Alameda Health System

Initial Financial Assessment

Report Excerpts for AHS Board Presentation
May 22, 2020

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HEALTH CARE PRACTICE

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Initial Financial Assessment –

AHS Board Presentation

Project Objectives

Executive Summary

- **Partnership/Collaboration**
- **Financial Trending**
- **Key Findings & Recommendations**

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Project Objectives

Project Objectives

Phase One

- Independent review of Alameda Health System's (AHS's) revenue and expenses for FY 2019 (actual) and FY 2020 (budget), including validity of assumptions and projections as provided by management.
- Review of sources and applications of funds by entity and discussion of potential options of closing the funding "gap."
- Analysis of AHS's structural foundation (through Alameda County Medical Center Hospital Authority) (the "Hospital Authority") to meet community expectations and repay debt in conjunction with a review of internally prepared financial statements.

Project Objectives

Phase Two: (Future Work)

We have been asked to support AHS address the very recent emerging cash flow crisis at AHS due in part to regulatory issues requiring capital investment to address, pending repayment of supplemental funding and the level of AHS Foundation contributions that are now expected to be $10M less than budgeted for FY 2020. This situation is significantly different than what was budgeted for FY 2020 and what was contemplated in our work and this initial report.

Given this situation, it was felt most prudent for the focus of our work for Phase 2 will include:

- Support for AHS finance team to develop a financially driven strategic plan to consider changes in staffing, review of services (and service locations) and other potential operational improvements to stabilize operations.
- Support AHS and the County to revise the Net Negative Balance model of cash flow funding to address this very recent, and significant cash flow gap at AHS.

Project Objectives

AHS consisted of the following at the date of the RFP. Since that time, the acute-care rehab hospital unit at Fairmont moved to San Leandro Hospital. The System has four federally qualified health centers (FQHCs) as part of its continuum of care including one at Highland Hospital ("Highland"). In addition, there are a number of primary care and specialty clinics throughout the campus.

Alameda Health System			
Facility		Beds	Services
Highland Hospital	HGH	236	Level 1 Trauma Teaching Hospital
San Leandro Hospital	SLH	93	Acute Care Community Hospital
Fairmont Hospital & Clinics	FH	159	Skilled Nursing Facility and Acute Care Rehab Hospital
Alameda Hospital	AH	251	70 Acute Care Beds, 35 Subacute Beds and 146 SNF Beds
John George Psychiatric Hospital	JGPH	80	Inpatient Psychiatric Hospital
Eastmont Wellness Center	EWC		FQHC
Hayward Wellness Center	HWC		FQHC
Newark Wellness Center	NWC		FQHC
Several primary care and specialty clinics	Various		Primary care and specialty care clinics
Total		819	

Executive Summary

Overview
Partnership & Collaboration – Qualitative View
Financial View – Quantitative View

Note: All forward looking financial information is subject to change as a result of the COVID-19 pandemic.

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Executive Summary

One Page of Key Talking Points

- AHS's current state cash flow, further challenged by the Covid-19 pandemic requires a modification to the current Permanent Agreement between AHS and Alameda County. The cash flow model developed by AHS though March 31, 2020 indicates a $20M cash shortfall with the required Net Negative Balance by June 2020, and a shortfall of $195M by June of 2021, assuming the County is not successful in waiving the required repayment of supplemental funds due back to the State as a result of the COVID-19 situation.
  - This full report summarizes the historical context of AHS both from a financial perspective as well as from a partnering perspective with the County. It is intended to provide a foundational understanding of AHS's current state such that a future state can be developed for AHS that all stakeholders are proud of.
  - This report also provides rationale for the requested change to the Permanent Agreement.
- The effectiveness of AHS's current governance model is in question to determine if the current model will be an effective future model to achieve AHS's Vision and Promise to the Community in a sustainable way.

Executive Summary - Overview

AHS Today

Alameda County remains the owner of AHS; however, a separate Hospital Authority structure was developed in 1998 to "improve the efficiency, effectiveness, and economy of the community health services provided at the medical center." AHS's financial statements are consolidated with County information, the Treasury function remains with the County for AHS's operations, and a running tally of net County funding since inception as a formal Hospital Authority has been tracked carefully.

From our interviews, we learned that the County has been a good steward of this community asset and cares deeply about the ongoing success of AHS as a world-class patient and family-centered system of care that promotes wellness, eliminates disparities, and optimizes the health of the County's diverse communities.

"Despite where we are, everyone is committed to make this work."

Source: Member of the Alameda County Board of Supervisors

Executive Summary - Overview

AHS Today

In this detailed report, we have identified a number of issues that should be addressed by AHS including:

- Inpatient cost of care which is higher than benchmark indicators by 8% or more (higher wage rates etc.) due in part to the value placed on organized labor in Alameda County
- Significant number of “administrative days” due in part to limitations on post acute care options which is inefficient, and not creating an optimal system of care experience for patients and patient satisfaction that is less than ideal
- Complexity of internal operations due in part to the number of organized labor unions at each facility operating somewhat in a siloed fashion

Executive Summary - Overview

AHS Today

In this detailed report, we have identified a number of issues that should be addressed by AHS including: (continued)

- Limitations on technology and other resources to understand total financial information by service line and by facility
- Lack of alignment with various stakeholders of Alameda County due in part to trust and communication issues and due in part to the complexity of AHS's funding stream – creating an adversarial "internally focused" working relationship

Until some of these structural issues are addressed, it will be difficult for AHS to optimize its value to members of the community in a synergistic way with other County based resources.

Partnership & Collaboration

Partnership and Collaboration

To understand the view of multiple stakeholders associated with AHS, we interviewed the following (as of the date of this report):

AHS Board of Trustees

Joe DeVries, now Board Member, formerly Board President
Louis Chicoine, Chair Finance Committee
Ross Peterson, now Board Vice President, formerly Chair Audit/Compliance

Alameda County Board of Supervisors

Wilma Chan, District 3 and Health Committee Chair
Richard Valle – Board Chair
Keith Carson, District 2

Alameda Health Care District

Michael Williams, President
Tracy Jensen, AHS Liaison & AHS Trustee

AHS Finance Team

Kim Miranda, CFO
Nancy Kaatz, former Interim CFO (through Toyon)
Ann Metzger, VP Finance
Shulin Lin, Director of Reimbursement
Rick Kibler, VP Compliance and Audit
Various other team members

Operations / Administrative

Delvecchio Finley, CEO
Luis Fonseca, COO
Tangerine Brigham, CAO Population Health

Alameda County

Melissa Wilk, Auditor/Controller
Colleen Chawla, County Health Care Services Agency Director
Rebecca Gebhart, Finance Director County Health Care Services Agency

Executive Summary - Partnership and Collaboration

Interview Themes

We found all interviewees to be truly vested in the long-term success of AHS as a safety net health system serving the County. There was also a great deal of consistency in the information provided by interview participants.

We organized interview themes into the following key areas of focus:

- Communication and trust
- Data (trust and understanding)
- AHS services (and efficiencies)
- "Competing interests"

In general, the communications reflected a strong desire to work *in partnership* to support the mission and vision of AHS on behalf of County members.

Partnership and Collaboration

"Despite where we are, everyone is committed to make this work."

Source: Member of the Alameda County Board of Supervisors

Partnership and Collaboration

County View (Board of Supervisors and County Leadership)

Communication	Data (Trust & Understand)	AHS Services	Competing Interests
Looking for a Collaborative Partnership - team building.	Feel responsible for the success of AHS yet do not trust the data - frustrating situation.	Sustainability of AHS as a safety net health care facility is VERY important for Alameda County.	County has many priorities to address beyond AHS that take time and resources.
Looking for better process to address proposed service changes - cannot announce significant issues before discernment process.	Do not understand data -too complex. Keep it simple.	No issues with the scope of services provided by AHS.	
Looking for timely communication of issues and potential concerns before they are in crisis - worried about surprises.	Frustration with changing information in budgets and financial analyses - how can decisions be made if the data is not accurate?	No perceived issues with AHS's quality of care and access to care (other than access to specialty services).	Concern with "heavy handed" communication with Organized Labor on behalf of AHS. We need to respect Organized Labor and its role in working collaboratively with Alameda County.
Willing to work collaboratively together in partnership with AHS to help solve key issues as they arise.		No formal strategic planning for health/social services between County and AHS to enhance/coordinate/plan for services.	
Looking for ways to inspire people to do their best work.	Flow of funds process (related to the line of credit) working well.	Population Health teams are beginning to work collaboratively on initiatives related to social determinants of health	Sense of gratitude and appreciation seen by other service providers not expressed by AHS.

