MEMORANDUM

To: California Hospitals Committee on Issues: California Hospital Association
From: Mandy Asgeirsson, Greg Russo
Date: July 14, 2022
Subject: Assessing the impact of the proposed healthcare workers minimum wage ordinances

This memorandum summarizes the methodology and results of our analyses of the healthcare marketplace with respect to the proposed minimum wage ordinances ("proposed ordinances") in Anaheim, Baldwin Park, Duarte, Culver City, Downey, Inglewood, Long Beach, Los Angeles, Lynwood, and Monterey Park (collectively, "at-issue cities").[1] We have calculated the potential financial impact that the proposed ordinances would have on portions of the healthcare marketplaces in each at-issue city as well as the % of healthcare workers in each city that are covered and those excluded by the measure. This analysis considers the proposed ordinance's requirement that the minimum wage for certain employees of privately owned healthcare facilities increase to $25 per hour.[2]

Summary of Findings:

- The ordinance is expected to have an inequitable impact on healthcare workers making less than $25 per hour. The ordinance excludes approximately 65% of those making less than $25 per hour across the ten (10) cities of interest. In some cities, more than 85% of healthcare workers would be excluded and not experience a minimum wage increase.
    - The ordinance excludes approximately 62% of healthcare workers making less than $35 per hour across the ten (10) cities of interest. We expect the ordinance to not only impact those making less than $25 per hour, but also those making less than $35 per hour.

[1] A listing of the relevant ordinances can be found in Appendix A.

[2] For purposes of this analysis, "facilities" includes most facilities covered by the ordinances: licensed general acute care hospitals, licensed acute psychiatric hospitals, clinics that are conducted, operated, or maintained as an outpatient department of a general acute care or acute psychiatric hospital, licensed chronic dialysis clinics, and licensed psychiatric health facilities. These facilities are further denoted in this memo as "covered facilities." "Facilities" also includes some facilities not covered by the ordinances, such as skilled nursing facilities, intermediate care facilities, residential facilities, congregate living health facilities, community mental health centers, federally qualified health centers, health clinics, home health agencies, hospice, and rural health clinics. These facilities are further denoted in this memo as "non-covered facilities." "Facilities" does not include facilities that are part of an integrated healthcare delivery system, ambulatory surgery centers, or other healthcare entities such as physician offices. Facility types are further defined in Appendix B.

- The proposed ordinances would increase salary costs at covered facilities such as privately owned hospitals, psychiatric facilities, and renal dialysis facilities by between 4.5% and 17.4%.
    - The largest impact is in Baldwin Park, where salary costs are estimated to increase by $2.9 million, or 17.4%.
    - In Los Angeles, the impact is approximately $287 million, a 6.7% increase in salary costs.
    - Across the ten (10) cities, the ordinance is estimated to increase costs for the covered facilities by more than $392 million per year, a 6.9% increase.
- Healthcare costs per encounter at covered facilities are expected to increase by approximately $54.[3]
- The additional expense of the ordinance will cause added financial strain and/or the closure of facilities in at-issue cities due to increased costs and more pressure on the bottom line. Already, 26% of affected facilities are operating with a negative margin.

Summary of Methodology:
To measure the effects of the proposed ordinances, we completed the following four (4) steps:

1. Identify the current wages and number of hours worked for covered employees at covered and non-covered facilities in each at-issue city,
2. Calculate the additional cost to each covered and non-covered facility to comply with the proposed minimum wage of $25 per hour,
3. Calculate the additional costs to each covered and non-covered facility for those employees that may be indirectly impacted and earn between $25 and $35 per hour,
4. Identify the impact that the proposed ordinances would have on patients, the healthcare industry in California, and healthcare practitioners.

The steps above address some of the financial impact of the proposed ordinances on the covered employees and the financial impact on the covered and non-covered facilities; however, this analysis does not encompass the totality of financial impacts that the proposed ordinances will have, if implemented. After discussing the points noted above, we provide some of the additional impacts of the proposed ordinances.

[3] The definition of encounter varies based on the facility type. Appendix B has the definition of encounter by facility type. For CMHCs, FQHCs, health clinics, home health agencies, and rural health clinics, an encounter is defined as a patient visit. For Hospice, an encounter is defined as an individual hospital day. Encounters at renal dialysis facilities are defined as the number of treatments. Encounters at acute care hospitals include inpatient discharges and outpatient visits as reported in the HCAI data. Encounters at long term care facilities are defined as the number of discharges.

