



[Issue](#) | [Background](#) | [Findings](#) | [Conclusions](#) | [Recommendations](#) | [Responses](#) | [Attachments](#)

San Mateo County Indigent Health Care

Issue

What can San Mateo County do to reduce the annual appropriation for indigent health care?

Summary of Recommendations

This report, prefaced with a brief Issue and Background discussion, is organized into the following four major sections, each with its own set of findings, conclusions, and recommendations:

- I. Overview of Health Care System Options
- II. San Mateo Medical Center Operations
- III. Attracting Private Pay Patients
- IV. Indigent Care and Charity Care Cost Sharing

To assist the reader, the recommendations offered in the four sections are summarized below in two sections. The first section addresses the primary reason the Grand Jury undertook this investigation to determine the most appropriate public health care model for the county.

The second group of recommendations offers short and intermediate term steps that can be taken to either enhance revenues or reduce costs.

To fully understand the context of each recommendation, a reading of the entire report is vital.

I. Public Health Care Alternatives

The Board of Supervisors should:

1. Issue a request for proposal (RFP), within 90 days, to review public health care services provided by the county with particular emphasis on indigent care. Qualified

proposals should demonstrate a high level of experience and active involvement with indigent care in California. The RFP should include but not be limited to a study of

- Advantages and disadvantages of the payer model as compared to San Mateo County's provider health care system and should include the fiscal, medical, and social effects of each.
- The effectiveness of the provider model currently employed.
- The sale or lease to a third party, (e.g. Stanford University Medical Center, University of California San Francisco Medical Center), of the San Mateo Medical Center and clinics with the agreement it remain a provider of medical care to the indigent.

II. Revenue Enhancement and Cost Reduction

San Mateo Medical Center

The Board of Supervisors should authorize the County Manager to direct the Director of the San Mateo Medical Center to:

General Operations:

2. Require enrollees of the WELL program to pay the annual fee within three months of enrollment or commit to a more suitable payment plan.
3. Triage WELL and other uninsured patients requesting emergency room services. Those determined not to be in need of immediate care should be directed to clinics for follow-up care. Although triage may slightly increase the possibility of medical liability and add initially to the administrative burden of emergency room personnel, it would dissuade patients from using emergency room services for non-emergency needs.
4. Instruct screeners to verbally verify patient eligibility with each hospital visit and annually confirm and document patient continued eligibility.
5. Develop a formal indigent care policy that specifies the qualifications required to receive medical care. This policy should be posted and published, where appropriate, and any individual seeking medical services should be required to formally acknowledge the qualifications established.
6. Transfer all accounts over 90 days past due and not eligible for the WELL program to the Revenue Services Collection Unit.
7. Suspend the 50% cash discount option that is available to uninsured patients with resources. Initiate a study that establishes the profitability of offering this option.

8. Require non-critical patients to provide identification prior to receiving initial treatment and inform them that a subsequent visit will require a documentation and verification process.

Screening Operations:

9. Investigate the cost, advisability, and timeliness of outsourcing the entire screening process as it relates to indigent care across all programs.
10. Upgrade the enrollment process to identify those individuals who do not qualify for medical care programs because of residency, income, or asset criteria by making verification of qualifying criteria mandatory in all cases and creating a prescribed script for screeners to determine that all relevant issues are covered.
11. Create or integrate a county wide, inter-departmental database to facilitate monitoring of program participants.
12. Combine all the screening processes under one department to enhance operational control and consistent application of qualifying criteria.
13. Redesign the WELL Program's self-declarative form to impress upon applicants the seriousness of the process and that providing false or inaccurate information may have legal ramifications.

Private Pay Patients

The San Mateo Board of Supervisors should require that San Mateo Medical Center:

14. Build a for-fee parking structure and offer valet parking providing convenient facility access for those unable or unwilling to negotiate parking lot distances.
15. Initiate a publicity campaign describing hospital capabilities and desirability as a provider of health care services.
16. Affiliate with other medical groups capable of referring doctors and patients.

Indigent Care and Charity Care Cost Sharing

17. The Board of Supervisors should research and explore methods to encourage the other non-profit hospitals to substantially increase their charity care.



San Mateo County Indigent Health Care

Issue

What can San Mateo County do to reduce the annual appropriation for indigent health care?

Background

San Mateo Medical Center (SMMC), the centerpiece of San Mateo County (SMC) government's health care plan, provides a full range of services including emergency care, surgical services, inpatient care, rehabilitation, laboratory, radiology and imaging services, senior support, and, in the planning stage, a maternity service. SMMC is available to all residents of the county and was built specifically to provide health care services for those not elsewhere supported; it represents the health care safety net for the community. Sixty per cent of its patients are enrolled in Medi-Cal or Medicare; 30% are categorized as indigent; and 10% are third party or full pay patients. For FY 2003/2004, SMC expended \$59.5 million in support of SMMC.

There are various approaches that can be taken to decrease the financial support required for public health:

- Determine the most cost effective indigent health care model consistent with county values – payer or provider model or combination of both.
- Increase hospital revenues by attracting more patients with private insurance coverage.
- Upgrade the interview and enrollment process to identify individuals who do not qualify for SMC supported medical services (i.e. WELL) due to out-of-county residency or for residents with incomes or assets that exceed established limits.
- Enlist other non-profit hospitals, which enjoy exemptions from income and property taxes, to actively serve the charity care patients of the county. They should either commit to serving this population or provide direct funding to SMMC in support of this population.

- Institute programs and procedures that minimize costs without degrading service provided.

The Grand Jury examined these issues by interviewing knowledgeable people involved with various aspects of public health care in the county; reviewing previously issued county studies; speaking with health services departments of other California counties; reading reports of other Grand Juries and non-profit research organizations; and interviewing vendors providing consulting and operational services in public health.

For purposes of this report, ‘charity care’ is defined as health care provided by non-public hospitals to recipients who are unable to pay and the hospital will not bill nor have any expectation of being paid.

‘Indigent care’ as defined by California’s Welfare and Institutions Code § 17000 is: “Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.”

