

On the Brink:

How the Crisis in California's Public Hospitals Threatens Access to Care for Millions



Our Mission

CAPH, a non-profit trade organization representing California's public hospitals and health systems since 1983, works to strengthen the capacity of its members to advance community health; ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians; and educate the next generation of health care professionals.

Our passionate belief that everyone deserves an equal opportunity to enjoy good health—regardless of insurance status, immigration status or ability to pay—drives our policy and advocacy agenda.

Contents

Executive Summary	2
Introduction	6
A System on the Brink of Collapse	6
What's at Stake	14
Unstable Patchwork of Funding	22
Further Cuts Loom	22
Policy Recommendations	26
Appendix A - CAPH Financial Forecast: Cost and Revenue Assumptions	30
Appendix B - Unstable Patchwork of Funding Summary	31
Footnotes	33
CAPH Members	33

Case Studies

Kern Medical Center	4
Los Angeles County Department of Health Services	8
Alameda County Medical Center	12
Tuolumne General Hospital	16
San Francisco General Hospital	20
UC Davis Medical Center	24
Natividad Medical Center	28

List of Figures

Figure 1: Concentration of Care to the Uninsured at Public Hospitals	6
Figure 2: Total Operating Expenses at Public Hospitals 1995-2001	7
Figure 3: Widening Expense-Revenue Gap at Public Hospitals 2002-2007	10
Figure 4: Expense-Revenue Gap at Public Hospitals With and Without Cost Containment Efforts	11
Figure 5: Percent Change in Uninsured Discharges 1995-2001	15
Figure 6: Federal Medicaid DSH Allotments to California	22

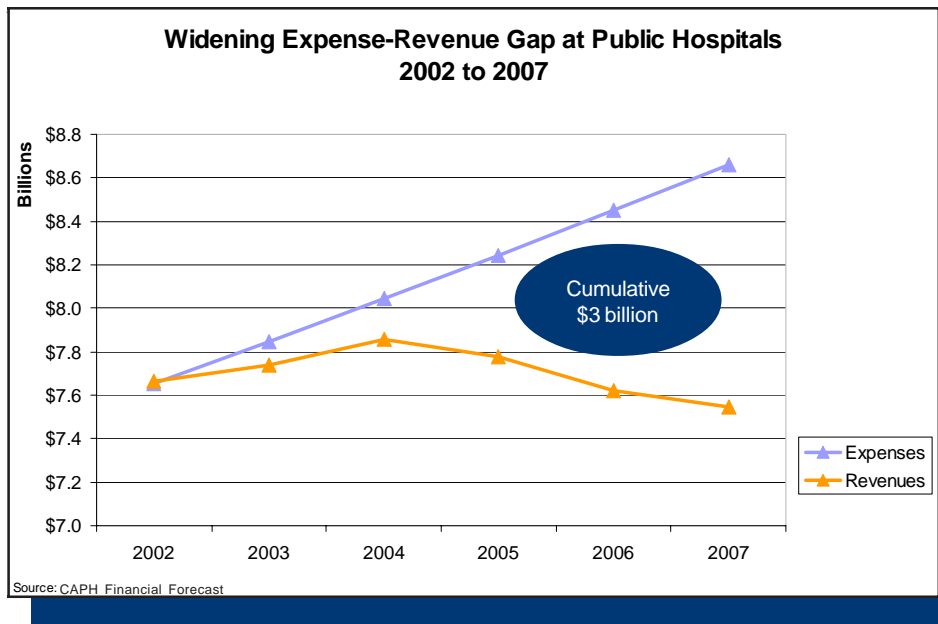
Executive Summary

California's public hospitals and health systems today confront a severe crisis. Driving this crisis is a steadily growing demand by uninsured and vulnerable patients for health care services matched against a shrinking pool of funds available to pay for that care. If the imbalance between rising costs and declining revenues is allowed to continue, draconian cuts will have to be made. Emergency rooms and trauma centers will close. Thousands of health care workers will be laid off. Entire public hospitals will close. *At stake is access to health care for millions of Californians.*

A System on the Brink of Collapse

Although the rising cost of delivering health care impacts all providers in the state, public hospitals and health systems are particularly hard hit because of the large number of uninsured patients they serve. In 2001 alone, public hospitals provided \$1.6 billion in care to the uninsured, more than half of the total statewide hospital cost of caring for the uninsured. At the same time, local, state and federal funding sources that support public hospitals and health systems have either declined significantly or, at best, remained flat.

The situation is only expected to worsen. Based on analysis by CAPH, over the next five years California's public hospitals and health systems will face a cumulative budget shortfall of at least \$3 billion. This drastic divergence between revenues and expenses cannot be sustained without extensive reductions in services and loss of access to care for millions of Californians.



What's at Stake

Although they make up six percent of hospitals statewide, public hospitals and health systems provide 55 percent of the cost of hospital care to the uninsured. They provide 11 million outpatient visits annually, serve a patient population that is 76 percent people of color and train half of the state's new physicians. Public hospitals also provide life-saving emergency and trauma care that benefits all members of their communities, both on a daily basis and in the event of a disaster or terrorist attack. Millions of low-income and uninsured Californians rely on these essential community providers for their care.

Public hospitals and health systems throughout the state have already been forced to close clinics, shut down inpatient units, lay off staff and reduce urgent care and other needed services. The harmful impact of these cuts is felt by all Californians, but falls most heavily on low-income families and individuals who rely on public hospitals for their care. Unless policymakers and stakeholders find ways to address this difficult issue, even more devastating cuts will have to be made.

Unstable Patchwork of Funding

Public hospitals and health systems are uniquely reliant on a tenuous patchwork of funding made up primarily of Medicaid revenues and state and local funds. This unstable patchwork is the result of the lack of a comprehensive public policy to ensure universal access to health care for everyone, particularly those least able to afford care. Moreover, available funds within this patchwork have not kept pace

Why the Crisis in Public Hospitals Matters to EVERYONE

Although they make up only six percent of hospitals statewide, California's public hospitals and health systems:

- Provide 55 percent of the cost of hospital care to the uninsured
- Serve a patient population that is 76 percent people of color, including more than 50 percent Latino
- Represent 62 percent of the state's level I trauma centers
- Train almost half of all medical residents in the state
- Provide 54 percent of all hospital-based outpatient visits to the uninsured
- Employ more than 70,000 health care workers

Without public hospitals, the state's emergency and trauma care network would collapse, thousands of jobs would be lost and millions of Californians would be forced to go without needed health care.

with the true costs of providing care and, in fact, have been cut substantially in recent years.

Further Cuts Loom

Additional funding reductions in the current and next fiscal years at the federal, state and local levels further threaten the ability of public hospitals and health systems to continue to meet the health needs of their communities. The federal government is currently contemplating several budget and policy proposals that would severely reduce federal Medicaid funds to the public health care safety net. In California, the state faces a projected \$26 billion to \$34.6 billion budget deficit and is proposing deep cuts in health care services for low-income patients. Counties throughout California also are experiencing tight fiscal constraints that limit their ability to fund vital health care programs. The combination of these proposed reductions, on top of the already divergent trend between costs and revenues, would accelerate the unraveling of the public health care safety net.

Policy Recommendations: A Two-Pronged Approach

1. Expand health insurance coverage for low-income, uninsured populations.

- Reduce the number of Californians without health insurance through comprehensive and/or incremental reforms.
- Maintain the integrity of the Medicaid program, including preventing cuts to eligibility at the state and federal level.

2. Preserve the public health care safety net.

- Maintain current levels of funding that support public hospitals and health systems.
- Target new funds to the public health care safety net.
- Invest additional resources in the public health care safety net to improve and enhance the delivery of services.

CASE STUDY

Kern Medical Center

Kern Medical Center (KMC), a 222-bed teaching hospital located in Bakersfield, is the only trauma center between Fresno and Los Angeles, offering life-saving medical care to critically injured patients 24 hours a day, seven days a week. It is also home to the only neonatal intensive care unit in the county, providing highly specialized care to vulnerable newborns and 50 percent of all pediatric inpatient care in the county. Nearly three-quarters of all KMC patients are Medi-Cal or uninsured, and nearly half of all inpatient care to the county's Medi-Cal population is provided by the hospital. As a teaching facility, KMC is the only area hospital dedicated to physician training, with thirty-five percent of all primary care doctors in the community trained at KMC.

In 2002, KMC was forced to lay off 130 employees, close a 25-bed inpatient unit and close a major outpatient clinic.

Unfortunately, these and other important services are currently at risk, as the medical center faces the unsustainable twin trends of severely declining revenues and rapidly rising costs. Two years ago, KMC experienced a 16 percent loss in revenues; last year, 12 percent. For fiscal year 2003, the medical center faces a further 10 percent loss. The medical center has no reserves left and for the last two years has been borrowing cash from the county to keep the medical center operating. The county auditor recently declared that, by private business standards, KMC is a non-viable financial entity and is essentially bankrupt.

In 2002, KMC was forced to lay off 130 employees and close a 25-bed inpatient unit. One major outpatient clinic was closed, and the hours of remaining clinics restricted, reducing KMC's outpatient volume by 15 percent and causing further overcrowding and longer wait times in an already overwhelmed emergency department. The medical center has bought no new equipment in two years. The result of these changes is that the people of Kern County, particularly the poor and uninsured, no longer have access to many basic health care services.

