

The Economics of Land Use



Draft Report

Special Study: Mount Diablo Health Care District Governance Options

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1. INTRODUCTION

Mount Diablo Health Care District

Formation

The Mount Diablo Health Care District (MDHCD) was formed pursuant to Health and Safety Code Sec. 32000 in 1948 as the Concord Hospital District by the registered voters of the District. Following the formation of the Concord Hospital District in 1948, the District built and operated the Mt. Diablo Community hospital with funding provided by property taxes.

In 1994 (SB 1169) the State Legislature amended the enabling legislation renaming hospital districts to healthcare districts. The definition of healthcare facilities was expanded to reflect the increased use and scope of outpatient services. The legislation enacted a number of other substantial regulations governing the transfer of property, conflicts of interest, health care secrets and the public meeting act, lease agreements, the sale of property and assets.

Boundaries

The MDHCD boundaries include the cities of Martinez, Lafayette (portions), Concord, and Pleasant Hill (portions), along with the unincorporated communities of Clyde and Pacheco. **Figure 1** shows the current boundaries of the MDHCD. The MDHCD has evolved over the years both in terms of its physical boundaries and its organizational structure. Between 1967 and 1991, there were a number of boundary changes relating to MDHCD (i.e., annexations, detachments), as well as two proposals to dissolve the District in 1972 and 1976, both of which were denied by LAFCO. The City of Pleasant Hill attempted unsuccessfully on two occasions to detach from the District.

Financing

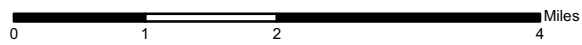
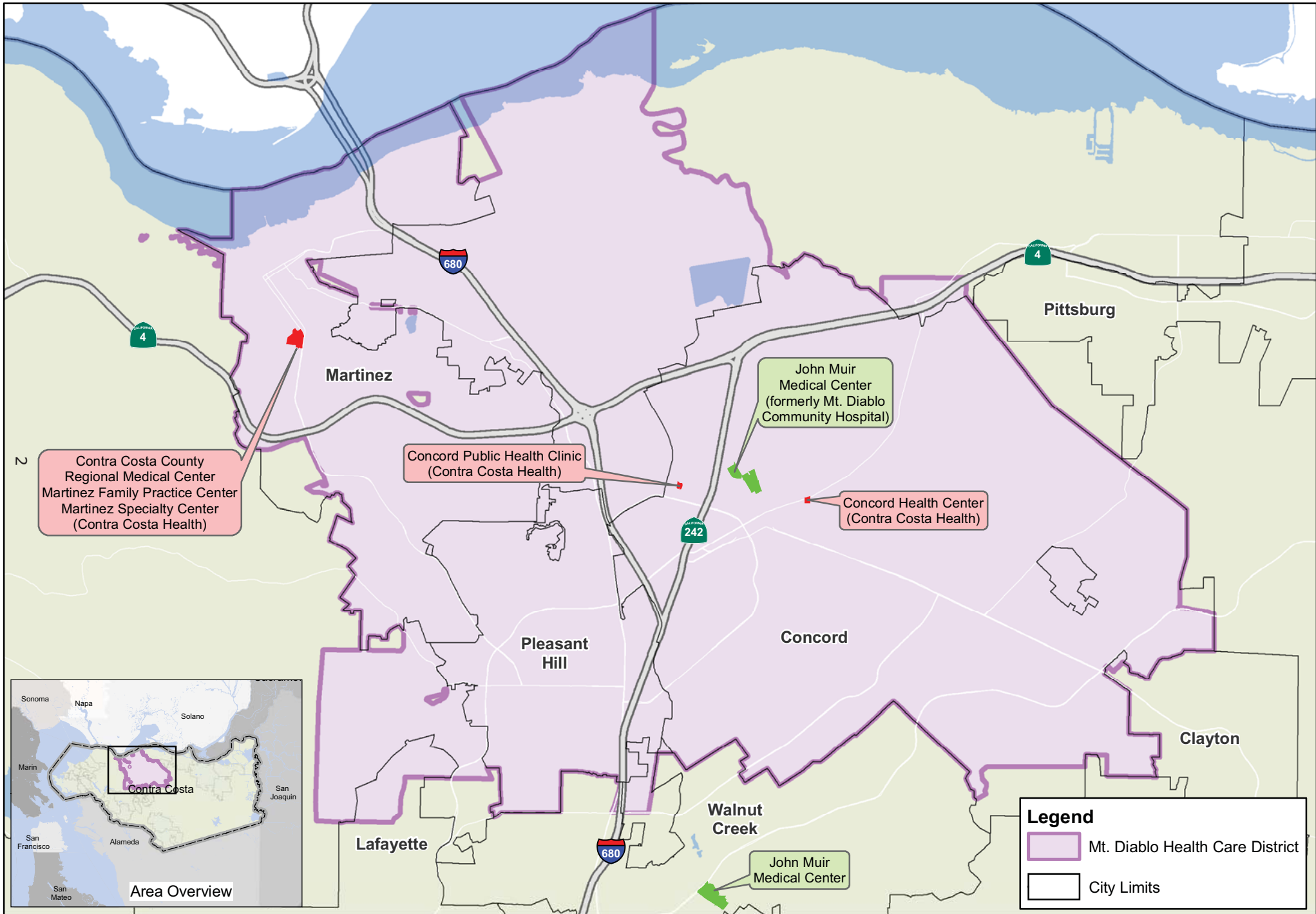
The MDHCD continues to receive property taxes to fund its operations. It currently receives approximately \$250,000 annually from taxable assessed value within its boundaries.

Other Relevant History

In 1996, MDHCD faced bankruptcy and entered into a Community Benefit Agreement (CBA) which transferred the assets of the District to John Muir Health (JMH) in exchange for certain assurances regarding health care services to be provided within the District.

The principal act for health care districts, Health and Safety (HSC) Code 32000, allows for transfer of district assets to either a private corporation or a nonprofit agency under certain conditions. HSC section 32121 (p) requires approval by the registered voters for the transfer of 50 percent or more of the district's assets. Measure MM was submitted to the voters on November 5, 1996. The measure requested approval of the merger of Mt. Diablo Medical Center and John Muir Medical Center. The transfer became effective when the voters approved Measure MM.

Figure 1 District Boundaries MDHCD Special Study



Map created 11/20/2011
 by Contra Costa County Department of Conservation and Development - GIS Group
 651 Pine Street, 4th Floor North Wing, Martinez, CA 94553-0095
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The MDHCD has been involved in lawsuits with John Muir regarding the provision of various services and facilities. During 2001 and 2002, MDHCD spent approximately \$739,000 on legal fees. The actions ultimately were settled.

In addition to the transfer of assets, the CBA also created the Community Health Fund (CHF); the CBA requires JMH to provide funding for CHF administrative expenses and to contribute \$1 million per year to fund CHF programs, grants and events that address health issues and promote a healthy community. In addition, the MDHCD Directors serve on the CHF Board (and/or appoint CHF Board representatives), along with JMH appointees, to participate in CHF allocations to health care needs within the District.

Purpose of the Study

LAFCO initiated this Special Study in response to past and ongoing community concerns about whether MDHCD should continue as a special district, and in response to recommendations of the Healthcare MSR adopted by Contra Costa LAFCO in 2007. The MDHCD was the subject of Grand Jury Reports in 2001, 2003, 2008 and 2011. The Grand Jury has been concerned that the District is no longer fulfilling a useful mission and should be dissolved. Other members of the community have called on LAFCO begin the process of dissolving the District.

Under Government Code (GC) §56375(a)(3), a commission may initiate the dissolution or consolidation of a district only if that change of organization or reorganization is consistent with a recommendation or conclusion of a study prepared pursuant to §56378 (special study), §57425, (SOI update), or §56430 (MSR). This is a Special Study undertaken pursuant to Government Code §56378. That statute requires that this study include an inventory of the agency and determine the maximum service area and service capacity.

Determinations Required to Dissolve or Consolidate Districts

Under §56881(b), if LAFCO initiates action to dissolve or consolidate a district the resolution making the determination must include both of the following determinations:

- a. That the public service costs resulting from a dissolution or change of organization would be less than or substantially similar to the costs of alternative means of providing the service.
- b. That a dissolution or change of organization would promote public access and accountability for the community services needs and financial resources.

This purpose of this study is to assist the Commission in evaluating whether it can make the required determinations.

Evaluation of Possible Changes of Organization

This Study evaluates the relative merits of the following potential actions by the Commission:

- a. Maintaining the status quo.

- b. Consolidation with another “like” or “unlike” district (i.e., formed under the same or different principal acts).
- c. Dissolution and appointment of a successor for winding up purposes only.
- d. Dissolution and appointment of a successor to continue health care services within the district.