This report is organized into the following four major sections, each with its own documentation of findings, conclusions, and recommendations.

	Section Topic	Page
I.	Overview of Health Care System Options	6
II.	San Mateo Medical Center Operation	9
III.	Private Pay Patients	15
IV.	Indigent Care and Charity Care Cost Sharing	17

Overview of Health Care System Options

Findings

Payer vs. Provider Model

In a provider model health care delivery system, the county provides the medical services and bears the costs. In a payer model delivery system, also called 'managed care,' the county contracts with a third party health care provider for patient services. A managed care system is designed to hold down costs by restricting the number of providers, establishing eligibility standards, and defining the health coverage that will be provided.

Health Care Delivery Models used by California Counties

Summarized below are the health care models used in San Mateo, San Diego, Orange, and Santa Barbara Counties, and the City and County of San Francisco.

San Mateo County Indigent Care Plan

SMC uses a provider model health care delivery system. The San Mateo Medical Center (SMMC) and its eleven associated clinics provide 95% of the charity care in the county. The county has three private clinics that address indigent care: Samaritan House, located in San Mateo and Redwood City, and Ravenswood, a Federally Qualified Health Clinic in East Palo Alto.

The SMC Controller's Office calculated that SMMC's daily average expenditures exceeded revenues by over \$150,000. Contributions from the general fund have increased from \$39.6 million in FY 2000/2001 to almost \$60 million in FY 2003/2004, a 52% increase.

Patient access consists of SMMC and 12 associated clinics. Cost per indigent patient is at \$1,997 annually.

San Diego County Indigent Care Plan

In 1983, San Diego County adopted a managed care method of health care delivery and created the San Diego County Medical Services System to meet the requirements of California's Medi-Cal Adult Indigent program. Currently, the provider is AmeriChoice, a health care services organization that handles most of the county's administrative functions for indigent care. County staff monitors the agreement with AmeriChoice and provides eligibility standards.

Patient access consists of 37 private clinics, 6 private dental clinics, and 15 private hospitals with cost per indigent patient at \$1,415 annually.

Orange County Indigent Care Plan

Since 1983, the county funded Medical Service for Indigent program (MSI) has served as the health care safety net for indigent adults. The program operates on a five-year plan that is reviewed and updated every six-months. MSI negotiates annual contracts with the Orange County Hospital Association representing county hospitals and the Orange County Medical Association representing 45,000 doctors.

Doctors decide individually whether to participate in the program and do not contract directly with the county but rather through the medical association. The current reimbursement rate for doctors is 80% of Medicare fees.

Patient access consists of 28 private hospitals and 10 private community clinics with costs per indigent patient at \$526 annually.

Santa Barbara Indigent Care Plan

In July 1983, Santa Barbara County formed the Medically Indigent Adults program (MIA) to provide the County's Public Health Department a quality assurance and cost containment system. This system consists of a large, county-run clinic in Santa Barbara that was formerly the county hospital, two large clinics located in Santa Maria and Lompoc and three smaller county operated clinics. All six are Federally Qualified Health Clinics. The MIA program contracts with three hospitals also located in Santa Barbara, Santa Maria and Lompoc. Contract doctors and specialists staff the county clinics and are available on specified days along with a pharmacy. A review manager refers patients needing care that cannot be provided by the clinics to an appropriate specialty doctor or hospital. The medical fee paid by Santa Barbara County for this service is the current Medi-Cal rate.

Patient access consists of six county-run clinics and three private hospitals. Cost per indigent patient per year was not available.

City and County of San Francisco

San Francisco City and County has outsourced part of its indigent care program to AmeriChoice, which serves as the fiscal administrator for the California Health Care for Indigents Program (CHIP). AmeriChoice provides financial administration, claims processing, and reporting.

Cost per indigent patient per year was not available.

Conclusions

The Grand Jury researched Orange, San Diego, and Santa Barbara counties regarding their indigent care programs as they approximated conditions in San Mateo County. Each has a different approach to indigent care but all use the managed care concept as the key factor to controlling costs. San Francisco City and County has outsourced a portion of its indigent care program.

The rising cost of supporting SMMC is not sustainable. Currently, expenditures exceed revenues by over \$150,000 a day. Indigent care is a complex issue beginning with patient screening and continuing through providing quality health care at a reasonable cost. SMC support of indigent health care for FY 2003/2004 was 150% of the expenditure for FY 2000/2001.

The counties reviewed, to varying degrees, have decided that outsourcing of medical services is an economically preferred alternative to the provider model. There is insufficient information available today to establish whether SMC should also consider outsourcing its medical services. See Appendix A, Converting of a Public Hospital to a Private Hospital for a discussion of the various effects of closing a public hospital.

Recommendations

The Board of Supervisors should:

1. Issue a request for proposal (RFP), within 90 days, to review public health care services provided by the county with particular emphasis on indigent care. Qualified proposals should demonstrate a high level of experience and active involvement with indigent care in California. The RFP should include but not be limited to a study of
 - Advantages and disadvantages of the payer model as compared to San Mateo County's provider health care system and should include the fiscal, medical, and social effects of each.
 - The effectiveness of the provider model currently employed.
 - The sale or lease to a third party, (e.g., Stanford University Medical Center, University of California San Francisco Medical Center), of the San Mateo Medical Center and clinics with the agreement it remain a provider of medical care to the indigent.

II. San Mateo Medical Center Operations

Findings

Overview

SMMC, a department of SMC, is a 227 bed, acute care hospital with 12 associated community clinics. Built in 2002 the hospital is a modern, seismically engineered facility constructed in response to California's Welfare and Institution Code requiring county government to support the incompetent, poor, indigent, and incapacitated not supported by family or other public or private institutions.

While fulfilling its obligations as mandated by the State of California, SMMC has expanded its initial purpose by including "excellence in health care" and "to be recognized as the best public health hospital and clinic system" as additional goals in serving the community.

