Summary of Provision of Indigent Health Care In San Mateo County

Issue

What can San Mateo County do to alleviate the growing financial burden that provision of health care to the financially indigent places upon San Mateo County?

Summary

Indigent and charity care growth is a national issue as medical costs increase and fewer people can afford medical insurance. San Mateo County is no exception. Indigent and charity care within the County is provided almost exclusively by the San Mateo Medical Center (SMMC). Contributions from the County General Fund for indigent and charity care have grown from $42 million in fiscal year 2001-2002 to a budgeted $70 million in fiscal year 2006-2007. The total County budget grew 39% over the five-year period, while the General Fund contributions to the SMMC grew 68%. However, the percentage of the SMMC budget which comes from the County General Fund has remained roughly constant. If growth in County income does not keep pace with the increase in the cost of indigent health care, then other County services will be impacted.

The County is sending mixed messages with respect to its obligation to provide indigent care. On one hand, the County Manager insists that the increasing SMMC budget deficits must be arrested. On the other hand, the Board of Supervisors has concurrently commissioned a study to determine the implications of broadening indigent care coverage. The Board of Supervisors should set a policy that reconciles budget concerns with the level of indigent health care the County will provide to meet or exceed statutory requirements.

Some of the proposals for containing indigent care costs at the SMMC that have been introduced in the recent past include:

- increasing revenue and reducing costs at the SMMC
- closing the SMMC or leasing it to a private operator
- reorganizing the County health care districts
- retaining the SMMC but changing the mix of services offered

Only the last of these proposals appears likely to result in significant cost reductions.

The Board of Supervisors and the County Manager must decide what level of indigent care the County can provide given the available funds and the fiscal demands of other County programs, and they should communicate this shared vision with the public. The Board of Supervisors should also initiate a review of how provision of indigent care in the County might be changed to reduce costs, with particular emphasis on what financial and social implications follow from changing the mix of services offered by the SMMC.

Provision of Indigent Health Care
In San Mateo County

Issue

What can San Mateo County do to alleviate the growing financial burden that provision of health care to the financially indigent places upon San Mateo County resources?

Background

Indigent Care

Growth in the cost of providing medical care for the uninsured poor is a national problem. Medical and insurance costs have been increasing faster than inflation. Nationwide medical costs rose 7.9% in 2004, two to three times the general inflation rate, or the growth rate of the wages for the working poor. Rising health care costs have resulted in rising numbers of uninsured. Nationwide, the number of uninsured has increased by 6.9 million since the year 2000 (New York Times, March 5, 2007). As a result, an increasing fraction of the population is becoming dependent on ever more costly subsidized care.

The Blue Ribbon Task Force on Adult Health Care Coverage Expansion (Task Force) "Report on Demographic Highlights of San Mateo County Uninsured Adult Population" estimated that in 2003, 12% to 13.5% (52,000 to 60,000) of San Mateo County (County) adults between the ages of 19 and 64 were uninsured. (See Appendix 1 for more statistical detail.) Of the uninsured, 70% are estimated to have an income below 400% of the Federal Poverty Level (FPL). For a family of three living in California, 400% of the FPL is $66,640/year. A *Glossary* can be found at the end of this Report that defines acronyms and technical terms used throughout.

Counties are required under California's Welfare and Institutions Code §17000 (Section 17000) to provide health care to their medically uninsured, indigent residents. The courts give little guidance about the specific obligations required under Section 17000, although they have

established some broad principles: (1) a county must offer care to all medically indigent that are lawfully resident in the county; (2) eligibility for care must be based on medical need, not simply on income or some other standard such as eligibility for Medi-Cal; and (3) the county must provide indigent residents not just emergency care but also that care necessary to preserve life and/or limb or to prevent avoidable suffering.

The County runs several financial assistance programs to cover medical costs for low-income patients. The Wellness, Education, Linkage, Low-cost (WELL) Program was created in July 1996 and the County relies largely on its eligibility criteria as a basis for satisfying Section 17000 requirements. To be eligible for the WELL Program, patients must be ineligible for other insurance programs such as Medi-Cal, must be a County resident, have an income at or below 200% of the FPL and have assets that do not exceed $2,000 per family unit member (excluding one vehicle). There are approximately 13,000 WELL patients who are charged a $250 annual fee and co-pays for visits to the County hospital, San Mateo Medical Center and its clinics (SMMC). A full fee waiver is available for those making less than 100% of the FPL with low assets. There is also a Discounted Health Care (DHC) program for residents who would not be considered "indigent," i.e., residents who have income at or below 400% of the FPL and family assets of less than $15,000.

The County is one of 13 California counties that meets the Section 17000 obligation by operating a county hospital – the SMMC. Because the County owns its own hospital, the cost of indigent medical care includes not only the direct cost of providing care, but also the total revenues and expenses associated with operating an acute care hospital and out-patient services. These costs include bad debt and "charity care" (which refers for purposes of this report to the cost of care provided to those who are uninsured or underinsured, do not have the ability to pay their medical expenses and are not eligible for the WELL Program). The term "indigent care" refers to the medical care provided under Section 17000 to those who, due to poverty, are unable to pay their medical expenses; meet the eligibility requirements of the County's WELL Program; or require in-patient and emergency psychiatric treatment. The term "subsidized health care" includes both indigent care and charity care.

The SMMC has historically provided more than 95% of the charity care in the County, serving not only those eligible for the WELL Program, but also ineligible uninsured patients. Ineligible uninsured patients could be nonresidents and/or could have income and assets that exceed certain limits. The cost for this medical care has been generally included in the annual financial subsidy provided to the SMMC by the County. Costs for providing the care are increasing faster than inflation. In fiscal year 2001-2002, the County's subsidy to the SMMC for provision of indigent and charity care was $41.8 million. The subsidy for fiscal year 2006-2007 is expected to be $70 million, which reflects an annual inflation rate of approximately 11%. Although the fraction of the County's total budget represented by the subsidy has been roughly constant in recent years, a recent study by the County Manager estimates that the subsidy will consume 60% of the County's property tax revenue by 2014, compared to the present 41%. Unless this growth is arrested, the subsidy will have a major impact on many other County-funded services including law enforcement, child welfare and public works.

