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October 30, 2020

Hon. Tara M. Desautels, Presiding Judge
Alameda County Superior Court
1225 Fallon Street, Department One
Oakland, Ca 94612

Re: **Response to 2019-2020 Alameda County Grand Jury Report: "Alameda Health System: Looming Insolvency of a Critical County Safety Net"**

Dear Judge Desautels,

Pursuant to California Penal Code Section 933.05(a), (b) and (c), Alameda Health System ("AHS") provides this letter in response to the section "Alameda Health System: Looming Insolvency of a Critical County Safety Net" in the recently completed 2019-2020 Alameda County Grand Jury Final Report. AHS appreciates the feedback provided by the Grand Jury and this opportunity to respond to the findings and recommendations.

I. Introduction/Background

AHS appreciates the Grand Jury's analysis and understanding of the relationship between AHS and the County as central to insuring the efficient delivery of quality health care to the community. Although our organization was established as an "independent" hospital authority, the reality – then and now – is the essentiality of aligned and cooperative collaboration between AHS and the County at all levels and in all pursuits.

As we explain in this response, work is needed to achieve this fundamental commitment to our community. The initial structure of the hospital authority could have better anticipated the potential fiscal issues the new organization would face. Further, the structure of the relationship and the roles of AHS and County have evolved over time as the dynamic landscape of healthcare delivery has evolved. Given these issues, a more thoughtful acknowledgement and understanding of the changed circumstances since the establishment of the hospital authority is key to charting the next steps between the organizations.

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II. AHS Fiscal Capacity is Challenged by Structural Deficiencies That Have Existed From the Time of Its Creation.

A. Establishment of the Hospital Authority

In February 1996, the Health Care Services Agency ("HCSA") recommended that the Board of Supervisors ("BoS") adopt the hospital authority model for (then) Alameda County Medical Center ("ACMC"). HCSA's recommendation came after the BoS had determined that the hospital authority was one of three options that held the most promise for the future of ACMC (the other two options were– a county commission (appointed and overseen by the BoS or a Non-Profit Benefit Corporation (governed by an independent board)). HCSA's recommendation was inspired by its assessment that the hospital authority presented a governance model that would "enable the Alameda County Medical Center to survive and thrive in a changing, competitive market economy." HCSA's recommendation noted that the hospital authority model:

- offered the "best balance between public values and private practices;"
- provided "speed and flexibility" to confront declining public funds and increased market competition; and
- that "the current system and the commission model are simply too bureaucratic and cumbersome to respond quickly.

In choosing the hospital authority, HCSA was guided by the principle that the governing board of the hospital authority "will be given the maximum autonomy and authority possible within the law in which to operate." In addition, HCSA cited the need for the hospital authority to have the "tools and be allowed to exploit financing, joint venture, bonds etc." and continued financial support from the County. Under the hospital authority model (also a feature of the NPBC) "the role of the [BoS] and the county structure would be that of a purchaser of services."

Significantly, in adopting this approach, ultimate responsibility for statutory obligations to provide health care services to the community – in particular the indigent population – remained the responsibility of the County. ACMC was created as the vehicle to facilitate discharge of this responsibility, but ACMC was not vested with complete or exclusive authority to determine or to direct the provision of services or provisioned with resources necessary to cover all of those services. The latter issue is particularly significant inasmuch as the cost of providing such services was not affected by the creation of the hospital authority. The community needs and cost obligations remained the same post-creation. In other words, the creation of the hospital authority did not automatically reduce the cost of providing such services and the initial plan required some consideration of maintaining the support that the County historically provided to meet these needs under the new structure.

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B. Structural Funding Gap

1. County Support to AHS – Original Intentions

As noted above the County acknowledged the need to provide a measure of resources to the hospital authority at the outset, beyond the revenue to be generated from services and the reimbursement available from state and federal government programs. Specifically, in the initial assessment, HCSA predicted the County appropriating to the hospital authority $77.0 million as compared to the $236.1 million that it appropriated to cover health care services at that time.