1. Identify the current wages and number of hours worked for covered employees at covered and non-covered facilities in each at-issue city

For hospitals and long-term care providers, we identified the current wages for employees using data from the California Department of Health Care Access and Information ("HCAI").[4,5] This data includes demographic information, financial information, and information on the wages of certain employee categories and their corresponding number of "productive hours."[6] For hospitals, relevant employee types from the HCAI data include: Aides & Orderlies, Clerical & Other, Environmental Services, Licensed Vocational Nurses ("LVNs"), Non-Physician Clinical, and Technical & Specialists.[7] For long-term care providers, relevant employee types include: Activities, Administration, Ancillary Services, Dietary, Geriatric Nurse Practitioners, Housekeeping, Inservice Education Nursing, Laundry & Linen, LVNs, Nurse Assistants, Aides & Orderlies, Other, Plant Operations & Maintenance, Psychiatric Technicians, Registered Nurses, Social Services, and Technicians & Specialists.

In order to assess the impact that the ordinances will have on employees of these hospitals and long-term care facilities, we categorized the employee types into four (4) categories: (1) those that had an average hourly wage of less than $25, (2) those between $25 and $29.99, (3) those between $30 and $34.99, and (4) those making $35 an hour or more. We also used the HCAI data to identify the number of productive hours worked for each employee type. Employees are split into these four (4) categories because of the indirect effects that will likely occur if the minimum wage at these facilities is increased to $25 per hour. First, we assume that the salaries of employees making less than $25 per hour will be increased to $25 per hour. Then, we assume that those that make between $25 and $29.99 per hour will experience an increase of 19%, those that make between $30 and $34.99 per hour will experience an increase of 9.5%, and those that make over $35 per hour will not be impacted. More details on this methodology can be found in section 3.

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[4] Hospital Annual Financial Data – Selected Data & Pivot Tables, 2020-2021. *California Health and Human Services Open Data,* California Department of Health Care Access and Information. https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/d30305d9-b150-43fb-8d99-2189fe5af87d?view_id=54997b30-65a2-4df0-8c01-0514ce098fe7.
2020 Selected File (As Submitted) - Long-Term Care Annual Financial Data - (November 2021). *California Health and Human Services Open Data,* California Department of Health Care Access and Information. https://data.chhs.ca.gov/dataset/long-term-care-facility-disclosure-report-data/resource/d8fb89b0-1f27-4333-aef9-118548ad4d3d.
[5] The HCAI hospital data includes information for short term acute care hospitals, acute psychiatric hospitals, children's hospitals, and specialty hospitals. The HCAI long-term annual financial data includes information on skilled nursing facilities, intermediate care facilities, skilled nursing facility/residential facilities, and congregate living health facilities.
[6] Productive hours are defined as "total hours actually worked, including paid time spent attending meetings and educational activities at or away from the hospital. Includes operating and non-operating cost centers. Included are hours for workers who do not receive a paycheck from the hospital's payroll system, such as registry nursing personnel and other temporary personnel. Does not include non-productive hours or 'on-call' hours."
[7] Physicians, management and supervision, and registered nurse categories are excluded.

For other covered facility types, average hourly wages were not available from HCAI. However, the Centers for Medicare & Medicaid Services ("CMS") publishes data through the Healthcare Cost Reporting Information System ("HCRIS" or "cost reports").[8] Similar to the HCAI data, cost reports include information on facility demographics, finances, and salaries by cost center. The cost reports are available for other covered facility types including renal dialysis centers, rural health clinic, hospice providers, home health agencies, health clinics, federally qualified health centers ("FQHCs"), and community mental health centers ("CMHC"). These facility types are defined in Appendix B. This data includes some wage information such as total salaries, but does not include average salaries, total hours or full-time employee equivalents ("FTEs") are not available for every relevant employee type.

We are unable to identify a source containing wage data for employees that are part of an integrated healthcare delivery system. As such, these providers are not included in the analyses we completed unless the employees are captured in one of the facility categories listed below.

The proposed ordinances only apply to private facilities, and not public institutions. As such, only a portion of the covered facilities will be impacted by the proposed ordinances. The HCAI data and the cost report data includes information on whether a facility is private or public. There are also some areas, identified by zip code, in the Los Angeles area that are exempt from the proposed ordinance.[9]

The table below outlines the provider types for which data was available, and the number of providers that are subject to the proposed ordinances.[10]

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[8] "Cost Reports." CMS, 11 Jun. 2022, https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/index.html.