Now, to close the estimated \$10 million operating loss for 2003, KMC must consider further service reductions. It has implemented an aggressive medical screening process in the emergency room and as a result, is turning away non-emergency patients, which has reduced the number of patients seen by 20%. They have also closed their primary care clinics in mid afternoon thereby reducing volume by 19%. The medical center has already taken multiple steps to improve the efficiency and effectiveness of its operations, but it continues to face rising costs in providing care.

Over twenty percent of Kern's population is at or below the federal poverty level, and the county suffers from one of the highest unemployment—and uninsured—rates in the state. Job losses due to the recession have left many workers in the county without health insurance, leading ever-larger numbers of low-income and uninsured patients to turn to KMC for care. Given state and federal budget cuts and the county's own fiscal situation, the county is closely evaluating the scope of services it is able to offer indigent patients.

CRITICAL FACTS

Kern Medical Center

- Only trauma center between Fresno and Los Angeles
- Only neonatal ICU in county
- Trains 35% of primary care doctors in the community
- 65% of outpatients are Latino
- 1500 employees; 130 employees laid off in 2002
- Current year operating loss of \$10 million on top of \$30 million lost in last two years
- County auditor declared KMC essentially bankrupt
- Turning patients away due to lack of funds to provide care



Introduction

California's public hospitals and health systems face a major crisis that threatens to unravel the state's entire health care safety net. Driving this crisis is a steadily growing demand by uninsured and vulnerable patients for health care services matched against a shrinking pool of funds available to pay for that care. As anyone who manages a household budget understands, a fundamental tenet of economic theory is that what goes out must come in—or serious trouble ensues.

In the absence of a comprehensive public policy at the national or state level to ensure universal access to health care for everyone, public hospitals and health systems form the cornerstone of the health care safety net. That cornerstone, however, is beginning to crumble under the tremendous weight of an uninsured population that is growing rapidly at the same time the cost of delivering care is skyrocketing.

At stake is access to health care for millions of low-income and uninsured Californians who already struggle to overcome many obstacles to receiving needed health care services and who often rely on public hospitals and health systems for their care. In many communities throughout the state, public hospitals and health systems are the only place where a person who is uninsured or has Medi-Cal can get an appointment to see a doctor

and get the health care services they need. Further, public hospital emergency rooms and trauma centers are a vital component of our state's emergency response system and threats to their stability are threats to our ability to respond and treat victims in the event of a disaster or terrorist attack.

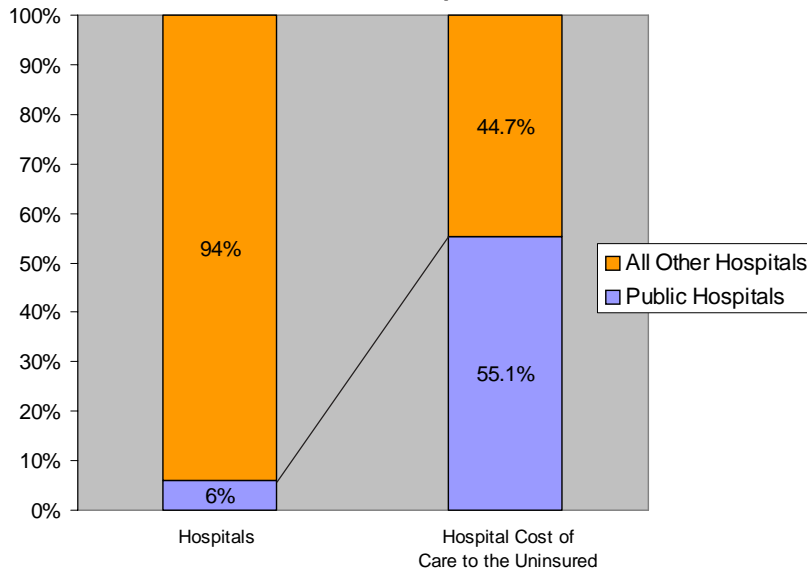
A System on the Brink of Collapse

Rising cost of care

The cost of providing care to California's 6.3 million and growing uninsured population puts singular strain on the state's 26 public hospitals¹. In 2001, these 26 hospitals incurred \$1.6 billion in care to the uninsured. This represents 55.1 percent of the total statewide hospital cost of caring for the uninsured (FIGURE 1). Even a relatively modest increase in the number of uninsured and a corresponding decrease in paying patients can have a dramatic impact on the bottom line. For example, a one percent change in public hospitals' payer mix—that is, going from a patient base that is 29 percent uninsured to one that is 30 percent uninsured—costs public hospitals \$147 million, 1.5 times the cost of complying with, say, the new nurse-staffing ratios.

In addition to the growing costs of providing unreimbursed care to a rising number of uninsured

Figure 1. Concentration of Care to the Uninsured at Public Hospitals



Source: OSHPD Annual Financial Disclosure Report

Although they represent only 6% of all hospitals, public hospitals provide the bulk of care to uninsured patients.

patients, public hospitals and health systems have experienced higher costs associated with providing care. Workforce shortages—including the severe nursing shortage—have caused sharp increases in labor costs. Pharmaceutical costs continue to soar, and medical malpractice insurance premiums are rising. Keeping pace with advances in medical technology, as well as undertaking capital expansions needed to ensure that patient care is delivered in seismically safe buildings, have also increased costs. And as is the case with mandatory nurse staffing ratios, no financial assistance has been made available from the state to help hospitals meet strict seismic-safety requirements.

Total operating expenses at public hospitals have risen 53% since 1995.

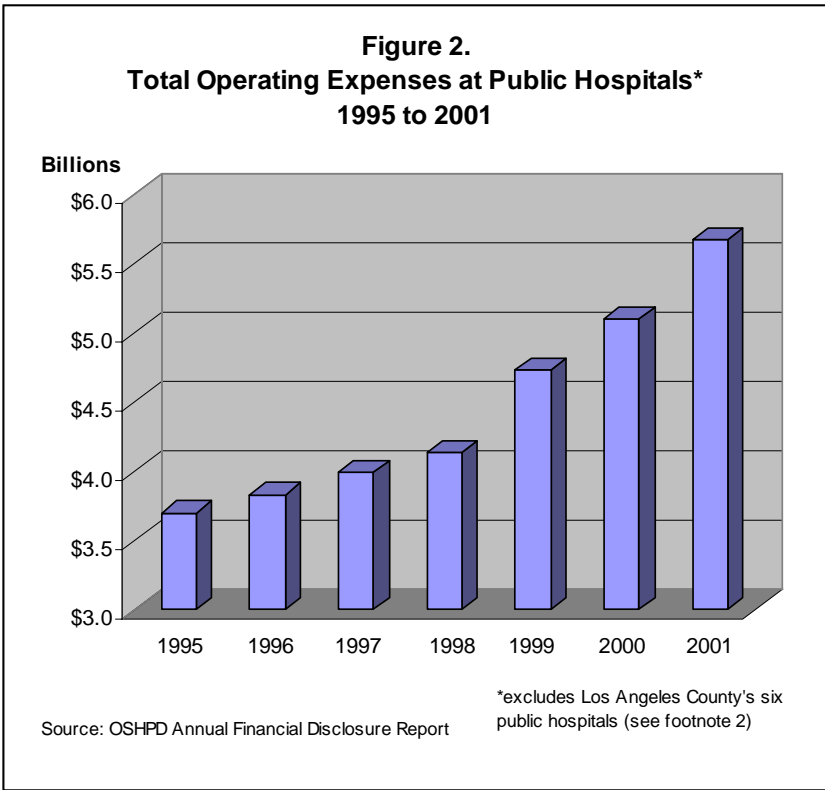
Consequently, public hospitals saw their total operating expenses increase by 35.4 percent between 1995 and 2001. If Los Angeles County is excluded from the equation (because of the downsizing requirements of its federal waiver), the adjusted increase in total operating expenses for all other public hospitals is a whopping 53.6 percent. (FIGURE 2)

Although they have taken extensive measures to reduce costs and increase efficiency, public hospitals and health systems experience higher costs due to their mission and role in serving low-income and uninsured populations, operating medical education programs and providing highly specialized, high cost services—such as trauma care—that serve the entire community.

As the number of uninsured grows and the costs of care have risen, the challenges facing public hospitals and health systems have grown exponentially because more of the patients they serve cannot afford to pay and the overall costs to the institution in providing care continue to go up.

Leader of the Pack

At the forefront of the crisis among California’s public hospitals and health systems is the Los Angeles County Department of Health Services, which operates six public hospitals and serves 800,000 people each year, most of them uninsured. In 2002, the department projected a \$700 million budget deficit over the next five years (see case study, next page).



In February 2003, the LAC DHS received a package of new federal aid to help narrow its budget gap. However, this aid does not address the larger, underlying structural problem characterized by the lack of a comprehensive public policy for care to the uninsured and an environment in which rising costs progressively outpace revenues. The persistent failure of funding sources to keep pace with the cost of providing care for low-income and uninsured patients has led to an imbalance that is simply not sustainable. At some point, the widening gap between the cost of providing care and the funds available to pay for that care will create a major meltdown of the system. Unfortunately, that point is disturbingly close at hand.