The record fails to establish that this level of support – through direct appropriation from the County – accompanied the establishment of the hospital authority. At inception, ACMC and the County entered into various agreements to govern services to be provided to ACMC, lease of facilities from the County, and risk management, but there was no record of specific financial support to ACMC. Under the enabling legislation (Health and Safety Code Section 101850 et seq. and Alameda County Administrative Code, Chapter 2.120), ACMC was empowered to collect for services and seek program reimbursements, but neither addresses the specific commitment of County resources to ACMC operations.[1]

2. Increasing "Debt"

Measure A, which provides some ongoing support to AHS, was not in existence at the time the hospital authority was created or during the first seven (7) years of its operation. By the time that Measure A came into effect, ACMC had a incurred a "debt" to the County that exceeded $200 million. Unfortunately, this "debt" has overshadowed the relationship between the County and AHS and complicated the discussion of resources that AHS requires. On the one hand, the County looks to AHS to repay a "debt"; on the other hand AHS struggles to make ends meet from current operations and capital investment needs and funding sources and to repay this "debt."

AHS submits that characterizing the money advanced by the County as a "debt" is not entirely accurate. AHS was created solely to provide health care services on behalf of the County. It has no mission or interests except in the satisfaction of its responsibilities under the enabling legislation. Furthermore, as a creation of the County, AHS is an asset of the County and has no authority to direct any support that it receives or revenue that it generates to any purpose that does not serve the County's interests. In the absence of the hospital authority structure, the resources channeled to AHS to provide services are resources that would have been committed/incurred by the County directly to provide services. Similarly, if the hospital authority structure is eliminated the County would continue to be responsible for most, if not all, of the current costs that are

[1] The Report notes County support to AHS from Measure A ($123 million) and contracts between the County and AHS ($81 million). As we note here, these two items should not be conflated. The funding from service contracts is offset by expenses incurred to provide those services. Moreover, to the extent that funding from the contracts does not entirely reimburse incurred costs (next section), the net impact to AHS is a negative number.

incurred by AHS (to the extent that it determines to maintain services provided by AHS) – and would reacquire control of all of the AHS assets.

As discussed below, operational revenue and government reimbursement have never been sufficient to cover the cost of operating the/a safety net system, much less cover debt obligations and needed capital investment. It was overly optimistic to assume that the new hospital authority could come into being with few assets, allocated pension liability, and no more than accumulated and future receivables and operational revenues to meet its needs. Unfortunately, neither the newly-created hospital authority nor the County identified the practical reality of a mechanism to fund or to create "working capital" to support the new organization. Likewise, the absence of a more robust plan to establish a financial footing for the organization before it began to experience difficulty and to address ongoing support in a concrete way as suggested in the feasibility study was a critical flaw that continues to impact the organization.

3. Difference in Approach to Use of Measure A Funds

While the Measure A funding is direct support – not tied to specific operational costs – AHS is not able to achieve the full value of that support. AHS has the opportunity to obtain reimbursement of some uncovered costs through Medi-Cal supplemental reimbursement; however, that supplemental reimbursement is dependent on local funds matched by the federal government. For example: if an eligible agency like AHS reports losses of $1M for a specific subset of services, that agency could proffer $500K and receive a federal match of $500K. In other jurisdictions in the state, the health care provider receives and retains the total $1M to cover the losses.

As noted in the Report, there is a conflict. In the County view, for a substantial portion of the supplemental reimbursement vehicles only the federal match (in the example above $500K) is apportioned to AHS; the "local funds" contributed by AHS are returned to the County upon receipt of the total reimbursement (local funds plus the federal match). This is done on the premise that those local funds are derived from Measure A.

In the AHS view, this approach undermines the support available from Measure A. AHS believes that Measure A was intended to further stabilize the safety-net by supplementing, not supplanting, existing fiscal commitments from the County. Designating Measure A funds as the nonfederal share for the purposes of supplemental funding programs ignores the fact that supplemental funding mechanisms never have reliably covered all of the losses AHS incurs even prior to Measure A. By making only the federal match available, AHS does not receive the full reimbursement intended for its operations.

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C. General – Services vs. Cost of Services

The foregoing points have proven to be significant impediments to a hospital authority tasked with providing care to an indigent population. By definition, many services provided by AHS are targeted to an indigent population that cannot pay and by design, reimbursement programs (i.e., Medi-Cal) that are not configured to cover the full costs of providing such services.

