COUNTY OF LOS ANGELES
CHIEF ADMINISTRATIVE OFFICE

713 KENNETH HAHN HALL OF ADMINISTRATION/LOS ANGELES, CALIFORNIA 90012
(213) 974-1101

SALLY R. REED
CHIEF ADMINISTRATIVE OFFICER

July 18, 1995

To: Supervisor Gloria Molina
First District

From: Sally R. Reed
Chief Administrative Officer

Subject: **LUMP SUM SETTLEMENT OF RETROACTIVE MAC CLAIM**

At the request of my staff, County Counsel has prepared the attached proposal which you may find useful in your discussions in Washington, D.C.

While our staff to staff discussions with the Administration have not been encouraging, County Counsel and we concur that, if articulated and agreed to at the very highest levels, this approach could offer a viable and quick means for settling past Medi-Cal Administrative Claiming (MAC) claims. Moreover, it could provide "bridge funding" in concert with other proposals (e.g., 1115 Waiver and Expansion of SB 1255 payments) also being advanced to provide ongoing funding.

Please let us know if we can be of further assistance.

SRR:GAR:dmm:g

Attachment

c: Each Supervisor
Executive Officer, Board of Supervisor
County Counsel
Burt Margolin

mac.sum

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To Diana Fortuna	From Jerry Roos
Co. White House	Co. Los Angeles County
Dept.	Phone # (213) 974-1151
Fax # (202) 456-7431	Fax # (213) 626-7827

COUNTY OF LOS ANGELES

OFFICE OF THE COUNTY COUNSEL

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DE WITT W. CLINTON, COUNTY COUNSEL

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July 17, 1995

TO: GERALD A. ROOS
Senior Asst. Admin. Officer

FROM: STEVEN J. CARNEVALE
Principal Deputy County Counsel
Public Services Division

RE: Lump Sum Settlement of Retroactive MAC Claim

As we discussed, one area of focus for the County's lobbying efforts in the immediate future might be federal approval of a lump sum payment to settle the appeal of the disallowance of the retroactive Medi-Cal Administrative Claiming ("MAC") funds. The following discusses this proposal:

Proposal:

Settle all claims of Los Angles County (and presumably the other affected counties) to disallowed MAC funds for all periods prior to July 1, 1995, though a lump sum payment. The total payment to Los Angeles County would be approximately $260 million. About $180 million, the portion representing payment for fiscal years 1992-93 and 1993-94, would be paid immediately. The remaining $80 million for 1994-95 would be paid as soon as state law could be amended to remove, or at least significantly reduce, the participation fee counties must pay the state to receive MAC funding for fiscal years after 1993-94.

Background:

- While Los Angeles County's original MAC claim for all periods prior to July 1, 1995, was significantly higher, the revised claim for this period was $454 million. The federal government approved about $90 million of this amount and disallowed the rest. Approvals and disallowances were also made for other counties. The state has appealed the disallowances on behalf of all the counties. State and federal representatives have agreed to stay this appeal while they discuss settlement.

- Through settlement discussions, the federal government has approved a methodology which will allow Los Angeles County to obtain MAC revenue of approximately $260 million for this retroactive period ($180 million for 1992-93 and 1993-94, and $80 million for 1994-95). However, federal officials have insisted that this payment be made through a prospective increase in the Medi-Cal outpatient rate for a limited time period. The state objects to payment in this manner because of a perceived adverse impact on Medi-Cal outpatient rate litigation the state is defending. The County has concerns that payment through a method which prospectively increases Medi-Cal rates could result in the loss of DSH funds depending on how the OBRA 1993 DSH Cap is applied.

- There is no legal reason why the federal government could not agree to settle the retroactive claim by making a lump sum payment in exchange for a dismissal of the state's appeal as to all disallowed MAC funds for periods prior to July 1, 1995. Phyllis Thompson of Covington and Burling, our contract counsel for MAC issues, strongly agrees.

- Technically, the settlement would be between the state and the federal government and would most likely include a settlement of all MAC claims statewide for this period. The federal funds would flow through the state to the counties. Of course, the state would need to agree to this approach, but state officials have previously expressed support for a lump sum settlement of the retroactive claims.

Advantages:

- The lump sum payment could be paid very soon and help ease the County's cash flow problems.

- A lump sum settlement helps avoid the state's concerns regarding an impact on its outpatient rate litigation.

- Since most of the payment is for fiscal years before the application of the OBRA 1993 DSH Cap, the potential for an offsetting loss of DSH revenue is minimized.

- The settlement would be structured to avoid, to the extent possible, the payment of a participation fee to the state.

- The lump sum payment could be used as "bridge funding" to allow more time to develop and implement proposals to restructure the County's delivery of health services.

SJC:sc

Revised?
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Last 9

TALKING POINTS REGARDING LA COUNTY MEDICAID ISSUES

Following is the status of the three main approaches HHS is pursuing to help Los Angeles County resolve its Medicaid fiscal difficulties: 1) resolution of payable claims included in the initial MAC claim; 2) technical assistance to the state on developing state plan amendments for targeted case management services; and 3) technical assistance to the state on outpatient provider rate increases. While HHS has worked diligently to find legitimate ways to help increase Medicaid payments to Los Angeles County, we have found no additional funding beyond the $66.8 million in federal funds approved for payment through the review of the initial MAC claim. However, we anticipate that there may be additional payments of up to $200 million dollars in federal funds resulting from the MAC resolution process and disproportionate share (DSH) claims.

- The special, accelerated resolution process for outstanding Medical Administrative Cost (MAC) claims established by HCFA in April is largely completed in Los Angeles County, awaiting closure of negotiations between the State and the counties on the amount of State "takeback." To date, LA County has received $66.8 million in federal funds from this process, and anticipates receiving $3 million more.

- HCFA has worked with the State to develop six plan amendments for Targeted Case Management Services to cover many of the costs counties had claimed under the disapproved MAC process. These changes will provide significant relief to a number of counties, but Los Angeles does not expect major benefit.

- Increases in Medi-Cal clinic rates are now part of the state budget negotiations, although they would require no new state dollars. Such an increase would be worth $50 to $80 million in new revenue to LA County this fiscal year; other counties would receive significantly less, but more in proportion to their needs, and are very eager for the increase and concerned that LA's lack of enthusiasm may damage their case. The rate increase will provide less benefit to LA than was previously thought because 1) when first proposed, it was expected to be of most benefit in the '94-95 fiscal year, which ended without an increase, and 2) because of uncertainty about the DSH cap and formula for the current fiscal year.

- In State fiscal year 1994 - 95, the state assessed each county a pro rata share of $200 million that the counties expected to receive from HCFA payments for administrative claims. This payment from the counties to the state is referred to as the "takeback"; it is a one time event. Originally, the state anticipated that total federal payments to the counties for

7/19

Waxman

1. MAC Claims - DOJ

2. Demo - more flex

- State must propose
- budget neutr.

~~26/375 - GM~~

Monday

(Whether $226 m - source)

GM - Gov ed no on rates?

* Karen Nelson

HW stresses demo -

BB - HCFA terrible

* Is 226 17?

* Daily mtg - 10-12 - John
Bruce
Darrel or Donna
Karen ?

MB - Lasowski/Tuffli

HW: swap from IP → OP shift?

Mimics POTUS HCR

POTUS say I have plan - press Gov.

administrative claims would be $700 million; of that amount, the state proposed taking back $200 million. Now it appears that federal payments will fall well below $700 million and may be less than the $200 million takeback. Legislation has been proposed to lower the takeback from $200 million to $20 million, but is still pending. Until the county and state resolve the takeback issue for 1994-95 claims, the county is not submitting additional claims for that year. Therefore, HCFA must wait for these final claims before achieving a final resolution of the administrative claims issue.

- In 1993, Congress enacted limits on amounts that may be paid to hospitals in disproportionate share (DSH) payments. These are payments made to hospitals for the costs they incur in serving disproportionate numbers of low-income people. These limits were imposed by Congress because some states were using DSH payments for non-health care purposes, or in substitution of state funding for traditionally state-funded health care. The limits enacted by Congress explicitly specified how these limits would be calculated for each hospital.

- Los Angeles County has proposed three methods to increase DSH payments by an additional $350 million in federal funds in state FY 1995 - 1996. It has asked to include payments of approximately $210 million that it is required to make to the state as part of its costs for serving low-income people. These payments are intergovernmental transfers (IGTs). HCFA has not approved the inclusion of IGTs in the calculation of DSH costs because we do not believe that they represent actual costs of providing health care and do not meet the requirements of the law. The county has also asked that a higher trend factor be used to inflate DSH payments. HCFA has given preliminary indications that it will approve the trend factor. The county's third proposal asks that HCFA include the costs of construction (principal and depreciation) in the DSH limits. Typically, principal costs are disallowed in these calculations, but HCFA has not yet made a decision on this issue. To date, the county has not been able to provide HCFA with estimates of much Medicaid payments would be increased if the trend factor and the construction proposals were approved, but we believe it may be as much as $140 million.

- HCFA has worked diligently to find legitimate ways to increase Medicaid payments to Los Angeles County. To date, neither the county nor the state has taken one step toward providing additional revenues to the county.

1. Layoffs/closure
2. 28700's
3. DOJ
4. Demo

July 19, 1995

TALKING POINTS REGARDING LA COUNTY MEDICAID ISSUES

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- HCFA has worked diligently to find legitimate ways to increase Medicaid payments to Los Angeles County. Additional payments may be as high as $200 million in federal funds in the current fiscal year. To date, neither the county nor the state has taken one step toward providing additional revenues to the county.

July 19, 1995

Background

- ***Proposed Budget.*** In June 1995, the Los Angeles County Chief Administrative Officer (CAO) submitted the county's 1995-96 proposed budget to the Board of Supervisors. It includes:

  - ◇ Major reductions in health care for the indigent and closure of the nation's largest hospital—the LAC/USC Medical Center.

  - ◇ Significant reductions to social service, public protection, recreation and other county programs.

  - ◇ Elimination of 18,250 budgeted positions (a reduction of 20 percent).

- ***Reason for Budget Reductions.*** The Los Angeles CAO indicates that the reductions are needed to close a $1.3 billion shortfall in the county budget, created by past shifts in property taxes to schools, reductions in federal support for health care, and other factors.

- ***Scope of LAO Review.*** The purpose of this document is to provide an overview and assessment of the county's current fiscal condition and budget problem, including:

  - ◇ The magnitude of the county's budget problem.

  - ◇ The major causes and components of the budget problem.

  - ◇ Options for addressing the problem.

What Is the Magnitude of the County's Budget Problem?

- ***$1.3 Billion Shortfall Identified by the County CAO.*** The CAO estimated in June 1995 that the county faces a $1.3 billion budget shortfall in 1995-96. Total county spending in the just-concluded fiscal year was about $12.4 billion. Thus the CAO's estimated shortfall represents about 10 percent of the county's overall 1994-95 budget.

  - ◇ However, roughly $10 billion of the county's spending is financed by a combination of federal and state funding or fee revenues that are tied to specific programs or services.

- Consequently, the shortfall identified by the CAO represents about half of the size of the county's general purpose revenues and represents a massive budget problem.

- The discussion that follows focuses on the shortfall in the county's general purpose budget.

- ***LAO Assessment of Budget Shortfall.*** Based on a review of the budget-related information made available to us, the county's estimate of its underlying budget problem appears generally correct.

  - If we use a methodology for calculating the county's budget shortfall that is similar to how we calculate the state's budget gaps, we would end up with a smaller gap than the county projects.

  - However, our methodology also would by definition reduce the value of the solutions the county is proposing by an equivalent amount.

  - The net effect is that our estimate of the need for actual budget reductions or additional revenues is similar to the county's.

  - Our methodologies differ because:

    - The CAO's shortfall estimate includes a net county cost of $167 million for the impact of the Governor's state/county realignment proposal, but also includes as a budget solution a deferral of action on this proposal. Our methodology would exclude this factor both as a cost and solution, because the current conference version of the state budget does not adopt the realignment proposal.

    - We also would include existing reserves as an available budget resource, whereas the CAO treats the drawdown of reserves as a budget solution.

What Factors Contribute to the County's Budget Problem?

Figure 1 indicates that there are seven principal factors which are responsible for the budget problem:

Figure 1

Factors Contributing to Los Angeles County's Fiscal Shortfall

- ☑ Property tax shift
- ☑ Past reliance on one-time measures
- ☑ County health program utilization and financing
- ☑ Major reduction in federal health care reimbursements
- ☑ State offset to federal health payments
- ☑ Slow growth in local taxes
- ☑ Employee pay increases

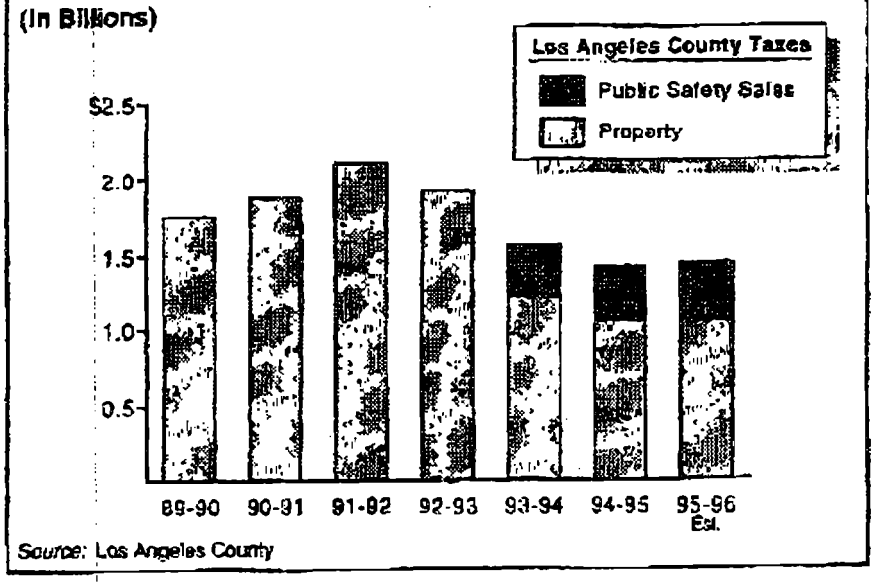
- *Property Tax Shifts.* The state's 1992-93 and 1993-94 Budget Acts shifted about $1 billion of property taxes from the county to public schools.

  - ◇ About 40 percent of these reductions in property taxes are mitigated by sales taxes dedicated to public safety purposes, as shown in Figure 2.

  - ◇ These sales tax revenues are the result of Proposition 172, that established a permanent statewide half-cent sales tax for support of local public safety functions in cities and counties.

Figure 2

Los Angeles County Property Taxes and Public Safety Sales Taxes



Source: Los Angeles County

- *County Health Program Utilization and Financing.* The county administers the nation's second largest public health care system, including 6 major hospitals, 6 comprehensive health centers, and 39 community health centers.

  - The county health system serves a large number of indigent patients and others who are uninsured.

  - Its system is significantly affected by changes in federal and state health care spending as well as the demand for health care services by low income residents.