The Market Place

SMMC is an independent and relatively small facility compared to other non-profit hospital networks such as Kaiser, Sutter Health, and Catholic Healthcare West. SMMC is disadvantaged when purchasing medical equipment and supplies because it lacks the purchasing volume to negotiate the lowest price available. With a higher cost structure, SMMC also loses advantage to the networks when establishing insurance and third party service fees.

The future of medicine will require ever increasing investments in specialized facilities, technologies, and services. This will become a significant problem for smaller health care providers dependent upon government for support or subsidy. The need for electronic health records; high cost clinical technologies with accelerated obsolescence curves; investment in capital intensive plant and equipment; genomic medicine; and computerized modeling for diagnosing illnesses, predicting therapy outcomes, and assessing risks are either here now or are just over the horizon.

SMMC is pursuing the development of state-of-the-art computer information systems. However, the Grand Jury review of patient screening and enrollment revealed a significant need for consolidation, simplification, and integration of existing system capabilities. It is unclear whether SMMC, as a lone community health care provider, has the resources or SMC the political will to support the hospital in the updating of its current systems as well as providing for the technological advances of the future.

Revenue / Service Enhancements

The SMC Controller's Audit Division conducted a review of SMMC and issued a document on January 1, 2005 titled, Operations Review Report, that offered the following:

- Thirty-five contracts with physicians were renegotiated, resulting in a stable medical staff.
- A new relationship was developed with the University of California, San Francisco for general and vascular surgery services. Vascular surgery is a new service and decreases the need to send patients to more costly outside providers.
- The Keller Center for Family Violence received a Management Excellence Award from the California Association of Public Hospitals.
- The Long Term Care Unit received the highest marks on the annual OBRA (Omnibus Budget Reconciliation Act - nursing home program) survey and no complaints were registered with the State Department of Health Services. This is highly unusual in the long-term care setting.
- The SMMC's cash factor (cash collections from patients / gross patient revenue) was 47% in FY 2003, second highest in the state compared with twelve other county-run hospitals.

The SMC Treasurer's office now receives all incoming payments directly from a post office lockbox at 6 a.m. and deposits the receipts into interest earning accounts within hours rather than days.

SMMC was awarded a \$1.6 million grant from the University of California AIDS Research Program.

WELL Program

The Wellness - Education - Linkage - Low cost (WELL) program provides coverage at or through SMMC for county residents who are not eligible for other plans such as Medicare, Medi-Cal, private insurance, or other third-party payers. To be eligible, residents must meet specified income and asset standards. WELL offers low cost, comprehensive coverage while providing a higher level of health care than most other California counties.

The individual annual, non-refundable enrollment fee is \$250 and co-payments are required. The fee does not have to be paid upon entry but payment is expected within one year of enrollment. Even with the program, enrollees still use hospital emergency room facilities for non-emergency services.

Although the requirements for WELL eligibility are established and available to hospital screeners, ineligible enrollees are still participating in the program.

Revenue Collections

The Revenue Services Collection Unit of SMC handles the collection of bad debts for SMMC. Their fees range from 4% to 35%, if legal services are required. They have collected between \$6 million and \$8.5 million for the years 2001 to 2003.

Delinquent claims, electronically forwarded for collection, frequently contain erroneous information due to incorrect data provided by the patient. As a result, the Revenue Service Collection Unit must research the account for the correct data, further delaying the collection process.

SMMC, at its option, can stop the collection effort by recalling an account from the collection unit. Account recall can occur when the patient protests the hospital's bill claiming eligibility in the WELL program. Upon recall, the delinquent debt is forgiven even though at some later date it may be determined that the patient failed to qualify for WELL.

Discounts

SMMC offers a 50% cash discount on incurred charges to both residents or non-residents not covered by public or private insurance. The effectiveness of the plan on collections has never been studied and it is unproven whether it serves the best interests of the hospital.

Discounts to non-county residents are offered under the assumption that these patients represent the biggest risk of non-payment after discharge. SMC's Revenue Services, with state of the art skip-tracing tools, believes a high success rate in locating and collecting outstanding receivables is possible.

Occupancy

In the last few years, inpatient days have fallen at most hospitals because of a trend to outpatient surgeries. The SMC Controller has calculated that SMMC had an occupancy rate below 50% (40,829 inpatient days / 227 beds * 365 days) for FY 2003/2004, down from 61% (50,461 inpatient days / 227 beds * 365 days) in FY 2000/2001 and, perhaps, the lowest rate of any hospital in the county.

Enrollment Screening, the Gateway to Health Care

From a taxpayer viewpoint, screeners are the gatekeepers to the public purse. Upon arrival, an SMMC patient must register with a screener. Screeners are entry-level administrative personnel who enroll patients and verify eligibility for one or more of the available programs. For those without insurance, SMC provides seven plans in addition to Medicare and Medi-Cal.

Screeners use several stand-alone computer programs for verification and enrollment. The registration process appears to be unnecessarily complex and time-consuming. Because the computer application systems are not integrated, the screener does not always know if the patient has unpaid hospital debts or if the driver's license or social security number provided is fraudulent.

Eligibility screeners follow no prescribed script but can question applicants as they determine necessary. They do not verify the information that the patient gives orally.

The County Controller, in a correspondence dated January 1, 2005 and addressing the issue of SMMC categorization of patients, offered that 20% of patients fail to meet eligibility guidelines. He estimated that \$2,183,800 could be saved annually by having screeners gather and verify relevant eligibility information instead of relying on patients' self-declaration.

Patient Costs (FY 2003/2004):

- Cost per indigent outpatient visit at the Medical Center or one of its clinics is \$384. Cost per indigent inpatient day is \$1,673.
- Bad debt and administrative write-offs were \$13,000,000.
- Due to federal regulations, Health Plan of San Mateo (HPSM), a managed care health plan for the Medi-Cal and other programs, excludes SMMC from \$5 million-\$7 million in annual supplemental payments.

Conclusions

SMMC provides a full range of health care services to all residents of the county and was specifically built to offer indigent care not elsewhere provided. SMMC represents the health care safety net for the community with over 90% of its patients supported by state, federal, or SMC public health programs.