Partnership and Collaboration

AHS View (Board of Trustees and AHS Leadership)

Communication	Data (Trust & Understand)	AHS Services	Competing Interests
Looking for more understanding and flexibility (relating to the Line of Credit limitations) related to the operational cash needs during the year.	Difficult to estimate supplemental income values to timing of regulatory information, timing of prior year audits etc. given significant amount of uncertainty.	Sustainability of AHS as a safety net health care facility is VERY important for Alameda County. before embarking on service line planning in a meaningful way.	County wants to support organized labor and create a margin on AHS operations to repay the Line of Credit which is unrealistic given AHS's balance sheet and reimbursement systems.
Looking for more understanding and flexibility (relating to the Line of Credit limitations) related to the operational cash needs during the year.	The FY 2020 budget was particularly difficult due to significant information that changed from June (draft budget) to August (final budget). Also, difficulty with multiple billing systems, and limited data analytics capabilities to create accurate analysis. This will improve with EPIC in FY 2020.	As an organization, needed to stabilize operations and get on EPIC before embarking on service line planning in a meaningful way.	County wantConcern about IGT funding process with County - is AHS getting non federal funding?

Partnership and Collaboration

Where Do We Go From Here?

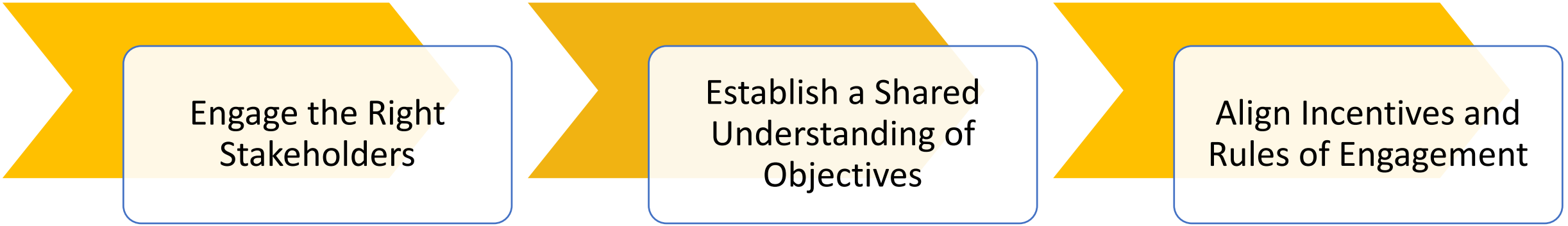
County Board Members and AHS Board of Trustees will need to come together to refresh why the separate entity was created to support the long term success of AHS as a safety net health system serving the County.

The following two pages describes a framework for effective healthcare governance and leadership. As we reviewed this framework, we determined that much more can be done to align objectives and incentives for the benefit of the County and its stakeholders in an effective manner.

The structure of AHS (as a separate entity) would be reasonable if the “us” and “they” concept of alignment was eliminated and the future focused on the framework of a “we” concept. Our recommendations that follow are an attempt to better understand and align incentives among stakeholders.

Partnership and Collaboration

Where is AHS in this Process of Effective Governance?



- Make a call to action and form the Leadership Team
- Identify high-level opportunities and assess organizational capabilities and readiness
- Adopt a consistent improvement methodology, align incentives, and keep polarities in balance

Partnership and Collaboration

Where is AHS in this Process of Effective Governance?

Practice Disciplined Prioritization

- Analyze opportunities and determine priorities
- Allocate resources
- Established prioritized teams
- Extend and sustain improvement

Partnership and Collaboration

Recommendations on Working Together

- Review together the concepts of Effective Governance and outline together shared objectives and available resources to achieve synergies as originally intended. Consider formal communication training and team building (Crucial Conversations, etc.).
- Launch a formal joint strategic planning process between AHS and the County's Health Services Department to develop a future state that optimizes healthcare and social supportive resources to care for vulnerable populations within the County. Acknowledge homelessness as a key driver to inefficiency at AHS and measure progress as plans are implemented.
- Ensure the voice of all key stakeholders is taken into consideration as key decisions are made regarding AHS (County residents, vulnerable populations, organized labor, County leadership concerns, etc.)
- Schedule more routine meetings between the County Board of Supervisors and the Health System Board of Trustees for learning and problem solving at the strategic level.

Partnership and Collaboration

Recommendations on Working Together (Continued)

- Gain alignment with AHS's goals to deliver high-quality, accessible safety net services consistent with the expectations of the residents in the County in an responsible manner. This analysis should be done in concert with the joint planning process as discussed earlier in this report.
- Develop formal process for evaluating new services or significant change/elimination of services to include a collaborative discernment process between AHS and the County. Seek external professional review of the AHS internal analyses to strengthen accuracy and completeness before bringing recommendations forward for discussion with County leadership. Work together on the solution in a partnership fashion.
- Work collaboratively on psychiatric services programming, operations, and billing (see financial recommendations).

Partnership and Collaboration

Recommendations - Organizational Structure (Continued)

Reorganizational Possibilities

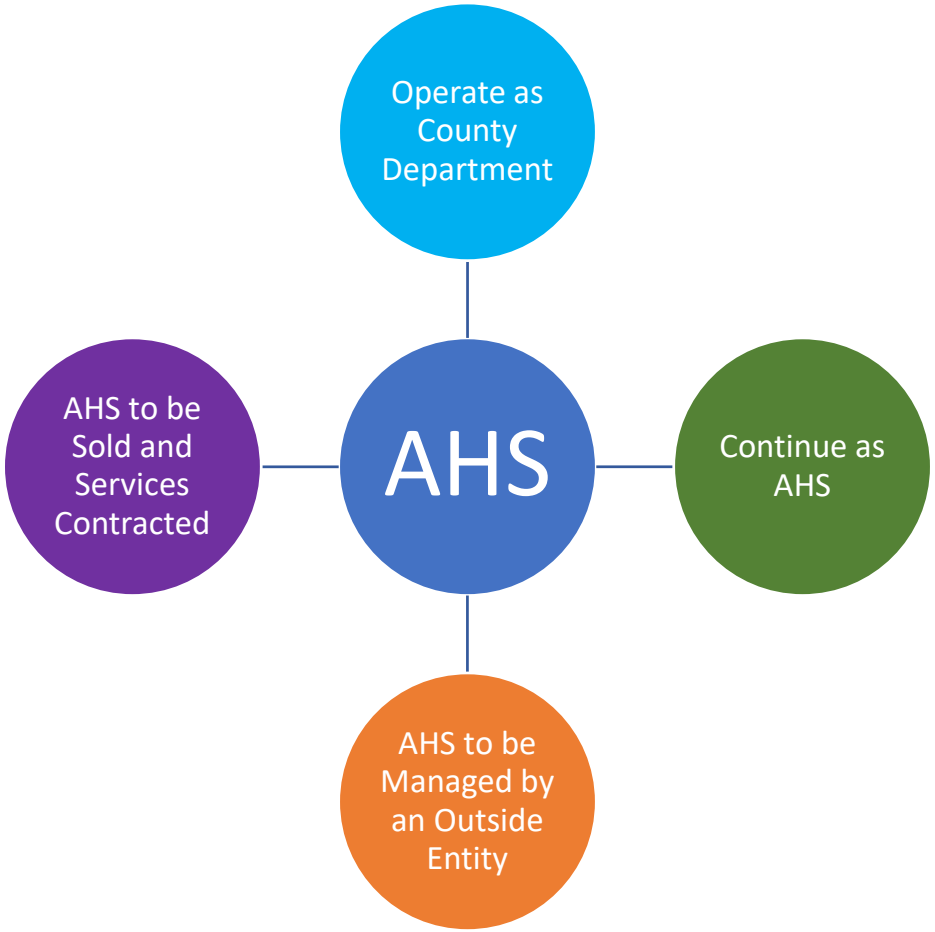
Since AHS is owned by the County, either the County will need to operate AHS as another "department" of the County (as in the past), or the current structure of assigning the oversight and operations of AHS to a separate entity however controlled by the County will need to be honored, supported and refined from a working together perspective.