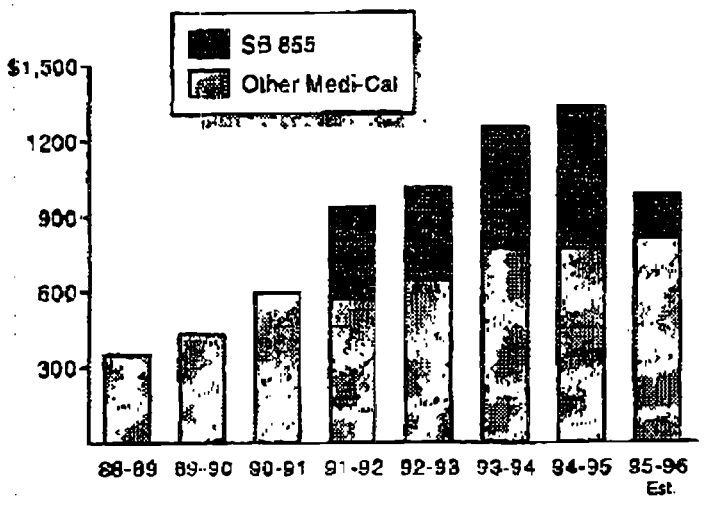
  - More generally, the county system is operating in an increasingly competitive environment and is facing many of the pressures that apply to the health care industry at-large.

- *Major Loss of Federal Funds.* As shown in Figure 3, total federal Medi-Cal related payments to the county Department of Health Services (DHS) are estimated to fall from $1.3 billion in 1994-95 to $982 million in 1995-96.

Figure 3

Los Angeles County Federal Funding For DHS

(In Millions)



Note: Other Medi-Cal includes SB 910 funds.
Source: Los Angeles County

- Much of the decline is related to reductions in the SB 855 program, that was created in 1991 to provide supplemental federal reimbursements to hospitals which serve a disproportionate share of low-income persons. Total funding for the SB 855 program will fall from $564 million in 1994-95 to $179 million in 1995-96, due to three factors:

  - ***The Settlement of One-Time Claims.*** The county covered part of its budget shortfalls in 1992-93 through 1994-95 through the settlement of prior year claims. In addition, it accelerated SB 855 payments from 1995-96 into 1994-95 to cover an unanticipated shortfall in SB 910 payments. These one-time sources are exhausted in 1995-96.

  - ***Caps on the Program.*** Federal law changes enacted in 1993 capped the amount of supplemental payments to hospitals, limiting growth in this program.

- *Declining Share Of Supplemental Funds.* The county also is receiving a declining share of federal benefits under the SB 855 program, due to increasing competition from private hospitals that serve low-income patients.

- *State Offset.* The loss in federal funding has been compounded by the state offset of federal SB 855 funds that would otherwise go to counties. In 1995-96, the county estimates that its loss due to the state offset will be $120 million.

- *Slow Growth in Local Taxes.* Property taxes, sales taxes, and vehicle license fees have been impacted by the recession. For example, the single largest general purpose revenue source, property taxes, increased by almost 10 percent per year in the 1980s, but is projected by the county to decline by 1.6 percent in 1995-96.

- *Employee Pay Increases.* In many county departments, employee salaries have increased faster than inflation since 1988-89. These salary increases have contributed to cost pressures within the county's budget. Specifically, our review of general salary increases granted to 58 job categories over the last seven years indicates that:

  - Nearly half of the county's job categories received a general salary increase ranging from 20.4 percent to 34 percent, that exceeded the growth in the Los Angeles area CPI (about 20 percent).

  - Nearly a third of the job categories received general salary increases exceeding 25 percent.

- *One-Time Measures.* The county has relied on one-time measures to cover recent budget shortfalls. Some of these actions aggravate the budget problem in 1995-96.

  - It issued bonds to cover operating expenses in 1992-93 (Marina Del Rey) and in 1994-95 (to cover its pension fund liabilities). These actions raise the ongoing debt service costs to the county.

  - It used prior-year settlement payments and acceleration of future federal payments under the SB 855 program to balance its health budget in the 1992-93 through 1994-95 fiscal years.

  - It also depleted reserves, deferred obligations to its workers' compensation fund, and deferred certain employee costs to balance recent budgets.

What Are the County's Plans for Dealing with its Fiscal Problem?

- *Overview.* The proposed budget relies almost exclusively upon program reductions as a means of addressing the county's fiscal problem.

- *Non-Health Reductions.* In general, the county's budget reduces all departments by 20 percent of the amount funded by *county* revenues, unless a statutory maintenance of effort (MOE) provision requires a higher level of county funding. As Figure 4 indicates, this reduction will lower county expenditures by $207 million. In addition, the budget requires county departments to absorb $103 million in baseline cost increases.

Figure 4

County Proposal for Addressing Budget Gap

(Dollars in Millions)

Action	Savings
Non-Health Budget	
20 percent cut in county costs to most budgets	$207
Require departments to absorb baseline increases	103
Use of reserves, fund balances	80
Assume rejection of Governor's Budget realignment proposal	167
Other	59
Subtotal	($615)
Department of Health Services	
Increase revenues, efficiencies, consolidations	$36
Administrative and limited service reductions	69
Close 25 Health Centers, eliminate mental health services, reduce outpatient services	149
Option A: Close Los Angeles County, USC Medical Center and four Comprehensive Health Centers, *or*	336
Option B: Close All Hospitals except Los Angeles County/USC and Martin Luther King Medical Center and six Comprehensive Health Centers	
Other	71
Subtotal	($656)
Total, all programs	$1,270

- *Public Protection.* Proposed total spending on public protection activities declines by 2.1 percent in 1995-96 compared with 1994-95 spending. The

reduction is relatively modest in part due to the need to meet state MOE funding requirements for continued Local Public Safety Fund allocations. However, the amount of reduction varies considerably among departments, and all departments would have to make cuts to absorb baseline cost increases.

- ◇ *Sheriff.* The proposed budget for the Sheriff's Department is essentially flat. Total spending would be $1.1 billion, including Local Public Safety Fund allocations with $567 million financed from general county revenues. However, budgeted positions decline by 452 (3.5 percent) in order to absorb baseline cost increases. The CAO indicates that any further reductions would reduce the Sheriff's budget below the state MOE requirement (the Sheriff believes that the budget slightly underfunds the MOE requirement).

- ◇ *District Attorney.* General county revenues provided to the District Attorney would decline by $7.4 million (11 percent) compared with 1994-95, and budgeted positions decline by 202 (12 percent).

- ◇ *Probation.* Proposed total spending of $259 million declines by $52.3 million from 1994-95, and budgeted positions decline by 1,034 (24 percent).

- ◇ *Courts.* The budget provides $427 million for the superior and municipal courts. Budgeted positions would decline by 350 (7.7 percent).

- ● ***Major Reductions in Health Care System.*** To cover an estimated $655 million shortfall in its DHS budget, the county proposes to substantially reduce the size of its health care system. The plan includes two options, both of which would involve the closure of at least one major hospital, and several comprehensive health centers. The proposal is summarized in Figure 4.

- ● ***Implementation costs create $300 million budget pressure.*** The CAO's budget proposal identifies $332 million (Option A) or $293 million (Option B) of additional one-time implementation costs that will partially offset the budgeted DHS savings of $655 million in 1995-96. These implementation costs reflect the loss of savings due to delayed action past July 1, amounts owed to laid-off employees, and the payoff of debt incurred to plan new facilities not included in the budget. These unfunded costs create a hole in the CAO's budget proposal of roughly $300 million, which the CAO proposes to fill by reserving additional federal funds that may result from the approval of pending county claims.

- ● ***Health Care Reductions Would Have Major Impact.*** The reductions proposed by the CAO would clearly have a major impact on health care services in the

county. The shutdown of major facilities would result in a combined loss in federal, state, and county funds for health care of $1.2 billion.

- ***Public Protection.*** The CAO's budget would reduce public protection services and resources in a number of areas.

  - ***Sheriff.*** The Sheriff's Department closed two jail facilities in March. Other savings would be achieved primarily by reducing or deferring purchases of equipment and supplies. The Sheriff indicates that he also may implement alternative or additional reductions if the board approves the CAO's proposed level of funding.

  - ***District Attorney.*** Reductions in the District Attorney's office would be concentrated in administrative and support functions, but there also would be a reduction of 154 prosecutor positions.

  - ***Probation.*** Proposed budget reductions include the closure of five juvenile camps or one juvenile hall, as well as the closure of six area offices.

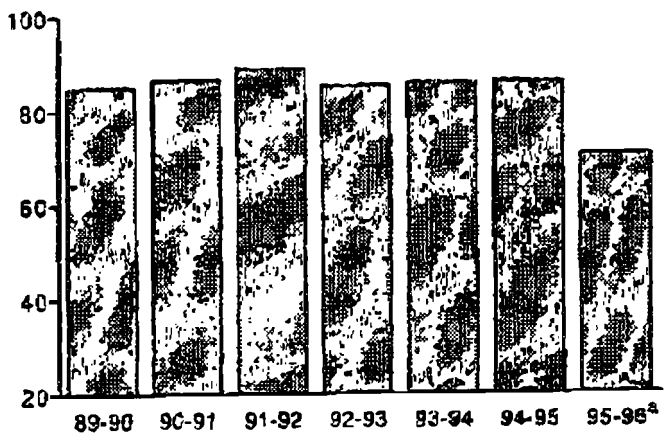
  - ***Courts.*** Reductions would eliminate 43 commissioners and 6 assigned judges. Electronic court reporting would be expanded and administrative and support functions would be reduced.

- *Number of Positions Eliminated.* The proposed county budget eliminates 18,250 positions, or over 20 percent of the county's *budgeted* positions. The number of county employees actually laid-off, however, would be lower than 18,250 because some budgeted positions are not filled and some employees normally choose to leave county employment in any year. The CAO estimates the actual number of employees to be laid-off will be about 10,000 to 12,000. The majority of these layoffs will involve health care workers. Figure 5 displays information on the number of county employees.

Figure 5

Los Angeles County Employees
Total Workforce as of June 30

(In Thousands)



[a] Midpoint of estimated range of the 1996 workforce.

Source: Los Angeles County

- ***Status of Layoffs.*** The county has already issued layoff notices to about 50 employees and will issue another 2,000 layoff notices by mid-July. The Board of Supervisors directed several large departments, including the DHS and the Sheriff, to postpone issuing layoff notices in order to give the board additional time to evaluate alternatives.

- ***Layoff Procedures.*** The county indicates that it expects the process of laying off non-health care employees to take about three to six weeks. Because the closure of medical centers requires the concurrence of state and federal regulatory agencies, the layoffs of health care workers likely would be phased over a longer time period. The county indicates that layoffs would be determined by seniority within a department and within a position classification.

- ***Unbudgeted Costs.*** The budget does not include costs to pay terminated employees for their accrued vacation time, sick leave, and any deferred

salary increases or accumulated time off. These county costs to terminate employees could be in the range of millions to tens of millions of dollars.

Other Options For Addressing County Fiscal Problem

- The Board of Supervisors is currently considering a variety of alternative options for dealing with the budget shortfall. For example, the board has created a Health Crisis Task Force to identify alternatives to the proposed cuts in the health care budget. It is our understanding that the task force will report its findings to the board by the end of the month.

- In addition, other proposals have been suggested by union representatives, public officials, and other public and private representatives for mitigating the proposed major budget cuts.

- Some of these and related options are summarized in Figure 6.

- *Federal Reimbursement Options.* The county is pursuing several proposals to increase federal health care revenues. For example, the county is currently negotiating with state and federal officials over the replacement of SB 910 reimbursement claims that were rejected last year. (The SB 910 program was created to enable counties to claim Medi-Cal reimbursements for administrative and case management expenses associated with health care. The majority of SB 910 claims were rejected by the federal government last year.)

  - A possible vehicle for SB 910 replacement is an increase in reimbursements for expanded health clinic visits. Retroactive provision for expanded care would increase reimbursements by up to $340 million in 1995-96, and $80 million thereafter. The state has been resistant to expanded payments because of their possible effects on existing litigation regarding Medi-Cal reimbursement rates.

  - The county is also submitting a proposal for expanding the SB 855 hospital caps, that would enable county hospitals to increase reimbursements under the program. However, the federal government has thus far resisted proposals for expansion of the caps, in part because of the possible impact on the federal budget deficit.

Figure 6

Options for Addressing Los Angeles County's Fiscal Shortfall

Option	Annual Amount	Comments
Options Under Consideration by County		
Increased federal funds: • expanded clinic visits rates. • expanded funds for disproportionate share hospitals.	Up to $400 million in 1995-96 and up to $150 million thereafter	• Requires modification of federal Medi-Cal spending limit. • Could weaken state's position in ongoing Medi-Cal lawsuit. • Could increase overall state and federal Medi-Cal program costs.
Increase private or foundation support.	Unknown	County Director of Health Services will meet with President of Blue Cross Wellness Foundation to request funding.
Reduction in state SB 855 offsets.	Up to $120 million	Requires state legislation. Increases state costs.
Shift in distribution of SB 855 payments from private to public hospitals.	$46 million	• Requires state legislation. • Reduces supplemental Medi-Cal benefits to private hospitals.
Impose local taxes authorized under state law. • 5 percent tax on sewer, cable TV and water use. • business license tax.	Up to $30 million	Board of Supervisors will hold public hearing on taxes this summer. Taxes may be imposed upon residents and businesses in *unincorporated* areas of county.
Institute 10 percent tax on consumption of alcoholic beverages.	Up to $250 million	Requires state legislation. Does not require local voter approval.
Other Options		
Increase sales tax by up to ½ percent.	Up to $400 million	Requires majority approval by local voters. If revenues are used for general county purposes.
One-time options: • divert funds reserved for capital outlay. • sell assets. • borrow to fund current operations.	Unknown	Does not address, and could aggravate, ongoing budget shortfall.
Adopt revenue assumptions consistent with state budget estimates.	Up to $50 million	• County's projection of revenues from sales and use, VLF and property taxes are more conservative than the state's. • Recent revenue trends have been slightly positive. • However, county's economic outlook still uncertain.
Employee pay modification.	Unknown	Subject to collective bargaining for represented employees.

- ***Currently-Authorized Tax Options.*** These include:

  - ***Sales Taxes.*** Upon approval by a majority of the county's voters, the county could increase the local sales tax by 1/4 or 1/2 of one percent and use the funds for *general* county purposes. (Taxes for specific purposes require a two-thirds vote of the electorate.) The sales tax rate in Los Angeles County is currently 8.25 percent. Increasing the sales tax rate by 1/2 of one percent would raise about $400 million annually.

  - ***Other Taxes.*** The county has scheduled a public hearing to consider imposing taxes on businesses in the unincorporated area—and instituting taxes on water, sewer and cable television use by people living in the unincorporated area. (Current law prohibits counties from imposing these taxes upon city businesses and residents.) Due to the limited nature of these taxes, the county estimates that they are unlikely to generate more than $30 million annually.

- ***New Local Revenue Option—Tipplers' Tax.*** The county developed a legislative proposal to grant it authority to impose a "tipplers' tax" on the consumption of alcohol in the county. Imposing such a tax would require a super-majority vote of the County Board of Supervisors. The county estimates that this tax could generate $200 million to $250 million annually.