Patients lacking either resources or insurance and not served by any other hospital in the county, require SMC to provide a general fund appropriation to SMMC totaling \$59.5 million dollars for the FY 2003/2004. The hospital has taken steps to ameliorate this subsidy by contracting with a cadre of physicians and attracting their patients, developing recognized specialty programs, and contracting or negotiating with established health insurers. Additional steps must be taken to improve account collections as well as strengthening patient screening to insure that all potential sources of patient funding have been evaluated.

The current screening process is operational and well managed, but there are many areas that require procedural reinforcement and improved computer system integration. The County Controller has stated that a sample eligibility test revealed that 20% of WELL patients were improperly enrolled and a savings was possible by verifying patient provided eligibility information.

Recommendations

The Board of Supervisors should authorize the County Manager to direct the Director of the San Mateo Medical Center to:

General Operations:

2. Require enrollees of the WELL program to pay the annual fee within three months of enrollment or commit to a more suitable payment plan.
3. Triage WELL and other uninsured patients requesting emergency room services. Those determined not to be in need of immediate care should be directed to clinics for follow-up care. Although triage may slightly increase the possibility of medical liability and add initially to the administrative burden of emergency room personnel, it would dissuade patients from using emergency room services for non-emergency needs.
4. Instruct screeners to verbally verify patient eligibility with each hospital visit and annually confirm and document patient continued eligibility.
5. Develop a formal indigent care policy that specifies the qualifications required to receive medical care. This policy should be posted and published, where appropriate, and any individual seeking medical services should be required to formally acknowledge the qualifications established.
6. Transfer all accounts over 90 days past due and not eligible for the WELL program to the Revenue Services Collection Unit.
7. Suspend the 50% cash discount option that is available to uninsured patients with resources. Initiate a study that establishes the profitability of offering this option.
8. Require non-critical patients to provide identification prior to receiving initial treatment and inform them that a subsequent visit will require a documentation and verification process.

Screening Operations:

9. Investigate the cost, advisability, and timeliness of outsourcing the entire screening process as it relates to indigent care across all programs.
10. Upgrade the enrollment process to identify those individuals who do not qualify for medical care programs because of residency, income, or asset criteria by making verification of qualifying criteria mandatory in all cases and creating a prescribed script for screeners to determine that all relevant issues are covered.

11. Create or integrate a county wide, inter-departmental database to facilitate monitoring of program participants.
12. Combine all the screening processes under one department to enhance operational control and consistent application of qualifying criteria.
13. Redesign the WELL Program's self-declarative form to impress upon applicants the seriousness of the process and that providing false or inaccurate information may have legal ramifications.

III. Private Pay Patients

Findings

SMMC hopes to increase revenues by attracting private, full-pay patients. To accomplish this, it signed a third party contract with Blue Shield and is in negotiations with Health Net and others. SMMC is considering a mailing to residents living in the area to encourage the use of hospital facilities and services.

SMMC is not affiliated with any private medical group serving the county that could serve as a conduit for enrolling doctors and providing medical services to their patients. Competition will increase in San Mateo County as Sequoia, Kaiser-Redwood City, Mills-Peninsula, Palo Alto Medical Group, and Stanford Clinic all have construction plans underway.

The Peninsula Health Care District (Mills-Peninsula Hospitals) has established facilities serving a core of physicians and patients and in close proximity to SMMC.

Access and parking are significant problems at the SMMC, with the parking lot full and the excess spilling over into the surrounding neighborhood. Convenient parking is required to attract private, full-fee patients.

SMMC, formerly known as Chope Community Hospital, is a new, modern facility. However, its origins as the “County Hospital” can be a challenge, when attracting community doctors and their insured patients.

Hospital outpatient visits for FY 2003/2004 were 194,019. Including Burlingame Long-Term Care and Ron Robinson Senior Center, the total is 204,264 visits. Estimates for FY 2004/2005 are 216,553, or approximately 5% increase (San Mateo County Adopted Budget Document 5-93).

The Controller’s San Mateo Medical Center Strategic Review stated that third party and full-pay patient net \$299 per inpatient day and \$236 per outpatient visit. Extrapolating from these values, it would require an additional 4,237 outpatient visits to increase a surplus by \$1 million.

Conclusions

SMMC has a significant access and parking problem that must be resolved to attract new revenue producing patients. Privately insured patients represent the biggest potential for revenue growth. Results to date indicate limited success in attracting this group.

Continuing efforts must be made to attract community doctors and their patients assuring them that SMMC is more than a “County Hospital”. Adding medical specialties,

publicizing the awarding of honors for excellence, and proclaiming the receipt of prestigious grants demonstrate the transformation that has occurred.

SMMC lacks affiliation with medical groups such as Mills-Peninsula Medical Group, Camino Medical Group, or Palo Alto Medical Foundation that serve as a source of doctor and patient referrals.

Recommendations

The Board of Supervisors should require the San Mateo Medical Center to:

14. Build a for-fee parking structure and offer valet parking that would provide convenient access for those unable or unwilling to negotiate parking lot distances.
15. Initiate a publicity campaign describing hospital capabilities and desirability as a provider of health care services.
16. Affiliate with other medical groups capable of referring doctors and patients.

IV. Indigent Care and Charity Care Cost Sharing

Findings

A non-profit hospital can earn a surplus on patient care and use the surplus for hospital reinvestment. For hospitals serving San Mateo County, Kaiser had a net surplus in 2002 of \$70 million, Sequoia Hospital had more than \$15 million, Palo Alto Medical Foundation almost \$7 million, and the Packard Children's Hospital over \$100 million. Despite these surpluses, these hospitals do not provide their share of charity care and continue to enjoy tax savings due to their non-profit status. Today, most hospitals maintain their non-profit status by contributing to the community, e.g., health fairs, community education, mobile vans, rather than contributing to charity care.

Nationally, the role of non-profit hospitals in providing charity care has received increasing attention. There is concern about the 'charitable purposes' of community hospitals and, in particular, aggressive billing and collections practices for the uninsured, underinsured or otherwise 'medically indigent.'