It was not the opinion of stakeholders we talked with to move back to operating AHS as a department of the County as in the past. The complexities of running a large health system and the potential political issues of the County operating AHS directly lean toward wanting to improve the working relationship between AHS and the County, rather than eliminating the relationship.

An alternative to the above would be to contract with a professional management company or other health system to "operate" AHS on behalf of the County. The final option although likely not desirable to anyone or even possible would be to sell AHS and purchase necessary safety services for County members in need from area healthcare systems.

Partnership and Collaboration

Recommendations - Organizational Structure (Continued)



Each option can be further defined at a future point in time, if needed. However, the benefit of remaining a County-owned/operated entity is significant with respect to supplemental funding sources.

Financial View

Executive Summary – Financial View

Key Takeaway - AHS is financially integrated with the County, and this structural arrangement does not allow for financial flexibility to operate successfully as a standalone health system.

AHS Today

In summary, AHS's financial position as a standalone organization is poor. AHS as a "freestanding" organization has only 15 days cash on hand, no unrestricted investments, limited fixed assets, and negative equity on its financial statement. This is due, in part, to the AHS/County structural design and the fact that AHS is a component of the County. Specifically, the County retains the Treasury function for AHS, deposits receipts as generated by AHS, releases funds as needed to fund AHS's operational expenses, owns AHS's fixed assets, and is tracking the ongoing line of credit (NNB) provided to launch AHS when the Hospital Authority was developed.

As we discuss in this report, while improvement opportunities exist, the likelihood of making significant improvements at AHS in the *short term* without a systemwide evaluation of services and facilities is limited. Volumes are relatively stagnant, most payors are paying less than cost, and strong, organized labor limits the opportunity to make significant changes quickly.

Executive Summary –Financial View

AHS Today

In 2015, there was a strategic decision to create a robust system of care with a multi-hospital platform. The ability to function as a true system of care and optimize economies of scale with three hospitals has been somewhat hindered by the organizational structure in place, including varying labor agreements for each individual hospital. This situation has contributed to the operating results of the health system.

Over the past several years, a centralized support structure was added to AHS, along with a population health organization and a structure to support physician services. Some of this infrastructure resulted from a shift in personnel rather than incremental staffing increases. However, overall staffing increased in the areas of revenue cycle/revenue integrity, business functions, and, most significantly, technology (EPIC implementation, etc.) As we understand, the vision is to create a true integrated system of care—which is a challenge and a work in progress.

While infrastructure investments are needed to some extent to accomplish this goal, fee-for-service reimbursement from payors is not valuing (funding) these additional investments to a significant extent.

Executive Summary – Financial View

Working With the County

AHS started with an available NNB of $150M from the County. In 1999, the NNB was $33M. Since that time, the NNB has fluctuated up and down, and was $85M (net of restricted cash) at June 30, 2019. Later in this report, we will describe key factors that impacted the NNB over time. However, *since Measure A was implemented in 2005, the NNB decreased from $173M to $85M.*

Measure A in 2005

A Permanent Agreement is in place to manage this NNB, which calls for it to be reduced to $50M by June 30, 2034.

AH and SLH join in 2014

Alameda Health System

County Working Capital Loan Amortization

Fiscal Year Ending 6/30/xx	Principal (added)/paid during fiscal year	Working Capital Balance @ YE	Restricted Cash Balance	NNB
1999	(32,678,635)	(32,678,635)		(32,678,635)
2000	29,175,770	(3,502,865)	-	(3,502,865)
2001	(28,159,532)	(31,662,397)	35,551,000	3,888,603
2002	(64,195,489)	(95,857,886)	27,420,000	(68,437,886)
2003	(47,816,814)	(143,674,700)	18,870,000	(124,804,700)
2004	(48,663,776)	(192,338,476)	19,439,000	(172,899,476)
2005	17,712,764	(174,625,712)	19,886,000	(154,739,712)
2006	21,135,916	(153,489,796)	20,369,000	(133,120,796)
2007	(21,562,062)	(175,051,858)	21,458,000	(153,593,858)
2008	6,147,378	(168,904,480)	22,385,000	(146,519,480)
2009	3,904,480	(165,000,000)	29,811,000	(135,189,000)
2010	19,106,891	(145,893,109)	27,351,000	(118,542,109)
2011	1,510,484	(144,382,625)	24,399,000	(119,983,625)
2012	(6,621,984)	(151,004,609)	23,284,000	(127,720,609)
2013	5,963,091	(145,041,518)	23,250,000	(121,791,518)
2014	(48,119,845)	(193,161,363)	23,378,000	(169,783,363)
2015	32,497,603	(160,663,760)	23,445,627	(137,218,133)
2016	35,456,236	(125,207,524)	23,579,564	(101,627,960)
2017	(4,305,564)	(129,513,088)	23,683,000	(105,830,088)
2018	43,507,418	(86,005,669)	23,858,377	(62,147,292)
2019	(23,029,518)	(109,035,187)	24,468,000	(84,567,187)

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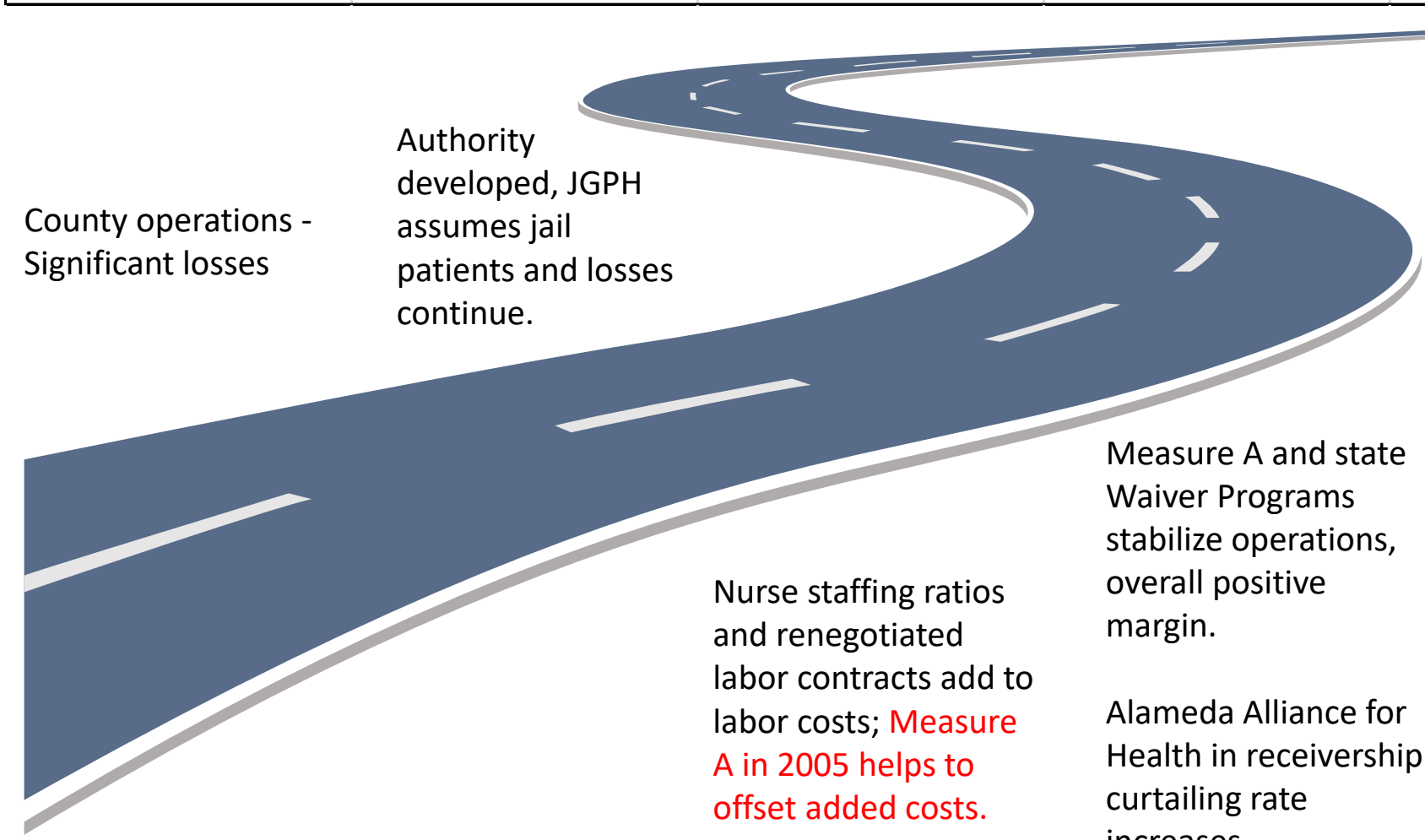
Executive Summary – Financial View