- ***Modify County Employee Salaries.*** The county could consider rescinding scheduled 1995-96 pay increases and/or reducing current pay levels.

  - We have been unable to verify the status of collective bargaining agreements (for example, when they expire, when negotiations are planned for new agreements, or whether the existing agreements can be reopened in a fiscal emergency).

  - During the course of our review, however, we found no evidence that the county has considered these options.

  - For non-represented employees, these options could be implemented regardless of the status/content of bargaining agreements.

Conclusion

- The current budget shortfall is reflective of a major structural imbalance between program costs and revenues, primarily caused by the combination of property tax shifts, sluggish revenue growth, and declining federal funds.

- Based on the current economic outlook for the state and county, it is extremely unlikely that revenue growth from existing sources will be sufficient to cover the gap in the foreseeable future.

- While the county could adopt one-time measures to cover part of the shortfall in 1995-96, longer-term solutions to its budget problem will need to include permanent revenue increases or program reductions. Furthermore, about $300 million of one-time funds would be needed to cover the implementation costs of the DHS reductions.

- More fundamentally, the county's hospital and health care delivery system is likely to face continuing fiscal pressures from intense competition for insured patients and continuing demand to provide uncompensated care.

An Overview and Assessment of Los Angeles County's 1995-96 Budget Problem

Elizabeth G. Hill
Legislative Analyst

July 11, 1995 LEGISLATIVE ANALYST'S OFFICE

LA Times 7/13/95

State Report Says L.A. County Fiscal Crisis Is Massive

■ **Budget:** Legislative analyst's study was requested by lawmakers skeptical of problem's dimensions. It confirms major cutbacks probably will be necessary.

By JOSH MEYER, TIMES STAFF WRITER

SACRAMENTO—A much-awaited state report on Los Angeles County's financial situation confirmed Wednesday that the county's fiscal crisis is massive, and probably will require unprecedented layoffs and closures of health clinics, parks, libraries—and perhaps even County-USC Medical Center.

The report from the legislative analyst's office was requested by state lawmakers who have been openly skeptical of the true nature of the county's alleged fiscal crisis, citing years of what they said was exaggeration by county officials.

But in 14 pages of detail, the report by the independent and nonpartisan state agency confirmed dire warnings issued last month by Chief Administrative Officer Sally Reed when she released a budget with $1.2 billion in proposed cuts to close the county's unprecedented deficit.

"There's no doubt that the problem is significant, and it's a structural problem," Legislative Analyst Elizabeth G. Hill said in an interview. "It represents a massive budget problem."

The state report—which comes at a time when county officials are here lobbying the state for help—says the county's proposed cuts "would clearly have a major impact on health care services" in the nation's second-largest public health care system and would dramatically cut services in areas such as the Sheriff's and Probation departments and the district attorney's office.

And although many factors outside the county's control were partly at fault for the huge budget gap, the report concluded, county officials in the last few years spent more money than they had coming in, gave too many raises to county employees and relied on stopgap funding measures that only put off

Please see COUNTY, A16

Faceoff Seen Over New Smog Limits Plan

By MARLA CONE
TIMES ENVIRONMENTAL WRITER

The Southland's smog-fighting agency has drafted its most ambitious measure of the decade and is now bracing for a faceoff with businesses that may shape the future of many of the region's manufacturers into the next century.

The proposal—expansion of a groundbreaking pollution trading market—represents the last great push toward cleaning up the Los Angeles Basin's industrial sources of smog, a world-renowned effort that debuted at the end of World War II.

Large factories and small businesses alike would be weaned off thousands of solvents, paints and other chemicals containing VOCs—volatile organic compounds—the highly evaporative hydrocarbons that along with nitrogen oxides mix in the sky to create smog.

Hydrocarbons are released into the air from the ubiquitous petroleum-based solvents used to clean

Please see SMOG, A14

COUNTY: Fiscal Report

Continued from A1

problems until later.

"Some of these actions aggravate the budget problem," said the report, which cited the county's issuance of bonds to cover operating expenses in Marina del Rey as an example of borrowing that helped cause the deficit. "It also depleted reserves, deferred obligations to its workers' compensation fund and deferred certain employee costs to balance recent budgets."

Hill and her staff said that if the county delays solving its fiscal crisis, it will have to spend $300 million in one-time costs for payouts to employees, delays in implementing needed cuts and payoff of incurred debt.

The report by the well-respected analyst is sure to add another important voice to the growing chorus of calls for an immediate and wholesale restructuring of the nation's largest county government, state and county lawmakers said.

"The current budget shortfall is reflective of a major structural imbalance between program costs and revenues," the report said. "Based on the current economic outlook for the state and county, it is extremely unlikely that revenue growth from existing sources will be sufficient to cover the gap in the foreseeable future."

What that means, many state and county lawmakers said Wednesday, is that the long-dreaded cuts in jobs and services that Reed proposed in her budget are all but inevitable in the very near future.

"The problem is real, it is substantial, and we need to deal with it," said Reed, who was widely accused of exaggerating the county's fiscal problems, initially even by Board of Supervisors Chairwoman Gloria Molina. "I think it is important in finally putting to rest the county's credibility problems."

State Sen. Tom Hayden (D-Santa Monica), one of several "skeptical" state lawmakers who ordered the report, agreed.

"The way the report is seen around here," he said, "is that the chickens have come home to roost after several years of Band-Aid fixes" by the county.

Hayden said the independent confirmation of the "billion-dollar-plus hole" will add even more urgency to efforts by the local delegation in Sacramento to help the county, either with financial aid or the freedom for county officials to impose countywide taxes to raise revenue themselves.

So concerned are state and local lawmakers that they are drafting an emergency letter to President Clinton, asking him to intervene and create a task force to look at ways to avert disastrous cuts and layoffs if the budget cuts go through, Hayden said. Already, the county has cut $257 million in jobs and services, but another $1 billion in cuts need to be made to balance the budget at $11.1 billion.

"We now have an obligation and a responsibility to respond, and very quickly," said Democratic Sen. Richard G. Polanco, whose Downtown Los Angeles district includes County-USC Medical Center, a bulwark of the safety net for the poor that Reed has proposed closing.

County officials said they planned to use the report to press state officials for aid, citing the independent confirmation of their claims that the county is quickly edging toward the fiscal precipice that could lead to bankruptcy.

"This is a call to action for the state and the county, for Democrats and Republicans, to come together on a comprehensive solution immediately to solve the county's fiscal crisis," Supervisor Zev Yaroslavsky said. "If that is not done, the county's crisis will become California's crisis, in very short order. When Los Angeles

County sneezes, the rest of California catches cold."

Democratic and Republican state lawmakers, however, characterized prospects for a state rescue Wednesday as dim, despite the frantic efforts of the five county supervisors and myriad department heads and lobbyists, all of whom have spent the week canvassing the state Capitol in trying to wring promises of aid out of state lawmakers.

Among the reasons: Republican Gov. Pete Wilson is running for President and wants to slash the state budget and cut taxes, and the Legislature has refused to help bankrupt Orange County as it wrestles with its own billion-dollar deficit, lawmakers said.

"Even if the Legislature and the governor could agree on something," Hayden said, "it would by no means close anything but a part of the hole."

Although its impact on the state budget remains to be seen, the report is expected to have a significant effect on the acrimonious debate over the county budget under way in Los Angeles.

Union leaders have accused the county of exaggerating its fiscal problems as a way of getting employees to stomach layoffs, and persuading the public to accept reductions in law enforcement and closures of parks, libraries and health clinics.

On Wednesday, union leaders—also in Sacramento lobbying for state aid for the county—said they would use the report to turn up the heat on state lawmakers.

"If the analyst has validated the shortfall, that is all the more reason for the Legislature to get off their butts and do something for L.A. County," said Dan Savage, a spokesman for Service Employees Union International, Local 660, representing half of the county's 88,000 employees. "It's one less reason, one less excuse, for not helping L.A. County."

By late Wednesday, some conservative members of the Legislature said they were willing to heed some of Los Angeles County's requests, including a change in state law that would allow the supervisors to raise revenue in the county—including a proposed tax on alcoholic drinks that could bring in $250 million a year.

But such an agreement would come, said Assemblyman Steven T. Kuykendall (R-Rancho Palos Verdes) and other Republicans, only if Democrats agree to allow the county to cut health care and other services to levels previously required by the state.

LA Times 7/13/95

Proposal to Close 2 Hospitals Irks Staffs

■ County: Olive View, Harbor-UCLA are targeted instead of County-USC. They serve many patients who can't pay for private care.

By DOUGLAS P. SHUIT
TIMES STAFF WRITER

It was noon Wednesday at the bustling Harbor-UCLA Medical Center, and Dr. Frederick Bongard, an emergency room surgeon, was well into his second straight day on duty. During the night, he did three emergency surgeries on victims of traffic accidents and a shooting.

But a fourth case stood out in his mind: an emergency surgery to correct a perforated appendix. That patient had been brought to the doorstep of Harbor-UCLA by a private hospital because he did not have health insurance.

"We see those patients every day," said Bongard, chief of the Harbor-UCLA trauma service. "We have wards literally full of patients sent by other hospitals

Please see HOSPITAL, B8

HOSPITAL

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because they are uninsured."

Bongard's experience is key to the debate going on in the county Hall of Administration over deep budget cuts in health services that might lead to the closure of Harbor-UCLA, Olive View-UCLA Medical Center or County-USC Medical Center.

County administrators, armed with maps of area hospitals, financial projections and plenty of wishful thinking, hope that nearby private hospitals will pick up many of the public hospitals' patients to help cushion the blow.

Until this week, the future of County-USC Medical Center seemed most in jeopardy. County Chief Administrative Officer Sally Reed last month recommended closing the public hospital to help correct a $655-million shortfall in the Department of Health Services' $2.5-billion budget.

But Tuesday, County Emergency Medical Services Director Virginia Price Hastings threw the names of Harbor-UCLA and Olive View into the mix, saying that closing these two public hospitals would have less impact on the county's emergency 911 network than closing the bigger hospital.

Hastings made clear that either scenario would leave gaping holes in the county's health system, but argued that there were more hospitals in the harbor and San Fernando Valley areas that could fill the void if Harbor-UCLA and Olive View closed than in the east Los Angeles County area served by County-USC.

Bongard, and other doctors and nurses who would be affected if Harbor-UCLA and Olive View closed, reacted Wednesday with dismay—and incredulity—to Hastings' proposal.

They stressed that they are hospitals of last resort for thousands of poor patients that other hospitals turn away.

"Right now, we treat 98% of the indigent patients in the harbor area," said Dr. Robert Hockberger, chairman of the department of emergency medicine at Harbor-UCLA.

Both hospitals Wednesday offered pictures of their strategic importance.

Every emergency bed at Harbor-UCLA was full at noon, with another 50 patients in the waiting room, some of the 103,000 patients who go through the hospital's emergency rooms each year. About 60% of them have no insurance, even state-subsidized Medi-Cal benefits.

A crew of doctors and nu overseen by Hockberger, were treating patients for electrical burns, congestive heart failure, asthma, appendicitis, high fever, a fractured jaw, a heart attack, internal bleeding, chest pains, a severe headache and so on.

A teaching hospital, Harbor-UCLA, which is near the junction of the Harbor and San Diego freeways and has a national reputation as a top emergency hospital.

At Olive View, in Sylmar, the emergency room is not as busy as Harbor-UCLA's, with 72,000 annual visits, but nevertheless it has the busiest maternity wards in the San Fernando Valley, delivering 4,800 babies a year, many of them to indigent mothers at high risk of problem pregnancies.

Back at Harbor-UCLA, emergency room nurse Laurie Anderson said the budget cuts were a hot topic. "We talk about it all the time," she said. "We don't quite believe it will happen, because we don't see how these other hospitals can take on all these patients."

LA Times 7/12/95

County-USC Closure Seen as Peril to 911 System

Health: Indigent patients would flood other hospitals and overextend resources, experts say. Alternate proposal calls for closing Harbor and Olive View facilities instead.

By DOUGLAS P. SHUIT
TIMES STAFF WRITER

Disaster experts warned Tuesday that closure of County-USC Medical Center would cripple the emergency 911 system, lead to deaths and force the closure of financially struggling hospitals by diverting too many patients their way who could not pay for treatment.

"What we would have is a disaster," Alan Cowen, chief of paramedics for the Los Angeles City Fire Department told the county Health Crisis Task Force.

As an alternative to closing County-USC, it was suggested that two other big public hospitals—Harbor-UCLA Medical Center in Torrance and Olive View-UCLA Medical Center in Sylmar—be closed.

That proposal came from County Emergency Medical Services Agency chief Virginia Hastings, who said there were more hospitals in the coastal area and San Fernando Valley to soften the blow than there are Downtown.

Although advisory in nature, the proposal clearly put closure of the two hospitals into the mix of various health service cuts being considered by the task force.

"We have to give her proposal very serious consideration," said Burt Margolin, a former state legislator who is heading the task force. "It will be a key factor we will weigh in the coming days. We are looking for ways not to close facilities, but if we have to engage in a process of assessing how do you best preserve the most critical and most vital services, what she said today was very important testimony."

The five-member panel was appointed by the Board of Supervisors to study a recommendation by county budget chief Sally Reed that would close County-USC, which handles just over one-quarter of all trauma cases in the county.

Reed's proposal to close the facility is part of a plan to correct a $1.2-billion shortfall in the county budget. In all, Reed proposed cutting $655 million in health services. She would also like to close four comprehensive health centers and 25 county clinics, slash $54 million from mental health services and cut public health programs 20%.

Reed said she considered closing Harbor and Olive View but decided to recommend closing County-USC because of its age—it opened in 1932—and because it is so badly in need of upgrading that a replacement hospital would cost more than $1 billion.

The disaster experts and hospital officials appeared in almost universal agreement that closure of County-USC, particularly its busy trauma center, would flood the health system with sick patients and quickly overextend available resources, leading to deaths and other hospital closures.

The doomsday scenario was based on a number of factors. One was the inability of other hospitals in central Los Angeles County to absorb all the emergency calls now handled by County-USC. City paramedics took 10,640 patients to County-USC during 1994, more than 2,000 of them gravely injured or ill trauma patients. At the same time, many of those patients were

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HEALTH

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poor, without any health insurance.

Experts who have studied the problem say that if the county followed through on its plan to close health centers and clinics, the indigent and sick patients would call 911, knowing that an ambulance would be sent and they would be taken to a hospital. All hospitals with emergency rooms are obligated to take 911 patients whether they can pay or not.

"If they don't have a . . . walk-in clinic [close by], they are going to call and access our system, which I might add is already terribly overburdened," said Cowen, the city paramedic chief. "Our 911 system will be absolutely inundated. . . . Blood is going to flow from the people that don't make it to the trauma centers."

Hastings, responsible for coordinating public and private health services during earthquakes, fires and other disasters, said, "The numbers of [911] patients are so large that we would start moving out to find open hospitals, and within a [short time] every hospital in the county would be filled."

Those views were shared by more than a dozen private hospital administrators and emergency room physicians who also appeared before the budget panel.