The options are evaluated based on relative costs of providing service, public access and accountability, and other factors related to community acceptability and provision of comparable functions and services.

Process

The process for a change in organization includes several basic steps summarized below, pursuant to GC §57077. There may be some variations depending on what action, if any, LAFCO decides to take regarding future service in the dissolved district boundaries.

- a. At a noticed public hearing, the Commission accepts the special study, considers adopting a zero SOI to signal proposed dissolution and for consistency with SOI (GC §56375.5), considers making findings in accordance with the conclusion/recommendation of the special study and considers adopting a resolution initiating dissolution.
- b. LAFCO notifies State agencies per GC §56131.5 and allows a 60-day comment period.
- c. At a noticed public hearing, LAFCO considers approving dissolution.
- d. Following 30-day reconsideration period (GC §56895), LAFCO staff holds protest hearing in the affected territory (GC §57008). The protest hearing is a ministerial action. While the Commission is the conducting authority, it often designates the Executive Officer to conduct the hearing.
- e. Absent requisite protest, Commission orders dissolution after determining whether an election is required.
- f. If there is no election or the dissolution is approved by the voters, LAFCO staff records dissolution paperwork and files with the State Board of Equalization making dissolution effective.

Additional LAFCO actions are noted in subsequent chapters for each option evaluated.

2. SUMMARY OF FINDINGS AND RECOMMENDATIONS

In accordance with the requirements of GC §56378, this section summarizes those items to be included as part of a special study. These items are discussed in additional detail in subsequent chapters. This chapter also includes recommendations regarding change of organization.

1. *Inventory of the District*

Assets - The MDHCD has no physical assets, other than office equipment. MDHCD had approximately \$833,946 in fund balances at the end of 2010; the projected fund balance at the end of 2011 is \$480,000. This balance could be greater depending on actual expenditures, including whether MDHCD expends the \$418,000 budgeted for Community Action grants (\$55,000 has been spent, and another \$142,500 committed, as of October 31, 2011).

Debts – MDHCD will be liable for contract termination costs for the newly hired interim Executive Director.¹ The MDHCD's long-term liability consists of health insurance benefits provided to two directors (one current director, one former director). As described in more detail below, the present value of the health insurance liability, including all potential future payments, is estimated at more than \$800,000.² These benefits and their cost to MDHCD have been reduced by agreement with the two directors, beginning January 1, 2012. According to the MDHCD, there are no other long-term obligations or liabilities.³

2. *Maximum Service Area and Service Capacity*

The MDHCD current service area corresponds to its SOI, which is coterminous.

The MDHCD service capacity is limited primarily by its financial resources, which total approximately \$267,000 annually including property tax and John Muir contributions, in addition to use of any available fund balances. Administrative and overhead costs consume a majority of these resources, as described below, limiting the amount available to expand programs.

3. *District's Accountability for Financial Resources*

Funds Allocated to Health Care – From 2000 through 2011, approximately 26 percent of MDHCD expenditures have been allocated to its Community Action programs. In 2011, MDHCD budgeted about 80 percent of its expenditures to Community Action programs, although if no additional grants are funded in 2011 beyond the current \$55,000 expenditures (as of October 31), Community Action programs would total \$137,000 or about 53 percent of total expenditures.

¹ Reported to be \$10,000 if termination occurs within first six months.

² Actuarial Report, Zacarias Consultants, December 31, 2010; file: "MDHCD OPEB Report as of 12-31-2010.pdf"

³ Roy Larkin, MDHCD Secretary/Treasurer, email transmittal received by EPS 10/21/11.

2011 budgeted expenditures draw upon current fund balances. After those fund balances are substantially reduced, which could occur in about one year at current budgeted rates, MDHCD expenditures will be limited to current annual revenues of approximately \$267,000 including property tax and John Muir contributions. After deducting 2011 budgeted overhead costs of \$120,000 (including insurance benefits), approximately 55 percent would remain for Community Action funding. Overhead expenditures are likely to increase in 2012 with the addition of an interim Executive Director, with partial offsets resulting from expected reductions in health insurance benefit costs. In addition, election costs could add a cost of \$128,400⁴ in 2012, pushing overhead expenditures to about \$248,400 leaving only \$18,000 of annual revenue available for healthcare (before utilizing fund balances).

Funds Allocated to Purposes other than Health Care – From 2000 through 2011, approximately 74 percent of expenditures went towards overhead and administrative costs, including office staff, health insurance benefits, legal fees and election costs. As noted above, if current 2011 budget forecasts are realized, these expenditures would account for about 20 percent of the total. However, after fund balances are drawn down in a year, overhead and administrative costs could equal at least 45 percent of total expenditures (before accounting for increases in staff costs, reduced health insurance costs, and potential added legal costs in 2012). After adding election costs, overhead will consume nearly all of MDHCD's annual operating revenues (before including the use of any available fund balances).

4. District's Accountability for the Community Services Needs

The MDHCD is run by directors locally elected within the boundaries of the District. However, there have been instances where board seats were uncontested, resulting in no election, and instances where vacancies have been filled by appointment. The relatively small size of the MDHCD budget and minimal financial resources (after accumulated fund balances are utilized) limit its ability to undertake significant actions which would increase its visibility within the community, which otherwise might mitigate these issues.

In the event of a dissolution, potential successor agencies have established records of achieving accountability. These agencies include the City of Concord, County Service Area EM-1, and the Los Medanos Community Healthcare District.

5. Public Access to the District

MDHCD recently hired an Executive Director; the District anticipates that this action will help to remedy public accessibility issues, both recent and historic, i.e., compliance with open meeting laws, public records requests, development of a needs analysis and strategic plan, noticing requirements, use of an open and explicit grant process, and grant monitoring.

⁴ Estimated election cost based on 102,701 registered voters within the MDHCD boundaries as of June 24, 2011, and a cost of \$1.25 per voter (Contra Costa County Elections Department). If a measure to dissolve the District is also on the ballot there would be an additional \$25,675 cost.

6. Public Costs and/or Savings Resulting from Dissolution or Consolidation as Compared to Maintaining the Status Quo

Dissolution without any further continuation of service would substantially eliminate annual expenditures of about \$267,000 (before accounting for the use of fund balances). Annual expenditures for ongoing health insurance benefits will remain for the life of each of the two benefiting directors; these expenditures currently are about \$45,000 annually, with a total estimated liability of \$800,000. Recent reductions of \$17,420 negotiated by the MDHCD have reduced these annual expenditures to about \$27,580.

Dissolution with the appointment of a successor to continue services is likely to result in annual savings of approximately \$75,000, which is the amount currently spent by MDHCD on overhead and administration (not including health insurance costs, or future increases in staff costs and potential legal charges). These administrative savings would be available for healthcare purposes. Potential successor agencies for continuation of services are expected to be able to continue to provide services through the use of existing staff. Annual obligations for ongoing health insurance benefits would continue, as noted above.

Recommendations

1. Justification exists for dissolution of MDHCD, considering that over the past ten years only 26 percent of MDHCD's expenditures have been applied towards community health care purposes.

From 2000 through 2007, virtually no funds were spent for community health care purposes. While the MDHCD recently has undertaken efforts to increase allocations to community health care, reduce insurance costs, and hire professional staff to implement a strategic plan, the latter action will also increase administrative costs and not necessarily result in additional community health programs or services.

After the MDHCD has drawn down its fund balances, overhead expenses will account for 45 percent or more of total expenditures. Potential insurance cost savings are unlikely to offset added costs for an Executive Director.

2. Dissolution with appointment of CSA EM-1 as successor for continuing service provides the ability to reduce costs and increase public accountability and access.

Creation of a zone within CSA EM-1, and appointment of an advisory board, would be one way to enable the continuation of services. This option would reduce existing overhead costs, since CSA EM-1 should be able to provide services without any significant increase in their current costs.

3. Organizational options exist that could better utilize existing MDHCD resources.

In addition to the "status quo" and "dissolution", this Special Study considers consolidation with other entities, including the Los Medanos Community Healthcare District (LMCHD). These options could provide comparable services at lower cost relative to the "status quo". Other agencies, public and private, provide similar services within the District boundaries. Both public and private agencies are currently providing health care services that duplicate the programs the MDHCD is presently funding.

4. If reorganization occurs, evaluation of options favors dissolving MDHCD and naming the existing CSA EM-1 as the successor agency. CSA EM-1 is under the oversight of the County of Contra Costa and management of County Health Services Department.

This option could substantially eliminate existing MDHCD administrative costs (with the exception of commitments to lifetime healthcare benefits). County Health Services Department has the administrative and professional staff to manage the use of current MDHCD resources and take over MDHCD functions.