Previous County Studies of Indigent Care

Until recently, the County did not have the relevant data and tools necessary to determine the costs of providing indigent medical care, nor did it have the population data needed to reliably estimate or categorize the number of indigents that needed the services of the SMMC. Over the past four years, however, the County initiated a series of studies intended to identify this outstanding information, including financial data needed to properly categorize its costs for indigent care, charity care and bad debt. Meanwhile, the County continues to contribute the difference between total expenses and revenues for the SMMC operations each year (in some cases, the "contribution" is considered a loan, e.g., where actual losses are greater than budgeted, although expectations are low that the loan will ever be repaid).

Since 2004, the County has undertaken a series of studies to gather the relevant data and tools. Examples of these efforts include the following:

- In July 2004 the Controller's Office completed a study of the indigent population served by the SMMC – the "Indigent Eligibility Study." Conclusions included:
  (a) at least 20% of patients treated as "indigents" by the SMMC did not meet the WELL Program indigent criteria;
  (b) the "payer" model for delivering health care remains the most compelling choice for the County;
  (c) an improved eligibility screening process should be implemented immediately; and
  (d) a formal indigent policy should be developed.
- Also in July 2004, a consulting firm hired by the County, analyzed both County and the SMMC expenditures and revenues related to indigent medical care, and released a report describing the net cost of indigent medical care and a list of recommendations. For fiscal year 2003-2004, the total cost was found to be approximately $63 million, with a net cost to the County of $44.5 million once certain discretionary funds, such as realignment funds[1] and tobacco settlement funds, were taken into account.
- In January 2005 the Controller's Office released a report "Categorization of Patients" that identified $2.1 million in cash flow enhancement opportunities through improved categorization of patients and collection from ineligible recipients of charity care.
- Also in January 2005, the County Manager released a report "Indigent Healthcare in San Mateo County: A Review of Policy Issues" that recommended formation of a County workgroup to address certain key issues, including:
  (a) a definition of the term "indigent;"
  (b) an eligibility screening process for the WELL Program;
  (c) agreed baseline figures for the indigent population and costs of indigent healthcare; and
  (d) agreed methodology (by all relevant County Departments) for cost per indigent patient comparisons and development of cost data.
- In May 2005 a County Medically Indigent Healthcare Workgroup made recommendations toward creating a long-term financially viable business model for the SMMC that met Section 17000 obligations for medically indigent health care in a cost-

[1] See Glossary

effective manner, defined responsibilities, apportioned costs between the General Fund and the SMMC Enterprise Fund and provided stable indigent funding to the SMMC. Their July 2005 findings included:

(a) There was no compelling case to establish a formal definition of the County's Section 17000 obligation. The County has implicitly defined this obligation as those patients who are eligible for the WELL Program. It was generally agreed that this issue should be reconsidered once a full eligibility study had been completed.

(b) County Counsel found that Section 17000 defines lawful residents as those who have resided in the County continuously for one year immediately preceding the application for assistance; undocumented persons are not deemed to be lawful residents. By providing care to undocumented persons, the County, as well as most other Bay Area counties, surpasses the minimum legal requirements of the Section 17000 obligation**.**

(c) There is a need to develop a charity care policy that mirrors those of local private hospitals. The County should be responsible for covering these costs but such costs should not be considered a Section 17000 obligation. Bad debt losses should be absorbed by the SMMC, not the County.

(d) The County Manager, the SMMC and the Controller's Office should work together to finalize cost information on the WELL Program, self-pay patients and the current WELL population.

(e) A memorandum of understanding (MOU) should be established to define responsibilities and division of costs between the County General Fund and the SMMC.

- In April 2006, a status report from the County Medically Indigent Workgroup indicated that the MOU and a determination of the Section 17000 obligation were still outstanding.
- In April 2007, the County released its report "Medically Indigent (WELL) Screening and Verification Pilot" that illustrated the results of implementing a full screening process that required uninsured applicants using the SMMC services to show proof of County residency, assets and income. There were 13,054 applicants in fiscal year 2005 and 9,837 in 2006, a 25% decline. It is not clear that a 25% decrease in cost was realized. In the same period, 597 patients were enrolled in the newly implemented Discounted Health Care program. The self-pay numbers remain about the same level (12,422 patients). The WELL Pilot report provides data for reliably estimating the size and demography of the indigent population in the County using the SMMC services.

San Mateo Medical Center

In 1994, the County Board of Supervisors approved the issuance of lease revenue bonds in the amount of approximately $125 million for the construction of an integrated health center that meets state seismic safety mandates. Completed in 2002, this project combined the former Chope Hospital and Crystal Springs Rehabilitation Center and was renamed the San Mateo Medical Center.

The SMMC provides inpatient and outpatient services through an acute care hospital (509 licensed beds which includes the 281-bed Burlingame Long-Term Center). The SMMC also

operates community health clinics located in Daly City, San Mateo, Redwood City, Menlo Park, Half Moon Bay and East Palo Alto. These clinics provide community oriented primary care and specialty services to meet the health care needs of the County. The mission of the SMMC is to serve the health care needs of all County residents, emphasizing education and prevention without regard for ability to pay. The SMMC includes 24-hour emergency care, a seven-bed intensive care unit, inpatient surgical services, long-term care, rehabilitation, inpatient and emergency psychiatric services, radiology and imaging, clinical trial research, and laboratory and pharmacy services. Outpatient clinics provide over 210,000 outpatient visits a year.