Secretary of Health and Human Services, Tommy Thompson, and the U.S. Inspector General have spoken out about hospitals charity care policies encouraging hospitals to provide more charity care and to discount their fees to the uninsured and underinsured.

Chairman of the House Ways and Means Committee, Bill Thomas said, "We really can't tell the difference, all that much, between a for-profit and a not-for-profit. What is the taxpayer getting in return for the tens of billions of dollars per year in tax subsidy?"

Counties have tried various approaches in urging hospitals to be more active providers to charity health care. The Grand Jury reviewed three of these counties: San Francisco, where it was hoped that public exposure would shame hospitals into action; Santa Cruz, where a fiscal agreement regarding charity care was signed with each hospital; and San Mateo County, where a voluntary approach backed by threat of a county ordinance is being discussed. . Appendix B explains further the efforts made by these counties.

In 1994, California's Senate Bill 697 (Torres) was signed into law requiring each private non-profit hospital in California to conduct a community needs assessment once every three years, develop a community benefit plan in consultation with the community, and annually submit a copy of its plan to the Office of Statewide Health Planning and Development. The bill has accomplished little because it contains no expenditure standards, but only the vague "community benefits." The required annual report to the state is not publicized and tends to exaggerate the amount spent on charity care by including items that are "community benefit" such as screening for prostate cancer or general health care publicity.

Conclusions

Although non-profit hospitals benefit from their tax advantages, they are not doing their share in providing charity care. San Mateo County seems indecisive and unable to come up with a viable solution to sharing the burden of charity care. “Critics argue that the county doesn’t have the authority to force a hospital, beyond current state and federal law, to care for a patient who can’t pay,” (Ref. 5).

As in Santa Cruz County, SMC must use leverage, such as approving new construction of a hospital, to force an Access to Medical Care Agreement with a non-profit hospital. If so, they must word any agreement clearly to focus on charity care and avoid the loophole of “community care.”

Recommendations

17. The Board of Supervisors should research and explore methods to encourage the non-profit hospitals to substantially increase their charity care services.

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- 7-"San Mateo hospitals urged to share charity-care costs," Silicon Valley Business, July 23, 2004.

Appendix A

The Effects of Converting a City or County Hospital to a Private Facility

California Welfare and Institutions Code Section 17000 defines the obligations of all counties and cities to provide medical care for residents without other means of support. “Every county and every city shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives and friends, by their own means, or by state hospitals or other state or private institutions.”

Local public hospitals have long served as medical providers of last resort for the uninsured poor, anchoring the safety net that provides access for the disadvantaged, especially in large urban areas. Such public hospitals provide not only emergency services but also urgent care and even primary care, through emergency rooms and outpatient clinics. After Medicare and Medicaid began in the mid-1960s, public hospitals became major providers of insured care as well, and many sought to broaden their appeal to the paying public. They frequently served as teaching hospitals for nearby medical schools, offering broad patient populations for teaching and research.

During the 1990s, fiscal pressures on public hospitals began to intensify. Since then, revenues have suffered because public programs and managed care have cut payment levels and because managed care and heightened competition have reduced admissions.

Medicaid managed care has shifted patients to lower-priced settings, and other hospitals have competed more vigorously for Medicaid patients because cutbacks under private managed care have made Medicaid clients more attractive. Expenses are high because of the growth in the numbers of uninsured patients. Public facilities also often have high costs as a result of caring for a low-income clientele with low health status, generally high staff-patient ratios, and often aging capital plants. Public hospitals also often have trouble responding to such challenges as nimbly as private competitors, as management flexibility and access to capital are harder to achieve under public ownership. At the same time, localities are hard pressed to raise taxes.

For these reasons, many counties have eliminated public-run hospitals. A September 2004 survey by the Institute for Health Policy Studies, University of California, San Francisco, found that for 48 California counties studied, 31 had eliminated their county hospitals.

The arguments for and against public versus private hospitals is given in the Urban Institute Study (ref. 1, p3):

“Supporters of public hospitals argue that only public operations can maintain the truly open door that guarantees good-quality care to all patients regardless of ability to pay.

Private hospitals, they assert, do not want to serve many of the uninsured and in any case cannot match the public sense of mission in doing so. Nor can they develop public providers' understanding for socio cultural factors that influence the medical needs of the disadvantaged. Not even an insurance card is enough to ensure good access to care for the uninsured poor, some advocates contend, because other impediments to care exist, including inconvenient location of most private facilities.”

“Proponents of privatizing the safety net counter that private operations improve access while saving money. They note that non-profit teaching hospitals and others also have safety net missions and suggest that even more uninsured care would be forthcoming if private facilities were given the public hospitals' funding. Private hospital operations are typically less bureaucratic, more efficient, and of higher quality, they assert. Moreover, reliance on a public hospital, they say, creates a medically inefficient safety net because timely ambulatory treatment can avoid the need for so many hospital services; more integrated delivery of care would be preferable.”

Appendix B

Indigent Care and Charity Care Cost Sharing

Santa Cruz County

The following material is taken from the 2003-2004 Santa Cruz County Grand Jury report “Hospitals and Charity Care in Santa Cruz County:

In addition to the state’s requirement for community benefit documentation, in 1993 Santa Cruz County created its own requirement, the Access to Medical Care Agreement (AMCA), which will be in effect until 2010. The AMCA agreement was the result of an announcement in 1992 by Sutter Health of its plans to build a hospital in Santa Cruz. Dominican Hospital and Watsonville Hospital opposed the idea, primarily because they questioned the need for another hospital. They cited the lack of an emergency room and intensive care unit as an important concern for Sutter’s patients. To settle this dispute and obtain County approval of the new hospital, representative of the three hospitals signed the AMCA agreement in 1993 that had two options: (1) they could spend at least 5.5% of their net operating expenses for charity care, exclusive of governmental supported insurance “losses,” or (2) they could spend 7% of the hospital’s net operating expenses as uncompensated care, which included charity care and bad debts, exclusive of governmentally supported insurance “losses.”