Even where a funding source is available, in addition to the gap between available funding and costs, the practical reality of providing services as the "safety net" requires incurring additional costs that will not be covered. For example, safety nets are often required to continue providing care beyond the point of clinical need because patients cannot be discharged (safely), there is a lack of necessary follow-on care available without which the patient would be at risk of relapse or exacerbation of a condition, and/or other social factors – in particular housing insecurity. AHS routinely is required to bear the cost of continuation in the clinical setting.

Significantly, these are obligations of every county safety net system under the Welfare and Institutions Code Section 17000[2], and represent financial responsibilities routinely incurred by the County prior to the establishment hospital authority. Over time, these responsibilities have increased with the increase in the number of community members requiring services intended for the indigent and those unhoused or facing housing insecurity. However, as there is not, and has never been, a specific funding to facilitate AHS providing these services and to meet these needs – which ultimately remain the obligation of the County under the enabling legislation - funding available to AHS continues to be substantially less than costs it is obligated to incur.

D. Variability/Inadequacy of Supplemental Funding

In general, a variety of supplemental funding programs fill some of the gaps described above. Medicaid Waiver programs, GME funding, as examples, provide cost support recognizing the special needs of providing services to the safety net population and other aspects of our operations (i.e., academic/training). These programs include funding tied to specific services being provided (meaning variability based on operations) and other funding not tied specifically to operations. Included here is funding that is provided by local government such as Measure A and the Alameda City parcel tax.

Measure A was passed in 2004, and from that point forward providing supplemental funding to AHS. Seventy five percent of Measure A funds are apportioned to AHS – for

[2] Health & Safety Code Section 101850 that authorizes the creation of the hospital authority provides in subsection (l)(1): "Notwithstanding any other provision of this section, a transfer of the administration, management, or assets of the medical center, whether or not accompanied by a change in licensing, does not relieve the county of the ultimate responsibility for indigent care pursuant to Section 17000 of the Welfare and Institutions Code or any obligation pursuant to Section 1442.5 of this code."

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FY19-20 this amounted to approximately $117million or approximately 9% of the AHS budget. The amount of funding varies according to tax revenue. In the economic downturn in 2008, the funding dropped significantly and in the current pandemic, the projection is that Measure A funding for the current fiscal year will be substantially less than prior years.

Under the Joint Powers Agreement with the Alameda City Health Care District, revenue generated by the local parcel tax (less administrative costs incurred by the district) is transferred to AHS. Typically the net transfer is $4-5 million annually. However, this amount is far less than what is needed to cover the gap between revenue/reimbursement from services and other supplemental funding and the costs to operate Alameda Hospital.

Periodically these supplemental funding sources have enabled the hospital authority to meet operational needs and address some capital requirements. However, supplemental funding has been declining for the past 4-5 years. For example, funding received from the Waiver dropped from $123.4 million to $108.2 million between FY2016 and FY 2020.[3] Measure A increases to some extent according to the rate of inflation, but that increase has been less than the reduction in the Waiver and neither Measure A nor the parcel tax change according to care needs/requirements or changes in the structure of care delivery. In addition, Measure A funding in particular is susceptible to downturns in economic conditions.

As a final point, supplemental funding has proven to be a moving and unstable target. The programs providing this support typically provide an amount of money to a group of safety net providers with the share for each calculated on expected costs. The grants are subject to audits that occur many years after the money is granted and can result in redistribution of the funding if the record shows that a hospital received a larger share initially than is justified by comparison of the operational costs of the entire grantee group. Consequently, if the subsequent review demonstrates that hospital A incurred higher costs (relative to others) than initially projected and hospital B incurred lower relative costs, the initial grant to hospital B might be reduced and the difference apportioned to hospital A. AHS is currently dealing with the recoupment of prior supplemental funding (from 2009-2014), further contributing to an overall decline in the stream of supplemental funding that exacerbates planning and operational challenges.

E. Accountability to Capital Investments

Apart from day-to-day operational matters, the scope and complexity of healthcare delivery requires continued investment to address changes in regulatory requirements, development of new technology and practice standards, and the replacement of clinical and facility management equipment essential to providing care and services. In the past five years, AHS has undertaken significant capital investments necessary to maintain and improve its health care delivery capability. Examples include: statutorily-

[3] Due to the pandemic, FY 2020 supplemental funding will be increased by $5 million.

