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Assembly
California Legislature
Committee on Local Government

CECILIA M. AGUIAR-CURRY
CHAIR

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COMMITTEE SECRETARY
DIXIE PETTY

OVERSIGHT HEARING: THE EVOLUTION OF HEALTHCARE DISTRICTS

WEDNESDAY, MARCH 8, 1:30 PM, ROOM 447

AGENDA

1) **Welcome and Opening Remarks**

   Assemblymember Cecilia M. Aguiar-Curry, Chair, Assembly Local Government Committee

2) **Overview of Healthcare Districts**

   a) *Carolyn Chu, Senior Fiscal and Policy Analyst, Legislative Analyst's Office*

   b) *Michael Colantuono, Shareholder, Colantuono, Highsmith & Whatley, PC*

3) **Case Studies**

   a) *Ted Owens, Executive Director Governance & Business Development, Tahoe Forest Hospital District, Placer and Nevada County*

   b) *Barry Jantz, Chief Executive Officer, Grossmont Healthcare District, San Diego County*

   c) *Karin Hennings, Administrative Director, Del Puerto Healthcare District, Stanislaus County*

   d) *Don Tatzin, Commissioner, Contra Costa Local Agency Formation Commission*

   e) *Mark Bramfitt, Executive Officer, Sonoma Local Agency Formation Commission*

4) **Public Testimony**

5) **Closing Remarks and Adjournment**

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Oversight Hearing: The Evolution of Healthcare Districts
March 8, 2017, 1:30 p.m., State Capitol, Room 447

Hearing Goal

The goal of the hearing is to provide oversight of healthcare districts in California and to educate the Committee about the history and evolution of healthcare districts since their creation. The hearing will also examine the relationship between healthcare districts and local agency formation commissions (LAFCOs).