If the hospitals did not meet the AMCA options, they could (1) make a direct cash and/or in-kind contribution to a charitable, health-related organization and/or medical services benefiting the ‘medically indigent’ and/or low-income residents, or (2) document that the hospital has incurred direct costs associated with an ongoing, non-charge charitable health or hospital service, such as operating a ‘Free Clinic.’ If the hospitals did not fulfill these requirements they were to pay to the County the difference between the total amount of funds identified in the Plan and the actual funds spent.

Due to loose interpretation of the agreement by the County, the AMCA agreement did not accomplish much. The Grand Jury found that Sutter Hospital not only contributed less than its fair share in charity care but that it also substituted questionable “community benefit” activities for outright health care. “The devil is in the details,” Santa Cruz County health officials responded when defending the county’s approval of the hospital figures.

San Francisco City and County

A report by the Health Care Workers Union, Ref. 2, p.2, 3, was critical of San Francisco’s three largest private hospitals, (St. Mary’s Medical Center, St. Francis Memorial Hospital, and California Pacific Medical Center). “In 1998 the three hospitals enjoyed an estimated \$28.5 million in tax savings, yet spent only \$2.3 million on charity care. Of each dollar in tax savings that the three hospitals received, they spent only 8 cents on charity care... Neither state nor county governments have established adequate mechanisms for ensuring that private hospitals provide their fair share of direct care to

the poor and uninsured.” The report recommended that the City and County should force the hospitals to match the national average of at least 3 percent of net patient revenue be spent on charity care.

In 2001, San Francisco passed Ordinance Number 163-01, the Charity Care Policy Reporting and Notice Requirement (the Charity Care Ordinance), which requires non-profit hospitals to notify patients of their charity care policies and to report annually to the Department of Public Health specific information about the charity care they provide. The purpose of the Ordinance was to enable the City and County of San Francisco to evaluate the need for charity care in the community and to plan for the continued fulfillment of the City’s responsibility to provide care.

The Ordinance provides only for informational reporting; there is no action taken on these reports.

San Mateo County

The net gain and fund balance of hospitals serving San Mateo County for 2002, Table 1, shows that they have positive gains and a healthy fund balances.

Table 1 - Net Gain and Fund Balance of Hospitals Serving San Mateo County (Ref. 5)

Hospital	Net Gain	Fund Balance
Kaiser Foundation Health Plan	\$70,000,000	N.A.
Palo Alto Medical Foundation	\$6,709,586	\$231,790,579
Sequoia Hospital	\$15,643,320	\$31,122,437
Mills-Peninsula	\$22,930,598	87,269,776

In contrast, the SMMC had a loss of more than \$59.5 million for that year and has a zero fund balance. Much of the reason for this is that SMMC provides 95% of charity care in the county. SMC Supervisor Jerry Hill has said, “Since the non-profit hospitals in the county are all making money, they should provide more care for the uninsured – not simply patch them up and send them to the county hospital once they’ve been identified as uninsured.” (Ref. 5)

The Southern San Mateo Task Force on New Hospital Construction, Ref. 1, reached the following conclusions concerning the charity care situation: “Because of increasing costs, decreasing government funding, and increasing workforce competition in the face of workforce shortages, the County will soon face a major crisis in its ability to rely on SMMC as a safety net provider. SMMC provides a range of services that other institutions cannot individually or collectively supply. While other hospitals cannot be expected to bear the full burden of charity care, neither can they legitimately distance themselves from participating in the solution.”

The Task Force recommended the following rather weak solution to the problem: “The County should create a vehicle that includes all hospitals in order to dialogue as a group and see how the charity care issue can be resolved.”



COUNTY OF SAN MATEO
Inter-Departmental Correspondence

County Manager's Office

DATE: September 12, 2005
BOARD MEETING DATE: September 20, 2005
SPECIAL NOTICE: None
VOTE REQUIRED: None

TO: Honorable Board of Supervisors
FROM: John L. Maltbie, County Manager
SUBJECT: 2004-05 Grand Jury Response

Recommendation

Accept this report containing the County's responses to the following 2004-05 Grand Jury reports on Youth Gangs in San Mateo County, San Mateo County Indigent Health Care, and Adult Protective Services and Public Guardian.

Vision Alignment:

Commitment: Responsive, effective and collaborative government.

Goal 20: Government decisions are based on careful consideration of future impact, rather than temporary relief or immediate gain.

This activity contributes to the goal by ensuring that all Grand Jury findings and recommendations are thoroughly reviewed by the appropriate County departments and that, when appropriate, process improvements are made to improve the quality and efficiency of services provided to the public and other agencies.

Discussion

The County is mandated to respond to the Grand Jury within 90 days from the date that reports are filed with the County Clerk and Elected Officials are mandated to respond within 60 days. It is also the County's policy to provide periodic updates to the Board and the Grand Jury on the progress of past Grand Jury recommendations requiring ongoing or further action. To that end, attached is the County's responses to the Grand Jury's reports on Youth Gangs in San Mateo County issued on June 23, 2005, and San Mateo County Indigent Health Care and Adult Protective Services and Public Guardian issued June 29, 2005.

San Mateo County Indigent Health Care

Findings:

The County and San Mateo Medical Center (SMMC) have been working to continually improve operational efficiency. Even though SMMC is currently operating above the allocated budget, more patients have been served in every department, all cost of living increases and unfunded mandates haven been absorbed, and the 2005 fiscal year actual County contribution was \$8M less than it was in fiscal year 2002. We agree that all efforts should be made to serve the un- and underinsured as efficiently and effectively as possible, but continued threats of closing the Medical Center have serious unintended consequences on recruitment and retention, attracting new patients and philanthropy.