CASE STUDY

Los Angeles County Department of Health Services

At the forefront of the crisis among California's public hospitals and health systems is the Los Angeles County Department of Health Services (LAC DHS), the second largest public health care system in the nation. More than one-third of the state's uninsured live in Los Angeles County. That is 2.2 million uninsured children and adults. The rate of uninsured persons in the county is 31 percent higher than in the rest of the state.

The cost of serving such high numbers of uninsured is driving the crisis in the county's public health care

system. LAC DHS serves 800,000 people each year, most of them uninsured and many undocumented immigrants. With more than 100,000 inpatient stays, over 300,000 emergency room visits and 2 million outpatient visits system-wide annually, LAC DHS provides critical access to care for low-income and uninsured patients. The fiscal pressure, however, of having 35 percent of inpatients uninsured and 55 percent of outpatients uninsured, with no source of payment for their care, threatens the future viability of the system.

The new federal aid to Los Angeles, though critical, does not address the larger, underlying structural problem of rising costs progressively outpacing revenues.

In 2002, the health department predicted it would face a deficit of more than \$700 million within three years. To bridge the funding gap, the board of supervisors voted to close 16 health centers, shut down 100

beds at 750-bed LAC+USC Medical Center, convert High Desert Hospital in Lancaster to an outpatient center and close Rancho Los Amigos National Rehabilitation Center in Downey, actions expected to save hundreds of millions of dollars but limit access to health care services for thousands of low-income people living in the county. In addition, the department slated for closure two additional hospitals—Olive-View/UCLA Medical Center in Sylmar and Harbor/UCLA Medical Center in Torrance—unless additional revenues could be obtained.

Two recent developments are expected to forestall additional cuts in the county's health care system for the next couple of years. In November 2002, voters passed a new property-tax increase, Measure B, which will raise \$168 million annually for emergency rooms and trauma centers in the county. In addition, Los Angeles County's public hospital system will receive an additional \$250 million from the federal government over the next two years.

Although the infusion of federal money is expected to avert additional cuts that had been slated for later this year, the \$250 million falls far short of the \$1.4 billion the county was seeking and is not enough to reverse the clinic cuts or keep the doors open at High Desert or Rancho, both of which will still be closed this year.

The new federal aid, though critical, does not address the larger, underlying structural problem of rising costs progressively outpacing revenues. Already the LAC DHS is projecting a \$265 million dollar budget deficit in three years. Unfortunately, further cuts in services, including the potential closure of additional hospitals, will be necessary if additional funds and real progress in addressing the needs of the uninsured are not forthcoming.

CRITICAL FACTS

Los Angeles County Department of Health Services

- More than 1/3 of state's uninsured live in Los Angeles County
- Serves 800,000 patients annually
- 63 percent of patients Hispanic
- Made major cuts in services to address projected \$700 million budget gap
- Closed 16 health Centers in 2002
- Eliminating 100 beds at LAC+USC medical center
- Closing Rancho
- Converting High Desert from inpatient to outpatient facility

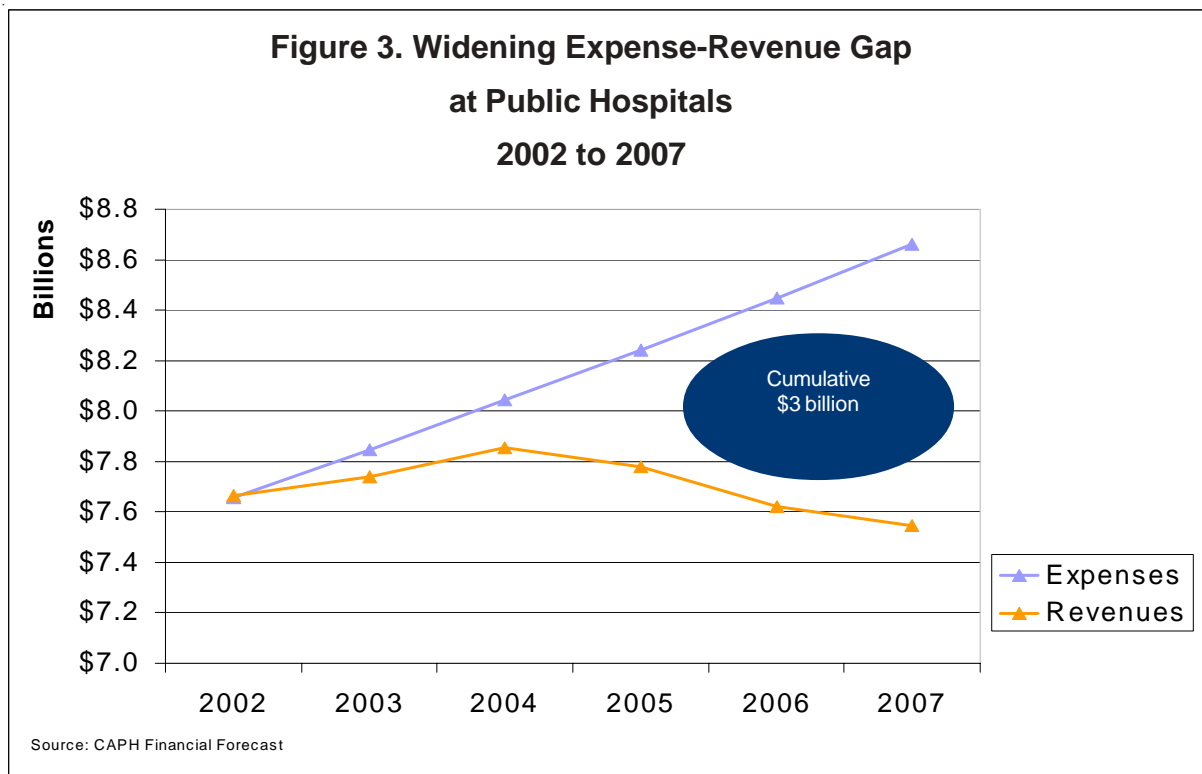


Although the sheer magnitude of the situation in Los Angeles—where the public health care system is the second largest in the nation—seems to dwarf the circumstances in other regions of the state, public hospitals and health systems in every county in the state are experiencing the very same financial pressures.

The widening cost-revenue gap

Based on a forecasting analysis by CAPH, over the next five years California’s public hospitals and health systems will face a cumulative shortfall of at least \$3 billion if they continue to serve patients at the current level (FIGURE 3). In the year 2007 alone, the

difference between revenues and expenses at California’s public hospitals is expected to top more than \$1 billion—an amount roughly equivalent to the total combined annual operating budgets of three major urban public hospitals that serve nearly one million Californians a year. If this divergent trend is allowed to continue, draconian cuts far beyond service reductions in the current year will have to be made, including emergency room and trauma center closures, layoffs of thousands of health care workers and the closure of entire hospitals.



Although the sheer magnitude of the situation in Los Angeles seems to dwarf the circumstances in other regions of the state, public hospitals and health systems in every county in the state are experiencing the very same financial pressures.

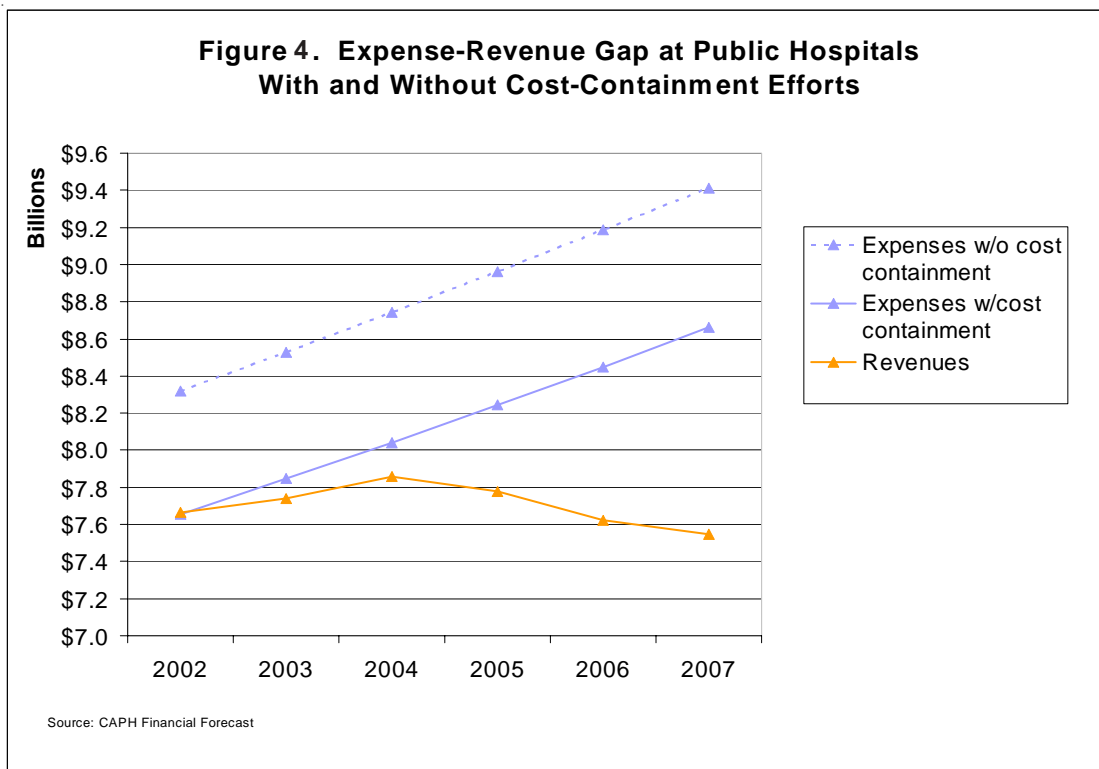
CAPH’s analysis is based on a number of cost and revenue assumptions that reflect the broad range of financial pressures facing public hospitals (see Appendix A).