[9] Information on the zip codes included vs. excluded from the ordinance was provided by the Hospital Association of Southern California.

[10] The facilities included in the analysis are those found in the HCAI or Cost Report data based on where the relevant information was published. These data sources may not be inclusive of all facilities in the ten (10) cities at-issue.

Table 1: Providers with Available Data by Source

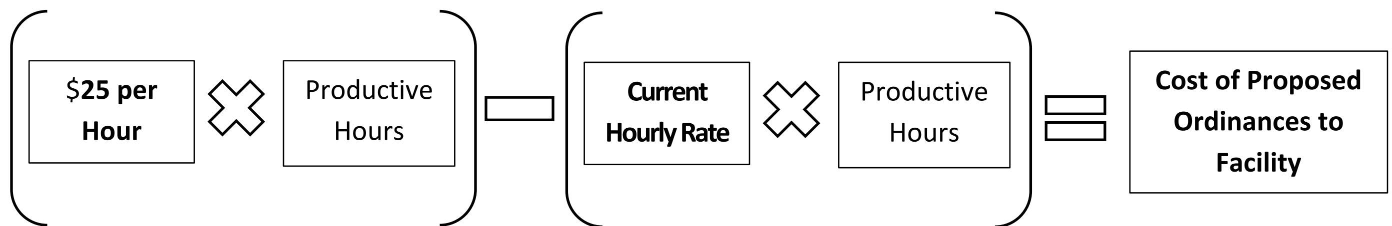
Facility Type	Source Data	Number of Facilities	Number of Private Facilities	Covered Healthcare Facility
Home Health Agency	Cost Report Data	479	477	No
Hospice	Cost Report Data	269	269	No
Skilled Nursing Facility	HCAI Data	177	177	No
Renal Dialysis	Cost Report Data	99	99	Yes
Federally Qualified Health Center	Cost Report Data	76	72	No
Other Long-Term Care	HCAI Data	60	58	No
Acute Care Hospital	HCAI Data	56	53	Yes
Psychiatric Hospital	HCAI Data	8	8	Yes
Community Mental Health Center	Cost Report Data	1	1	No

The available data covers most facilities in the at-issue cities as detailed in the table above. We were able to assess the impact of the proposed ordinances on these provider types.[11]

2. **Calculate the additional cost to each covered and non-covered facility to comply with the proposed minimum wage of $25 per hour**

For hospitals and long-term care providers, we identified employee types with an average hourly wage of less than $25. We calculated the additional cost to the covered facilities if the hourly wages were to be increased. If an employee type had an average hourly wage of less than $15, we estimated that the employee type's average wage was $15 due to the recently updated minimum wage requirements of $15 in California.[12] Figure 1 below illustrates this calculation.

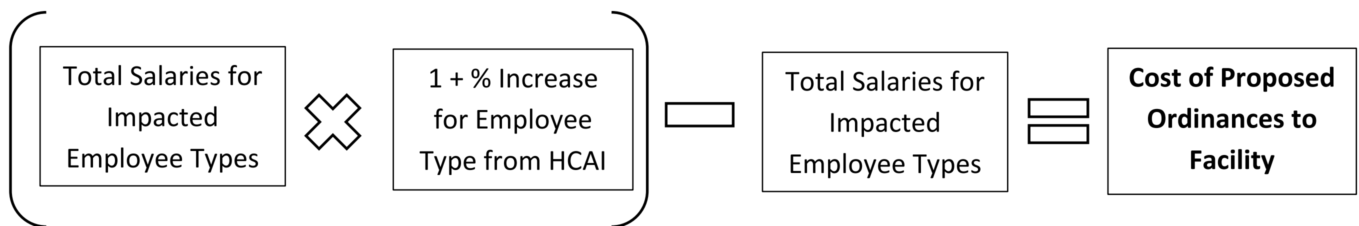
Figure 1: Hourly Rate Calculation for Employees Earning Below $25 / Hour in HCAI Data



[11] The facility counts by facility type are based on the available data and the available data source. There may be facilities excluded from these counts, and therefore the analysis, if the facility did not submit a cost report or data to HCAI.
[12] "Minimum Wage". Labor Commissioner's Office, State of California Department of Industrial Relations. https://www.dir.ca.gov/dlse/faq_minimumwage.htm.

To assess the additional cost that the proposed ordinances will have on other covered facility types (i.e., not the hospital or long-term care providers), we mapped each cost center from the cost report data to a similar employee type in the HCAI data. We then applied the weighted average percent increase by employee type from the HCAI data to the total salaries in the cost report data. Figure 2 below illustrates this calculation.

