Five Year Forecast for the Public Health Department
Special Revenue Fund

This five year financial forecast focuses on changes in Revenues and Expenditure levels for those programs that are currently housed as part of the Public Health Department's healthcare special revenue fund as listed below. The Human Services Commission, California Healthcare for Indigents Program (CHIP), and Tobacco Settlement (TSAC) programs are not part of this Special Revenue fund.

Executive Summary

An analysis of expenditures and revenues over the past decade demonstrates that the Public Health Department has been successful in maintaining services with minimal reliance on local funding sources. The five-year funding forecast for the Department indicates that it will be necessary to restructure, reduce, and relocate services to address the revenue-expenditure tipping point. The Department's strategic initiatives are focused on a number of strategies to bring expenditures into alignment with revenues. Even with success of these initiatives over the next five years, it is clear that the Department will face a need for increased local funding in order to maintain needed medical care and health programs for County residents.

The Department has had to rely on its special revenue fund for operational expenses for the past 3 years. At the current rate of expenditures, the Special Revenue Fund is projected to be depleted by Fiscal Year 2008-09. The depletion of the PHD Special Revenue Fund has significant implications to the County and the maintenance of the health care safety net.

Background and Introduction

The Santa Barbara Public Health Department (PHD) is responsible for the following mandated programs contained within the Health and Safety Code and Welfare and Institutions Code:

- Indigent Health Care
- Communicable Disease Prevention, Detection and Surveillance
- Environmental Health and Protection
- Children's Medical Services
- Health Education

The Department provides these program services and many non-mandated, discretionary services through the management of approximately 192 separate programs.

Most importantly, the Department enjoys the status as a Federally Qualified Health Center (FQHC) by virtue of the acceptance of a grant to provide services to homeless individuals. This provides for higher reimbursement from the governmental insurers of Medicaid (Medi-Cal) and Medicare because of our status as a 'safety net' provider and our obligation to 'see all who present' in our clinics.