On the cost side, the analysis takes into account more than a dozen factors driving up the cost of care, including, but not limited to:

- Higher concentration of services to the uninsured
- Growing expenses related to salaries and employee benefits of 14 to 28 percent
- Additional costs of implementing nurse staffing ratios at approximately \$97 million annually beginning in FY 2003-04 and inflated 3.5 percent annually thereafter
- Pharmacy cost inflation of 13.5 percent to 15.5 percent a year

On the revenue side, key factors influencing the downward trend of funding for public hospitals and health systems include, but are not limited to:

- Loss of \$96 million per year due to the “cliff” in federal Medicaid Disproportionate Share Hospital (DSH) funds
- Loss of \$32 million per year due to recent increase in the “administrative fee” the state takes for DSH
- Anticipated losses in state and federal funding due to budget cuts in the Medi-Cal program



It is worth noting that this analysis assumes that public hospitals and health systems will continue to take many of the same aggressive measures to control costs that they have instituted over the past several years. Without these ongoing efforts to reduce the historical rate of growth of eight percent a year, the shortfall by 2007 would be significantly worse (FIGURE 4).

CASE STUDY

Alameda County Medical Center

As the open door provider for the people of Alameda County, Alameda County Medical Center (ACMC) serves a patient population that is more than 80 percent low-income or uninsured. 63 percent of ACMC's revenues come from Medi-Cal and more than 22 percent of patients are uninsured and cannot afford to pay for their care—adding up to \$31 million in uncompensated charity care annually. ACMC provides services 24 hours a day, in 28 different languages, serving medical, psychiatric, rehabilitation and skilled nursing patients.

Two clinics are being closed... 15,000 patients will lose access to primary care. More than 100 workers will lose their jobs.

One of the major teaching hospitals and trauma providers in the San Francisco Bay Area, ACMC operates 468 licensed beds on three campuses and a network of four free-standing clinics offering more than 40 different primary and medical specialty services. Its certified Level II trauma center sees 2,000 patients a year, more than any other trauma facility in the East Bay. Along with ACMC's trauma center, its emergency department, which sees 68,000 visits annually, is among the busiest and most respected operations in the country.

ACMC also provides 24-hour inpatient psychiatric services for all county residents with mental health problems and offers a comprehensive acute rehabilitation program that handles more than 9,000 inpatient acute rehabilitation days and 4,000 outpatient visits per year. A nationally recognized teaching facility, more than 116 health professionals are trained at ACMC each year, ensuring a much-needed supply of skilled caregivers in the region.

Despite the important role ACMC plays in providing access to health care for the 1.4 million people of Alameda County, and notwithstanding a series of aggressive measures management has taken to maximize available funding and trim operations, declining revenues threaten seriously to undermine the medical center's continued ability to meet the needs of the community.

The medical center faces a current year cash deficit between \$12-\$14 million and operating expenses continue to escalate. Given the state's budget crisis, a budget deficit in the county of more than \$110 million and the loss of \$7 million in federal Medicaid DSH funds this year, APMC announced in April 2003 that it would immediately cut \$12-\$14 million from its budget. Two clinics are being closed, which will mean nearly 15,000 patients may lose access to primary and specialty care. Some of these patients may be able to be seen elsewhere, but other county clinics, including community-based organizations—already overburdened by high patient demand—would be able to absorb only a fraction of the displaced patients. More than 100 workers could lose their jobs. Some ancillary and support services will be closed. Major reductions in administrative and non-patient care areas will be made. And there is likely more to come. The hospital's skilled nursing facility may be closed if additional funds from the county are not available. And cuts in the state or federal budget could also mean further reductions in care to patients at APMC. The result is that access to care for the people of Alameda County, particularly the poor and uninsured, is being jeopardized.

CRITICAL FACTS

Alameda County Medical Center

- 80% of patients low-income or uninsured
- Largest and busiest trauma center in the East Bay
- Offers 28 languages served by medical interpreters
- Making \$14 million in immediate budget cuts, including:
 - Closing two clinics, displacing 15,000 patients
 - Laying off 100 employees



What's at Stake

Given this situation, it is vitally important that elected officials, policymakers and voters clearly understand the circumstances under which public hospitals and health systems currently operate, as well as the devastating implications if action is not taken to address the crisis public hospitals face. No less than the future of California's public health care safety net, the capacity of our medical emergency response system, the soundness of our entire health care system and the ability of our state to provide access to essential health services for entire communities are at stake.

To address current year budget deficits and further cuts next fiscal year from local, state and federal sources, public hospitals and health systems throughout the state have already begun taking the painful steps of closing clinics, shutting down inpatient units, laying off staff and reducing urgent care and other needed services. Unfortunately, it is clear that the serious under-funding of the public health care safety net is already forcing rationing of care to our state's most vulnerable and under-served populations. Chronic under-funding also destabilizes the ability of public hospitals and health systems to invest in systems and programs that improve and enhance care to vulnerable populations. And it is important to note that current services do not even begin to address the considerable unmet needs for health care.

Comprehensive range of services

California's public hospitals and health systems offer a comprehensive array of high quality, culturally appropriate health services, including inpatient and emergency care, prevention-oriented primary care for the whole family, outpatient specialty care, public health services, home health care, substance abuse services and mental health care. Some also operate long-term care facilities or provide special rehabilitation services. In short, public hospitals and health systems offer services to meet the full health care needs of patients and communities they serve.

Health Care "Spectrum"

- Primary care
- Public health services
- Hospital care
- Mental health services
- Substance abuse treatment
- Long term care
- Home health care
- Diagnostic services
- Specialty care
- Emergency medical services
- Well-baby and well-child care
- Routine physical exams
- Immunizations
- Urgent care
- Adult primary care
- Pediatric care
- Women's health
- Ambulatory surgery
- Health education
- Wellness programs
- Disease management programs
- Dental care
- Eye exams for glasses
- Mental health day treatment

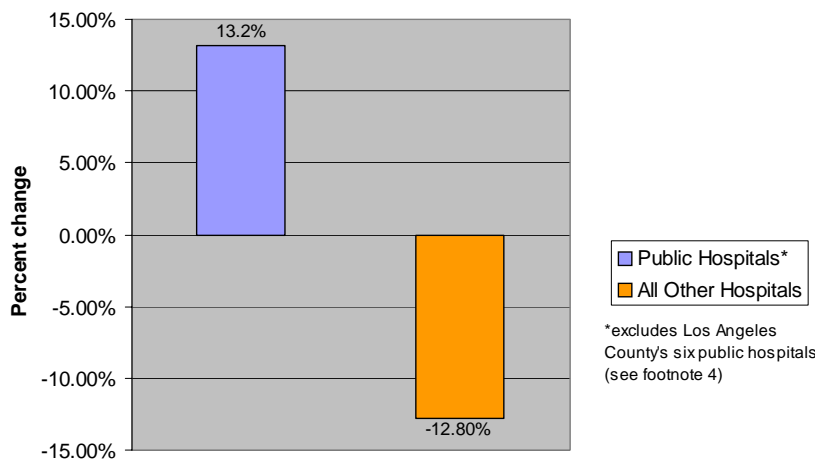
Growing demand for services among low-income, uninsured populations

As part of their mission, public hospitals and health systems are especially dedicated to serving the health care needs of California's low-income, uninsured and vulnerable populations. As a group, public hospitals and health systems serve a patient population that is 70 percent low-income, including uninsured, Medi-Cal and undocumented immigrant patients.

As the sheer number of uninsured in California has increased, so too has the *concentration* of uninsured patients in public hospitals. Between 1995 and 2001, the total number of uninsured discharges for county-owned and operated hospitals increased 13.3 percent.² During this same period, non-public hospitals saw a 12.8 percent *decrease* in uninsured discharges (FIGURE 5). In short, more of what public hospitals are doing is providing care to the uninsured, and that care represents a greater proportion of the total care they provide. No business can be expected to remain financially viable when an ever-increasing number of its customers cannot pay.

More of what public hospitals are doing is providing care to the uninsured...No business can be expected to remain financially viable when an ever-increasing number of its customers cannot pay.

Figure 5. Percent Change in Uninsured Discharges 1995 to 2001



Source: OSHPD Annual Financial Disclosure Report

CASE STUDY

Tuolumne General Hospital

Tuolumne General Hospital (TGH) is an 80-bed general acute facility operated by Tuolumne County for over 153 years. Due to operating deficits over the past several years, the hospital has had to borrow \$6.0 million from the County, and has required an additional \$11.0 million in contributions from the County's General Fund. After a legacy of 153 years of service to the poor and underinsured people in Tuolumne County, TGH is at risk of closing.