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required seismic improvement projects at San Leandro Hospital[4] and Alameda Hospital, implementation of an electronic health record, and capital projects to support equipment improvements (i.e., installation of MRI at the Highland campus). In addition to these large projects, ongoing support/maintenance of Information Systems, routine repair and facilities maintenance, support for regulatory improvements, and continued infrastructure development have required substantial capital investments.

AHS does not receive specific outside support to address these capital needs. Rather, AHS has attempted to fund these capital needs from ongoing operating revenue and limited philanthropy. As explained above, the inadequacy of funding to cover operational costs results in slim margin opportunity to address these capital requirements. Likewise, the general fiscal structure of AHS from its inception did not account for these future requirements.

F. Responding to Community Needs and Changing Circumstances

Ongoing reform in health care delivery has required continuous realignment of AHS's strategic priorities. In particular changes anticipated with the passage of the Affordable Care Act ("ACA") resulted in plans to reconfigure the organization to compete in an anticipated, market-driven environment that placed a premium on attracting business to the organization. Although the planned approach to the implementation of ACA sought to integrate a competitive focus with the safety net mission, AHS has not capitalized on or benefitted as anticipated. In part, subsequent legislative changes altered the anticipated landscape. In addition, it is not clear AHS strategic planning incorporated the best approach to better position the organization for success. In addition, two large initiatives – acquisition of San Leandro Hospital and operating responsibility for Alameda Hospital - were encouraged by the County as roles for AHS to preserve those institutions. Ultimately, these initiatives were incorporated in a strategy to reposition AHS in an ACA-driven health care delivery model, but neither has lived up to fiscal expectations for a variety of reasons. This path was pursued despite insufficient capital support or resources[5], and inadequate revenue that could be generated by AHS operations. Thus, it is reasonable to conclude that these initiatives were undertaken without adequate due diligence and stakeholder buy-in.

As a result, the challenge to AHS's fiscal situation has become more complicated in that anticipated synergies have not developed to provide resources to meet these added operational and capital costs. Covering costs associated with these initiatives is a further challenge to the AHS fiscal model.

[4] To accommodate a relocation of services from a seismically unfit location at the Fairmont campus.
[5] Sutter Health, City of San Leandro, and Alameda County did provide limited short-term dollars to AHS for San Leandro Hospital; however, substantial support from Eden Healthcare District never materialized.

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III. **There Is a Significant Challenge To Modifying Services to Accommodate Available Resources As AHS Lacks Unilateral Authority To Make Such Decisions.**

Presently, 70-80% of AHS's costs are tied to labor costs to meet the scope of operations. As a result, to the extent that fiscal resources are unavailable or insufficient, the sole solution to conform operations to fiscal support is modification of programs and services that result in the reduction of labor costs. This situation presents a two-way challenge given the impact on the patient population and the workforce.

As the hospital authority, AHS seeks to identify appropriate programs and services to fulfill the County's statutory obligations. However, a decision by AHS to respond to fiscal shortcomings by reducing or eliminating programs, necessarily affects, or interferes with, the County's statutory responsibilities. Moreover, proposed changes invariably impact the interests of other stakeholders who have come to rely on established programs, services or support. Yet, a failure by AHS to consider or engage such modification exacerbates its fiscal dilemma. In the absence of close alignment: the County clearly identifying and articulating needs and priorities (as well as encouraging the cooperation of other stakeholders) and AHS responding/executing on such direction, a stalemate results. This present impact of this type of stalemate is clearly articulated in the Grand Jury report.

Consequently, for AHS to meet the County's need for efficiency in the use of resources it makes available requires improved clarification of priorities that AHS should focus on, particularly where priorities involve other stakeholders. Moreover, it is incumbent upon the County to play an active and leading role in the decision to eliminate or modify services if it determines that it cannot continue to fund a program. AHS can advise and plan strategy in this regard, but the County is the decisionmaker as it retains authority over such matters. In addition, as the Grand Jury notes, the County must support such change in the direction/scope of operations before the patient population and stakeholders (such as the workforce). As noted by the Grand Jury, it is ineffective for the County to require improved operational performance without articulating priorities and supporting steps AHS must take to achieve those priorities.