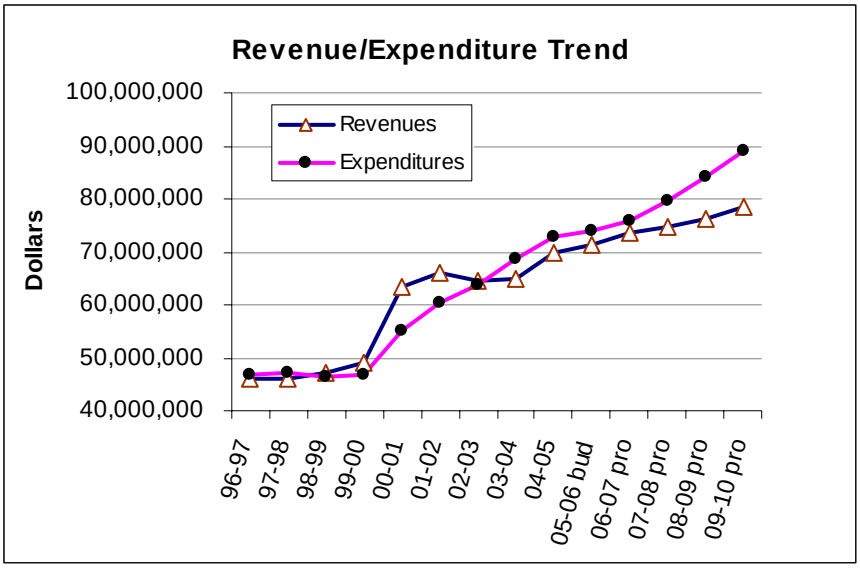
Revenue-Expenditure Tipping Point

From 1996 until FQHC revenues were "capped" by Medicaid in the year 2000, FQHC status had allowed for growth in the department, because cost increases attributable to services provided to the Medicaid population in the County's clinics could be recouped from Federal and State sources. In addition, because Realignment revenues from Sales Taxes and Motor Vehicle In-lieu fees were also very strong during this period, the PHD was able to establish a designated reserve fund balance. This was possible because many of the fixed costs covered by the Realignment revenues were also covered by these new FQHC revenues. (This is allowed, as long as the reserves built by the excess FQHC program revenues are used for FQHC purposes.) The Department was then able to use its general fund resources to cover cost increases and subsidize capped grant and allocation and fee-driven programs, without any increase in its general fund allocation (a "swap" of FQHC revenues in medical services to make general fund dollars available to other department programs, such as Animal Services and our many discretionary grant programs)

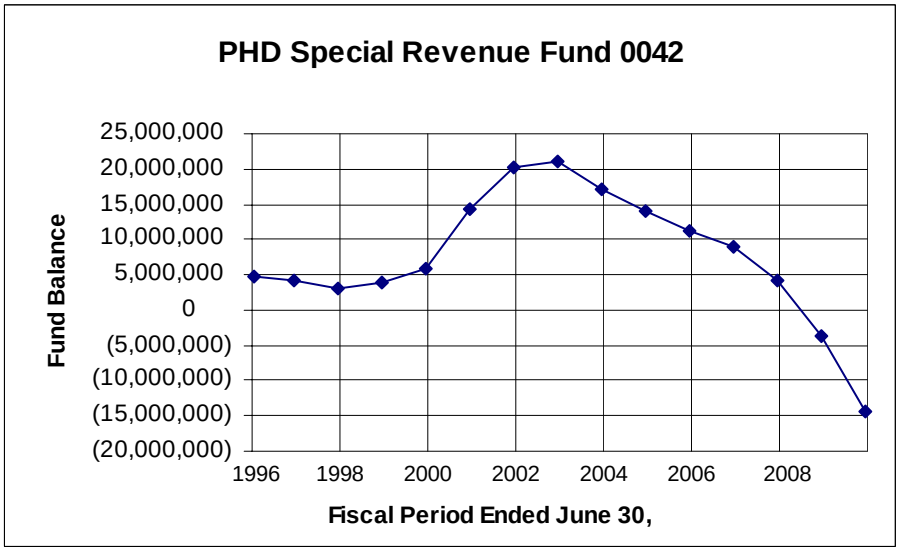
After FQHC revenues were capped, they could only grow by a small cost of living allowance, called the Medicare Economic Index (MEI) which has averaged around 2.5%. Departmental fixed and variable medical and personnel cost increases have averaged approximately 6.4% during that same time period.

Because of retroactive payments, the effect of this capping was not felt until Fiscal Year 2002-03, when the trend mentioned above (where fixed and variable costs were covered by FQHC revenues) was reversed. Since then,

the PHD has had to use its reserves to fund existing medical operations. The fact that Realignment funds have had limited growth and other funding has been inadequate to cover increasing costs has resulted in a revenue-expenditure tipping point. For Fiscal Years 2002-03 through 2005-06, the PHD projects to use approximately $3.5 Million from its designated reserves for medical operations. At existing levels of service, this trend is expected to continue and worsen over the next five years:



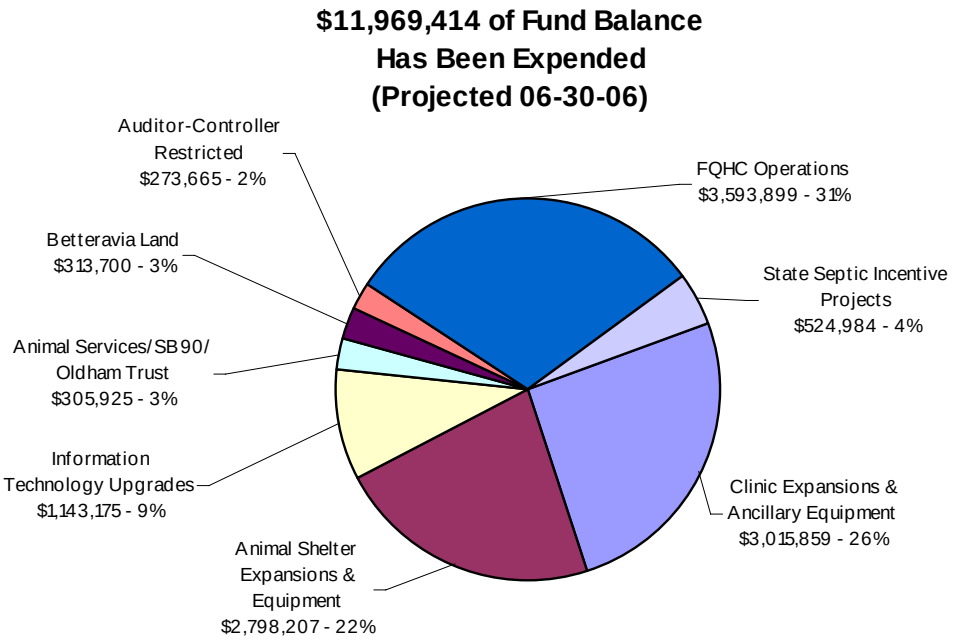
The following chart illustrates the year-end balances and a five-year projection of the PHD Special Revenue Fund:

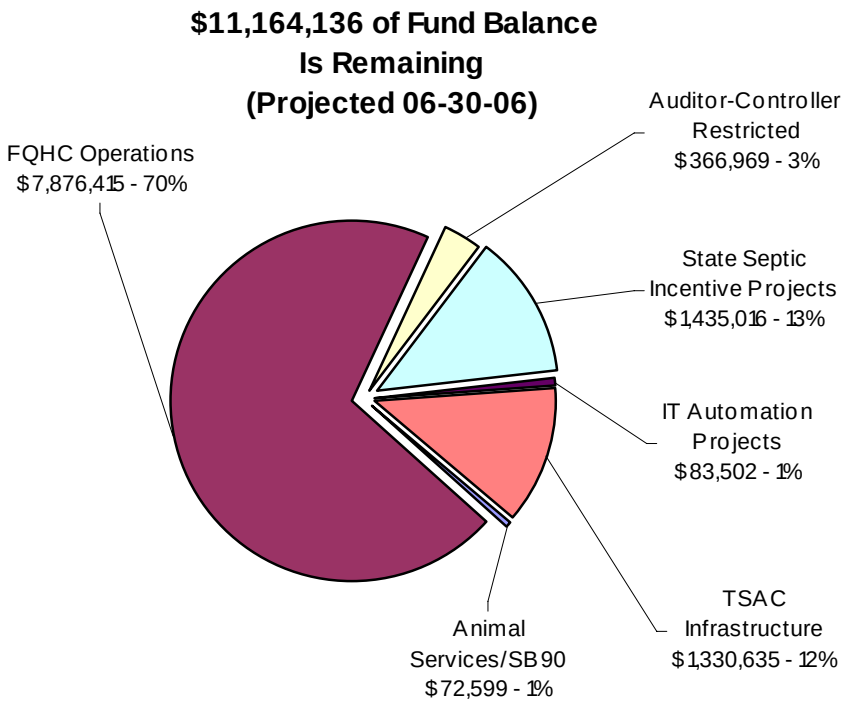


These trends are also expressed in the following table:

Revenue/Expenditure Trend and Change in Fund Balance					
	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10
Projected Revenues	71,220,158	73,580,978	74,782,544	76,213,716	78,375,489
Projected Expenditures	73,998,812	75,754,713	79,576,514	84,211,626	89,080,857
Projected Change in Fund Balance	(2,778,654)	(2,173,735)	(4,793,970)	(7,997,910)	(10,705,368)
Projected Fund Balance	11,164,136	8,990,401	4,196,431	(3,801,479)	(14,506,847)