After a legacy of 153 years of service to the poor and underinsured people in Tuolumne County, Tuolumne General Hospital is at risk of closing.

Tuolumne County consists of approximately 55,000 residents. Last fiscal year, TGH admitted 1764 patients for a total 21,000 patient days of care to the residents of the county and the visitors who come to the county for leisure activities. In addition, 12,300 patients needed emergency services, and an additional 60,000 patient visits were provided through the hospital's ambulatory care services and outpatient rehabilitation, cardiac, physical and occupational therapy services. In addition, TGH provided 10,700 patient encounters to Adult Day Health Care patients at two locations. That's a total of 103,000 patient visits.

Tuolumne County has had to subsidize services at the hospital since 1997. Since that time, declining reimbursement and rising costs have made the hospital more cash dependent on the County to keep its doors open. General fund resources have been diverted from other County Department programs and services to subsidize the operating losses of the hospital.

The Board of Supervisors is under significant pressure to close the hospital due to increasing costs to keep the facility open. The hospital was budgeted to lose \$5.5 million in FY 2002 and was able to reduce losses to \$4.5 million. The hospital has further reduced operating losses to a projected \$3.2 million in the current fiscal year, and projects a further reduction in losses in the next fiscal year. The problem is that the County is out of time and money to further fund these operating losses. TGH has been directed to develop an alternate plan to reduce the hospital services to an "outpatient-services program." Should TGH

be forced to close acute hospital services, access to care for uninsured and Medi-Cal patients will be severely reduced and there is serious question whether the county will be able to continue operating any of the tertiary health programs in mental health and long term care, hospice and home health, and adult day health care. Further, the unemployment and economic impact of closing the hospital on a small rural county could be devastating.

Unfortunately, lack of funding is forcing the county to downsize health services at a time when it should be planning for future growth. Currently 30% of Tuolumne County residents are admitted to hospitals in adjacent counties for their in-patient needs. Many patients have to travel to Stanislaus and Merced Counties to see physician specialists and dentists willing to accept Medi-Cal patients. Already, there are 40 patients on a waiting list to access TGH's long-term care beds, which have a 100% occupancy rate. And the needs of the community are growing rapidly. Over the next 20 years, the county is projected to have an increase in the "over 65" age bracket of 94%.

The next few months will determine the future of Tuolumne General Hospital and the future of healthcare for its patients and the people of Tuolumne County.

CRITICAL FACTS

Tuolumne General Hospital

- 30 percent of county residents must already go outside the county when they need hospital care
- Base station for hospital emergency services in the county
- Only facility offering psychiatric, adult day health and hospice services to the community
- Third largest employer in the county with 422 employees
- Sole hospital in the county that contracts with the state to provide inpatient services for Medi-Cal patients
- Independent auditors recently cited hospital operations as essentially bankrupt
- At risk of closing



Caring for communities of color

California's public health care safety net cares for a patient population that reflects the state's "majority minority." Seventy-six percent of the patients they serve are people of color. More than half are Latino. In many regions of the state, the public hospital and health system is the "medical home" for many racial and ethnic groups and is a major provider of services to the undocumented. Kern Medical Center in Bakersfield, for example, serves a patient base that is nearly two-thirds Latino. Roughly 45 percent of all patients served by the Martin Luther King/Drew Medical Center in Los Angeles are African American. Asian and Pacific Islanders make up about twenty percent of San Francisco General Hospital's patient load.

In recognition of the rich diversity of the patients they serve, public hospitals and health systems take special care to deliver services in a culturally and linguistically appropriate manner. In addition to ensuring the availability of necessary translation and medical interpretation services, many offer unique clinics or programs targeted to the particular clinical needs of different ethnic or racial groups. For example, San Joaquin County Public Health Services has designed special services for long-term control of diabetes in the Latino and African American populations, where the prevalence rate of diabetes is estimated to be almost twice the rate among whites. Santa Clara Valley Hospital and Health system is part of a coalition of health care providers that promotes cervical cancer screening among Vietnamese American women, who have a cervical cancer rate that is five times that of women in the general U.S. population.

Emergency Room and Trauma Care

Public hospitals and health systems form the core of the state's emergency and trauma care network. They provide more than 1.4 million emergency room and trauma visits each year and operate almost two-thirds of the state's Level I trauma centers. Hit especially hard by the growing number of uninsured, public hospital emergency rooms and trauma centers are a microcosm of the crisis in the public health care delivery system. Overcrowding due to increased volume and lack of nurses to staff needed inpatient beds, an increasing number of patients with mental disorders, substance abuse and homelessness in combination with chronic

In coordination with police, fire and others, public hospitals are on the front lines in responding to a disaster, whether an earthquake, a biological or chemical attack or public health outbreak.

diseases such as diabetes and HIV/AIDS and patients being more seriously ill when they present to the emergency room all contribute to the growing strain on public hospitals and health systems.

Public hospitals and health systems also play a crucial role in their local and regional public health and safety system and are on the frontlines of our state's defense against the threat of a terrorist attack. In coordination with police, fire, emergency rescue personnel, physicians and others, public hospitals and health systems are on the front lines in responding to a disaster, whether natural, such as an earthquake or public health outbreak, or man-made, such as a biological or chemical attack or incidents of violence. At a time when emergency preparedness is critical to all Californians and all Americans, we must preserve the ability of public hospitals and health systems to respond and care for victims in the event of a disaster or terrorist attack.

Inpatient Services

Public hospitals and health systems provide the full range of inpatient hospital services, including labor and delivery, pediatrics, internal medicine, surgery, intensive care, geriatrics, psychiatry, rehabilitative care, and physical and occupational therapy, as well as the full scope of ancillary services such as lab, diagnostic imaging and pharmacy.

These inpatient services are vital to meeting the health care needs of patients and communities throughout the state. Comprising six percent of hospitals statewide, public hospitals and health systems provide 55 percent of the cost of hospital care to the state's uninsured. Availability of inpatient beds, however, is becoming constrained as public hospitals and health systems face

increased demand for services, a limited number of nurses to provide hospital care and cost constraints that have forced the closure of some inpatient units.

Outpatient Care

Public hospitals and health systems offer a comprehensive range of outpatient services from prenatal and well-baby care to primary care to cardiology and orthopedics in hospital-based and free-standing clinics located throughout the communities they serve. They provide 11 million outpatient visits annually and more than half of all hospital-based outpatient visits to the uninsured are at public hospitals and health systems.

Public hospitals and health systems are also a major source of health care for farm workers, providing a range of services specially tailored to meet the needs of workers and their families. Mobile health vans operated by public hospitals and health systems, as well as regular clinics held in locations where farm workers live and work, provide vital access to care for the population.

Public hospitals and health systems also provide crucial access to outpatient specialty services, serving as an important resource for referrals from other providers and as the exclusive providers of certain services in the community. Many physician specialists will not see Medi-Cal patients due to the low reimbursement rates. In addition, community clinics and primary care physicians in private practice routinely send their patients to the local public hospital for specialty care that is beyond the scope of the primary care services they offer. In too many communities, the public hospital and health system is the only source of specialty care for

vulnerable populations, leading to extremely high demand that the public hospital cannot meet. As a result, low-income patients needing specialty services frequently turn to the emergency room for care.

Who are California's uninsured?

- Of the 6.3 million uninsured in California, nearly 80 percent come from working families. Nearly one million of the uninsured are children.
- Twenty-eight percent of Latinos are uninsured. Thirteen percent of Asians and Pacific Islanders, nearly ten percent of African Americans and 8.6 percent of whites are uninsured.
- Approximately 1.1 million of the state's uninsured are eligible for Medi-Cal or Healthy Families. Even if all those who are eligible were enrolled, more than five million Californians would remain uninsured.
- Current state budget proposals to cut the Medi-Cal program are estimated to impact one million Californians, adding them to the ranks of the uninsured and underinsured.

Preparing the next generation of health professionals

California's public hospitals and health systems operate extensive education and training programs for physicians, nurses, laboratory and radiology technologists and other health care professionals. As a group, they train almost half of all physician residents in the state, contributing significantly to the growing need for a skilled health care workforce.

Preparing the next generation of health care providers is critical to the future of our state's health care system. California already faces major challenges in meeting the tremendous demand for experienced health professionals. Without the work of public hospitals and health systems in this area, the state would confront even more serious workforce shortages, greatly limiting access to care in both the public and private sectors.

CASE STUDY

San Francisco General Hospital

San Francisco General Hospital (SFGH) is one of the nation's flagship public hospitals. An international leader and pioneer in the treatment of HIV/AIDS, a premier teaching institution, the only trauma center in San Francisco and Northern San Mateo County and a facility renowned for its outreach and treatment of vulnerable populations, SFGH provides primary and preventive care, inpatient hospital services, labor and delivery, emergency and trauma care (including being at the center of the city's disaster preparedness and terrorism response efforts) and extensive psychiatric services. SFGH, a critical safety net provider, serves

nearly 100,000 patients every year, half of whom are uninsured. The patients reflect the ethnicity of the city, with 29 percent of patients Hispanic, 24 percent white, 21 percent African American and 20 percent Asian.