Public access and accountability would be promoted by use of existing County governance and management structure, creation of a zone to assure the use of funds for health care needs within the existing MDHCD boundaries, and establishment of an advisory board consisting of knowledgeable, experienced professionals and members of the community. LAFCO could condition the transfer of property tax revenues on the implementation of the zone.

5. CSA EM-1, through the County's Health Services Department, could take over the District's obligations under the CBA.

CSA EM-1 could work with John Muir to monitor the agreement and its terms, appoint members to the board of the CHF to continue participation in CHF allocations of \$1 million annually, and assume other aspects of the agreement. The County would assure that obligations of the MDHCD, including payment of lifetime health insurance benefits to two directors, were met through the use of MDHCD reserves and property tax revenues.

3. HEALTHCARE DISTRICTS

Health Care Districts in California

California at the end of World War II faced a shortage of hospital beds and acute care facilities, especially in rural areas of the state. In 1945 the legislature enacted the Local Hospital District Law⁵ to establish local agencies to provide and operate community hospitals and other health care facilities in underserved areas, and to recruit and support physicians. In 1993 the State Legislature amended the enabling legislation renaming hospital districts to healthcare districts. The definition of healthcare facilities was expanded to reflect the increased use and scope of outpatient services.

In total, 82 healthcare districts in California provide a variety of services. Some of the characteristics are displayed in **Table 1**. The table shows that 30 districts do not operate hospitals, five provide ambulance service, and 29 are located in rural areas. Many districts have been dissolved, and/or transferred ownership or operation of facilities to other entities.

As further described in the MSR, the healthcare industry “in general is going through changes, many of which are financially driven. Hospitals and their medical staffs are experiencing declining public financing through MediCal and Medicare. Costs for construction and personnel are rising, and the overall emphasis by consumers and their medical providers for expensive technologies are driving costs up. In addition, human resources gaps at all health provider levels threaten the stability of providers in the provision of services, especially hospitals when attempting to staff beds. Other unique legislative parameters also face California hospital providers. California remains the only state with required nurse staffing ratios, and hospitals are continuing to grapple with the State-mandated seismic retrofit requirements due to impact the hospitals as early as 2013.⁶

Dissolution of hospital/healthcare districts has been considered in the past in Contra Costa County. The dissolution of the LMCHD was considered in 1999, but never completed. Other districts in Fresno, Sierra, and Plumas counties have been closed and consolidated into other districts.

⁵ Health and Safety Code section 32000 et seq.

⁶ Excerpted from the Public Healthcare Services MSR, 2007.

Table 1 Overview of Healthcare Districts in California

Statistic	Number
Healthcare Districts in California	82
Counties with Healthcare Districts	40
Counties with multiple Healthcare Districts	19
County with most healthcare districts	Kern (7)
Rural healthcare districts	29
Healthcare districts without hospitals	30
Districts providing ambulance service	5
Districts that have declared bankruptcy	4
Districts that are dissolved or otherwise reorganized	5

Source: ACHD 2011

Health care districts are commonly funded through a share of property taxes and by grants from public and private sources. Health care districts are special districts with the typical powers of a district such as the authority to enter into contracts purchase property, issue debt and hire staff. Under the HSC⁷ health care districts may provide the following services:

- Health facilities, diagnostic and testing centers, and free clinics
- Outpatient programs, services, and facilities
- Retirement programs services and facilities
- Chemical dependency services, and facilities
- Other healthcare programs, services, and facilities
- Health education programs
- Wellness and prevention programs
- Support other health care service providers, groups, and organizations
- Ambulance or ambulance services
- Participate in or manage health insurance programs

Public health care agencies within the MDHCD that provide services similar to those authorized for health care districts are described in the following section.

⁷ HSC Section 32000 et seq

Current Public Health Care Providers in MDHCD Service Area

Within the boundaries of the MDHCD, public health care services are provided by several public and private agencies. **Table 2** shows the public agencies that provide those services relative to the MDHCD, and which have been considered as part of potential reorganization of the MDHCD. In addition, there are a number of private, nonprofit organizations providing health care and related services. Broader medical services are provided by private doctors, clinics and the major hospitals serving the area.

Table 2

HCD Authorized Services Provided by Selected Public Agencies in Contra Costa County

Service	Agency and Services Provided			
	MDHCD	LMCHD	Contra Costa Cnty	EM-1
Health facilities, diagnostic and testing centers, free clinics, and services	None	Owns Pittsburg Health Center, which it leases to Contra Costa Health Services	Contra Costa Regional Medical Center and Family Practice Center/Martinez Specialty Center in Martinez; Concord Health Center and Public Health Clinic in Concord	None
Outpatient programs, services, facilities	None	None	Outpatient services provided at Martinez Family Practice and Center Concord Health Center	None
Retirement programs, services, facilities	None	None	CCHS Public Guardian Program; CCHS Senior Nutrition Program; Geriatric Consultation Team	None
Chemical dependency programs, services, facilities	None	None	Addiction medical services available at Concord Health Center and Martinez Family Practice Center	None
Other health care programs, services, facilities	Provides defibrillators to community facilities	Monitors legislation, participates in HCA activities, & policy briefings	Broad range of other health care programs, services and facilities (see www.cchealth.org/services/)	None
Health education programs	Provides CPR materials to train High School Students (w/County Health)	Website provides links to educational events and healthcare information and resources	Provides public education materials, CPR training (w/MDHCD)	Defibrillator Program provides information on developing programs; CPR & defibrillator training to 1st responders
Wellness and prevention programs	Grant programs	LMCHD Health & Wellness Funding Program provides services & grants	Community wellness and prevention programs	None
Support other health care service providers, and organizations	Grant programs; participates in Community Health Fund with JMH	Provides grant funding to community health programs	Provides information for other health care providers on various health related topics i.e. avian flu, west nile virus, nail salons	Coordinates all EMS activities in Contra Costa County,
Ambulances or ambulance services	None	None	As Local Emergency Medical Services Agency, County Health provides direction, planning, and monitoring for pre-hospital EMS system	EM-1 contracts for ambulance service, provides EMS 1st responder training, communications, Haz Mat Program
Participate in or manage health insurance programs	None	None	Contra Costa Health Plan	None

4. MOUNT DIABLO HEALTH CARE DISTRICT

The MDHCD boundaries encompass a population of approximately 204,700 residents, as shown in **Table 3**. The total assessed valuation within the MDHCD is \$25.9 billion.

Table 3 MDHCD Assessed Value and Population by Jurisdiction

Jurisdiction within MDHCD	MDHCD			
	Assessed Value	%	Population	%
Concord	11,541,837,426	44.5%	119,859	58.5%
Martinez	4,214,778,686	16.2%	35,538	17.4%
Walnut Creek (portion)	10,120,279	0.0%	66	0.0%
Pleasant Hill	4,386,936,836	16.9%	33,152	16.2%
Clayton (portion)	19,328,121	0.1%	28	0.0%
Lafayette (portion)	<u>190,157,016</u>	<u>0.7%</u>	<u>728</u>	0.4%
Subtotal, Incorporated	20,363,158,364	78.5%	189,371	92.5%
Unincorporated	5,578,655,447	21.5%	15,344	7.5%
TOTAL MDHCD	25,941,813,811	100.0%	204,715	100.0%

Source: Contra Costa County Auditor-Controller (Rpt. EA3211, proc. 8/1/11) for FY11-12
Includes land, improvements, personal property, and local exemptions.

As stated in the MSR, the MDHCD Board sees its role as being: 1) an overseer of the CBA and monitoring District assets that have been transferred to John Muir, 2) promoting community health improvement, 3) facilitating community health partnerships, 4) advocating for the community's interests, and 5) serving as a liaison from the community to the JMH Board. The MDHCD has undertaken various Community Action programs and awarded grants in furtherance of its mission. These functions are described further in this chapter, as well as the related expenditures, sources of funding, assets and liabilities.

Monitoring of Community Benefits Agreement

In exchange for the facilities and equipment transferred from MDHCD to John Muir (referred to as the “System” in the CBA), the CBA requires the System to agree to a number of terms. Key terms include the following:⁸

1. Operate and maintain District’s health care facilities and its assets for the benefit of the communities served by the District,
2. Maintain basic emergency services at the Hospital and Medical Center,
3. Maintain acute care hospital licenses for the Hospital and Medical Center, and
4. Establish and operate a Community Benefit Corporation.⁹

The MDHCD monitors those key terms to assure compliance by the System.

Participation in Community Health Fund

In the CBA, the System agreed to transfer \$1 million annually (or more, at its discretion) to the CHF, and up to \$200,000 for administrative expenses, to fund unmet community healthcare needs within a defined service area.¹⁰ The service area of the CHF encompasses most of eastern Contra Costa County, an area much broader than the MDHCD boundaries (see **Attachment A**). Five members of the 10-member board of directors are appointed by MDHCD.