Therefore, since 7/1/96 when the fund began with approximately $5 million, the balance grew to approximately $21 million in 2003. The fund balance is projected to be approximately $11.2 million at 6/30/06. The majority of the fund balance has been used for capital improvements and expansions, but for Fiscal Year 2003-04 and subsequent years, an increasing amount is projected to be used to fund existing medical operations. The following pie charts illustrate both how the fund has been used since its inception and what designated balances are to remain, as of 6/30/06:





Thus, at 6/30/06, approximately $7.9 million is projected to be available to subsidize and sustain medical FQHC operations. Approximately, $1.9 million is externally restricted and cannot be spent on medical services. This includes State funds for Septic projects ($1,435,000); funds on deposit to comply with Government Accounting Standards Board (GASB) policies ($367,000); and funds from partner agencies for information technology projects ($24,000).

At the current rate of projected expenditure and revenue growth, the reserves could be exhausted by Fiscal Year 2008-09. This does not take into consideration any additional use for necessary capital investment in new technologies (such as an Electronic Medical Record or Digital Radiology System), or for the contingency type expenditures such as equipment or facilities repairs and maintenance, or for unfunded salaries, cost of living, inequity, or benefits rates increases.

The *Major Strategic Initiatives* section of this discussion summarizes the actions already taken and planned by the PHD in response to this structural deficit.

Five-Year 2005-06 through 2009-10 Revenue Projections

Revenues were projected based upon historical trends, existing grant contracts and allocations, and estimated volume increases in fee-driven programs. Very few of the grants and allocations in the PHD have any elasticity to cost increases, so for the majority of the non-mandated grant and allocation programs no increase is projected. A planned increase in Animal Services consumer fees is incorporated, but no other increases to fee-driven programs are included.

In addition, there are several unknown factors that could affect the department's Medi-Cal revenue that are not included because the effects can not be easily determined at this time. These are: 1) Any reductions in funding from Federal Medicaid and/or State Medi-Cal reform; 2) Any reductions in revenues (or costs) because of the recent November ballot initiatives; 3) Any increased revenues due to contracts still under negotiation with the Santa Barbara Regional Health Authority; and, 4) Any reduction due to the Medicare Part D Prescription Drug Act.

Major Revenue Projection Assumptions

Medicare and Medi-Cal FQHC

The seven county clinics provide services to a patient population that is approximately 65% Medi-Cal and Medicare, 7% other public programs and Medically Indigent Adults, and 28% uninsured. Any growth in FQHC Medi-Cal and Medicare program revenues can only be attributable to this 65% of the costs of the clinic services, provided our 'market share' of these patients remains stable. Any decrease in our Medi-Cal population will reduce our revenues from this program.

Our basic forecast for the next five years is based upon the current Medicare Economic Index (MEI) for 2005; a reimbursement rate increase of 3.0% per year. In addition, changes in clinic service models and process improvements are projected to yield an additional 1% per year volume increase in FQHC program visits.

Sales Tax and Property Tax In-lieu of Motor Vehicle License Fees: Realignment

These revenue streams were put into place in 1991 to allow for stable funding for mandated medical services to Medically Indigent Adults (MIA) and traditional public health functions. The growth in these revenues streams has declined in recent years, due to the downturn of the California state economy. Therefore, a modest growth rate of 2% per year is projected.

Licenses, Permits, and Fees

Many of the department's program services are funded in part by the use of license, permit and fee revenues, particularly in the Environmental Health and Animal Services programs. A planned cost of living fee increase in Animal Services consumer fees (14%) is projected for Fiscal Year 2006-07. In addition, beginning with Fiscal Year 2007-08, The County Executive's Office has planned to have departments bring cost of living consumer fee increases to the Board of Supervisors every other year. These increases for consumer fee driven programs are included in the projections at 3.5% per year.