Along the same lines, there must be increased cooperation between the two to insure challenges faced by the County in the health care delivery for which it is responsible are not transferred to AHS. For example, as noted above the unique nature of providing services to the indigent population creates situations that require AHS to provide services at the expense of unreimbursed costs. A patient at John George Psychiatric Hospital (JGPH) who cannot be discharged because of the lack of available community resources to meet their needs, results in unreimbursed cost to AHS. In the absence of a plan either to provide adequate community resources or to fully fund unreimbursed costs to AHS, neither the County nor AHS can be successful in meeting community needs.

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Finally, it must be understood that AHS was not intended or configured to meet all healthcare needs within the County. The County has broader responsibilities for meeting community health care needs beyond care for the indigent population – AHS's mission. Accordingly, setting priorities has to respect the scope and limited resources of AHS and facilitate focus on its core mission. Committing AHS to involvement in other health care initiatives the County has identified as priorities (i.e., preserving emergency and acute care services at struggling facilities) requires providing resources to address these needs or authorization for AHS to modify other current commitments.

IV. **The Establishment of the Separate Hospital Authority Complicated Competition Between Health Care Services and Other County Obligations.**

As a part of the County, the former medical center was one element of county operations that competed for resources amongst the other county services. The creation of the hospital authority divided health care delivery between the Health Care Services Agency and AHS. As a result, competition between County retained health care obligations and the independent hospital authority is apparent. Furthermore, HCSA's continuing general responsibility over health care created some divide between its continuing responsibilities and its support to the hospital authority.

The reality of this situation is relevant to the challenges described in the prior section, but also an element of the hospital authority's challenge to maintain a priority for fiscal consideration within the County structure. Again, the creation of the hospital authority anticipated relieving the County of governance responsibility for certain health care delivery responsibilities, but the governance responsibility is inherently tied to fiscal resources. The AHS governing board is challenged to navigate good stewardship and efficiency where it has limited fiscal authority given the lack of dedicated funding to AHS and limited involvement in the County planning and priority-setting discussions.[6]

In our view, this challenge does not mandate abandoning the hospital authority model. However, it requires greater focus on the relationship between the two governing bodies. The Board of Trustees needs clear direction on County priorities and direction and opportunity to engage the Board of Supervisors in decision-making that sets such priorities and direction. Although the governance structure provides for joint planning and discussion with the County governing board, that structure has not been effective in aligning priorities and direction. Too often, the communication in joint meetings has been one-way, focused on AHS finances with little insight or engagement on broader issues that impact the direction and execution of health care delivery at the County level. With better of understanding of the County roadmap to address the challenges inherent in health care delivery, the Board of Trustees can be more effective providing oversight of the AHS role in the County's plans.

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[6] In this point, we are not ignoring Measure A, but reiterating that the support of Measure A alone is insufficient to meet all of the health care needs that fall to the responsibility of the County.

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V. **Current State: Plan for FY20-21 Budget**

Despite the challenges outlined above, AHS has nearly completed development of a final budget for FY20-21 that can result in an EBIDA margin of 3%. This budget includes substantial risks and uncertainties, including the ongoing effects of the Covid-19 pandemic, ongoing managed care contracting during the economic downturn, and major labor contract negotiations. The budget does not rely on modifications to current services, though at least one outpatient behavioral health service may be eliminated and replaced by another service over the course of the year. Even if AHS is successful in meeting budgeted forecasts, this budget still will not generate sufficient resources to address critical capital requirements contemplated in this fiscal year. Similarly, this budget does not provide for repayment of supplemental funding recoupments that will come due in the fiscal year, nor paying down of the aforementioned “debt.”

VI. **Conclusion**

As noted in the Grand Jury’s Report, our community is faced with a challenging set of circumstances without many options given the essential nature of the services and needs at issue. However, the lack of options provides a degree of clarity as to steps to be taken to address the issues. As set forth below, we are committed to following the plan outlined by the Grand Jury for increased communication, collaboration, and cooperation between the County and our organization that is focused on insuring the health care needs of the community are met.

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VII. AHS Responses to Findings

Finding 20-7: "The friction between AHS's responsibility for operational control and Alameda County's health service mandate and allegiance to other constituencies continues to frustrate both parties, exacerbate their mutual distrust, and interfere with their ability to communicate and implement long-lasting solutions to AHS's financial crises."

AHS Response to Finding 20-7:

AHS agrees with this finding.

Finding 20-8: "AHS's narrow focus on a balanced operating budget and EBIDA does not adequately represent the actual financial position of AHS."