Since inception in 1997 through 2010, the CHF has granted over \$20 million to local health care projects and collaborative health initiatives. Initiatives include increased access to dental care, expansion of services to an aging population, women’s cancer services, and an initiative integrating behavioral health care with primary care at clinics in central and east Contra Costa.¹¹

Community Action Program (Grants and Other Programs)

The MDHCD website includes a list of focus areas and funding priorities, which it identifies as its “Strategic Plan”. The Strategic Plan’s five categories are healthy lifestyle, health services, health access, support services, and workforce development. The Plan contains no further information or analysis regarding health needs within its service area, specific goals or targets for addressing those needs, or strategies for achieving goals. The MDHCD recently hired an Interim Executive

⁸ Article 7, Sections 7.1-7.4 and 7.7, Community Benefit Agreement by and between Mt. Diablo Health Care District and John Muir Medical Center, August 9, 1996.

⁹ Also referred to as the “Community Health Corporation”.

¹⁰ Section 5.6, Attachment 2.5 (System Bylaws) to the Community Benefit Agreement

¹¹ Fact Sheet for the Community Health Fund, John Muir/Mt. Diablo Community Health Fund, 10/25/11.

Director who will be responsible for developing and implementing a strategic plan for addressing unmet health needs.¹²

The MDHCD has provided grants to numerous community organizations which fit within their targeted categories. During 2011 (through October 31), the MDHCD spent \$55,000 on grants, and committed another \$142,500.¹³ An additional \$284,960 in grant requests are under review. The MDHCD budgeted, and has spent, approximately \$80,000 in 2011 for its “CPR Anytime” program, which provides CPR kits to high school students. MDHCD budgeted to spend nearly \$500,000 in 2011, including its grants and CPR program.

The MDHCD has provided CPR kits as a part of CPR training program for high school students, in association with the American Red Cross and Contra Costa Public Health. In 2011 MDHCD spent approximately \$80,000 to support the program.

MDHCD Financial Resources

Table 4 shows annual revenues to the MDHCD from 2000 to the present.

Operating revenues projected for 2011 total \$266,700. The District is funded primarily by property tax revenues (ad valorem). The 2011 budget included \$239,000 in property tax revenues, which represent approximately 90 percent of annual operating revenues. An additional \$25,000 is budgeted from payments from John Muir pursuant to the Community Benefits Agreement. Another \$2,700 of income was budgeted from interest earnings.

The 2011 budget also included \$833,946 in beginning fund balances from the prior year, consistent with the amount reported by the MDHCD 2010 Financial Report (pg. 10). The fund balance accumulated during periods when MDHCD was not funding its Community Action program (less than \$1,000 was spent on Community Action programs from 2000 through 2007), or during years in which it spent less than it received in annual revenues. These fund balances are in cash or other short-term (three months or less) investments. By the end of the current year, the ending fund balance is projected to decline to \$480,000,¹⁴ depending on grant activity in the remainder of the year, and any additional staff hiring and legal expenses.

Property Taxes

As shown in **Table 4**, property tax represents about 90 percent of MDHCD revenues. Over the past twelve years, revenues peaked at \$291,000 in 2007, then declined to the current budgeted \$239,000.

Although assessed value within the MDHCD totals about \$25.9 million, substantial areas within the MDHCD boundaries do not contribute incremental increases in property tax growth (or

¹² MDHCD posting 10/24/11.

¹³ “Mt. Diablo Community Outreach Commitments, October 31, 2011”

¹⁴ “Budget vs. Actual, January 1, 2011 to October 31, 2011”, Mt. Diablo Health Care District

decline) to the MDHCD. Those areas do not show any Tax Increment Allocation Factors, which allocate incremental changes in property tax to specific entities serving the corresponding area. A review of Tax Rate Areas (TRAs) within the MDHCD show that substantially all of the TRAs within the City of Concord contribute incremental property tax to the MDHCD, as well as nearly all of the parcels within the City of Pleasant Hill and unincorporated areas to the north of Concord. However, none of the TRAs within the City of Martinez contributes, nor do certain unincorporated areas to the east of Martinez.

Table 4 Summary of MDHCD Revenues (2000 to Present)

Year	REVENUES			TOTAL
	Property Tax	John Muir Grants	Other Income	
2000	\$149,154	\$25,000	\$17,586	\$191,740
2001	157,037	25,000	1,459	183,496
2002	181,724	25,000	(11,012)	195,712
2003	194,215	25,000	50,435	269,650
2004	203,594	25,000	8,189	236,783
2005	223,369	25,000	18,500	266,869
2006	255,649	25,000	15,989	296,638
2007	290,638	25,000	17,274	332,912
2008	276,694	165,600	10,339	452,633
2009	267,630	25,000	8,635	301,265
2010	226,550	25,000	15,254	266,804
2011*	239,000	25,000	2,700	266,700
TOTAL	\$2,665,254	\$440,600	\$155,348	\$3,261,202

* Estimate for 2011, source: "Budget vs. Actual, Jan. 1, 2011 to Oct. 31, 2011".

A number of factors may have contributed to the absence of increment allocations to the MDHCD. For example, at the time that AB8 created increment factors (in 1979, to implement Prop. 13), MDHCD may not have been collecting property taxes from certain areas within its boundaries; therefore, no increment factor would have been created. Another factor may be that MDHCD was not allocated a share of property taxes when parcels were annexed to MDHCD. A separate study would be necessary to audit these historical factors, and the conclusions of that study would not necessarily change any current allocations or amounts of property tax to MDHCD.

Contributions from John Muir Health

Pursuant to the CBA, JMH contributes \$25,000 annually to MDHCD to help fund administrative expenses. In 2008, JMH provided additional funding to pay for a grants consultant to help MDHCD establish grant criteria and process, including a system for reporting and monitoring of grants. A review of recent MDHCD minutes and public documents does not indicate that a criteria and review process, or monitoring system, is currently active.

Other Revenues

The MDHCD receives miscellaneous other revenues, primarily interest earnings on deposits.

Other Assets - Property

As a part of the CBA, the MDHCD transferred ownership of all hospital assets, including land, buildings and equipment, to JMH (referred to as the "System" in the CBA). Section 1.4 of the CBA states (as excerpted):

"1.4 District Assets. On the Closing Date, subject to the terms and conditions of this Agreement, District shall assign, grant, convey, transfer and deliver to System, and System shall accept from District, all of District's right, title and interest in and to all of the assets and properties owned by District, of every kind, character and description, whether tangible, intangible, personal, or mixed, and wherever located including.....

(l) Mt. Diablo Medical Center. All rights and title in and to the land and buildings described on Exhibit 1.4(l) ("Hospital Land" and "Hospital Buildings", respectively) and all permanent fixtures and improvements to such Hospital Land and Hospital Buildings;..."

Measure MM, which was passed by MDHCD voters on November 5, 1996, approved "the transfer of District assets" in accordance with the CBA and resolution by the MDHCD. The transfer of real property from MDHCD to "John Muir Medical Center" is also documented in the grant deed recorded December 31, 1996. The transfer of ownership was consistent with HSC 32121; had the transfer occurred as a lease, it would have been subject to a 30-year maximum term rather than the current 50-year term (plus extensions), and would not have included the provisions for reversion of assets which are part of the CBA.

Cash and Other Liquid Assets

At the beginning of 2011, MDHCD reported \$833,946 in fund balances according to the MDHCD 2010 Financial Report (pg. 10). These fund balances are in cash or other short-term (three months or less) investments. The fund balance accumulated during periods when MDHCD was not funding its Community Action program (less than \$1,000 was spent on Community Action programs from 2000 through 2007), or during years in which it spent less than it received in annual revenues.

By the end of the current year, the ending fund balance is projected to decline to \$480,000,¹⁵ depending on grant activity in the remainder of the year, and any additional staff hiring and legal expenses.

Expenditures

Table 5 shows MDHCD expenditures since 2000, up through the current 2011 budget year. Overhead and administration, including insurance benefits, accounted for nearly all of the expenditures until the last four years. On average over the twelve-year period, about 74 percent of expenditures were for non-Community Action expenditures. In 2011, the ratio is projected to be 19.4 percent, assuming that the MDHCD achieves its projected grant allocation of \$500,000 for the current year.

Overhead and Management

MDHCD currently employs one part-time office employee to assist with administrative duties. In addition, the District recently hired an interim part-time Executive Director. Board members are paid a stipend, and undertake various overhead and administrative tasks. The MDHCD engaged an attorney in 2011, and recently hired an interim Executive Director. The MDHCD maintains a website. One current board member also receives health insurance benefits (see “Liabilities”, below), and MDHCD provides health insurance benefits to one former board member.