Capped Grants and Allocations

There are approximately 45 grant and allocation programs, both mandated and discretionary, within the department. Many of these grant programs have served the community a long time, provide services that would not exist otherwise, and have very strong advocacy. However, the vast majority, (70 %) are capped and have little or no ability to absorb cost increases from salaries and benefits, county-wide cost allocation, and other direct

and indirect costs. No increases in revenues are projected for these State/Federal grant programs. Examples of these programs include the Multipurpose Seniors Services Program (MSSP), the Women Infants and Children's nutrition program (WIC), and our HIV/AIDS education and prevention grants.

Children's Medical Services

The Children's Medical Services programs are entitlement programs defined by statute for children from birth to age 21 with specific, grave diagnoses. The programs have various cost sharing ratios, but the majority are funded in the ratio of 50% State/50% County. Of this county share, 50% can come from a Realignment trust account housed at the Department of Social Services. Further use of this revenue source has been capped, however, due to needs at the Department of Social Services. Fortunately, the Department has not experienced serious cost overruns in this program in recent years and it is projected to stay stable for the next five years. The programs can cover a majority of their salaries and benefits cost increases. However, a serious increase in the treatment costs for the program's caseload or a change in Medi-Cal rules or eligibility could be problematic and require additional general fund resources. (This program does not meet the criteria for use of the FQHC reserves).

General Fund Contribution

Where it goes: The programs contained within the department's health care special revenue fund vary widely in their use of local dollars. Animal Services receives approximately 50% of its funding from the General Fund while overall our medical services programs receive approximately 5%. In addition, General Fund dollars are used for mandated matches in Children's Medical Services Programs, for some community services provided by the Environmental Health Department, for the Emergency Medical Services program, for mandated communicable disease control programs, and for many discretionary capped grant and allocation programs (such as the Multipurpose Seniors Services Program (MSSP), Geriatric Assessment Program (GAP), and Maternal Child Health Program (MCH)).

How It Grows: The annual growth in the general fund contribution to a department is based on a simple formula: the percentage of their funding from the general fund divided by their total funding from all sources, times the amount of salaries and benefit increases from cost of living adjustments. Worker's compensation increases are not included in this calculation and receive no assistance from the general fund. There is also no provision for increased general fund contribution for those programs that have capped funding and can't absorb further increases. Nor is there any provision for non-salary expenditure cost increases that have no other funding source and require additional general funding, such as the mandated match on Children's Medical Services treatment costs, pharmaceuticals, and Medically Indigent Adult Inpatient and Specialty Referral Services. Therefore, increases in the general fund contribution are projected to increase by approximately only 10% of the increase in salaries costs attributable to the cost of living increases (projected at 3.5% per year).

The "Swap": As described earlier, the medical services programs enjoyed strong growth in FQHC Medi-Cal and Realignment revenues prior to the year 2000 when FQHC revenues were capped and the California economy suffered a downturn. During this period of growth, the PHD was able to "swap" out the general fund dollars necessary to fund care for indigents and use these local dollars for discretionary grant programs and fee-driven programs without requesting any additional general fund dollars. In fact the department was able to cover insurance increases, cost of living increases, and other cost increases in all areas of the department because of the strong revenue growth (essentially supplanting the increased use of general fund sources and the increase of fees to consumers and businesses). Since this trend has reversed, the PHD must use its general fund resources for indigent and public health services.

Maintenance of Effort (MOE): The codification of Realignment in 1991 reaffirmed and reformulated the Maintenance of Effort level (MOE) that had been put into place around the time of the passage of Proposition 13 in 1978. Prior to this time, increases in costs to local health services could be funded by increases in local property taxes. After the passage of Proposition 13, other funding streams were put into place with a specified amount of funding for health services, provided that counties continue to 'maintain' their matching levels of funding from local sources. This prescribed level of local funding along with the current levels of Realignment funding constitutes the MOE.