Health Care Districts

In the late 1940s two hospital districts were formed in the County to build Sequoia and Peninsula Hospitals. Each district was run by an elected board, and the hospitals were funded from tax proceeds and fees from patients. In the 1960s and 1970s greater scrutiny of hospital costs by insurers, and a variety of other factors resulted in shorter hospital stays, more outpatient care, more empty beds and budget deficits for most hospitals. In the 1980s and 1990s this caused many hospital districts throughout California to transfer the management of the hospitals to private, for-profit or non-profit hospital companies and to use their tax revenues to support a range of community wellness programs. Key events related to changes in hospital districts include:

- Proposition 13 defined the fraction of property tax revenue allocated to health care districts
- In 1993, the California legislature amended hospital district-enabling legislation renaming hospital districts “health care districts” and expanding the definition of health care facilities to reflect changes in medical practice as health care was evolving more into outpatient services
- In 1994, the Legislature established seismic safety standards for hospitals requiring compliance by 2013 and in most cases, replacement of existing hospitals

Following an election in 1996, the Sequoia Hospital health care district affiliated with Catholic Healthcare West (CHW) to form a new non-profit corporation, Sequoia Health Services (SHS). A ten-member board of directors, five from CHW and five from the district, now oversees SHS and the hospital. The district itself does not directly manage the hospital but currently collects about $5.8 million per year in taxes within its district boundaries and spends roughly $4.0 million per year on community health, wellness and disease prevention programs including: grants to the Samaritan House free clinic, the Children’s Health Initiative, nursing school education, community grants and capital projects at Sequoia Hospital. It has accumulated roughly $65 million in reserves of which $25 million is committed to rebuilding Sequoia Hospital, and the remainder to protect itself against any contractual default by CHW. CHW has a 30-year hospital management contract with SHS but does not own the hospital. Neither CHW nor the hospital has an obligation to provide indigent care except in emergencies. The courts have ruled that the County must accept transfers of indigent, non-emergency, ill residents from private hospitals as part of its Section 17000 obligations.

The Peninsula Health Care District (PHD) was formed mainly to operate Peninsula Hospital. Now, after several mergers and consolidations, Sutter Health operates the Peninsula and Mills Hospital facilities under a 30-year contract with PHD. Peninsula Hospital is still owned by PHD and Mills Hospital is owned by Mills-Peninsula Health Services. The PHD currently collects about $3.4 million in taxes from which it funds various health-related community services such as support to the Samaritan House free clinic, grants to the Children's Health Initiative and nursing education programs. It has accumulated roughly $24.5 million in reserves to protect itself against any contractual default by Sutter Health. Again, Sutter Health has no obligation to provide indigent care except in emergencies.

The two hospital districts have been criticized in that they collect roughly $9 million annually in taxes and, while they do support a number of community health care programs, they do not contribute directly to fund indigent care at the SMMC or help cover its operating shortfalls. The enabling health care district legislation specifically bars districts from providing services to offset counties' indigent care obligations at less than their cost yet it does not bar districts from offering grants to non-profits or other entities that provide health care services. The two health care districts are the subject of a recent Municipal Service Review by the Local Agency Formation Commission (LAFCo)[2] including structural options for governance alternatives, such as consolidation or reorganization. These April reports provide an interesting discussion of alternatives whereby tax funds collected for the provision of district health care services might be used to offset indigent health care costs.

Blue Ribbon Task Force on Adult Health Care Coverage Expansion

In June 2006, the Board of Supervisors created the Task Force with the following charges:

- Explore options for providing comprehensive health care access and/or insurance to uninsured adults in the County living at or below 400% of the FPL ($66,640/year for a family of three)
- Present recommendations to the Board of Supervisors by July 2007

Note that the Task Force was not charged with exploring ways to reduce County costs for indigent care, the main thrust of this Grand Jury Report, but instead was asked to determine what provision of health care to uninsured living below 400% of the FPL would entail. The Task Force activities are summarized in the Findings below because they shed additional light on the indigent/charity care population and many of the Task Force findings are relevant to understanding the indigent/charity health care costs to the County.

The Task Force membership is an impressive group of business and community leaders, including representatives from the County and cities, labor groups, County health and human services, private hospitals, health care districts, hospital foundations, clinics and community foundations. Three workgroups were formed, each tasked with gathering data to answer specific questions. The Population Definition Workgroup was asked to develop a profile of the uninsured adult population in the County (e.g., income, employment status, ethnicity, place of

[2] April 2, 2007 Municipal Review for Sequoia Health Care District and Peninsula Health Care District and its April 16, 2007 Addendum Report (www.sanmateolafco.org).

residence and health profile). The Health Care Model Development Workgroup was charged with determining the scope of benefits for inclusion/exclusion in a coverage or insurance product, ascertaining provider capacity, and determining whether innovative health care delivery mechanisms could be employed. The Financing Mechanism Development Workgroup considered the estimated costs of new coverage and/or insurance options, the availability of public or private financing vehicles, and whether such costs would be shared by the community.

State and Legislative Initiatives

Governor Schwarzenegger unveiled a health care plan in January 2007 that sought to provide universal coverage, and all but the smallest businesses would be asked to provide coverage. All Californians would be required to have insurance, while insurance providers would be required to offer polices to anyone who applied. This plan has yet to be introduced into the Legislature, while health care bills sponsored by Speaker Nunez and Senate President Pro Tem Perata have recently been approved by committees in the Assembly and the Senate.

On March 29, 2007, Governor Schwarzenegger announced the allocation of $540 million to counties to test innovative ways of providing health care for the uninsured, including nearly $7.6 million annually for three years to the SMMC. This money will be used to further develop the WELL Program.

Findings

I. Indigent and Charity Care at the SMMC

There are two overriding and potentially conflicting issues with respect to indigent care: First, is the County facing a financial crisis and, if so, what should be done about it? Second, in the interest of the health and well-being of the general population, should the County provide subsidized care to a larger fraction of the uninsured than at present, thereby incurring even greater costs? Many previous studies, including previous grand jury reports[3], have addressed the first issue. The Task Force is addressing the second issue.