MDHCD expenditures for overhead and management costs (including Director’s stipends, post-retirement benefits, administration, and website) totaled \$120,703 in the 2011 budget (revised as of October). This represents approximately 20 percent of operating expenditures (excluding reserve allocations).

From 2000 through 2011, approximately 74 percent of expenditures went towards overhead and administrative costs, including office staff, health insurance benefits, legal fees and election costs. As noted above, if current 2011 budget forecasts are realized, these expenditures would account for about 20 percent of the total. However, after fund balances are drawn down in a year, overhead and administrative costs could equal at least 45 percent of total expenditures (before accounting for increases in staff costs, reduced health insurance costs, and potential added legal costs in 2012). After adding election costs, overhead will consume nearly all of MDHCD’s annual operating revenues (before including the use of any available fund balances).

¹⁵ “Budget vs. Actual, January 1, 2011 to October 31, 2011”, Mt. Diablo Health Care District; ending 2011 balance based on 2011 budgeted expenditures of \$418,000 for Community Action funding. As of October 31, Community Action expenditures totaled \$55,000 on a cash basis (commitments totaled \$142,500 as of October 31).

Table 5 Summary of MDHCD Expenditures (2000 to Present)

Year	EXPENDITURES						Ending Balance
	Overhead & Admin.	Medical/Dental Insurance	Subtotal	% of Total	Community Action	TOTAL	
2000	\$119,066	\$27,010	\$146,076	99.7%	\$403	\$146,479	**
2001	603,852	31,249	635,101	99.9%	500	635,601	**
2002	517,713	38,527	556,240	100.0%	0	556,240	**
2003	71,521	53,974	125,495	99.9%	87	125,582	**
2004	62,642	27,978	90,620	100.0%	0	90,620	**
2005	178,080	33,717	211,797	100.0%	0	211,797	244,596
2006	103,866	41,190	145,056	100.0%	0	145,056	396,178
2007	170,462	38,103	208,565	100.0%	0	208,565	520,525
2008	70,060	34,959	105,019	33.2%	211,000	316,019	657,139
2009	42,347	34,990	77,337	75.1%	25,683	103,020	855,384
2010	53,301	44,937	98,238	43.5%	127,827	226,065	833,946
2011*	75,703	45,000	120,703	19.4%	499,943	620,646	480,000
TOTAL	\$2,068,613	\$451,634	\$2,520,247		\$865,443	\$3,385,690	
	61%	13%	74%		26%	100%	

* Estimate for 2011 from "Budget vs. Actual, Jan. 1, 2011 to Oct. 31, 2011", except as indicated below. 2011 Programs & Grants based on budget; amount spent through October approx. \$250,000. 2011 Ending balance based on prior end of year plus projected 2011 contributions to reserves. Note: Ending balances don't equal prior balance plus annual change due to additional accrual adjustments in financial statements.

** MDHCD adopted GASB accounting methods in 2004; ending fund balances were negative through 2004. Insurance on cash basis; prior years also included "Net periodic post-retirement" included in the "Overhead & Admin." category for purposes of this table. 2002 included \$326,941 in legal fees, in 2001 legal totalled \$412,203

Community Action Program (Grants and Other Programs)

From 2000 through 2007, Community Action Program expenditures totaled less than \$1,000. Approximately \$365,000 was spent in 2008 through 2010.

During 2011 (through October 31), the MDHCD spent \$55,000 on grants, and committed another \$142,500.¹⁶ An additional \$284,960 in grant requests are under review. The MDHCD budgeted, and has spent, approximately \$80,000 in 2011 for its "CPR Anytime" program, which provides CPR kits to high school students.

¹⁶ "Mt. Diablo Community Outreach Commitments, October 31, 2011"

Liabilities

The MDHCD's only long-term liability consists of health insurance benefits provided to two directors (one current director, one former director). As described in more detail below, the present value of the health insurance liability, including all potential future payments, is estimated at more than \$800,000.¹⁷ These benefits and their cost to MDHCD have been reduced by agreement with the two directors, beginning January 1, 2012. According to the MDHCD, there are no other long-term obligations or liabilities.¹⁸

Lifetime Health Insurance Benefits

Government Code Section 53201(b) allows public agencies to provide health insurance benefits to former elective members of the legislative body who served in office after January 1, 1981, and whose total service at the time of termination was not less than 12 years. This allowance was discontinued by GC §53201(c) which disallows those benefits to any person first elected to a term of office that begins on or after January 1, 1995.

Currently, one former Board member and one current Board member are receiving health insurance benefits paid by MDHCD. These benefits are projected to cost approximately \$45,000 in 2011 (Budget vs. Actual, January 1, 2011 to October 31, 2011). An actuarial report prepared for MDHCD (Zacarias Actuarial Consultants, April 14, 2011) estimated a pension liability of \$806,649 as of the end of 2010. This amount represents a present value of all future payments for the provision of these health care benefits.

A resolution adopted by MDHCD at its meeting November 15, 2011, accepted proposals from its two directors that would reduce current costs to the MDHCD. The two directors reserved their right to receive current levels of benefits in the future.

According to the resolution, one of the directors (Grace Ellis, current Director) is in the process of applying for PERSCare Supplemental/Managed Medicare, plan code 1322 at a monthly cost of \$865, or an annual total of \$10,380. This is compared to the current monthly cost of approximately \$1,900, or current total annual cost of \$22,800. The annual savings to MDHCD is more than half of the current cost for this director, or a savings of about \$12,420 annually. Ms. Ellis also agreed to evaluate less expensive dental coverage.

The other person (Ron Leone, former director) currently receiving health insurance benefits, has agreed to obtain alternative coverage if the MDHCD reimburses him approximately \$580 per month, or about \$7,000 annually (potentially including dental and vision). The current monthly MDHCD cost for this director is approximately \$22,000 annually, so the reduction would be an annual savings of about \$15,000.

¹⁷ Actuarial Report, Zacarias Consultants, December 31, 2010; file: "MDHCD OPEB Report as of 12-31- 2010.pdf"

¹⁸ Roy Larkin, MDHCD Secretary/Treasurer, email transmittal received by EPS 10/21/11.

Facilities

Office space is provided to the MDHCD by JMH at no cost. The MDHCD has no other facilities.

5. PRIOR LAFCO AND OTHER REVIEWS OF MDHCD

The MDHCD has been the subject of multiple reviews, including a LAFCO MSR,¹⁹ Grand Jury reports,²⁰ and other community review and comment (e.g., Contra Costa Taxpayers Association). This chapter summarizes key comments from those reviews.

Public Healthcare Services Municipal Service Review

The Public Healthcare Services MSR focused on the healthcare services provided by agencies under LAFCO's purview, including the three health care districts: LMCHD, MDHCD, and West Contra Costa Healthcare District. The MSR, which is required by State law, provides a comprehensive review of the delivery of municipal services provided in the county.

In summary, the MSR identified a number of key issues and made the following determinations for the MDHCD. Where applicable, these determinations have been updated with more recent information.

- **Growth and Population** - The MSR expected the population within the MDHCD service area to reach 281,000 by 2035. The current population is approximately 205,000 according to the 2010 census.
- **Infrastructure Needs or Deficiencies** - As described in the MSR, the MDHCD does not own or manage any facilities. Per the terms of the 1996 CBA with JMH, all rights and title to the District's assets, including the Mt. Diablo Community Hospital, transferred to JMH. In February 2007, JMH approved a \$170 million expansion of this campus, including a cardiovascular institute and expanded emergency room.

The MSR identified significant healthcare issues, unmet needs, and underserved populations within the MDHCD service area. However, because of the District's financial condition, the District was not funding any healthcare services or programs at the time of the MSR, a deficiency which the MSR said could be addressed by refocusing MDHCD efforts from oversight of the CBA towards supporting healthcare services and programs. In recent years, including 2011, MDHCD has increased its spending on healthcare grants and programs relative to prior years reviewed by the MSR.

- **Financing Constraints and Opportunities** - The MSR identified MDHCD financial constraints that limited the District's ability to fund healthcare services and programs; 43 percent of its 2006 revenues were budgeted for election and audit expenses and 22 percent to Board-related expenses. In addition, the MSR described a \$760,037 unfunded liability associated with lifetime healthcare benefits for board. In the most recent 2011 budget year, MDHCD budget 19 percent of its revenues for administration and health benefits, although this percentage could more than double if MDHCD does not achieve its grant targets.

¹⁹ 2007

²⁰ 2001, 2003, 2008 and 2011

The current unfunded healthcare benefit liability was approximately \$800,000 at the end of 2010; however, this could be significantly reduced if MDHCD reduces its benefit obligations (see next item).