1994	1999	2004	2009	2014	2019



County operations - Significant losses

Authority developed, JGPH assumes jail patients and losses continue.

Nurse staffing ratios and renegotiated labor contracts add to labor costs; Measure A in 2005 helps to offset added costs.

Measure A and state Waiver Programs stabilize operations, overall positive margin.

Alameda Alliance for Health in receivership curtailing rate increases.

Strategic decision to move from a County Hospital model to a Health System model of care.

Pension reporting rules add costs to the system.

In 2014, ACA adds patient volumes to Medi-Cal roles. AHP established in 2016.

Operations stabilize through improvement efforts and finances improve with Measure A overperformance.

Planning for EPIC will require cash flow support.

Significant paybacks expected on supplemental funds.

Rehab unit move in progress.

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Executive Summary – Financial View

Historical Financial View in Five-Year Increments (fiscal year view)

AHS Financial Trend over Time **						
	1994-1998	**1999-2003**	**2004-2008**	**2009-2013**	**2014-2018**	**2019**
Ownership	**County operations**	**Authority developed**	**Authority**	**Authority**	**Authority**	**Authority**
Financial Trend (5 year increments)	5 Years	5 Years	5 Years	5 Years	5 Years	1 Year
Patient Revenues	783,526	1,281,476	1,250,524	1,291,735	2,306,216	555,266
Supplemental income (net)*	Not available	Not available	279,070	869,357	1,528,651	366,172
Measure A			**333,481**	**401,124**	**510,084**	**125,493**
Total Revenues	783,526	1,281,476	1,863,075	2,562,216	4,344,952	1,046,930
Expenses	1,003,015	1,372,398	1,879,356	2,468,727	4,355,668	1,014,731
Operating Margin	**(219,489)**	**(90,922)**	**(16,281)**	**93,489**	**(10,717)**	**32,199**
Non Operating *	172,656	(7,562)	(3,301)	4,362	(75,645)	(58,407)
Net Margin *	(46,833)	(98,484)	(19,582)	97,851	(86,362)	(26,208)
Average Operating Margin per Year	***(43,898)***	***(18,184)***	***(3,256)***	***18,698***	***(2,143)***	***32,199***
Key Events	Limited information available from this time period	Jail inpatient program closes	Nurse staffing ratios	Measure A stabilizes operations	Strategic decision made to create a multi-hospital health system	Operations stabilize
Key Events		State 1115 Waiver Program helps to fund uninsured	Labor contracts renegotiated		ACA begins 2014	Measure A high point
Key Events			Offset with Measure A		AHP in 2016	Planning for EPIC
Key Events					AB 85 changes AHS's available waiver funding due in part to Measure A	Payments from old waiver getting settled

* Excludes extraordinary items and accounting changes

** Financial information provided by AHS staff - may not agree with audit reports due to reclassifications etc.

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Executive Summary – Financial View

Moving Forward to 2020

The 2020 *cash flow* budget reflects a deficit of $145M due, in part, to the timing of Supplemental Payments as reflected below (which are a component of AHS's current liabilities on the balance sheet):

AHS Long-Range Financial Plan						
(Stated in thousands)	ACTUAL 2017	ACTUAL 2018	ACTUAL 2019	BUDGET 2020	FORECAST 2021	FORECAST 2022
Cash From Operations	**$ 52,407**	**$ 15,525**	**$ 48,293**	**$ 40,671**	**$ (53,667)**	**$ (64,887)**
Working Capital	(8,317)	(6,034)	(8,768)	(8,606)	12,159	(3,365)
Supplemental Payments Timing	-	97,483	(71,319)	(117,544)	(44,241)	-
Cash Flow	**44,090**	**106,974**	**(31,794)**	**(85,479)**	**(85,748)**	**(68,252)**
Capital Expenditures	**(29,836)**	**(22,367)**	**(65,792)**	**(62,118)**	**(27,752)**	**(11,000)**
Other	-	-	-	2,278	-	-
Total Cash Needs	**(41,496)**	**(26,564)**	**(72,820)**	**(59,841)**	**(37,745)**	**(14,102)**
Cash Surplus/(Deficit)	**$ 2,594**	**$ 80,409**	**$ (104,614)**	**$ (145,320)**	**$ (123,493)**	**$ (82,354)**

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Executive Summary – Financial View

Moving Forward to 2020 (Continued)

Commentary on the 2020 cash flow budget:

- Positive cash flow from operations of $40.6M (expected total revenues more than expenses).
- Cash require for investment in capital assets of $62M (EPIC and other).
- Cash requirement expected for repayment of supplemental funding settlements from prior years expected repayment of $117M in 2020 or 2021 (part of AHS's liabilities at June 30, 2019).

Alameda Health System - Cash & Due To/From Third Parties						
	2014	2015	2016	2017	2018	2019
Cash and cash equivalents	30,504	13,772	11,306	8,797	18,589	15,903
Due from third party payers	108,521	46,735	134,206	203,096	135,243	173,885
Amounts payable to third-parties	74,247	78,802	127,643	146,535	180,595	200,880
Net	34,274	(32,067)	6,563	56,561	(45,352)	(26,995)

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Executive Summary – Financial View

Moving Forward to 2020 (Continued)

Details of the $200M liability due to supplemental payors as of June 30, 2019 is reflected below:

Amounts Payable to Third Parties	
As of June 30, 2019	
	(in Millions)
Old Medi-Cal Waiver	(70.73)
Medi-Cal	(40.67)
FQHC Medi-Cal	(48.00)
Other program liabilities	(41.47)
Total	(200.88)

Executive Summary – Financial View

Moving Forward to 2020 (Continued)

***Key Takeaway* - The FY 2020 budget and FY 2021 cash flow projections indicate a need for cash over and above what is generated from operations. Cash is needed to repay accrued supplemental settlements from prior years which are included in AHS's liability accounts, invest in capital projects, and address the slowdown in patient receipts expected with the transition to EPIC in FY 2020.**

- The ultimate timing of repayment of accrued supplemental settlements (both payables and receivables) from prior years remains uncertain; however, AHS must plan based on available information.
- Since the FY 2020 budget was approved (September 2019), additional information was made available that indicates some settlement obligations may shift into FY 2021 or later years.
- Supplemental funding is increasingly dependent upon quality and other metrics that are not calculated in real time—leaving the timing of ultimate payments subject to retrospective review and settlement.

Executive Summary – Financial View

Moving Forward to 2020 (Continued)

Recommendation: Review/Revise the Permanent Agreement to increase the Net Negative Balance by $200M effective immediately, and remain at that level until an integrated planning process between AHS and the County transpires to confirm the future state of AHS's services and programs.