The San Francisco Department of Public Health must cope with a \$38 million minimum reduction in county funds next fiscal year...a \$6 million cut in federal funding...and proposed state budget cuts that would increase the number of uninsured.

The continuation of the hospital's 130-year legacy of serving the people of San Francisco is at risk, however, as rising costs from treating a growing number of low-income and uninsured patients and fiscal deficits at the county, state and federal level threaten the financial stability of SFGH.

Locally, San Francisco city and county faces a budget deficit of \$350 million on a total budget of \$5 billion. As a result, the San Francisco Department of Public Health (the agency under which SFGH operates) must cope with a \$38 million minimum reduction in county funds next fiscal year. Further local general fund reductions of \$28

are also on the table if the county cannot close its budget gap. These budget reductions come at the same time that SFGH is facing a \$6 million cut in federal DSH funding, and when proposed state budget cuts would increase the number of uninsured and, consequently, reliance on SFGH's services.

In response to the severe decrease in available funding, SFGH and the SF Department of Public Health

have slated multiple services for reduction or elimination. They include eliminating long-term care mental health services available on the SFGH campus, reduction of interpreter services, elimination of outpatient substance abuse services, reduction by half of community-based outpatient clinic hours, closure of all mental health day treatment services, elimination of adult dental services, reduction of outpatient pharmacy benefits and decrease in staff by nearly 300 FTEs, of which about 200 are from SFGH.

The result of these cuts would be devastating. Access to care for low-income and uninsured San Franciscans will be severely reduced. The existing ambulance diversion rate of 25 percent would double and ambulances would be rerouted from SFGH to other area hospitals 50 percent of the time. Further, the hospital's Level I trauma center status would be jeopardized as funding cuts begin to impact the ability of the hospital to maintain the critical staff and equipment necessary to operate a trauma center.

CRITICAL FACTS

San Francisco General Hospital

- Serves nearly 100,000 patients each year
- 1 out of 2 SFGH patients uninsured
- 29% Hispanic, 24% white, 21% African American, 20% Asian
- Only level I trauma center in San Francisco
- Services slated for reduction or elimination:
 - Mental Health Rehab (144 beds)
 - Interpreter Services
 - Outpatient substance abuse
 - All mental health day treatment
 - Community-based primary care
 - Adult dental services
 - Eliminate 200 SFGH jobs



Unstable Patchwork of Funding

A combination of public policy decisions made over the last decade and the dynamics of the health care marketplace have brought us to this point of crisis in the public health care safety net.

A critical issue impacting public hospitals and health systems and the low-income and uninsured patients they serve is the lack of a coherent public policy to provide dedicated funding to ensure care of the uninsured. Incremental reforms to expand coverage and use of marketplace mechanisms to contain costs in government programs have dominated the health policy agenda over the last decade.

As part of these efforts, questions of how we pay for coverage for low-income and uninsured populations have been widely discussed and debated. Less attention, however, has been paid in the public policy arena to ensuring that patients have meaningful access to care through a stable and viable delivery system.

The result is that California's public hospitals and health systems must rely on a tenuous and unpredictable patchwork of funding—based primarily on Medi-Cal revenues and state and local subsidies—to carry out their mission and mandate to serve the health care needs of all residents, regardless of insurance status or ability

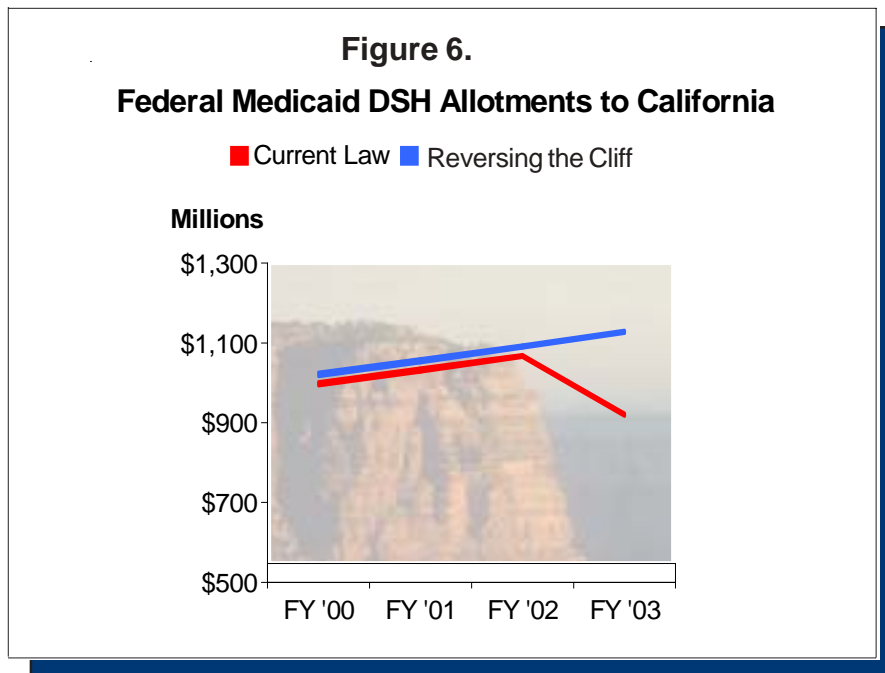
to pay. Unfortunately, over much of the last two decades, these programs have not kept pace with the rising cost of, and demand for, health care services, particularly for uninsured patients.

Six main financing mechanisms exist to support health care services to California's uninsured: Medi-Cal, Medi-Cal supplemental payments (such as DSH), tobacco-related sources (tobacco tax and tobacco settlement agreement funds), Medicare add-on payments such as Graduate Medical Education funds, realignment funds, and county general funds (see Appendix B for a detailed description of these funding mechanisms). This limited and shrinking pool of federal, state and local funding is uncertain from one year to the next. Severe reductions in safety net funding, including the “cliff” in federal Medicaid DSH funding (FIGURE 6) and state cuts to the Medicaid DSH program have already occurred this fiscal year and additional proposals to further reduce funds are being considered at the federal, state and local levels.

Further Cuts Loom

Federal Medicaid Reform Efforts

The Bush Administration has proposed major Medicaid reforms that would cap federal Medicaid expenditures and provide states tremendous discretion in setting eligibility and benefit levels for millions of Medi-Cal



beneficiaries. Rather than enhancing the ability of low-income populations to access health care services, there is serious concern that the president's proposal would result in an elimination of the entitlement to coverage and essential benefits for our most vulnerable populations. A federally enforceable entitlement to coverage is the foundation of Medicaid's success. Eroding that entitlement for current recipients would be a major step backwards for a country that must already confront the dilemma of over 41 million uninsured residents, more than 6 million of whom reside in California. By limiting federal Medicaid funds to the amount spent in an arbitrarily set base year, the president's proposal undermines the ability of Medicaid to meet changing needs. Medicaid is a counter-cyclical program; as the economy slows and people lose jobs or cannot afford health insurance, Medicaid can step in to provide needed health coverage. Capping the program would instead put pressure on states to reduce coverage, benefits and payments to providers at times when need for the program is greatest, resulting in increases in the number of uninsured and underinsured.

Further, as discussed above, Medicaid—in particular, the Medicaid DSH program—is a critical source of funding for the public health care safety net. Rather than eliminating the Medicaid DSH program or blending DSH funds into overall Medicaid funding to states as proposed by the administration, Medicaid reform should preserve and strengthen safety net providers. As the number of Medicaid enrollees and uninsured are increasing, further reducing or eliminating direct payments to public hospitals and health systems would rapidly destroy our state's fragile system for providing care to low-income and uninsured patients.

State Budget Deficit: Increased Uninsured, Further Cuts to Public Hospitals

At a time when our nation's health care costs are ballooning, unemployment in the state is at 6.9 percent—its highest in nearly seven years—and the number of uninsured is rising, states are facing the largest budget deficits in the last fifty years—totaling \$70 billion to \$85 billion nationwide—according to the Center on Budget and Policy Priorities. Deep cuts in health care and other programs are expected as states seek to close their budget gaps.

In California, the state faces a \$26 billion to \$34.6 billion deficit. To deal with this shortfall, significant reductions in the Medi-Cal program—which serves 6.1 million Californians—have been proposed. The proposed changes to Medi-Cal would affect nearly one million people: over half a million would lose Medi-Cal coverage and hundreds of thousands more would lose access to critical services and equipment, such as dental care, prosthetics and hospice. Consequently, reliance on the public health care safety net will increase as a growing uninsured and underinsured population turns to public hospitals and health systems to access needed care.

In addition, state budget proposals to cut the vehicle license fee backfill and shift financial responsibility for large portions of Medi-Cal and other health programs to the county will place at risk state and local funds that support public hospitals and health systems. The result will be a continued widening of the gap between the cost of providing care to low-income and uninsured Californians and the revenue available to support it.

County Budget Deficits Threaten Funding for Essential Services

Many counties use local tax dollars to support health care services for the poorest members of their community. Unfortunately, counties throughout the state face severe budget deficits that will impact the ability of local government to deliver essential services, including health care.

In the past, public hospitals and health systems have turned to local government to help them through difficult financial periods. The severe fiscal situation of counties, however, makes further reliance on local government for financial support very unlikely.

