are from fiscal years 1996–97 through 2000–01; projected compound annual growth rates are from fiscal years 2000–01 through 2005–06.

* Annual rate of growth.

Most of Health Services' employees have contracted salaries and are covered under collective bargaining agreements with various labor unions. Health Services' estimates assume that it will increase salaries by 4.7 percent in fiscal year 2001–02 and by 3.5 percent in 2002–03, based upon an analysis of agreements that have been approved by the County Board of Supervisors. Thus, its short-term forecasts of salary and benefits expenses should be reliable. When its contracts are renegotiated, however, the risk exists that new rates will be greater than forecasted, particularly in light of possible nursing shortages. Beyond fiscal year 2002–03, Health Services has estimated that salaries will increase by 3 percent annually. Figure 8 on page 27 shows the

salary levels and employee benefits costs for fiscal years 1996–97 through 2004–05. Since fiscal year 1996–97, salaries have grown at a slower rate than employee benefits, a relationship that Health Services predicts will continue into the future.

TABLE 2

FTEs by Fiscal Year for Enterprise Units Only

Fiscal Year	FTEs	Change in FTEs
1996–97	18,658	(858)
1997–98	18,225	(433)
1998–99	18,267	42
1999–2000	18,586	319
2000–01	18,935	349
2001–02*	19,589	654
2002–03*	19,589	0
2003–04*	19,589	0
2004–05*	19,589	0
2005–06*	19,589	0

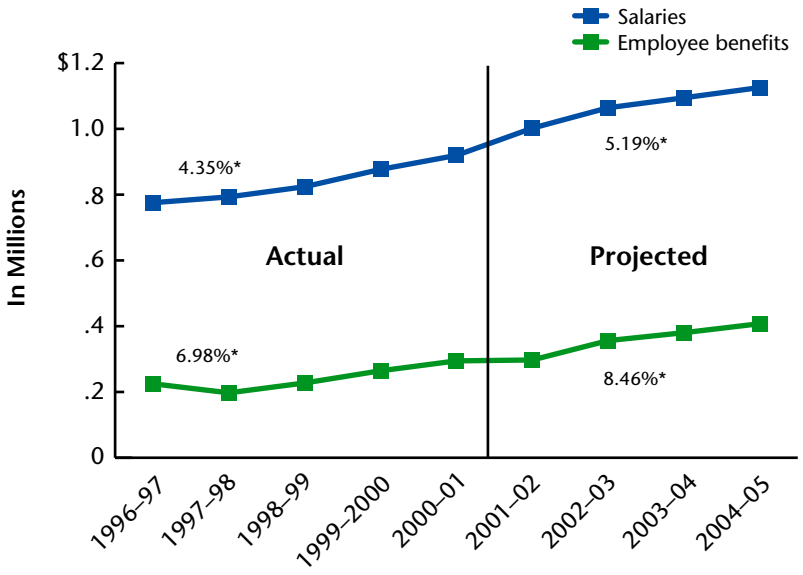
Source: Fiscal years 1996–97 through 2000–01 Health Services Workload Statistics, fiscal years 2001–02 through 2005–06 Board Adopted Budget Fiscal Year 2001–02.

*Figures represent budgeted positions.

For planning and reporting purposes, Health Services divides employee benefits into two categories; fixed benefits and variable benefits. Fixed employee benefits include pension bond cost, workers' compensation, long-term disability, and retiree health insurance. Variable benefits include items that vary with the level of salary expense, such as payroll taxes, health insurance, life insurance, and retirement contributions. In total, employee benefits are forecasted to grow at an annual compound rate somewhat greater than the rate of growth since 1997.

FIGURE 8

Actual and Projected Growth of Health Services' Salaries and Employee Benefits Fiscal Years 1996–97 Through 2004–05



Source: Health Services.

Note 1: Historical compound annual growth rates are from fiscal years 1996–97 through 2000–01; projected compound annual growth rates are from fiscal years 2000–01 through 2004–05.

Note 2: Salaries include other compensation and are net of salary savings.

* Annual rate of growth.

Health Services Has Projected That Its Costs for Services, Supplies, and Other Expenses Will Increase at Historical Rates

Services and supplies, the second largest expense category, represented 41 percent of Health Services' total costs in fiscal year 2000–01. Included in this category are contracts with outside service providers, direct purchases of services and supplies, and costs associated with services provided by other county departments. Most expenses not categorized as salary and employee benefits are included in services and supplies.

Health Services' forecast assumes that pharmaceutical costs will increase by 15 percent in fiscal year 2001–02, but that this growth rate will fall to 11.5 percent in fiscal year 2005–06.

Health Services has projected that expenditures for items within the services and supplies categories will grow at various rates, depending on the type of item. Its price growth assumption is 3.8 percent, which it based on a recent Bureau of Labor Statistics report. However, for pharmacy costs, it has assumed a significantly greater rate of growth. The budget forecast assumes that the total cost of pharmaceuticals will increase by 15 percent in fiscal year 2001–02, but that this rate of growth will fall to 11.5 percent in fiscal year 2005–06. In reaching its estimates regarding drug costs, Health Services considered projected increases in utilization, the rate at which new products are likely to be introduced, and the price increases that are likely to occur for drugs currently in use. The cost assumptions are based upon published research and projections by health system pharmacists and by the Centers for Medicare and Medicaid Services.

The final category, other expenses, accounts for approximately 5 percent of Health Services' costs and includes expenses for debt service charges and medical malpractice expense that the county self-insures. As shown in Figure 7 on page 25, Health Services has estimated that its other expenses will remain virtually unchanged from historical levels.

Regulatory Changes May Increase Costs Beyond the Baseline Forecast

As part of its monthly budgeting and forecasting process, Health Services identifies changes in laws, regulations, or other factors that could potentially affect future revenues and costs. When possible, its Finance Department attempts to estimate the impact of such factors and, as their likelihood of occurring increases, to incorporate them into the baseline forecast reported in the scorecard.[10] We found five factors that we believe are either highly likely to occur or likely to have a significant effect on Health Services if they do occur. These factors are not yet reflected in Health Services' baseline forecast, although they are reported separately.

The first factor concerns mandatory minimum nurse staffing ratios. AB 394, Chapter 945, Statutes of 1999, as amended by AB 1760, Chapter 148, Statutes of 2000, required the State Department of Health Services to establish minimum nurse-to-patient staffing ratios for licensed health facilities.

[10] Appendix C of this report presents a summary of these factors that were identified in our interviews or review of the scorecard.

The proposed ratios are currently under public review and are expected to take effect in July 2003. Health Services' preliminary estimate of its cost to implement these new requirements is $35 million per year.

Health Services' budget forecast does not include costs to implement minimum nurse staffing ratios, which it estimates could cost $35 million annually.

The second factor relates to a possible increase in the rates Health Services pays to public-private partnership/General Relief providers. The County Board of Supervisors (board) approved an 11 percent rate increase to public-private partnership/General Relief providers effective October 31, 2000, which Health Services included in its estimates. However, Health Services plans to propose an additional cost-of-living adjustment of approximately 3 percent for these providers. Until the board adopts this proposal, Health Services will not include the increase in its baseline forecast. If the increase is adopted as proposed, Health Services estimates that it will increase costs by $8.6 million by fiscal year 2005–06.

Third, Health Services has budgeted for the costs of complying with some requirements of the Health Insurance Portability and Accountability Act but has not accounted for other requirements. The baseline budget reflects the cost of the Itemized Data Collection (IDC) effort to standardize the coding for health care procedures across Health Services' facilities. As we discuss in Chapter 2, the IDC initiative for outpatient services involved consolidating multiple revenue activity codes into one master list of procedure codes used in the outpatient setting, addressing some of the requirements of the Health Insurance Portability and Accountability Act. However, there are other requirements of the act for which no provisions have been made. The county has retained a consultant to prepare an assessment of the cost of complying with the act; the preliminary estimate is at least $10 million annually beginning in fiscal year 2002–03.

Fourth, a second piece of legislation, Chapter 740, Statutes of 1994 (SB 1953), requires hospitals throughout the state to meet enhanced seismic safety standards. The baseline budget provides for the costs of planning the retrofitting of the buildings but does not include costs, or lost revenue, associated with accommodating construction activity at the facilities. These costs are associated with moving equipment, closing sections of the hospital, or modifying areas to make them suitable for occupancy during construction. Health Services estimates that these costs will total $40 million in fiscal year 2005–06.

Although Health Services expects to spend $49.8 million for equipment to be used at the new Los Angeles County–University of Southern California Medical Center, its baseline budget includes no provision for these outlays.

Finally, Health Services expects to spend approximately $49.8 million for equipment to be used at the new Los Angeles County–University of Southern California Medical Center that will replace the existing facility when completed. Health Services proposes to establish an accumulated capital outlay fund into which approximately $10 million per year would be placed in each of the next five years to fund the purchase of the equipment. The baseline budget includes no provision for these outlays. In all, this cost, in addition to the other possible increased expenses just discussed, could cause Health Services' forecasted enterprise budget deficit of $628 million in fiscal year 2005–06 to increase by approximately $103.4 million, or 16 percent, to $731 million.

THE SCORECARD IS AN ADEQUATE TOOL TO TRACK THE DEFICIT

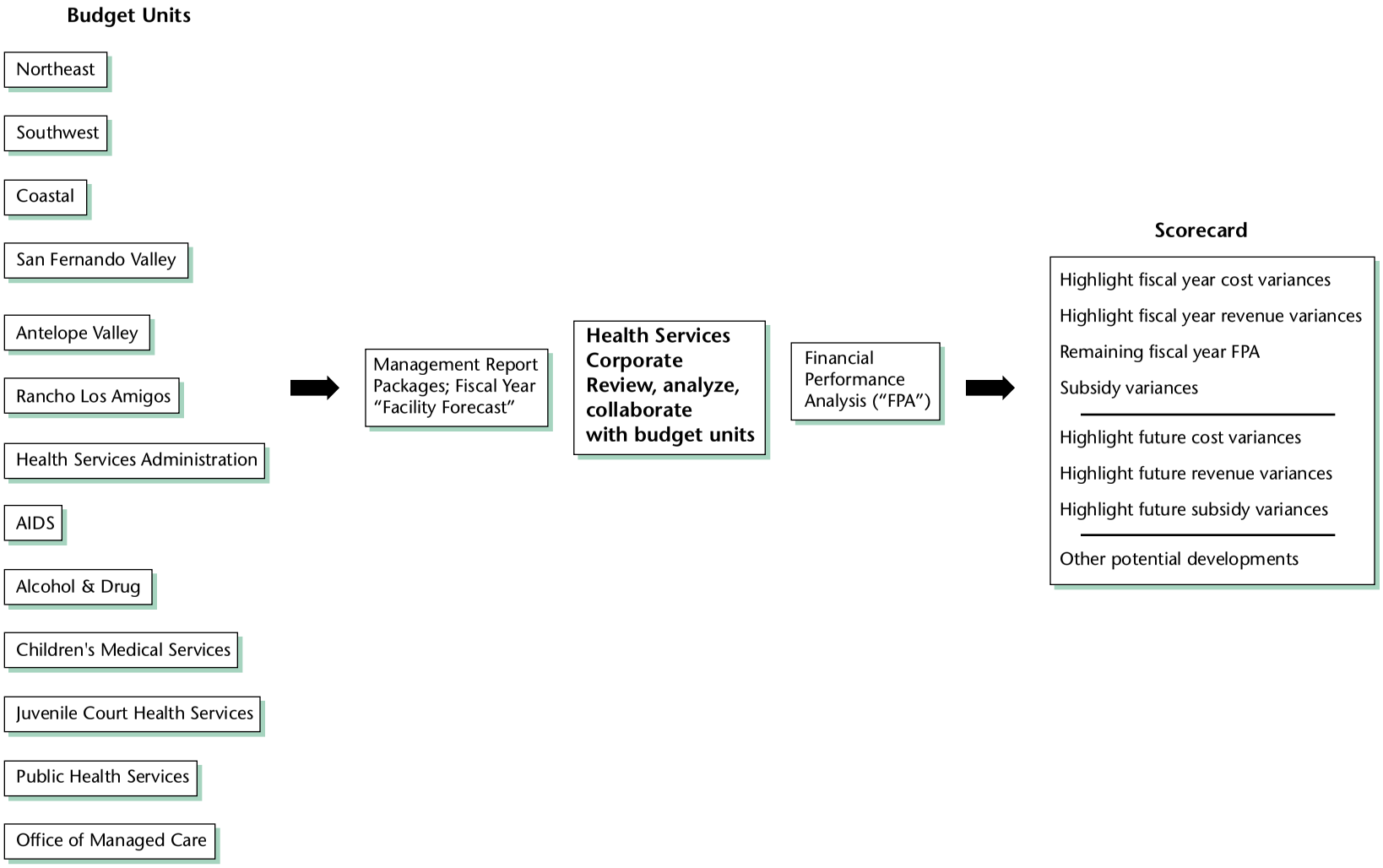
Overall, we found that the scorecard is an adequate tool for tracking the status of the budget deficit but that Health Services' current accounting system lacks the ability to provide the information necessary for making management decisions regarding cost control and resource allocation across departments. To create the scorecard, Health Services follows a fairly comprehensive process. First, it collects financial information from the enterprise hospitals, comprehensive health centers and health centers, and general fund units, which it compiles and forwards to its corporate administrative unit in monthly packages referred to as management reports. Thirteen of these management reports are prepared each month.[11] Health Services reviews, analyzes, and often adjusts budget units' forecasts to arrive at the expected surplus or deficit for each enterprise unit for the fiscal year, which it uses to produce its financial performance analysis.

The financial performance analysis is the foundation of the scorecard, and Health Services uses the two together to track budget surpluses or deficits. The scorecard reflects the net surplus or deficit from the consolidated financial performance analysis, adjustments that are specifically identified in the scorecard (and therefore excluded from the financial performance analysis results), and adjustments to subsidy amounts. A flow chart of Health Services' reporting process is shown in Figure 9.

[11] While hospitals and comprehensive health centers are generally considered separate units, the results of a particular region (for example, southwest, northeast, coastal, San Fernando Valley, and Antelope Valley) are usually consolidated and reported together.

FIGURE 9

Health Services Reporting Flow Chart



This system of data collection, review, and consolidation appears to accurately report the operating results of the 13 budget units. The corporate administrative unit has demonstrated that it can effectively compile and present the actual operating results through the financial performance analysis, and Health Services has shown its ability to effectively incorporate the impact of new information and activity into the scorecard. However, the monthly management reports do not enable Health Services to prospectively manage costs or revenues. The only report that presents the relative costs and revenues for providing specific services at Health Services' various facilities is called Schedule G. However, because of deficiencies in the accounting system and the complexity of the report, this information is compiled only once a year. The result is that the monthly reports include many cost allocations that obscure the actual relationship of costs to revenues—that is, the cost of providing a specific service at a specific facility. Moreover, the usefulness of Schedule G may be compromised by the inconsistency of the data reported by the facilities.[12]

In general, the current cost accounting system is oriented toward evaluating broad, overall cost trends on an annual basis. A better system would be capable of providing information more frequently and with more reliable allocations of shared expenses. Such a system would require consistent (across facilities and departments) and detailed cost information. Currently, Health Services does not have the necessary data, information technology systems, and accounting tools to implement such a system. ■

[12] Inconsistencies in coding among facilities have been addressed, in part, by the IDC initiative.

CHAPTER 2

Although the Los Angeles County Department of Health Services Has Made Efforts to Resolve Its Budget Deficit, It May Not Be Able to Avert a Crisis When the Waiver Extension Ends in Fiscal Year 2004–05

CHAPTER SUMMARY

To address its budget shortfall, the Los Angeles County Department of Health Services (Health Services) has implemented three major cost-reduction and efficiency improvement programs since the mid-1990s. In the reengineering program, which it started in late 1996, it elected to pursue aggressive savings targets that would have reduced its total spending by $294 million annually by fiscal year 1999–2000 and placed its hospitals among the top 25 percent in operating efficiency. Although these initial targets proved unattainable, Health Services reported savings of nearly $211 million in fiscal year 2000–01, $16.6 million more than its revised targets. The Waiver extension required Health Services to implement its second initiative, the austerity program, which set as a goal the reduction of costs by $91 million annually by fiscal year 2004–05. Health Services reports achieving $47.7 million of these reductions by fiscal year 2000–01, compared to its target of $21.2 million. The third initiative, the clinical resource management program, was also required under the terms of the Waiver extension; its purpose was to reduce unnecessary variability in clinical care, thereby lowering costs and improving outcomes. The Waiver extension expects the program to lead to modest cost savings—approximately $6 million by fiscal year 2004–05—but Health Services has not documented any savings from it to date.

In general, we found that Health Services has done a reasonable job of controlling its costs and that it has been innovative in finding new state and federal sources of revenue. It experienced a decline in labor productivity at its hospitals during the early 1990s, both in absolute terms and relative to other public and teaching hospitals in California. Since fiscal year 1994–95, however, it has stabilized its efficiency in absolute terms and

improved somewhat relative to the average for other public hospitals. From fiscal years 1989–90 through 1997–98, inpatient expenses at Health Services' hospitals grew slightly faster than inpatient expenses at other public and teaching hospitals, but in fiscal years 1998–99 and 1999–2000, its costs per patient day and per discharge declined significantly, a decrease that corresponded to its implementation of the reengineering program. During this same time, Health Services was continuing to be very successful with the application of intergovernmental transfers under the Acute Inpatient Disproportionate Share Hospital Program (DSH) and the Emergency Services and Supplemental Payment Fund (Emergency Services Fund). Since their inception, Health Services has received some $5.6 billion through these programs, although new restrictions will limit the programs as sources of funds in the future.

Although in Chapter 1 we discuss the reasonableness of its accounting tools, Health Services has a history of performing better than its budget forecasts, which results in an average surplus of $153.5 million annually. In fiscal year 2000–01, it earned a surplus of $27.2 million, and it also had carried over surpluses from previous years. Because it has consistently earned surpluses, the county administrative officer required Health Services to incorporate a $50 million addition to its revenues in its fiscal year 2001–02 budget as an estimate of the excess revenue it would earn over the previous year's budget, or fiscal year 2000–01.

In spite of its cost containment efforts, Health Services currently forecasts an enterprise budget deficit of $628 million by fiscal year 2005–06.

HEALTH SERVICES' COST CONTAINMENT EFFORTS HAVE HELPED LIMIT GROWTH IN ITS SPENDING, BUT HAVE NOT GONE FAR ENOUGH

Since the financial crisis of the mid-1990s, Health Services has initiated three major programs to reduce its costs and improve the efficiency of its health care delivery system.[1] Based upon the success of a reengineering effort at its Rancho Los Amigos National Rehabilitation Center, it began a system-wide reengineering effort in 1996. Later, as a requirement of the Waiver extension, it initiated a cost-reduction effort known as the austerity

[1] As in Chapter 1, our analysis in this chapter focuses on the enterprise units. For a discussion of which units we have included specifically, see the Scope and Methodology section in the Introduction.

Health Services initiated three major programs to reduce its costs and improve the efficiency of its health care delivery system.

program. A third initiative, the clinical resource management program, was a component of the reengineering effort and has since become a requirement of the Waiver extension. Both the reengineering effort and the austerity program have resulted in significant savings, while Health Services has yet to document any savings from the clinical resource management program.

However, even with these cost containment efforts, Health Services currently forecasts an enterprise budget deficit beginning in fiscal year 2003–04 of nearly $333 million and projects that the shortfall will grow to $628 million by fiscal year 2005–06, when the Wavier extension has ended.

The Reengineering Program Has Saved Health Services Over $210 Million Annually, But Whether These Savings Will Continue Is Unclear

In late 1996 Health Services retained consultants to analyze its hospital operations and determine how and to what extent cost reductions could be achieved. These consultants identified several areas for improvement, and by comparing Health Services' hospitals with a number of benchmark facilities, they established a proposed range of financial savings goals. Health Services elected to pursue the consultant's most aggressive cost savings targets, setting as its goals that it would improve hospital cost performance to the 25th percentile of the benchmark group and save $294 million annually by fiscal year 1999–2000. At the 25th percentile, Health Services would become a better cost performer than 75 percent of the benchmark group. In a grassroots effort, Health Services' employees identified more than 1,200 potential savings ideas. By the beginning of the implementation phase, however, it became evident that the original target would not be achieved. As a result, Health Services adjusted its overall savings target downward to the 50th percentile of the benchmark group, with savings of $194 million annually by fiscal year 2000–01. In May 1997, $194 million represented a 13 percent reduction in overall expenditures for Health Services' five hospitals and health centers.

In October 2001, at the end of the 4-year reengineering project, Health Services had implemented some 481 reengineering ideas for a total savings annually of $210.6 million. These ranged from system-wide initiatives, such as standardizing contracting procedures, to facility specific changes, such a streamlining patient admitting processes. Table 3 on the following page summarizes the savings targets and the actual level of savings

Health Services reports achieving. The county auditor-controller, in his review of the program, found that Health Services' estimates of savings were reasonable but noted that some of the savings were the result of one-time events that may not recur in future years. In our interviews, Health Services' employees expressed similar concerns about the permanence of the savings, stating that some savings had resulted from temporary "belt-tightening" rather than true system reengineering. In addition, some employees felt that savings in one area were at least partially offset by increased spending in another.

TABLE 3

Reengineering Targets and Actual Savings (In Millions of Dollars)

Fiscal Year	Cumulative Savings Target	Cumulative Actual Savings
1997–98	0.0	$ 5.3
1998–99	$ 40.7	54.1
1999–2000	111.6	123.7
2000–01	194.0	210.6

Source: Health Services.

As part of the Waiver extension, Health Services committed to achieving an additional $6 million in reengineering savings by the end of the Wavier extension in fiscal year 2004–05. If these savings are fully achieved, it would bring the total savings from reengineering to $216.6 million. As of the end of fiscal year 2000–01, Health Services reported achieving $4.5 million of the additional $6 million.

Health Services Expects to Save $135 Million Annually Through Its Austerity Program

During negotiations leading up to the Waiver extension, the Centers for Medicare and Medicaid Services (CMS) requested that Health Services reduce its costs by $91 million over the 5-year period of the extension through an austerity program.[2] The terms and conditions of the Waiver extension specify that austerity program savings must consist of non-service-related cost reductions in areas such as purchasing and consulting fees.

[2] At the time of these negotiations, CMS was known as the Health Care Financing Administration.

Table 4 shows information from the October 2001 management report on Health Services' actual and projected savings in comparison to the Waiver targets for fiscal years 2000–01 through 2004–05. Health Services established its projections based on staff assessments for each targeted area.

TABLE 4

Austerity Program Targets and Savings (In Millions of Dollars)

Fiscal Year	Cumulative Savings Target	Cumulative Actual Savings
2000–01	$21.2	$ 47.7
2001–02	32.9	76.8*
2002–03	48.3	92.1*
2003–04	67.5	111.4*
2004–05	90.9	134.8*

Source: Health Services, Medicaid Demonstration Project: Management Report, October 2001.

* Estimated actual savings.

The bulk of the actual savings to date come from reductions in its purchased services and information/telecommunications systems. If Health Services achieves its estimated actual savings, it will save $43.9 million above its target savings for the austerity program. Based on the level of actual savings obtained in fiscal year 2000–01, it appears reasonable that Health Services can achieve its estimated actual savings for the last four years of the austerity program.

Health Services Expects the Clinical Resource Management Program to Have Limited Impact on the Reduction of Its Costs

The goal of Health Services' clinical resource management program is to reduce variability in clinical care and thereby reduce costs and improve outcomes. As implemented at Health Services, the program involves two parallel tracks: inpatient clinical pathways for inpatient procedures and disease management for outpatients. Inpatient clinical pathways are guidelines that help caregivers make sure that the right tests are ordered, drugs given, and therapies initiated at the appropriate times during the course of treatment. These guidelines are embodied in preprinted patient encounter forms that include the required elements of care. Health Services intends the pathways to be used for the treatment of "standard" cases—

perhaps 70 percent to 80 percent of the patients with the indicated condition. Recognizing that a single approach to care is not appropriate for all patients, the program allows caregivers the flexibility to prescribe non-standard treatment if required.

Health Services has implemented six clinical pathways: (1) appendectomy with rupture; (2) appendectomy without rupture; (3) congestive heart failure; (4) pneumonia; (5) vaginal delivery; and (6) C-section delivery. If these first six inpatient pathways are successful, it is considering 29 others for implementation. The use of care protocols and guidelines are a standard practice in hospitals seeking to improve quality and safety as well as to reduce overall costs. Health Services can reasonably expect improvements in its clinical outcomes, although it is too early in the implementation for such data to be available.

Disease management provides similar prestructured, disease-specific care plans for use in outpatient settings. So far, Health Services has implemented only one disease management program, for pediatric asthma. It designed the program to get children to the doctor before they have asthma attacks. Using a network of mobile vans, health care providers work with local schools to reduce the need for emergency department visits and inpatient hospitalizations. In February 2002 the program became the first disease management program to be certified under a disease-specific care certification program offered by the Joint Commission on Accreditation of Healthcare Organizations.

The clinical resource management program will probably result in modest cost savings, although no savings have been documented yet.

Before the approval of the Waiver extension, the clinical resource management program was part of the reengineering project. The clinical resource management program will probably result in modest cost savings, although no savings from it have been documented to date. The Waiver extension calls for the clinical pathways to save $3 million in fiscal year 2003–04 and $6 million during fiscal year 2004–05, with estimates of savings to be calculated based upon reductions in the lengths of stay for pathway patients. (See the discussion of the Waiver extension requirements in Appendix C for details.)

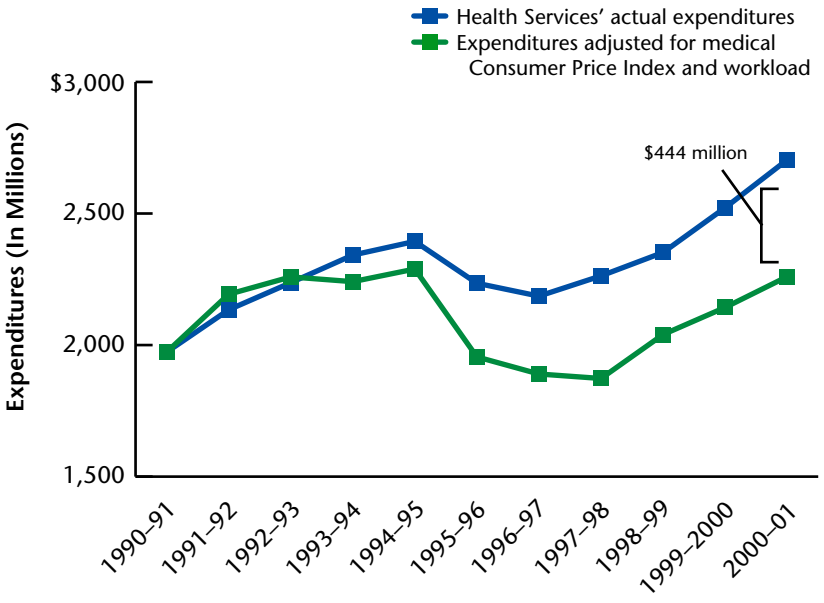
ALTHOUGH HEALTH SERVICES' COSTS GREW IN THE 1990s, IT HAS PERFORMED MORE EFFICIENTLY THAN MOST BENCHMARKS SINCE 1997

In discussing Health Services' success in controlling costs, its current strategic plan states, "While actions taken over the past 10 years to reduce the deficit have been successful in realizing

savings—Fiscal Year 2001–02 expenditures are $410.2 million less than they would have been had Health Service's workload adjusted expenditures increased at the same rate as the medical Consumer Price Index—these efforts have not been sufficient to resolve a deficit." In investigating this assertion, we learned that Health Services actually calculated the $410.2 million by using data for the 22-year period from fiscal years 1980–81 through 2001–02. We calculated Health Services' expenditures for fiscal years 1990–91 through 2000–01 and found that over this period, its expenditures were actually $444 million more than they would have been had expenditures increased at the same rate as the medical Consumer Price Index after workload adjustments. Figure 10 shows Health Services' expenditures compared to the medical Consumer Price Index for this time period.

FIGURE 10

Growth in Health Services' Expenditures Versus a Measure of Medical Cost Inflation Fiscal Years 1990–91 Through 2000–01



Source: Health Services.

This calculation would appear to suggest that the growth in costs at Health Services over the past decade has been excessive. However, we believe that the value and accuracy of this sort of analysis is limited.[3] To achieve a more informative analysis, we compared three productivity measures for Health Services with those of other hospitals in California over the 10-year period: employee days per patient day, inpatient operating expense per patient day, and case-mix-adjusted inpatient operating expense per discharge.[4] In Figures 11 through 13 on the following pages, we compare Health Services' performance over the past 10 years to that of other public and teaching hospitals in the state. These comparisons are at best rough indicators of the relative operating performance of the hospitals. The statistics we analyzed do not take into account many factors that may cause variation in costs across facilities, including differences in wage rates in different markets, the age and configuration of physical facilities, the level of patient services and amenities, and the quality of care provided. (See Appendix B for a full discussion of the benchmarking analysis, including its limitations.)

Health Services' efforts to cut costs appear to have produced measurable savings, particularly in fiscal years 1998–99 and 1999–2000.

Over this period, Health Services' performance followed industry averages fairly closely, with some evidence that in the later half of the decade it improved relative to the benchmarks. This evidence indicates that the efforts by Health Services to cut costs appear to have produced measurable savings, particularly in fiscal years 1998–99 and 1999–2000.

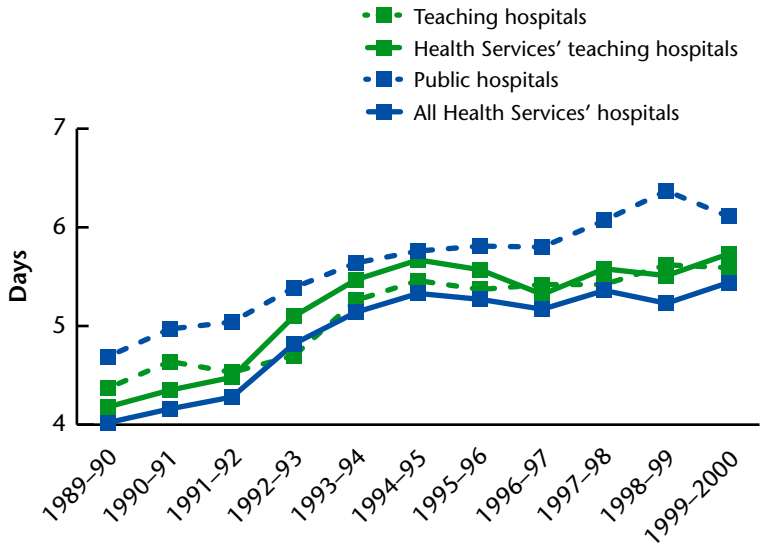
Figure 11 compares the performance of Health Services' two public and four teaching hospitals to benchmark public and teaching hospitals in terms of the number of employee days per patient day, a measure of labor productivity. For this measure, lower values indicate more productive facilities. Since personnel cost is a large share of total cost, this is an important indicator for hospitals. As shown, Health Services experienced declining efficiency during the first half of the decade, both in absolute

[3] This approach has certain technical shortcomings. Specifically, since there is no standard unit of output in health care, the method of adjusting index growth for changes in Health Services' service levels is extremely crude, and since Health Services is a producer rather than a consumer of health care services, a producer-level price index rather than a consumer-level index would be appropriate. Moreover, the basket of goods represented in the consumer index does not reflect the mix of inputs purchased by Health Services, and labor and other market conditions in Los Angeles County are not reflected in the national medical Consumer Price Index.

[4] The source of this data is the California Office of Statewide Health Planning and Development. The benchmark hospitals consist of 28 public hospitals and teaching hospitals. For details on how the benchmark data sets were created, please refer to Appendix B.