- **Cost Avoidance Opportunities** – The MSR recommended that the MDHCD should pursue opportunities to participate in Joint Powers Insurance Agreements and other programs to reduce liability and medical insurance costs. Currently, MDHCD provides health insurance benefits through CALPERS; MDHCD is in the process of considering revisions to the lifetime health benefits it provides to two directors, with the goal of reducing these costs.
- **Opportunities for Rate Restructuring** – The MDHCD does not charge fees for service as they are not directly providing services.
- **Opportunities for Shared Facilities** – The MSR explained how the MDHCD participates in the decision-making process for grants provided through the John Muir/Mt. Diablo Community Health Fund. It also identified opportunities for the District to leverage its resources to support the new health center being opened by the County in the area. The MDHCD currently is considering grants to La Clinica.
- **Evaluation of Management Efficiencies** – The MSR described how the MDHCD operated under the direction of the Board of Directors with one part-time staff. Recently, the MDHCD hired an interim Executive Director to help develop and implement its strategic plan and address other recognized procedural issues.
- **Government Structure Options** – The MSR identified a number of options for re-organization, which would require further study, but did not make a recommendation. The MSR also indicated that LAFCO could maintain the status quo, and require progress reports from MDHCD. **Chapter 6** in the current study describes these and other options in greater detail.
- **Local Accountability and Governance** – The MSR did not identify any issues or concerns; it indicated that the districts encourage public participation and make documents available, hold open and accessible public meetings, and that recent elections were contested, evidence of public interest in the health care organizations. However, the last two MDHCD elections have been uncontested.

Grand Jury Reports

Dissolution of the MDHCD has been the subject and recommendation of four Grand Jury reports in 2001, 2003, 2008 and 2011. The Grand Jury reports have repeatedly raised the same concerns as summarized below:

- MDHCD does not own or operate any health care facility nor provide assistance in the operation of health facilities nor any other medical services to its constituents
- Pursuant to the CBA, MDHCD has limited duties to a) perpetuate itself as the body to reclaim the assets the District transferred in the merger, should that merger fail; b) approve payments from two pension funds to former District employees; c) nominate five members to

the board of the JMH/Mt. Diablo Health Benefit Corporation; and d) accept or reject (but not nominate) eight of the 16 JMH/Mt. Diablo Health System Directors.

- The primary source of revenue for the MDHCD is property tax revenue which is largely used to support the District's own administrative and operating expenses including lawyers, accountants, election costs, and the Board's medical benefits.
- Since the merger, the MDHCD has had little success and continues to search for some tangible health-related activity to perform. Instead of being directly involved in managing and overseeing healthcare programs, the District Board functions more as administrators and grant allocators.

These issues and related recommendations are further described in the LAFCO staff transmittal to the LAFCO board May 11, 2011 related to Agenda Item 11.

Other Reviews

LAFCO received correspondence from the Contra Costa Taxpayers Association expressing concerns with the MDHCD, and requesting that LAFCO begin the process to dissolve the District.²¹ The Association raised issues related to primary use of MDHCD revenue to support administrative costs; ongoing fiscal issues including granting of life-time health insurance benefits, lack of financial procedures, and alleged embezzlement; frequent board turnover and perennial internal disputes; lack of professional staff; and ongoing disputes with JMH which consume resources.

²¹ Correspondence received by LAFCO, May 2, 2011 (see Attachment A to LAFCO May 11, 2011 agenda (Item 11)).

6. GOVERNANCE OPTIONS

In August 2007, LAFCO completed the *Public Healthcare Services Municipal Service Review*. The MSR report identified four government structure options for MDHCD to respond to issues identified in the MSR.

Subsequent analysis eliminated the MSR option of “Formation of a Subsidiary District” because the creation of a subsidiary district from the MDHCD does not meet legal criteria. GC §57105 requires that the MDHCD be entirely contained within a city, or that the city contain both 70 percent of the land area and 70 percent of the registered voters. The area of the district is much larger than any of the cities it serves and the population is not concentrated in any one city.

The options evaluated in this report include:

- Maintain Status Quo
- Consolidation (of like and unlike districts) and/or creating a new district
- Dissolution with appointment of successor only for the purpose of winding up MDHCD affairs
- Dissolution with appointment of successor for continuing service

These options are compared and evaluated in the following sections and are summarized on **Table 6**. Specific aspects of the LAFCO process which differ from the basic steps described in **Chapter 1** are summarized.

CEQA

Dissolution will first require the creation of a zero sphere. The zero sphere signals LAFCO’s intent to dissolve the district. This action qualifies for a general exemption from CEQA review since establishing a zero sphere will not result in a change in regulations, land use or development.

Maintain Status Quo

This option would continue to allow the MDHCD to exist and function under its current organization. The MDHCD would continue its oversight of the Community Benefits Agreement and participation on the Community Health Foundation Board which allocates in excess of \$1 million annually provided by JMH to address various community health needs.

Table 6
Governance/Agency Options

Governance Option	Description	Advantages	Disadvantages
Status Quo	No change to existing MDHCD.	MDHCD recently hired interim Exec. Director who could improve operations, public accountability & access.	MDHCD at risk of continuing past practices, including lack of activity and high expenditures for overhead.
Establish Subsidiary District	Does not qualify since 70% of the territory and 70% of the population are not within the city boundary.	NA	NA
Consolidation MDHCD and LMCHD	Unite two or more districts into a single new successor health care district.	Existing territory served by MDHCD would continue to be served by successor district. Revenues of the two districts could be used to enhance services of the combined district Successor district provides similar services. Economies of scale result in reduced administrative costs.	Revenues generated by MDHCD taxpayers would be expended for benefit of all residents of new, larger district, reducing benefits to existing MDHCD taxpayers. Likely political opposition to consolidation due to differing communities of interest. Reduced local representation.
Dissolution Successor for the purpose only to wind up affairs of MDHCD	Existing district ceases all functions and services. The City of Concord statutorily qualifies as successor for the purpose of winding up affairs, or CSA EM-1 could be designated as successor.	Elimination of MDHCD admin. expenses. Existing MDHCD property tax revenues revert to other agencies (after payment of MDHCD obligations).	No further provision of current MDHCD health-related services, & its property tax no longer available for health care purposes. Loss of CBA provisions, including oversight of facilities and licenses, and participation in CHF grant process.
Dissolution Successor for continuing service	Designate CSA EM-1 as successor to continue the service. Zone of benefit would be created corresponding to current MDHCD boundaries for continued collection of existing property taxes. Creation of an advisory body.	Existing territory served by MDHCD would continue to be served by CSA EM-1 zone, including use of property taxes and advisory board. Elimination of MDHCD admin. expenses, funds become available for health care. Professional staff to implement policies and programs. Continuation of CBA provisions, including oversight of facilities and licenses, and participation in CHF grant process.	Primary function of EM1 is ambulance service, with some related training services (CPR, defibrillators). One or more cities could opt out, potentially reducing property tax increment in the future. Reduced local representation.

The MDHCD has begun to address issues and concerns raised against it in the past and as identified in the MSR; recent actions include:

- Awarding of grant funds to community organizations
- Financial assistance to CPR training programs in high schools
- Recent reductions to current health insurance benefits programs which will reduce MDHCD overhead expenditures
- Hiring of an Interim Executive Director

However, MDHCD revenues remain limited and subject to further declines depending on economic trends. While the addition of professional staff could help to improve its operations and focus and remediate past issues related to accountability and public access, this hiring would increase administrative expenditures. As noted in "Expenditures", **Chapter 4**, after fund balances are drawn down in a year (at current budgeted rates), overhead and administrative costs could equal at least 45 percent or more of total expenditures depending on costs for the interim Executive Director and legal fees compared to potential health insurance savings beginning in 2012. Including election costs, overhead will consume virtually all MDHCD operating revenues (before use of any available fund balances).

Advantages

1. Property taxes collected within the district will continue to be spent for services within the district.
2. As indicated by the MSR, maintaining the status quo provides the district time to make changes to its operations. The MDHCD is actively increasing program spending, attempting to reduce its health insurance liabilities, and has hired an executive director.

Disadvantages

1. The district has a history of not spending revenues on programs but on administration and benefits to its directors. Although the MDHCD is actively increasing program spending and has hired an executive director, the additional staff costs will increase the proportion of revenues spent on overhead.
2. Issues raised by the Grand Jury and other community members related to fiscal and operational problems, lack of activity, and dysfunctional management could continue.

Consolidation (of like and unlike districts) and/or creating a new district

Consolidation with Los Medanos Community Healthcare District (LMCHD)

This option is not recommended since discussions with LMCHD indicated the likelihood of strong community opposition to the proposal based on geographical, social, and historical differences between the differing areas served by the two districts. Political opposition was also identified by the MSR as a disadvantage of this option.