Figure 2: Hourly Rate Calculation for Employee Types Making Less Than $25 / Hour Not in HCAI Data



3. **Calculate the additional costs to each covered and non-covered facility for those employees that may be indirectly impacted and earn between $25 and $35 per hour**

While the proposed ordinances identify that only employees earning less than $25 per hour would be impacted, research indicates that employees earning a wage slightly higher than the proposed minimum wage will also be impacted. In a study conducted by the Washington Center for Equitable Growth, researchers found that increasing the minimum wage impacts wages for those earning an hourly wage that is less than the 25th percentile of hourly wages. Above the threshold of the 25th percentile, researchers found that the impact on wages is very small or non-existent.[13] In order to assess the ripple effect that increasing the minimum wage has on other employees, we assumed that those making between $25 and $35 were also impacted by the increase in minimum wage. However, the study indicates that the ripple effect is not uniform across all employees. Those making more will see an increase that is lower than those making less. As such, we applied an increase of 19% to those employees making between $25 and $29.99 per hour and applied an increase of 9.5% for those making between $30 and $34.99 per hour.[14]

We then followed a similar process that we did for those employees making less than $25 per hour. For hospitals and long-term care providers, we isolated employee types that had an average hourly wage between $25 and $29.99 per hour. We calculated the additional cost to the facility for increasing the

[13] Zipperer, Ben. "How Raising the Minimum Wage Ripples Through the Workforce". Washington Center for Equitable Growth. Accessed June 11, 2022 at https://equitablegrowth.org/raising-minimum-wage-ripples-workforce/.

[14] The study found that for a 10% increase, the ripple effect on wages would be approximately 2.9%. This minimum wage increase represents an increase of 66.7% from $15 (as of the 2019-2020 data used in this memo), and in turn, we assumed that direct impact would be approximately 19% for those making between $25 and $29.99 per hour. We assumed this estimate would be cut in half for the next cohort and increased the wage by 9.5% for those making between $30 and $34.99 per hour.

average hourly wages for these employee types by 19%. We conducted a similar analysis for those earning between $30 per hour and $34.99 per hour, on average, but for these employees we increased the average hourly wage by 9.5%.

To assess the impact that the proposed ordinances will have on other covered facility types (not the hospital or long-term care providers), we used wage data from the cost reports and adjusted this data by the weighted average percent by employee type collected from the hospital and long-term care HCAI data.

This methodology assumes that only those earning less than $35 per hour will be impacted by the proposed ordinances, and that those earning between $25 and $29.99 will be impacted at a higher rate than those earning between $30 and $34.99.

Table 2 includes a summary of the total change in salaries by at-issue city in which the proposed ordinance would be enacted. The adjusted salaries only relate to the covered facility types that are subject to the proposed ordinance and include adjustments for workers making less than $35 per hour.

Table 2: Total Salaries and Adjusted Salaries Due to the Proposed Ordinances, In the First Year

City	Covered Facilities (Private Facilities Subject to Ordinance)			
	Total Salaries	Adjusted Salaries	Difference	% Difference
Anaheim	$154,703,291	$171,402,132	$16,698,842	10.8%
Baldwin Park	16,711,248	19,625,265	2,914,017	17.4%
Culver City	7,654,792	8,544,703	889,910	11.6%
Downey	76,690,130	84,748,744	8,058,614	10.5%
Duarte	330,599,519	345,553,332	14,953,814	4.5%
Inglewood	93,403,999	102,036,780	8,632,782	9.2%
Long Beach	475,300,127	513,156,311	37,856,184	8.0%
Los Angeles	4,306,721,891	4,593,883,339	287,161,448	6.7%
Lynwood	139,546,501	146,261,032	6,714,531	4.8%
Monterey Park	92,676,870	101,268,102	8,591,231	9.3%
Total	**$5,694,008,367**	**$6,086,479,740**	**$392,471,373**	**6.9%**

The overall salary expenses at covered facilities would increase overall by approximately 6.9%. In Baldwin Park, that increase is 17.4% whereas in Duarte the increase is only 4.5%. This increase in costs may result in pressure on covered facilities already struggling to stay in business. Of the covered facilities, 26% already report a negative operating margin. These costs cause an additional 7% to have a negative operating margin, putting the facilities at risk of closure or financial instability. Non-covered facility types are experiencing negative operating margins at an even higher rate (38%).