Indigent and charity care growth is a national issue as medical costs increase and fewer people can afford medical insurance. San Mateo County is no exception. Indigent and charity care within the County is provided almost exclusively by the SMMC. As shown in Table 1, contributions from the County General Fund for indigent and charity care have grown from $42 million in fiscal year 2001-2002 to a budgeted $70 million in fiscal year 2006-2007, reflecting an annual growth rate of 11%. The total County budget grew 39% over the five-year period represented in the table, while the General Fund contributions to the SMMC grew 68%. However, the percentage of the SMMC budget which comes from the County General Fund has remained roughly constant, increasing from 29% to 32% over the same period. One of the reasons for this slow growth is the revenue enhancement measures implemented by the SMMC, but there appears to be little room for additional enhancement.

[3] See, for example, 2004-2005 San Mateo County Civil Grand Jury Report on "San Mateo County Indigent Health Care."

Table 1

FY2002-FY2007 ($ in Millions)							
	FY01-02	FY02-03	FY03-04	FY04-05	FY05-06	FY06-07	**% Increase over 5-year period**
Total County Budget (net appropriations)	$991.1	$1,049.7	$1,105.2	$1,132.4	$1,256.7	$1,374.1	38.6%
Total SMMC Budget including capital (net appropriations)	$144.3	$155.5	$166.9	$187.7	$209.2	$223.4	54.8%
Total General Fund contributions to SMMC	$41.8	$46.0	$58.5	$56.4	$58.9	$70.3	68.0%
SMMC Budget as % of County Budget	14.6%	14.8%	15.1%	16.6%	16.6%	16.3%	
General Fund contribution as % of SMMC Budget	29.0%	29.6%	35.1%	30.0%	28.2%	32.1%	

The costs incurred by the SMMC to provide medical care to the indigent population over the last five years are presented below in Table 2. This Table should be viewed with caution because it was not until fiscal year 2005-2006 that the County was able to estimate accurately the SMMC costs that went specifically for indigent care. During this five-year period, indigent care costs increased by 54% which is in keeping with the increase of the total SMMC budget of 55%. The cost of indigent care as a percentage of the SMMC budget has remained relatively steady.

Table 2

Estimated Cost for SMMC to Provide Healthcare to the Indigent Population FY2002-FY2007 $ in Millions							
	FY01-02	FY02-03	FY03-04	FY04-05	FY05-06	FY06-07	**% Increase over 5-year period**
Estimated cost of indigent care	$25.9	$26.5	$32.5	$35.2	$37.1	$39.8	53.5%
As a % of SMMC Budget	18.0%	17.0%	19.5%	18.7%	17.7%	17.8%	

In fiscal year 2005-2006 the General Fund contribution to the SMMC was $58.9 million, of which $37.1 million was for indigent patients (mostly in the WELL Program), as shown in Table 2. While the costs of the WELL Program are reasonably well understood, the causes of the remaining $21.8 million deficit are not. The latest cost study performed by the SMMC, which is still in progress, indicates that the remaining, non-indigent deficit comes from the sources shown in Table 3.

Table 3

Sources of Non-Indigent Deficit - FY 05-06

Financial Class	Amount	Percent of non-indigent deficit
Self Pay	$1,186,249	5.4%
HMO's	$2,934,888	13.4%
Insurance	$4,691,486	21.5%
Medicare	$5,242,928	24.0%
Pending Final Determination of Financial class	$5,814,568	26.6%
Costs not used in cost study	$1,920,626	8.8%
Other	$37,249	0.2%
Total	$21,827,994	100.0%

Medi-Cal does not appear as a financial class in Table 3 because, although previous analyses by the County have identified meager Medi-Cal revenue as a major cause of the deficit, the SMMC's management has recently noted that State and Federal supplements to Medi-Cal revenue are available to, and collected by, the SMMC as a safety net hospital. When these supplements are taken into account, it appears that Medi-Cal service does cover its costs. The profitability of service lines other than Medi-Cal, particularly Medicare, may be called into question as this cost study proceeds.

Funding for the SMMC is provided not only from the County General Fund but also includes the sources identified in Table 4 below. These revenue sources were identified by the Task Force based on 2005 data. Any restructuring of the way indigent care is provided by the SMMC must be evaluated in light of the potential loss of revenue from these sources.

Table 4

Source of funds	2005
Realignment – Vehicle License Fees	$21.4 million*
Required County Match	$6.8 million
County Over-Match	$8.4 million (FY 03-04)
Proposition 99 Tobacco Tax	0.4 million*
SB 12/Maddy	$1.1 million
Net Medi-Cal DSH	$4.9 Million*
Tobacco Settlement	$7.6 million
GRAND TOTAL	**$50.7 million**

* County would lose these revenues with move to payer system

The Grand Jury is skeptical that further increases in efficiencies at the SMMC will lead to significant reductions in the County subsidy. A 2006 study showed that costs per day for inpatient care are lower at the SMMC than at San Francisco General Hospital (SFGH) and Santa Clara Valley Medical Center (SCVMC) in the adjacent counties. The lower costs result in part from the narrower range of services provided by the SMMC. Both SFGH and SCVMC are major trauma centers, offer a wide range of acute care services and are teaching hospitals with

multiple residency programs. The costs at the SMMC are also significantly lower than those at other hospitals in the County.

Although the SMMC has introduced effective cost-cutting measures in recent years, the County Manager has demonstrated concern over growth in the deficit accumulated by the SMMC. This concern is evident in the MOU between the County Manager and the SMMC, dated August 15, 2006, which states that over-budget contributions from the County General Fund to the SMMC, accumulated from fiscal year 2003-2004 to fiscal year 2005-2006, in the amount of $43.5 million, shall be treated as a 30-year interest-free installment loan. Repayment would begin on July 1, 2007. Subsequent over-budget contributions would also be considered 30-year interest-free installment loans, subject to a limit of $70 million in total borrowing. This MOU has ***not*** been executed (signed) by either party. Since no new source of funds (cash flow) for repayment of these loans has been identified, it is unlikely that the SMMC can make the payments without worsening its deficit.

II. Health Care Districts – Governance Alternatives

Various suggestions have been made to reorganize the hospital districts within the County so that the nine million dollars in taxes collected annually by the districts could be used to help cover the cost of indigent care. None of the options summarized below will significantly reduce the current $70 million cost to the County for indigent care and/or operating shortfalls at the SMMC. Thus, while there may be other reasons for reorganizing the districts, reorganization is not a solution to the indigent care crisis. These options are covered in greater detail in the recently issued LAFCo report[4].