CASE STUDY

UC Davis Medical Center

UC Davis Medical Center, one of five teaching hospitals of the University of California, is a 528-bed hospital that is the only area provider of many medical services that are integral to the health and well-being of Northern Californians. It is the leading tertiary care referral center for 33 counties and nearly 5 million residents covering more than 50,000 square miles. Through its telemedicine program, UC Davis Medical Center extends its specialized medical care and education to rural communities that otherwise would not have access to these services. The medical center has inland Northern California's only adult and pediatric level I trauma center and comprehensive pediatric emergency department.

UC Davis Medical Center is the leading tertiary care referral center for 33 counties and nearly 5 million residents.

UC Davis Medical Center is also the dominant provider of uncompensated care to the uninsured and indigent in the region, despite having the smallest share of the commercial market among the four hospital systems in Sacramento. While it has only about 13 percent of the commercial market share in Sacramento, the medical center provides 42 percent of the indigent care. Last year alone, the

hospital provided more than \$140 million in uncompensated care to patients in financial need.

That figure does not take into account services provided by free community clinics, run by students, residents and faculty in many non-English-speaking neighborhoods. The clinics employ a culturally sensitive approach in providing prenatal and well baby/child examinations, immunizations and physical exams for school-age children, diagnosis and treatment of diabetes and hypertension, pregnancy testing and other women's health services, preventive education and flu shots. The Paul Hom Asian Clinic is the oldest Asian health clinic in the United States, and provides basic health-care services to the Sacramento Chinese community, but welcomes patients of all ages and backgrounds. Clinica Tepati, founded in 1974, caters to the medically underserved Latino population of Sacramento, and provides about 900 patient visits a year. The Imani Clinic was established to address the high and persistent incidence of hypertension, heart disease, cancer and inadequate prenatal care among African Americans. The Shifa Commu-

nity Clinic was formed to serve members of the Muslim community, who face language barriers in obtaining health care in the traditional health-care system.

The medical center's ability to continue providing these vital services is threatened by rising costs and declining revenues. Maintaining even modest margins will be difficult in light of the financial pressures facing the medical center. Like every other hospital in Sacramento, UC Davis must rely on patient-care revenue to support its operations. But at UC Davis, much of this revenue comes from government payers, such as the Medi-Cal, Medicare and Sacramento County indigent programs. Last year, 60 percent of the hospital's patient days were from government-sponsored programs.

Hospital administrators anticipate that combined reductions in federal, state and county programs could result in a reduction in reimbursement of \$20-\$30 million next year. To prepare for the decrease in revenue, the medical center has reduced its workforce by about 300 positions, is reducing its operating budget and reviewing new programs and existing services for possible cuts. One reduction that already has occurred involves Life Flight, the hospital's emergency air transport program, which will be reduced from two helicopters to one. In recent years, UC Davis has undertaken other budget reducing measures, including the elimination of 775 full-time positions over the last five years and the closure of primary care offices in Chico and Vacaville.

CRITICAL FACTS

UC Davis Medical Center

- Serves 5 million residents in 33 counties in Northern California
- Employs 8,500 people that generate \$2.3 billion in local economic activity each year
- Provides 42 percent of indigent care in the Sacramento region
- Projected reduction in reimbursement of \$20-\$30 million next year
- Cut 775 positions over last 5 years; 300 more positions eliminated Spring 2003



Policy Recommendations

The nearly \$3 billion cumulative budget shortfall that California’s public hospital and health systems are projected to face over the next five years is an unparalleled crisis in California’s health care delivery system. At stake is access to care for the millions of Californians who rely on the public health care safety net for their health care needs. In the absence of major policy changes to address this unsustainable situation, vast numbers of low-income families and uninsured workers will be forced to do without even the most basic health care services.

CAPH urges policy makers and stakeholders to ensure access to care for all Californians through a two-pronged approach of (1) expanding health insurance coverage and (2) maintaining a stable and viable safety net delivery system. CAPH supports raising revenues to achieve these goals and prevent drastic cuts to essential services and programs.

Policy Recommendations: A Two-Pronged Approach

- 1 Expand health insurance coverage for low-income, uninsured populations.**
 - Reduce the number of Californians without health insurance through comprehensive and/or incremental reforms.
 - Maintain the integrity of the Medicaid program. Reduced commitment of the federal government to the entitlement nature of the program or reductions in Medicaid eligibility at the federal or state level will add to the ranks of the uninsured and further strain the public health care safety net.

- 2 Preserve the public health care safety net.**
 - Maintain current levels of funding that support public hospitals and health systems. The public health care safety net is already under-funded and demand for services continues to grow as the number of uninsured rises.
 - Target new funds to the public health care safety net for care of low-income and uninsured Californians and to maintain the availability of highly specialized, high cost services that benefit the entire community, such as emergency and trauma care.
 - Invest additional resources in the public health care safety net to improve and enhance the delivery of services, including the use of technology and computerized systems to improve chronic disease management, care coordination and access to care.

CASE STUDY

Natividad Medical Center

Natividad Medical Center is a 163-bed acute care medical center owned and operated by Monterey County. With an annual budget of \$120 million, the medical center employs 900 people and serves the bulk of the county's underinsured and uninsured patients, including migrant farm workers. Nearly half of Monterey County's population is Latino and 13.5 percent of residents live under the federal poverty level. Seventy percent of Natividad's patients are enrolled in Medi-Cal or Medicare. The medical center is also a primary provider for uninsured workers in the county's agricultural and tourism industries.

Natividad ensures access to care for all residents of Monterey county and is a center of excellence for women, children and families.

Natividad ensures access to care for all residents of Monterey county and is a center of excellence for women, children and families. Natividad delivers 50 percent of all babies in Monterey County and 70 percent of all babies borne to mothers with Medi-Cal. It is the only CCS-certified Level II Neonatal Intensive Care Unit in Monterey County, and is on pace to serve more than 470 medically fragile infants from throughout the county this year. And Natividad cares for more than 15,000 women each year in its Women's Health Center. Natividad also offers an array of primary and specialty care services on the hospital campus and at two satellite locations,

providing more than 150,000 outpatient visits each year.

Affiliated with the University of California at San Francisco School of Medicine since 1974, Natividad is the only academic medical center on the Central Coast. It has trained hundreds of family practice physicians, many of whom have remained in the area and continue to provide care in the community.

Natividad is on a trajectory to face a \$12 million deficit by the end of the 2002-03 fiscal year due to declining revenues and the rising cost of caring for low-income and uninsured Monterey county residents. NMC is currently losing \$30,000 per day on operations. On top of this its double-digit deficit, Natividad faces an additional cut of nearly \$1 million in federal DSH funds.

The medical center has had to borrow cash from the county to continue to operate; however, the county has decided to stop providing cash flows if the medical center goes over certain borrowing limits, which would shut down operations at the hospital. Further, the county administrator has ordered all county departments to prepare for possible 25 percent budget cuts. Natividad Medical Center currently receives only a very small portion of its funding from county government and the county has indicated it will not backfill state and federal cuts affecting the medical center's bottom line.

CRITICAL FACTS

Natividad Medical Center

- Delivers 50 percent of all babies in the county
- Only CCS-certified neonatal ICU in the county
- 70 percent of patients Medi-Cal or Medicare
- \$12 million current year budget deficit
- 900 employees; 200 + jobs at risk

To close Natividad's severe budget gap, a series of cuts are being considered. On the table are shutting down inpatient beds, closing some inpatient services, closing outpatient clinics and laying off hospital workers, with as many as 200 hospital jobs at stake. The medical center is simultaneously seeking to develop new services to enhance care to the community and improve the hospital's fiscal situation, but these longer-term efforts may not be able to stave off severe, near-term cuts in services.

Natividad Medical Center is currently losing \$30,000 per day on operations.



Appendix A

CAPH Financial Forecast: Cost and Revenue Assumptions

Factors Increasing Costs

- Higher number and concentration of uninsured
- Salaries & employee benefit costs
- Nursing shortage related costs
- Nursing staff ratio implementation costs
- Physician related expenses
- Shortage of specific job classifications costs
- Pharmacy cost inflation of 13.5 percent to 15.5 percent per year
- Technology related costs
- Services and supplies inflation of 3.9 percent per year
- One-time costs over the next three years related to lay-off/pay-off and unemployment insurance costs, non-employee costs related to facility closures, and facility transition costs
- Implementation of AAMC standards for interns and residents
- Ongoing and new debt service obligations
- SB 1953 physical plant requirements
- HIPPA related costs beginning in 2002-03 of at least \$44 M.
- Acuity intensity and resource consumption increases
- Increased utilization pressures anticipated

Revenue Related Factors

- Medicaid DSH Cliff loss of \$ 96 M per year
- DSH administrative fee increase
- Service availability reductions resulting in decreased revenues
- Change in payer mix resulting in decreased revenues
- Increase in Medi-Cal SPCP supplementals through 2005
- Decreases in Medi-Cal SPCP supplementals after 2005
- Increase in Medi-Cal outpatient payments
- Developments of Medi-Cal managed care supplemental payment
- Revenue optimization efforts
- Payment limit vulnerabilities
- Medicare payment reductions
- State FY 2003-04 and forward budgets
- Federal FY 2003-04 and forward budgets

Appendix B

Unstable Patchwork of Funding Summary

California's public hospitals and health systems must rely on a tenuous and unpredictable patchwork of funding—based primarily on Medi-Cal revenues and state and local subsidies—to carry out their mission and mandate to serve the health care needs of all residents, regardless of insurance status or ability to pay. Unfortunately, over much of the last two decades, these programs have not kept pace with the rising cost of, and demand for, health care services, particularly for uninsured patients.