4. **Identify the impact that this requirement would have on patients, the healthcare industry, and healthcare practitioners in California.**

Inequitable Impact on Healthcare Workers

The proposed ordinances would impact only a portion of healthcare workers and healthcare facilities in the ten (10) at-issue cities. The proposed ordinances exclude portions of the healthcare industry, such as independent physician offices, publicly owned hospitals and clinics, and many community and outpatient health centers. The ordinances are inequitable in their impact on FTEs at the covered facilities. In order to assess the impact on FTEs, we used statistics of U.S. business data from the U.S. Census Bureau to identify all healthcare workers in the state. When considering all employees working in the healthcare marketplace, we find that 62% are included in the HCAI and/or Cost Report data used for our analyses.[15,16] We used this proportion to understand the percent of healthcare workers in the state that were subject to the ordinance.

This analysis includes all FTEs at covered facilities and non-covered facilities, as well as the other healthcare providers for which we do not have data. However, we know that only a portion of employees are making less than $35 per hour and are therefore impacted by the ordinance. Using the HCAI data for hospitals and long-term care providers, we identified that approximately 35% of employees are making less than $25 per hour, and approximately 60% of employees are making less than $35 per hour. We then used that proportion of employees to identify the FTEs that are employed at covered facilities, non-covered facilities, and the other healthcare providers making less than $25 per hour and less than $35 per hour. Table 3 includes the proportion of FTEs making less than $25 per hour and less than $35 per hour that are excluded from the ordinance, by facility type. We found that overall, 65% of employees making less than $25 per hour are not covered by the ordinances and 62% of employees earning less than $35 per hour are not covered by the ordinances, shown in Table 3.[17]

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[15] "Data by Enterprise Employments Size."2019 SUSB Annual Datasets by Establishment Industry, U.S. Census Bureau. Accessed June 11, 2022 at https://www.census.gov/data/datasets/2019/econ/susb/2019-susb.html.

[16] In order to estimate the percentage of FTEs in the covered and non-covered facilities as compared to all healthcare workers, we calculated the proportion of employees in the state of California using the six (6) digit North American Industry Classification System ("NAICS") codes. This includes FTEs for Office of Physicians, Dentist, and "Other Health" practitioners, Family Planning Centers, HMO Medical Centers, Freestanding Ambulatory Surgical and Emergency Centers, Medical and Diagnostic Laboratories, and Other Ambulatory Health Care Services. Using this information, we determined that 38% of healthcare FTEs are not employed at the covered and non-covered facilities analyzed.

[17] In the hospital HCAI data, we estimated that 28% of FTEs were making less than $25 per hour and 53% were making less than $35 per hour. In the long-term care provider data from HCAI, 62% of FTEs were making less than $25 per hour and 86% were making less than $35 per hour. We then calculated a weighted average from the two (2) datasets and found that approximately 35% of employees were making less than $25 per hour and approximately 60% were making less than $35 per hour. In order to assess the other facility types for which we did not have this data, we assumed that 35% of FTEs were making less than $25 per hour and 60% of FTEs were making less than $35 per hour. We also assumed that the data used covered 62% of all FTEs making less than $25/$35 per hour, the same proportion of FTEs that were included in the analysis of all FTEs.

Table 3: Proportion of FTEs Making Less than $25 or $35 per Hour Excluded from the Ordinance

Facility Type	Covered Healthcare Facility	Estimated FTEs making < $25 per hour		Estimated FTEs making < $35 per hour	
		Private	Public	Private	Public
Acute Care Hospital	Yes	20,603	3,460	38,807	6,517
Skilled Nursing Facility	No	11,055	0	15,369	0
Federally Qualified Health Center	No	951	0	1,622	0
Home Health Agency	No	807	0	1,376	0
Renal Dialysis	Yes	804	0	1,371	0
Psychiatric Hospital	Yes	599	0	1,129	0
Other Long-Term Care	No	923	0	1,284	0
Community Mental Health Center	No	0-	0	0	0
Other Healthcare Providers	*No*	22,298	2,158	38,029	*4,066*
Total		**58,041**	**5,618**	**98,987**	**10,582**
Facilities / Other Providers Not Covered by Ordinance		**41,653**		**68,262**	
% Not Covered by Ordinance		**65%**		**62%**	

While the main focus is on employees making less than $25 or $35 per hour, we also estimated the total FTEs that would not be included under the ordinance. We found that approximately 58% of the healthcare workers in the ten (10) at-issue cities are not covered by the ordinances. This analysis can be found in table 4.