- Dissolve both SHD and PHD and designate the County as the successor agency that would collect the tax revenues and assume the responsibilities of the current districts. Both health care districts have challenged the legality of this option as residing outside the authority granted LAFCo.

- Consolidate SHD and PHD. Savings might be available from eliminating one administrative staff and board of directors but considerable governance and conflict of interest issues arise as the consolidated district would be a partner with two competitors. Moreover, the SMMC would remain outside the jurisdiction of the consolidated district and continue to have responsibility for the costs of providing indigent care.

- Expand the Districts. In this option, the boundaries of the two districts would be expanded to include the areas not currently in either district. While there may be certain advantages for this proposal such as more opportunities for regional planning, approval would be required by voters in the annexed areas who would have to contribute a fair share of tax revenues.

[4] Id. at www.sanmateolafco.org,

III. Blue Ribbon Task Force

The Task Force was scheduled to finish its work in July 2007 by providing recommendations to the County's Board of Supervisors that address health care coverage proposals for uninsured adults having low income. The Task Force appears close to agreeing on a general outline of a coverage plan but will extend its term until year-end. This section provides highlights of the findings and deliberations to date. Note that the problem addressed by the Task Force was not how to reduce County costs for indigent care but what it would cost to provide health care for the adult population of the County that is living below 400% of the FPL. The WELL Program eligibility limit is currently 200% of the FPL.

- The Population Workgroup of the Task Force reported that the proportion of uninsured adults ages 19-64 in the County is in the range of 12% to 13.5% of the total adult population. [5] Given the current adult population, it is estimated that there are between 52,000 and 60,000 uninsured adults in the County (9,000 - 11,000 of these are currently enrolled in the WELL Program). It is estimated that 70% of uninsured adults have a household income at or below 400% of the FPL, translating to a total uninsured adult population range between 36,000 and 44,000.

- In January 2007 the Financing Development Workgroup presented its findings to the Task Force.[6] The current cost of care to uninsured adults in the County that is spent by the County, private hospitals and charitable entities, were summarized as shown in Table 5:

Table 5

Organization incurring Costs	**Cost of Care (2004/5)** (range due to data differences)
SMMC (including WELL)	$48 million to $53.6 million
Private Hospitals	$12.7 million
Free and Community Clinics	$6.1 million
GRAND TOTAL	**$66.8 million to $72.4 million**

- The actuarial analysis performed by consultants hired by the County presented its total cost estimates to cover all 36,000 to 44,000 uninsured adults living in the County with income below 400% of the FPL. The County's plan is estimated to cost $165 million annually, of which $48 million would be funded through coordination with other programs, such as those listed in the above table, leaving the County to fund $117 million for this coverage, unless third parties and/or patients assist in this funding. The projection shows average costs of $344 per month per individual for the type of coverage the County is hoping to provide.

[5] These findings and more are provided in the December 2006 Report to the Task Force: Demographic Highlights of the San Mateo County Uninsured Adult Population). See also Appendix 1.
[6] January 9, 2007 presentation, Current Spending and Funding for Care to the Uninsured

Conclusions

The County, as represented by the County Manager and the Board of Supervisors, is sending mixed messages with respect to providing indigent care. On one hand, the County Manager claims there is an imminent crisis and that the growing cost of providing indigent care will have significant negative effects on other County programs such as law enforcement and child welfare. On the other hand, the Board of Supervisors concurrently commissioned a study of the effects of increasing the scope of the County-subsidized indigent and charity care, which could result in increased health care costs to the County.

The Board of Supervisors must be willing to entertain discussion of serious public policy issues such as who is eligible for subsidized care, what the breadth of that care should be, and what the consequences might be of providing or not providing broader coverage. There is no written legal opinion addressing the minimum legal requirements of Section 17000, rather the eligibility requirements established for the WELL Program remains the *de facto* standard used by the County. The Board of Supervisors needs to decide whether to restrict subsidized care to the legal minimum, leave it unchanged or further expand such coverage to a broader population with its attendant costs. The County currently estimates that it spends $40 million on "true" indigent care, yet its total contribution is $70 million which includes costs for charity care. The proposed adult coverage expansion will require an even greater contribution from the County General Fund, should it be adopted.

Proposals for Reducing Costs for Indigent Care – SMMC

Several suggestions have been made on how the County might reduce the costs for indigent care:

(1) Improve revenue enhancement and cost reductions at the SMMC, and attempt to get private hospitals to carry more of the indigent burden. This is unlikely to produce significant cost reductions. The costs at the SMMC are already lower than at private hospitals in the County and public hospitals in the adjacent counties, and programs for more complete debt collection and closer scrutiny of eligibility for WELL Program benefits are underway.

(2) Consolidate the health care districts into one countywide district so that the taxes currently collected by the districts can be used to offset indigent care costs. Apart from legal and practical considerations, this is unlikely to provide much relief as charity and other services currently provided by the districts would have to be assumed by the County.

(3) Sell, lease or donate the SMMC hospital facility to a private entity and have the County reimburse the operator for indigent and charity care. This presumes that a buyer, a lessee or a recipient could be found, which may be problematic given the perceived stigma associated with a county hospital, the underutilization by paying patients, and other negative factors such as inadequate parking.

(4) Close the SMMC and contract with private hospitals for indigent patient care. Complete closure of the SMMC with its clinics, long-term care, psychiatric facilities, and other programs would leave a gap in health care coverage in the County. It is not clear to the Grand Jury how this proposal would reduce costs.