FIGURE 11

Average Employee Days per Patient Day: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



Source: Office of Statewide Health Planning and Development.

Note: Employee days are calculated by dividing the reported productive hours for all hospital employees by eight (number of hours in a standard workday).

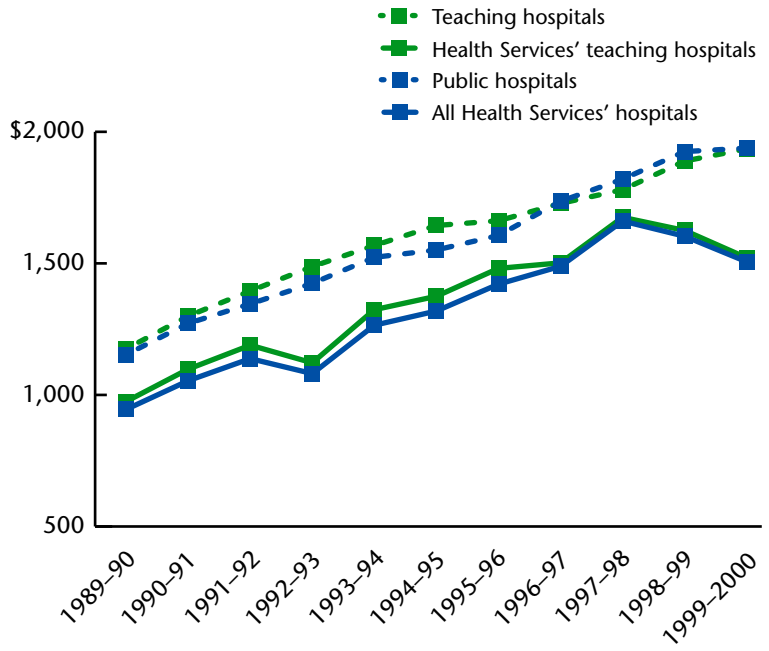
terms and relative to the benchmarks. After fiscal year 1994–95, however, its efficiency stabilized in absolute terms and improved somewhat relative to other public hospitals. The average of all six Health Services' hospitals was consistently below the average for all benchmark public hospitals, while Health Services' teaching hospitals were close to the average for other teaching hospitals in the State.

As shown in Figure 12 on the following page, average inpatient operating expenses per day at Health Services' hospitals grew at a rate consistent with or slightly higher than the average rate for other hospitals from fiscal years 1989–90 through 1997–98, while the actual expenses for Health Services' hospitals were consistently below average.[5] The data indicate that for Health Services' hospitals, inpatient operating expenses per patient day fell by 3.5 percent from fiscal years 1997–98 to 1998–99 and

[5] As we discuss in more detail in Appendix B, the averages for both benchmark groups were affected by a few high-cost hospitals. For this reason, the distance between the curves is less significant than the relative trends in the curves over time.

FIGURE 12

Average Inpatient Operating Expense per Patient Day: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



Source: Office of Statewide Health Planning and Development, except fiscal year 1999–2000. Health Services for fiscal year 1999–2000 data.

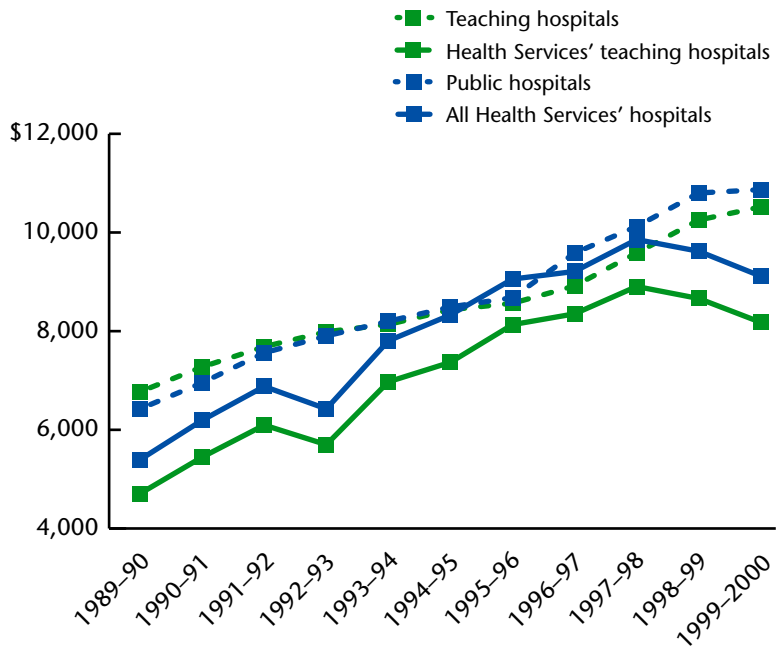
Note: Average inpatient operating expense excludes physician fees.

by 6 percent from fiscal years 1998–99 to 1999–2000. A similar decline is shown for other hospitals in fiscal year 1999–2000, but not in fiscal year 1998–99. The timing of this decline is consistent with the timing of reported cost savings achieved under Health Services' reengineering program.

Figure 13 shows the performance of Health Services' hospitals over time as measured by average inpatient operating expenses per discharge, adjusted for differences in case mix among the hospitals. (See Appendix B for a description of the case mix adjustment.) The figure shows that between fiscal years 1989–90 and 1997–98, the average cost per discharge at Health Services' hospitals grew at rates slightly higher than that of the benchmark hospitals. As with inpatient operating expenses per patient day, the data on inpatient operating expenses per discharge show that costs fell at Health Services' hospitals in the

FIGURE 13

Average Inpatient Operating Expense per Discharge: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



Source: Office of Statewide Health Planning and Development, except fiscal year 1999–2000. Health Services for fiscal year 1999–2000.

Note 1: Average inpatient operating expense excludes physician fees.

last two years, by 2.6 percent from fiscal years 1997–98 to 1998–99 and by 5.3 percent from fiscal years 1998–99 to 1999–2000. Overall, our analysis of all three benchmarks supports Health Services' estimates of improved efficiency at its hospitals as a consequence of its cost-reduction programs.

HEALTH SERVICES' EFFORTS TO FIND NEW SOURCES OF REVENUE HAVE BEEN HIGHLY SUCCESSFUL

The loss in county property tax related to the passage of Proposition 13 in 1978 forced Health Services to find new and creative ways to generate revenues. To address this problem, Health Services has taken advantage of intergovernmental transfers (fund transfers) under DSH and the Emergency Services Fund. As we discussed in the Introduction, these fund transfers work by using funds sent from the county to the State so the

The use of intergovernmental transfers has enabled Health Services to raise an additional $5.6 billion in revenues.

State can obtain federal matching funds, which it passes back to the county along with the county funds originally transferred to the State. Since the fund transfer process enables the State to receive matching funds from the federal government for the county without contributing any of its own funds, the process exploits the participating federal fund match programs that the county cannot participate in but the State can. The use of fund transfers has enabled Health Services to raise an additional $2.9 billion in federal revenue since the inception of the DSH program in fiscal year 1991–92. It has also raised $2.7 billion under the Emergency Services Fund, which began in fiscal year 1989–90.

While Health Services' use of fund transfers has been very successful, in one sense it has become the victim of its own success. CMS could rightfully view the use of fund transfers as an abuse of the Medicaid system, which Congress intended to be a partnership between the federal and state governments. According to the legislated formula, the Federal Medical Assistance Percentage for California as of April 2002 is 51.4 percent. This means that the federal share of Medi-Cal payments should be approximately 50 percent. Yet by means of fund transfers, Health Services has succeeded in raising the federal share to an estimated 75 percent. Federal legislation to reduce the Medicaid upper payment limit may in part be an attempt by the federal government to rein in the aggressive use of fund transfers in many states. This federal legislation will limit Health Services' future ability to derive additional funding from the use of fund transfers.

HEALTH SERVICES HAS OUTPERFORMED ITS FINANCIAL TARGETS OVER THE PAST SEVEN YEARS

Not only did Health Services meet its overall budget expectations in fiscal year 2000–01, it actually outperformed its target and achieved a surplus of over $82 million. It earned a surplus from its current year operations of $27.2 million—consisting of $99.9 million in cost savings, offset by $72.7 million of unachieved revenues—and had a $55.6 million surplus related to excess prior year revenues.[6] Its total current year and

[6] Although Health Services recognizes revenues for services performed each year, the payment for such services can occur in the following fiscal year. When Health Services receives revenues (for services performed in a prior year) in excess of the amount expected, it has a surplus related to the prior year's revenues.

From fiscal year 1994–95 through fiscal year 2000–01, Health Services has averaged budget surpluses of $153.5 million per year.

prior year surplus was therefore $82.8 million, to which it added $31.3 million in surplus sales tax, vehicle license fees, and capital project savings.[7] This result appears to be consistent with Health Services' financial performance in comparison to its budget over the past 7 fiscal years. From fiscal year 1994–95 through fiscal year 2000–01, Health Services has averaged surpluses of $153.5 million per year. It has used its surpluses to contribute an average of $109.3 million to the subsequent year's budget. As of fiscal year 2000–01, the balance in the Designation Fund, which is where all the budget surpluses are accumulated, was $318.2 million.

One way to interpret these consistent surpluses is to conclude that Health Services has significantly outperformed its budget targets over the past 7 years. A more pessimistic view would be that it has been overly conservative in its budget forecasts. In fact, the county administrative officer required Health Services to incorporate a $50 million addition to its revenues in its fiscal year 2001–02 budget as an estimate of excess prior-year revenues. Still, much of Health Services' success in realizing higher prior-year revenues has been due to its ability to properly manage and control its overall budget. For example, over the past 7 years, Health Services has received $270 million more in settlements from Medi-Cal and Medicare than it initially budgeted, which is more than 25 percent of the total surplus. Thus, Health Services' diligence in negotiating for higher reimbursement settlements has helped create these large surpluses. ■

[7] As stated, the focus of this report is the enterprise units. For the same year, the general fund units had a surplus of $7.8 million. In total, its fiscal year 2000–01 budget surplus was $121.9 million.

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CHAPTER 3

Additional Sources of Revenue Are Necessary for the Los Angeles County Department of Health Services to Continue Providing Current Levels of Service

CHAPTER SUMMARY

The Los Angeles County Department of Health Services (Health Services) is currently in the process of developing a strategic and operating plan to address its forecasted budget deficit. As the first stage of this process, it has begun identifying immediate opportunities to reduce costs and enhance revenues in ways that would allow it to maintain the county health system in its current form. At present, however, it has identified only a limited number of stage-one opportunities in sufficient detail to allow their potential fiscal benefits to be estimated. It has projected that, when fully implemented, proposals involving the streamlining of its administration, the consolidation of its clinical services, and the improvement of its clinical resource management are likely to reduce the deficit by approximately $22.5 million annually. It also plans to increase revenue by $60.5 million annually by revising the terms under which it provides services to other county departments. It has not estimated the possible savings associated with other proposals under consideration, such as further increasing administrative efficiency, emphasizing core public health responsibilities, strengthening the Community Health Plan, and reconfiguring clinical care delivery.

However, even if Health Services successfully implements all of its current stage-one proposals, it will not be able to eliminate its deficit. Our analysis of Health Services' hospitals indicates that, with a few exceptions, they perform moderately well in terms of costs and efficiency compared to other public and teaching hospitals in California. This fact, combined with the size of the projected deficit, indicates that improvements in efficiency alone will not solve Health Services' financial crisis. To maintain the current level of service and system of delivery, Health Services must identify additional funding sources. This will involve reforming existing reimbursement programs that

discourage the adoption of lower-cost methods of delivering care. It will also involve increasing overall funding from county, state, and federal financing programs.

In case it cannot address its budget deficit through cost reductions and new funding sources, Health Services is also developing a stage-two proposal that would reduce the size of the system in order to close the budget gap. The options that it is currently discussing represent vastly disparate alternatives, ranging from closing all its health care facilities and contracting for mandated services with private providers, to providing hospital-based trauma, emergency, and acute care services with limited primary and outpatient care. Each of these options would require Health Services to focus its resources on providing care to the mandated population, those the county is legally obligated to serve. Such patients currently represent some 140,000 of the 800,000 patients to whom Health Services provides care each year.[1]

HEALTH SERVICES HAS NOT YET FULLY DEVELOPED ITS PROPOSALS TO ADDRESS THE FORECASTED BUDGET DEFICIT

On January 29, 2002, Health Services presented to the County Board of Supervisors (board) its strategic and operational action plan. Because it had not yet fully developed its proposals, Health Services summarized the strategic and operational planning process in which it was engaged. It outlined two stages to the process. The first involved identifying immediate changes and improvements that it could enact that would reduce its costs and increase its efficiency. These proposals represent an effort to preserve Health Services' health care delivery system in its present form. The second stage involved evaluating alternatives for reducing the size of the system if savings identified in the first stage were not sufficient to close the projected budget deficit and adequate alternative sources of funding could not be found.

On June 18, 2002, Health Services plans to present the County Board of Supervisors its full recommendations for stage-one system improvements and stage-two consolidations and/or reductions.

At the board's direction, Health Services has begun implementing specific stage-one improvements, such as consolidating certain administrative and clinical functions. By June 2002, it plans to present the board its full recommendations both for the stage-one system improvements and for stage-two consolidations

[1] The number of individuals to whom Health Services is obligated to provide services is subject to interpretation of the law.

and/or reductions. It has requested that, following a period of public comment, the board vote on its recommendations by October 2002. However, this date leaves it with little time to implement potentially significant changes before the start of fiscal year 2003–04, when it has estimated that its enterprise deficit will reach nearly $333 million.[2] Health Services has noted that, depending on the nature and scope of the recommended reductions, considerable advanced planning and preparation may be required on its part, as well as on the part of the board and perhaps the county. The board must adopt a balanced budget for fiscal year 2003–04 by July 1, 2003.

INCREASED EFFICIENCY ALONE IS UNLIKELY TO ELIMINATE THE BUDGET DEFICIT

In terms of operating efficiency, Health Services' hospitals, with the exception of Martin Luther King Jr./Drew Medical Center, performed moderately well when compared to other public and teaching hospitals across the State.

One of the premises of Health Services' strategic plan is that efforts to increase efficiency alone will not solve its projected deficit problems. Because of the size of the deficit, Health Services would need to have to significant inefficiencies in its present system in order for cost cutting to result in sufficient savings. To determine whether such inefficiencies exist, we compared Health Services' hospitals as a group to similar facilities, as discussed in Chapter 2. We also used the three benchmarks—employee days per patient day, operating expense per patient day, and operating expense per discharge, adjusted for case mix—to evaluate how Health Services' six hospitals ranked individually compared to their peers in fiscal year 1999–2000, the most recent year for which data are available.[3] As we discuss in more detail in Appendix B, it is important to recognize that these comparisons are at best rough indicators of the relative operating performance of hospitals. The statistics we analyze do not control for many factors that may cause variation in costs across facilities, including differences in wage rates in different markets, the age and configuration of physical facilities, the level of patient services and amenities, and the quality of care provided.

We found that, with the exception of Martin Luther King Jr./Drew Medical Center (MLK/Drew), Health Services' hospitals performed moderately well when compared to other

[2] The lack of a permanent director from March 2001 until February 2002 contributed to Health Services' delay in developing its proposals.

[3] The source of this data is the Office of Statewide Health Planning and Development. The benchmark hospitals consist of 28 public and teaching hospitals.

public and teaching hospitals across the State. This evidence supports Health Services' premise that while there is room for improvement, increased efficiency is not likely to close the deficit completely.

As shown in Figure 14, the six Health Services hospitals range over the middle of the distribution when one compares the number of employee days per patient day, a measure of labor productivity. Lower values indicate more-productive facilities. High Desert Hospital (High Desert) and Rancho Los Amigos National Rehabilitation Center (Rancho Los Amigos) have low ratios because of the mix of services they offer—High Desert has a large proportion of skilled nursing beds and Rancho Los Amigos is a rehabilitation hospital, which requires less interaction between patients and hospital staff than most general acute-care hospitals. At the other extreme, MLK/Drew has a relatively high ratio of staff to patients, indicating lower than normal productivity. The other three Health Services teaching hospitals, Los Angeles County Olive View–University of California Los Angeles Medical Center (Olive View/UCLA), Los Angeles County–University of Southern California Medical Center (LAC/USC), and Los Angeles County Harbor/UCLA Medical Center (Harbor/UCLA), are close to, though slightly above, the median, indicating that staffing at these hospitals is somewhat higher than at most other hospitals in the benchmark group.

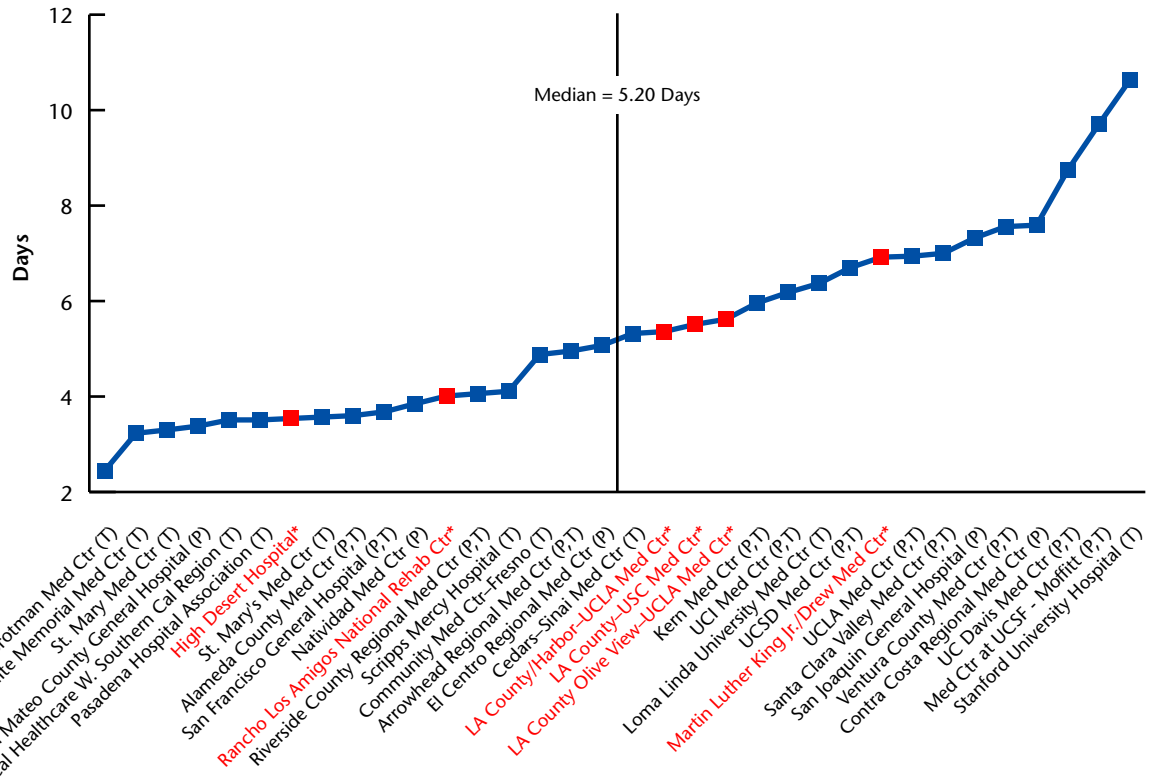
In terms of inpatient operating expense per patient day, Health Services' hospitals demonstrated considerable variation. As shown in Figure 15 on page 52, High Desert had the lowest cost, with an average cost per patient day well within the lowest 20 percent of the hospitals reviewed. MLK/Drew had the highest average cost per patient day, near the highest 25 percent. All other Health Services' hospitals are in the lower 60 percent of the distribution.

Figure 16 on page 53 shows the average inpatient operating expense per discharge.[4] As expected, Rancho Los Amigos and High Desert have among the highest costs per discharge, due, at least in part, to greater average lengths of stay. Again, there is significant cost variation among Health Services' teaching hospitals. MLK/Drew ranks in the highest 25 percent, while the other three teaching hospitals all rank below the median.

[4] To improve comparability, we adjusted these costs to take into account differences in the complexity of cases. We made adjustments for differences in case mix using average costs by Diagnostic Related Group for Medicaid patients in the State of Texas. (See Appendix B for further details.)

FIGURE 14

Employee Days per Patient Day:
A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

Note: Employee days are calculated by dividing the reported productive hours for all hospital employees by eight (number of hours in a standard workday).

T - Classified as a teaching hospital.

P - Classified as a public hospital.

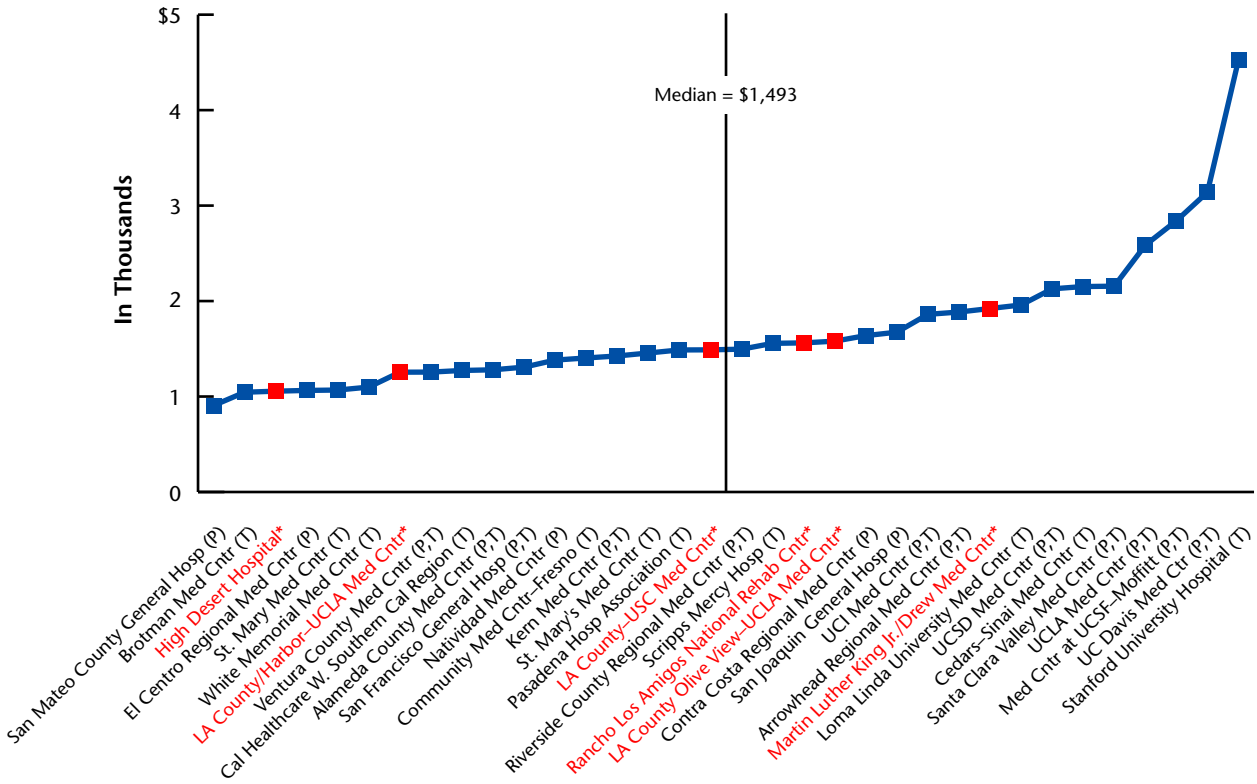
P,T - Included in both benchmark groups.

* Health Services' hospital.

Overall, Harbor/UCLA outperformed the other Health Services teaching hospitals under all three measures, while MLK/Drew was consistently the least efficient. The analysis suggests that staffing level may be a potential source of inefficiency, as all four hospitals fell above the median in the number of employees per patient day. To evaluate whether cost savings alone are likely to close the budget deficit, we estimated the savings that Health Services could achieve if all its teaching hospitals were to reduce their costs to the level at Harbor/UCLA. We have not

FIGURE 15

Inpatient Operating Expense per Patient Day:
A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Health Services.

Note: Total inpatient operating expense excludes physician fees.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

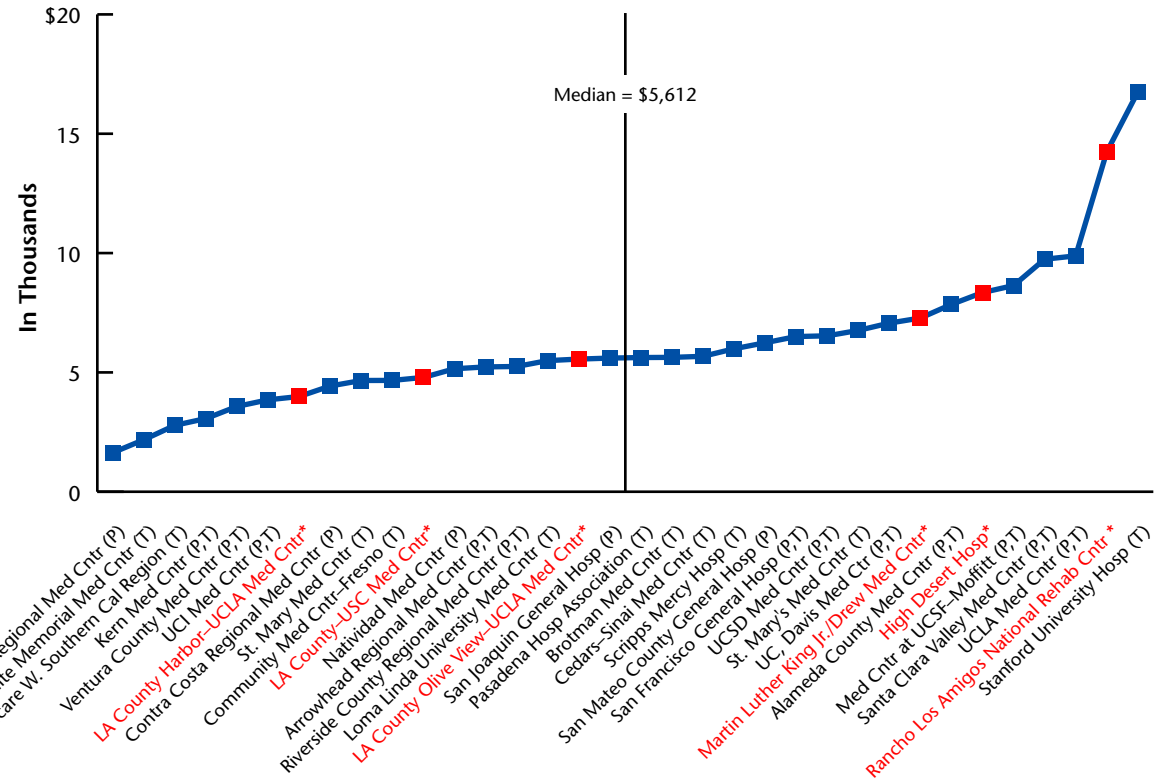
P,T - Included in both benchmark groups.

* Health Services' hospital.

attempted to assess whether cost reductions of this magnitude are reasonable. Nevertheless, multiplying the differences in cost per day between the other three teaching hospitals and Harbor/UCLA by the number of patient days at each teaching facility yields an estimated potential cost reduction of approximately $145 million per year. Although this would be a significant savings, it represents less than 24 percent of the forecasted enterprise deficit in fiscal year 2005–06.

FIGURE 16

**Inpatient Operating Expense per Discharge, Adjusted for Case Mix:
A Comparison of All Hospitals
Fiscal Year 1999–2000**



Source: Health Services.

Note 1: Total inpatient operating expense excludes physician fees.

Note 2: Operating expense per discharge is adjusted using the Texas Case Mix Index provided by Health Services.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

* Health Services' hospital.

THE CURRENT REIMBURSEMENT SYSTEM PROVIDES LIMITED INCENTIVES FOR REDUCING COSTS

Another premise of Health Services' strategic plan is that key aspects of the current reimbursement system provide few incentives, and in some cases offer disincentives, for health care providers to act in ways that could reduce the total cost of serving a given population. For instance, Medi-Cal provides a

fixed reimbursement amount for each day that a Medi-Cal-eligible patient spends in a hospital. Under this system, hospitals that reduce costs by reducing their average length of stay also receive less revenue. As shown in the upper panel of Figure 17, a disproportionate share of treatment costs is typically incurred in the first few days after admission. Since Medi-Cal provides reimbursement on a per diem basis, hospitals lose money in the early days of a patient's stay but recoup those losses in the later days, when its costs are lower. When a hospital reduces the length of a stay, it lowers its total costs but sacrifices the profits it would have earned in the last few days of the stay. Thus, under the per diem system, hospitals may have an incentive to keep patients hospitalized longer, increasing their total cost of providing care to a given population.

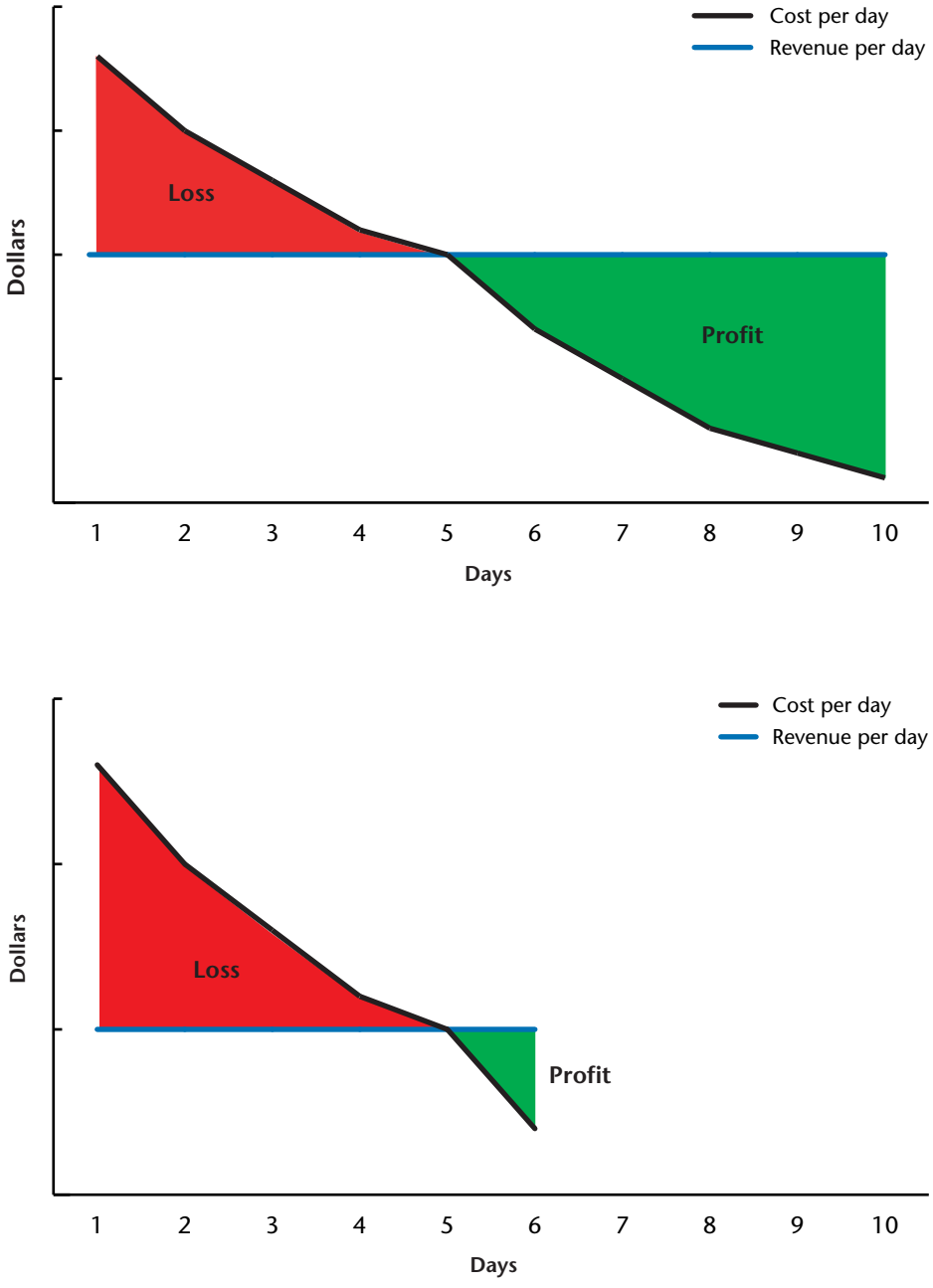
A second example of this sort of disincentive involves the Acute Inpatient Disproportionate Share Hospital Program (DSH). DSH funding, upon which Health Services is highly dependent, increases with the number of inpatient days provided to Medi-Cal patients but is independent of the number of outpatient visits. Advances in medical technology and improved modes of care now allow many conditions that previously required expensive hospital stays to be treated in less expensive outpatient settings. By substituting lower-cost outpatient visits for more costly inpatient stays, Health Services can reduce its total cost of providing care. However, because DSH funding is tied to inpatient stays, the revenue that Health Services receives from this source declines as patient care is moved to outpatient settings.