This option would consolidate the MDHCD with the LMCHD, which are “like” districts formed under the same statutes. The boundaries of the consolidated entity would correspond to the combined boundaries of the two existing districts. The current share of MDHCD property taxes would be collected by the consolidated entity; these revenues would be available for use throughout the consolidated entity unless a zone is created to geographically restrict use of the revenues. An advisory board could be established to oversee and guide the use of funds. Existing LMCHD staff would be responsible for staff support, with direction from the Board of the consolidated entity. The board of the consolidated entity would replace MDHCD as party to the Community Benefits Agreement, and would succeed to all rights and responsibilities of the Agreement. LAFCO could establish terms and conditions related to the initial and ultimate composition of the consolidated Board.

LAFCO Process

At a public hearing, LAFCO recommends the consolidation and schedules a protest hearing. The consolidation can be completed without an election unless 25 percent of the registered voters or 25 percent of the landowners with 25 percent of the assessed value protest.²²

Advantages

1. Enhances revenue base of LMCHD to be used for community health care needs.
2. Reduces/eliminates existing MDHCD administrative costs.
3. Continues mission and goals of MDHCD (subject to decisions of LMCHD board).
4. Continues community role in CBA.

Disadvantages

1. Reduces board representation from within MDHCD boundaries (assuming number of LMCHD board members does not change).
2. Distributes property tax resources over a broader service area.
3. LMCHD represents a different community of interest, and there is a strong probability that consolidation would be met with community opposition.

Dissolution with appointment of successor only for the purpose of winding up MDHCD affairs

Dissolution would eliminate the MDHCD and its share of property taxes would revert to other taxing entities, after obligations of MDHCD have been paid. LAFCO would appoint a successor agency to wind up the affairs of MDHCD; see further discussion of successor agencies below.

²² GC 57081(b)

Successor Agency Responsibilities and Obligations

- 1. Payment of Medical Insurance Benefits** – Currently MDHCD spend approximately \$45,000 annually for lifetime medical insurance benefits for two directors (one current, one former); the successor would need to continue this payment, which could be funded through some combination of MDHCD remaining assets and property tax revenues until the obligation is fully funded. MDHCD recently negotiated reductions in the cost of this program, reducing future liabilities; however, the program participants reserved their rights to return to the original program.
- 2. Disposition of Property** – The MDHCD does not own real property. The successor would be responsible for disposing of any unsecured property, such as office equipment.
- 3. Debt** – Other than obligations related to the medical insurance benefits noted above, the MDHCD has no debt or other long-term financial obligations.²³
- 4. Litigation and Claims** – No litigation or other legal or financial claims are pending.
- 5. CBA** – It is assumed that the JMH and the successor agency would terminate the CBA as part of winding up the affairs of the MDHCD. It is assumed that John Muir would continue the CHF without MDHCD representation; however, John Muir would be under no contractual requirement to do so. Similarly, John Muir would not be bound by the other provisions of the CBA related to specific facilities and licenses.

Successor Agency

GC §57451 addresses the determination of a successor for the purpose of winding up the affairs of a dissolved district. Subsection (c) indicates that the City of Concord qualifies as the successor because the MDHCD boundaries overlap multiple cities and unincorporated area, and the City of Concord contains the greater assessed value relative to other cities and the included unincorporated territory as shown in **Table 3**.

However, GC §57451(d) provides that if LAFCO's terms and conditions distribute all of the remaining assets of a dissolved district to a single existing district, then the single existing district is the successor.

Potential successor agencies include:

- 1. City of Concord** – The City currently does not provide health care services. The City of Concord could be designated as successor agency to wind up the affairs of the District pursuant to GC §57451(c). Preliminary discussions with City staff indicate that the City has the capability to undertake actions to wind up the affairs of the MDHCD, assuming that all financial obligations and administrative costs are funded by resources of the MDHCD. The City could replace MDHCD as party to the CBA; however, the City only represents 58 percent of the population of the MDHCD and therefore would not necessarily be in a position to fully represent the interests of all current MDHCD residents. Given that the boundary of MDHCD

²³ Roy Larkin, MDHCD Secretary/Treasurer, email transmittal received by EPS 10/21/11.

extends significantly beyond the City of Concord boundary, the City could not be named the successor agency for the purpose of continuation of MDHCD services.

2. **CSA EM-1** – The CSA EM-1 could be designated as successor pursuant to GC §57451(d), which allows a district to be designated successor if all the remaining assets will be transferred to the district, e.g., CSA EM-1. Contra Costa Health Services Department, which manages EM-1, is under the direction of the County Board of Supervisors, and would have the ability and capacity to undertake actions to wind up the affairs of the MDHCD.

LAFCO Process

The process will follow the basic steps identified in **Chapter 1**. In addition, it will be necessary for LAFCO to identify a successor for the purpose of winding up the affairs of the MDHCD. It may also be necessary for LAFCO to specify a Gann limit applicable to CSA EM-1 which will allow for an increase collection and use of property taxes for the purpose of winding up the affairs of the MDHCD.

Advantages

1. Elimination of administrative expenses, including staff, legal, election costs, and health benefit costs (after current obligations are paid).
2. Elimination of \$25,000 of annual JMH contribution to administration.
3. Avoids duplication of services provided by other public and private agencies.
4. Returns tax dollars currently utilized by MDHCD to other existing public entities serving the area, after payment of all MDHCD obligations.

Disadvantages

1. Loss of MDHCD allocation of annual property taxes to community health needs. In 2011, approximately \$170,000 (through October) was granted to local health programs, and \$80,000 was directed to CPR training of high school students.
2. Loss of MDHCD participation (direct participation and/or through designated representatives) on the Board of the Community Health Foundation, which allocates over \$1 million annually to community health needs.
3. Loss of MDHCD oversight of certain aspects of JMH facilities and licenses.
4. Loss of MDHCD as receiver of hospital assets in the event of termination of the CBA.

The disadvantages noted above assume that the CBA does not continue in force. However, it would be possible to continue the CBA or split certain responsibilities of the CBA between the City and CSA EM-1 as allowed by GC §56886. This would require the cooperation of John Muir Health, the City and Contra Costa County.

Dissolution with appointment of successor for continuing service

This option is similar to the dissolution described above; however, services would continue under the designated successor. Ongoing responsibility for continuing healthcare services could not be assigned to the City of Concord and enforced, because the boundaries of the MHHCD extend well beyond the City limits and statutes do not allow for the formation of a subsidiary district within the City to continue services of the MDHCD.

CSA EM-1 as a Successor

This option would require the County to establish a zone within CSA EM-1 corresponding to the current boundaries of the MDHCD. The current share of MDHCD property taxes would be collected within the zone and restricted to providing extended services which address unmet health care needs within the zone. An advisory board, including representatives from the zone, could be established to oversee and guide the use of funds. While LAFCO cannot enforce the ongoing use of a zone and advisory board, LAFCO can provision the continued allocation of property taxes as long as EM-1 meets those terms and conditions. Contra Costa Health Services Department would be responsible for staff support, with direction from the Board of Supervisors. CSA EM-1 would replace MDHCD as party to the CBA, and would succeed to all rights and responsibilities of the CBA.

CSA EM-1 is administered by the Contra Costa Health Services Department (as the EMS Agency) under the direction of the County Board of Supervisors.²⁴ In 1989, CSA EM-1 was established to provide funding for enhancement of emergency medical services including expansion of paramedic services, upgrades to the EMS communications system, and additional medical training and equipment for fire first responders. EM-1 is authorized to provide emergency medical services and “miscellaneous extended services”, which includes services the county is authorized by law to perform, and which the county does not also perform to the same extent on a county-wide basis.

In addition to serving as the EMS Agency overseeing EM-1, Contra Costa Health Services Department provides a broad range of community health services spanning the range of services also authorized for health care districts. Numerous advisory groups exist which provide input and direction on specific issues and services. Contra Costa Health Services Department operates health facilities, clinics, outpatient programs and services, senior services, other health care programs and services, wellness and prevention programs, provides health insurance programs, and disseminates health information. The Contra Costa Health Services Department’s community outreach program has benefited from funding provided by the MDHCD.

LAFCO Process

The process will follow the basic steps identified in **Chapter 1**. In addition, it will be necessary for LAFCO to identify a successor for the purpose of winding up the affairs of the MDHCD and for

²⁴ Public Healthcare Services MSR, Contra Costa LAFCO, 2007.

continuation of services. LAFCO will also establish terms and conditions requiring the creation of a zone and advisory board, predicated on the allocation of property tax upon ongoing fulfillment of those terms and conditions. It may also be necessary for LAFCO to specify a Gann limit applicable to CSA EM-1 which will allow for an increase in collection and use of property taxes, if applicable.