Recommendations:

I. Public Health Care Alternatives

The Board of Supervisors should:

1. **Issue a request for proposal (RFP), within 90 days, to review public health care services provided by the county with particular emphasis on indigent care. Qualified proposals should demonstrate a high level of experience and active involvement with indigent care in California. The RFP should include but not be limited to a study of:**
 - **Advantages and disadvantages of the payer model as compared to San Mateo County's provider health care system and should include the fiscal, medical, and social effects of each.**
 - **The effectiveness of the provider model currently employed.**
 - **The sale or lease to a third party, (e.g. Stanford Medical Center, University of California San Francisco Medical Center), of the San Mateo Medical Center and clinics with the agreement it remain a provider of medical care to the indigent.**

Response: Disagree. It is premature to issue a request for proposal (RFP) until the County has the information needed to make decisions related to employing a payer vs. provider model. The County acknowledges that it needs to determine the best approach to providing and funding indigent healthcare to meet its obligation under Section 17000 of the California Welfare and Institutions Code. It has recently developed separate financial assistance policies for the medically indigent, charity care, and self-pay, and has begun a pilot process to conduct full screening and verification of uninsured persons applying for health care coverage.

The data gathered during the pilot (October 2005 through March 2006) will be used to better define the medically indigent population and the County's financial responsibility under Section 17000. It will also provide more information about the charity care population being served at SMMC. This type of information is needed by County staff or outside consultants to analyze the advantages and disadvantages of a payer vs. provider model.

It should be noted that a similar proposal to examine a payer model was considered in 1993 when the construction funding for SMMC was being discussed. At that time, there was little interest on the part of the private community hospitals to assume responsibility for SMMC's population, particularly the psychiatric and long-term care components, which comprise over half of SMMC's current bed capacity. There is also limited capacity in the private sector for absorbing the large volume of SMMC outpatient clinic visits. The current SMMC leadership has more recently attempted to create affiliations with Sutter, Kaiser, CHW, UCSF, Stanford and Palo Alto Medical Foundation, with limited success.

II. Revenue Enhancement and Cost Reduction

San Mateo Medical Center

The Board of Supervisors should authorize the County Manager to direct the Director of the San Mateo Medical Center to:

General Operations

- 2. Require enrollees of the WELL program to pay the annual fee within three months of enrollment or commit to a more suitable payment plan.**

Response: Agree. Currently patients are asked for payment prior to or on the same day of the visit. Patients should expect to pay off the full amount of the annual fee in a timely manner. SMMC will explore shortening the timeframe in which a patient must pay the annual fee and what the penalty should be for non-compliance. This will be accomplished by the end of the fiscal year.

- 3. Triage WELL and other uninsured patients requesting emergency room services. Those determined not to be in need of immediate care should be directed to clinics for follow-up care. Although triage may slightly increase the medical liability and add initially to the administrative burden of emergency personnel, it would dissuade patients from using emergency services for non-emergency needs.**

Response: Agree in principle but find it difficult to implement due to recently enacted federal legislation called the Emergency Medical Treatment and Labor Act (EMTALA). This act requires all patients to be medically stabilized in the emergency room by a physician prior to discharge. In addition, all patients seeking emergency room care must be seen and treated by a physician regardless of ability to pay or type of insurance coverage. It is doubtful that this type of change would ultimately lower the Medical Center's costs since the patient, if referred later to a clinic, would be treated twice by a physician. However, Emergency Room management and Ambulatory Care management are currently looking at ways to reduce the number of patients being seen in the emergency room for non-urgent care. This includes educating patients on the alternatives for receiving non-urgent care outside of the emergency room.

- 4. Instruct screeners to verbally verify patient eligibility with each hospital visit and annually confirm and document patient continued eligibility.**

Response: Agree. SMMC does annually confirm and document continued WELL eligibility and verify patient eligibility with each hospital visit. In the outpatient clinics, registrars verbally verify demographic and insurance information with each visit.

- 5. Develop a formal indigent care policy that specifies the qualifications required to receive medical care. This policy should be posted and published, where appropriate and any individual seeking medical services should be required to formally acknowledge the qualifications established.**

Response: Agree. The Health Department, Human Services Agency, the County Manager's Office and SMMC have recently developed four financial assistance policies, including a formal indigent care policy. They will be posted and published in conjunction with the expanded WELL eligibility pilot program. Patients will be required to acknowledge the qualifications established to be eligible to receive financial assistance.

- 6. Transfer all accounts over 90 days past due and not eligible for the WELL program to the Revenue Services Collection Unit.**

Response: Agree. Currently any self-pay account greater than 30 days is assigned to the Revenue Services Collection Unit. As part of the new WELL Eligibility pilot program, this timeframe will be extended to any account greater than 90 days delinquent because SMMC will be forming an in-house self-pay team to collect on accounts that did not qualify for WELL or other coverage, including additional self-pay accounts that receive the new Health Care Discount option (charity care discount).

- 7. Suspend the 50% cash discount option that is available to uninsured patients with resources. Initiate a study that establishes the profitability of offering this option.**

Response: Agree that a study should be established to review the profitability of offering this option, but do not concur on suspending the cash discount option for uninsured patients with resources. The compelling reasons for offering discounts to self-pay patients are threefold, 1) self-pay patients represent the only payer group that has no option but to pay full charges, while all other payers receive some sort of discount. It is difficult to justify not offering a discount without the appearance of exploitation and it has become a community standard among hospitals to offer a discount, 2) this discount still allows the Medical Center to recover its costs, and 3) offering a discount allows the Medical Center to resolve its outstanding bills sooner, which lowers days in accounts receivable and reduces bad debt write-offs. A study will be performed by the end of the fiscal year.

8. **Require non-critical patients to provide identification prior to receiving initial treatment and inform them that a subsequent visit will require a documentation and verification process.**

Response: Agree with the implementation of the new WELL Eligibility pilot program. All patients that present without insurance coverage will be screened for financial assistance through a formal documentation and verification process.

Screening Operations

9. **Investigate the cost, advisability, and timeliness of outsourcing the entire screening process as it relates to indigent care across all programs.**

Response: Agree. Community Health Advocates from the SMMC and the Health Department, as well as community-based organizations, will be performing the screening function during the pilot process to conduct full screening and verification of uninsured applicants. The Human Services Agency will also be reviewing a portion of applications that are determined eligible for the WELL and Discounted Health Care (charity care) programs. Outsourcing of the screening process will be explored after the pilot has been completed and results evaluated at the end of the current fiscal year.