Using data from fiscal year 1998–99, Figure 18 on page 56 shows that when Health Services' hospitals provided a relatively low number of days of inpatient care, they lost money because the revenues they received were not sufficient to cover the fixed costs of the facility plus the variable costs of patient care. But when they provided more days of inpatient care, their revenues exceeded their cost. The average break-even volume per hospital was approximately 114,000 inpatient days.[5] As inpatient volumes have declined in recent years, as shown in Figure 6 on page 22, Health Services' hospitals have had more difficulty earning revenue sufficient to meet costs.

[5] The break-even volume varied from hospital to hospital, depending, in part, upon the fixed costs at each facility. The average across all six Health Services' hospitals was 114,000 inpatient days.

FIGURE 17

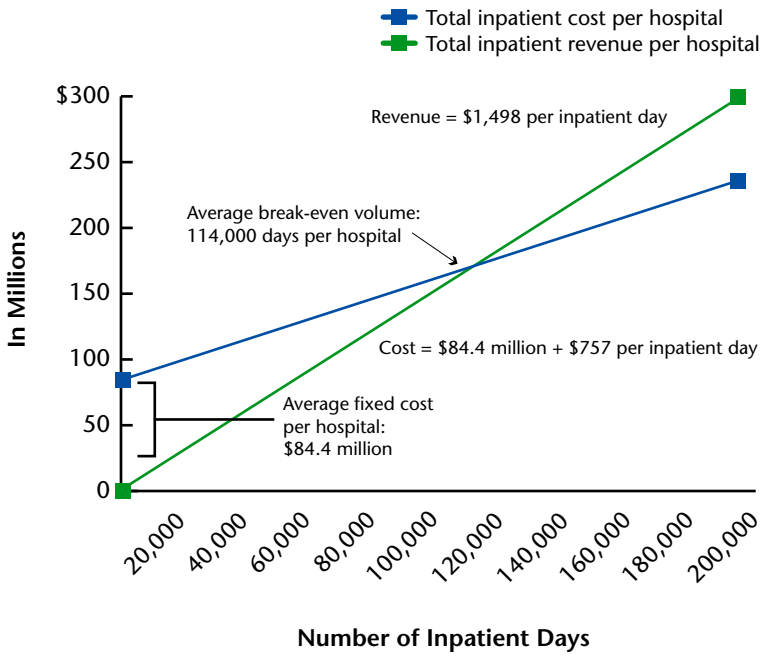
Profit and Loss Under Per Diem Reimbursement System: Effect of Length of Stay on Cost and Revenue



Source: Health Services.

FIGURE 18

Average Inpatient Revenue and Cost per Health Services' Hospital Fiscal Year 1998–99



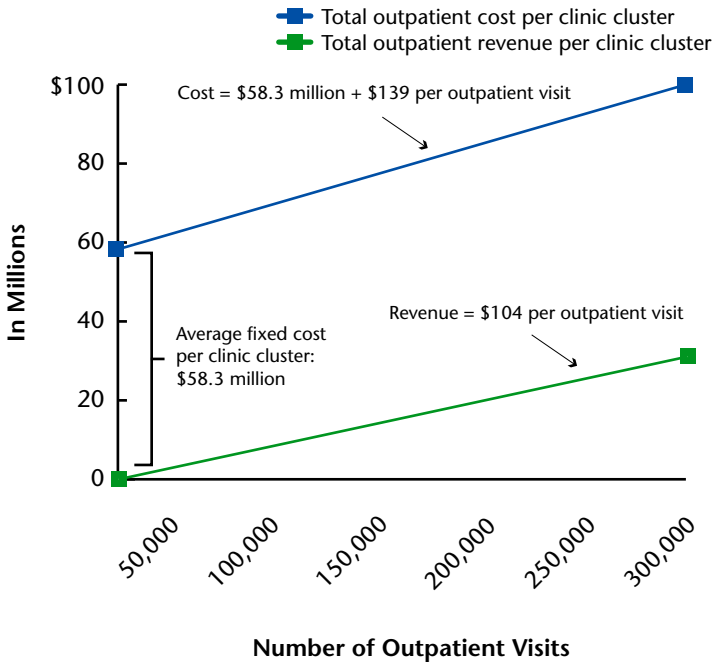
Source: Health Services.

Unlike the situation for inpatient services, increasing the volume of outpatient services widens the gap between revenue and cost. Figure 19 shows the relationship of Health Services' average outpatient revenue and cost per clinic cluster to the number of outpatient visits.[6] Taken together, Figures 18 and 19 indicate that Health Services' efforts in recent years to decrease the volume of inpatient services it offers and increase its volume of outpatient services has reduced its ability to balance revenue and costs, even though moving more treatment to outpatient settings may reduce its total costs. These two examples—per diem reimbursement for inpatient services and Medi-Cal funding tied to inpatient days—demonstrate how the current system of reimbursement can provide perverse incentives to Health Services and other public health systems. Greater flexibility to modify or redesign reimbursement systems could

[6] Health Services has a total of six clinic clusters, comprising hospital outpatient departments, comprehensive health centers, and health clinics. Public-private partnership clinics have not been included in this analysis.

FIGURE 19

Average Outpatient Revenue and Cost per Clinic Cluster
Fiscal Year 1998–99



Source: Health Services.

enhance Health Services' ability to address its budget deficit while reducing its total cost of providing care to the population as a whole.

HEALTH SERVICES' STAGE-ONE PROPOSALS ARE INCOMPLETE AND INSUFFICIENT

We reviewed the 17 reform proposals included in the first stage of the strategic plan and assessed each based on the following criteria:

- Are there projected savings?
- Is there a well-developed plan for implementation?
- Are milestones for completion of tasks clearly identified?
- Are tools in place for tracking progress?
- Is the proposal likely to achieve projected savings?

A summary of our findings is provided in Table 5. To date, Health Services has identified potential cost savings and revenue enhancements totaling $83 million. However, more than $60 million of this amount represents revenue transfers from other county departments—in other words, these funds also come from the county. Health Services has developed only two of the stage-one proposals far enough to have comprehensive plans for their implementation. It has established clearly identified milestones for only three proposals, and it has tools currently in place to track the progress of only two, administrative streamlining and clinical resource management. These findings reflect the fact that Health Services' strategic plan needs further development. Moreover, the proposed cost savings and revenue-enhancing initiatives it presents are not sufficient to significantly reduce its projected deficit—and, as we discussed in Chapter 1, the deficit is likely to be larger than it currently forecasts.

Proposals to Enhance Health Services' Administrative Efficiency Should Provide Long-Term Benefits but Are Likely to Result in Only Modest Savings

Health Services is developing three proposals that it believes will enhance its administrative efficiency.

Health Services is in the process of developing three proposals that it believes will enhance its administrative efficiency. It projects that the first of these, headquarters administrative streamlining, will result in $13 million in savings when fully implemented. The proposal focuses on eliminating duplicate administrative activities and consolidating or centralizing other functions. For instance, it calls for centralizing several public health administration activities, such as public information, planning, finance, facilities management, and human resources, within the Health Services Administration. It also calls for consolidating similar functions that are performed in several departments, such as contracting and external relations, into one office. It will decrease the degree of supervision within the chronic disease prevention, health promotion, and quality assurance programs; reduce the number of area health officers; and eliminate the psycho-social behaviors program.[7]

[7] These are general fund units and not part of Health Services' enterprise units.

TABLE 5

Assessment of the January 29, 2002, Strategic Plan

Proposal	Projected Savings ($ in Millions)	Well-Developed Plan for Implementation	Clearly Identified Milestones	Tools to Track Progress Are in Place	Likely to Achieve Projected Savings
Enhancing Administrative Efficiency					
Health Services-headquarters administrative streamlining	$13.0	Somewhat	Yes	Yes	Yes
Facility administrative streamlining	None Projected	No	No	No	None Projected
Blue Ribbon Health Task Force and county administrative officer recommendations	None Projected	Somewhat	No	No	None Projected
Emphasizing core public health responsibilities	None Projected	Somewhat	No	No	None Projected
Strengthening community health plan	Insignificant	No	No	No	Unknown
Consolidation Proposals					
Consolidation of clinical services-first round	0.5	Yes	Yes	Somewhat	Yes
Consolidation of clinical services-later rounds	None Projected	Somewhat	No	Somewhat	None Projected
Reconfiguring outpatient care	None Projected	Somewhat	Somewhat	Somewhat	None Projected
Resource Allocation					
Aligning resource consumption to service delivery	None Projected	Somewhat	Somewhat	No	None Projected
Service provided to other county departments	60.5	No	Somewhat	Somewhat	Unknown
Partnering with private sector	None Projected	No	No	No	None Projected
Medical school affiliations	None Projected	No	No	No	None Projected
Standardize Treatment and Costs					
Clinical resource management	9.0	Yes	Yes	Yes	Yes
Reducing variability in cost of services	None Projected	No	No	No	None Projected
Revenue Options					
Private sector revenue enhancement	None Projected	No	No	No	None Projected
Federal and state financing	None Projected	No	No	No	None Projected
Assessment to pay for trauma and E/R services	None Projected	No	No	No	None Projected
Grand Total: Savings for All Proposals	**$83.0**				

Source: Health Services.

On March 19, 2002, Health Services presented to the County Board of Supervisors (board) its detailed implementation plans for the first phase of its administrative streamlining, with targeted savings of from $8 million to $10 million annually. It reassigned affected employees on March 28. In April, it proposed the second phase of its consolidations, which it projects will save an additional $5 million per year. It has assigned targets to individual departments and will allow them to work out the details of how to achieve their department's goal. Given the modest size of the goals, the likelihood of success is high. Health Services plans to reinvest approximately $2 million of the savings from these consolidations in its core public health services, leaving $8 million from the first phase to reduce the Health Services deficit. After the second phase, this amount will increase to $13 million.

In a similar proposal, facility administrative streamlining, Health Services is considering consolidating certain of its administrative functions that have historically been decentralized, such as human resources and purchasing. It is also considering the possibility of contracting for security services. At this time, many of the plans involved in this proposal are tentative, with no milestones identified or tools in place to track their progress. Health Services does intend to give facility managers targets and to allow them to make cuts where they see fit in order to reach their targets.

As part of its facility-streamlining proposal, Health Services is also considering a program to implement performance standards for administrative personnel. In the past, it has adopted such measures in its clinical service delivery, and it believes a similar approach could be fruitfully applied to nonclinical positions. Examples of these standards are the number of Medi-Cal or Healthy Family applications completed or the accuracy and timeliness of claims processed. These performance standards may benefit Health Services in the long term but will not have sufficient immediate impact to solve the short-term budget crisis.

Health Services' final administrative enhancement proposal relates to recommendations from the Blue Ribbon Health Task Force and the county administrative officer. On September 15, 2000, the Blue Ribbon Health Task Force presented its recommendations to the county board. The board had established the task force to address issues related to Health Services' reengineering activities begun in fiscal year 1997–98,

but the task force's recommendations were more wide-ranging and covered an array of topics, such as governance, management authority, clinical resource management, centralized purchasing, information systems, and worker retraining/cross-training. Because many of the recommendations represent ongoing efforts to improve the operational efficiency of Health Services, they have been incorporated into the strategic plan.

Several reforms proposed by the county administrative officer are likely to benefit Health Services in the long term, but they will not alleviate the short-term budget crisis.

The county administrative officer has proposed several reforms in administrative oversight and flexibility to improve the governance of Health Services. The strategic plan focuses on four areas: (1) delegating authority to Health Services to enter into certain contracts without board approval; (2) delegating authority on employee classifications and hiring; (3) increasing the flexibility of Health Services' programs to adjust budgets; and (4) increasing flexibility in capital projects. These reforms are likely to benefit Health Services in the long term, but they will not address the short-term budget crisis.

Health Services Plans to Emphasize Core Public Health Responsibilities and to Direct Its Efforts Toward Programs With High Returns on Investment

As we discussed previously, the focus of this report is Health Services' enterprise units. However, we feel that it is important to mention the proposals outlined in the strategic plan that involve one general fund unit: public health. Federal funding has not kept pace with growing public health needs in a number of core areas, including disease surveillance, control of sexually transmitted diseases, and toxics epidemiology, although additional funds for bioterrorism preparedness, in the wake of September 11, may help. As part of the strategic plan, Health Services plans to redefine its core public health responsibilities and redirect efforts toward those programs with the highest return on investment.

At least two issues related to public health affect the enterprise units. First, in fiscal year 2001–02, Health Services' public health programs face a $121 million shortfall that Health Services will fund through the same sources it will use to fund its overall deficit: sales taxes, vehicle licensing fees, tobacco settlement funds, and county general funds. When more is required for public health, less is available to maintain the health care safety net.

Second, the strategic plan calls for clinical public health services to be integrated with personal care. Currently, there are 12 independently operated public health centers, which provide services such as immunizations and tests for tuberculosis and sexually transmitted diseases. The strategic plan calls for the clinical public health services to be integrated into primary care centers. These primary care centers are enterprise units. Health Services has not yet estimated the projected savings associated with this proposal, but it will not help reduce the enterprise deficit.

The Strategic Plan Calls for Strengthening the Community Health Plan but Does Not Define This Goal in Specific Terms

The Community Health Plan is a health maintenance organization owned and operated by the county. It provides health insurance to approximately 150,000 Medi-Cal and Healthy Families program participants. For fiscal year 2001–02, the Community Health Plan projects a surplus of $13 million. This means that the per-member, per-month (capitation) payments the health plan receives from Medi-Cal and Healthy Families will exceed its administrative costs and the capitation payments it makes to providers. On the surface, this potential surplus might be interpreted as an indication of the success of the program. However, the total financial impact of the Community Health Plan on Health Services is unknown and could be negative.

Because of the capitation payments the Community Health Plan must make to providers, the financial risk of offering this health insurance coverage has largely been shifted to Health Services' providers such as its clinics and its partners in the public-private partnership program. Health Services does not have an adequate cost accounting system or managed care infrastructure to track the resources utilized by Community Health Plan patients. It treats the Community Health Plan capitation payments as a general revenue source and processes information concerning Community Health Plan patients in the same manner as it does information about all other patients, without determining whether the capitation amounts are adequate to cover the costs of services provided. To assess the profitability of providing care to Community Health Plan enrollees—and thus to determine whether the program is producing a surplus—Health Services relies on historical average cost data for various services.[8]

[8] Health Services currently relies on average cost data for fiscal year 1999–2000. These averages are now almost two years out of date.

Although the Community Health Plan is financially structured like commercial managed care plans, Health Services does not have the infrastructure commonly used in other organizations to manage both the care and the financial risk created by the capitation agreement.

Without better information on the cost of providing care to enrollees, it is not possible to determine the net financial impact of expanding the Community Health Plan.

The strategic plan calls for strengthening the Community Health Plan. It does not specify whether this means that Health Services should seek a long-term expansion or a contraction of the plan. But according to the strategic plan, the Community Health Plan will expand in at least the short term. Beginning in April 2002, In-Home Supportive Services workers (in-home workers) become eligible to join the plan. In-home workers provide care to the homebound. Based on current totals, they represent 10,000 to 20,000 potential enrollees. Moreover, the governor has proposed expanding the State's Healthy Families program to include parents of children covered under the plan. (See the discussion in Appendix C.) Health Services expects this to result in approximately 10,000 additional covered participants. It anticipates that increases in the number of covered participants will have a small positive impact on reducing the deficit. However, without better information on the cost of providing care to enrollees, it is not possible to determine what the net financial impact will be.

Health Services Faces Certain Challenges in Moving Forward With Its Plans for Consolidation

One of Health Services' primary focuses in its strategic plan is the reconfiguration of its clinical health care delivery. Its proposals regarding clinical care delivery can be divided into three main categories: those that involve the consolidation of services, those that involve the allocation of resources, and those that involve the standardization of practices. The strategic plan contains three proposals that focus on the first of these, the consolidation of services. As part of one proposal, which it refers to as the first round of consolidation of clinical services, Health Services has begun to assess its ability to consolidate clinical service delivery into fewer locations. It believes that consolidation will allow it to take advantage of economies of scale and to perform procedures in minimum-cost settings. It is also considering creating "centers of excellence" for highly specialized services, such as open-heart surgery or joint replacements, where high-volume experience has been shown to produce improved outcomes.

Health Services believes that consolidating services will allow it to take advantage of economies of scale and to perform procedures in minimum-cost settings.

Health Services' first round of consolidations will focus on the following services: inpatient rehabilitation, chronic ventilator/pulmonary services, and pediatric orthopedic surgery. It plans to begin consolidating these services in May and June 2002. Although these candidates for consolidation are the least controversial, Health Services expects this first round to have little economic impact. It plans to consolidate inpatient rehabilitation at Rancho Los Amigos, a national center of excellence for rehabilitative care, and to close its acute inpatient rehabilitation service at High Desert, which it believes will result in an annual savings of $500,000. It also plans to offer chronic ventilator/pulmonary services and pediatric orthopedic surgery only at Rancho Los Amigos. Although it currently provides these services at all of its hospitals, the consolidation will require it to shift only the small number of patients located at other facilities to Rancho Los Amigos. Consequently, it will see little cost savings. If these three consolidations do not succeed, the more challenging consolidations are not likely to be successful. However, interviews with Health Services staff suggest that the first round will be accomplished without significant problems.

For its second round of consolidations, Health Services is considering consolidating adult cardiac surgery, angioplasty/electrophysiology study, cleft palate, transplant surgery, radiation oncology, and pediatric cardiac surgery. All of these services were targeted for consolidation in order to reap the benefits that various authorities have concluded can be achieved by performing a large number of individual procedures at one facility. These conclusions are based on the premise that surgical outcomes improve due to the learning that occurs from performing a higher volume of procedures. As a result, authorities have developed guidelines for different surgical procedures. For example, the guidelines of the Leapfrog Group for Patient Safety recommend that a hospital offering open-heart surgery perform a minimum of 400 to 500 such procedures per year. Health Services is considering consolidating another 10 or 12 types of procedures in single facilities so that it can meet the Leapfrog Group's guidelines at the same time as cutting costs.

Health Services faces two key challenges in moving forward with its second round of clinical services consolidations. The first involves its relationships with the three medical schools. If it consolidates its specialized services, Health Services may leave some medical schools without representation in specialties that they consider important to their medical education programs. It will have to deal with the competing aims of the

three universities and their medical staff. The second challenge involves information technology. Without a cost accounting system, the clinical consolidation team has to create its own financial model to estimate the costs of providing various services. Using this ad hoc system, Health Services hopes to identify additional candidates for consolidation.

Health Services is considering closing four primary care health centers: Northeast, Compton, Paramount, and Burbank.

As a result of a third proposal, which focuses on reconfiguring outpatient care, Health Services is considering closing four primary care health centers: Northeast, Compton, Paramount, and Burbank. It chose these facilities based on its assessment of community need, health center performance, and opportunities for consolidation. It could not provide estimates of cost savings from these closures. Over the long term, it has proposed renegotiating the terms of the Waiver extension to substitute a required minimum number of patients served in place of the current required number of outpatient visits. This could allow Health Services to benefit from disease management programs that reduce the frequency of clinic visits by those with chronic health conditions. To make such a change, it would have to renegotiate the terms and conditions of the Waiver with the State, the DSH, and the Centers for Medicare and Medicaid Services. It has not yet begun these negotiations.

As an additional part of its proposal to reconfigure outpatient care, the strategic plan also calls for reforming its public-private partnership program. Health Services issued a request for proposals to assist it in selecting public-private partnership clinics that would be viable long-term partners. These "strategic partners" will be expected to have Federally Qualified Health Center status[9] and several sources of revenue in addition to the county's public-private partnership/General Relief programs; they also must participate in programs to reduce the cost of buying pharmaceuticals. Health Services intends to gradually phase out any public-private partnerships that do not meet these qualifications.

[9] See the section "Applying for Federally Qualified Health Center Status" on page 116 for more on this requirement.

By More Carefully Controlling the Allocation of Its Resources, Health Services Could Cut Costs and Enhance Its Revenues

Over the past decade, several Health Services' programs, particularly obstetrics and neonatal intensive care, have experienced declining caseloads.

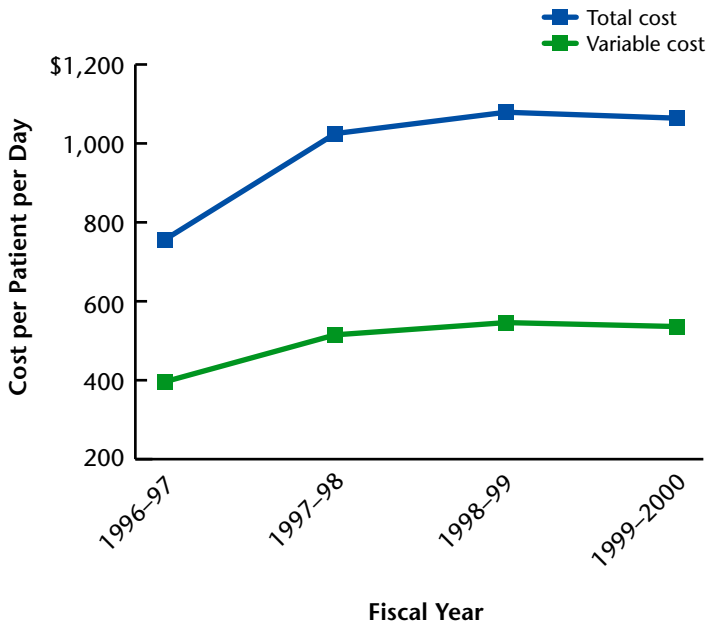
Broadly defined, "allocation of resources" refers not just to an entity's distribution of its funds, but also to its decisions regarding the uses of its resources. Under this definition, four of the proposals outlined in Health Services' strategic plan may be seen as concerning its allocation of resources. The first of these proposals, aligning resource consumption to service delivery, involves the need to adjust resources, such as staffing levels, in departments whose caseloads have declined. Over the past decade, several programs within Health Services, particularly obstetrics and neonatal intensive care, have experienced declines in caseloads. From fiscal years 1992–93 to 1998–99, the number of obstetrics inpatient days fell by 70 percent, from 93,469 to 27,775. Significant declines also have been experienced in neonatal intensive care. Many women who are covered by Medi-Cal have elected to deliver their babies in hospitals that are not affiliated with Health Services. In fact, Health Services reports that private hospitals send recruiters to its prenatal clinics to sign up expectant mothers.

The effect of this decline can be seen in Figure 20, which shows Health Services' increasing costs between fiscal years 1996–97 and 1999–2000 for inpatient obstetric services. Had obstetric staffing fully adjusted to the changing volume of care, the variable-cost line would have been flat. Instead, variable costs rose by 35 percent (in nominal dollars), from $396 per patient day to $536. This rise in costs mirrors the 29 percent decline in the number of patients over the period. Health Services' failure to adjust its staffing is in part a result of the fact that its hospitals do not have automated staffing and productivity systems, commonly found in other hospitals, which facilitate the reduction of direct cost on a routine basis. Health Services' staffing appears to be largely fixed rather than based on volume of service, so it is more difficult for the hospitals to reduce staff when opportunities arise. Health Services plans to gather data on resource allocation during the remainder of fiscal year 2001–02 and consolidate or reallocate resources in fiscal year 2002–03. It does not provide an estimate of its cost savings in its strategic plan.

In a different sort of allocation issue, Health Services currently provides services to other county departments, sometimes at a loss, in effect contributing its limited resources to those departments. Specifically, it provides emergency and acute inpatient services to psychiatric patients under a memorandum of understanding with the Department of Mental Health at an

FIGURE 20

Health Services' Cost for Providing Obstetric Services



Source: Health Services.

estimated annual loss of $31.7 million in fiscal year 2000–01. Similarly, it provides services to patients from county jails and juvenile hall under an understanding with Jail Health Services at an estimated loss of $28.8 million in fiscal year 2000–01. If these estimates are accurate, Health Services' memorandums of understanding with these two county departments alone account for $60.5 million of its deficit in fiscal year 2000–01.

In its strategic plan, Health Services proposes adjusting these memorandums of understanding so that it receives adequate compensation for services to other county departments. To the county as a whole, this would not be a new source of revenue; nevertheless, it would provide for a more accurate measurement of Health Services' deficit.

A final sort of resource allocation addressed by the strategic plan involves Health Services' partnerships and affiliations. Health Services has long-standing relationships with three medical schools—UCLA, USC, and Charles R. Drew University of Medicine and Science. These are complex relationships in which Health Services receives the services of residents, interns,

and medical school faculty, and the medical schools gain access to venues for training students. Health Services believes that the academic relationships have brought distinction to its four teaching hospitals and improved the quality of care, research, and innovation that occurs at these facilities. However, if Health Services is forced to reconfigure its delivery system, it recognizes that its interests and those of the medical schools may no longer coincide. Any significant restructuring of Health Services will undoubtedly affect the medical schools and add complexity to any transition.[10]

Any significant restructuring of Health Services will affect its relationships with three medical schools and add complexity to any transition.

At the same time, another strategic plan proposal calls for Health Services to continue to explore potential partnerships with the private sector. Health Services is currently considering ways in which it could enlist the private sector to help support the health care safety net. It reports discussions with Antelope Valley Hospital about possible joint ventures in providing urgent care, which could relieve overcrowding in the emergency room at Antelope Valley Hospital and help defer the cost of continuing urgent care at High Desert. It has not yet identified targets for outsourcing (apart from security services mentioned earlier), but earlier restructuring plans suggested potential outsourcing of such services as emergency room, clinical laboratory, information technology, and pharmacy. It is not clear why Health Services deemphasized outsourcing in its current plan. It has rejected emergency medical services as an outsourcing candidate because of both operational and fiscal difficulties, but the other candidates are presumably still available for consideration.

Health Services' Efforts to Standardize Its Treatments and Reduce Variability in Its Costs Could Result in Significant Long-Term Benefits

In addition to other approaches to reconfiguring clinical care, Health Services' strategic plan focuses on standardizing treatments as well as standardizing costs. One of its proposals concerns clinical resource management, which involves two methods of standardizing the care provided to patients: inpatient clinical pathways, aimed at the treatment of specific conditions, and disease management programs, aimed at the treatment of specific diseases. By reducing the variability in the type of care its facilities offer, the pharmaceuticals they use, and

[10] It should be pointed out that significant lead times are required for any changes in the contracts with the various affiliates. The result is that any restructuring involving the medical schools requires a lengthy period of time for negotiation, planning, and transition.

Clinical resource management is intended to standardize the care provided to patients.

the tests they conduct, Health Services expects to cut costs per patient and increase the quality of the care it provides. For more details on clinical resource management, see Chapter 2.

According to Health Services, LAC/USC implemented its congestive heart failure, vaginal delivery, and C-section pathways by July 1, 2001, as required under the Waiver extension. Early, tentative results at LAC/USC suggest that 30-day readmission rates for congestive heart failure patients have been cut in half. More data will show whether this improvement persists over time and can be replicated at other facilities. All indications we have seen support the idea that the program should be successful. However, because Health Services must work with the medical schools with which it is affiliated to develop and deploy pathways, it may face challenges in meeting their educational needs while moving forward in its goal.

A further challenge for the pathways program involves aligning reimbursement methods so that reductions in lengths of stay do not adversely affect Health Services' revenue. As we discussed earlier, Medi-Cal reimbursement rates are based on the number of inpatient days. The department is currently negotiating with the California Medical Assistance Commission to obtain per-discharge rates for patients admitted under the pathway diagnoses. That way, Health Services stands to benefit if the clinical resource management program is successful in lowering costs. The strategic plan does not provide estimates of cost savings associated with the program, but the requirements of the Waiver extension call for it to result in savings of $9 million. (A complete discussion of the Waiver requirements appears in Appendix C.) In Table 5 on page 59, we used the $9 million target as an estimate of the projected savings.

Disease management provides similar prestructured, disease-specific care plans in an outpatient setting. Only one disease management program has been implemented so far, pediatric asthma. Health Services indicates that this program has reduced variability in patient care and improved clinical outcomes. As we mentioned in Chapter 2, the pediatric asthma program was the first disease management program to earn a disease-specific care certification from the Joint Commission on Accreditation of Healthcare Organizations. As of May 2002, Health Services has been unable to document any direct savings associated with this program.

The challenges Health Services faces in standardizing its costs are even greater than those it faces in standardizing its care.

The challenges Health Services faces in standardizing its costs are even greater than those it faces in standardizing its care. Although it believes that costs for the same procedures vary significantly among its facilities, Health Services cannot directly measure costs at a single facility with its current systems, much less make cost comparisons across facilities for specific procedures. Its Itemized Data Collection (IDC) project, implemented in July 2001 for outpatient facilities only, represents a first step toward identifying the variation in costs across facilities. The IDC project is an effort to standardize coding for health care procedures across Health Services' outpatient facilities. Prior to this project, different facilities used different codes for the same procedures, making it impossible to compare costs.

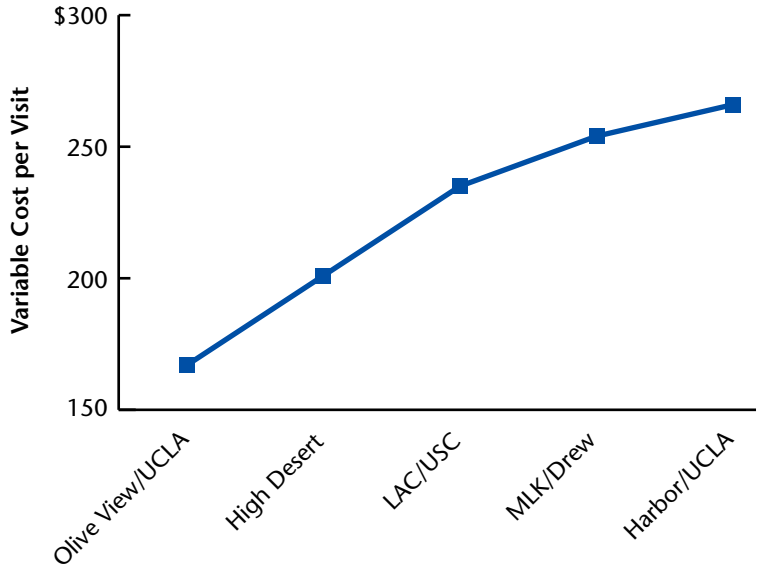
Implementation of IDC should allow Health Services to compare certain cost items—such as labor hours—across facilities for the same procedures, enabling it to identify best practices and attempt to reduce variability in cost. While significant cost savings may be possible as a result, Health Services did not provide an estimate of these savings in the strategic plan because of the current lack of data. Moreover, significant obstacles to reducing variability in the costs of service remain. IDC is not a cost accounting system; rather, it is means of standardizing procedure codes. Further, Health Services has only begun to implement IDC for its outpatient facilities.