Table 4: Proportion of FTEs Excluded from the Ordinance

Facility Type	Covered Healthcare Facility	Total FTEs	
		Private	Public
Acute Care Hospital	Yes	72,969	12,254
Skilled Nursing Facility	No	17,784	0
Federally Qualified Health Center	No	2,704	0
Home Health Agency	No	2,295	0
Renal Dialysis	Yes	2,287	0
Psychiatric Hospital	Yes	2,122	0
Other Long-Term Care	No	1,486	0
Community Mental Health Center	No	0	0
Other Healthcare Providers	No	63,412	7,644
Total		**165,059**	**19,898**
Facilities / Other Providers Not Covered by Ordinance		**107,578**	
% Not Covered by Ordinance		**58%**	

We also analyzed this statistic by city and found some variation across each at-issue city. Table 5 includes the percent of FTEs that are excluded from the ordinance by city.

Table 5: Percent of FTEs Making Less than $25 per hour, and FTEs Making Less than $35 per hour Excluded from the Ordinance

City	% of FTEs Not Covered by Ordinance	
	FTEs Making < $25 per Hour	**FTEs Making < $35 per Hour**
Anaheim	77%	73%
Baldwin Park	85%	81%
Culver City	82%	79%
Downey	79%	77%
Duarte	51%	48%
Inglewood	63%	59%
Long Beach	65%	61%
Los Angeles	65%	62%
Lynwood	57%	53%
Monterey Park	54%	51%
Total	**65%**	**62%**

Ordinances Impact Overall Cost of Care

In addition, the ordinances would increase the overall cost of providing care in the ten (10) at-issue cities. We identified the total number of encounters at each facility and calculated the additional salary expense per encounter.[18] For covered facilities, the expenses per encounter would increase by about 2% ($54). This 2% increase will have an impact on the covered facilities, particularly those that already have low margins. Table 6 shows the number of facilities that had a negative operating margin prior to the ordinance, as well as the estimated number of facilities that would have a negative operating margin if the ordinance was enacted. Of the covered healthcare facilities, 26% are already operating with a negative margin. If the ordinance were to be enacted, we estimate that an additional 7% of the covered facilities would be operating with a negative margin.

[18] The definition of encounter varies based on the facility type. Appendix B has the definition of encounter by facility type. For CMHCs, FQHCs, Health Clinics, Home Health Agencies, and Rural Health Clinics, an encounter is defined as a patient visit. For Hospice, an encounter is defined as an individual hospital day. Encounters at renal dialysis facilities are defined as the number of treatments. Encounters at hospitals include discharges and outpatient visits as reported in the HCAI data. Encounters at long term care facilities are defined as the number of discharges.

Table 6: Operating Margin of Covered and Non-Covered Facilities

Provider Type	Covered Healthcare Facility	Operating Margin is Negative Pre and Post Ordinance	Operating Margin is Negative Post-Ordinance Only
Renal Dialysis	Yes	18	2
Acute Care Hospital	Yes	15	7
Psychiatric Hospital	Yes	6	1
Covered Healthcare Facilities Subtotal		***39***	***10***
% with Negative Margin		***26%***	***7%***
Home Health Agency	No	105	0
Hospice	No	100	0
Skilled Nursing Facility	No	81	0
Other Long-Term Care	No	13	0
Federally Qualified Health Center	No	0	0
Community Mental Health Center	No	0	0
Non-Covered Healthcare Facilities Subtotal		***299***	***0***
% with Negative Margin		***38%***	***0%***

At least 26% of covered facilities are experiencing low margins, making it difficult to absorb a 2% increase in costs. Alternatively, covered facilities could cut costs, which may impact patient quality and/or access to care. Additionally, increased costs will cause covered facilities to either reduce operating expenses or look to private insurers to increase reimbursements/payments, which requires a lengthy negotiating process that often takes months and may or may not be successful in raising rates. If a covered facility is successful in raising rates, then members' premiums and/or out of pocket expenses may be increased. Finally, many facilities that experience low margins have a high proportion of patients with a government payer, further resulting in low margins that are hard to increase.