(5) Discontinue some services currently provided by the SMMC and consolidate some of the off-campus clinics in the vacated space. One proposal is to close the inpatient medical/surgical/ICU facilities, replace the emergency unit with urgent care, and consolidate all long-term care onto one campus. Inpatient care for the WELL Program participants could be provided by private hospitals through enrollment with a third party provider, such as the Health Plan of San Mateo. There are many variations of this particular option when factors such as a possible expansion of psychiatric care at the SMMC and the consolidation of services at the Burlingame Long-Term Center, are included in the mix. The Grand Jury believes that some variation of this option may constrain costs yet provide acceptable levels of indigent and charity care within the County.

A common feature of the payer models is that cost savings are realized not through reduced costs for WELL Program participants, whose care would likely cost more at private hospitals, but rather by the avoidance of losses caused by inadequate revenue from public sources, charity care and bad debt. In private hospitals, such costs are offset by insured, paying patients.

The Board of Supervisors must seriously consider alternative models and decide whether it wishes to maintain the existing model with its growing deficits or transition into a mix of payer and provider models. Once that initial decision is made, then the different payer alternatives can be assessed for their effects on the overall provision of health care services financed by the County.

A better understanding of the SMMC finances is needed before an informed decision can be made. The results of a study to be undertaken by the SMMC and the County Manager's Office are due prior to the 2008-2009 budget discussions. This study should shed light on the true costs of differentiated services at the SMMC, and provide the data essential to perform an informed cost-benefit analysis addressing the options for continued operation or possible, sale, lease, outsourcing or other disposal of the SMMC departments or services. The County needs and deserves more than "back of the envelope" calculations to substantiate any recommended change in status.

Health Care Districts

Both SHD and PHD participate in numerous health initiatives in the County. In the combined 2006-2007 budgets of both districts, approximately $9.7 million is allocated for community health programs and contributions. Should a significant amount of these funds be redirected to pay for county-mandated indigent care, many local wellness and prevention programs for district residents that help limit costs might lose funding.

The districts are moving forward to build hospitals that meet seismic standards and substantial commitments of reserve funds have been made for these projects.

Existing contractual relationships between both districts and third parties provide major obstacles to any organizational change.

SHD and PHD are members of the current Task Force and should be encouraged to continue to engage in countywide forums and to find ways in which each district can make a meaningful contribution to the treatment of the medically indigent.

Blue Ribbon Task Force

The goal of this Task Force was to provide one or more recommendations to the Board of Supervisors by July 2007. That deadline has recently been extended to December 2007. The Task Force is moving forward with a proposal to establish an eligibility ceiling for adult medical coverage at 400% of the FPL – an expansion over the 200% of the FPL WELL Program eligibility cap. The cost of this proposal, currently estimated at $165 million, remains one of the fundamental hurdles to its implementation.

The Task Force has estimated that the SMMC currently receives $48 million under federal and state medical reimbursement plans. Caution is needed to ensure that any provider-to-payer model change proposed for the future operation of the SMMC will not reduce this estimated $48 million. Any negative impact on these funding sources will likely increase the County's contribution to any proposed coverage plan.

Assuming the entire $48 million funds remain, the Task Force concludes that the total cost for providing the 400% of the FPL target population will be $117 million. Of the $117 million, the Task Force assumed that if the $35 million County contribution to the WELL Program and the three-year State grant of $7.5 million annually were taken into account, the additional revenue required to fund this coverage model would be reduced to $74.5 million, which is still more money than the County has budgeted for indigent care.

Recommendations

The Grand Jury recommends that the San Mateo County Board of Supervisors:

1. Decide prior to May 2008 what level of indigent health care San Mateo County can provide given the available funds and demands of other San Mateo County programs.

2. Work with the County Manager to communicate a shared vision and message to the public concerning San Mateo County's policy on subsidized health care.

3. Commission a formal legal opinion as to San Mateo County's minimum legal requirement under California's Welfare and Institution Code Section 17000 to provide medical care to the indigent. Once such minimum legal requirements are

ascertained, the Board of Supervisors can knowingly decide whether San Mateo County should satisfy only the legal minimum or whether and to what extent it should exceed it.

4. Withhold implementation of any Blue Ribbon Task Force recommendation until the full financial implications, including impacts on other County programs, are well developed and understood. If any such recommendation is adopted, consideration should be given to its implementation initially as a pilot program so that no long-term commitment is made before its financial feasibility is established.

5. Issue a request for proposal (RFP) by October 1, 2007, to review public health care services provided by San Mateo County with particular emphasis on indigent care. Qualified proposals should demonstrate a high level of experience and active involvement with indigent care models in California. The RFP should include but not be limited to the following tasks:
   (a) Ascertain the financial strengths and weaknesses of the San Mateo Medical Center, including identifying all cost efficiencies, sources of revenue and consideration of the impact that any proposed change would have on such revenue sources.
   (b) Identify the advantages and disadvantages of different payer or hybrid models as compared to San Mateo County's provider health care system, including the fiscal, medical, and social effects of each.
   (c) Consider the impact of shortages of primary care physicians, nurses, dentists and specialist physicians amid increasing demand for medical services.
   (d) Estimate the number of uninsured and under-insured patients and plan for future increases in the cost of health care services for an aging population.
   (e) Review how other public agencies are delivering service and where true efficiencies can be obtained.
   (f) Determine how other communities have reduced costs and improved services, or at the very least, maintained a level of service.
   (g) Consider how current and evolving state health care initiatives may impact any San Mateo County proposal.
   (h) Consider the impact of health care issues that affect the whole San Mateo County community, such as the obesity epidemic, disparities in access to prenatal care, and a lack of access to preventative dental care.

The Grand Jury recommends that the Board of Trustees for the Sequoia Health Care District and the Peninsula Health Care District:

1. Review the funding for community health care initiatives and consider increasing contributions for direct indigent health care.

2. Work with the San Mateo Medical Center to promote proactive, preventative health care initiatives to WELL Program participants and to the broader community.