Although Health Services does not collect data to allow a detailed, service-by-service assessment of cost, we examined aggregate data for one category of service—obstetrical/gynecological visits—to gauge the degree of cost variability. We selected obstetrical/gynecological services because they are largely made up of routine office visits and are likely to be fairly homogeneous, compared to other possible categories. Figure 21 shows that even for this fairly homogeneous category of outpatient services, costs varied significantly, from $266 per visit at Harbor/UCLA to $167 at Olive View/UCLA.[11] Although these comparisons are crude, a 59 percent difference between facilities indicates that efforts to identify best practices and eliminate cost variability could lead to significant savings. Efforts to reduce variability in costs are likely to benefit Health Services in the long term but will probably not have a material effect on the budget deficit in the short term.

[11] Data were for each hospital network, including outpatient visits at the hospitals and the clinics in their administrative areas.

FIGURE 21

Cost per Obstetrical/Gynecological Outpatient Visit for Health Services' Hospitals Fiscal Year 1999–2000



Source: Health Services.

Health Services' Proposals to Enhance Its Revenues May or May Not Succeed

Three of the proposals in the strategic plan address ways to enhance revenue. One recommends that Health Services reevaluate and possibly renegotiate its agreements with private sector insurance plans. Health Services can increase its system revenues by increasing the volume of patients covered by Medicare and private insurance, including managed care. To this end, over the past few years, Health Services has entered into provider agreements with a number of private managed care plans. Health Services asserts that many of these insurance plans are paying a low basic rate but are sending their most expensive patients to Health Services for treatment because of its ability to treat people who are very sick or very seriously injured. However, Health Services' lack of adequate cost accounting data makes it difficult to assess this claim.

As part of the strategic plan, Health Services will make an effort to reevaluate the benefits of these agreements. One alternative would be to negotiate with private health plans to provide

services to those with chronic conditions. Overall, Health Services appears to have paid little attention to private revenue enhancements in this iteration of the strategic planning process, and it did not provide any estimates of additional revenues from this source.

To minimize reductions in service levels, Health Services proposes to seek legislative and regulatory reforms of state and federal funding sources.

A second proposal involves federal and state financing reforms. To minimize reductions in the level of services that will be required to balance the budget, Health Services proposes to seek a number of legislative and regulatory reforms of state and federal funding sources. These efforts are aimed largely at increasing flexibility in existing programs. The strategic plan identifies the following targets:

- Develop a proposal to increase flexibility in Medi-Cal reimbursement so that Health Services can adopt improved methods of care without adversely affecting its financial condition.
- Reform the DSH program to eliminate the incentives to treat patients in inpatient rather than outpatient settings.
- Revise the requirements of the Waiver to provide Health Services with greater flexibility to adopt new methods of care.
- Seek legislative relief from the recent revisions to the Medi-Cal upper payment limit.
- For selected inpatient services associated with the clinical resource management initiative, negotiate a pilot per-discharge Medi-Cal reimbursement rate in place of the current per diem rate.
- Seek funds available for terrorism preparedness and responsiveness.

As it acknowledges in its strategic plan, Health Services will need to implement a substantial and well-coordinated advocacy effort to achieve these goals.

The third proposal involves charging local taxpayers an assessment to pay for trauma and emergency services. Health Services' estimates indicate that trauma and emergency services are major contributors to the budget deficit, accounting for $166 million in hospital costs while generating only $31 million in revenue. The resulting $135 million loss represents 29 percent of the total operating deficit for the enterprise units in fiscal year 2001–02. If maintaining a stable trauma and emergency system is important to local taxpayers, a special assessment to support these services would seem to be a logical revenue option. While the Board of

Trauma and emergency services contribute an estimated $135 million to the total operating deficit for Health Services' enterprise units in fiscal year 2001–02.

Supervisors has the authority to establish a special assessment district, a new property tax to support Health Services' trauma and emergency care would require approval by a two-thirds majority of voters. Health Services has not analyzed its prospects for receiving this approval.

HEALTH SERVICES IS CONSIDERING A VARIETY OF OPTIONS FOR DRASTICALLY REDUCING THE SIZE OF ITS HEALTH CARE SYSTEM

In the second stage of its strategic plan, Health Services outlined four vastly different options for reducing the size and capacity of its health care system should stage-one reforms prove unsuccessful in eliminating the projected deficit. It has not yet decided which, if any, of these options it will ultimately propose. In deciding, it will have to define the population that it will serve and the services that it will provide. In one form or another, all of the proposals it is considering call for shrinking the size of the county's health care safety net, which currently provides care not just to those individuals it is mandated to serve, but also to many of Los Angeles County's other low-income and uninsured residents.

Of the 800,000 Patients to Whom It Provides Care Each Year, Health Services Is Legally Obligated to Serve Only 140,000

As part of the strategic planning process, Health Services evaluated its core mission and statutory obligations and mandates. It has defined its legal mandate generally as follows: "To assure public health services for all persons in the county and to assure access to emergency and acute care for the General Relief (Section 17000 of the Welfare and Institutions Code) and medically indigent populations." According to Health Services, its responsibilities under the public health mandate consist of providing basic public health services such as communicable disease control, environmental health and sanitation, and maternal and child health services to all county residents. Under the second half of the mandate, it is responsible for ensuring access to emergency and acute care for approximately 626,000 to 729,000 county residents—those who are medically indigent or who qualify for General Relief. Of this latter group, Health Services annually serves an estimated 140,000 residents through its hospitals, county-run outpatient facilities, and public-private partnership clinics. However, as shown in Table 6 on the following page, Health Services also chooses to serve an

additional 660,000 other county residents, approximately 430,000 of whom are uninsured. In developing its proposal to reduce the size and scope of its health system, Health Services must determine how far beyond its legal mandate it can afford to go in providing access to health care services for residents of the county.

TABLE 6

Los Angeles County Population and Number of Users Served by Health Services (In Thousands)

	Los Angeles County Residents			Health Services' Users
Total County Population		9,764		
Mandated Population				
General Relief	43	to	70	30
Uninsured, ages 18-64, 100% to 200% of federal poverty level	583	to	659	110
Subtotals	626		729	140
Those Health Services Elects to Serve				
Uninsured, ages 18-64, <100% of federal poverty level	565	to	640	230
Uninsured, ages <18 and >64, <200% of federal poverty level	513	to	587	80
Uninsured, all ages, > 200% of federal poverty level	712	to	826	120
Medi-Cal	1,560	to	1,719	150
Medicare	627	to	716	20
Other third-party insurance	4,891	to	5,115	60
Subtotals	8,868		9,603	660
Total				**800**

Source: Health Services', *Strategic and Operation Action Plan,* January 29, 2002.

Health Services Is Considering Four Vastly Different Approaches to Reducing the Size of Its Health Care System

In its strategic plan, Health Services presents four very different possible approaches to drastically reducing the size of its health care system. Each of these represents an extreme form of a particular model, and Health Services acknowledges that the final proposed plan will likely consist of a hybrid of these alternatives. All of the plans call for reducing the population to which Health Services provides care.

Under one proposal, Health Services would close all of its facilities and purchase health care services for the mandated population.

Under the strategic plan, the first option Health Services proposes is closing all of its facilities. To meet its responsibilities, Health Services would either purchase health insurance coverage or purchase health care services from private providers for the mandated population. This model is similar to the ones adopted in San Diego and Orange counties, and the experience of those counties indicates that this approach can be successful in containing health care expenditures. An important question with this option is whether sufficient excess capacity exists in the private sector to absorb the patient volume. In key geographic areas, such as those served by LAC/USC and MLK/Drew, the increased demand for services might overwhelm the private sector. Moreover, the survival of the county trauma network would be threatened, as Health Services' facilities currently provide one-half of all trauma care in the county.

The second option outlined in the strategic plan involves limiting the emergency room "front door." This option would limit Health Services' inpatient admissions by reducing or closing the emergency rooms at its hospitals. Instead, Health Services would provide limited outpatient care to the mandated population only. Most primary care as well as emergency care for the mandated population would be purchased from the private sector. Since Health Services and other providers are obligated by federal law to treat all patients who seek treatment at their emergency rooms, closing its emergency rooms would enable it to control its inpatient population and better manage the costs of providing inpatient services.[12] To offset the loss of emergency services, Health Services would increase the availability of urgent and walk-in care at its comprehensive health centers. This option would allow Health Services to remain a hospital system and to exercise greater control over costs. However, it is likely to threaten the viability of the county trauma network and swamp the emergency facilities of the private sector, particularly in the current environment in which many private hospitals are also closing their emergency room doors.

Health Services' third proposed option is to limit the scope of its services. Under this option, it would prioritize the services it offers by cost-effectiveness and likelihood of benefit to patients. Specifically, it would continue to provide acute care, treat chronic illnesses, and operate trauma centers at some or all of its hospitals, but it would significantly limit its primary care

[12] The Emergency Medical Treatment and Active Labor Act governs when and how a patient may be (a) refused treatment or (b) transferred from one hospital to another when he is in an unstable medical condition (1986).

facilities and services. It would select the services that it would provide through current research and the consensus of expert panels of physicians. This option could raise ethical challenges as well as organizational ones. Although Health Services has never provided extremely costly and heroic measures, such as heart and liver transplants, limiting its scope of services further might mean that it would not offer procedures commonly provided by private hospitals. Moreover, the elimination of county and public-private partnership clinics could lead to increased inappropriate use of Health Services' emergency rooms for primary care.

Under the strategic plan's fourth option, Health Services would continue to provide trauma, emergency services, urgent care, and acute hospital care, but would limit its primary and outpatient care to the mandated population. It would relegate primary care to the private sector and would provide only limited outpatient specialty care. It would close all of its clinics and keep only its trauma care hospitals open. This option offers certain advantages: Health Services could focus on its core competencies while retaining the flexibility to restore primary and outpatient services should funding become available in the future. However, it represents a complete reversal in the direction Health Services has taken under both Waiver agreements, which has been to increase access to outpatient care for indigent patients.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: May 30, 2002

Staff: Ann K. Campbell, CFE, Audit Principal
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APPENDIX A

Los Angeles County Department of Health Services' Budget and Scorecard

The Los Angeles County Department of Health Services (Health Services) relies upon its scorecard to track its budget deficit, as discussed in the Introduction. Table A.1 shows detailed scorecard adjustments for the enterprise fund units for fiscal years 2001–02 through 2005–06. Table A.2 contains the enterprise fund unit portion of the budget adopted by the County Board of Supervisors for fiscal year 2001–02. Explanations of many of the budget terms can be found in the glossary in Appendix D.

TABLE A.1

Los Angeles County Department of Health Services' Scorecard Detail for Enterprise Units* Only (In Millions of Dollars)

	Fiscal Year 2000–01	Fiscal Year 2001–02			Fiscal Year 2002–03		Fiscal Year 2003–04		Fiscal Year 2004–05		Fiscal Year 2005–06		
	Actual Results	Board Adopted Budget	Scorecard Adjustments	Totals	Scorecard Adjustments	Totals	Scorecard Adjustments	Totals	Scorecard Adjustments	Totals	Scorecard Adjustments	Totals	Total Scorecard Adjustments
Reimbursement Revenue													
Medi-Cal (Regular)	$289.94	$296.33	$7.04	$303.38	($4.83)	$298.54	0.00	$298.54	0.00	$298.54	0.00	$298.54	$2.21
Cost-based Reimbursement Medi-Cal	80.77	134.67	(13.93)	120.74	2.80	123.54	$1.44	124.97	$1.37	126.34	$1.17	127.51	(7.16)
Medi-Cal Pharmacy	2.94	$0.00	(17.97)	(17.97)	0.00	(17.97)	0.00	(17.97)	0.00	(17.97)	0.00	(17.97)	(17.97)
Community Health Plan	111.93	127.37	0.00	127.37	1.72	129.09	1.96	131.04	2.10	133.14	2.32	135.46	8.10
SB 855: DSH Program	206.76	204.30	1.06	205.36	(27.93)	177.43	5.58	183.02	5.78	188.79	5.98	194.77	(9.54)
SB 1255: Emergency Services Program	344.00	344.00	0.00	344.00	0.00	344.00	0.00	344.00	0.00	344.00	0.00	344.00	0.00
SB 1732: Construction Debt Service Funding	6.44	10.14	0.00	10.14	0.00	10.13	0.00	10.13	0.00	10.13	0.00	10.13	0.00
Medicare	70.37	85.23	(1.59)	83.64	2.75	86.39	1.88	88.27	2.02	90.29	2.09	92.37	7.14
Self-pay	29.71	15.86	4.93	20.79	(4.69)	16.11	0.00	16.11	0.00	16.11	0.00	16.11	0.24
Insurance	68.97	50.50	16.63	67.13	(14.28)	52.85	0.00	52.85	0.00	52.85	0.00	52.85	2.35
Subtotals	1,211.83	1,268.40	(3.83)	1,264.57	(44.46)	1,220.11	10.86	1,230.96	11.26	1,242.23	11.55	1,253.77	(14.63)
Waiver Revenue													
Suppl. Pool (CHC) 1115 Waiver	178.72	110.90	0.00	110.90	(27.83)	83.07	(22.26)	60.81	(22.26)	38.55	(38.55)	0.00	(110.90)
1115 Waiver Indigent Care Match	28.64	95.93	0.00	95.93	(24.07)	71.86	(19.26)	52.60	(19.26)	33.34	(33.34)	0.00	(95.93)
1115 Waiver Administration Claim	4.39	4.99	(0.41)	4.58	0.41	4.99	0.00	4.99	0.00	4.99	(4.99)	0.00	(4.99)
Other County Departments–Mental Health 1115 Waiver	20.00	20.00	0.00	20.00	(5.00)	15.00	(4.00)	11.00	(4.00)	7.00	(7.00)	0.00	(20.00)
Subtotals	231.75	231.82	(0.41)	231.41	(56.48)	174.92	(45.52)	129.40	(45.52)	83.88	(83.88)	0.00	(231.82)
Other Revenue													
Patient Financial Services Worker	13.87	14.24	(0.10)	14.14	(0.16)	13.98	0.00	13.98	0.00	13.98	0.00	13.98	(0.26)
State–Other	35.13	48.70	(21.01)	27.69	25.90	53.59	0.38	53.97	0.40	54.37	0.42	54.79	6.09
Federal–Other	0.34	0.62	(4.93)	(4.31)	5.30	0.99	0.05	1.04	0.06	1.10	0.06	1.16	0.53
Other County Departments–Mental Health	23.02	29.35	0.00	29.35	0.00	29.35	0.00	29.35	0.00	29.35	0.00	29.35	0.00
Other County Departments–Other	115.21	57.21	1.67	58.88	(1.56)	57.32	0.00	57.32	0.00	57.32	0.00	57.32	0.11
Oper Trans In–Special Funds	67.81	1.97	(17.59)	(15.62)	17.59	1.97	0.00	1.97	0.00	1.97	0.00	1.97	0.00
Oper Trans In–SB 612	0.00	3.00	0.00	3.00	(3.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(3.00)
SB 612: Community Mental Health	5.10	2.55	0.00	2.55	0.00	2.55	0.00	2.55	0.00	2.55	0.00	2.55	0.00
Interest	1.34	1.79	0.00	1.79	0.00	1.79	0.00	1.79	0.00	1.79	0.00	1.79	0.00
Other Revenue	19.18	22.71	(0.88)	21.83	1.70	23.52	0.00	23.52	0.00	23.52	0.00	23.52	0.82
Overrealization of Prior-Year Revenue	55.64	118.24	24.86	143.10	(93.00)	50.11	(0.03)	50.08	(0.02)	50.06	(0.06)	50.00	(68.24)
Subtotals	336.63	300.38	(17.97)	282.41	(47.24)	235.17	0.41	235.58	0.43	236.01	0.42	236.43	(63.95)
Total Revenue	**1,780.21**	**1,800.60**	**(22.22)**	**1,778.38**	**(148.19)**	**1,630.20**	**(34.26)**	**1,595.94**	**(33.83)**	**1,562.12**	**(71.92)**	**1,490.20**	**(310.40)**

TABLE A.1 (continued)

	Fiscal Year 2000–01	Fiscal Year 2001–02			Fiscal Year 2002–03		Fiscal Year 2003–04		Fiscal Year 2004–05		Fiscal Year 2005–06		
	Actual Results	Board Adopted Budget	Scorecard Adjustments	Totals	Scorecard Adjustments	Totals	Scorecard Adjustments	Totals	Scorecard Adjustments	Totals	Scorecard Adjustments	Total	Total Scorecard Adjustments
Expense													
Salaries and Employee Benefits	$1,213.88	$1,327.77	$(28.40)	$1,299.37	$120.97	$1,420.34	$ 54.44	$1,474.78	$ 58.48	$1,533.25	$ 63.26	$1,596.51	$268.75
Services and Supplies	927.52	932.54	3.28	935.82	39.27	975.09	23.00	998.09	27.67	1,025.76	31.00	1,056.76	124.23
Other Charges	103.92	116.21	(15.34)	100.87	10.82	111.69	(4.72)	106.97	(0.19)	106.78	(4.63)	102.15	(14.06)
Fixed Assets	5.99	7.96	0.85	8.81	(0.73)	8.08	(0.02)	8.06	0.00	8.06	1.70	9.77	1.81
Operating Transfer Out	0.00	0.27	0.00	0.27	0.00	0.27	0.00	0.27	0.00	0.27	0.00	0.27	0.00
Subtotals	2,251.31	2,384.74	(39.61)	2,345.13	170.34	2,515.47	72.70	2,588.17	85.95	2,674.12	91.34	2,765.46	380.72
Intrafund Transfer	10.92	10.26	(4.65)	5.61	5.29	10.89	0.34	11.23	0.36	11.59	0.38	11.96	1.71
Total Expenses	**2,240.39**	**2,374.48**	**(34.95)**	**2,339.53**	**165.05**	**2,504.58**	**72.36**	**2,576.94**	**85.60**	**2,662.54**	**90.96**	**2,753.50**	**379.02**
Revenue Less Expense	**(460.18)**	**(573.88)**	**(12.74)**	**(561.14)**	**313.24**	**(874.38)**	**106.62**	**(981.00)**	**119.42**	**(1,100.42)**	**162.88**	**(1,263.29)**	**689.41**
Operating Subsidy													
California Healthcare for Indigent Program		33.33	(2.44)	30.89	0.00	30.89	0.00	30.89	0.00	30.89	0.00	30.89	(2.44)
Sales Tax		89.54	3.89	93.43	0.00	93.43	0.00	93.43	0.00	93.43	0.00	93.43	3.89
Vehicle License Fees		248.26	3.33	251.59	5.67	257.26	8.30	265.56	8.51	274.07	8.72	282.80	34.53
Fund Balance		7.09	0.00	7.09	277.92	285.01	(244.27)	40.75	(40.75)	0.00	0.00	0.00	(7.09)
County Contribution		133.00	2.14	135.13	10.00	145.13	10.00	155.13	10.00	165.13	0.00	165.13	32.14
Tobacco Settlement		46.64	0.00	46.64	0.00	46.64	0.00	46.64	0.00	46.64	0.00	46.64	0.00
Tobacco Unit Settlement		16.01	0.00	16.01	0.00	16.01	0.00	16.01	0.00	16.01	0.00	16.01	0.00
Total Identified Operating Subsidy		**$573.88**	**$6.91**	**$580.79**	**$293.59**	**$874.38**	**($225.96)**	**$648.41**	**($22.24)**	**$626.18**	**$8.72**	**$634.90**	**$61.02**
Unidentified Operating Subsidy		**0.00**	**$19.65**	**$19.65**	**($19.65)**	**0.00**	**($332.58)**	**($332.58)**	**($141.66)**	**($474.24)**	**($154.15)**	**($628.39)**	**($628.39)**

Source: August 23, 2001, Final Financial Performance Analysis for Fiscal Year 2000–01. Board Adopted Budget for Enterprise Units 2001–02, see Table A.2. January 22, 2002, Health Services Fiscal Outlook ("Scorecard") and scorecard adjustment detail by budget unit.

Note: Some subtotals and totals may not foot due to rounding.

* Includes LAC/USC Hospital, Northeast CHCs/HCs, Harbor/UCLA Hospital, Coastal CHCs/HCs, MLK/Drew Hospital, Southwest CHCs/HCs, Olive View/UCLA Hospital, San Fernando Valley CHCs/HCs, Rancho Los Amigos Hospital, High Desert Hospital, Antelope Valley CHCs/CHs, Antelope Valley Rehabilitation Center, Health Services Administration, and the Office of Managed Care.

TABLE A.2

Los Angeles County Department of Health Services' Board Adopted Budget for Fiscal Year 2001–02 Enterprise Units Only (In Millions of Dollars)

	Hospitals						Comprehensive and Community Health Centers								
	LAC/USC	Harbor/ UCLA	MLK/ Drew	Rancho Los Amigos	Olive View/ UCLA	High Desert	North-east	Coastal	South-west	San Fernando Valley	Antelope Valley	Antelope Valley Reha-bilitation Center	Office of Managed Care	Health Services' Adminis-tration	Totals
Reimbursement Revenue															
Medi-Cal (Regular)	$108.470	$48.028	$52.079	$43.835	$36.537	$7.384	0.000	0.000	0.000	$0.000	0.000	0.000	0.000	.000	$ 296.333
Cost-based Reimbursement Medi-Cal	36.495	27.166	17.823	6.084	13.322	2.869	$11.074	$1.759	$8.647	7.266	$2.164	0.000	0.000	0.000	134.669
Medi-Cal Pharmacy	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Community Health Plan	14.471	7.975	11.802	0.007	4.640	5.053	1.668	0.648	1.678	0.606	1.030	0.000	$77.788	0.000	127.366
SB 855: DSH Program	92.050	36.671	30.244	15.539	28.582	1.218	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	204.304
SB 1255: Emergency Services Program	149.640	65.700	61.241	22.360	38.180	6.880	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	344.001
SB 1732: Construction Debt Service Funding	0.000	0.609	3.772	5.756	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.137
Medicare	26.514	23.694	16.511	9.603	7.068	1.170	0.155	0.096	0.357	0.002	0.059	0.000	0.000	0.000	85.229
Self-Pay	6.590	3.251	0.911	0.472	1.475	0.408	0.752	0.117	0.451	0.035	0.117	$1.283	0.000	0.000	15.862
Insurance	16.029	17.329	10.652	3.000	2.665	0.665	0.003	0.066	0.004	0.087	0.002	0.000	0.000	0.000	50.502
Subtotals	450.259	230.423	205.035	106.656	132.469	25.647	13.652	2.686	11.137	7.996	3.372	1.283	77.788	0.000	1,268.403
Waiver Revenue															
Suppl. Pool (CHC) 1115 Waiver	0.000	0.000	0.000	0.000	0.000	0.000	49.146	10.301	29.888	17.073	4.492	0.000	0.000	0.000	110.900
1115 Waiver Indigent Care Match	0.000	0.000	0.000	0.000	0.000	0.000	35.120	8.770	18.680	9.130	2.570	0.000	21.660	0.000	95.930
1115 Waiver Administration Claim	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.984	$4.006	4.990
Other County Depts.–Mental Health 1115 Waiver	5.496	3.467	7.078	0.000	3.959	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	20.000
Subtotals	5.496	3.467	7.078	0.000	3.959	0.000	84.266	19.071	48.568	26.203	7.062	0.000	22.644	4.006	231.820
Other Revenue															
Patient Financial Services Worker	5.665	2.594	1.586	0.667	2.496	0.667	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.562	14.237
State–Other	7.785	2.494	2.042	0.066	1.181	1.374	1.860	1.345	0.878	3.488	0.196	0.311	25.485	0.198	48.703
Federal–Other	0.000	0.000	0.400	0.000	0.000	0.159	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.062	0.621
Other County Departments–Mental Health	15.923	5.860	3.843	0.000	3.723	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	29.349
Other County Departments–Other	7.520	1.924	3.944	0.192	1.093	1.387	0.273	0.663	0.293	0.000	0.000	4.163	0.000	35.756	57.208
Oper Trans In–Special Funds	0.000	0.000	0.229	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1.741	1.970
Oper Trans In–SB 612	1.787	0.555	0.658	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.000
SB 612: Community Mental Health	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	2.551	2.551
Interest	0.406	0.030	0.027	0.018	0.054	0.031	0.000	0.000	0.000	0.000	0.000	0.000	1.227	0.000	1.793
Other Revenue	9.607	2.472	1.526	1.096	1.518	0.243	1.465	0.352	0.733	1.111	0.018	0.041	0.080	2.445	22.707
Overrealization of Prior-Year Revenue	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	118.240	118.240
Subtotals	48.693	15.929	14.255	2.039	10.065	3.861	3.598	2.360	1.904	4.599	0.214	4.515	26.792	161.555	300.379
Total Revenue	**504.448**	**249.819**	**226.368**	**108.695**	**146.493**	**29.508**	**101.516**	**24.117**	**61.609**	**38.798**	**10.648**	**5.798**	**127.224**	**165.561**	**1,800.602**

TABLE A.2 (continued)

	Hospitals						Comprehensive and Community Health Centers								
	LAC/USC	Harbor/ UCLA	MLK/ Drew	Rancho Los Amigos	Olive View/ UCLA	High Desert	North-east	Coastal	South-west	San Fernando Valley	Antelope Valley	Antelope Valley Reha-bilitation Center	Office of Managed Care	Health Services' Adminis-tration	Totals
Expense															
Salaries and Employee Benefits	$443.245	$207.375	$207.090	$97.629	$120.193	$ 33.407	$56.470	$14.279	$33.966	$18.714	$ 5.464	$ 4.892	$ 9.646	$ 75.396	$1,327.766
Services and Supplies	278.465	105.872	103.556	44.712	77.053	18.656	36.134	7.558	13.414	7.972	4.941	1.835	153.645	78.722	932.535
Other Charges	44.308	10.715	21.065	18.029	14.758	1.137	0.746	1.584	0.080	0.480	1.943	0.081	0.003	1.280	116.209
Fixed Assets	1.392	0.825	1.026	0.201	0.243	0.032	0.000	0.043	0.357	0.920	0.000	0.014	0.000	2.905	7.958
Operating Transfer Out	0.000	0.000	0.091	0.000	0.179	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.270
Subtotals	767.410	324.787	332.828	160.571	212.426	53.232	93.350	23.464	47.817	28.086	12.348	6.822	163.294	158.303	2,384.738
Intrafund Transfer	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.258	10.258
Total Expenses	**767.410**	**324.787**	**332.828**	**160.571**	**212.426**	**53.232**	**93.350**	**23.464**	**47.817**	**28.086**	**12.348**	**6.822**	**163.294**	**148.045**	**2,374.480**
Revenue Less Expense	**(262.962)**	**(74.968)**	**(106.460)**	**(51.876)**	**(65.933)**	**(23.724)**	**8.166**	**0.653**	**13.792**	**10.712**	**(1.700)**	**(1.024)**	**(36.070)**	**17.516**	**(573.878)**
Operating Subsidy															
California Healthcare for Indigent Program	18.372	5.081	4.746	2.119	2.360	0.656	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	33.334
Sales Tax	40.774	11.932	17.444	8.525	10.901	3.957	(0.299)	(0.113)	(2.393)	(1.859)	0.295	0.177	3.568	(3.366)	89.543
Vehicle License Fees	113.048	33.084	48.364	23.636	30.223	10.970	(0.829)	(0.314)	(6.635)	(5.153)	0.818	0.493	9.891	(9.333)	248.263
Fund Balance	9.599	1.117	1.180	0.626	0.750	0.265	(6.443)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	7.094
County Contribution	59.932	17.539	25.640	12.530	16.022	5.815	(0.439)	(0.167)	(3.517)	(2.732)	0.434	0.261	5.244	(3.564)	132.998
Tobacco Settlement	21.237	6.215	9.086	4.440	5.677	2.061	(0.156)	(0.059)	(1.247)	(0.968)	0.153	0.093	1.858	(1.753)	46.637
Tobacco Unit Settlement	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	15.509	0.500	16.009
Total Identified Subsidy	**$262.962**	**$74.968**	**$106.460**	**$51.876**	**$65.933**	**$23.724**	**($8.166)**	**($0.653)**	**($13.792)**	**($10.712)**	**$1.700**	**$1.024**	**$36.070**	**($17.516)**	**$573.878**

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APPENDIX B

Benchmarking Hospital Performance

This appendix compares the operating and financial performance from fiscal years 1989–90 to 1999–2000 of Los Angeles County Department of Health Services' (Health Services) hospitals with the performance of two groups of benchmark hospitals, using data from the Office of Statewide Health Planning and Development.[1] One benchmark group, public hospitals, includes between 17 and 22 other hospitals owned by local governments (counties or cities) or the University of California that report data to the Office of Statewide Health Planning and Development.[2] The number of hospitals varies due to closures and/or reclassifications of facilities. In the following figures we compared Health Services' six hospitals with these public hospitals, both collectively and as individual facilities. The second benchmark group, teaching hospitals, includes between 23 and 25 other hospitals designated as teaching hospitals by the Office of Statewide Health Planning and Development. We compared Health Services' four teaching hospitals to this benchmark group.[3] Hospitals with fewer than 110 available beds have been excluded from the benchmark groups. There is considerable overlap between hospitals in the two benchmark groups, since several hospitals are classified as both public and teaching hospitals.

[1] The accrual basis of accounting used in preparing the Office of Statewide Health Planning and Development's financial reports is different from the basis of accounting used in the financial statements of the county. Health Services reports data to the State consistent with Office of Statewide Health Planning and Development requirements. As a result, the operating performance of Health Services' hospitals reported in this appendix is different from that reported in the county's audited financial statements.

[2] All non-federal acute-care hospitals in California report operating statistics to the Office of Statewide Health Planning and Development. "Comparable" facilities also report financial data, while certain "non-comparable" hospitals, primarily Kaiser facilities, do not. Hospitals typically report data to the Office of Statewide Health Planning and Development based upon their fiscal years. All data were taken from Office of Statewide Health Planning and Development annual reports.

[3] Health Services' teaching hospitals are Los Angeles County/USC Medical Center (LAC/USC), Harbor/UCLA Medical Center (Harbor/UCLA), Olive View/UCLA Medical Center (Olive View/UCLA), and Martin Luther King Jr./Drew Medical Center (MLK/Drew).

Like any benchmarking study, this analysis is subject to limitations. While the benchmark facilities have been chosen to include hospitals of comparable size, with missions similar to those of Health Services' hospitals, there remain many uncontrolled factors affecting the relative performance of the hospitals. For example, the attributes of some of Health Services hospitals make them different from most of the benchmark facilities. Because Rancho Los Amigos National Rehabilitation Center (Rancho Los Amigos) provides both acute care and rehabilitation services, it has longer stays than other hospitals. In addition, High Desert Hospital (High Desert) has a larger proportion of long-term care beds, affecting the operating and financial statistics for that facility.