Dr. Brian D. Johnston, an emergency room physician and president-elect of the Los Angeles County Medical Assn., called Reed's budget plan "a recipe for hospital closure."

"In six months or a year you are going to have major closures. You are going to have closures of emergency departments and closures of hospitals," Johnston said.

"What's the choice? Do you close to protect yourself, or do you bankrupt yourself and then close?"

The Board of Supervisors asked the task force to produce a report on the cuts, along with suggestions of alternatives, by July 25.

County Workers Begin Work Stoppage Over Cutbacks

By JOSH MEYER
TIMES STAFF WRITER

As Los Angeles County officials pleaded for budget help in Sacramento, the first of many expected job actions by county workers threatened with layoffs occurred Tuesday at welfare offices throughout Los Angeles.

Employees in at least six welfare offices called in sick or walked off their jobs in protest of the county's efforts to cut as many as 18,255 jobs and slash services in an effort to resolve an unprecedented budget deficit of $1.2 billion.

Recipients of food stamps, Medi-Cal and Aid to Families With Dependent Children money were forced to wait in long lines to get checks or address problems. Hundreds were told to come back another day unless they had emergencies, said Department of Public Social Services officials.

"I think the staff are of the opinion that this is the way to express their displeasure with what is going on," said Eddy S. Tanaka, department director. "Obviously it is very disruptive. I think the message needs to be given to someone else, the people in Sacramento."

Tanaka and aide Carol Matsui blamed union leaders and said the walkouts were timed to protest 1,782 layoff notices set to go out Monday. In all, there are 7,000 department employees in 31 county offices.

Gilbert Cedillo, general manager of Service Employees International Union Local 660, said union members were trying to send a message to state lawmakers in Sacramento. They chose to walk off the job Tuesday, he said, because they knew the five county supervisors were in the state capital and would inform state legislators of the walkouts.

Cedillo said the walkouts were spontaneous, but that similar job actions are expected at least through the week while the supervisors are in Sacramento, where they are asking state lawmakers for help in finding alternatives to layoffs and closures of hospitals, parks and other services.

Board Chairwoman Gloria Molina said the walkouts are counterproductive and not the way to get state lawmakers' attention.

Although Cedillo was in Los Angeles, the top echelon of Local 660 were in Sacramento, making the same rounds as the supervisors.

At the Southwest Family Services office in Inglewood, 111 of 219 employees called in sick early Tuesday, followed by 149 of 312 employees at the Southwest Special Office in South-Central Los Angeles.

"We have a lot of homeless people needing immediate cash, food stamps and Medi-Cal," said district Director Joyce Washington. "We managed to do it, but it was very, very stressful even to address the emergencies."

DRAFT

LA County Medicaid Update

The Original Plan

- We were working with LA County on a plan to increase Medi-Cal rates. This rate increase was meant to compensate LA County for the fact that it sees many hard-to-manage Medi-Cal and uninsured patients, and reimbursement rates in the state have not been increased for several years.

- Since Medi-Cal is 50/50 Federal/state, the plan was for LA County to pay the state's share, with the net gain to LA County only the increased Federal funds.

- Like other hospitals, LA County participates in the DSH program, which reimburses hospitals for the unreimbursed costs of caring for Medicaid and uninsured patients.

The Problem

- It turns out that, for every dollar LA County would gain through a rate increase, they would lose a dollar in DSH.

- This is because DSH pays for unreimbursed care; a rate increase directly reduces the amount of unreimbursed care.

- This is only a problem because DSH reimburses LA County for 100% of its unreimbursed costs. If DSH were paying LA County for less than 100% of its unreimbursed costs, the rate could increase up to some point without affecting DSH.

- A legitimate question is why LA County has a deficit if DSH compensates LA County for 100% of its unreimbursed costs.

- It turns out that the state rips off the counties to pay for the DSH program, as follows:

  Example: LA County has $100 in unreimbursed costs.
  Private hospital has $40 in unreimbursed costs.

How DSH should be funded:

Feds kick in $70; state kicks in $70; together these fully reimburse the 2 hospitals.

What Actually Happens in California:

Feds kick in $70; state kicks in nothing; LA County kicks in $70, or the state share for <u>both</u> hospitals; net gain to LA County is only $30 -- even though on paper the DSH program is fully reimbursing them for their costs.

LA County/State Proposal

- They want to count the payment by LA County to the state as a cost, in the calculation of the cap on "unreimbursed care" under DSH:

Example: Calculation of Unreimbursed Care ("DSH Cap"):

Costs of providing care to Medi-Cal and uninsured	$300
Revenue from Medi-Cal	-200
Net Unreimbursed Care	100

If We Agreed to the LA County Proposal:

Costs of providing care as above plus payment to state	$370
Revenue as above	-200
Net Unreimbursed Care	170

Problems with this Plan

- Fear that other states would impose mandatory payments upon counties as a way of increasing the current cap on DSH.

- The DSH program has a history of abuse that attracted much Congressional and other interest, and Congress has cracked down on it twice since 1991.

- Agreeing to count this as a cost may imply that the federal government will be matching these dollars more than once.

→ +50--

* Other stuff - $140m

Mikva - just count private? - Do other states do it?
- kept thru DOJ

1915b HCFA has had for 30 days; RO has promised state quick 30 day review; OMB has some problem with trend factor

Conn blended their rates nat'l with state

why was deal made?

Can do TF:

SB 1255 - sell bonds

- recognize debt service (principal + interest)
- we'll pay dep + int, shldn't make a diff.

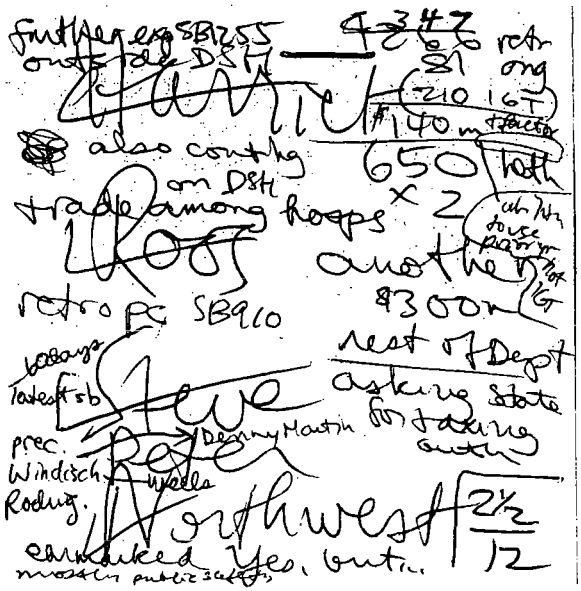
Rozann / Eden /

San Mateo Eshoo: Supervisors - resolution screwed

sold out to CA

Total MAC claim $8 - got $1m - one of wealthiest

All MA servs capitated - State adamant



trend factor

Black Point Inn

PROUTS NECK, MAINE 04074

Reassigned - Marilyn
rel probs w/other cties
Sally Reed

Jenny Roos / DSH - admittedly aggressive

266[redacted] + retro
81 ongoing

Prior yr expends

Barbara Maynard:
Can't claim as prior expenditure
settlement issue

TELEPHONE (207) 883-4126

7/13

Truffer

$140m: technical issues on DSH limit; construction costs, extremely generous inflation factor; all they have is formula, not numbers;

SB1255: construction bill: bless MA pymts under ; can borrow to do construction; we've said we don't pay for constr, but depr when constructed; tried to sneak into

Windisch is mouthpiece; they can strip that out

DSH and rate increase; we could do it without rate increase!!!

Deems

Meharry - Reagan Adm about to go down

PHS? / DOE

Bob Ricklard → OS ~~Appeals~~ (Ed Martin - Koops might am)

↳ PHS 690 - 6925

Bush - VP - 2nd go - round black medical schools

DOD/VA contracting out - look at?

Steve Joseph

7/13

Roos

Further expansion SB1255 outside DSH
Also counting on DSH trade among hospitals
retro pc SB 910

latest county budget was 60 days

2.5 out fo 12b is health, much earmarked; public safety

expect 266 retro plus 81 ongoing; total $347
$210 is agt; another $140 due to trend factor and ability to use prior year not IGT

cuts must be 650 x 2
Another $300m rest of Dept; asking state for taxing authority

LA County Medicaid

The Original Plan

- We were working with LA County on a plan to increase Medi-Cal rates. This rate increase was meant to compensate LA County for the fact that it sees many hard-to-manage Medi-Cal and uninsured patients, and reimbursement rates in the state have not been increased for several years.

- Since Medi-Cal is 50/50 Federal/state, the plan was for LA County to pay the state's share, with the net gain to LA County only the increased Federal funds.

- Like other hospitals, LA County participates in the DSH program, which reimburses hospitals for the unreimbursed costs of caring for Medicaid and uninsured patients.

New limits ~100% costs

The Problem

- It turns out that, for every dollar LA County would gain through a rate increase, they would lose a dollar in DSH.

- This is because DSH pays for unreimbursed care; a rate increase directly reduces the amount of unreimbursed care.

- This is only a problem if DSH is reimbursing LA County for 100% of its unreimbursed costs. If DSH were paying LA County for only 50% of its unreimbursed costs, the rate could increase up to some point without affecting DSH.

Why HCFA Just Figured This Out

- No one spotted this problem at first because they assumed that the DSH program was not compensating LA County for 100% of its unreimbursed costs -- or else they wouldn't have a deficit in the first place.

One might wonder ... why, if DSH reimbs for 100%, LA City has gen fd left?

- It turns out that the state rips off the counties to pay for the DSH program, as follows:

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Revenue as above	-200
Net Unreimbursed Care	170

Problems with this Plan

- Fear that other states would impose mandatory payments upon counties as a way of increasing the current cap on DSH. There would be nothing to stop New York from requiring its public hospitals to pay the state's pension costs, and increasing DSH by this amount.

- The DSH program has a history of abuse that attracted much Congressional and other interest, and Congress has cracked down on it twice since 1991.

- Recycling problem (explain this better!!!!) Somehow, agreeing to count this as a cost implies that the federal government will be matching these dollars more than once.

DG: pd by County
beds
@ S-W Cap?
Ex:
$300 assessment pub h's
But, incr pymts by $300; feds $150; inst'n even, no benefit
State $150
Probs w/ saying no
Eviscerate 33 DSH
No increased DSH costs
Louisiana wld have been problem
State won't ↑ DSH? Who says?
Could you do just DSH?
* discretion to do atb, or can you do it just
* Make sure $250/650
State budget — end of wk?
Asbly gave Gov tax cut
budget gap works (Maynard)
Recycling
All 100% Fed
DG: State has done nada

Black Point Inn
PROUTS NECK, MAINE 04074

Cong offices tour

will escalate it

Grantland: pressing

State

Hasowsk: I didn't know

$ max $20 m - 33%

TELEPHONE (207) 883-4126

[42 U.S.C. § 1396r-4]

Sec. 1923. (g) LIMIT ON AMOUNT OF PAYMENT TO HOSPITAL.—

(1) AMOUNT OF ADJUSTMENT SUBJECT TO UNCOMPENSATED COSTS.—

(A) IN GENERAL.—A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) LIMIT TO PUBLIC HOSPITALS DURING TRANSITION PERIOD.—With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) MODIFICATIONS FOR PRIVATE HOSPITALS.—With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.,

(2) ADDITIONAL AMOUNT DURING TRANSITION PERIOD FOR CERTAIN HOSPITALS WITH HIGH DISPROPORTIONATE SHARE.—

(A)IN GENERAL.—In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) if the payment adjustment does not exceed 200 percent of the costs of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital's applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year, there shall be excluded any amounts received under the Public Health Service Act, title V, title XVIII, or from third party payors (not including the State plan under this title) that are used for providing such services during the year.

(B) HOSPITALS WITH HIGH DISPROPORTIONATE SHARE DEFINED.—In subparagraph (A), a hospital is a "hospital with high disproportionate share" if—

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital—

(I) meets the requirement described in subsection (b)(1)(A), or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) APPLICABLE MINIMUM AMOUNT DEFINED.—In subparagraph (A), the "applicable minimum amount" for a hospital for a fiscal year is equal to the difference between the amount of the hospital's payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

1993 Amendments:

Section 13621(b)(1) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(b)(3) of these Amendments at ¶ 17,810, added at the end new subsection (g).

History:

Sec. 13621(b) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

PETE WILSON, Governor

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

(916) 654-0391

July 10, 1995

Bruce C. Vladeck, Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 309G
Washington, D.C. 20201

Dear Mr. Vladeck:

MEDI-CAL PROGRAM -- IMPLEMENTATION OF OBRA 1993 LIMITATIONS

As you are aware, Section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) modified the Medicaid Act regarding payments to disproportionate share hospitals (DSH). Specifically, as a result of OBRA 1993, federal law now imposes hospital-specific limitations on the amount of federal financial participation (FFP) available for payment adjustments that DSHs may receive during a given year. The OBRA 1993 amendment prohibits FFP where DSH payment adjustments to any particular hospital exceed:

> . . . the *costs incurred* during the year of furnishing hospital services (*as determined by the Secretary* and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

(Soc. Sec. Act § 1923(g), 42 U.S.C. § 1396r-4(g); emphases added.) The OBRA 1993 limitations apply with respect to public DSHs in California commencing with the 1994-95 state fiscal year, and to all other DSHs in California commencing with the 1995-96 state fiscal year.

California's DSH program, sometimes referred to as the (SB 855 program) is basically *prospective* in nature. Hospital eligibility for payments under the program is determined annually, on a final basis, at the commencement of each state fiscal year. The determination is based entirely on prior year hospital data.[1] Prior to the start of each state fiscal year, the projected maximum amount of DSH payment adjustments available for each eligible hospital is determined, so as to promote predictability of funding for such facilities. In this manner, the amount of nonfederal expenditures necessary to fund the SB

1/ Much of the hospital data used for this purpose are collected and maintained by the Office of Statewide Health Planning and Development ("OSHPD"), pursuant to a system that provides one of the most complete and accurate hospital data bases in the nation.

Cost (MA + uninS) (including GT)
- paymts (MA + uninS)

DSH cap → Feds match

855 program is also established prospectively. Thus, absent unusual circumstances, the size of the SB 855 program, and the individual hospital payment adjustment allocations, are calculated at the beginning of the applicable state fiscal year.

The proposed approach for implementing the OBRA 1993 limitations in California was developed with the key components of the existing SB 855 program in mind. Under the proposal, the OBRA 1993 limitation for each eligible hospital would be determined *prospectively*, using data elements (including prior year OSHPD data) that are integral to the existing SB 855 program. Calculations of hospitals' costs of providing services to Medi-Cal beneficiaries and uninsured individuals would be linked to the OSHPD data, while computations regarding hospital revenue would be derived from other data sources used in the current SB 855 program. Thus, the methodology for determining and applying the OBRA 1993 limitations would be carefully coordinated with and integrated into the existing system.

In recent weeks, public hospital representatives and State Department of Health Services (DHS) personnel have discussed the proposed approach with representatives of the Department of Health and Human Services (DHHS) and the Health Care Financing Administration (HCFA). While accepting many of the key components of the methodology, DHHS and HCFA representatives have expressed concerns over a few important elements of California's proposed approach. In particular, significant concern has been expressed regarding the treatment of intergovernmental transfers as costs. Secondarily, comments have arisen regarding the use of the Hospital and Related Services Consumer Price Index (C.P.I.) as the "trending factor" for projecting prior year costs into future fiscal years.