Glossary

Term	Definition
Bad Debt	Receivables determined to be uncollectible because the debtors cannot pay or the creditor finds it impractical or uneconomic to enforce payment.
Charity Care	Cost of care provided to those who do not have the ability to pay their medical expenses by being uninsured, underinsured, or not eligible for the WELL Program, and in some contexts may include bad debt.
Disproportionate Hospital Share (DSH)	Federal funds provided to states to offset the cost of providing indigent health care. Requires state matching funds (see Intergovernmental Transfer).
Federal Poverty Level (FPL)	Poverty guidelines, a version of the federal poverty measure, are sometimes loosely referred to as the "federal poverty level" (FPL). These guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs. The guidelines are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). For 2006, the FPL for a family of three living in California was $16,600.
Indigent Care	Cost of care provided to those who, due to poverty, are unable to pay their medical expenses and either meet the eligibility requirements of the County's WELL Program or require inpatient and emergency psychiatric treatment.
Intergovernmental Transfer	Matching funds paid by counties to the state, which the state uses to obtain DSH funding. SB 855 refers to base DSH matching funds, and SB 1255 refers to supplemental DSH matching funds.
Payer Model	In a payer model health care delivery system, also called "managed care," a 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 to be provided.
Provider Model	In a provider model health care delivery system, a county provides the medical services and bears the costs.
Realignment/Sales Tax	Sales tax revenue shared by the state with county general hospitals under a realignment formula.
Realignment/VLF	Vehicle license fees shared by the state with counties under a realignment formula.
SB 12/Maddy	Funds paid for provision of emergency medical services.
Tobacco Settlement	Monies paid through states to counties as part of a national settlement with tobacco manufacturers.
WELL Program	San Mateo County's Wellness, Education, Linkage, Low-Cost program for providing medical care to certain (those under 200% of the FPL) of the County's indigent population.

Appendix
San Mateo County Demographics

These population statistics are found in the December 2006 "*Report to the Task Force: Demographic Highlights of the San Mateo County Uninsured Adult Population*" and in the April 2007 LAFCo Reports.

- The proportion of uninsured adults ages 19 through 64 in the County is in the range of 12% to 13.5% of the total adult population. Given the current adult population, it is estimated that there are between 52,000-60,000 uninsured adults in the County (Note that 9,000-11,000 of this estimated range are currently enrolled in the WELL program). It is estimated that 70% of uninsured adults have a household income at or below 400% of FPL, translating to a total uninsured adult population range between 36,000-44,000.
- Nearly half (45.7%) of uninsured adults, almost 26,000 people, report working full-time (greater than 21 hours/week). Sixty-three percent report being employed either full/part-time or sporadically, translating to 35,000 uninsured adults working in some capacity. Of these working uninsured, 84% report that they are not eligible for benefits offered by an employer or that such benefits are not offered.
- Fifty-one percent of uninsured adults are female – the same distribution as the overall County population. Just over half of uninsured adults are age 19-39 (52%) and the remaining 48% are between the ages 40-64. In comparison, 44% of insured adults are age 19-39. Fifty-one percent of uninsured adults (29,000) have children in their household.
- There are disproportionately more Hispanic/Latino and Asian/Pacific Islander adults who are uninsured.
- Uninsured adults are more likely to be non-citizens than insured adults; 55% of uninsured adults, or almost 31,000, report that they are not U.S. citizens.
- Population projections from the Association of Bay Area Governments' "Projections 2007" provide estimates for county and individual cities. County population growth is projected at 19%, an increase from 707,163 (2000 Census) to 842,600 by 2030.
- At 14.5%, the proportion of the population aged 65 years and older in the County is well above the California average, and that projections suggest this proportion will increase over the next 20 years.

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October 12, 2007

Honorable John L. Grandsaert
Judge of the Superior Court
Hall of Justice
400 County Center, 2nd Floor
Redwood City, CA 94063-1655

Subject: Response to the 2006-2007 Civil Grand Jury Report: Provision of Indigent Health Care in San Mateo County

Honorable Judge Grandsaert:

Sequoia Healthcare District submits the attached response to the recommendations made to Sequoia Healthcare District by the 2006-2007 Civil Grand Jury.

Sincerely,

Stephani Scott, CEO

Kathleen Kane, Board Chair

Sequoia Healthcare District commends the 2006-2007 Grand Jury for its thorough study of the complex issues surrounding indigent care in San Mateo County.

Per the instruction to respond to findings filed by the 2006-2007 Grand Jury, Sequoia Healthcare District agrees with the information under the subheading entitled "Findings" in the report.

To complement the information whereby Sequoia Healthcare District is referenced under "Background" in the Report, we respectfully submit the supplemental information below.

The Report, on page 8 states, "...while they (health care districts) do support a number of community health care programs, they do not contribute directly to fund indigent care at the SMMC ..."

> Sequoia Healthcare District is in year one of a two-year arrangement with SMMC to directly fund indigent care at SMMC's Fair Oaks Medical Clinic in the amount of $3.2 million ($1.6 million per year) to serve as bridge funding while SMMC implements systems that will enable them to increase cost efficiencies at the Clinic.
>
> Sequoia Healthcare District's funding of the premiums for District children enrolled in Children's Health Initiative (CHI) at $1.35 million per year makes it possible for SMMC to receive payment for the care provided to CHI enrollees.
>
> Additionally, Samaritan House Free Medical Clinic of Redwood City is a service initiated and 99% funded by Sequoia Healthcare District at $500,000 per year. Patients receiving care at Samaritan House's Free Medical Clinic of Redwood City are those who would otherwise receive care at one of SMMC's facilities or at a local emergency room.

Per the instruction to respond to each recommendation:

1. **Review funding for community health care initiatives and consider increasing contributions for direct indigent care.**

   Reviewing priorities for health care initiatives is part and parcel of what we do as a health care district. As part of our Community Grants Program, we analyze existing funding needs, determine focus areas, budget appropriately and invite nonprofit and governmental organizations serving District residents to apply for funding.

   Indigent care will be a component of the discussion with our local health care counterparts for as long as there is a medically underserved population in the District. Collaboratively, we determine impact processes, respective roles of various health partners and appropriate organizational levels of resource allocation.