Shortage of Workers Could be Exacerbated at Non-Covered Facilities

According to a study conducted by Avalere Health, a shortage of workers in the healthcare market impacts both clinical staff (nurses and primary care physicians) and lower-wage healthcare positions such as hospital support staff and home health workers.[19] As only some facilities are subject to the proposed ordinances, there is a potential for lower wage workers to leave the non-covered facilities (e.g., publicly-owned hospitals) to work at covered facilities where the minimum wage will be increased to $25 per hour. If employees seek employment at covered facilities, the non-covered facilities will have

[19] Beveridge, R. et al. "How Healthcare Staffing Shortages Are Changing the Labor Market". Avalere Insights & Analysis. https://avalere.com/insights/how-healthcare-staffing-shortages-are-changing-the-labor-market.

difficulty hiring employees or will be forced to increase wages to be competitive with covered facilities. This will likely exacerbate the shortage of low wage workers at places like clinics and physicians' offices.

Potential Impacts for Other Industries or Small Businesses

Many of the healthcare workers impacted by this ordinance (i.e., those that work in covered facilities and make less than $25 per hour) do not have a clinical background. The employees working in maintenance, laundry, security, food services, etc. are impacted by the proposed increased wages. As such, the proposed minimum wage of $25 per hour may attract workers from other industries to instead apply for work in the healthcare industry. This will put pressure on non-covered facilities, industries with similar workers, and small business in the region. These other industries will have to either increase wages or cope with a smaller workforce.

Monitoring Compliance Would Cost the At-Issue Cities

The cost of ensuring compliance with the proposed ordinances is a real cost that will be borne by the at-issue cities and its taxpayers. Our work has not sought to quantify the financial impact of this on the State.

Conclusion

The proposed ordinances will have a material impact on the healthcare marketplaces in the at-issue cities. The proposed ordinances will affect the wages of those earning less than $25 per hour, as is dictated by the proposed ordinances. However, the impacts will go beyond just affecting the wages. The proposed ordinances will also affect the wages of those earning close to but greater than $25 per hour. As a result of wage increases, the costs at covered facilities will increase. Since these are low margin businesses, we question how the healthcare facilities will cope with the increased costs. The covered facilities may try to pass that cost along to payers/insurers and if successful, may in turn pass those increased costs along to the patient or reduce operating expenses, which could reduce patient services. Finally, the ordinances inequitably impact only a portion of the healthcare marketplace, excluding 65% of employees making less than $25 per hour and over 58% of full-time employees.

Appendix A: Ordinance Source by City

City	Ordinance Source
Anaheim	Anaheim BallotTitle_Summary_Healthcare Facility Employee Minimum Wage Initiative.pdf
Baldwin Park	Baldwin Park – Notice of Intent.pdf
Duarte	Ballot Initiative Title and Summary – Healthcare Workers Minimum Wage (1)CityofDuarte.pdf
Culver City	Culver City Potential Text for Healthcare Worker's Minimum Wage Ordinance Initiative.pdf
Downey	Downey Notice of Intent – Healthcare Workers MInimum Wage Ordinance.pdf
Inglewood	Indlewood Initiative Petition.pdf
Long Beach	Long Beach ballot-title-and-summary-for-minimum-wage-for-healthcare-workers.pdf
Los Angeles	Los Angeles PUBLIC Request for Title and Summary_Min Wage.pdf
Lynwood	Lynwood Ordinance – Healthcare Workers Minimum Wage.pdf
Monterey Park	Proponent PublicationNoticeofIntentMontereyPark.pdf

Appendix B: List of Facility Types Tracked

Type of Facility	Definition	Encounter Definition
Acute Care Hospital[20]	These can be short-term or long-term and can be further divided into four categories based on the preponderance of care provided at the hospital: General - hospitals which provide general acute care; Children's - hospitals which primarily treat children; Psychiatric - hospitals which emphasize psychiatric care; and Specialty - specialty hospitals, such as chemical dependency recovery hospitals and rehabilitation hospitals.	Number of outpatient visits and inpatient discharges
Community Mental Health Center[21]	An entity that provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and clients of its mental health service area who have been discharged from inpatient treatment at a mental health facility; provides 24-hour-a-day emergency care services; provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services; provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission; meets applicable licensing or certification requirements for CMHCs in California; and provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act.	Number of visits
Federally Qualified Health Center[22]	This category includes Community Health Centers, Migrant Health Centers, Healthcare for the Homeless Health Centers, Public Housing Primary Care Centers, and outpatient health programs/facilities operated by a tribe or tribal organization or by an urban Indian organization.	Number of visits
Health Clinics[23]	This category includes both Independent Rural Health Clinics and Freestanding Federally Qualified Health Centers.	Number of visits
Home Health Agency[24]	An agency or organization which is primarily engaged in providing skilled nursing services and other therapeutic services; has policies established by a group of professionals (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services which it provides. This does not include any	Number of visits