10. **Upgrade the enrollment process to identify those individuals who do not qualify for medical care programs because of residency, income, or asset criteria by making verification of qualifying criteria mandatory in all cases and creating a prescribed script for screeners to determine that all relevant issues are covered.**

Response: Agree. The County has initiated a pilot process to conduct full screening and verification of uninsured persons applying for health care coverage. Data collection will take place from October 2005 through March 2006 using a web-based screening tool called One-e-App. It is estimated that this effort will cost \$950,000. This includes modifications to One-e-App, extra help staffing and increases to community-based provider contracts, equipment and supplies.

11. **Create or integrate a countywide, inter-departmental database to facilitate monitoring of program participants.**

Response: Agree. As part of its information technology strategic plan, SMMC, along with the County's Information Services Department and other applicable departments has begun work on an unduplicated client database that will track health and social services provided to individuals by County departments including SMMC, the Health Department and Human Services Agency. The unduplicated client database will use a common client database across these three departments so that program data about common clients can facilitate better services for clients and for analytical and statistical

reporting purposes. This is referred to as the "Applicable Client Record Store (ACRS) and this technology approach lays important groundwork for other County operations. ACRS allows County departments who share clients to identify client records in the same way. This process will allow better Countywide reporting to measure the effectiveness of services provided by the County and to determine unmet needs. Cost estimates are not available at this time, but there will be costs incurred by the County for these efforts.

12. Combine all screening processes under one department to enhance operational control and consistent application of qualifying criteria.

Response: Agree. Alternatives to performing the screening process will be explored after the screening and verification pilot process has been completed and evaluated at the end of the fiscal year. There will be consistent application of qualifying criteria during the pilot, given the features offered by the One-e-App screening tool, including eligibility calculation logics for all programs and the validation of all required data fields and verification documents.

13. Redesign the WELL Program's self-declarative form to impress upon applicants the seriousness of the process and that providing false or inaccurate information may have legal ramifications.

Response: Agree. The WELL self-declaration process has been eliminated as part of the screening and verification pilot that is estimated to cost \$950,000. The financial assistance policies, application forms, and brochures have been modified in order to emphasize the consequences of providing false or inaccurate information, including denial or dis-enrollment, and criminal charges for perjury.

Private Pay Patients

The San Mateo Board of Supervisors should require that San Mateo Medical Center:

14. Build a for-fee parking structure and offer valet parking providing convenient facility access for those unable or unwilling to negotiate parking lot distances.

Response: A study is currently underway to evaluate additional parking. We anticipate recommendations by the end of October. However, it is doubtful that the majority of patients and visitors to SMMC would be able to pay for parking.

15. Initiate a publicity campaign describing hospital capabilities and desirability as a provider of health care services.

Response: Agree. We agree that SMMC is more than a "County hospital" and that its new hospital, in addition to its clinics and its many key programs, offer County residents quality services that anyone should be proud to use.

Unfortunately, because many people have not seen or heard from the Medical Center, public perception may not match this reality.

As the Grand Jury report states, to date we have signed agreements that enable us to accommodate private-pay patients yet the hard work of attracting them remains. We will be working on this effort through targeted outreach and publicity campaigns that focus on service lines where we have capacity. It is important to note that most of the clinics are filled to capacity and some have waits as long as three months for non-urgent visits so we can therefore only market certain services unless we open additional capacity. As much of the Grand Jury report focuses on cost, it is also important to note that publicity campaigns will require an investment in order to generate goodwill and eventual growth in volume. For example, we are developing an outreach campaign for the Ron Robinson Senior Care Center, in order to tell the community about its services and most important, about the benefits that this Center offers to seniors and caregivers. We will be preparing a similar campaign for the new Keller Women and Children's Center, scheduled to open in 2006.

16. Affiliate with other medical groups capable of referring doctors and patients.

Response: Numerous conversations with private physicians and medical groups were unsuccessful in generating significant additional private patients. Most physicians are affiliated with a hospital and are not interested in the additional drive time to SMMC. We are considering opening a private primary care office near SMMC to increase capacity and access for private pay patients and increase ancillary and hospital volume.

Indigent Care and Charity Care Cost Sharing

17. The Board of Supervisors should research and explore methods to encourage the other non-profit hospitals to substantially increase their charity care.

Response: Agree. Charity care is defined as free or discounted health and health-related services provided to persons who are uninsured and cannot afford to pay or who are not eligible for public programs. SMMC provides 95% of indigent in the county and a majority of the Medi-Cal or underinsured care. The County General Fund will contribute over \$54 million in FY 2005-06 toward these costs. It is anticipated that these costs will rise given continued increases in costs related to providing healthcare.

While most private hospitals have maintained their non-profit status by contributing to the community for the community's benefit and or by providing care to the underinsured, they have not significantly contributed to costs directly related to indigent care. There have been efforts to highlight the need for other hospitals to contribute to costs incurred by SMMC for indigent patients. One of the recommendations from the Southern San Mateo County

Task Force on New Hospital Construction in its June 2004 report was for the County to “create a vehicle that includes all hospitals in order to dialogue as a group and see how the charity care issue can be resolved.” The Hospital Consortium of San Mateo County, which includes SMMC, Mills-Peninsula Health Services, Sequoia Hospital and Seton Medical Center/Seton Coastsides, has recently attempted to quantify each organization’s contribution to indigent/charity care and benefits provided to the community.

The County is developing separate policies for medically indigent care, for which the County is financially responsible under its Section 17000 mandate, and charity care, in an attempt to further quantify costs incurred for charity care patients. The charity care policy was developed based on income and asset standards used by other community hospitals. The policies will be implemented during the eligibility screening and verification pilot that will start in late October. The results of the pilot will be used to further define the County’s obligation under Section 17000, which will not include charity care. Estimated costs for charity care will then be developed so that the Board can make decisions on how these costs should be funded by the County and other hospitals in the community.

The County has also reviewed San Francisco’s charity care ordinance that requires annual publication and dissemination of charity care statistics for all hospitals in the City, and will explore recommending a similar ordinance after completion of the pilot at the end of the fiscal year.