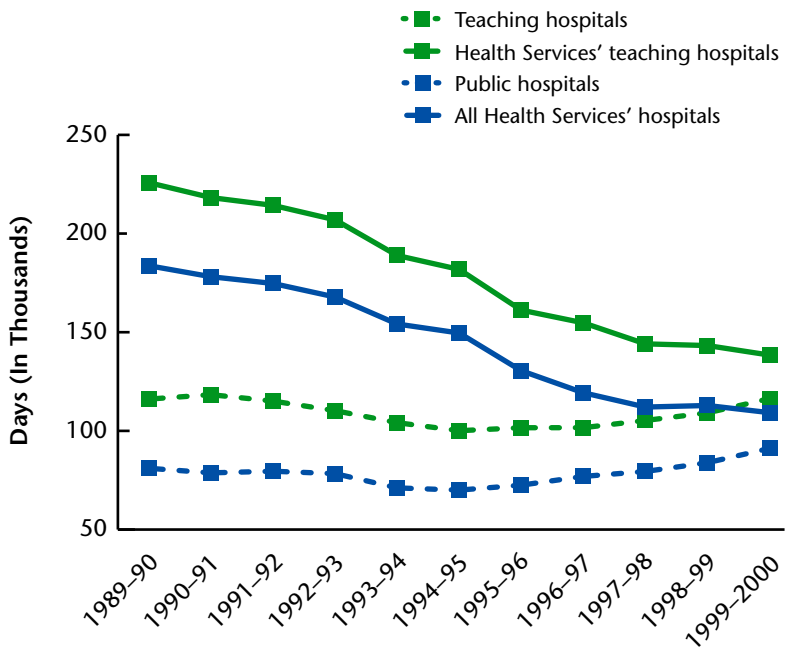
SERVICE LEVELS

Number of Inpatient Days

As shown in Figure B.1, since fiscal year 1989–90, the average number of inpatient days at Health Services' hospitals has declined significantly, while the average number at other public and teaching hospitals has remained flat or has increased slightly. The average annual number of inpatient days at Health Services' hospitals has declined from approximately 184,000 per hospital in fiscal year 1989–90 to approximately 109,000 in fiscal year 1999–2000, a decline of 41 percent. This trend is consistent with that of the benchmark hospitals until fiscal year 1995–96, when patient days at other hospitals began to increase. This coincides with the first year of the Waiver when Health Services was required to shift care from inpatient to outpatient settings.

FIGURE B.1

**Average Number of Inpatient Days per Hospital:
A Comparison of Health Services' Hospitals to Other Hospitals
Fiscal Years 1989–90 Through 1999–2000**

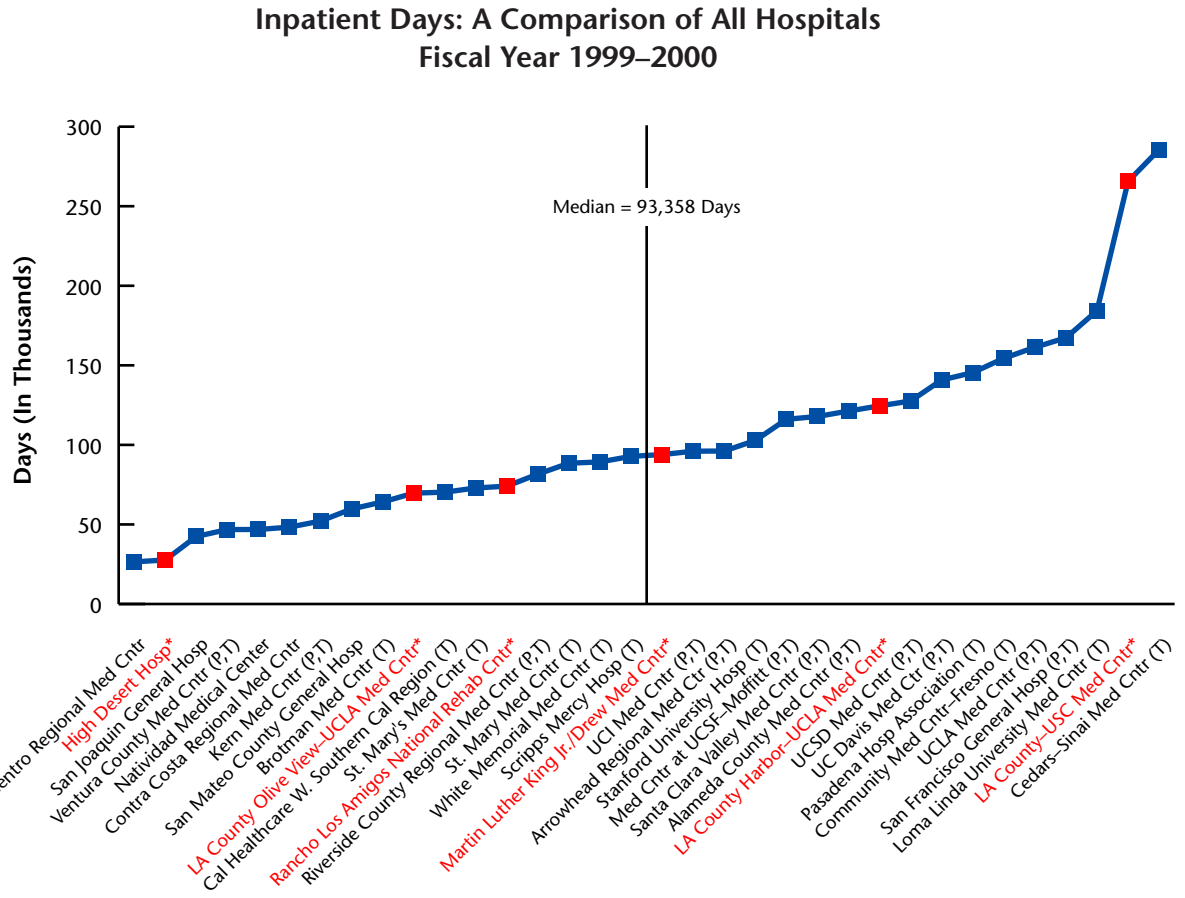


Source: Office of Statewide Health Planning and Development.

Figure B.2 on the following page shows the number of inpatient days in fiscal year 1999–2000 at each public and/or teaching hospital included in the benchmark groups. Measured by total patient days, the size of public and teaching hospitals, including that of Health Services' hospitals, varies widely.[4] LAC/USC is the largest public hospital and the second largest teaching hospital in the State by this metric, with more than 265,000 inpatient days (or an average daily census of over 725 patients). In contrast, Health Services' High Desert is one of the smaller public facilities, with fewer than 28,000 annual inpatient days (or an average daily census of approximately 76 patients).

[4] Five public hospitals with less than 110 available beds were excluded from our benchmark group in 2000.

FIGURE B.2



Source: Office of Statewide Health Planning and Development.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

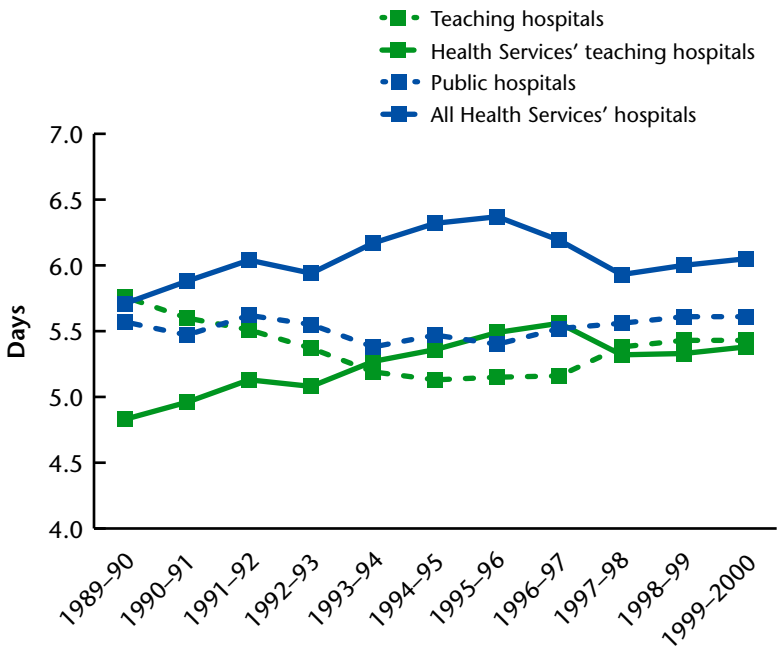
* Health Services' hospital.

Average Length of Stay

The decline in the number of inpatient days at Health Services' hospitals from fiscal years 1989–90 to 1999–2000 did not result from a decline in the average length of stay. As shown in Figure B.3, over the decade of the 1990s the average length of stay at all Health Services' hospitals increased slightly, from 5.7 days to 6 days. At Health Services' teaching hospitals, the average length of stay increased from 4.8 days to 5.4 days but currently is below the average for other teaching hospitals in the State. By comparison, the average length of stay at the benchmark public

FIGURE B.3

Average Length of Stay: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



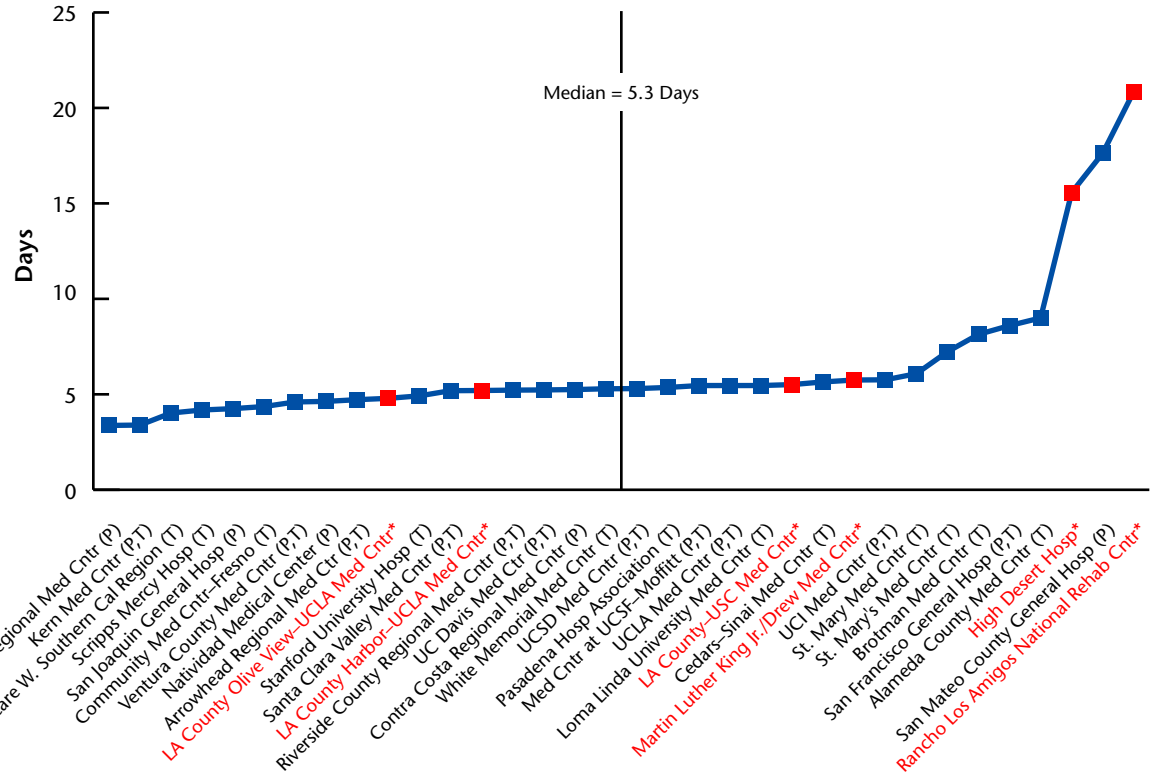
Source: Office of Statewide Health Planning and Development.

hospitals was flat at 5.6 days, while the average length of stay at the benchmark teaching hospitals declined from 5.8 to 5.4 days. The increase in the average length of stay at Health Services' hospitals is attributable in part to changes in the case mix. According to Health Services' January 2002 Strategic Plan, its hospitals experienced a significant decline in the number of obstetrical cases, from 93,469 in fiscal year 1992–93 to 27,775 in fiscal year 1998–99. These cases, on average, require relatively short hospital stays.

The average length of stay at Health Services' hospitals overall is greater than the average length of stay at the benchmark hospitals. As shown in Figure B.4 on the following page, this is due to the relatively long average stays at High Desert (16 days in fiscal year 1999–2000) and Rancho Los Amigos (21 days in fiscal year 1999–2000). As we noted earlier, the type of care provided at these facilities—long-term care at High Desert and rehabilitation services at Rancho Los Amigos—accounts

FIGURE B.4

Average Length of Stay: A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

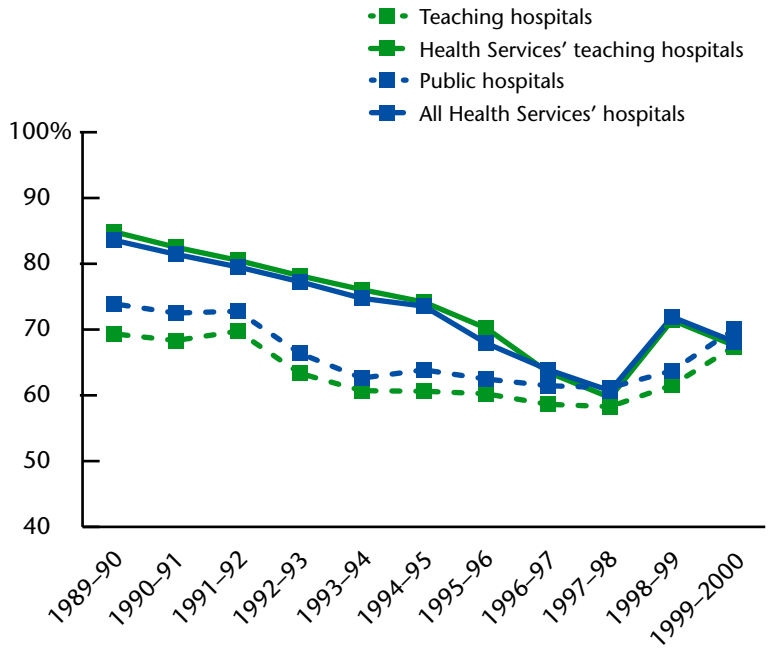
P,T - Included in both benchmark groups.

* Health Services' hospital.

for these longer average lengths of stay. Excluding these two facilities, the average length of stay at Health Services' hospitals is below that of other public or teaching hospitals, as shown in the line labeled "Health Services' Teaching Hospitals" in Figure B.3. Among Health Services' teaching hospitals, the average length of stay ranged from 4.8 days at Olive View/UCLA to 5.8 days at MLK/Drew.

FIGURE B.5

Average Occupancy Rate on Available Beds: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



Source: Office of Statewide Health Planning and Development.

Occupancy Rates

Hospital occupancy rates fell across the State during the early and mid-1990s as advancements in medical technology and the growth of managed care reduced the demand for inpatient services. Figure B.5 depicts this decline. At Health Services' hospitals, the average occupancy rate declined from 84 percent in fiscal year 1989–90 to 68 percent in fiscal year 1999–2000 and is now comparable to the average for other public and teaching hospitals.[5] Occupancy rates fall when inpatient days decline faster than hospital capacity as measured by the average number of available beds. For Health Services systemwide, the average number of available beds was reduced from 3,612 in

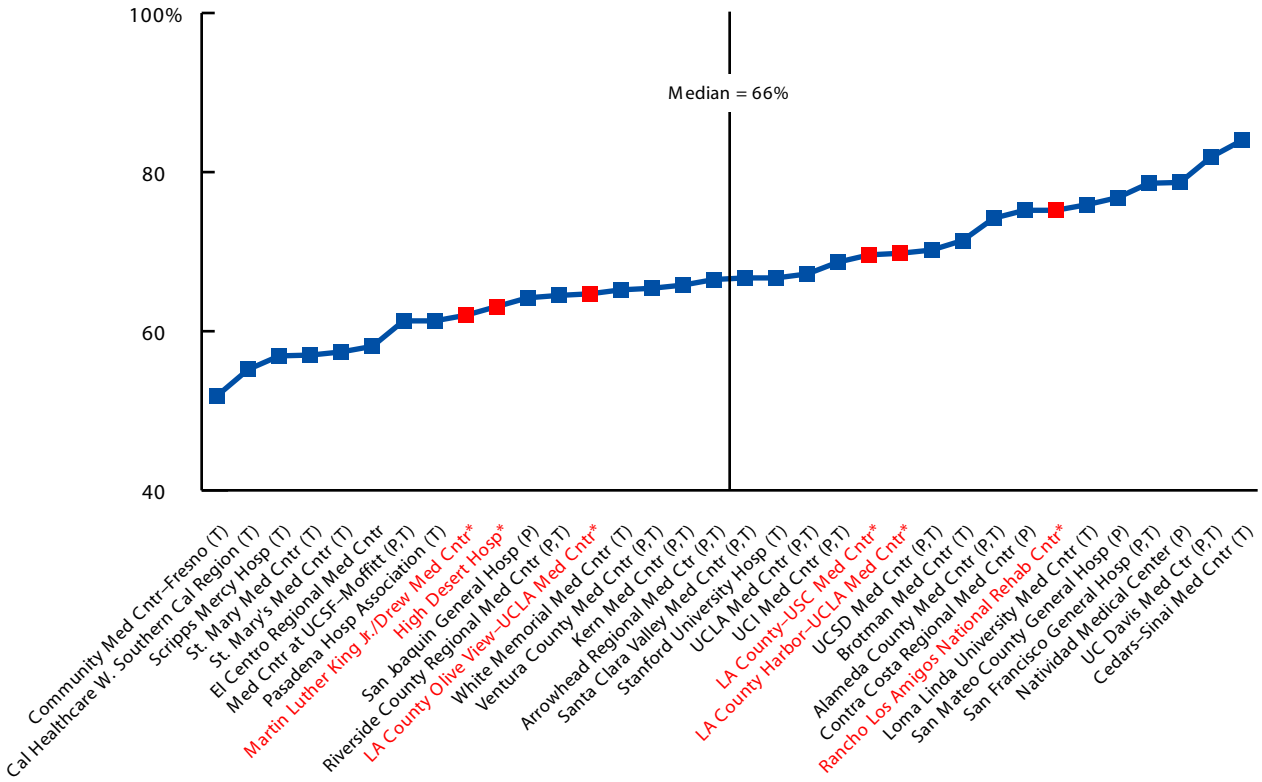
[5] Occupancy rates are calculated on available beds, which are defined by the Office of Statewide Health Planning and Development as the average complement of beds (excluding bassinets) physically existing and actually available for overnight use, regardless of staffing levels.

fiscal year 1989–90 to 2,635 in fiscal year 1999–2000. Because Health Services was able to reduce its number of beds by 456 in fiscal year 1998–99, it increased its average occupancy rate from 61 percent to 72 percent.

As shown in Figure B.6, occupancy rates in fiscal year 1999–2000 at Health Services' hospitals ranged from a low of 62 percent at MLK/Drew to a high of 75 percent at Rancho Los Amigos. Half of the benchmark hospitals had higher or lower occupancy rates than Health Services' hospitals.

FIGURE B.6

Occupancy Rate on Available Beds: A Comparison of All Hospitals Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

Note: Employee days are calculated by dividing the reported productive hours for all hospital employees by eight (number of hours in a standard workday).

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

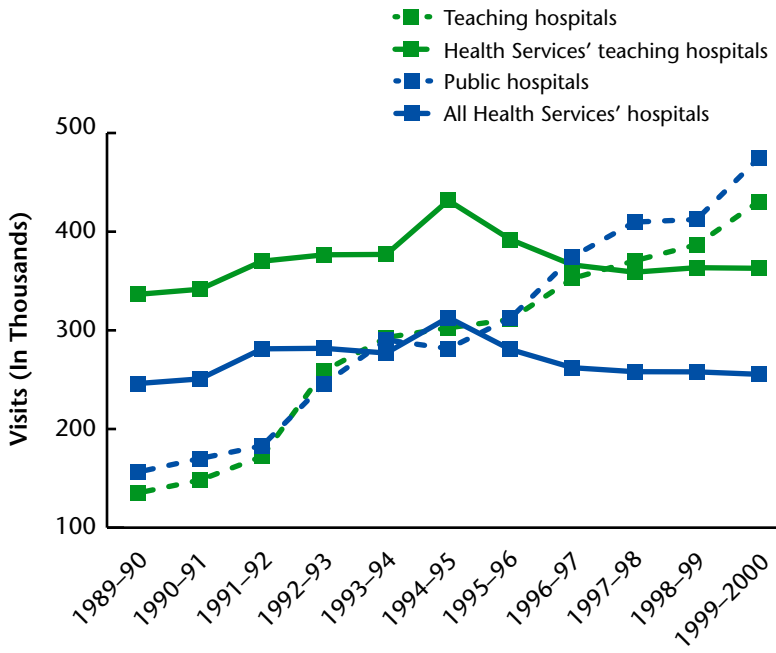
* Health Services' hospital.

Number of Outpatient Visits

While the average number of outpatient visits to the benchmark hospitals more than tripled between fiscal years 1989–90 and 1999–2000, the average number of visits to Health Services' hospital outpatient clinics increased only slightly.[6] As shown in Figure B.7, the average number of outpatient visits at Health Services' six hospitals rose from 246,000 in fiscal year 1989–90 to 313,000 in fiscal year 1994–95 before declining to 255,000 in fiscal year 1999–2000, a net increase of 4 percent over 1990 levels. Outpatient visits to non-hospital-based Health Services clinics, which are not reflected in the Office of Statewide Health

FIGURE B.7

Average Number of Outpatient Visits per Hospital: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



Source: Office of Statewide Health Planning and Development.

[6] Outpatient visits reported by the Office of Statewide Health Planning and Development include emergency room (and psychiatric emergency) visits, among others.

Planning and Development data, have fallen somewhat over the period. Total outpatient visits to these non-hospital-based facilities declined from 2,409,000 in fiscal year 1991–92 to 2,174,000 in fiscal year 1999–2000, a decrease of 10 percent.[7]

REVENUE

Net Inpatient Revenue Versus Net Outpatient Revenue

Relative to the benchmark facilities, Health Services' hospitals derive a larger share of net revenue from inpatient services and a smaller share from outpatient services, as shown in Figure B.8. However, since Office of Statewide Health Planning and Development data reflect only outpatient visits to hospital-based clinics, this does not mean that Health Services as a whole is necessarily more dependent on inpatient services than other public and teaching hospitals. Approximately two-thirds of Health Services' outpatient services are delivered at non-hospital-based sites of care.

Net Inpatient Revenue per Patient Day

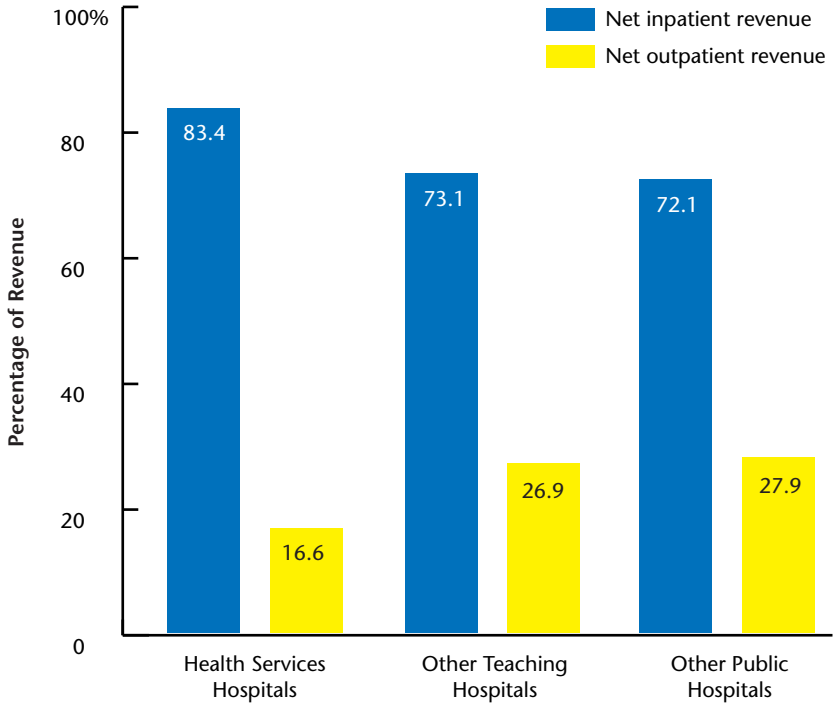
A variety of factors led to differences in revenue per patient day among the hospitals, including the following:

- The mix of payors (Medi-Cal, Medicare, private insurance, etc.).
- The level of charity care provided.
- Competitive conditions within hospitals' immediate market areas.
- The level of patient service and amenities.

[7] Data are from Health Services' Workload Statistics. Visits include outpatient care visits to comprehensive health centers, health centers, and public-private partnership clinics. General Relief visits (77,000 in 2000), and public health visits at county comprehensive health centers and health centers (525,000 in 2000).

FIGURE B.8

Net Inpatient Revenue Versus Net Outpatient Revenue: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



Source: Office of Statewide Health Planning and Development.

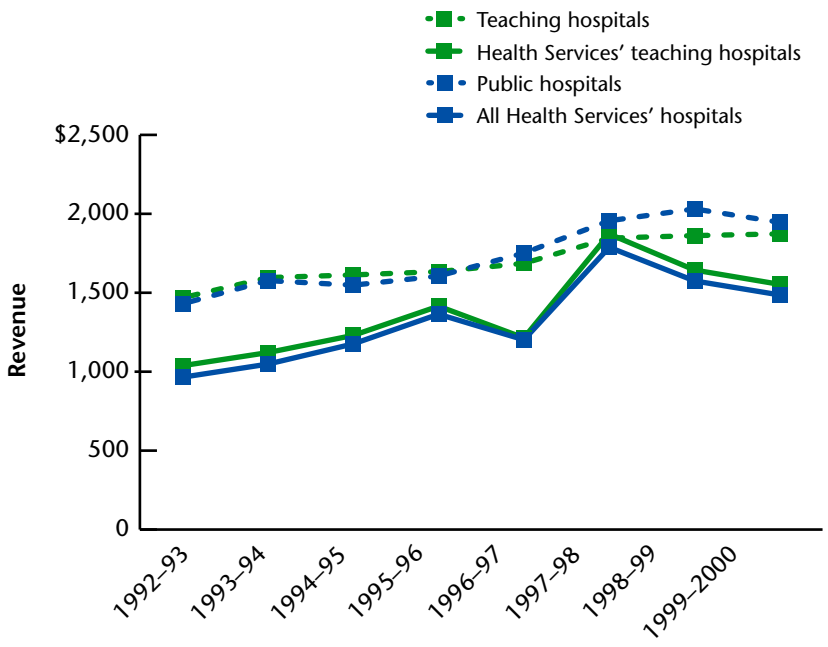
Note: Hospitals that are classified as both teaching and public appear in teaching hospitals and public hospitals.

Net inpatient revenue per patient day is a summary measure of compensation per unit of output. Since fiscal year 1992–93, net inpatient revenue per patient day at Health Services' hospitals has increased by $521, or 54 percent, from $965 in fiscal year 1992–93 to $1,486 in fiscal year 1999–2000.[8] As shown in Figure B.9 on the following page, this increase was greater than the average increase of $516 at other public hospitals and the $405 average increase at other teaching hospitals in the State.

[8] The method used by the Office of Statewide Health Planning and Development to allocate net Medi-Cal revenue between inpatient and outpatient services may tend to overstate net inpatient revenue and understate net outpatient revenue for Health Services' hospitals relative to other hospitals.

FIGURE B.9

**Average Net Inpatient Revenue per Patient Day:
A Comparison of Health Services' Hospitals to Other Hospitals
Fiscal Years 1992–93 Through 1999–2000**



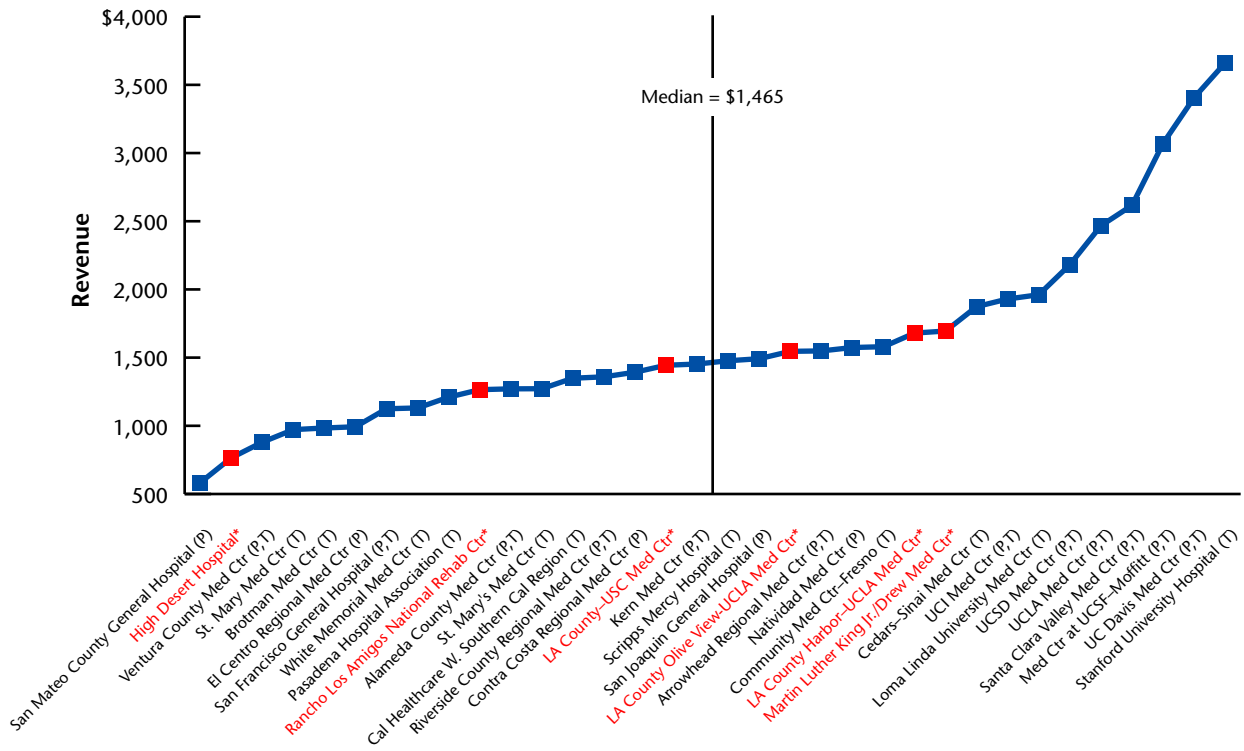
Source: Office of Statewide Health Planning and Development.

The average net revenue per patient day shown for public and teaching hospitals in Figure B.9 is strongly influenced by a handful of benchmark hospitals. These hospitals receive exceptionally high revenue per day. The high-revenue (and typically high-cost) hospitals include Stanford University Hospital ($3,661 per day), UC Davis Medical Center ($3,406 per day), and the Medical Center at UCSF ($3,070 per day). Because of these outliers, comparing a Health Services' hospital to the mean of the benchmark hospitals can be misleading. A ranking of hospitals, as shown in Figure B.10, is more informative. This ranking indicates that the average inpatient revenue per day for three of Health Services' four teaching hospitals was greater than the median for public and teaching hospitals. High Desert and, to a lesser extent Rancho Los Amigos, received substantially less than the median inpatient revenue per day, reflecting the mix of services they provide.

Health Services can influence, to some extent, the distribution of revenue among its six hospitals. For example, each year Health Services negotiates with the California Medical Assistance Commission to determine the amount of revenue it receives under the Emergency Services and Supplemental Payment Fund (Emergency Services Fund) established by Chapter 996, Statutes of 1989 (SB 1255). This amount, which totaled $344 million in fiscal year 2000–01, is effectively a county-wide allotment that is allocated to individual facilities largely at Health Services' discretion. The allocation is typically made to maximize revenue under other state and federal programs, rather than to reflect

FIGURE B.10

Net Inpatient Revenue per Patient Day: A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

* Health Services' hospital.