Due to several factors, it has become clear that the manner in which the OBRA 1993 limitations are implemented will be critical for the survival of the health care safety net in California. Since its inception, the SB 855 program has provided funding that has supported the survival of numerous DSHs in California, particularly county hospitals. Nevertheless, as a result of California's significant recession over the past five years, key state and local funding sources have been unable to keep pace with the health care service needs of our State's growing uninsured population, which is now approaching 25 percent of the total population. Local government in particular has been unable to sustain its historic levels of funding for indigent health care in the face of unprecedented fiscal pressures and competition for scarce resources. Many public hospitals are struggling to maintain their viability. This economic reality, combined with the potential effect of HCFA's reluctance to approve the proposed approach for implementing OBRA 1993, has now placed several county hospitals on the verge of closure. In Los Angeles County, for example, the closure of LAC+USC Medical Center, one of the nation's largest hospitals, is under serious consideration.

Placeholder - plan only does distribution

Did plan originally submitted by State + rejected count DSH IGT as a cost?

Given the critical nature of the situation at hand, DHHS and HCFA staff invited the submission of a position statement regarding the major areas of disagreement or concern in connection with California's proposed methodology. This letter is submitted in that regard. *As set forth below, we strongly believe that California's proposed approach is fully consistent with the provisions of OBRA 1993, and that the proposed methodology should be approved by your office.*

I. SECRETARY'S DISCRETION

A central element of the OBRA 1993 statute relates to the determination of hospital costs for purposes of calculating the maximum DSH payments for which FFP will be available. As quoted above, the statute refers to the hospital's:

> "costs incurred . . . as determined by the Secretary . . . ."

Given this language, it is clear that Congress conferred on the Secretary an *extraordinary scope of discretion* with respect to the recognition and determination of hospital costs. As discussed below, given the statutory language and the case law in this area, the Secretary's discretion would seem to extend to the broadest ranges permitted to an administrative agency.

In the Medicaid and Medicare areas, the courts have routinely recognized the Secretary's broad scope of discretion. For example, with respect to the definition of "reasonable costs" under Medicare, the Secretary's interpretation is entitled to considerable deference, so long as it is within the general statutory guidelines established by Congress. The Secretary's broad discretion in this regard has been confirmed in recent decisions of the United States Supreme Court (see Shalala v. Guernsey Mem. Hosp., __ U.S. __, 115 S.Ct. 1232, 1236 (1995); Good Samaritan Hosp. v. Shalala, __ U.S. __, 113 S.Ct. 2151, 2159 (1993)). (*See also* Conn. Dept. of Income Maintenance v. Heckler, 471 U.S. 524, 530-31, 105 S.Ct. 2210, 2214 (1985), regarding Medicaid definition of the term "institution for mental diseases.") As noted in Thomas Jefferson Univ. v. Shalala, __ U.S. __, 114 S.Ct. 2381, 2387 (1994), broad deference is especially warranted when, as here, the issue concerns "a complex and highly technical regulatory program," and "entail[s] the exercise of judgment grounded in policy concerns."

Through the language of OBRA 1993, however, Congress conferred upon the Secretary more than the normal level of program discretion. The text of OBRA 1993, as quoted above, grants the Secretary the authority to act "*with legislative effect.*" (*See, e.g.*, Batterton v. Francis, 432 U.S. 416, 425, 97 S.Ct. 2399, 2405 (1977).) *In allowing the Secretary to "determine" the hospital's costs, without reference to any other touchstones, Congress has authorized the Secretary broad latitude to include costs that normally might not be recognized by HCFA or DHHS for other purposes.*

The scope of the Secretary's extraordinary discretion here is evident from cases such as Schweiker v. Gray Panthers, 453 U.S. 34, 101 S.Ct. 2633 (1981). In that case, Medicaid regulations pertaining to income and resources requirements for program eligibility were at issue, specifically those describing the circumstances under which the income of one spouse may be deemed "available" to the other. The particular statute upon which the Secretary relied, Section 1902(a)(17)(B) of the Social Security Act (Act), specified that a State plan must:

> . . . provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant . . . .

No further guidelines were enumerated by the statute regarding the concept of "available" resources. On review, the Supreme Court ruled that, in view of this "explicit delegation of substantive authority," the Secretary's definition of the term "available" as promulgated in the regulations is "entitled to more than mere deference or weight." Rather, the Secretary's definition was entitled to "legislative effect" because:

> . . . in a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term.

(Schweiker v. Gray Panthers, at 44, *quoting* Batterton v. Francis, at 425.)

The manner and scope in which Congress delegated authority to the Secretary regarding the computation of the OBRA 1993 limitations is similar to the situation at issue in Schweiker v. Gray Panthers. Thus, in view of the ruling by the Supreme Court, it is apparent that the Secretary has the broadest possible authority and discretion to approve California's proposed methodology for implementing OBRA 1993.

In addition, the absence of any federal regulations implementing the OBRA 1993 provisions suggests that maximum flexibility should be granted to the states at this juncture. In the context of a federal/state cooperative program, such as Medicaid, the State, in its partnership role with the Federal Government, is entitled to regulatory guidance from the Secretary regarding the application of federal limitations. Where, as here, the Secretary has vast discretion, but, as here, has published no regulations, the equities are clearly in favor of California to craft its program within the wide bounds of the Secretary's discretion.

II. CALIFORNIA PROPOSAL FOR CALCULATION OF OBRA 1993 LIMITATIONS

Based on several recent discussions with DHHS and HCFA representatives, two topics have emerged as the primary federal concerns regarding California's proposed methodology. These topics are (1) the inclusion of certain intergovernmental transfers as hospital costs, and (2) the trend factor to be used in the expense formula. Both of these topics are discussed below:

A. Inclusion Of Transfers As Costs

1. Discretionary Authority

In light of the Secretary's extraordinary discretion to interpret and apply the OBRA 1993 provisions, set forth below is supporting rationale for California's methodology on the points in question. California has proposed, for purposes of the OBRA 1993 calculations, that certain amounts paid by counties to the State in support of the Medi-Cal program be included as hospital costs. These payments consist of *mandatory* intergovernmental transfer assessments upon those counties that are the licensees of hospitals determined to have DSH status for a particular State fiscal year. Transfer amounts are assessed on such counties as of July 1 of each year, solely as a result of their ownership and operation of a hospital (*see* Calif. Welf. and Inst. Code § 14163(e),(f),(g)). The counties have no choice as to whether to pay the transfer amounts in question. Should a county not pay the funds to the State on a timely basis, the State Controller must offset immediately the amount owed against any funds that would otherwise be payable by the State to the particular county (*see* Calif. Welf. and Inst. Code § 14163(j)(1)). For the reasons discussed below, these mandatory transfer amounts should be recognized as hospital costs for OBRA 1993 purposes.

The OBRA 1993 limitations are intended to restrict FFP to the federal share of each hospital's *net costs* of providing services to Medicaid beneficiaries and individuals without health insurance. A key element of the calculation, therefore, is the determination of *net costs*. The concept of *net costs* logically should include all costs incurred by or on behalf of the hospital in connection with its operations, especially those costs incurred *as a result of providing services to Medi-Cal and uninsured patients*. Where an expense must be paid (as a matter of law) solely as a result of operating the hospital, and is closely tied to services to indigent patients, it is as much an element of *net costs* as is any labor cost or cost of supplies.

In the case of the transfers in question, the cost is incurred by the county based *solely on its ownership and operation of a hospital*. This, by itself, should be sufficient for the Secretary to recognize the cost as relating to hospital activities for purposes of the OBRA 1993 calculations. Further support exists for the proposition, however, since recognition of the transfers as a cost of hospital operations is *fully consistent with the concepts contained in the Secretary's own Medicare cost reimbursement principles.*

2. Medicare Principles

Although the Secretary is not limited to the application of Medicare reasonable cost principles, the transfer costs in question meet the general Medicare principles for recognition of costs, since they are costs related to patient care incurred by a related organization on behalf of a hospital, as discussed below.

Under the Medicare program, reasonable costs are those "actually incurred," excluding any cost found to be unnecessary in the efficient delivery of needed health services. (Soc. Sec. Act § 1861(v)(1)(A); 42 U.S.C. § 1395x(v)(1)(A).) Reasonable costs include all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. (42 C.F.R. § 413.9(a).) Costs related to patient care "include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity." (Provider Reimbursement Manual (PRM) § 2102.2; 42 C.F.R. § 413.9(b)(2).)

The Medicare regulations provide that costs applicable to services, facilities and supplies incurred by organizations related to the provider by common ownership or control may be included in the allowable costs of the provider. (42 C.F.R. § 413.17(a).) Under this rule, an organization related to a provider as a result of common ownership or control is treated as if it were a part of the provider. With respect to providers operated by agencies and departments of local governments, the Medicare rules provide specifically for allowable costs of government support services to local governmental providers. (PRM § 2156.) Such costs are includable in the allowable costs of the provider to the extent they are: (1) reasonable; (2) related to patient care; (3) allowable under Medicare regulations; and (4) allocated on an acceptable basis. *Id.* Costs that are allocated to a provider from a servicing governmental unit must fairly represent the benefits received by the provider. (PRM § 2156.2.)

In general, Medicare cost principles recognize certain tax expenses as allowable costs, so long as there are no legally available exemptions, and such taxes are not assessed on the basis of income or excess profit. Allowable tax expenses do not include fines and penalties. (PRM §§ 2122.1 - 2122.2.) As discussed below, the mandatory transfers in question are substantially equivalent to a tax; therefore, the recognition under Medicare principles that taxes can be allowable costs provides solid support for California's methodology.

3. Inclusion Of The Mandatory Transfers As Costs Is Consistent With Medicare Principles

HCFA has consistently acknowledged the common ownership and control relationship between public entities (such as counties) and their hospitals. Counties and their hospitals routinely have been treated as related organizations under 42 C.F.R § 413.17. Thus, the transfer costs incurred by counties should be regarded as having been incurred by their hospitals.

The transfers under the SB 855 program are assessed upon counties based upon the health care operations of the hospital(s) for which they are the licensees. The assessments are for Medi-Cal purposes, and do not fall within the categories of general governmental expenses that would not be allowed under Medicare cost principles. Rather, payment of the transfers is analogous to tax assessments recognized as costs under Medicare principles.

Because California law *mandates* the payment of the transfer amounts, and because the transfers arise from the operation of a hospital, the transfers are necessary and proper and related to patient care. Furthermore, since such transfers are required of several dozen public agencies in California (including counties and hospital districts), the transfers constitute costs that are common and accepted occurrences in the field of the provider's activity.

The transfer of funds in this situation also involves an important element that does not exist in some other states. Here, the transfers are made *by* numerous local agencies *to* the State. The transfers are not solely between and among State agencies themselves. The transfers clearly involve a *change of ownership of the funds* between the local agencies and the State. This change of ownership supports recognition of the transfers as a cost at the local level, since the transfer involves a divestiture of assets (*i.e.*, an expenditure) at the local level.[2] Where there is no divestiture, and ownership of the funds never

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[2] California law is clear that a change of ownership occurs regarding the funds. Upon receipt of the transfers, the funds are immediately deposited by the State in the State Treasury (*see* Calif. Welf. and Inst. Code § 14163(b), (k)), and are owned by the State. Most of the funds are used for the S.B. 855 program. However, a portion of the funds, once owned by the State, is directed to the Health Care Deposit Fund, to be used for other Medi-Cal purposes (*see* Calif. Welf. and Inst. Code § 14163(d)(2)).

Bruce C. Vladeck
July 10, 1995
Page 8

really changes (as might be the case in other states where transfers occur primarily between and among state agencies), the analysis might not be the same.

Given the foregoing, we believe that Medicare concepts and principles provide strong support for the OBRA 1993 calculation methodology proposed by California.[3]

4. **Medicaid Principles**

Given the extraordinary discretion afforded to the Secretary under OBRA 1993, and the support provided by Medicare principles for California's proposed methodology, a final area of authority to consider is the Medicaid statute, regulations and case law. As discussed below, there is no Medicaid statutory provision or regulation that precludes the transfers in question from being recognized as costs for purposes of California's implementation of OBRA 1993. On the contrary, Medicaid statutory provisions enacted in 1991 lend support to recognition of the transfers as costs for OBRA 1993 purposes.

a. <u>Medicaid Statutes, Regulations And Cases</u>

There is no Medicaid statute, regulation or controlling case authority that precludes the Secretary from permitting California's recognition of the transfers as costs for OBRA 1993 purposes. The Medicaid statutes, regulations and cases typically focus on the appropriateness and validity of State expenditures under particular federal statutes or regulations. (*See, e.g.*, 42 C.F.R Part 441.) Here, as discussed above, the OBRA 1993 language provides vast discretion to the Secretary and there are no regulations (or for that matter, even proposed regulations). There is no controlling case law, since the OBRA 1993 provisions have not been addressed by the courts. Thus, there is no legal barrier to the Secretary's approval of California's methodology.

b. <u>H.R. 3595 Provisions</u>

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (H.R. 3595) addressed certain issues concerning the treatment of taxes, donations and intergovernmental transfers for Medicaid purposes. H.R. 3595 added Section 1903(w), which restricts FFP when states are involved in certain provider-related donations or health care-related taxes.

3/ While Medicare concepts and principles support California's proposal, it is not our suggestion that these mandatory transfer costs must be recognized and reimbursed under the Medicare program itself. The Secretary's discretion under OBRA 1993 is extraordinarily extensive. An exercise of that discretion for purposes of a highly technical calculation relating to a particular Medicaid limitation does *not* mean that the same treatment of the costs should or must be granted for any other federal purpose or under any other federal program.

Under Section 1903(w), the definition of taxes includes "any licensing fee, assessment, or other *mandatory payment* . . . " (Soc. Sec. Act § 1903(w)(7)(F), 42 U.S.C. § 1396b(w)(7)(F); emphasis added). With respect to the treatment of intergovernmental transfers, Section 1903(w) specifically provides:

> For purposes of this subsection [§ 1903(w)], funds the use of which the Secretary may not restrict under subparagraph (A) [funds transferred from or certified by units of government within a state], shall *not* be considered to be a provider-related donation or a *health care related* tax.

(Soc. Sec. Act § 1903(w)(6)(B), 42 U.S.C. § 1396b(w)(6)(B); emphases added.)

It is clear that intergovernmental transfers are *not* to be considered within the ambit of the term "health care related taxes" and subjected to the restrictions of Section 1903(w). By its terms, Section 1903(w) precludes transfers from being part of the disfavored category of "*health care related*" taxes. Further, in no way does Section 1903(w) or any other component of H.R. 3595 take any step to preclude the recognition of such assessments as the substantial equivalent of a general tax for Medicaid purposes, including the recognition of such expenditures as a cost in calculations under OBRA 1993. Thus, *there is absolutely no indication that such transfers cannot be included as costs of hospital operations for OBRA 1993 purposes*.