AHS Response to Finding 20-8:

AHS partially disagrees with this finding.

The Permanent agreement with the County requires a balanced annual operating budget and for AHS to be under the line of credit limits at limits described in the agreement. AHS cash transactions, receipts and disbursements are accounted for and reflected under the Line of Credit. These items are a point of focus and are designed to provide clarity as to AHS's ability to meet its mission to provide service to the community and remain compliant with the terms of the Permanent agreement with the County.

AHS financial reporting also includes estimates for assets and liabilities including recoupments of supplemental funds in the Balance Sheet and these amounts are audited annually and are consistent with accounting standards each year.

Beginning is 2016, AHS began reporting separately and emphasizing the requirement to repay supplemental funding that had been received in prior periods. In 2018, The Centers for Medicare & Medicaid Services (CMS) identified a specific schedule/timeline for assessing these prior payment recoupments that called for these obligations to come due beginning in FY19-20. The Line of Credit forecast with the County reflects the cash projection of AHS, including material receivables and payables (this document is included in the monthly Finance materials).

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Finding 20-9: "Even with transparent and efficient management, an average annual EBIDA Margin of 3% to 5% is not sufficient for AHS to pay off its outstanding debt and buffer against any future financial crises."

AHS Response to Finding 20-9:

AHS agrees with this finding.

Finding 20-10: "AHS and Alameda County do not agree on whether AHS can establish a cash reserve to pay prior-year liabilities. The lack of a cash reserve exacerbates the long-term financial stability of AHS and its ability to comply with the Permanent Agreement, leading to further distrust between AHS and Alameda County."

AHS Response to Finding 20-10:

AHS agrees with this finding.

Finding 20-11: "AHS does not provide its financial reports to county supervisors and staff sufficiently in advance of regularly scheduled meetings between the parties to allow county supervisors and staff time to familiarize themselves with those reports prior to being presented by AHS."

AHS Response to Finding 20-11:

AHS partially disagrees with this finding.

AHS provides a quarterly report to the Alameda County Board of Supervisors Health Committee. The substance of this report reflects the latest financial report from its monthly meeting of the Board of Trustees Finance Committee, which is typically two weeks before the report to the Health Committee. Staff from the offices of the supervisors regularly attend the Finance Committee and the reports from that meeting are posted publicly.

AHS acknowledges that at times the actual condensed and tailored presentation is delivered to the Health Committee after the set deadline before the Health Committee meeting.

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Finding 20-12: "AHS and Alameda County acknowledge the need for flexibility in the use of Measure A funds to take advantage of matching-fund opportunities. However, they often disagree on how AHS should specifically allocate Measure A funds to support its operations. This disagreement magnifies and exacerbates the distrust between AHS and Alameda County."

AHS Response to Finding 20-12:

AHS agrees with this finding.

Finding 20-13: "Political pressure from some Alameda County supervisors has interfered with AHS operations and efforts to control costs."

AHS Response to Finding 20-13:

AHS agrees with this finding.

Finding 20-14: "Negotiating separate contracts with 18 different labor unions is both time consuming and expensive for AHS and limits AHS's negotiating flexibility. AHS's negotiations with labor have been further compromised by public support of negotiating labor unions from some county supervisors."

AHS Response to Finding 20-14:

AHS agrees with this finding.

Finding 20-15: "AHS and Alameda County agree that the governance structure of AHS is problematic and needs to be revisited and strengthened in order for the parties to better understand and respect each other's governance and operational roles."

AHS Response to Finding 20-15:

AHS agrees with this finding.

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VIII. AHS Responses to Recommendations

Recommendation 20-6: "If resources prove insufficient to adopt and maintain a balanced AHS budget, AHS and the county must identify and agree on the scope of services and on the least politically damaging way to provide them—by cutting back on services, increasing the county's financial support, or some combination of the two. Both parties then must present a uniform public face in support of that decision."

AHS Response to Recommendation 20-6:

This recommendation will be implemented.

AHS is fully committed to a close partnership and alignment with the County, but it requires clear direction from the County to identify priorities, strategies, and resources to execute on such priorities. AHS has initiated discussions with the County to address these issues. AHS would expect to reach agreement with the County on priorities and strategies by December 31, 2020.