Advantages

1. Enhances revenue base of CSA EM-1 for community health care needs within a zone corresponding to the boundaries of the MDHCD.
2. Eliminates existing MCHCD administrative costs.
3. County Health Services Department provides a broad range of programs, including programs and facilities within MDHCD boundaries.
4. Contra Costa Health Services Department has extensive professional and support staff resources, and established public accountability and public access mechanisms.

Disadvantages

1. Loss of representation by locally-elected board.
2. Requires creation of a zone within CSA EM-1 to assure that property taxes continue to be collected from the MDHCD boundaries and directed to health care needs within the area.
3. May require resolution by affected cities approving of the creation of the zone and implementation of additional services by the CSA within their boundaries. CSA law allows for the creation of a zone to provide new and/or enhanced services.
4. If a city opts out of the CSA zone, for example the City of Concord, the CSA zone could experience a significant loss of future property tax increment. However, it appears likely that community support would exist for continuation of the use of property taxes for healthcare purposes in the area.

7. REFERENCES

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8. ACRONYMS AND ABBREVIATIONS

ACHD	Association of California Healthcare Districts
CHF	Community Health Fund
CKH	Cortese-Knox-Herzberg Local Government Reorganization Act of 2000
CBA	Community Benefit Agreement
CSA	County Service Area
GC	Government Code
HSC	Health and Safety Code
JMH	John Muir Health
LMCHD	Los Medanos Community Healthcare District
MDHCD	Mount Diablo Healthcare District
MSR	Municipal Service Review
TRA	Tax Rate Area



APPENDIX A
Map of CHF Service Area
(Exhibit C to JMH Bylaws, Section 5.6)

Health Facilities Planning Area 411

(Includes Concord, Danville/San Ramon, East County, Lamorinda, Martinez, and Walnut Creek Planning Zones)

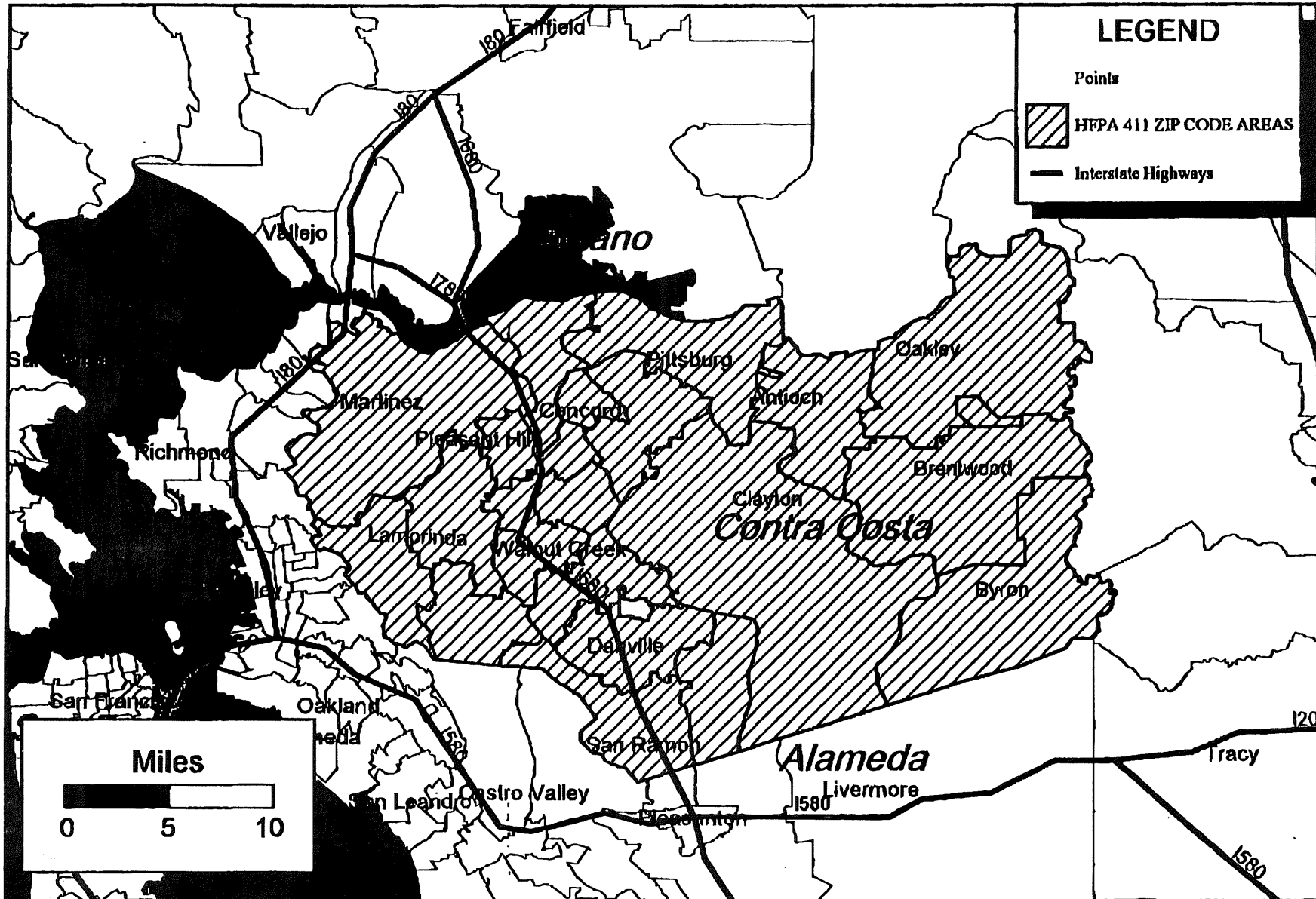
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APPENDIX B

Applicable Laws

GC §57302 (Dissolution or Consolidation). Allows the Commission to impose terms and conditions on any change of organization pursuant to §56886. If there is a conflict, terms and conditions imposed under §56886 preempt other portions of CKH dealing with changes of organization.

GC §56886 (Dissolution or Consolidation). Specifies the terms and conditions that the Commission may impose include the following:

- (i) The disposition, transfer, or division of any moneys or funds including cash on hand and monies due but uncollected, and any other obligations;
- (m) The designation of a city, county, or district as the successor to any local agency that is extinguished as result of any change of organization or reorganization, for the purpose of succeeding to all the rights, duties, and obligations of the extinguished local agency with respect to the enforcement, performance or payment of any outstanding bonds, including revenue bonds, or other contracts and obligations of the extinguished local agency.
- (r) The continuation or provision of any service provided at that time, or previously authorized to be provided by an official act of the local agency;
- (t) The extension or continuation of any previously authorized charge, fee, assessment, or tax by the local agency or a successor local agency in the affected territory;
- (v) Any other matters necessary or incidental to any of the terms and conditions specified in this section.

GC §57451 (Dissolution) For the purpose of winding up the affairs of a dissolved district, the successor of the dissolved district shall be determined as follows:

- (c) If the territory of a dissolved district is located in the incorporated territory of more than one city or the unincorporated territory of more than one county, or any combination of the incorporated or unincorporated territory of two or more such cities and counties, the successor is that city whose incorporated territory or that county whose unincorporated territory shall, upon the effective date of dissolution, contain the greater assessed value of all taxable property within the territory of the dissolved district, as shown on the last equalized assessment roll or rolls.
- (d) If the terms and conditions provide that all of the remaining assets of a dissolved district shall be distributed to a single existing district, the single existing district is the successor.

GC §57452 (Dissolution) Upon the effective date of dissolution, control over all the moneys or funds, including cash on hand and moneys due but uncollected, and all property, real or personal, of the dissolved district is vested in the successor for the purpose of winding up the affairs of the district.

GC §56375 (LAFCO Powers and Duties) The Commission may initiate certain actions including district consolidations and dissolutions.

GC §56375.5 (Consistency with SOI). LAFCO actions must be consistent with the sphere of influence.

GC §56378 (Authorization for LAFCO to Initiate a Special Study) Provides LAFCO’s authority to initiate special studies and contents of such studies.

GC §57077 (LAFCO Actions and Elections) Authorizes LAFCO to order a change of organization or reorganization without an election.

GC §57102 (Resolution Ordering Dissolution and Making Findings) Specifies findings the Commission must make in a dissolution proceeding.

GC §56131.5 (Notification of State Agencies) – Requires that LAFCO notify specific State agencies regarding LAFCO actions involving health care districts, and provides a 60 comment period to State agencies.

GC §57008 (Protest Hearing in Affected Territory) - For LAFCO initiated proposals, requires LAFCO to hold the protest hearing in the affected territory.

GC §25210 – 25217.4 - County Service Area (CSA) Law

GC §25217 (a) (CSA Zones) – The Board of Supervisors may form zones within CSAs whenever the board determines that it is in the public interest to provide different authorized services, provide different levels of service, provide different authorized facilities, or raise additional revenues within specific areas of a CSA.