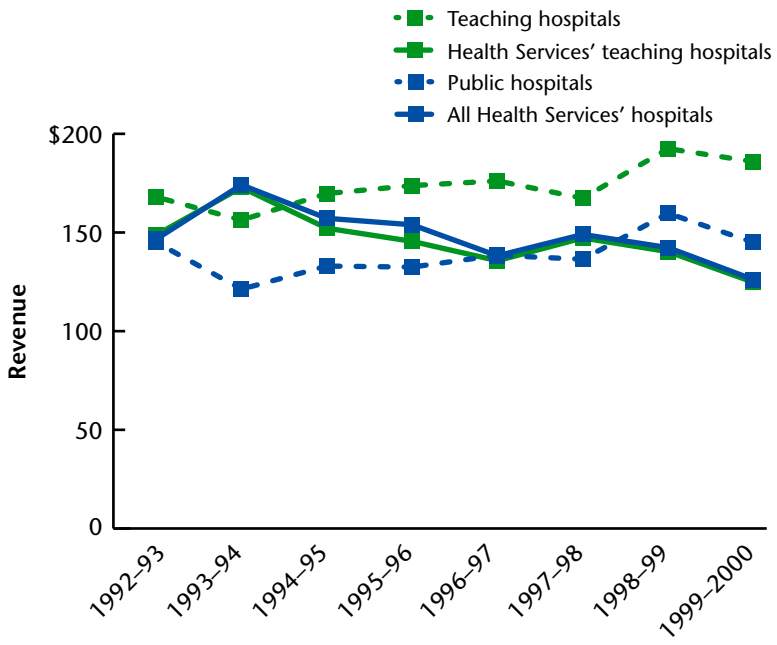
the underlying level of service provided at each hospital. This "engineering" enhances the county's total revenue but limits the insights that can be drawn from comparing revenue (and profit/loss) per patient day across Health Services' facilities.

Net Outpatient Revenue per Outpatient Visit

Figure B.11 shows the net outpatient revenue per outpatient visit from fiscal years 1992–93 through 1999–2000. As we just discussed, the Office of Statewide Health Planning and Development's method of allocating Medi-Cal revenues between inpatient and outpatient services suggests placing limited weight on this analysis. With this caveat, outpatient revenue per visit has not increased significantly at public hospitals and has declined slightly for Health Services' hospital-based outpatient visits.

FIGURE B.11

Average Net Outpatient Revenue per Outpatient Visit: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1992–93 Through 1999–2000

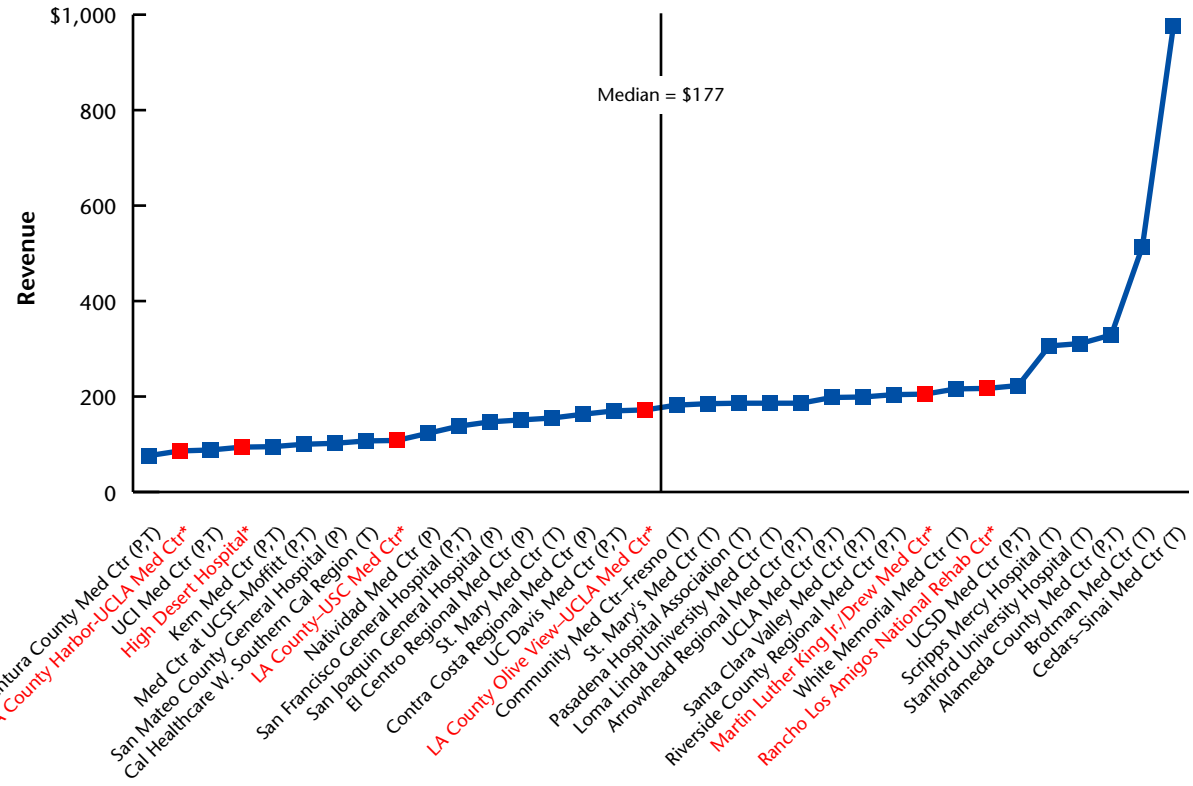


Source: Office of Statewide Health Planning and Development.

As with other series, the average outpatient revenue per visit is influenced by a few exceptional facilities. Figure B.12 shows that the Cedars-Sinai and Brotman Medical Centers tend to raise the average outpatient revenue per visit for the teaching hospitals. These two facilities account for virtually all the difference between the averages for teaching and public hospitals as previously shown in Figure B.11. Among Health Services' facilities, outpatient revenue varies widely, from $86 per visit at Harbor/UCLA to $217 at Rancho Los Amigos.

FIGURE B.12

Net Outpatient Revenue per Outpatient Visit: A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

* Health Services' hospital.

Percentage of Total Inpatient Days by Type of Payor

Figure B.13 shows the percentage of total inpatient days by type of payor. The role of Health Services' hospitals as safety net providers is evident from this figure. Nearly 1 in 3 patient days at Health Services' hospitals are for the care of medically indigent patients. This is nearly four times the average share of indigent patient care at other public hospitals and nearly seven times the average for teaching hospitals in California. Medi-Cal patients represent a greater proportion of Health Services' clientele than of the benchmark hospitals. Indigent and Medi-Cal patient days combined account for 86 percent of all patient days at Health Services' hospitals, compared with 52 percent at other public hospitals and 39 percent at teaching hospitals. Relative to the benchmark hospitals, Health Services has a smaller share of traditional Medicare patients and patients covered by other third-party insurers.

The Office of Statewide Health Planning and Development reports data for the following payor categories:

- **County indigent:** Includes indigent patients covered under Welfare and Institutions Code, Section 17000, or all indigent patients for whom a county is responsible. This payor category also includes county-responsible indigent patients who are provided care in certain non-county hospitals under a county contract.
- **Medi-Cal:** A state-administered third-party reimbursement program designed to underwrite health facility costs of the medically indigent and those on certain public welfare programs.
- **Medicare:** A third-party reimbursement program administered by the Social Security Administration that underwrites the medical costs of persons 65 and over and some qualified persons under 65.
- **Other third-party payors:** Includes patients covered by a variety of third-party contractual purchasers of health care as well as indemnity plans. Also includes patients whose care is provided under managed contracts funded by Medicare or Medi-Cal.

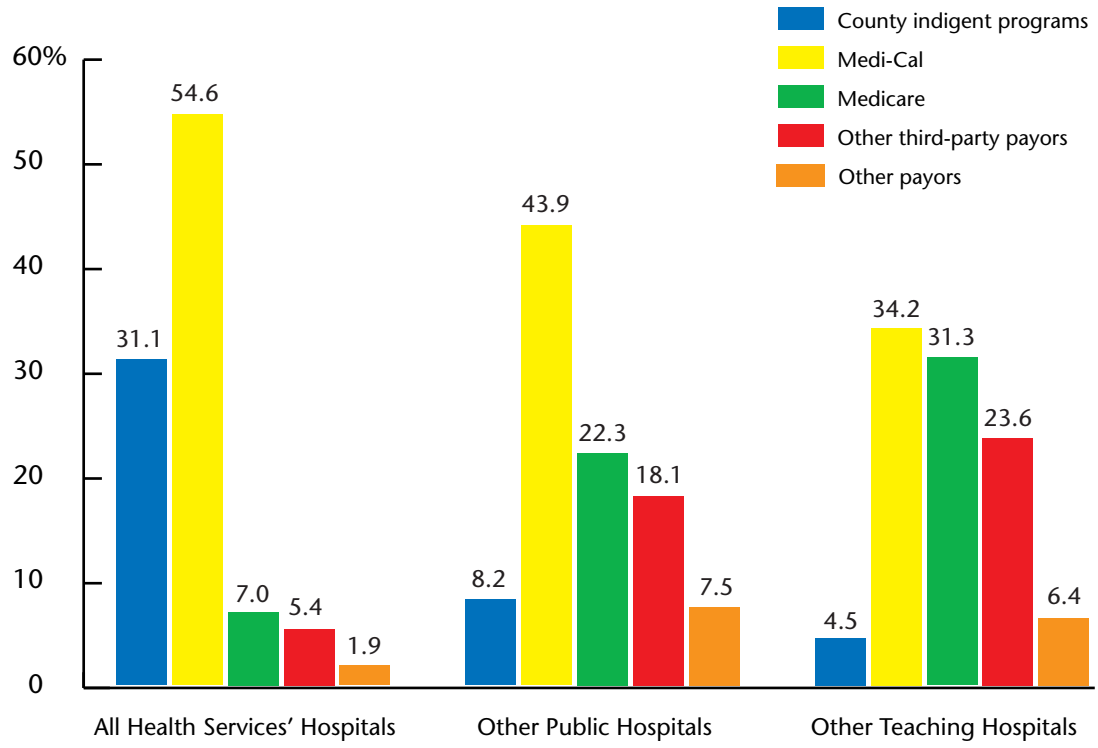
Percentage of Net Inpatient Revenue by Type of Payor

While Figure B.13 shows the volume of inpatient services by type of payor, Figure B.14 on page 102 shows inpatient revenue by type of payor. Figure B.14 highlights the importance of Medi-Cal to California's public hospitals in general and to Health Services in particular.[9] More than 81 percent of inpatient revenue at Health Services' hospitals is from Medi-Cal, nearly twice the average for the benchmark public hospitals. Also, the distribution of revenue for the benchmark facilities is more balanced among Medi-Cal, Medicare, and other third-party payors.

[9] In the Medi-Cal category, the Office of Statewide Health Planning and Development includes not only per diem payments for inpatient stays by Medi-Cal enrollees and capitation payments for those enrolled in Medi-Cal managed care plans, but also lump-sum DSH and Emergency Services Fund payments.

FIGURE B.13

**Percentage of Inpatient Days Paid by Types of Payor:
A Comparison of Health Services' Hospitals to Other Hospitals
Fiscal Year 1999–2000**



Source: Office of Statewide Health Planning and Development.

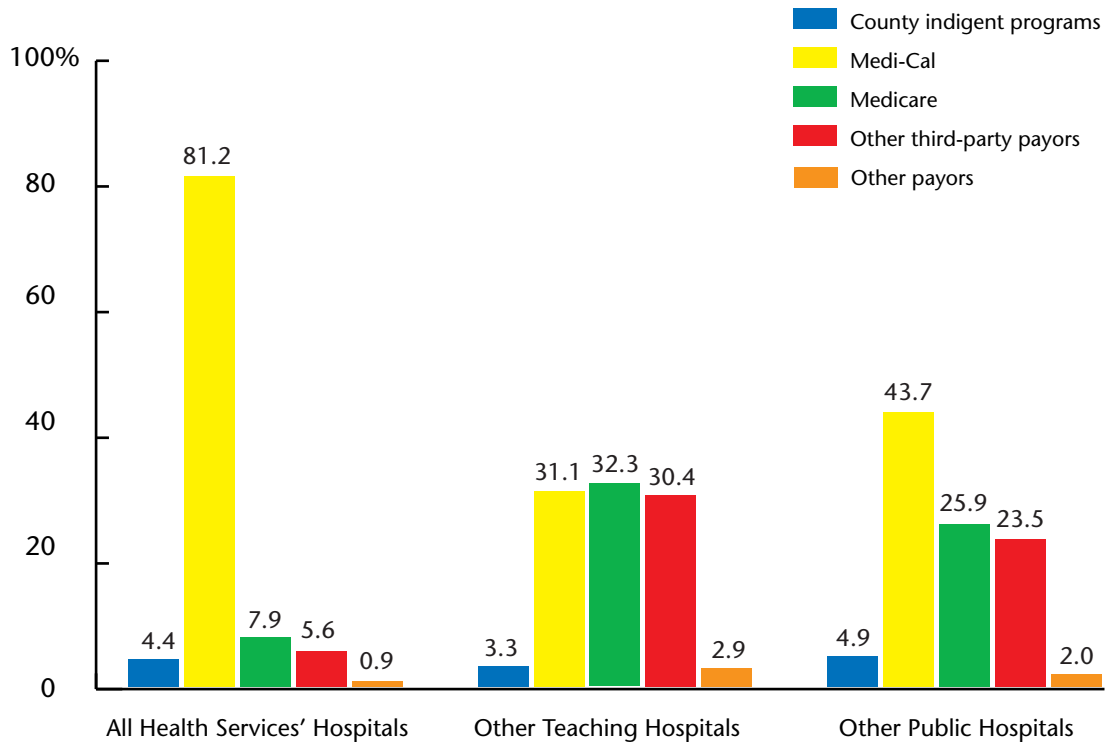
Note: Hospitals that are classified as both teaching and public appear in teaching hospitals and public hospitals.

Net Inpatient Revenue per Day by Type of Payor

Figure B.15 on page 103 shows net inpatient revenue per day by type of payor. A striking feature of this figure is the high revenue per day for Medi-Cal and the low revenue per day for indigent patient care at Health Services' hospitals relative to the benchmark hospital groups. In part, this difference is due to the inclusion by the Office of Statewide Health Planning and Development of revenue from the Emergency Services Fund and DSH under the Medi-Cal category. In fact, DSH payments are determined in part by the amount of care hospitals provide to low-income patients, both those enrolled in Medi-Cal and

FIGURE B.14

**Percentage of Net Inpatient Revenue by Type of Payor:
A Comparison of Health Services' Hospitals to Other Hospitals
Fiscal Year 1999–2000**



Source: Office of Statewide Health Planning and Development.

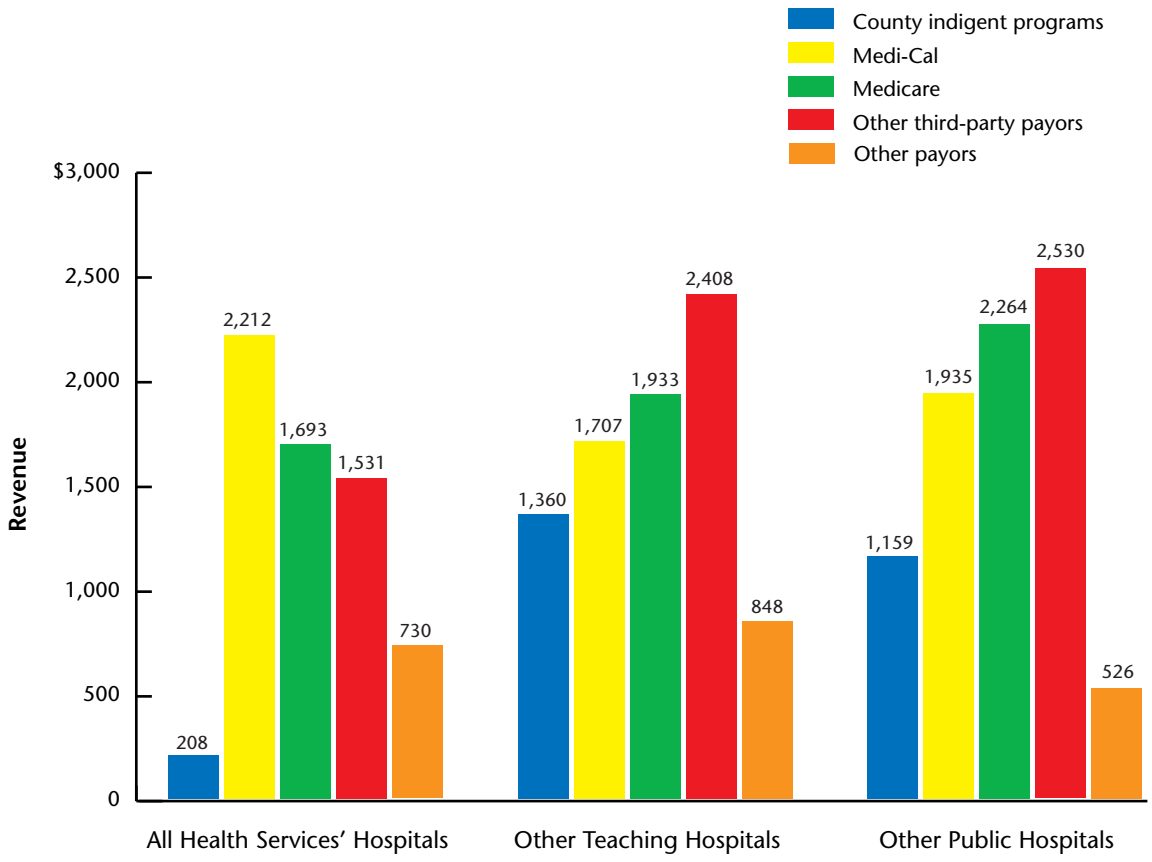
Note: Hospitals that are classified as both teaching and public appear in teaching hospitals and public hospitals.

indigent patients. Grouping DSH payments exclusively under Medi-Cal tends to overstate Medi-Cal revenue and understate reimbursement for care of indigent patients. This tendency is particularly pronounced at Health Services' hospitals because indigent patients constitute a large share of the patients served, as shown previously in Figure B.13. Combining county indigent and Medi-Cal to produce a blended rate yields inpatient revenue per day of $1,484 for Health Services, $1,812 for other public hospitals, and $1,668 for other teaching hospitals.

Figure B.15 also shows that, on average, Health Services receives lower compensation per patient day from Medicare and other third-party payors than the benchmark hospitals do. This may be the result of differences in case mix between Health Services' hospitals and hospitals in the benchmark groups.

FIGURE B.15

**Net Inpatient Revenue per Day by Type of Payor:
A Comparison of Health Services' Hospitals to Other Hospitals
Fiscal Year 1999–2000**



Source: Office of Statewide Health Planning and Development.

Note: Hospitals that are classified as both teaching and public appear in teaching hospitals and public hospitals.

OPERATING EFFICIENCY

Total Inpatient Operating Expense per Patient Day

Among the factors affecting variation in operating costs across hospitals are differences in the following:

- Wage rates and the cost of other inputs in the local market.
- The age and configuration of physical facilities.
- The level of patient services and amenities.
- The demographic profile and general health status of patients served.

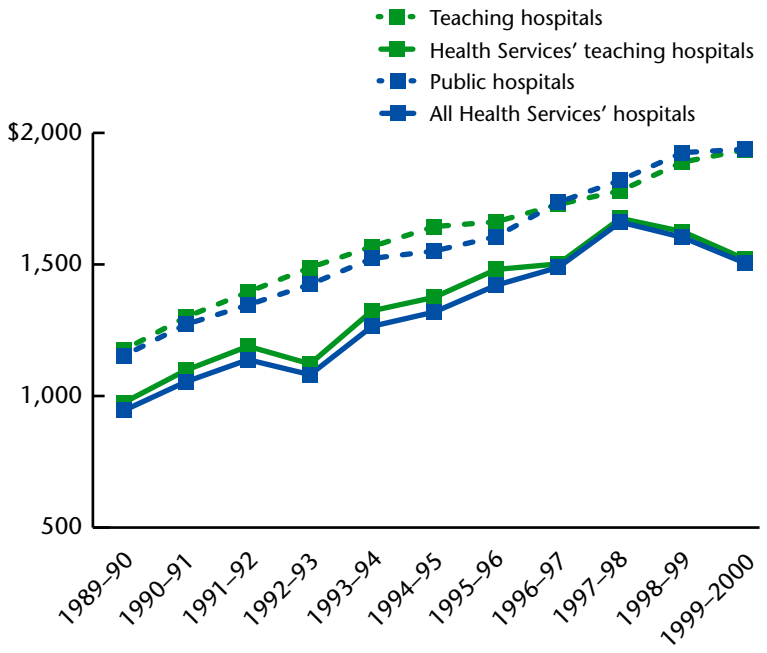
Figure B.16 shows the average inpatient operating expense per patient day for Health Services and the benchmark hospitals.[10] Between fiscal years 1989–90 and 1999–2000, the average operating expense per day at Health Services' hospitals was lower than the average for other public and teaching hospitals in the State by approximately $200 to $400 per patient day. However, as we discuss later, the higher average cost for other facilities is caused by a few high-cost hospitals that tended to increase the benchmark averages.

Between fiscal years 1989–90 and 1999–2000, average operating expense per patient day increased significantly at both Health Services' hospitals and the benchmark hospitals. The increase at Health Services' hospitals was 59 percent, compared with 68 percent at the public hospitals and 65 percent at the teaching hospitals. However, since fiscal year 1995–96, operating costs per patient day have risen more slowly on average at Health Services' hospitals than at the benchmark facilities.

[10] Fees for physician and resident/intern services are reported differently at different hospitals. Some include these fees in hospital costs, while others bill separately for these services. To improve comparability across hospitals, fees for physician and resident/intern services have been removed from operating expenses for all hospitals.

FIGURE B.16

Average Inpatient Operating Expense per Patient Day: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



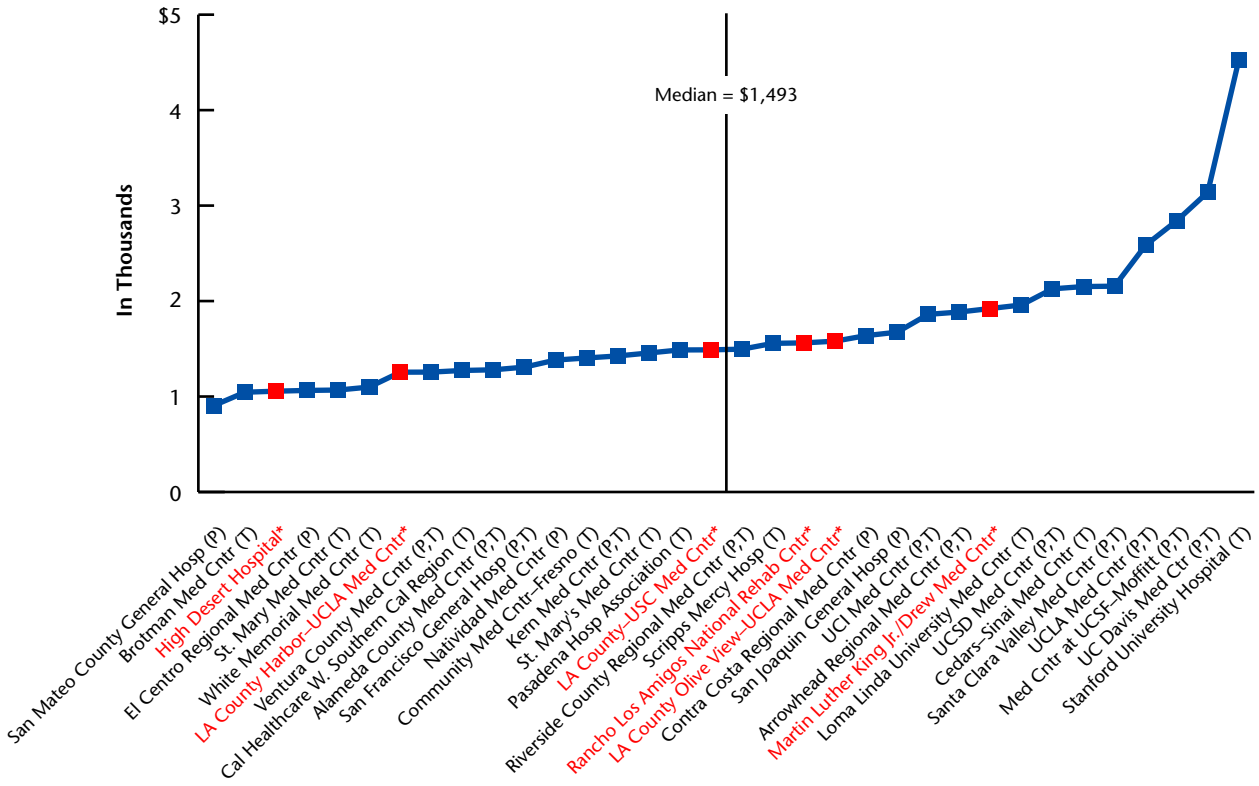
Source: Office of Statewide Health Planning and Development except fiscal year 1999–2000. Health Services for fiscal year 1999–2000 data.

Note: Average inpatient operating expense excludes physician fees.

Figure B.17 on the following page shows the inpatient operating expense per patient day in fiscal year 1999–2000 for the individual Health Services' and benchmark hospitals. The distribution confirms that the average operating cost per patient day for the benchmark hospitals shown in Figure B.16 is strongly influenced by a few relatively high-cost hospitals, including Stanford University Hospital ($4,526 per day), UC Davis Medical Center ($3,140 per day), and the Medical Center at UCSF ($2,841 per day). For Health Services' hospitals, the average operating cost ranged from a low of $1,056 per day at High Desert (with its relatively low-cost skilled nursing unit) to $1,922 per day at MLK/Drew. Three of the county's six hospitals had average inpatient operating expenses per patient day that were above the median for the benchmark hospitals, and three had operating expenses that were below the median.

FIGURE B.17

Inpatient Operating Expense per Patient Day: A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Health Services.

Note: Total inpatient operating expense excludes physician fees.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

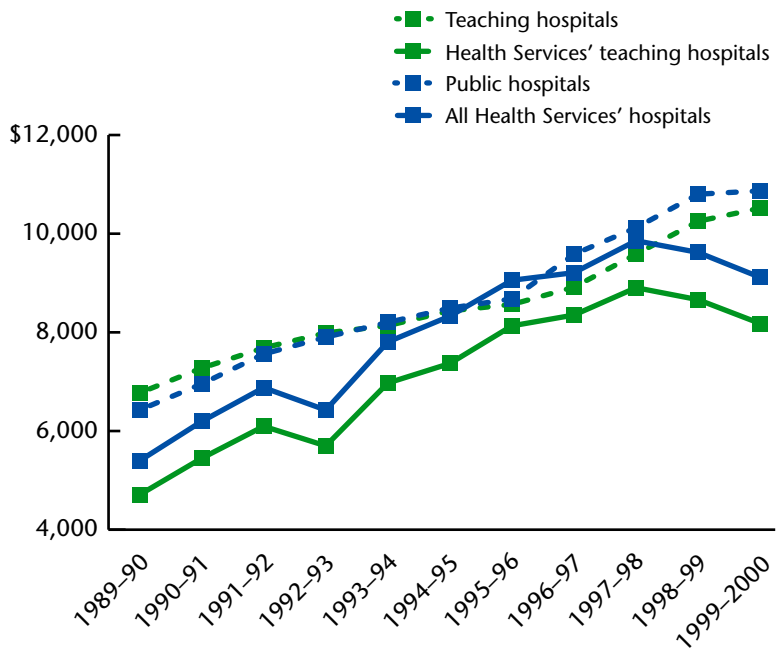
* Health Services' hospital.

Total Inpatient Operating Expense per Discharge

Inpatient operating expense per discharge, shown in Figure B.18, is similar to inpatient operating expense per day but also accounts for differences in the average length of stay across facilities. The relatively long lengths of stay at Rancho Los Amigos and High Desert hospitals tend to increase the average operating expense per discharge at Health Services' hospitals overall. Like the operating expense per day, average operating expense per discharge at Health Services' facilities is somewhat lower than

FIGURE B.18

**Average Inpatient Operating Expense per Discharge:
A Comparison of Health Services' Hospitals to Other Hospitals
Fiscal Years 1989–90 Through 1999–2000**



Source: Office of Statewide Health Planning and Development except fiscal year 1999–2000. Health Services for fiscal year 1999–2000.

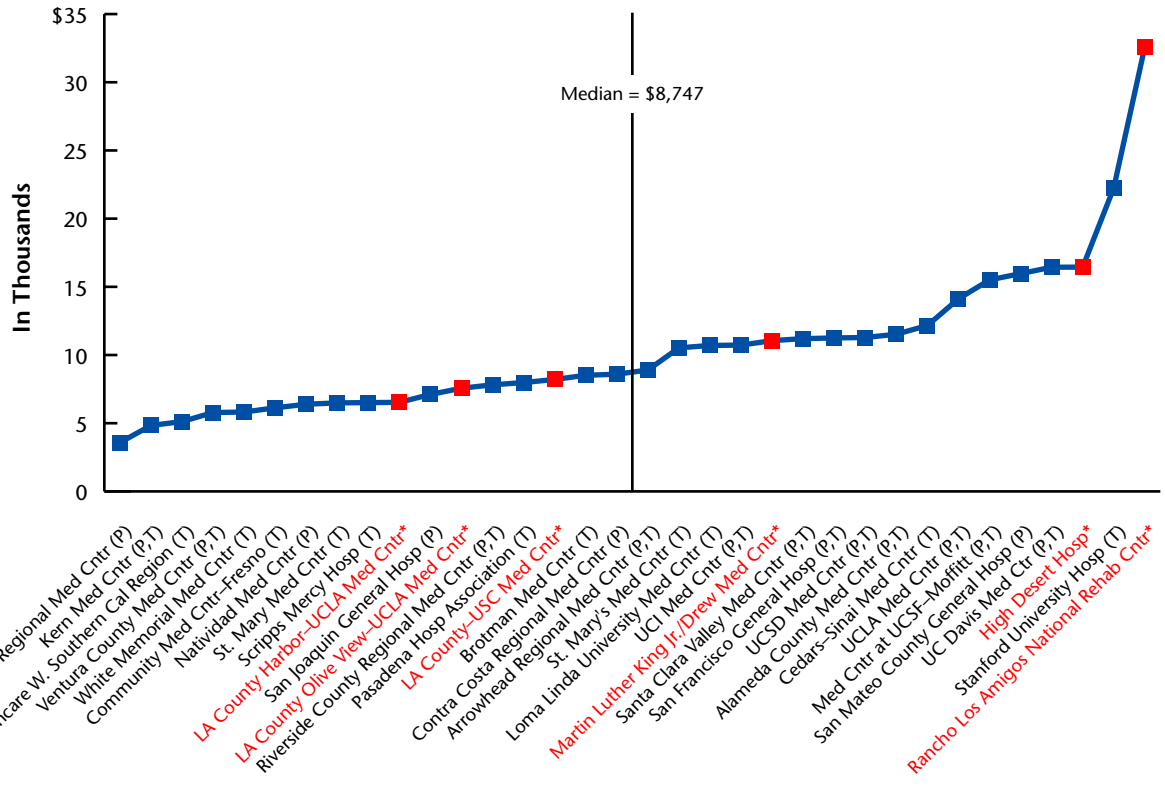
Note 1: Average inpatient operating expense excludes physician fees.

that for the benchmark hospitals over the past decade but, with the exception of fiscal years 1998–99 and 1999–2000, has followed a similar trend.

Three Health Services' hospitals are above the median in operating expense per discharge, and three are below the median, as shown in Figure B.19 on the following page. Three of the four Health Services' teaching hospitals, which are more comparable to the benchmark facilities, have operating expenses per discharge that are below the median.

FIGURE B.19

Inpatient Operating Expense per Discharge: A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Health Services.