Recommendation 20-7: "Beginning with its FY2021 budget and continuing with its presentation of financial results, AHS must include all revenue and expense accounts in accordance with pronouncements of the Governmental Accounting Standards Board (GASB). The budget and presentation of financial results must not exclude accounts, believed by AHS, to be outside its control."

AHS Response to Recommendation 20-7:

This recommendation has been implemented.

AHS financial and budget reports include all revenue and expense accounts. AHS is not aware of any time that accounts were excluded from the financial statements. AHS has revised the financial format to be in accordance with the pronouncements of the GASB and consistent with of our annual audited financial statement. A current copy of the financial statements and proposed budget for FY21 are attached to this response.

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Recommendation 20-8: "AHS must, by September 30, 2020 and in consultation with Alameda County supervisors and staff, develop and regularly report a cash flow statement of sufficient scope and detail to provide an early warning system as to the approach of another cash crisis."

AHS Response to Recommendation 20-8:

This recommendation has been implemented.

The AHS standard monthly financial report includes a cash flow statement consistent with GASB. AHS cash receipts are swept to the County Treasury and reduce the amount owed under the NNB. AHS will include a projection of the NNB or Line of Credit balance with the County and specifically note when AHS is expecting to exceed the amount of credit available for the Organization. Attached is a copy of the report.

Recommendation 20-9: "Alameda County and AHS must collaboratively resolve how to pay for AHS's long-term debts with the county."

AHS Response to Recommendation 20-9:

This recommendation will be implemented.

AHS believes this is a high priority. AHS has initiated a discussion with County leaders of the current status of the Permanent Agreement. In addition to the steps described under Recommendation 20-6, AHS anticipates the discussion with the County will result in clarity on future funding sources for AHS (aligned to the priorities identified by the County). AHS expects that agreement with the County will be reached by December 31, 2020.

Recommendation 20-10: "AHS and Alameda County must develop a procedure whereby AHS has the ability to set aside cash to pay prior-year liabilities."

AHS Response to Recommendation 20-10:

This recommendation will be implemented.

AHS has initiated a discussion with County leaders on this point as it relates to liabilities related to 2009-2014. Subject to the discussions related Recommendations 20-6 and 20-8, AHS anticipates the discussion with the County will result in a future funding plan to address this issue. AHS expects that agreement with the County will be reached by December 31, 2020.

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Recommendation 20-11: "AHS must provide financial reports to county supervisors and staff at least one calendar week prior to any regularly scheduled meeting at which those reports are to be presented."

AHS Response to Recommendation 20-11:

This recommendation has been implemented.

AHS will forward to County supervisors and staff the most recent monthly financial statements at least one week before the quarterly Health Committee report outs. The CEO will forward the financial statements after Finance Committee with an invitation to the County officials to identify any questions they may have that should be addressed in the report out. The CEO will continue to prepare and submit a slide deck in time for the Health Committee meeting. An example of this process is attached.

Recommendation 20-12: "AHS and Alameda County must agree on how AHS allocates its share of Measure A funds as part of its budget."

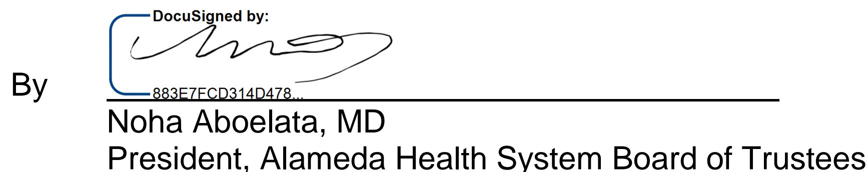
AHS Response to Recommendation 20-12:

This recommendation will be implemented.

Measure A funding and how it should be allocated has been an ongoing discussion between AHS and County leaders. AHS BOT has engaged an outside firm, WIPFLI, to develop a financial model to allow AHS to report profitability by location and major program.[7] As part of the engagement, WIPFLI will recommend an allocation methodology for allocating Measure A as well as other supplemental revenue and overhead expenses.

Respectfully submitted,

ALAMEDA HEALTH SYSTEM

By 

Noha Aboelata, MD
President, Alameda Health System Board of Trustees

cc: Chief Executive Officer, Alameda Health System

[7] A copy of the report from WIPFLI setting forth a discussion of a financial model is attached.