Furthermore, the amount of the MOE only increases with the growth in Realignment revenues (projected at 2%) per year. There is no growth factor on the amount of general fund contribution. Interestingly, at the time the MOE was set, the amount of General Fund Contribution to the Department was $3,794,166 (with no county-wide cost plan payback requirement) approximately 18 years ago. The $3,794,166 went completely for the county's obligation for direct services rendered. Using a Consumer Price Index calculator, $3,794,166 of services in Fiscal Year 1989-90 dollars would require approximately $8,686,000 in Fiscal Year 2005-06 dollars. Again, this figure is

just for the amount used for direct services rendered, not including any county-wide cost allocation plan charges. The amount of general fund received for Fiscal Year 2005-06, net of any repaid county-wide cost allocation plan charges is $5,319,000: an increase of 2% in 10 years, compared to $5,216,000 received in Fiscal Year 1995-96 when the Public Health Department was still part of the general fund. The Department is currently budgeted right at its MOE amount (unlike many other counties that have large MOE overmatches). In order to comply with the MOE for the next five years, the county will need to continue its direct funding of programs (net of any repaid county-wide cost allocation plan charges) at, at least, existing levels.

Five-Year 2005-06 through 2009-10 Expenditure Projections

Major Expenditure Projection Assumptions

Salary and Benefits Costs

As is common in the healthcare industry, 61% of overall expenditure costs are attributable to salaries and benefits. The department must compete and recruit for highly paid and highly trained, licensed staff. This presents many challenges as cost increases from cost-of-living adjustments, benefit and retirement rate increases, workers' compensation increases, and inequity adjustments are granted without increases in local funding.

With the capping of FQHC revenues, capped grant and allocation revenue, and a general slowdown in realignment growth, the PHD has extremely limited ability to cover these increasing costs. Unfortunately, the current formula for calculating the 'local share' of these cost increases does not take capped funding sources into consideration and increases to programs are granted solely based upon their current percentage of local funding. Costs for salaries and benefits are projected to rise by 3.5% per year (along with even greater increases for retirement, worker's compensation, and health benefits) and the five year projection includes a 16% inequity increase for nurses, of which only approximately 20% can be reimbursed by current clinic funding sources. Overall, incorporating all programs, since only approximately 17% of any cost of living increase can be reimbursed by the department's revenue sources, the PHD may have no alternative but consider reducing program service levels and staff to incorporate these cost increases.

Pharmaceuticals

Prescription drug therapies are an essential part of a healthcare delivery system and can act to reduce costly hospitalizations if made available. The PHD currently operates three regional pharmacies that provide pharmaceuticals to its patients, particularly those that are Medically Indigent Adults (MIA) or uninsured. (These two populations constitute 55% of the annual pharmaceuticals prescribed). Additionally, new and expensive drug therapies are being used to control HIV/AIDS, diabetes, and other chronic diseases. Pharmaceutical cost and volume increases have resulted in a 12% growth per year for the past three years and are expected to increase by 10% per year through Fiscal Year 2009-10, based upon historical averages and industry projections.

Medically Indigent Adults (MIA) Inpatient and Referral Specialty Care

The County is mandated to operate a County hospital or to provide for hospital services for the indigent. Contracts with the five acute care hospitals and with area specialty physicians are necessary in order to provide access to these services to fulfill the county obligation for Medically Indigent Adults. This patient population, which is increasing, tends to have expensive, chronic illnesses that require extensive pharmaceutical and internal medicine subspecialty attention. In order to keep access to certain specialties, the PHD will need to pay for all services at Santa Barbara Regional Health Authority Medi-Cal rates, which is the standard and is higher than the rates paid by the State Medi-Cal program. This change will increase these costs by 4% in Fiscal Year 2006-07, and by 2% per year thereafter.

Contract Physicians and Registry Nursing

Many physician services are provided by the use of independent contract physicians; particularly in specialty and obstetrical care. In addition, staffing vacancies, recruiting difficulties, and leave situations create the need to use temporary labor, such as registry nursing and locum tenens physician services. Although many of these costs occur because of staff vacancies that will have related salary savings, providing services in this manner tends to be more expensive than using employee labor and these costs are projected to increase at a rate of 4% per year.