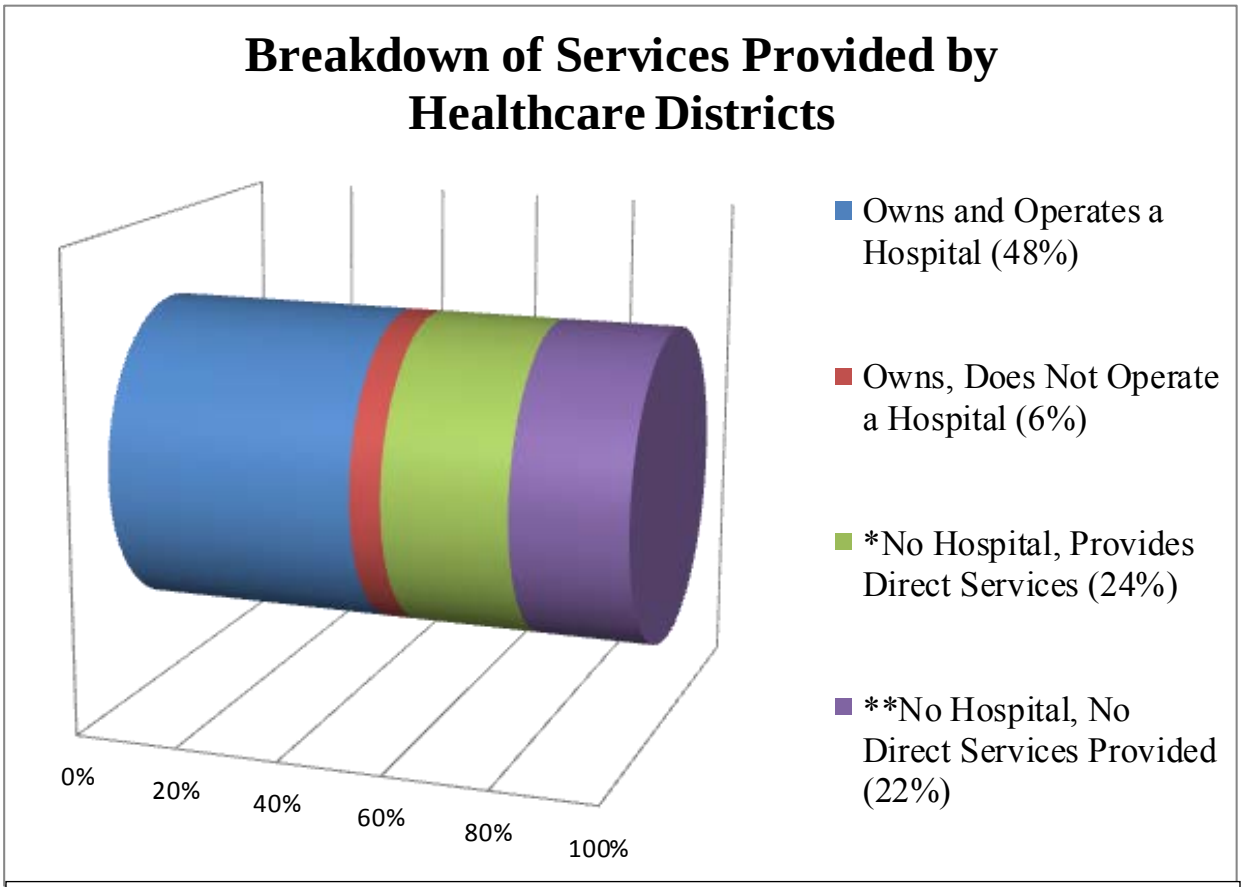
Background on Healthcare Districts

History. Near the end of World War II, California faced a severe shortage of hospital beds. To respond to the inadequacy of acute care services in the non-urban areas of the state, the Legislature enacted the Local Hospital District Law, with the intent to give rural, low-income areas without ready access to hospital facilities a source of tax dollars that could be used to construct and operate community hospitals and health care institutions in medically underserved areas, to recruit physicians and support their practices.

The Local Hospital District Law allowed communities to create a new governmental entity – independent of local and county jurisdictions – that had the power to impose property taxes, enter into contracts, purchase property, issue debt, and hire staff. In general, the process of creating a hospital district started with citizens in a community identifying the need for improved access to medical care. The hospital district's boundaries were usually based on the distance between communities and the closest available acute care hospital services. A petition for formation was then filed by the community to the county board of supervisors, and then residents of the proposed district voted in favor of the measure to create the hospital district. In 1963, the Knox Nisbet Act was passed, which created LAFCOs and clarified and formalized the process for establishing a hospital district.

SB 1169 (Maddy), Chapter 696, Statutes of 1994, changed the name of the principal act from 'The Local Hospital District Law' to 'The Local Healthcare District Law.' Senate Local Government and Assembly Health Committee's analyses of SB 1169 noted that "renaming hospital districts to healthcare districts better reflected the focus of healthcare provision outside of hospital settings." The powers and duties granted to healthcare districts have remained largely unchanged while the demographics of areas being served by the districts, access and provision of healthcare services, and the districts themselves have vastly changed. For example, over one-third of the healthcare districts in California have either closed or sold their hospital thus moving away from the original intent of 'hospital districts.'

Healthcare Districts in California. There are currently 79 healthcare districts in California. According to the Association of Healthcare Districts, 54 healthcare districts are in rural areas of the state. Of the total 79 healthcare districts, 38 healthcare districts own and operate a hospital, five districts own, but do not operate the hospital, and 36 healthcare districts do not own or operate a hospital. Of the 36 districts that do not own or operate a hospital: 19 districts provide direct services, seven provide ambulance services, three have clinics, one provides ambulance services and has a clinic, four have skilled nursing facilities, and four provide community based services. Seventeen districts do not provide direct services and instead administer grant funding as their sole purpose.



***Direct Services includes ambulance services, clinics, skilled nursing facilities, and other community-based services.

****Districts that provide no direct services administer grant-funding as their sole purpose.

Funding. The issue of funding for healthcare districts has come under fire in recent years. The funding for healthcare districts varies, but can include the following:

- *Property Taxes* – Most districts receive a share of local property taxes. The share of local property tax going to districts varies among districts.

- *Special Taxes* – Some healthcare districts have received two-thirds voter approval to levy parcel taxes.

- *Service Charges* – Healthcare districts may run hospitals, clinics, skilled nursing facilities, and ambulance services. These activities earn revenue and are entirely or predominately self-supporting through service charges. These are sometimes referred to as "enterprise activities."

- *Debt Financing* – Healthcare districts can issue debt to borrow money needed for capital projects such as hospital construction. General obligation bonds require two-thirds voter approval to raise property tax rates for district residents to serve as the mechanism to repay the bonds. Revenue bonds are backed by user fees. Districts may also issue promissory notes and receive loans from the state and the federal government.

- *Other Revenue* – Some healthcare districts generate revenues from district resources, such as property lease income and interest earnings from investments. They may also receive grants from public and private sources.

Recent Controversy. Recent controversies have brought greater statewide attention to healthcare districts in the following areas: overall fiscal management, compliance with the Ralph M. Brown Act and conflict of interest laws, executive compensation policies, lack of provision of direct healthcare services, and overall accountability and transparency issues for healthcare districts.

The Assembly Committee on Accountability and Administrative Review conducted several hearings in 2012 regarding healthcare districts, and focused specifically on healthcare districts that do not operate hospitals, but were maintaining reserve balances in the tens of millions of dollars. Additionally, the Legislative Analyst's Office (LAO) produced a report entitled, "Overview of Health Care Districts" in April 2012 in response to several healthcare districts that have declared bankruptcy since 2000.