Six main financing mechanisms exist to support health care services to California's uninsured: Medi-Cal, Medi-Cal supplemental payments (such as DSH), tobacco-related sources (tobacco tax and tobacco settlement agreement funds), Medicare add-on payments such as Graduate Medical Education funds, realignment funds, and county general funds.

Medi-Cal Reimbursement. California has a long history of keeping Medi-Cal provider rates low. The state ranks 51st nationwide in total Medi-Cal expenditures per beneficiary³. Hospitals that contract with the state to provide inpatient services to Medi-Cal beneficiaries have received no or minimal increases in their base rates for over ten years.

Similarly, Medi-Cal outpatient rates have remained generally stagnant for most of the last 14 years and now reimburse providers, at most, at about 43 percent of actual costs. Even with the recent settlement of a lawsuit regarding Medi-Cal outpatient rates, these rates will remain significantly lower than the cost of providing care.

The state's low spending rates have compelled Medi-Cal providers to be among the most cost-efficient in the nation. Still, the state's failure to keep Medi-Cal rates in pace with health care inflation has weakened the safety net delivery system and means that Medi-Cal providers must rely on additional funding sources to cover shortfalls.

Medi-Cal Supplemental Payments. To address low Medi-Cal base rates, the State has created three programs over the last decade—the SB 855, SB 1255, and Graduate Medical Education programs—to provide supplemental Medi-Cal payments to targeted groups of hospitals.

The SB 855 Medi-Cal disproportionate share hospital payment program (DSH) was created in 1991 to generate new federal funding for hospitals that treat the greatest numbers of Medi-Cal and uninsured low-income patients. Under cuts enacted by the federal government in the Balanced Budget Act of 1997, including a 20 percent reduction in Medicaid DSH funding to states, California has already seen reductions in recent years of more than \$264 million in federal Medicaid DSH funds. California lost an additional \$184 million in federal Medicaid DSH funds effective October 1, 2002, and this cut will remain in place each year unless further congressional action is taken (FIGURE 9). Also, the 2002-2003 California state budget reduced DSH funds to safety net hospitals by a further \$55 million, for a total state administrative fee of \$85 million in DSH funding.

The SB 1255 and Graduate Medical Education programs, which provide supplemental payments to eligible safety net hospitals, are designed to recognize the added value of and higher costs associated with the mission of public hospitals and health systems, including trauma care, teaching and serving a higher concentration of seriously ill patients. However, these programs—subject to annual negotiations and new federal limits, and dependent on fiscally strapped local governments to fund the state's share of the program—lack predictability and stability needed to ensure public hospitals' long-term viability. Due to recent federal regulations lowering the Medicaid Upper Payment Limit and the lack of state dollars in the program, public hospitals also face substantial reductions in federal Medicaid supplemental payments throughout this decade.

Tobacco Tax (Proposition 99). When Proposition 99 was enacted in 1988, it increased the tax on cigarettes and devoted those revenues to a variety of health purposes, including indigent health services. The County Health Indigent Program (CHIP), which counties administer, received more than \$336 million in fiscal year 1989-90. Public hospitals and health systems throughout the state received a significant portion of those funds. As smoking rates in the state have declined and funds have been shifted to other programs, fewer dollars are available to fund programs such as CHIP. In state fiscal year 2001-02, the CHIP account decreased to less than \$66 million.

Medicare Add-On Payments, Including Medicare Graduate Medical Education. Together, 30 core open door providers train about half of the state's medical residents. Although most open door providers treat a small proportion of Medicare beneficiaries, Medicare GME financing is a significant funding source for these hospitals. Support of graduate medical education through the Medicare program, however, has come under fire in recent years and public hospitals and health systems face diminishing financial support for teaching programs.

Realignment.

In the original state-county budget realignment in 1991, health realignment funds were intended to partially subsidize counties for providing care to the medically indigent. These funds do not cover—nor were they intended to cover—counties' full costs in caring for the uninsured. Rather, they support care to the medically indigent, which are a subset of the overall uninsured population. Funds for the medically indigent, however, are placed at risk by the Governor's current budget proposal to reduce the vehicle license fee (VLF) backfill to counties. Maintenance of the VLF backfill and realignment funding are essential if public hospitals and health systems are to continue to meet their section 17000 obligation to serve the medically indigent and provide public health services for all residents. For fiscal year 2002-03 alone, a \$150 million shortfall in state realignment funds to counties is expected due to the slow economy and declining sales tax revenues.

Current budget proposals to further “realign” and shift financial responsibility for major portions of the Medi-Cal program and other health programs from the state to counties would increase the complexity and uncertainty of the patchwork funding system. Of serious concern are whether proposed new revenues would cover the actual costs of the realigned services, the likelihood that medical inflation generally and growth in the cost of the Medi-Cal program specifically will exceed the growth in allocated revenues (placing counties at risk for the costs of programs which are not in fact under counties' control) and the implications for non caseload-driven programs such as CHIP that provide vital support for care to the uninsured.

County general funds. Counties use local tax dollars from their general fund to subsidize health care for the indigent. Some spending is required in order to receive the state matching funds, but many counties appropriate additional discretionary funds to cover the costs of serving the uninsured. However, a decade of property tax shifts has severely constrained the ability of local governments to adequately fund health care services to the uninsured. Although there have been measures enacted to mitigate the impacts, these efforts have not provided full relief nor did they restore flexibility and discretion to the counties.

Footnotes

¹ The term “public hospitals” refers to the following 26 providers, which have both a mission and a legal mandate (either directly or via contract with county government) to fulfill the county’s obligation under §17000 of the Welfare and Institutions code to care for low-income uninsured populations: Alameda County Medical Center, Contra Costa Regional Medical Center, Harbor/UCLA Medical Center, High Desert Hospital, Kern Medical Center, King/Drew Medical Center, Laguna Honda Hospital and Rehabilitation Center, LAC+USC Medical Center, Modoc Medical Center, Natividad Medical Center, Olive View Medical Center, Rancho Los Amigos Medical Center, Riverside County Regional Medical Center, San Bernardino County Medical Center (now Arrowhead Regional Medical Center), San Francisco General Hospital, San Joaquin General Hospital, San Luis Obispo General Hospital, San Mateo Medical Center, Santa Clara Valley Medical Center, Trinity General Hospital, Tuolumne General Hospital, University of California Davis Medical Center, University of California Irvine Medical Center, University of California San Diego Medical Center, University Medical Center, Ventura County Medical Center. “All others” refers to all hospitals—excluding public hospitals, state-owned hospitals, alcohol and drug rehabilitation hospitals, large skilled-nursing-emphasis hospitals, and prepaid health plan hospitals—filing a financial report with the Office of Statewide Health Planning and Development. Unless otherwise noted, all California data are based on financial, utilization and discharge reports submitted to OSHPD with analysis conducted by the California Association of Public Hospitals and Health Systems.

² This figure excludes Los Angeles County which in recent years has downsized its capacity and contracted with the private sector for certain services per its federal waiver.

³ Kaiser Family Foundation, State Health Facts Online, Total Medicaid Spending Per Enrollee, FFY 1998

CAPH Members

[Alameda County](#)

Alameda County Medical Center

[Contra Costa County](#)

Contra Costa Health Services
Contra Costa Regional Medical Center

[Fresno County](#)

Community Medical Centers

[Kern County](#)

Kern Medical Center

[Los Angeles County](#)

Los Angeles County Department of Health Services
Harbor/UCLA Medical Center
High Desert Hospital
King/Drew Medical Center
Olive View/UCLA Medical Center
Rancho Los Amigos National Rehabilitation Center
LAC+USC Medical Center

[Marin County](#)

Health & Human Services of Marin County

[Monterey County](#)

Natividad Medical Center

[Orange County](#)

University of California Irvine Medical Center

[Riverside County](#)

Riverside County Regional Medical Center

[Sacramento County](#)

University of California Davis Medical Center

[San Bernardino County](#)

Arrowhead Regional Medical Center

[San Diego County](#)

University of California San Diego Medical Center

[San Francisco County](#)

San Francisco Department of Public Health/
Community Health Network of San Francisco
San Francisco General Hospital
Laguna Honda Hospital and Rehabilitation Center

[San Joaquin County](#)

San Joaquin County Health Services
San Joaquin General Hospital

[San Luis Obispo County](#)

San Luis Obispo County Health Agency
San Luis Obispo General Hospital

[San Mateo County](#)

San Mateo County Health Services Agency
San Mateo Medical Center

[Santa Clara County](#)

Santa Clara Valley Health & Hospital System
Santa Clara Valley Medical Center

[Tuolumne County](#)

Tuolumne General Hospital

[Ventura County](#)

Ventura County Health Care Agency
Ventura County Medical Center



CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS
70 Washington Street, Suite 310 ■ Oakland, CA 94607 ■ 510.874.7100 ■ fax: 510.874.7111 ■ www.caph.org