Specific details for revising the Permanent Agreement will be provided to County leadership in a separate document.

Addendum:

The FY 2020 budget information was based on best available information at the time the budget was developed, with information subject to change should new information be forthcoming. Subsequent to the completion of our analysis, it was determined that certain amounts owned to supplemental funding sources shifted to fiscal 2021 from fiscal 2020 which impacted the cash flow analysis. However, the recommendation stands, as it is imperative to add flexibility to the Permanent Agreement for future cash flow fluctuations as described in this report.

Executive Summary – Financial View

Moving Forward to 2020 (Continued)

Recommendation - Review/Revise the Permanent Agreement - Rationale

While operational performance is to be the clear focus, the Treasury function with the County and related NNB arrangement needs to consider AHS's unique situation as it currently exists:

- Unusually low days cash on hand (15 days at June 30, 2019) with all cash swept to County accounts.
- No unrestricted investments available to fund working capital needs.
- Limited cash available for fixed asset replacement because of limited depreciation expense as part of operations (a noncash item), which is typically used by hospitals to fund future capital purchases.
- Increasing liabilities related to supplemental payments potentially owed to supplemental funders ($200M at June 30, 2019), with uncertainly regarding the ultimate amount and timing of these payments. While receivables are also due from payors, the ultimate amount and timing of these receipts is uncertain.

Executive Summary – Financial View

Moving Forward to 2020 (Continued)

Recommendation - Review/Revise the Permanent Agreement - Rationale

In summary, given the unique nature of revenue sources with almost 50% of revenue derived from supplemental sources, which are uncertain as to amounts and timing, the limited assets on AHS's balance sheet is due to the reporting relationship with the County and the Treasury that sweeps cash on a daily basis, **we recommend revising the Permanent Agreement to add flexibility regarding AHS's cash needs to address working capital timing, ongoing capital requirements, and other initiatives. In addition, consideration should be given to reclassifying the initial $150M balance to a permanent contribution or long-term liability with more flexible repayment terms.**

However, revising the Permanent Agreement is not the end point. Significant risks and opportunities related to AHS's future finances can only be addressed with County collaboration. Healthcare is complex and changing rapidly. For AHS to compete as a health system, as envisioned, investments will need to be made to further integrate systems of care. Difficult decisions need to be made regarding future scope/location of services.

AHS Today

Key Drivers Impacting Current State
Summary of High-Level Recommendations

Executive Summary - AHS Challenges

Volumes

- Patient volumes stagnant - Difficult to compete with Kaiser and others in current state
- Capacity issues at Highland and JGPH (due, in part, to justice patients)
- Payor mix primarily Medi-Cal Managed Care with reimbursement less than cost

Revenue

- Collection percent is declining - Revenue cycle opportunities
- Fluctuation in supplemental revenue from current and prior year create multiyear revenue swings. Need better process for managing NNB process

Expenses

- Labor expense and high cost of care compared to benchmarks organized labor and inefficiencies identified due to care transitions ("avoidable days")
- Operational infrastructure challenged due to multitude of labor unions and ability to function as a system

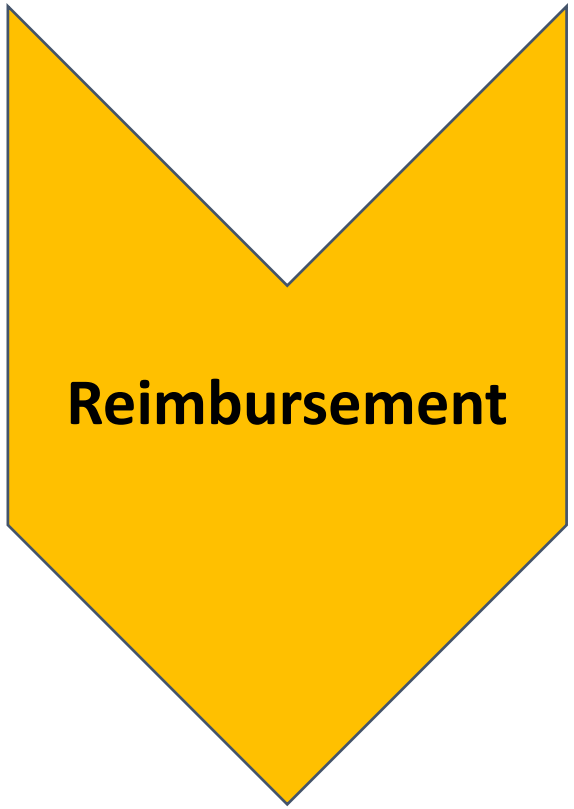
Key challenges for AHS as outlined above are **interrelated** to County decisions—all for the benefit of County residents in need but with a financial impact to AHS as a standalone entity. **AHS is not functioning as a true "System" of care today.**

Executive Summary - Key Drivers Impacting Current State

Volumes

- Stagnant due, in part, to capacity issues in post-acute care at JGPH and Highland.
- Quality/service issues (Medicare Star rating of 2).
- Strong competition from Kaiser and Sutter.
- Physician staffing challenges.
- Social determinants of health creating patient volumes for AHS (ED, JGPH, etc.) that could possibly be better served in other non acute settings.

Executive Summary - Key Drivers Impacting Current State



- Payor mix primarily Medi-Cal Managed Care with reimbursement significantly less than cost, reliant on supplemental revenues to cover costs.
- HPAC and full-risk contract
- Limited commercial paying patients with low rates
- Declining fee-for-service collection percentage
- FY2020 collections disrupted by EPIC transition and turnover in revenue cycle leadership
- Lacking analytical tools and systems to identify opportunities related to revenue cycle improvement such as coding, documentation, claim denials—possibly future EPIC features to implement

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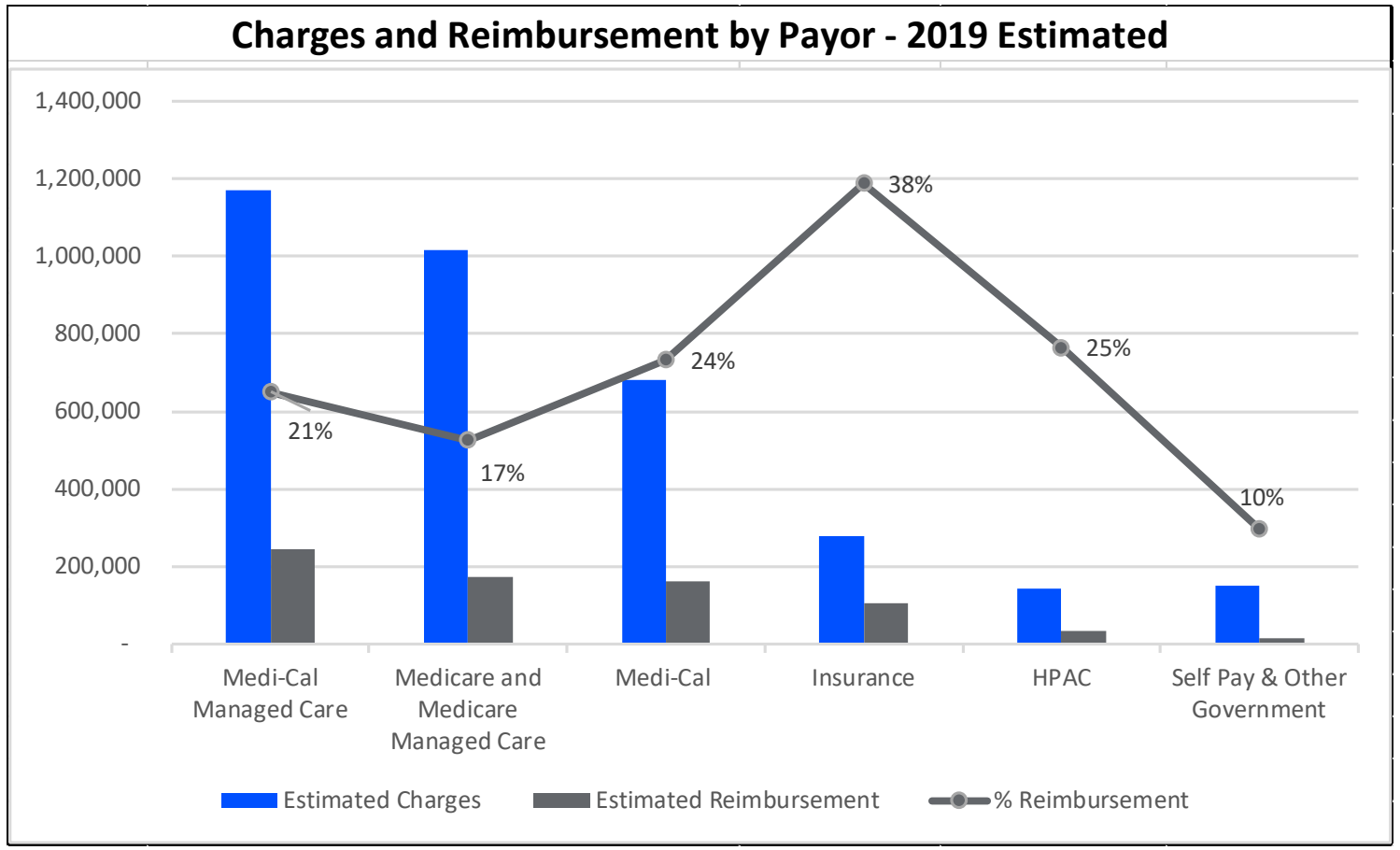
Executive Summary - Key Drivers Impacting Current State