Note: Total inpatient operating expense excludes physician fees.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

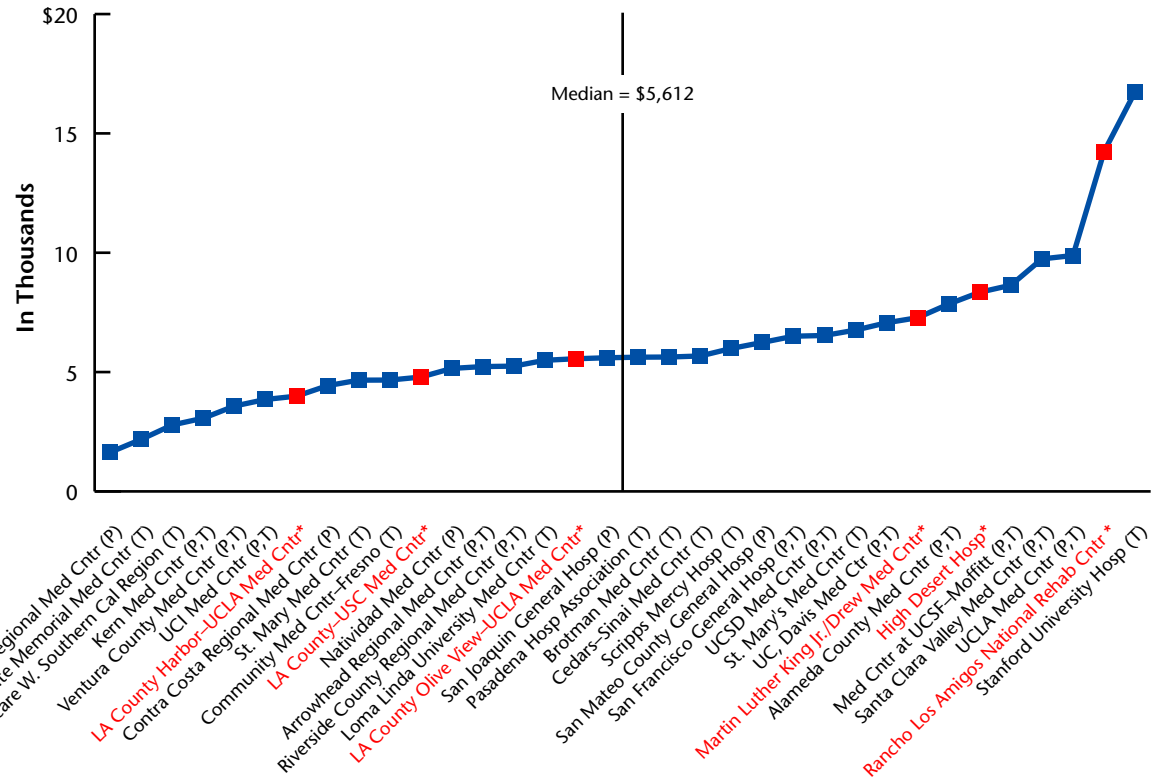
* Health Services' hospital.

Average operating expense per discharge can be affected by differences in the types of cases treated at different hospitals. Hospitals specializing in highly complex cases will tend to have longer average lengths of stay and, therefore, a higher cost per discharge than facilities treating less-complex cases. To control for possible differences in case mix across hospitals, we adjusted the operating expense per discharge in fiscal year 1999–2000 for

differences in case mix.[11] The results are shown in Figure B.20. Adjusting operating expenses tends to improve the relative ranking of four Health Services' hospitals—Harbor/UCLA, LAC/USC, High Desert, and Rancho Los Amigos—and worsen the ranking of Olive View/UCLA and MLK/Drew.

FIGURE B.20

Inpatient Operating Expense per Discharge, Adjusted for Case Mix: A Comparison of All Hospitals Fiscal Year 1999–2000



Source: Health Services.

Note 1: Total inpatient operating expense excludes physician fees.
Note 2: Operating expense per discharge is adjusted using the Texas Case Mix Index provided by Health Services.

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

* Health Services' hospital.

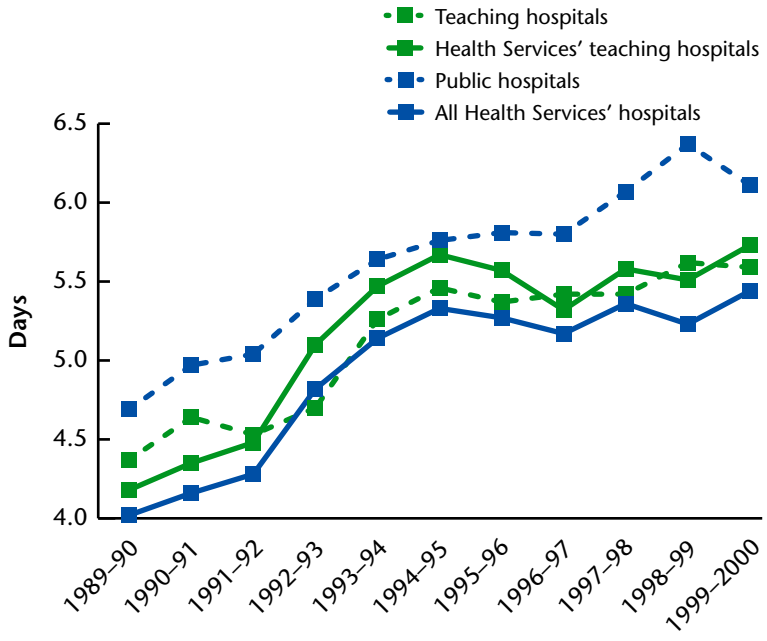
[11] Costs have been adjusted for differences in case mix using average cost per discharge by patient diagnosis for Medicaid patients in Texas. The diagnostic categories used are the Medicare Diagnostic Related Groups. Medicaid cost data were used rather than Medicare cost data because the demographic profiles and diagnoses of Health Services patients more closely resemble Medicaid eligibles than Medicare eligibles, who are generally over 65 years of age.

Employee Days per Patient Day

Personnel costs are a major component of total hospital expenses. Figure B.21 shows the average number of full-time equivalent employees per patient day. This figure shows that, on average, public hospitals have higher ratios of employees to patients than teaching hospitals do. The Health Services' hospitals are near the average for teaching hospitals and below the average for other public hospitals, including those that are also teaching hospitals.

FIGURE B.21

Average Employee Days per Patient Day: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



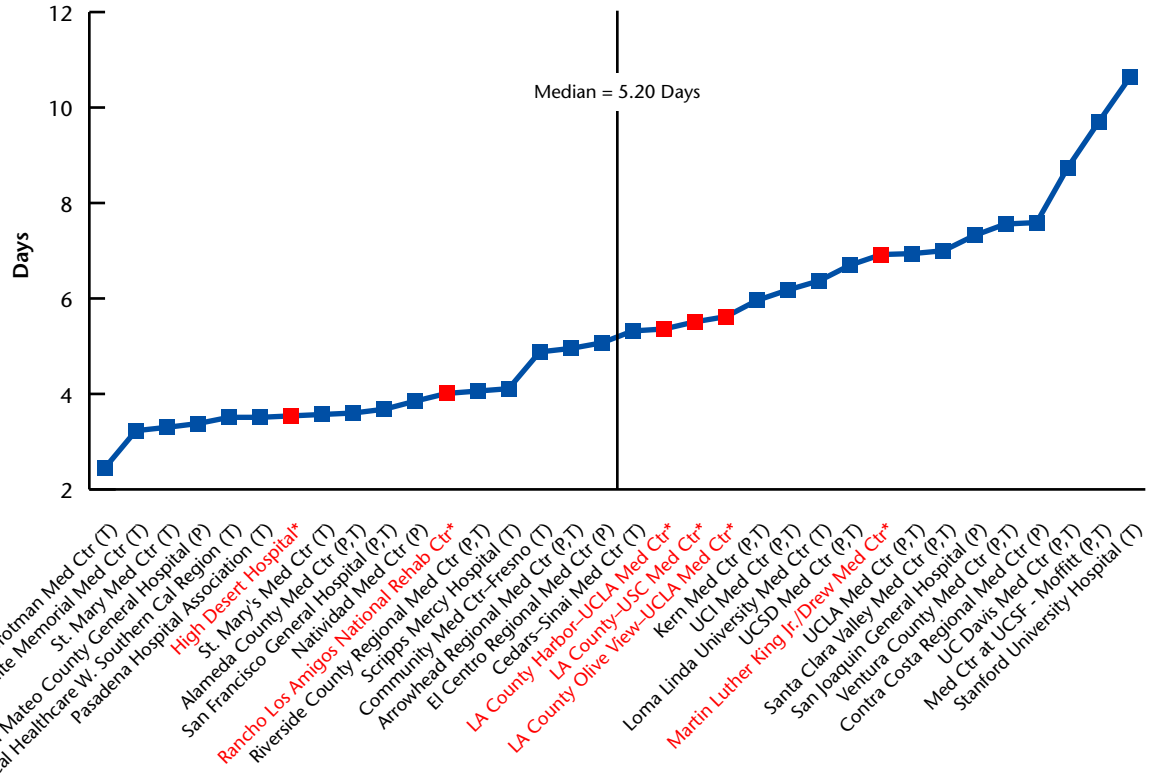
Source: Office of Statewide Health Planning and Development.

Note: Employee days are calculated by dividing the reported productive hours for all hospital employees by eight (number of hours in a standard workday).

Averages for the benchmark groups are affected by a few less productive hospitals, as shown in Figure B.22. At Health Services' hospitals, the number of employee days per patient day ranges from 3.5 at High Desert to 7 at MLK/Drew. With the exception of MLK/Drew, Health Services' teaching hospitals cluster slightly above the median. Overall, these data indicate that Health Services' hospitals have somewhat greater numbers of employee days per patient day than the majority of benchmark hospitals do.

FIGURE B.22

Employee Days per Patient Day: A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

Note: Employee days are calculated by dividing the reported productive hours for all hospital employees by eight (number of hours in a standard workday).

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

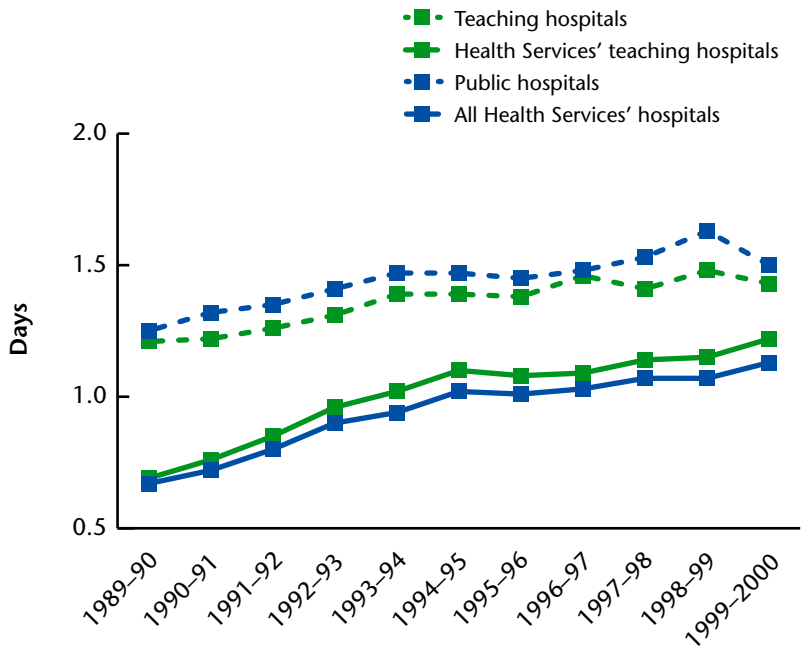
* Health Services' hospital.

Nursing Days per Patient Day

To further measure staff levels, we examined the average number of full-time equivalent nursing staff per patient day. Compared with the average number of employees per patient day, the nurse-to-patient ratio is an indication of the number of employees directly involved in patient care. Nursing staff includes registered nurses and licensed vocational nurses (including registry nurses working under contract). Using this measure, as seen in Figure B.23, Health Services' hospitals are significantly below the averages for both teaching and public hospitals.

FIGURE B.23

Average Number of Nursing Days per Patient Day: A Comparison of Health Services' Hospitals to Other Hospitals Fiscal Years 1989–90 Through 1999–2000



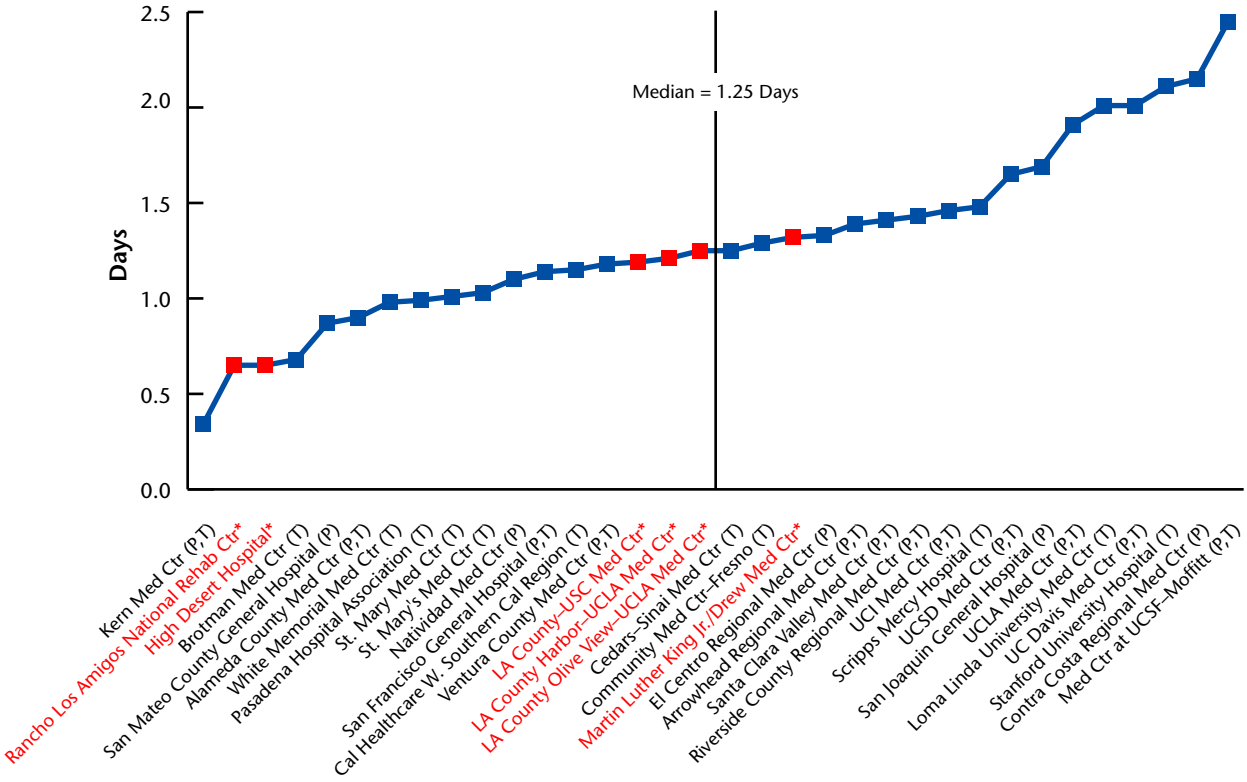
Source: Office of Statewide Health Planning and Development.

Note: Nursing days are calculated by dividing reported productive hours for registered nurses by eight (the number of hours in a standard workday).

As with previous measures, average nurse-to-patient ratios are strongly affected by a few outliers. Figure B.24 shows that all Health Services hospitals except MLK/Drew have lower nurse-to-patient ratios than the median of 1.25. In total, these data suggest that opportunities to reduce operating expenses by reducing staffing levels are greater among non-nursing hospital employees than among nurses. This is particularly so given the minimum nurse staffing ratios that will be implemented shortly.

FIGURE B.24

Nursing Days per Patient Day: A Comparison of All Hospitals
Fiscal Year 1999–2000



Source: Office of Statewide Health Planning and Development.

Note: Nursing days are calculated by dividing reported productive hours for registered nurses, registry nursing, and licensed vocational nurses by eight (the number of hours in a standard workday).

T - Classified as a teaching hospital.

P - Classified as a public hospital.

P,T - Included in both benchmark groups.

* Health Services' hospital.

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APPENDIX C

The Effects of Waiver Extension Requirements and Changes in Laws and Regulations on Health Services' Deficit

The five-year Waiver extension granted to the Los Angeles County Department of Health Services (Health Services) expires at the end of fiscal year 2004–05. This appendix describes the requirements of the Waiver extension and evaluates the progress that Health Services has made toward implementing those requirements. The Waiver extension responsibilities include maintaining a certain minimum level of outpatient care visits, improving clinical resource management, and enrolling clients in health coverage, among others. For each requirement, we also indicate whether it will have an impact on revenues or costs and whether the impact on the budget deficit can be estimated.

Apart from the terms of the Waiver extension, there are other external influences that may affect Health Services' budget deficit. These include state and federal legislative initiatives and regulations affecting the provision of health care. Examples include changes to the State's Acute Inpatient Disproportionate Share Hospital Program (DSH) administration fee, the federal reduction of the Medicaid upper payment limit, mandatory minimum nurse staffing ratios, and Health Insurance Portability and Accountability Act (HIPAA) requirements. We describe each of these initiatives here and evaluate their likely impact on Health Services' budget.

THE REQUIREMENTS OF THE WAIVER EXTENSION

The governing documents for the Waiver extension detail Los Angeles County's responsibilities during the extension period, July 1, 2000, through June 30, 2005.[1] These requirements

[1] There are several documents governing the Waiver extension that present the requirements. The Special Terms and Conditions document is the agreement between the Centers for Medicare and Medicaid Services and the State of California. The Interagency Agreement is between the California Department of Health Services and the County of Los Angeles.

include providing a minimum number of outpatient visits each year, implementing clinical resource management practices, submitting applications to achieve Federally Qualified Health Center (FQHC) or look-alike status, simplifying the financial screening process to determine a patient's ability to pay, enrolling patients in health coverage, increasing the number of certified Medi-Cal-eligibles, and updating diagnostic coding systems to comply with HIPAA. The following discussion of the Waiver extension requirements first covers the requirements that affect Health Services' revenues and then describes those that affect its costs.

The discussions of Health Services' progress toward meeting each requirement are based on information from Health Services' progress reports and interviews with Health Services staff. For each requirement, the effects on Health Services' budget deficit are taken from Health Services' forecast scorecard, with additional information obtained from a memo from the director of Health Services to the County Board of Supervisors.

Waiver Requirements Aimed at Increasing Revenues

Applying for Federally Qualified Health Center Status

Health Services is required to submit applications to the Health Resources and Services Administration to achieve FQHC or FQHC look-alike status for its health centers, comprehensive health centers, hospital outpatient departments, and public-private partnership (PPP) clinics. The major advantage of obtaining FQHC status is that the clinics will then be eligible for cost-based reimbursement, thereby reducing potential Health Services' budget deficits. The Waiver extension requires that Health Services begin submitting applications by April 1, 2001.

Health Services has met this deadline and has achieved FQHC status for one clinic. In the first year of the extension, Health Services submitted a work plan and two PPP providers submitted applications for FQHC status by the April 1, 2001, deadline. The Centers for Medicare and Medicaid Services (CMS) granted FQHC status to Queens Care/Franciscan Clinics. A FQHC application was submitted for South Bay Family Healthcare Center, and a FQHC look-alike application was submitted for Community Health Alliance of Pasadena.

The budgetary impact of this initiative is unknown. According to Health Services, the cost of submitting applications is relatively small. Health Services currently receives cost-based reimbursement for outpatient services as part of the Waiver extension, and its forecasts include the impact of applying for cost-based reimbursement. Applying for FQHC status will increase the deficit slightly because of the cost of staff time to apply. Once cost-based reimbursement is achieved, its impact depends on the extent to which cost-based reimbursement covers Health Services' costs. If the reimbursement covers the costs, then achieving FQHC status has no impact on the deficit. However, some services are not covered, and reimbursed costs must be reasonable based on Medicare reimbursement methodologies. Therefore, it is still possible under cost-based reimbursement that Medi-Cal patients will cost Health Services more than the associated reimbursement.[2] Quantifying the impact of this effect involves an analysis of Medi-Cal reimbursement rates and Health Services' costs for the same visit. At this stage, these cost data are not available, so the impact on the deficit is unknown.

Simplifying Financial Screening Processes

This requirement calls on Health Services to simplify its processes for determining an uninsured individual's ability to pay for health care services at Health Services' hospital outpatient departments and clinics. The implementation of this requirement is summarized in the Outpatient Reduced-Cost Simplified Application Plan (simplified application plan). The simplified application plan is designed to simplify the process of determining patients' ability to pay so that financial screening and health care delivery occur at the same location, to improve access to eligibility programs (such as Medi-Cal, Healthy Families, etc.), and to eliminate other unreasonable obstacles to access associated with the screening process. The Los Angeles County Board of Supervisors approved the plan in November 2000, and implementation began in January 2001. Health Services hired 45 new patient services staff, which were trained to perform the financial screening. Between November 2001 and mid-January 2002, 22 screeners began work in the field.

[2] Furthermore, FQHCs may be (upon agreement between the State and each clinic) reimbursed under the Prospective Payment System (PPS). Under the SCHIP Benefits Improvement and Protection Act of 2000, the PPS is based on average cost per visit for 1999 and 2000, and it then ties reimbursement to medical inflation in future years.

The impact of this requirement on Health Services' deficit is unknown at this point. Simplifying enrollment of uninsured and indigent patients requires expenditures on staffing and has an impact on revenue. Health Services estimates the staffing costs of this requirement at $900,000 in fiscal year 2000–01 and $1.9 million for fiscal years 2001–02 through 2004–05. It expects the revenue impact, through the end of the Waiver extension, to be negative. The numbers of prepaying patients and self-paying patients are expected to decline, with an impact of $2.2 million in fiscal year 2000–01 and $6.6 million for fiscal years 2001–02 through 2004–05.

An effect left unaddressed in Health Services' estimates of revenue impact is how many of the screened patients will qualify for other programs. These individuals may bring revenue from external sources—for example, from the Medi-Cal program—which could lead to a net increase in revenue, or at least to a smaller reduction in revenue than anticipated. A more complete analysis would require estimates of the number of patients who would qualify for coverage, the type of coverage, and the revenue impact relative to what they were providing under the prepayment program. These data are unavailable at this time, so the magnitude of the impact is unknown.

Enrolling Clients in Health Coverage

Health Services is required to implement a comprehensive process to offer every person who receives services from the Health Services' system the opportunity to apply for Medi-Cal, Healthy Families, Kaiser Kids,[3] or other health coverage for which he or she may be eligible. Health Services was to assess the workload for this requirement by January 1, 2001, and to station eligibility workers at Health Services' and PPP sites by July 1, 2001. During the first year of the Waiver extension, the county Department of Public Social Services, working on behalf of Health Services, completed the workload assessment at all PPP sites and placed staff accordingly.

Expenditures on staff to enroll clients in health coverage directly increase the deficit. Indirect impacts of this requirement stem from the revenue implications of enrolling existing

[3] Kaiser Kids is coverage for children aged 0 to 19 who are not eligible for Medi-Cal or Healthy Families, who are in families with at least one child enrolled in a public school, and whose family income is between 200 percent and 275 percent of the federal poverty level.

clients versus enrolling new clients. The enrollment of existing clients could lead to new revenue sources (Medi-Cal, Healthy Families, etc.) instead of reliance upon county funds, and thus could decrease the deficit. The impact of enrolling new clients is unclear. For a new Medi-Cal patient treated in the outpatient setting, Health Services receives cost-based reimbursement during the Waiver extension period. For a new patient treated in the inpatient setting or belonging to a managed care program, Health Services is reimbursed on a capitation basis. These latter patients may or may not increase the deficit, depending on the costs relative to the reimbursements. At this stage, the potential impact of this requirement is unknown.

Increasing the Number of Medi-Cal Certified Eligibles in Los Angeles County

The preceding section applies to enrolling patients in health coverage of any type. However, the predominant form of coverage for the Health Services' patient population is Medi-Cal. For Medi-Cal, the Waiver extension specifies explicit Medi-Cal enrollment targets for each year of the Waiver extension.[4]

Preliminary data from the June 2001 report from the Department of Public Social Services indicated that Health Services had more than 1 million certified eligibles enrolled for the October month of eligibility, meeting the requirement for that year. Similarly, Health Services reported that more than 1.1 million certified eligibles were enrolled for the December 2001 month of eligibility, meeting the requirement for the second year.

The budgetary impact of this requirement is unknown. Increasing the number of Medi-Cal-eligibles has a negligible impact at the time of the increase and an indeterminate impact in the long term. The long-term impact depends on whether those who sign up with Medi-Cal are already in the Health Services' system or are new to it. As we described earlier, existing patients participating in Medi-Cal will decrease the deficit. New patients, however, could increase or decrease the deficit. At this stage, the impact is uncertain.

[4] These targets are 950,000 by June 2001; 997,500 by June 2002; 1,047,400 by June 2003; 1,099,800 by June 2004; and 1,154,800 by June 2005.

Waiver Extension Requirements Aimed at Reducing Costs

Providing Greater Access to Outpatient Care

The Waiver extension requires that Health Services provide a minimum of 3 million outpatient visits annually during the extension period, at least 700,000 of which should be provided through private providers under PPP agreements. For this requirement, a visit is "a face-to-face encounter between a clinic patient and a health care professional." Visits can be provided through county facilities (comprehensive health centers, health centers, public mental health clinics, and hospital-based clinics) or PPP clinics (providing either health services or mental health services). PPP clinics are privately owned under contract with Health Services to provide primary care to low-income patients.

Health Services met these requirements in the initial year of the Waiver extension and appears likely to meet them in the second year. In fact, the total number of outpatient visits far exceeds the annual number required by the Waiver extension. During the first fiscal year, July 1, 2000, through June 30, 2001, Health Services reported providing more than 2.7 million outpatient visits through its facilities and more than 719,000 visits through PPP clinics. Additionally, there were more than 2 million county Department of Mental Health outpatient care visits. This is a total of more than 5.4 million visits, far in excess of the 3 million annually required by the Waiver extension.

Based on preliminary numbers for July 1, 2001, through November 2001 from the progress status report for fiscal year 2000–01, Health Services reports providing more than 964,000 outpatient visits. When annualized, this number indicates more than 2.3 million outpatient visits for the year. The report also shows that more than 170,000 visits were provided at PPP clinics through September 2001, for an annualized total of more than 681,840 visits, slightly fewer than the required number. However, recently collected preliminary numbers indicate that Health Services will exceed this requirement. Additionally, more than 533,000 outpatient visits were provided at the county's Department of Mental Health facilities through September 2001, which also count toward the requirement.

There are several issues to consider in assessing the budgetary impact of these requirements. Increasing access to outpatient care was intended to lower overall costs by shifting patients from inpatient to outpatient care. However, Health Services indicates that a large fraction (60 percent) of these patients

seek treatment only when symptoms are acute, and many of these (90 percent) are seen only once. This has apparently led to more acute care because routine preventative care and health monitoring have not occurred. Thus, shifting patients to outpatient care has increased costs relative to having the same patients served in an inpatient setting. Health Services also finds that increased outpatient care has led to an increase in referrals to specialists and inpatient services.

There are several additional points to consider in assessing the effect of this Waiver extension requirement on Health Services' ability to resolve its budgetary problems. Health Services is currently providing outpatient visits beyond the number required by the Waiver extension. If Health Services were to reduce the number of outpatient visits to a level closer to the Waiver extension requirement, it would need to consider the following consequences. First, Medi-Cal visits during the Waiver extension are provided on a cost-reimbursed basis, so the revenue for some visits matches the cost, yet, as we discussed in the earlier section on achieving FQHC status, this may not be the case for other visits. Second, the number of outpatient visits must be considered in light of Waiver extension funding limits. These limits apply to cost-based reimbursement for care provided to indigent patients, so the number of visits that Health Services can provide under the limits declines as the Waiver extension funding phases out. Third, some portion of a reduction in outpatient visits would be provided through more expensive emergency room visits. Fourth, a much-reduced outpatient system would likely lead to fewer people presenting themselves for care, leading to more-acute medical problems and higher costs in the future.

Similar issues arise when we analyze the budget impact of the target number of visits to PPP clinics. Given that Health Services pays a PPP $82.83 for a primary care visit, the decision as to whether Health Services should be providing more care through PPP clinics depends on whether it could provide the same care at a lower cost at its own facilities. Without a cost accounting system, Health Services cannot make this cost comparison.

Health Services' current and forecasted budgets use information about current service levels to produce revenue and cost estimates. Therefore, the required service levels (3 million outpatient visits and 700,000 PPP visits) are reflected in Health Services' current and forecasted budgets.

Implementing Clinical Resource Management

The Waiver extension requires that Health Services implement clinical resource management practices—that is, methods of standardizing the care provided to patients. Health Services has two types of clinical resource management practices: (1) inpatient clinical pathways, aimed at standardizing the treatment of specific conditions, and (2) disease management programs, aimed at standardizing the treatment of specific diseases. By reducing the variability in the type of care provided, pharmaceuticals used, and tests conducted, Health Services expects to realize economies that help cut costs per patient and increase the quality of care provided. The Waiver extension requires Health Services to begin implementing inpatient clinical pathways by July 1, 2001, and to begin implementing the disease management programs by July 1, 2002.

Health Services met the July 1, 2001, deadline in the initial year of the Waiver extension and appears likely to meet the July 1, 2002, deadline in the second year. The most recent progress report indicates that Health Services developed the methodology for baseline hospital services data for inpatient clinical pathways and submitted that methodology to the State Department of Health Services by the July 1, 2001, deadline. Savings under the program are calculated as the reduction in the average length of stay multiplied by the average cost per day for a given diagnosis. Furthermore, the Los Angeles County–University of Southern California Medical Center implemented the congestive heart failure, post-partum vaginal, and C-section pathways by the July 1, 2001, target date. These efforts are likely to lead to modest cost savings. The Waiver extension documents describe anticipated cost savings of $3 million during fiscal year 2003–04 from the use of clinical resource management practices, increasing to $6 million in savings during fiscal year 2004–05. These anticipated savings are not reflected in Health Services' forecasts. Health Services has not completed an analysis assessing the baseline cost estimates for the pathways. In addition, current estimates of the costs for treating patients using the pathways are unavailable. Thus, the data are insufficient to substantiate the anticipated savings.

Improving Data Reporting

Health Services is required to improve its data reporting capabilities during the Waiver extension. First, it was to have implemented a standardized department-wide charge

description by July 1, 2001. Second, it was to implement the facility-based outpatient Itemized Data Collection (IDC) project by December 31, 2001. Finally, it is required to update and convert its coding systems for claims for Medi-Cal services to conform to all HIPAA requirements, concurrent with the State's compliance with HIPAA. There are three main HIPAA requirements: privacy, security, and coding.

In the first annual progress report, Health Services stated that it had implemented the department-wide charge description master and was on target to comply with HIPAA coding requirements. In the latest report, Health Services reported that it had implemented the facility-based outpatient IDC at county facilities by the December 31, 2001, implementation date.

The HIPAA requirements will be costly to implement, but the total cost is indeterminate at this point. Health Services will soon receive a consultant's report analyzing the costs of complying with HIPAA, including the costs of complying with privacy requirements, security requirements, and coding requirements. The memo from the director of Health Services to each county supervisor indicates that the cost of non-IDC components could be at least $10 million and a factor in creating a deficit beginning in fiscal year 2002–03. A consultant provided estimates that the privacy and security components will cost between $10 million and $12 million. The total impact on the deficit, while likely to be greater than $10 million or $12 million, will be unknown until the consultant's report is available later this spring. In the long term, better data and data systems will assist Health Services in managing its operations efficiently, and they are also likely to decrease costs.

CHANGES IN LAWS AND REGULATION

Apart from the terms of the Waiver extension itself, there are other external influences that may affect Health Services' budget deficit. These include state and federal legislation and regulations affecting the provision of health care. Table C.1 on the following page lists these external factors. This section describes each of these requirements, evaluates their impact on Health Services' budget, reports Health Services' estimates of deficit impact, and indicates the likelihood of each external influence occurring.