[20] "Hospital Annual Financial Data Selected File Documentation." pg. 14. State of California Office of Statewide Health Planning and Development, Sep. 2005. https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/842c8bcb-bfac-4aa9-9de8-b11eb049f6de
[21] "The Certification Process." *State Operations Manual* pg. 232-233. CMS, 11 Mar. 2022. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf
[22] "Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services." *Medicare Benefit Policy Manual* pg. 9. CMS, 26 Apr. 2021. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
[23] "Health Clinic 222-1992 form." CMS, 1 Dec. 2021. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
[24] "Home Health Providers." CMS, 6 May 2022. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs

Type of Facility	Definition	Encounter Definition
	agency or organization which is primarily for the care and treatment of mental diseases.	
Hospice[25]	A facility that is primarily engaged in providing care and services to terminally ill patients. This includes the following services to reduce pain or disease severity and manage the terminal illness and related conditions: services from a hospice-employed physician, nurse practitioner (NP), or other physicians chosen by the patient, nursing care, medical equipment, medical supplies, drugs to manage pain and symptoms, hospice aide and homemaker services, physical therapy, occupational therapy, speech-language pathology services, medical social services, dietary counseling, spiritual counseling, individual and family or just family grief and loss counseling before and after the patient's death, short-term inpatient pain control and symptom management and respite care.	Number of days
Other Long-Term Care[26], [27], [28]	Includes Intermediate Care Facilities (ICF); Skilled Nursing/Residential facilities (SNF/RES); and Congregate Health Living Facilities (CHLF). An ICF is a facility that primarily provides nursing and supportive care for patients who are ambulatory or semi-ambulatory and have a recurring need for skilled nursing supervision and supportive care but who do not require continuous nursing care. SNF/RES facilities are licensed for skilled nursing care but are an integral part of a residential care facility. A CHLF is typically a small facility which provides care to patients with terminal or life-threatening illnesses, catastrophic and severe injury, or residential treatment for eating or other disorders.	Number of discharges
Renal Dialysis Facility[29]	An entity that provides outpatient maintenance dialysis services, or home dialysis training and support services, or both. A dialysis facility may be an independent or hospital-based unit that includes a selfcare dialysis unit that furnishes only self-dialysis services.	Number of treatments

[25] "Hospice." CMS, 14 Mar. 2022. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice
[26] "Documentation – Selected Data – Long Term Care Facility Annual Financial." pg. 17. State of California Office of Statewide Health Planning and Development, Oct. 2013. https://data.chhs.ca.gov/dataset/long-term-care-facility-disclosure-report-data/resource/5d8c2a00-88b4-43cb-8f16-b4a72e35212c?inner_span=True
[27] "Documentation – Selected Data – Long Term Care Facility Annual Financial." pgs. 10, 12. State of California Office of Statewide Health Planning and Development, Oct. 2013. https://data.chhs.ca.gov/dataset/long-term-care-facility-disclosure-report-data/resource/5d8c2a00-88b4-43cb-8f16-b4a72e35212c?inner_span=True
[28] "Documentation – Selected Data – Long Term Care Facility Annual Financial." pg. 49. State of California Office of Statewide Health Planning and Development, Oct. 2013. https://data.chhs.ca.gov/dataset/long-term-care-facility-disclosure-report-data/resource/5d8c2a00-88b4-43cb-8f16-b4a72e35212c?inner_span=True
[29] "Part 494 Conditions for Coverage for End-stage Renal Disease Facilities" pg. 7. CMS, 7 May 2014. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/esrdpgmguidance.pdf

Type of Facility	Definition	Encounter Definition
Rural Health Clinic[30]	A clinic that is in a rural area designated as a shortage area and is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.	Number of visits
Skilled Nursing Facility[31]	A facility that provides a level of nursing and supportive care provided by licensed nurses to patients who need 24 - hour nursing service on an extended basis.	Number of discharges

[30] "Rural Health Clinics." CMS, 1 Dec. 2021. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/RHCs

[31] "Documentation – Selected Data – Long Term Care Facility Annual Financial." pgs. 10, 12. State of California Office of Statewide Health Planning and Development, Oct. 2013. https://data.chhs.ca.gov/dataset/long-term-care-facility-disclosure-report-data/resource/5d8c2a00-88b4-43cb-8f16-b4a72e35212c?inner_span=True