The Committee is aware of 14 healthcare districts that have filed for bankruptcy:

- Los Medanos Hospital District, Contra Costa County (1994)
- Heffernan Memorial Hospital District, Imperial County (1996)
- Corcoran Hospital District, Kings County (1996)
- Kingsburg Hospital District, Fresno County (1997)
- Southern Humboldt Community Healthcare District, Humboldt County (1999)
- Chowchilla Memorial Hospital District, Madera County (2000)
- Sierra Valley District Hospital, Sierra County (2000)
- Alta Healthcare District, Tulare County (2001)
- Coalinga Regional Medical Center, Fresno County (2003)
- Indian Valley Healthcare District, Plumas County (2003)
- Valley Health System, Riverside County (2008)
- Sierra Kings Healthcare District, Fresno County (2009)
- Mendocino Coast Healthcare District, Mendocino County (2012)
- Palm Drive Hospital District, Sonoma County (2007 and 2014)
- West Contra Costa Healthcare District, Contra Costa County (2006 and 2016)

Additionally, according to the LAO report, several LAFCOs have considered dissolving districts. Five districts have been dissolved or otherwise reorganized since 2000. Since that time, the Contra Costa County LAFCO consolidated Mount Diablo Healthcare District into the City of Concord. The Mount Diablo Healthcare District did not operate a hospital and concerns were expressed about the amount of revenue spent on administrative costs, instead of on grant funding for community health needs.

A 2012 Bureau of State Audits' (BSA) report on Salinas Valley Memorial Health Care System found that the District's Board violated open meeting laws to grant overly generous compensation, retirement, and benefits to the chief executive officer. This Committee heard several bills addressing the employment contract between a healthcare district and hospital administrator.

Most recently the discussion in the Legislature has focused on healthcare districts that no longer operate hospitals, and no longer provide any direct healthcare services to the community.

Healthcare District Legislation

SB 134 (Corbett) of 2011 would have required healthcare districts to appraise the fair market value of assets that they transfer to other corporations for less than fair market value. This bill failed passage on the Assembly Floor.

SB 644 (Hancock), Chapter 742, Statutes of 2011, required all certificates of participation executed and delivered by the West Contra Costa Healthcare District, between June 8, 2014, and December 31, 2012, to be secured by a statutory lien on all the revenues generated from a parcel tax passed by District voters in 2004.

AB 2115 (Alejo) of 2012 would have required a local health care district, if the district employs or contracts for a hospital administrator or chief executive officer, to enter into a written employment contract, not to exceed four years. This bill was vetoed.

AB 2180 (Alejo), Chapter 322, Statutes of 2012, requires, if a health care district and hospital administrator enter into a written employment agreement, that the written agreement include specified information regarding compensation, severance, and other benefits.

AB 2407 (Chesbro) of 2012 would have authorized various district hospitals and private, nonprofit hospitals in the County of Mendocino to enter into a joint powers agreement with the Northern California Health Care Authority. This bill failed passage in the Assembly Health Committee.

AB 2418 (Gordon and Dickinson) of 2012 would have required health care districts to expend 95% of any property tax revenue on current community health care benefits. This bill was held in the Assembly Appropriations Committee.

SB 804 (Corbett), Chapter 684, Statutes of 2012, requires health care districts to include, in an agreement transferring more than 50% of the health care district's assets, the appraised fair market value of any asset transferred to a nonprofit corporation.

AB 1303 (Wieckowski) of 2012 would have authorized St. Rose Hospital, a private, nonprofit hospital in the County of Alameda, to enter into a joint powers agreement with the Washington Township Healthcare District. This bill failed passage in the Senate Governance and Finance Committee.

AB 130 (Alejo), Chapter 92, Statutes of 2013, prohibits an employment contract between a healthcare district and a hospital administrator, on or after January 1, 2014, from authorizing retirement plan benefits to be paid prior to his or her retirement.

AB 678 (Gordon) of 2013 would have required a healthcare district that leases or transfers its assets to a corporation to conduct a community health needs assessment, and places new requirements on LAFCOs to consider these community health needs assessments in their municipal service reviews. This bill was held in the Senate Appropriations Committee.

AB 582 (Levine), Chapter 23, Statutes of 2014, enacts a statutory lien to secure certificates of participation issued by the Palm Drive Healthcare District.

SB 883 (Hancock), Chapter 691, Statutes of 2014, provides $3 million of special funds from the Major Medical Risk Insurance Fund to West Contra Costa County Healthcare District for the Doctor's Medical Center in San Pablo, California.

AB 2737 (Bonta), Chapter 421, Statutes of 2016, requires specified healthcare districts to spend at least 80% of their annual budget on community grants awarded to organizations that provide direct health services, and prohibits more than 20% of their annual budget from being spent on administrative expenses. The parameters of AB 2737 were established to address the Eden Township Healthcare District.

AB 2471 (Quirk) of 2016 would have required Alameda County LAFCO to order the dissolution of the Eden Township Healthcare District, if the District met specified criteria. This bill passed out of this Committee, but was placed on the inactive file in the Senate.

SB 957 (Hueso), Chapter 212, Statutes of 2016, allows healthcare districts that own or operate hospitals or clinics to use design-build contracting for the construction of those facilities.

SB 994 (Hill and Allen) of 2016 would have authorized, until January 1, 2022, the Beach Cities Healthcare District and the Peninsula Healthcare District to use the design-build process for the construction of facilities or other buildings in those districts. This bill passed the Senate and was never heard in the Assembly.