Supplemental Payments

- Represents almost 50% of organizational revenue
- Significant fluctuations in supplemental payments due, in part, to prior-year settlements, which are difficult to estimate (timing and amount)
- Measure A funding and waiver funding have helped support the growing cost for health/social services for the County's diverse populations and is now depended on to balance the budget—risk of decline

Executive Summary - Key Drivers Impacting Current State

Reimbursement



The majority of charges are related to Medi-Cal Managed Care patients, which is paid at approximately 21% of charges.

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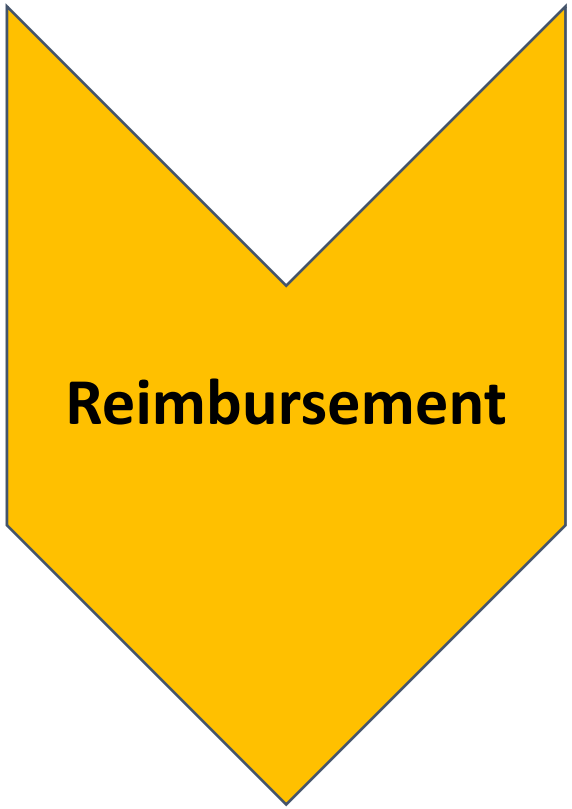
Executive Summary - Key Drivers Impacting Current State



The FY 2019 detail of charges and reimbursement by payor is reflected below:

Calculation of Reimbursement % by Payor 2019 - Based on Payment Postings by Payor				
Patient Service Revenue	**% of Gross Charges**	**Overall % of Charges**	**Reimbursement**	**Calculated Reimbursement %**
Medi-Cal Managed Care	34%	1,171,323	245,059	21%
Medicare and Medicare Managed Care	30%	1,014,550	171,294	17%
Medi-Cal	20%	680,034	160,114	24%
Insurance	8%	277,789	106,133	38%
HPAC	4%	142,677	35,068	25%
Self Pay	3%	114,829	4,135	4%
Other Government	1%	36,099	10,249	28%
Total direct patient service reimbursement	100%	**3,437,988**	**732,051**	**21%**
Other Reimbursement:				
Supplemental Waiver			113,892	
Supplemental Realignment			28,730	
Supplemental Other			11,094	
Measure A			125,493	
Revenue not related to direct patient services (grant and other)			35,670	
Total Operating Revenue Per Audit Report			**1,046,930**	

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Executive Summary - Key Drivers Impacting Current State

Labor and Benefits

- Represents almost 70% of organizational cost
- High wage rates compared to benchmarks, cost per day/discharge higher than benchmark facilities
- Multiple labor unions at each hospital create challenges to optimize staffing levels and functions
- Multiple organized labor contracts for each facility create significant duplication of internal functions (HR, payroll systems, negotiations)
- Labor expenses are high due to patient complexity and expanding patient needs outside the hospital setting to address social determinants of health
- Need to consider pension and other post-retirement benefit costs required to be funded by AHS

Executive Summary - Key Drivers Impacting Current State

- Outdated/underdeveloped technology systems (financial systems, data analytics, service line reporting, facility-based reporting)—need for efficient integration
- Lack of "system-ness" for a three-hospital organization means duplicative processes for each facility (payroll, reimbursement, financial, etc.)
- Data governance not aligning all reporting within AHS to be created from a single source of truth creating data concerns, variation in data reported, etc.)
- EPIC transition requires significant training, testing, and other investments—likely ongoing investment to optimize its value
- Quest for integrated delivery model requires investment in population health and other infrastructure without direct reimbursement benefit

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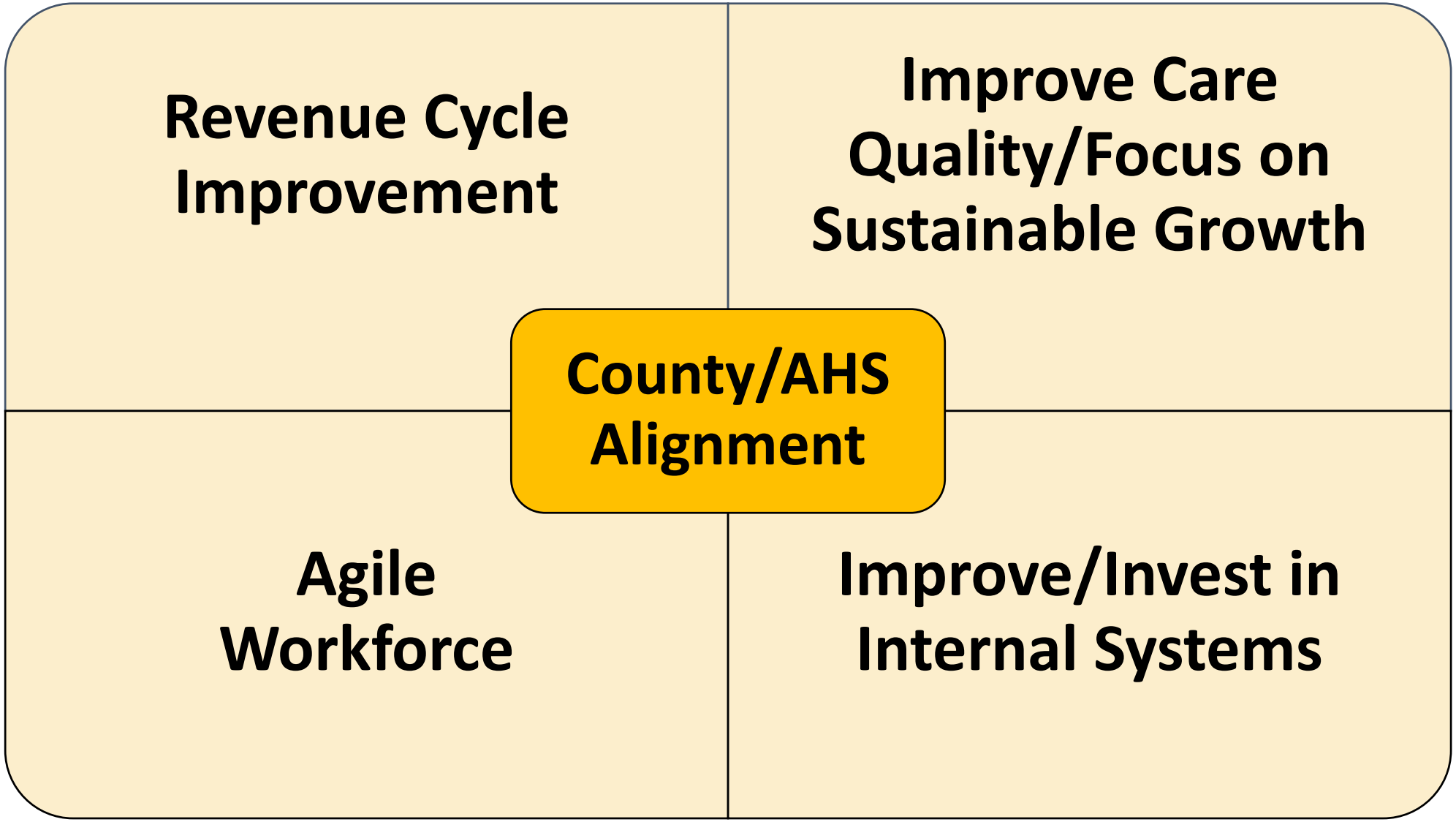
Executive Summary - Key Recommendations