County-Wide Cost Allocation Charges – A87 Plan costs

As a Special Revenue Fund, the PHD is charged with the repayment of county-wide cost allocation plan charges from infrastructure departments such as the County Executive Office, County Counsel, General Services, and

Human Resources. In addition, the department must also bear common facilities costs for occupancy charges such as utilities, cleaning, and necessary maintenance. The bases for allocating these costs vary, but the majority are allocated by square footage and size of staff. As a large department with many sites, the PHD understandably has a very large share of these allocated costs; particularly as costs increase in the infrastructure departments.

With the capping of FQHC revenues, capped grant and allocation revenue, and a general slowdown in realignment growth, the PHD has extremely limited ability to cover these increasing costs from existing State/Federal revenue sources. PHD may have no alternative but consider reducing program service levels and staff to continue to pay these administrative costs, which are projected to increase at 12% per year (based on historical trends), because of infrastructure department salary and staffing increases, increased building maintenance needs, and increased usage of these necessary general government services.

Major Strategic Initiatives

Fixing the Structural Deficit

One of the Department's major strategic initiatives is to address and resolve the financial structural deficit. In order to do this, the Department must decrease expenditures and/or increase revenues. Because the Department's expenditures are staff and service driven, the department is evaluating the services it offers and exploring ways that those services can be delivered at less cost. Departmental resources need to be focused on the core mandated public health services such as indigent medical care, communicable disease, and disaster response. This requires the Department to seek alternative methods of providing discretionary services.

Relocating Programs

Many services that have traditionally been provided by the Public Health Department could be provided through community-based and other organizations. By partnering with these organizations, it can be possible to maintain needed services and reduce costs. Program opportunities can be transitioned to the non-profit community when the Public Health Department declines to renew grant-funded programs and new service providers can be established.

Evaluating Service Levels

Another opportunity to maximize revenues is by evaluating service levels. This will enable the department to prioritize areas to make service level reductions should funding no longer keep pace with growing costs. The department has identified core programs and discretionary programs and is assessing ways to redirect staff time to the services that are essential to maintaining the safety net. The concept here is to be sure that the safety net floor is maintained for the broadest sector of the population possible which may entail reducing the availability of services currently available that are discretionary in nature.

Preservation of a Public Health Strategic Reserve

Part of the advantage of the establishment of a designated reserve for healthcare services is the fact that the department was able to manage in a way that more reflected its peers in the medical community. That is, the department was able to use its reserves for necessary equipment purchases and replacement (such as the purchase of ultrasound machines and chemistry analyzers), and was able to respond to community needs for increased access to county safety net services by expanding services in Lompoc, Santa Maria, and Carpinteria. All without any use of general fund dollars.

Therefore, a goal of the PHD is to preserve enough of a designated reserve that could accessed in order to quickly respond to necessary screening and diagnostic equipment replacements and, more importantly, to allow for planned investment in contemporary technologies such as an Electronic Medical Record and a Digital Radiology System.

Building PHD Infrastructure

Staffing

In response to the eroding funding base, the department has, over the years, maintained or reduced staffing levels despite growing service delivery and administrative burdens. In some core areas of service, this situation has resulted in inadequate infrastructure to support minimum levels of service. A major strategic initiative for the department over the next three to five years is to assess the support levels needed and develop strategies to achieve adequate staffing levels.

Recruitment and Recruitment

To be successful building staffing levels in core service areas, the department must address recruitment and retention for health professionals. A full and stable complement of health professionals is needed to meet the health needs of those needing services and is crucial to optimizing revenue which supports the safety net. Achieving low vacancy and turn over rates for health professionals will reduce expenditures for costly locum tenens physicians or temporary nursing services.