Given the considerable attention devoted to provider taxes and intergovernmental transfers in connection with the development of H.R. 3595 in 1991, it would have been appropriate for Congress to address directly the topic of transfers had it intended to absolutely bar their recognition as provider costs for all Medicaid purposes.5/ The topic could have been addressed again in the development of OBRA 1993. *In light of the silence of Congress on this topic, it is apparent that the Secretary has discretion to approve, and should approve, California's proposed methodology for implementing OBRA 1993.*

B. Trend Factor

California's proposed methodology for prospective determination of the OBRA 1993 limitations applies a trend factor to project hospital costs for an upcoming State fiscal year from prior year data. The specific trend factor used is the C.P.I. for Hospital and Related Services for All Urban Consumers, developed by the Bureau of Labor Statistics of the U.S. Department of Labor.

5/ Under H.R. 3595, the Secretary has continuing authority to address the topic of intergovernmental transfers through the formal Administrative Procedure Act regulatory process. (H.R. 3595, § 5(b); House Conf. Rept. No. 102-409, *reprinted in* U.S. Code Cong. & Admin. News 1441, 1442.) To date, the Secretary has not taken steps in that regard.

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5184

Because the Hospital and Related Services C.P.I. is specific to *hospital* services, and includes both inpatient and outpatient services, its use is appropriate for projecting prior year data to determine prospectively the OBRA 1993 limitations. As a statistic that is regularly issued by a federal agency, it should be reliable and accurate from year to year.

To date, the primary comment by DHHS and HCFA representatives regarding California's proposed trend factor is that the proposal "warrants further review and consideration." For California, and especially for the public DSH hospitals, it is imperative that an appropriate trend factor be included in the OBRA 1993 calculations. The trend factor proposed by California is reliable, accurate and appropriate. Accordingly, it should be approved for use in California's methodology for implementing OBRA 1993.

III. IMPACT ON FEDERAL DSH EXPENDITURES

It is important to recognize that *California's proposal will not increase federal DSH expenditures from current levels.* Because federal law imposes an annual limit on total DSH payment adjustment amounts on a statewide basis, California's proposed OBRA 1993 methodology cannot result in an increase in federal DSH expenditures. Section 1923(f) of the Act (42 U.S.C. § 1396r-4(f)) provides that no federal funds are available to match state DSH expenditures in excess of each state's DSH allotment. California's allotment is approximately $2.2 billion in total DSH payments per federal fiscal year, $1.1 billion of which represents federal funds. (60 *Federal Register* 3250 (January 13, 1995).) *Nothing in the State's proposal would permit or cause California to exceed this maximum federal allotment.* Instead, federal expenditures under the S.B. 855 program will remain at current levels or will decrease (because some hospitals will suffer DSH payment reductions under the proposed methodology).[5/]

5/ As you may know, the S.B. 855 program has always been structured to provide DSH payments only to those hospitals that regularly provide large volumes or ratios of services to Medi-Cal and/or indigent patients. No hospital receives S.B. 855 payments unless its Medi-Cal utilization rate is at least one standard deviation above the mean, or its low income utilization rate exceeds 25 percent (*see* Calif. Welf. and Inst. Code § 14105.98(e)(2)). These are the most rigid eligibility standards permitted under federal law (*see* Soc. Sec. Act § 1923(b)(1), 42 U.S.C. § 1396r-4(b)(1)). If it's proposal for implementing OBRA 1993 were rejected, California could maintain it full federal allotment by applying less rigorous eligibility standards, as permitted by federal law. This would maintain the federal expenditure level at about $1.1 billion per year, would provide federal DSH funds to hospitals that provide far fewer services to the indigent, and could severely undermine the health care safety net in California. It is difficult to believe that such a counter-productive result could have been intended by Congress. Rather, we believe that Congressional intent for the DSH program supports a methodology for OBRA 1993 calculations that

(continued...)

BV: even if we don't approve
100%, but state out

If we pay more

3rd/4th try if out back door

Embarrass
Clock fast, playing defense

Contravenes ~~statute~~

$50 non-hosp pymts + $ under cap

The California proposal will not result in the absence of an actual and practical limitation on hospital-specific DSH payments. It is anticipated that, under the proposed methodology, numerous DSHs in California will, in fact, have their SB 855 payments reduced. At the same time, the methodology involves a reasonable and balanced approach that will serve to preserve California's health care safety net. As such, we believe the California methodology will fully and properly implement Congressional intent.

IV. CONCLUSION

For the reasons discussed above, it is requested that DHHS and HCFA approve California's proposed methodology for implementing the OBRA 1993 limitations. The proposal is legally sound, appropriate under the circumstances, and within the Secretary's discretion to approve.

Sincerely,

John Rodriguez
Deputy Director
Medical Care Services

cc: The Honorable Donna Shalala
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Ms. Nancy J. Dapper
Acting Regional Administrator
Health Care Finaincing Administration
75 Hawthorne Street, Fourth Floor
San Francisco, California 94105

Ms. S. Kimberly Belshé
Director
714 P Street, Room 1253
Sacramento, California 95814

3/(...continued)
maintains and preserves the safety net.

07/09/95 11:37am

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Back
900

In
600

California Association of Public Hospitals and Health Systems
2000 Center Street, Suite 308, Berkeley, CA 94704 Phone 510 / 649-7650 Fax 510 / 649-1533

July 11, 1995

Bruce C. Vladeck, Ph.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314G
Washington, DC 20201

Re: Medi-Cal Program - Implementation of OBRA 1993 Limitations

Dear Dr. Vladeck:

On behalf of the members of the California Association of Public Hospitals and Health Systems (CAPH), I am writing to express our full support for the attached State Department of Health Services' (SDHS) letter regarding two critical components of California's proposed methodology to implement the OBRA 1993 limitations. CAPH has worked closely with Los Angeles County, numerous other counties around the state, and with representatives of SDHS to develop a methodology implementing the hospital-specific payment limitations that is coordinated with and integrated into California's existing disproportionate share payment program. We believe that the proposal fully complies with federal statute at the same time that it preserves vital federal dollars for California's increasingly fragile health care safety net.

California's five-year recession has disproportionately impacted local government, which by legal and moral mandate serves as the state's health care safety net. Faced with increasing economic pressures, counties have simply been unable to keep pace with the demand for needed health care services and mounting competition for scarce resources. Many public hospitals are facing substantial service reductions; some are facing potential closure.

Despite a recent upturn in the economy, California still has one of the highest unemployment rates in the country. More than 6.5 million Californians have no insurance at all, while millions more are underinsured. The vast majority of our state's vulnerable and low income populations rely on public hospitals and health systems as their only source of care. The disproportionate share program has provided a critical funding source for counties in their efforts to maintain a safety net system of care.

The manner in which the OBRA 1993 limitations are implemented will be critical for the survival of this safety net. We stand ready to work with you and with representatives of SDHS to ensure a speedy resolution to this critical issue.

I look forward to talking with you at your earliest possible convenience.

Sincerely,

Denise K. Martin
President & CEO

c: Kim Belshé, Director, State Department of Health Services
John Rodriguez, Deputy Director, Medical Care Services, State Department of Health Services
CAPH Board Members

ILLUSTRATION OF CA USE OF IGTs FUNDS (I.E. DSH TAKEBACK) DURING SFY 1993/1994

COMPUTATION OF EXCESS IGT AMOUNT RECEIVED BY STATE FROM IGT HOSPTIALS:

HOSPITAL TYPE	A TOTAL DSH PAYMENT AMOUNT	B IGT NEEDED AS STATE SHARE OF DSH PAYMENT (A x 50%)	C TOTAL IGT PAYMENT AMOUNT TO STATE	D NET "EXCESS IGT PAYMENT TO STATE (C-B)	E NET REVENUE AMOUNT RECEIVED BY IGT HOSPITAL (A-C)
IGT HOSPITALS					
County Hospitals except LA CO	$730,691,246	$365,345,623	$484,317,022	$118,971,399	$246,374,224
Los Angeles County Hospitals	$968,921,310	$484,460,655	$642,220,755	$157,760,100	$326,700,555
District Hospitals	$2,745,900	$1,372,950	$1,820,038	$447,088	$925,862
University of California Hospitals	$148,140,495	$74,070,248	$98,190,533	$24,120,286	$49,949,962
Statewide Totals IGT Hospitals	$1,850,498,951	$925,249,476	$1,226,548,348	**$301,298,873**	$623,950,603

STATE APPLICATION OF EXCESS $301,298,873 IGT AMOUNT RECEIVED FROM IGT HOSPITALS:

				EXCESS IGT AMOUNT APPLIED AS STATE SHARE	NET REVENUE AMOUNT RECEIVED BY NON-IGT HOSPITAL
NON-IGT HOSPITALS					
Community Hospitals except Childrens	$220,178,264	$110,089,132	$0	$110,089,132	$220,178,264
Childrens' Hospitals	$73,329,300	$36,664,650	$0	$36,664,650	$73,329,300
Statewide Totals Non-IGT Hospitals	$293,507,564	$146,753,782	$0	**$146,753,782**	$293,507,564

NET EXCESS IGT RETAINED BY STATE **$154,545,091**

FILENAME:IGTUSE DISC;CAMAC7

Small amt from clinics not pt of hosps
- don't get DSH
- don't know how much

State makes money
SEIU,

ILLUSTRATION OF CA USE OF IGTs FUNDS (I.E. DSH TAKEBACK) DURING SFY 1994/1995

COMPUTATION OF EXCESS IGT AMOUNT RECEIVED BY STATE FROM IGT HOSPTIALS:

HOSPITAL TYPE	A TOTAL DSH PAYMENT AMOUNT	B IGT NEEDED AS STATE SHARE OF DSH PAYMENT (A x 50%)	C TOTAL IGT PAYMENT AMOUNT TO STATE	D NET "EXCESS IGT PAYMENT TO STATE (C-B)	E NET REVENUE AMOUNT RECEIVED BY IGT HOSPITAL (A-C)
IGT HOSPITALS					
County Hospitals except LA CO	$716,150,926	$358,075,463	$524,767,403	$166,691,940	$191,383,523
Los Angeles County Hospitals	$948,442,435	$474,221,218	$694,981,539	$220,760,322	$253,460,896
District Hospitals	$5,039,915	$2,519,958	$3,693,053	$1,173,096	$1,346,862
University of California Hospitals	$138,032,650	$69,016,325	$101,144,930	$32,128,605	$36,887,720
Statewide Totals IGT Hospitals	$1,807,665,926	$903,832,963	$1,324,586,925	**$420,753,962**	$483,079,001

STATE APPLICATION OF EXCESS $420,753,962 IGT AMOUNT RECEIVED FROM IGT HOSPITALS:

				EXCESS IGT AMOUNT APPLIED AS STATE SHARE	NET REVENUE AMOUNT RECEIVED BY NON-IGT HOSPITAL
NON-IGT HOSPITALS					
Community Hospitals except Childrens	$298,115,888	$149,057,944	$0	$149,057,944	$298,115,888
Childrens' Hospitals	$63,876,650	$31,938,325	$0	$31,938,325	$63,876,650
Statewide Totals Non-IGT Hospitals	$361,992,538	$180,996,269	$0	**$180,996,269**	$361,992,538

NET EXCESS IGT RETAINED BY STATE **$239,757,693**

FILENAME:IGTUSE DISC;CAMAC7

Special Medi-Cal Payments by Counties to State

(Referred to as "Takebacks" by Counties)

During the course of our Administrative Claiming Resolution Process in California, county personnel commonly noted that the state was balancing the Medi-Cal budget at county expense through two so-called "takebacks": Medi-Cal Administrative Claiming (MAC) and Intergovernmental Transfers (IGTs) for Disproportionate Share Hospital (DSH) payments.

MAC TAKEBACK

The current MAC legislation requires each County to remit to the State a pro-rata share of its MAC revenues each SFY year beginning in SFY 94/95. This amount totals $200 million Statewide and is contained as a line item in the original State budget for SFY 94/95.

The original MAC takeback estimate included in the State budget was based upon the inflated MAC revenue projections developed under the original MAC proposal. However, as a result of the HCFA disallowance and the revised MAC revenue estimates being projected under the resolution process (which may not reach $200 million Statewide), the State is proposing legislation which will reduce the MAC resolution process takeback to a total of $20 million Statewide. This amount was contained in Governor Wilson's May budget revision. Pending passage of this legislation, Counties are refusing to submit any resolution process claims for SFY 94/95 since any revenues generated for the Counties by these claims are subject to the original $200 million takeback until the legislation is changed. The $200 million was to be deposited to the Health Care Deposit Fund for support of the Medi-Cal program. There is no direct state outlay for match under MAC. The counties pay the non-Federal share of the match through Certified Public Expenditures (CPE) and also reimburse the state its costs of administering the MAC program.

In addition, we understand from the Counties that the State is also proposing legislation that will alter the takeback mechanism and tie the takeback prospectively to the recently implemented TCM services. Thus, the Counties will again be subject to a takeback under TCM.

The State could provide immediate relief to the Counties by releasing them from the MAC resolution process takeback amounts and from the future proposed legislation that requires the takeback to be imposed upon the TCM services.

IGT - DSH TAKEBACK

The IGT - DSH payments have just recently become an issue, and only then in the context of our providing technical assistance with respect to raising outpatient rates to public providers. OBRA 93 establishes hospital-specific payment limits which many county hospitals will likely exceed if they get substantial increases to their outpatient rates. As currently structured under OBRA 93, public providers could find themselves losing $1 DSH for every $1 of increased Outpatient rate. CA counties and the CA Association of Public Hospitals (CAPH) will soon propose (it's unclear whether the state will endorse the proposal) to the Administrator that the OBRA 93 hospital-specific limit include IGT payments as a provider cost. If calculated in this manner, the hospitals would be able to have much higher DSH limits and be able to retain the increased OP rate money. We have told the state, LA County, CAPH, and Willie Brown's staff that the IGT-as-a-cost proposal could not be endorsed by HCFA's technical and policy staff.

CA's DSH allotment is right at $2.2 billion: $1.1 billion is FFP and $1.1 billion is IGT provided by the counties. An IGT payment to the state has three components:

1. The DSH match for that county's DSH hospitals.
2. The DSH match for private hospitals for which the state has not required an IGT. (Community and Children's Hospitals - see middle column of Lotus Chart I earlier sent you).
3. The county share of funds which will be used for general health purposes.

Referring to the 93/94 chart:

Gross DSH Payment divided by 2 = IGT needed for DSH Match is $1,072,003,258. but total IGT payments were budgeted at $1,226,548,348. The excess IGT payments of $154,545,090 were used for general health purposes. According to state DSH staff, the excess IGT payments for SFY 94/95 are in excess of $200 million.