TABLE C.1

Estimated Effects of Recent and Proposed Changes in Legislation, Regulation or Administrative Interpretation and Other Potential Impacts on Health Services' Deficit

Changes	Effect on Deficit	Estimated Impact Through Fiscal Year 2005–06 (in Millions of Dollars)	Likelihood of Change
Changes that may result in increased revenue			
Medi-Cal outpatient settlement	Decrease	+20 to +50	Unknown
Medi-Cal outpatient rate increase	Decrease	+1.4	Unknown
Changes that may result in decreased revenue			
Reduction of hospital upper payment limit	Increase	-56.3	Certain
Governor's fiscal year 2002–03 budget–DSH administration fee	Increase	-11.0	Unknown
PPP/General Relief rate increases not yet board approved	Increase	-8.6	Unknown
Governor's fiscal year 2002–03 budget–non-Medi-Cal CHDP	Increase	-1.7	Unknown
Governor's fiscal year 2002–03 budget–reimbursement reduction for emergency room co-payments	Increase	-0.2	Unknown
Changes whose impact is not yet determined			
Upper payment limit–clinics	Neutral	0.0	Unknown
Governor's fiscal year 2002–03 budget–reduction in fiscal year 2000–01 physician rate increases	Unknown	Unknown	Unknown
Governor's fiscal year 2002–03 budget–reduction in eligibility workers and patient financial services workers administrative cost reimbursement	Unknown	Unknown	Unknown
Potential additional DSH program reductions	Unknown	Unknown	Unknown
Expand Healthy Families to adults not currently covered	Unknown	None	Unknown
State Assembly Bill 557–financial assistance for hospitals' seismic retrofitting	Decrease	None	In Committee
State Senate Bill 402–coverage for 19- and 20-year-olds	Unknown	None	In Committee
U.S. Congress Bill–Medicaid Safety Net Hospital Continued Preservation Act	Decrease	None	In Committee
Changes that may result in increasing costs			
Chapter 740, Statutes of 1994 (SB 1953), operational costs	Increase	-40.0	Certain
Nurse staffing ratios law	Increase	-35.0	Certain
Non-IDC HIPAA	Increase	-10 to -12	Certain
Physician bargaining unit #324	Increase	0.0	Unknown

Source: Health Services.

This list of changes was compiled from three sources: (1) items not included in the baseline budget but identified by Health Services in the "Other Potential Needs and Developments" section of its scorecard; (2) current legislation under consideration by the California State Legislature; (3) current legislation under consideration by the U.S. Congress.

Health Services provides estimates of the effect on the deficit of each change in its January 22, 2002, scorecard. When applicable, pertinent information from the memo from the director of Health Services to each county supervisor is mentioned here and reported in Table C.1. The estimates presented below and in Table C.1 are for fiscal years 2001–02 through 2005–06.

Table C.1 also presents an assessment of the likelihood of each change. For many of these changes, the likelihood is unknown at this time. However, the discussion below provides explanations for those items indicating "certain" or "in committee" in the Likelihood of Change column.

The regulatory changes are presented here according to their effect on revenue or cost. We first discuss those changes that could potentially increase Health Services' revenue, followed by those that could potentially decrease Health Services' revenue; next we present those with an unknown or indeterminate impact on Health Services' revenue; and finally we cover those potentially increasing Health Services' costs. None of the changes potentially decreases Health Services' costs.

Changes Potentially Increasing Revenue

Medi-Cal Outpatient Services Settlement: Retroactive Payment

A settlement is pending that arises from three lawsuits brought by several counties, providers, and the California Hospital Association against the State of California for alleged under-reimbursement for outpatient services. A retroactive component, $175 million, will be divided among eligible hospitals.

It has not been decided how the settlement amount will be divided among the plaintiffs. Thus, Health Services has not included the effect of the settlement in its forecast. However, the notes to the January 22, 2002, scorecard present an estimate of $25 million based on a "very preliminary" analysis. The memo from the Health Services' director to each county supervisor gives an estimate of between $20 million and $50 million for this amount.

Medi-Cal Outpatient Services Settlement: Rate Increase

In addition to the retrospective lump sum discussed in the previous section, the settlement will provide a 30 percent increase in emergency room outpatient reimbursement rates, effective July 2001. This has been accounted for in the fiscal year 2001–02 budget. Also, Health Services anticipates receiving a 3.3 percent increase in outpatient rates each year for 3 years. Health Services anticipates a small windfall from this increase, which is estimated to provide a gain of $1.4 million over the 3-year period.

Changes Potentially Decreasing Revenue

Reduction of Hospital Upper Payment Limit

A recently promulgated final federal rule limits the aggregate amount that a group of hospitals may claim for Medicaid services. The limit is stated in terms of the reimbursement allowed for the same services under Medicare. Prior to the rule, an upper payment limit of 150 percent of the Medicare amount applied to the group of hospitals to which Health Services belongs. The new rule lowers the upper payment limit for Health Services hospitals from 150 percent to 100 percent.

A provision in the law allows certain states to be given a transition period over which the reduction can be phased in. If California qualifies for the transition period, this requirement would be phased in over an 8-year period.

In order to qualify for the transition period, Health Services must show that its Medicaid expenditures exceeded the upper payment limit by at least 150 percent in fiscal year 1999–2000. Although this is yet to be determined, if Health Services does qualify, beginning in fiscal year 2003–04, it will be required to reduce the gap in the upper payment limit (between where it currently is and 100 percent) by 15 percent each year until October 1, 2008, when it will have reached full compliance.

Health Services' estimates of this requirement's impact are based on the current upper payment limit gap of $125 million, which is based on estimates from the California Association of Public Hospitals. Thus, Health Services anticipates an impact that will increase the deficit by 15 percent of $125 million, or $18.75 million cumulatively, each year. For example, the impact is $18.75 million in fiscal year 2003–04, $37.50 million in fiscal year 2004–05, etc. In Table C.1, this is reported for the final two

years of the Waiver extension, fiscal years 2003–04 and 2004–05, and for the first post-Waiver extension year, fiscal year 2005–06, an amount equal to $56.25 million. Since this change has been published in a final federal rule, it is highly likely to occur.

Governor's Fiscal Year 2002–03 Budget: DSH Administrative Fee

Under the DSH program, funds are returned to the State after the federal government applies its match. Before these funds are returned to individual hospitals, the State charges an administrative fee that is deducted from the total. The governor's budget proposes increasing the total fee from $29.8 million to $85 million. This affects Health Services because a larger fee translates to a smaller net portion of DSH funding available for hospitals.

According to the chief of Fiscal Programs, the current agreement between public and private hospitals states that each type of hospital will cover half of the fee. Therefore, the public sector is responsible for approximately one half of the $55.2 million increase (the difference between $85 million and $29.8 million), or $27.6 million.[5] Los Angeles County's share of DSH receipts is approximately 40 percent, yielding an estimated $11 million in additional administrative fees.

Increases in the Rate Paid to Public-Private Partnership Clinics Not Yet Board Approved

The county administrative office originally approved an 11 percent increase in the rate paid to PPP clinics, effective October 2000. Health Services would like to have an additional cost-of-living increase of approximately 3 percent approved to raise the rate in future years. The Board of Supervisors has not approved the increases. Health Services calculates that the additional cost-of-living increase would cost Health Services approximately $2 million each year, or a total of $8.6 million.

Governor's Fiscal Year 2002–03 Budget: Child Health Caseload Ineligible for Medi-Cal

The governor's budget proposes to shift the caseload for the Child Health and Disability Prevention program (child health program) to Medi-Cal and the Healthy Families program. While this appears to be a simple accounting change, the chief of

[5] According to the chief of Fiscal Programs, the agreement between public and private systems also states that any further increases in this fee above $85 million are solely the responsibility of the public sector.

Health Services' Controller's Division thinks that some child health program participants may not be eligible for Medi-Cal or the Healthy Families program.

Health Services estimates that up to $1.7 million in revenue received for child health program participants who are ineligible for Medi-Cal is at risk with this change. The impact could be the entire $1.7 million if none of the patients in question can be covered by Medi-Cal or Healthy Families.

Governor's Fiscal Year 2002–03 Budget: Reduction in Reimbursement for Emergency Room Co-Payments

The governor's budget proposes requiring co-payments from Medi-Cal recipients to the extent permitted by federal law. These payments, ranging from $1 to $3 (and up to $5 for emergency room services), will be deducted from provider reimbursements. This policy could increase costs to Health Services when participants cannot afford the co-payments; and because emergency room patients cannot be turned away, Health Services has no way of demanding co-payments from these Medi-Cal patients prior to treatment.

While the governor's budget suggests that the co-payments will be paid by patients (and thus will have no impact on Health Services' budget), Health Services does not expect indigent patients to pay, so it has included a modest negative impact, estimated at $200,000 in the budget.

Changes Potentially Affecting Revenue With an Indeterminable Impact on Budget

Upper Payment Limit Applied to Clinics

A proposed federal rule change would apply the Medicaid upper payment limit to non-state government clinics. This rule imposes a limit on clinics similar to the limit on hospitals. The impact of this change is uncertain at this point. CMS and the State must develop a plan based on the law, but according to the chief of Fiscal Programs, many features of Los Angeles County's system are atypical compared to other states, making the fiscal impact to Health Services unclear. Health Services has estimated that this change will have no fiscal impact.

Governor's Fiscal Year 2002–03 Budget: Reduction in Fiscal Year 2000–01 Physician Rate Increases

Under Medi-Cal, physicians are reimbursed for the care they provide to Medi-Cal patients at rates set by the State. The State's Year 2000 Budget Act specified increases in Medi-Cal provider rates totaling approximately $800 million. The increases included a 16.7 percent increase in overall physician services rates and a 10 percent increase in long-term care rates. Given the State's current budget situation, the governor finds "it is necessary to partially rescind the 2000–01 provider rate increases, reflecting a savings of $155.1 million." The impact of this change on Health Services is uncertain.

Governor's Fiscal Year 2002–03 Budget: Reduction in Administrative Cost Reimbursement for Certain Workers

The chief of the Controller's Division at Health Services stated that the governor's January 2002 proposed budget for 2002–03 calls for a reduction in the reimbursement of administrative costs related to eligibility workers and patient financial services workers. These are Health Services' and Department of Public Social Services' employees who assist clients with establishing eligibility and guide their selection of health plans. The chief estimates that there will be little impact from this change, but the precise impact is unknown.

Potential Additional Reductions in the DSH Program

In their planning, Health Services staff identify the possibility that the president's budget may include reductions in DSH funding. The impact of such a change is unknown.

Expansion of Healthy Families Program to Adults Not Currently Covered

On January 25, 2002, the governor announced that he would support an expansion of the State's Healthy Families program to cover the parents of children covered under the plan. Funding for the program would come from $200 million in state funds and a two-to-one match from the federal government. The State's portion, however, has not been allocated by the Legislature. The expansion depends on whether it is supported by the Legislature.

This program could have a neutral effect on the budget, to the extent that the additional beneficiaries are new to the system and their treatment is fully covered by the program. But to the extent that the program covers existing Health Services' patients, it could reduce the budget deficit. At this time, the effect is unknown.

State Assembly Bill 557: Financial Assistance for Hospitals' Seismic Retrofitting

State Assembly Bill 557 would authorize the issuance of two $1 billion general obligation bonds to provide financial assistance to hospitals for the purposes of meeting the 2008 and 2030 structural and nonstructural deadlines of the Alquist Hospital Facilities Seismic Safety Act. The bill is currently in committee, and a hearing on it has been postponed. The bill could reduce the deficit to the extent that it reduces planned outlays for seismic retrofitting, but no impact has been estimated by Health Services.

State Senate Bill 402: Coverage for 19- and 20-Year-Olds

State Senate Bill 402 would provide no-cost Medi-Cal to 19- and 20-year-olds in families with incomes up to 100 percent of the federal poverty level and would also make 19- and 20-year-olds eligible for the Healthy Families program. Essentially, this bill would raise the age ceiling for no-cost Medi-Cal and the Healthy Families program from the 19th birthday to the 21st birthday. During the Waiver extension period, Medi-Cal services would be eligible for cost-based reimbursement. After the Waiver extension period, the bill should have a neutral effect on the budget, to the extent that the additional beneficiaries are new to the system and their treatment is fully covered by the program. Existing Health Services' patients who are without coverage could be covered under the program, possibly reducing the budget shortfall. This bill is currently in committee, so its future is uncertain and its impact is unknown.

U.S. Congress Bill: Medicaid Safety Net Hospital Continued Preservation Act

A bill currently in committee in the U.S. Congress would eliminate the planned fiscal year 2002–03 decline in federal Medicaid DSH funding. This change would increase Health Services' DSH funding and would likely decrease the deficit. No current financial estimates exist.

Changes Potentially Increasing Costs

State Senate Bill 1953: Operational Costs

Signed into law in 1994, Senate Bill 1953, Chapter 740, Statutes of 1994, requires seismic retrofitting of hospitals throughout the State. For a facility to remain a general acute care hospital, the owner must conduct seismic evaluations and prepare both a comprehensive evaluation report and a compliance plan to attain specified structural integrity and nonstructural performance levels. These reports and plans must be submitted to the Office of Statewide Health Planning and Development. The costs related to planning the retrofitting of the buildings are already in the budget. Based on conversations with Health Services' staff, the cost changes involved with this law are primarily related to moving patients and reducing space in hospitals during the retrofitting.

Health Services requested estimates from each of the hospitals of the cost of these accommodations during the construction involved in retrofitting its facilities. These costs are estimated to increase the deficit by approximately $25.2 million in fiscal years 2003–04 and 2004–05. The memo from Health Services' director to each county supervisor contains an alternate estimate of $40 million in lost revenues and capital costs starting in fiscal year 2003–04.

Nurse Staffing Ratio Law

In 1999 California passed a nurse staffing ratio law requiring hospitals-to-staff nurses at certain levels relative to the number of patients cared for. The State Department of Health Services has recently decided on the ratios that will be used, but these ratios must go through a public comment period before they become final. State officials expect the rules to be implemented beginning in July 2003. Health Services is still analyzing the impact, but preliminary estimates are for $35 million in additional costs.

HIPAA Costs Not Related to IDC

Implementing the requirements of HIPAA involves certain costs that are not related to IDC. IDC is an effort to standardize the coding for health care delivery throughout the Health Services' facilities. These non-IDC costs include the cost of creating a system to maintain patient records and keep them secure.

Discussions with Health Services' staff indicate that implementing these requirements is likely to be costly, but it is difficult to estimate the cost at this time. Consultants are in the process of analyzing the requirements. The memo from the director of Health Services to each county supervisor contains an estimate of at least $10 million, beginning in fiscal year 2002–03. As we discussed earlier in this appendix, preliminary estimates conveyed to Health Services from the consultants indicate a cost of $10 million to $12 million for a portion of this program.

Physician Bargaining Unit #324

Physicians directly employed by Health Services have recently formed a union. This change has several costs and benefits for the county. Prior to the union, physicians directly employed by Health Services received benefits under Megaflex (the Health Services' benefits program). Since these physicians have unionized, they no longer qualify for Megaflex, which decreases Health Services' costs. Increased costs associated with unionization include (1) Health Services must now pay physicians "standby pay"—hourly pay to physicians who are not working but who are on standby to work, and (2) physicians were given a 3 percent pay increase.

In estimating the impact of this change, Health Services has considered the various issues that increase the deficit and that decrease it. The net effect is to increase the deficit by $20,000.

APPENDIX D

Glossary of Terms and Abbreviations

Term	Definition
1115 Waiver administrative claim	Costs paid by the federal government under the Waiver for administrative costs associated with indigent patient care.
1115 Waiver indigent care match	Costs paid by the federal government under the Waiver for outpatient care provided to indigent patients.
Acute	Sudden or severe. An acute health problem is one in which symptoms appear, change, or worsen rapidly. The opposite of chronic.
Acute care	A pattern of health care in which the patient is treated for an acute episode of illness, for the sequel of an accident or other trauma, or during recovery from surgery. It may involve intensive care and is often necessary for only a short period of time.
AIM: Access for Infants and Mothers	A state medical program that provides low-cost health insurance coverage to uninsured, low-income pregnant women and their infants. AIM is part of California's efforts to increase health coverage of pregnant women and their infants. The average subscriber is a married woman living in a household with a family income between 200 percent and 300 percent of the federal poverty level. A pregnant woman and her infant(s) enrolled in AIM receive their care from one of nine health plans participating in the program. The pregnant woman pays part of the cost of her health care services through a low-cost subscriber contribution. The State of California supplements the subscriber contribution to cover the full cost of care. AIM is funded by Tobacco Tax funds.
Chapter 945 Statutes of 1999 (AB 394)	A law requiring the California State Department of Health Services to adopt regulations that establish minimum nurse-to-patient ratios for all health facilities and that limit the nursing-related duties performed by unlicensed assistive personnel.
Capitation	A method of payment for health services in which the provider is paid a fixed amount for each patient without regard to the actual number or nature of services provided. Capitation payments are characteristic of managed care. Compare to cost-based reimbursement.
CBRC: cost-based reimbursement clinic	Under the Waiver, the county receives full cost-based reimbursement of all Medi-Cal services provided through the county's public-private partnership clinics. In order to sustain CBRC status beyond the 5 years of the Waiver, the county must apply for Federally Qualified Health Center (FQHC) status for all of its outpatient facilities. Federal law requires that states reimburse public-private partnership clinics that are FQHC for the full cost of care.
CHDP: Child Health and Disability Prevention	A program that is California's version of the Early and Periodic Screening, Diagnostic, and Treatment Program. This program mandates Medi-Cal coverage of examinations and follow-up care for children under age 21.
Chronic	A condition that is continuous or persistent over an extended period of time. The opposite of acute. A chronic condition is one that is long-standing and is not easily or quickly resolved.
Clinical resource management	A program that seeks to standardize the care provided to patients. It involves using standardized forms and guides and establishing agreed-upon clinical protocols for patients with the same diagnoses. By reducing the variability in the type of care provided, pharmaceuticals used, and tests conducted, Health Services expects to realize economies that help cut costs per patient and increase the quality of care provided. Health Services' physicians, nurses, managers, and others have spent more than a year developing this program for a number of diagnoses, such as congestive heart failure.

Term	Definition
CMAC: California Medical Assistance Commission	A small, independent commission, established in 1982 to negotiate contracts for specific services in the Medi-Cal program. The goal of the commission is to promote efficient and cost-effective Medi-Cal program expenditures through a system of negotiated contracts fostering competition and maintaining access to quality health care for beneficiaries.
Community Health Plan	A health maintenance organization (HMO), owned and operated by the county, that provides health insurance to approximately 150,000 Medi-Cal and Healthy Families program participants.
Consolidated Omnibus Budget Reconciliation Act of 1986	This federal act, commonly known as COBRA, gives certain employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. It applies to group health plans with 20 or more employees in the private sector and to those sponsored by state and local governments.
Cost-based reimbursement	Medicaid reimbursement rates that are set based on facility-specific costs as reported on the provider's cost reports. Compare to capitation.
Department of Health and Human Services	The federal department responsible for health-related programs and issues. Formerly the Department of Health, Education, and Welfare.
DRG: diagnosis related group	A classification system that uses diagnosis information to establish hospital payments under Medicare. This system groups patient needs into 467 categories, based upon the coding system of the International Classification of Disease, Ninth Revision—Clinical Modification.
DSH: Disproportionate share hospitals	California (and other states) has special reimbursement programs aimed at making up the shortfall for hospitals when care is provided to a patient who has little or no funds to cover the cost of care or who is a Medi-Cal beneficiary. Under Chapter 279, Statutes of 1991 (SB 855), a hospital that provides a certain amount of uncompensated care is designated as a disproportionate share hospital (DSH) and may qualify for additional funds. DSHs receive supplemental payments in addition to Medi-Cal payments for services rendered. To qualify, a hospital must have a Medi-Cal inpatient utilization rate at least one standard deviation above the statewide mean or a low-income utilization rate in excess of 25 percent. Intergovernmental transfers from public entities and matching federal financial participation fund payments; no state funds are involved.
EMTALA: Emergency Medical Treatment and Active Labor Act	A federal law that governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he or she is in an unstable medical condition. EMTALA is part of the Comprehensive Omnibus Budget Reconciliation Act of 1986.
Enterprise units	Health Services' budget units that are partially supported by patient fees.
Federal Medical Assistance Percentage	The share of the medical assistance expenditures under each state's Medicaid program paid by the federal government. Determined by a formula that compares the state's average per capita income level with the national income average.
FFP: federal financial participation	In state assistance expenditures, FFP indicates that the federal government provides a matching contribution.
FQHC: Federally Qualified Health Center	A federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants, and certified nurse midwives. Many outpatient clinics and specialty outreach services are qualified under this provision.
General fund units	Health Services' budget units that are supported almost entirely by general fund contributions, as opposed to patient fees.
HCFA: Health Care Financing Administration	Now known as the Centers for Medicare and Medicaid Services.

Term	Definition
Healthy Families program – California's SCHIP	Healthy Families program provides low-cost health, dental, and vision coverage to uninsured children in low-wage families. Families participating in the program choose their health, dental, and vision plan. Families pay premiums of $4 to $9 per child per month (to a maximum of $27 per family) to participate in the program.
HIPAA: Health Insurance Portability and Accountability Act (1996)	A federal law that protects health insurance coverage for workers and their families when they change or lose their jobs. The HIPAA privacy rule gives patients greater access to their own medical records and more control over how their personal health information is used.
IDC: Itemized Data Collection	A requirement of the Waiver extension, the IDC project was implemented across all outpatient clinics in the latter half of 2001. The IDC project is an effort to standardize the coding for health care procedures across Health Services' facilities. Prior to the IDC initiative, different clinics were using different codes for the same health care procedures.
Indigent	See Medically indigent.
In-Home Supportive Services workers	County health workers recently offered an opportunity to receive coverage under the Community Health Plan.
Inpatient service/care	Care given a registered bed patient in a hospital, nursing home, or other medical or post-acute-care institution.
Intrafund Tran	A Health Services budget item that stands for "intrafund transfers." These are payments from trust funds set up by state legislation. For example, the county receives special revenue funds from the Substance Abuse Trust Fund (created by Proposition 36) to cover local costs for drug abuse treatment.
JCHS: Juvenile Court Health Services	A Health Services budget unit that administers care to juveniles in the county Probation Department detention and residential treatment facilities and the Department of Children's Services' MacLaren Hall.
LACERA: Los Angeles County Employees Retirement Association	Provides retirement, disability, and death benefits to eligible county employees and their beneficiaries.
Los Angeles County Department of Health Services	The department that oversees health affairs in Los Angeles County as part of its mission to protect, maintain, and improve the health of the county. Health Services is the county department responsible for health care for the medically indigent.
Medicaid	A federal entitlement program for the poor who are blind, aged, disabled, or members of families with dependent children. Each state has its own standards for qualification. Authorized by Title XIX of the Social Security Act, Medicaid does not cover all of the poor, but only persons who meet specified eligibility criteria. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program. All states but Arizona have Medicaid programs.
Medi-Cal	California's version of the federal Medicaid program.
Medically indigent	Medical indigency is the nexus of health need and inability to pay. Health insurance status and family income are two important factors driving medical indigency and can be considered risk factors.
Medicare	A federal program for the elderly and disabled, regardless of financial status. It is not necessary, unlike Medicaid, for Medicare recipients to be poor. Medicare is for people aged 65 and over, for persons eligible for Social Security disability payments for 2 years or longer, and for certain workers and their dependents who need a kidney transplant or dialysis. It consists of two separate but coordinated programs: hospital insurance (part A) and supplementary medical insurance (part B). Medicare covers more than 34 million Americans (16 percent of the population) at an annual estimated cost of more than $133 billion.

Term	Definition
MRMIB: Managed Risk Medical Insurance Board	The MRMIB was created in 1990 with a broad mandate to advise the governor and the Legislature on strategies for reducing the number of uninsured persons in the State. It administers three health care programs: the Access for Infants and Mothers program, the Healthy Families program, and the Major Risk Medical Insurance program.
Office of Statewide Health Planning and Development	A state office whose mission is to plan for and support the development of health care systems in California. Its activities include ensuring that patients in hospitals and nursing homes are safe in the event of an earthquake or other disaster and that facilities remain functional after such an event; providing loan insurance to not-for-profit health facilities, especially those providing health care in underserved communities; supporting the training of health professionals, especially primary care doctors and nurses practicing in underserved communities; and collecting, analyzing, and disseminating information about hospitals, nursing homes, clinics, and home health agencies licensed in California.
Oper Trans In–SB 612, Chapter 945 of the Statutes of 1988	A Health Services budget item consisting of funds to offset trauma costs. These funds will be phased out in fiscal year 2002–03.
Oper Trans In–Special Funds	A Health Services budget item consisting of special funds earmarked for alcohol and drug programs.
Oper Trans Out	A Health Services budget item consisting of transfers to other county funds or to other departments.
Outpatient care	Care given a person who is not bedridden. Also called ambulatory care. Many surgeries and treatments are now provided on an outpatient basis, while previously they had been considered reason for inpatient hospitalization.
Outpatient Reduced-Cost Simplified Application Plan	A plan developed by Health Services to simplify the process of determining a patient's ability to pay for the cost of outpatient medical care and medicine.
Over-realization of prior-year revenue	Amounts budgeted to account for surpluses in prior-year revenues received. Since 1995, Health Services has received revenues in excess of expectations for prior years.
PPP: public-private partnership	A collaborative effort between Health Services and private, community-based providers (partners) that are committed to providing quality health services in a culturally and linguistically appropriate environment to low-income and uninsured communities.
Primary care	Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine.
Salaries and employee benefits	Salaries for employees of Health Services, as well as fixed and variable employee benefits. Variable benefits include employment taxes and health insurance. Fixed benefits include pension (LACERA), workers' compensation, and other insurance programs.
SCHIP: State Children's Health Insurance Program	A state and federal partnership designed to help children without health insurance, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance. The SCHIP law appropriated $40 billion in federal funds over 10 years to improve children's access to health coverage. See Healthy Families program.
Secondary care	Services provided by medical specialists, such as cardiologists, urologists, and dermatologists, who generally do not have first contact with patients.

Term	Definition
Senate Bill 1255, Chapter 996 of the Statutes of 1989	Welfare and Institutions Code, Section 14085.6. The law that created the Emergency Services and Supplemental Payment Fund. Supplemental payments are made to qualifying hospitals based on negotiations between the hospital and CMAC. Qualifying hospitals must be DSH-qualified, contracting under the Selective Provider Contracting Program to provide Medi-Cal services, and licensed to provide emergency services on site. Children's hospitals, however, can maintain emergency services in conjunction with other hospitals. Hospitals that provide emergency services must demonstrate a need for extra funding to cover the costs of these services. CMAC determines the award levels, and the California State Department of Health Services administers and distributes the funds. There is no ceiling on the individual payments. For fiscal year 1999–2000, 74 hospitals were eligible but only 72 received payments, which totaled $1.2 billion. Funding is through intergovernmental transfers and matching federal financial participation.
Senate Bill 1732, Chapter 1635 of the Statutes of 1988	This program reimburses qualifying hospitals for a portion of their debt service on revenue bonds issued to fund hospital construction and renovations. Hospitals must qualify on an annual basis. For fiscal year 1999–2000, 27 hospitals qualified, but only 15 received payments, which totaled $94.9 million. Funding is from the State's General Fund and matching federal financial participation.
Senate Bill 1953, Chapter 740 of the Statutes of 1994	Passed in 1994, this act was based on the Milestone 4 Report (prepared by the Hospital Safety Board and the Office of Statewide Health Planning and Development) from 1990 and was a long-term plan to bring existing hospitals up to the requirements of the 1973 Alquist Hospital Seismic Safety Act. The intent of the act is to ensure that hospitals remain functional after an earthquake, are able to maintain care of the patients already there at the time of the earthquake, and are able to provide care to persons injured in the earthquake.
Senate Bill 612, Chapter 945 of the Statutes of 1988	Provides funding for emergency medical services for the indigent.
Senate Bill 855, Chapter 279 of the Statutes of 1991	The law that created the inpatient DSH program. Hospitals qualify on an annual basis. Supplemental payment adjustments are made to qualified inpatient acute-care hospitals in addition to Medi-Cal payments for services rendered. To qualify, a hospital must have a Medi-Cal inpatient utilization rate at least one standard deviation above the statewide mean or a low-income utilization rate in excess of 25 percent with at least a 1 percent Medi-Cal utilization rate. Payments are based on the hospital's peer group and low-income rate. Payments are funded by intergovernmental transfers from public entities and matching federal financial participation; no state funds are involved. For the 1999–2000 fiscal year, the program budget was $1.75 billion.
ST–Other	A Health Services budget item, for other state funds, which consists of mainly grant revenues. Includes the Child Health and Disability Program.
Supplemental pool, 1115 Waiver	A Health Services budget item for up to $900 million to be paid to the county after the amount of federal financial participation under the indigent care match and the administrative match (see Waiver indigent care match) are calculated. Supplemental pool funds fill in the federal share until the $900 million limit is reached.
Tertiary care	Health care services provided by specialized providers such as neurosurgeons, thoracic surgeons, and intensive care units. These services often require highly sophisticated technologies and facilities.
Tobacco settlement	The tobacco settlement, known as the master settlement agreement, presented the states with a unique opportunity to reduce the terrible burden exacted by tobacco on America's families and communities. The settlement requires the tobacco industry each year for 10 years to pay $25 million to fund a charitable foundation that will support the study of programs to reduce teen smoking and substance abuse and the prevention of diseases associated with tobacco use.

Term	Definition
Upper payment limit	The maximum amount of reimbursement that Medicaid will pay a hospital system for a given set of services. The limit is expressed as a percentage of the costs allowed for the same services under Medicare. A recent federal policy change will reduce the upper payment limit from 150 percent to 100 percent.
Urgent care	Health care required promptly but in a nonemergency situation. Examples of urgent-care needs include ear infections, sprains, high fevers, vomiting, and urinary tract infections. Urgent-care situations are not considered to be emergencies.
Waiver	Refers to Section 1115 of the federal Social Security Act, which allows the Secretary of Health and Human Services to waive any provision of the Medicaid law for demonstration projects that test a program improvement or an innovation of interest to the federal government. For example, under a Section 1115 Waiver, a state may be exempt from compliance with usual requirements or may receive federal matching funds for expenditures not ordinarily eligible under Medicaid.

Agency's comments provided as text only.

County of Los Angeles
Department of Health Services
313 N. Figueroa
Los Angeles, CA 90012

May 20, 2002

Elaine M. Howle
State Auditor
555 Capitol Mall, Suite 300
Sacramento, California 95814

Dear Ms. Howle:

The Los Angeles County Department of Health Services appreciates the Bureau of State Audits' detailed Report No. 2001-119 titled *Los Angeles County's Health Services: Unless It Finds Significant Additional Sources of Revenue, Its Budget Crisis Will Force It to Limit the Services it Offers.* In addition, the Department would also like to take this opportunity to thank all members of the audit team for the thoughtful and conscientious manner in which they conducted this review.

The Department generally agrees with the analysis conducted. As indicated in your report, the Department presented its Strategic and Operational Action Plan to the Los Angeles County Board of Supervisors in January 2002. As outlined in that plan, the Department is preparing a recommendation and implementation plan for consideration by the Board of Supervisors at their June 18, 2002 meeting. The implementation plan will contain a redesigned health care delivery system that will balance the Department's budget within available resources through Fiscal Year 2005-06.

The magnitude of the budget shortfall facing the Department will require many tough choices and service reductions. Our first priority will continue to be to make our delivery system as efficient as possible to protect direct patient care resources.

The Department is conducting a more in-depth analysis of your report and will provide you with any additional information as necessary.

Again, the Department appreciates the State's willingness to examine the important public policy and financial issues facing the health care safety-net in Los Angeles County.

Sincerely,

(Signed by: Fred Leaf for)

Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer
Los Angeles County Department of Health Services

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press