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Executive Summary - Key Summary Recommendations

County/AHS Alignment

Business Case for Updating the Permanent Agreement (as stated previously)

- The Permanent Agreement is too restrictive based on multiyear swings in supplemental revenue funding, which now accounts for nearly 50% of AHS's revenue stream. Recommendation to increase the Net Negative Balance.
- Communication and trust between County and AHS leaders needs to be enhanced for mutual support given the significant challenges to provide the appropriate services within the community given the increasing complex community needs and social health determinants.

Recommendation

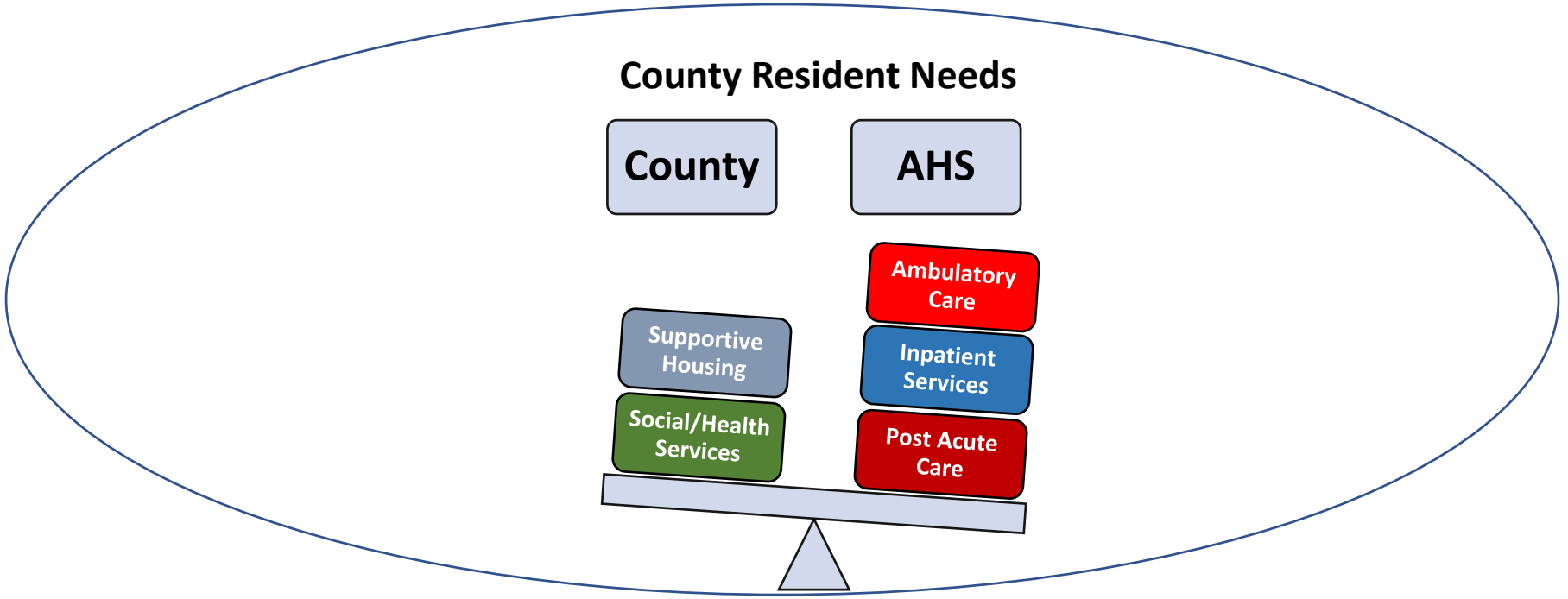
Jointly discuss and modify the Loan Agreement between AHS and the County to add flexibility to account for liabilities due to supplemental programs and the need for capital. Consider "setting aside funds" for repayment of supplemental program liabilities, if possible.

Executive Summary - Key Recommendations

County/AHS Alignment (Continued)

Business Case for Joint Planning

It is clear that a number of County residents have growing needs for integrated health and social care, creating a stronger interdependency between County and AHS services to most effectively and efficiently address these needs.



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Executive Summary - Key Recommendations

County/AHS Alignment (Continued)

Business Case for Joint Planning (Continued)

- Over 8,000 administrative days in FY 2019.
- Capacity issues as a result primarily in Highland's ED and JGPH and in "observation status" waiting for patient transitions of care from the acute setting.

Recommendations for Joint Planning

- We recommend an integrated planning process to best rationalize/optimize County/AHS resources to best address the County's needs as a growing and diverse community. The County's patients/clients have needs that are addressed by the County and AHS, and the interdependency between social and medical needs is expanding.

Executive Summary - Key Recommendations

County/AHS Alignment (Continued)

Recommendations for Joint Planning (Continued)

- More specifically, we recommend a joint planning process for County and AHS leadership to work together, focusing on high-opportunity areas to stabilize AHS. Planning should be done in the context of a true trusting partnership for the growing needs of County residents to include labor/pension costs and contracts.

- The joint planning process should focus on the following key points on patient flow:
  - JGPH (psychiatric patients in the ED and in the inpatient setting) as well as the billing process.
  - For patients arriving at Highland's ED without a real need for emergency care (many of whom are homeless).
  - For patients (acute and long term) who are able to be discharged from AHS facilities.
  - Highland observation unit/parking.

Executive Summary - Key Recommendations

County/AHS Alignment (Continued)

Recommendations for Joint Planning (Continued)

- The analysis will also need to assess services by facility to eliminate unnecessary duplication of services based on changing healthcare market conditions and service delivery models.
- Continued focus is needed on joint County/AHS planning for care transitions (supportive housing, home care, etc.). The cost savings of avoidable days at AHS could approximate up to $16M annually based on high-level assumptions if the administrative days were eliminated. The expected impact of this analysis would be to eliminate waste at AHS (8,000+ "avoidable days" and excess volumes), potentially shift investments made by the County to other impactful services for safety-net patients, and improve operations and patient satisfaction (quality) indicators for AHS. While this will help, it may not close the existing gap between AHS's expenses and reimbursement.