Revised Wednesday, 7/5/95 AM by Tom Coupar and Bill Lasowski. File renamed 'TAKE5.WP" on Coupar's Dunn No.1. PROFS'd to The Administrator's Office and Bill Lasowski, with a hard-copy to Grantland Johnson.

filename:take disc:camac7

Budgeted Disproportionate Share Hospital Payments For State Fiscal Year July 1993 Through June 1994

Hospital Type	Gross Payments to Hospitals		Intergovernmental Transfer		Net Revenue to Hospital	
	% of Total	Amount	% of Total	Amount	% of Total	Amount
County Hospitals except LA CO	34.08%	$730,691,246	22.59%	$484,317,022	11.49%	$246,374,224
Los Angeles County Hospitals	45.19%	$968,921,310	29.95%	$642,220,755	15.24%	$326,700,555
County Hospitals Sub-Total	79.27%	$1,699,612,556	52.54%	$1,126,537,777	26.73%	$573,074,779
Community Hospitals except Childrens	10.27%	$220,178,264	0.00%	$0	10.27%	$220,178,264
Childrens' Hospitals	3.42%	$73,329,300	0.00%	$0	3.42%	$73,329,300
Community Hospital Sub-Total	13.69%	$293,507,564	0.00%	$0	13.69%	$293,507,564
District Hospitals	0.13%	$2,745,900	0.08%	$1,820,038	0.04%	$925,862
University of California Hospitals	6.91%	$148,140,495	4.58%	$98,190,533	2.33%	$49,949,962
Statewide Total for 97 Hospitals	100.00%	$2,144,006,515	57.21%	$1,226,548,348	42.79%	$917,458,167
Detail of Los Angeles County Hospitals						
Harbor -UCLA	7.77%	$166,644,590	5.15%	$110,455,424	2.62%	$56,189,166
High Desert	0.28%	$5,975,360	0.18%	$3,960,590	0.09%	$2,014,770
Martin Luther King/Drew Medical Cntr	5.66%	$121,311,360	3.75%	$80,407,637	1.91%	$40,903,723
Rancho Los Amigos	4.17%	$89,321,700	2.76%	$59,204,240	1.40%	$30,117,460
USC Medical Center	20.63%	$442,327,320	13.67%	$293,183,546	6.96%	$149,143,774
Olive View Med Center	6.69%	$143,340,980	4.43%	$95,009,318	2.25%	$48,331,662
Total LACO Hospitals	45.19%	$968,921,310	29.95%	$642,220,755	15.24%	$326,700,555

Purpose To show the general relationship of DSH activity in CA and in Los Angeles County. Final DSH allotment was $2,191
Source Prepared from CA State budget reports by Thom Coupar 4/17/95. Dunn #1 Disc 'DSH495.wk1 & IMpress

Note State match for Community and Childrens Hospitals is funded by the Intergovernmental Transfers Account.
filename:dsh495x disc:camac7

Budgeted Disproportionate Share Hospital Payments For State Fiscal Year July 1994 Through June 1995

Hospital Type	Gross Payments to Hospitals % of Total	Gross Payments to Hospitals Amount	Intergovernmental Transfer % of Total	Intergovernmental Transfer Amount	Net Revenue to Hospital % of Total	Net Revenue to Hospital Amount
County Hospitals except LA CO	33.01%	$716,150,926	24.19%	$524,767,403	8.82%	$191,383,523
Los Angeles County Hospitals	43.71%	$948,442,435	32.03%	$694,981,539	11.68%	$253,460,896
County Hospitals Sub-Total	76.72%	$1,664,593,361	56.22%	$1,219,748,942	20.50%	$444,844,419
Community Hospitals except Childrens *	13.74%	$298,115,888	0.00%	$0	13.74%	$298,115,888
Childrens' Hospitals *	2.94%	$63,876,650	0.00%	$0	2.94%	$63,876,650
Community Hospital Sub-Total	16.68%	$361,992,538	0.00%	$0	16.68%	$361,992,538
District Hospitals	0.23%	$5,039,915	0.17%	$3,693,053	0.06%	$1,346,862
University of California Hospitals	6.36%	$138,032,650	4.66%	$101,144,930	1.70%	$36,887,720
Statewide Total for 97 Hospitals	100.00%	$2,169,658,464	61.05%	$1,324,586,925	38.95%	$845,071,539
Detail of Los Angeles County Hospitals						
Harbor -UCLA	7.15%	$155,099,460	5.24%	$113,650,821	1.91%	$41,448,639
High Desert	0.25%	$5,331,010	0.18%	$3,906,356	0.07%	$1,424,654
Martin Luther King/Drew Medical Cntr	6.97%	$151,228,720	5.11%	$110,814,494	1.86%	$40,414,226
Rancho Los Amigos	3.66%	$79,514,105	2.69%	$58,264,828	0.98%	$21,249,277
USC Medical Center	18.65%	$404,621,060	13.67%	$296,490,509	4.98%	$108,130,571
Olive View Med Center	7.04%	$152,648,060	5.16%	$111,854,531	1.88%	$40,793,529
					0.00%	
Total LACO Hospitals	43.71%	$948,442,435	32.03%	$694,981,539	11.68%	$253,460,896

Purpose To show the general relationship of DSH activity in CA and in Los Angeles County. Final DSH allotment was $2,191
Source Prepared from CA State budget reports by Thom Coupar 7/03/95. Dunn #1 Disc 'DSH495.wk1 & IMpress
Note State match for Community and Childrens Hospitals is funded by the Intergovernmental Transfers Account.
DSH allotment is $2,191,451,000 - State will pay up to the allotment with a lump sum adjustment. 97 dsh hospitals sfy 94/95 same as previous yr
filename:dsh495x disc:camac7

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Health Care Financing Division

JUL 11 1995

NOTE TO BRUCE VLADECK

Re: California's Calculation of the Costs of Furnishing Hospital Services Under OBRA '93

Section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) established hospital specific limits on the amount of Medicaid payment adjustments States may make to disproportionate share hospitals. The statutory limit for any hospital is the amount by which "the costs incurred during the year of furnishing hospital services" for Medicaid beneficiaries and the uninsured exceeds the payments the hospital receives from Medicaid and the uninsured. The applicable legislative history provides that Congress sought to limit DSH payment adjustments to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less any payments the hospital received on their account.

You have requested our comments on LA County's proposal to include, as a cost of furnishing hospital services to Medicaid beneficiaries and the uninsured, that amount of the public hospitals' Medicaid disproportionate share hospital (DSH) payments that the counties are required to return to the State. After several conversations with representatives of LA County and reviewing the relevant statutes and legislative history, we have concluded that such inter-governmental transfers (IGTs) of funds between certain counties and the State of California do not qualify as "costs" of furnishing hospital services.[1]

---

[1] Under California's arrangements for financing its Medicaid program, certain public facilities, including the large public hospitals such as those in Los Angeles County, are required as a matter of State law to return to the State treasury a significant percentage of the payments made to the hospital under the Medicaid DSH program. The State uses these payments to finance portions of its Medicaid program, thus being able to generate additional Federal matching payments without using any additional State money.

New mats - request from State
- LA City mats, too.

Hand issue to state - DSH

Other counties

Attack state?

VISIT MIGT proposal

MB

DOJ

In order to facilitate State calculation of the "costs... of furnishing hospital services", HCFA permits States to use the definition of allowable costs in the State plan, or any other definition, as long as the costs determined under the definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. While we have not been able to confirm with Medicare cost experts whether these transfers would be recognizable under Medicare cost principles, we doubt that they would. However, as a threshold matter, it must first be determined whether these transfers are a cost at all. In fact, these payments are in no way related to the cost of providing hospital services, much less as a cost of providing services to Medicaid beneficiaries and the uninsured. These payments are merely a device, called an intergovernmental transfer (IGT), by which the State finances a portion of its Medicaid program.

Rather than try to argue that the mandatory county inter-governmental transfers are Medicaid or uninsured costs, LA County claims that the IGTs are total facility costs that apply to all payors (all counties operating county hospitals) and are allowable under the Medicare principles of cost reimbursement as a cost related to health care. We believe the County understands and agrees that IGTs do not qualify as expenditures or costs of providing care to Medicaid beneficiaries. Accordingly, the County's argument seems to be based on its characterization that such IGT costs are related to beneficiary care or are necessary and proper costs incurred in furnishing hospital services in accordance with Medicare cost principles.

We find no evidence to support a claim that the mandatory inter-governmental transfer from the counties to the State is an allowable cost or a necessary and proper cost incurred in furnishing hospital services. In fact, the State establishes in advance the amount of the so called "costs" that must be transferred back to the State by the counties. The transferred amounts are then paid out by the State to other providers under the Medicaid program. If we were to agree that these amounts are recognizable as costs to the counties, we would have to acknowledge that they are being recognized again as costs to the State's Medicaid program when they are used as a basis for claiming federal financial participation in these additional provider payments made by the State. The transfer does not contribute to the provision of services to any Medicaid beneficiary or uninsured individual at the facility by which they would be claimed or in any other way increase the actual cost of any medical services rendered. There is no evidence that the transfer provides services or goods that are related to medical services. There is no evidence that the transfer is related to patient care except that the State, through state law, earmarks the transferred funds to be used, in part, for DSH payments to other facilities.

only?

For the above reasons we conclude that there is no basis in law for HCFA to recognize the intergovernmental transfers, required by California law to be made by county facilities to the State, as part of the costs of providing hospital services to Medicaid beneficiaries and uninsured individuals for purposes of the DSH payment limits in section 13621 of OBRA '93.

Darrel Grinstead
Associate General Counsel

7/10 Sandra Hernandez – Health Comm SF
– HCFA no longer spfg rate↑?

~~Peter~~
~~Steve~~

* Comm IGT deal – Martha

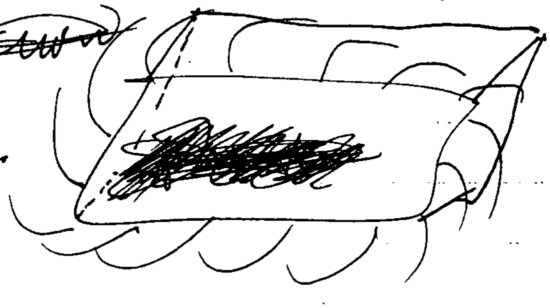
7-7-95

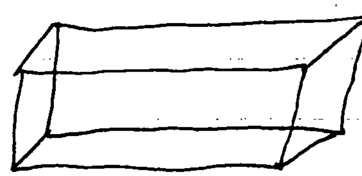
LA Cty / Lockyer
→ 7/1 was impt? maybe

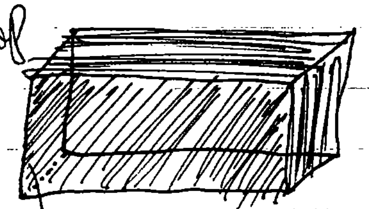
my CPE idea? → Grantland • checking w/ CSAC on commonality
salvage algo?

2 ① retroactive? not sure – ~~know~~
1 ② break off clinics → know by Mon.
(5/24)
③ ②a state statute steer to freestdg clinics

④ CPE – only if State prop'l to forego
3 ⑤ Pressure state





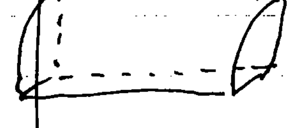


$50 m from non-chdren hosp't CCP (only LA)

Boren ??

sources
rev

IGT



PARTMENT OF HEALTH SERVICES

W/UCLA MEDICAL CENTER

AR 1995/96

reference for OBRA '93 Page 7 of 12

(A6) CRRP Current Expenses (FY 1995-96)	(A7) Projected Non-Medical Svs. MAC Exp. (FY 1995-96) (3)	(A8) Projected Mandatory IGT Expenses (4)	(A9) Medi-Cal / Uninsured Patient Mix (5)	(A10) Hospital Medi-Cal / Uninsured Operating Expenses
$0.00	$10.00	$111.85	87.04%	$304.35
$0.00	$1.53	$111.85	87.04%	$311.72
$0.00	$1.53	$0.00	87.04%	$214.37
$0.00	$1.53	$128.75	87.04%	$326.43

reference for OBRA '93 Page 10 of 12

(B5a) Expended clinic visit revenue (gross)	(B6) Estimated cash payments from Uninsured (Inflated) (6)	(B7) Sum of (B1) to (B6) Medi-Cal/ Uninsured Revenue	(C) (A10)-(B7) Hospital Specific DSH Limit	(D) Projected DSH Revenue (1995-96) (4)	(E) (C) - (D) Under / (Over) DSH Limit (1995-96)	(F) (E) / 2 Projected DSH Losses (1995-96)
$0.00	$3.38	$136.01	$169.33	$152.65	$16.68	— (7)
$44.20	$3.38	$177.63	$134.10	$152.65	($18.55)	($9.28)
$44.20	$3.38	$177.63	$36.74	$152.65	($115.91)	($57.95)
$44.20	$3.38	$177.63	$148.80	$152.65	($3.85)	($1.92)

(1) This data is from the OSHPD report Page 8 line 200 Column 1
(2) This data is from the OSHPD report Page 8 line 35 Column 1
(3) Revised to reflect more current estimates of SB 910 claims (MAC)
(4) The SB 855 data is from the 1994-95 program
(5) This data is from OSHPD report page 12 line 415 columns 5, 7, 9,11, 17 and 1
(6) This data is from the OSHPD report Page 12 line 460 Column 17 and 19 inflated to 1995-96
(7) OV/UCLA MC is $16.68 million under DSH limit for Scenario 1

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH

OBRA '93 FORMULA - OLIVE VIEW/UCLA M

FISCAL YEAR 1995/96

Medi-Cal / Uninsured Expenses

($ In Millions)

	(A1) Prior Year Total Operating Expenses (1)	(A2) Prior Year Unreimbursed Cost by the Uninsured (2)	(A3) Prior Year CRRP Expenses (FY 1992-93)	(A4) Trending Factor	(A5) [(A1) + (A3)] * A4 Projected Adj. Operating Expenses for Upcoming DSH Pmt. Adjustment Year	(A6) CRRP Current Expenses (FY 1995-96)	(A7) Proje Non-M Svs. MA (FY
Scenario 1	$191.15	$2.04	$0.00	128.28%	$247.82	$0.00	$10.
Scenario 2	$191.15	$2.04	$0.00	128.28%	$247.82	$0.00	$1.
Scenario 3	$191.15	$2.04	$0.00	128.28%	$247.82	$0.00	$1.
Scenario 4	$191.15	$2.04	$0.00	128.28%	$247.82	$0.00	$1.

Medi-Cal / Uninsured Revenues

($ In Millions)

	(B1) Medi-Cal Revenue		(B2)	(B3)	(B4)	(B5)	(B5a)	(Bc
	Inpatient	Outpatient		Est. CRRP Rev for upcoming DSH payment adjustment year (1995-96)	Est. SB1255 as as of June 1 prior to the upcoming DSH payment adjustment year (1995-96)	Est. patient related MAC revenue for the upcoming DSH payment adjustment year (1995-96) (3)	Expanded clinic visit revenue (gross)	Estim cas paym fro uninsu (Inflate
Scenario 1	$59.00	$28.00	$0.00	$41.63	$3.00	$0.00		$3.3
Scenario 2	$59.00	$28.00	$0.00	$41.63	$1.41	$44.20		$3.3
Scenario 3	$59.00	$28.00	$0.00	$41.63	$1.41	$44.20		$3.3
Scenario 4	$59.00	$28.00	$0.00	$41.63	$1.41	$44.20		$3.3

Notes:

Scenario 1 = Original 1995/96 OV/UCLA MC data as submitted on 06/15/95

Scenario 2 = Scenario 1 adjusted for expanded clinic visit gross revenue
Total LAC-DHS = $680 million, OV/UCLA MC = $44.20 million

Scenario 3 = Scenario 2 adjusted for removal of IGT (A6) as an expense

Scenario 4 = Scenario 2 adjusted to add Expanded Clinic Visit IGT to column (A6)

(1) This da
(2) This da
(3) Revise
(4) The SE
(5) This da
(6) This da
(7) OV/UC

COUNTY OF LOS ANGELES
Chief Administrative Office
Revenue Maximization

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NOTE: Copy of material I sent to Lasauski to help Wladek understand need for inclusion of DHY. We are going to need your help on this.