Executive Summary - Key Recommendations

County/AHS Alignment (Continued)

Recommendations for Joint Planning (Continued)

- We were pleased to learn that a number of County initiatives are in progress to address the social determinants of health and community needs that will positively impact the administrative (and possibly denied) days experienced by AHS. The potential impact of these initiatives is not known at this time.

- **The County owns AHS; therefore, the shared vision needs to align with actionable support of each other. If AHS fails, the County fails. If AHS is strengthened and has the support to evolve based on market dynamics, the County also succeeds.**

Executive Summary - Key Recommendations

Revenue Cycle Improvement

Business Case

- AHS's collection percentage has been declining over time and receivable aging is higher than benchmarks.
- Claim denials need to be reduced (at JGPH for example).
- Insurance contracts should pay AHS competitive market rates for all services.

Recommendations for Revenue Cycle Improvement

- Strong revenue cycle leadership will be needed to optimize EPIC for documentation, coding, billing, and collections and for data to analyze trends and identify opportunities for improvement. An overall improvement of 1% in patient collections would impact revenue by about $6.3M per year.

Executive Summary - Key Recommendations

Revenue Cycle Improvement (Continued)

Recommendations for Revenue Cycle Improvement (Continued)

- Secure more favorable insurance contracts (in process). Commercial business is less than 10% of total patient charges. If reimbursement increased by 10%, annual reimbursement could increase by $4.5M (net of the 1% improvement as previously discussed).
- As AHS's contracts are increasingly becoming "value based" and managing patients with chronic conditions and gaps in care will need to be the focus to optimize care quality and reimbursement incentives.

Executive Summary - Key Recommendations

Improve Quality of Care and Focus on Sustainable Growth

Business Case:

AHS as a Medicare 2 Star Health System (2 out of 5 star) is competing with Kaiser and Sutter for patients, including certain MediCal patients. As patients increasingly have choices on what facilities and providers they go to for care, it will be increasingly important for AHS to focus on improvement.

Recommendations for Improvement of Quality of Care and Focus on Sustainable Growth

- AHS should continue to focus on quality improvement. Its accountability should include incentives for improvement in quality/patient satisfaction indicators for all employees since healthcare is a team sport. Complacency should not be tolerated since a further shift in Medi-Cal volumes (most favorably funded) is likely to competitors that focus on patient satisfaction with each and every touchpoint.

Executive Summary - Key Recommendations

Improve Quality of Care and Focus on Sustainable Growth (Continued)

Recommendations for Improvement of Quality of Care and Focus on Sustainable Growth (Continued)

- Clinical integration and process improvement efforts should continue in order to remain a competitive health care system. Highlight the value of medical education within the system and use as a differentiator in the market.

- Take steps to grow market share for services that provide AHS a positive margin to ensure funding is available to support needed services in the community (such as behavioral health).

Executive Summary - Key Recommendations

Agile Workforce

Business Case:

- The complexity of the labor structure as it relates to operations should be highlighted as AHS is working with multiple unions at each of its facilities. The goal is to operate as an integrated system of care with the ability to optimize staffing efficiencies at all facilities.
- Benchmarks indicate that AHS's costs and wage rates are higher than benchmark facilities.

Recommendations for Agile Workforce

- Continue to review staffing models and wage rates for reasonableness. AHS is working to manage labor expenses within the constraints of organized labor and system integration that is not yet complete.

Executive Summary - Key Recommendations

Improve/Invest in Internal Systems

Business Case:

- AHS has developed a significant overhead structure due, in part, to the duplicate systems and processes related to the number of unions operating at each hospital.
- AHS key stakeholders are increasingly frustrated with the financial data provided by AHS, noting that it is changing, confusing, and hard to understand. In addition, there is some uncertainty regarding the method of allocating overhead expenses and supplemental payments between services and facilities.
- Revenue data by facility (patient and supplemental) direct and allocated by service line is lacking due, in part, to insufficient technologies to report and allocate revenue and expenses in an automated manner.

Executive Summary - Key Recommendations

Improve/Invest in Internal Systems (Continued)

Recommendations to Improve/Invest in Internal Systems

- Develop strong data governance policies to include finance, reimbursement, clinical and business intelligence teams from one single source of data to enhance consistency of reporting with a data "certification" process in place to ensure accuracy and completeness of data as reported.
- Document and adopt standard allocation methodologies for reporting supplemental income by program and reporting overhead expenses by division or service to enhance the consistency of information.
- Enhance reporting capabilities by facility and by service line for strategic decision making.

Executive Summary - Key Recommendations

Improve/Invest in Internal Systems (Continued)

Recommendations to Improve/Invest in Internal Systems (Continued)

- Invest in integrated systems and financial tools to streamline overhead functions - The lack of "system-ness" inherently creates the need for additional labor to address AHS's reporting and operational needs. As a high-level estimate, assuming 10% of non direct staffing and benefits is focused on the issues as identified ($88M), a non-value-added cost factor of $8.8M would be calculated. Efforts to address these key barriers should be a priority for AHS and the County. However, technology investments will be required to realize these efficiencies.

Executive Summary

Moving Forward to 2020

As previously stated, the fiscal 2020 *cash flow budget* reflects a deficit of $145M due, in part, to the timing of Supplemental Payments. It remains uncertain as to the specific amounts and timing of these repayments, which makes the management of cash flow a challenge for AHS.

AHS Long-Range Financial Plan						
(Stated in thousands)	ACTUAL 2017	ACTUAL 2018	ACTUAL 2019	BUDGET 2020	FORECAST 2021	FORECAST 2022
Cash From Operations	**$ 52,407**	**$ 15,525**	**$ 48,293**	**$ 40,671**	**$ (53,667)**	**$ (64,887)**
Working Capital	(8,317)	(6,034)	(8,768)	(8,606)	12,159	(3,365)
Supplemental Payments Timing	-	97,483	(71,319)	(117,544)	(44,241)	-
Cash Flow	**44,090**	**106,974**	**(31,794)**	**(85,479)**	**(85,748)**	**(68,252)**
Capital Expenditures	**(29,836)**	**(22,367)**	**(65,792)**	**(62,118)**	**(27,752)**	**(11,000)**
Other	-	-	-	2,278	-	-
Total Cash Needs	**(41,496)**	**(26,564)**	**(72,820)**	**(59,841)**	**(37,745)**	**(14,102)**
Cash Surplus/(Deficit)	**$ 2,594**	**$ 80,409**	**$ (104,614)**	**$ (145,320)**	**$ (123,493)**	**$ (82,354)**

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Executive Summary - "What-If" Analysis

Hypothetical Analysis

The $145M cash shortfall on AHS's 2020 approved budget is significant. Can high-level "what if" initiatives as outlined on this table possibly close this gap? Based on the hypothetical and very high-level assumptions regarding impact items that likely would not be realized in one year, AHS's cash shortfall gap would not be closed. *For internal discussion only*.

For discussion purposes, this exercise demonstrates that AHS and the County need to work together on a short-term strategy for cash flow until a longer-term, joint strategic plan can be developed.

"What if" Concepts to Close the Budget Gap - Hypothetical for Discussion Only

	(in 000)	
Cash "shortfall" on the 2020 approved budget	(145,320)	
Revenue opportunities		
Could avoidable days be reduced? (including JG)	16,000	stretch goal, not short term
Could commercial reimbursement be increased by 10% with contracting strategies?	4,500	stretch goal, not short term
Could overall collections on patient revenues increase by 1% due to coding/billing and documentation improvements	6,300	stretch goal, not short term
Expense opportunities		
Could 10% of non direct wages & benefits be eliminated with streamlining and integration of systems?	8,840	stretch goal, not short term
Wage rates and labor hours over benchmarks - what if direct labor & benefits could be decreased by 5%?	31,400	stretch goal, not short term
Total high level impact items	67,040	
Cash "shortfall" on the 2020 approved budget with impact items considered	(78,280)	

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Executive Summary

In Closing

We look forward to working with AHS and the County on the opportunities discussed in this report to sustain AHS as a safety-net healthcare system for the County in Phase Two of this effort.

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