Please call me if the telecopy you receive is incomplete or illegible.

OBRA '93

Hospital-Specific DSH Payment Limitations

Proposed Draft Formula
June 19, 1995

Hospital-Specific DSH Payment Limitations

- Limitation on total Medi-Cal disproportionate share hospital (DSH) payments each DSH hospital can receive per year
- Effective Date
  - Public hospitals beginning in State FY 1994-95
  - Private hospitals beginning in State FY 1995-96

Implementation

- Complete & apply calculation prior to start of each DSH payment adjustment year
- Promote certainty of DSH funding for each payment adjustment year
- Promote consistency with current DSH program (SB 855)

Hospital Expenses Data Sources

- OSHPD Annual Hospital Financial Disclosure Report
  - Specific to California
  - Same data source used to determine DSH eligibility
  - Administrative ease
  - Audited
  - Only data source to delineate Medi-Cal and uninsured costs
- Hospital-specific survey
  - Medi-Cal Construction Renovation and Replacement Program (CRRP)
  - Non-medical services related MAC

Hospital Revenues Data Sources

- Medi-Cal
  - Medi-Cal paid claims (Short-Doyle and all other acute)
    - Same data used to determine DSH payments
    - Actual Medi-Cal payments to hospitals
    - Administrative ease
  - Survey of hospitals participating in:
    - Medi-Cal Construction Renovation and Replacement Program (CRRP)
    - Non-medical services related MAC
- Uninsured
  - OSHPD Annual Hospital Financial Disclosure Report
    - Audited
    - Only audited report which includes cash payments to hospitals by the uninsured
- SB 1255
  - Most recent SB 1255 contract rates on file with CMAC at the time the hospital-specific DSH limit is being calculated

as of 06/19/95

DSH Payment Limitations

Calculations

FY 1994-95

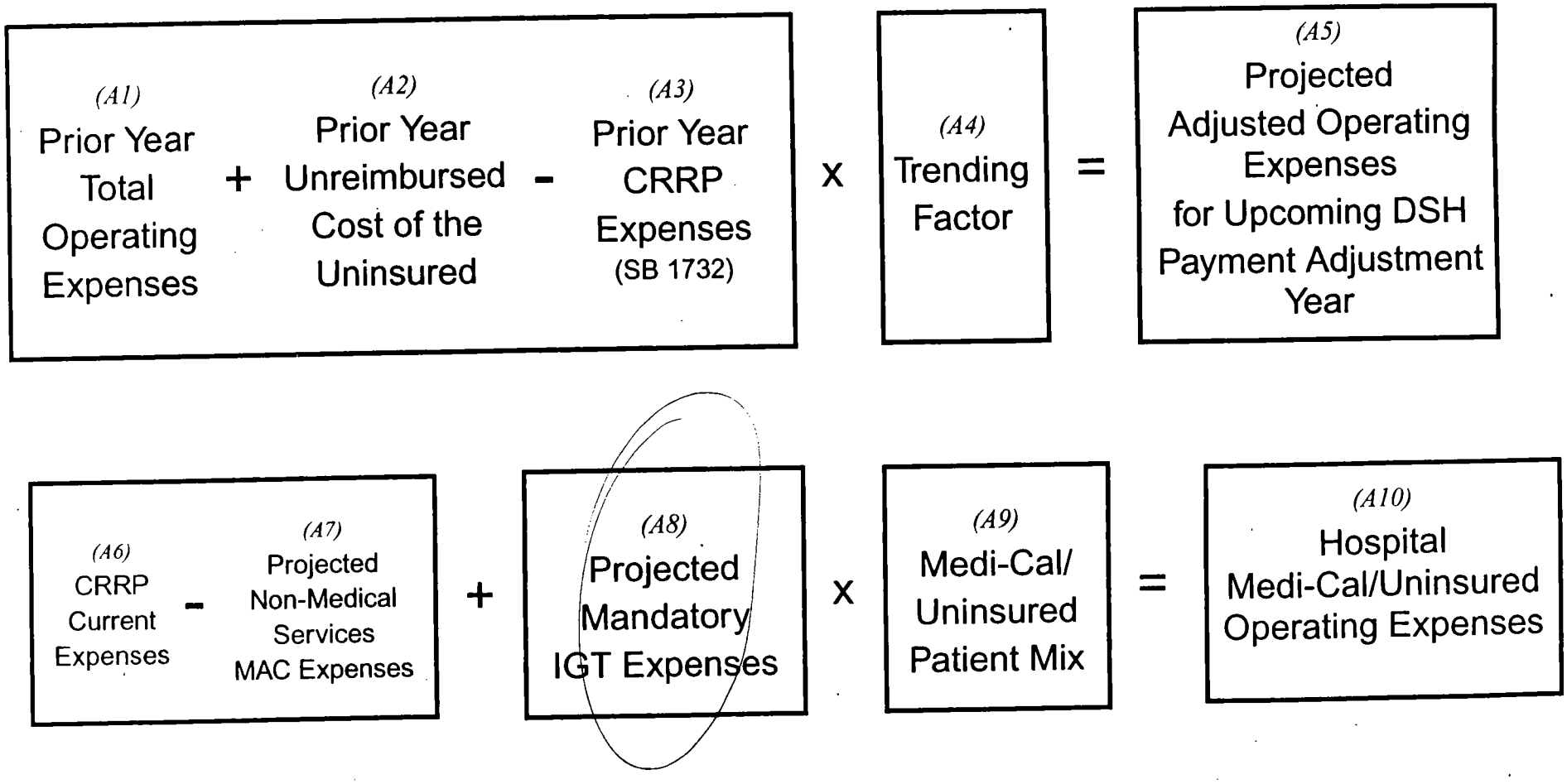
Hospital Medi-Cal/Uninsured Operating Expenses	-	Hospital Medi-Cal/Uninsured Revenues	=	Hospital-specific DSH Limit	x	2*

* Doubling effect applies only to public hospitals whose Medi-Cal utilization is at least one standard deviation above the State mean

FY 1995-96

Hospital Medi-Cal/Uninsured Operating Expenses	-	Hospital Medi-Cal/Uninsured Revenues	=	Hospital-specific DSH Limit

Hospital Medi-Cal / Uninsured Operating Expenses



as of 06/19/95

Medi-Cal / Uninsured Patient Mix

Numerator

- County Indigent Program
- Medi-Cal gross revenues (charges)
- Uninsured gross revenues (charges)

Denominator

Total gross revenues(charges)

Notes

Medi-Cal / Uninsured Operating Expenses

- Operating expenses
  - Unreimbursed cost for uninsured
    - Cash recognized in revenue
    - Total gross costs recognized in expenses
- CRRP Expenses
  - Matching revenues with expenses

Medi-Cal/Uninsured Revenue

Total Medi-Cal days paid in prior calendar year **X** Medi-Cal inpatient rates effective June 1 prior to upcoming DSH payment adjustment year **=** *(B1)* Medi-Cal Inpatient Revenue

+

Total measure units of services by procedure code paid in prior calendar year **X** Medi-Cal outpatient rates effective June 1 prior to upcoming DSH payment adjustment year **=** *(B2)* Medi-Cal Outpatient Revenue

+

(B3) Estimated CRRP revenue for upcoming DSH payment adjustment year **+** *(B4)* Estimated SB 1255 as of June 1 prior to the upcoming DSH payment adjustment year **+** *(B5)* Est. patient related MAC revenue for the upcoming DSH payment adjustment year **+** *(B6)* Estimated cash payments from uninsured *

=

(B7) Medi-Cal / Uninsured Revenue

* OSHPD Annual Financial Disclosure Report

CRRP Survey

Reasons	*Questions*
• Matches revenues and expenses • Limited number of hospitals • No Statewide data • Minimal data to be requested	• Amount of CRRP expenses in prior year OSHPD Annual Report • Upcoming DSH year amount of: – Expenses – Revenues

MAC Survey

Reasons	*Questions*
• Matches revenues and expenses • No Statewide data • Impacts public hospitals only • Minimal data to be requested	• Amount of patient care MAC revenue in upcoming DSH year • Amount of non-patient care MAC expenses in upcoming DSH year

DSH Payment Limitations

Terms

CMAC - California Medical Assistance Commission

CRRP - Medi-Cal Construction Renovation and Replacement Program (SB 1732)

DSH - Disproportionate Share Hospitals (SB 855)

OSHPD - Office of Statewide Health Planning and Development

MAC - Medi-Cal Administrative Claiming

SB 1255 - Medi-Cal Inpatient Rate Augmentation

as of 06/19/95

Los Angeles Times; 7-14-95

Supervisors Hope for Aid From Clinton

■ Lobbying: Even as efforts in Sacramento bear some fruit, they and California lawmakers urge the White House to restore health care funds.

By JOSH MEYER
TIMES STAFF WRITER

With an intense lobbying effort still under way in Sacramento, the County Board of Supervisors on Thursday turned its attention to the White House to help solve the county's unprecedented budget crisis.

By late afternoon, the Sacramento lobbying effort had paid a small dividend. State Sen. Hilda Solis (D-El Monte) said she would introduce a measure that would authorize the supervisors to increase sales taxes by a ½-cent, raising up to $400 million a year to help close the county's $1.2-billion deficit.

The bill needs to pass both houses of the Legislature and gain the approval of four of five supervisors before it could be put into effect, and many state lawmakers are averse to raising taxes.

Because of this, supervisors said they are pinning their hopes on President Clinton to help balance the budget. Without his help, several said Thursday, they will be forced to make catastrophic cuts in services and lay off thousands of employees, even if aid from Sacramento comes through.

Supervisor Mike Antonovich said an administrative decision by Clinton resulted in the loss of at least $650 million in health care funds last year. He and several other supervisors said they want to get back that money.

"It is vital," Antonovich said. "Failure of Washington to honor its commitment [to health care] will result in sizable downsizing of health services in L.A. County."

As a result, at least two supervisors—board Chairwoman Gloria Molina and Supervisor Zev Yaroslavsky—plan to fly to Washington next week for a series of meetings with lawmakers aimed at pressuring Clinton to restore the funds.

The supervisors spent much of this week in Sacramento making similar appeals, and several said they were buoyed by promises of aid during the ongoing state budget deliberations. They hope arm-

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twisting in Washington will prompt similar promises of help by the local delegation.

"There's not enough of a financial solution in Sacramento to alleviate the need to make deep and hurtful cuts," Yaroslavsky said. "Washington is critical in helping us manage this crisis.

"We are hopeful that the Administration and our congressional delegation will be helpful," he said.

As part of the general lobbying effort, members of the California congressional delegation are scheduled to meet next week at the White House with members of Clinton's staff, including Chief of Staff Leon Panetta, a former California congressman.

State lawmakers also are turning toward Washington as a way of trying to help beleaguered Los Angeles County.

In a letter, 21 state lawmakers issued an "urgent plea" to President Clinton on Thursday, asking for his intervention in the county budget crisis.

Specifically, the lawmakers asked the President to help the county obtain $226 million of the health care funds denied in the past several years and to get back other federal health care money that they say is critical in keeping the county health care network up and working.

"We know of your deep concern for health care and the crisis of Los Angeles," state Senate President Pro Tem Bill Lockyer (D-San Leandro) and Sen. Tom Hayden (D-Santa Monica) said in the letter. "We look forward to working with you for both an immediate as well as a long-term solution."

The county also has a law firm on retainer in Washington to help with its lobbying efforts, and many top county officials—including Health Services Director Robert C. Gates and Children and Family Services Director Peter Digre—have traveled to Washington in recent weeks to lobby for more federal aid.

"We can't forget that [federal officials] also are making decisions and policy changes that will impact our budget," said Alma Martinez, Molina's chief of staff.

Also Thursday, the supervisors took a mostly symbolic step of calling on department heads to join them in forgoing cost-of-living raises or to give the raises to charity.

But even if they all agree, such a move would save the county only $40,000.

Meanwhile, protests continued at at least seven Department of Public Social Services offices.

About 900 workers administering general welfare, Aid to Families With Dependent Children, Medi-Cal and food stamp money either called in sick or walked off the job during the day to protest about 1,800 proposed layoffs in the department that could go into effect by early August.

"The protests have been very disruptive," said spokeswoman Carol Matsui, "but we have not had to close any offices."

'There's not enough of a financial solution in Sacramento to alleviate the need to make deep and hurtful cuts. Washington is critical in helping us manage this crisis.'

ZEV YAROSLAVSKY
County supervisor

July 19, 1995

MEMORANDUM FOR THE VICE-PRESIDENT

FROM: Diana Fortuna
Domestic Policy Council

SUBJECT: Los Angeles County Fiscal Problems

I understand that you met Los Angeles County Supervisor Gloria Molina at an event on Friday, and that she brought to your attention the county's fiscal problems, particularly related to Medicaid, and the potential closing of its major hospital (Los Angeles County-USC Medical Center). The administration has had continuing involvement with county officials on this issue for several months; this memo is intended to bring you up to date.

L.A. County has a budget deficit of approximately $1 billion for the fiscal year that began July 1; $650 million of this total is associated with the health department budget. L.A. has an extensive system of public hospitals and clinics. To close the gap, the county's administrative officer has proposed closing County-USC Hospital, but the five supervisors are searching for alternatives. Two or three of them are here this week to lobby for assistance. Final budget decisions will probably be made within two weeks.

In March, HHS denied a Medicaid claim by L.A. County for $300 million. The claim was based on a new state-wide system designed to maximize reimbursement for administrative costs, and would have netted the county $600-800 million per year. HCFA disallowed the claim based on its position that these were not legitimate administrative costs.

Since the denial of the claim is subject to appeal and ultimately litigation, the administration asked the Justice Department to review potential litigation claims in order to see whether there is a way to resolve this issue without litigation. We understand that they are attempting to do this on an expedited basis. Justice has had several meetings with the county and state with no resolution to date.

In addition, HHS attempted to identify alternative sources of federal assistance to the county, and has approved approximately $60 million in legitimate administrative costs. For several months, HHS told us that an increase in the clinic reimbursement rate would solve the county's problems, if only the Governor would agree to sign such legislation. However, we just learned that this plan does not work for technical reasons; the county is not happy with this development.

Supervisor Molina is meeting with the chief of staff today at 4 pm. I understand that at that time she may present a new proposal for a demonstration waiver that L.A. County believes would benefit them financially. I am attempting to learn more about this proposal.

cc: Leon Panetta
Abner Mikva
Carol Rasco
John Emerson