   In accordance with its mandate, Sequoia Healthcare District supports overall community health and wellness. The examples of direct indigent care funding described above (SMMC, CHI, Samaritan House) represent only a portion of Sequoia Healthcare District's contributions to indigent care. It should be noted that through these specific programs alone, Sequoia Healthcare District provides $3.45 million per year -- **63%** of the District's annual property tax income -- to indigent care, both at SMMC and through other local programs and services. The actual amount of annual District funding that affects indigent care is significantly higher due to District support for programs that benefit the entire spectrum of community members - including the medically underserved.

2. Work with San Mateo Medical Center to promote proactive, preventive care initiatives.

Examples of how Sequoia Healthcare District works with San Mateo Medical Center (SMMC) to promote proactive, preventive care initiatives include:

- Sequoia Healthcare District, alongside SMMC, is a member of the Blue Ribbon Task Force for Indigent Care and participates in the Finance Mechanism Workgroup in the hope for a collaborative, near-term solution.

- SMMC's CEO is a member of Sequoia Healthcare District's Community Advisory Panel. The purpose of the Panel is to unite individuals of diverse professional backgrounds in efforts to enhance the effectiveness of the District's delivery of health care services to District residents. Panel members assist in identifying the unmet health care needs of our community and are encouraged to identify possible opportunities for us to collaborate with other agencies.

- Sequoia Healthcare District staff takes part in on the Countywide Prevention of Childhood Obesity Task Force with San Mateo Medical Center, among many other organizations joining forces towards this effort.

- Sequoia Healthcare District will be embarking on a strategic planning effort in our 2007-2008 fiscal year. As part of this process, the District will confer with SMMC to determine how the District and SMMC may work together to ensure the continued health and wellness of all District residents.

- In addition to collaborative efforts with SMMC, Sequoia Healthcare District makes possible programs preventive in nature that we offer directly or through grants to our community partners, which include the following:

    - In partnership with First Five, San Mateo County and other local funders, Sequoia Healthcare District funds the Children's Health Initiative to ensure that all children in southern San Mateo County have health insurance coverage.
    - To ensure a ready supply of highly skilled nurses, Sequoia Healthcare District founded and underwrites a 4-way baccalaureate in nursing education partnership between Sequoia Healthcare District, Cañada College, San Francisco State University and Sequoia Hospital with the goal of producing 300-400 new nurses for this region over the next ten years.
    - Sequoia Healthcare District administers the HeartSafe Program to increase the survival rate for victims of sudden cardiac arrest, a program that has already saved a life at Woodside High School.
    - Sequoia Healthcare District established and funds operation of the Samaritan House Free Medical Clinic of Redwood City in Sequoia Healthcare District's Fair Oaks neighborhood, a known medically underserved and economically challenged area in an amount of up to $500,000 per year. Samaritan House's medical clinic provides primary medical care to those that would otherwise not receive care or end up in emergency rooms with more acute illnesses.
    - Sequoia Healthcare District provides funds to help maintain the Redwood City School District's school nursing program, which was threatened by budget cuts in education.
    - See attached summary of programs currently funded through our Community Grants Program.

Detail of Sequoia Healthcare District Grants for 06-07
Focus Areas: Youth Access to Fitness & Nutrition, Senior Access to Health Services and Disaster Preparedness: Prevention, Preparedness & Response

Program/Agency: Program Detail	Year & Funding		
	1	2	3
	2006-07	2007-08	2008-09
Triple Play/Boys & Girls Club: Educates boys and girls about good nutrition, making physical fitness a daily practice to improve their physical and emotional well-being.	$60,000	$60,000	$60,000
San Carlos Adult Day Support/Catholic Charities CYO: Provides professional day care services and case management for frail seniors and their caregivers.	$75,000	$75,000	$75,000
Disaster Preparedness Plan/Center for Independence of the Disabled: For seniors and people living with disabilities to plan and prepare to keep themselves healthy during a disaster.	$25,000	$25,000	$25,000
Disaster Preparedness Project/Child Care Coordinating Council: Project to help those who care for children respond and recover from disaster.	$85,268	$85,268	$85,268
HealthyKin Program/Edgewood Center for Children and Families: For children exiting the foster care system and placed with family members, provides guidance, education and support through health care system for families with financial and physical obstacles.	$96,306	$96,742	$100,000
Primeros Pasos/El Concilio: Prevention and reduction of obesity in children ages 0-13 through trained peer educators to work with Latino families, to institutionalize language and culture specific approaches for reducing obesity, overweight and diabetes and cardiovascular risk factors.	$100,000	$100,000	$0
Fair Oaks Intergenerational Center/Family Service Agency: Healthy breakfasts and exercise for seniors.	$30,000	$0	$0

Detail of Sequoia Healthcare District Grants for 06-07
Focus Areas: Youth Access to Fitness & Nutrition, Senior Access to Health Services and Disaster Preparedness: Prevention, Preparedness & Response

Program/Agency: Program Detail	Year & Funding		
	1	2	3
	2006-07	2007-08	2008-09
Mentoring Wellness Project/Friends for Youth: Serving at-risk youth, provides fitness, nutrition and wellness activity to all youth participating in the mentoring program.	$30,000	$0	$0
Disaster Preparedness Training/Kainos Home and Training Center: Disaster preparedness training program for individuals with developmental disabilities.	$55,000	$0	$0
Service Coordinator Program/Leslie Foundation: Serves older adults at Bonnie Brae Terrace, an affordable housing community in Belmont for older adults and persons with disabilities.	$22,500	$22,500	$22,500
LiveItUp/Mid-Peninsula Housing Services Corporation: For 5 low-income rental housing communities, to integrate nutrition education and physical fitness into the after-school and summer programs, on-site health educations for seniors and implementation of health fairs.	$81,235	$72,268	$75,870
Friday Fitness/OICW: Regular exercise, improved diet and health nutrition information at OICW's School for After School Program for at-risk youth.	$15,000	$15,000	$15,000
Advocacy Program/Ombudsman Services: Helps residents in long-term care facilities gain access to health care and helps care facilities maintain high quality service levels.	$45,000	$0	$0
Disaster Preparedness/Peninsula Clergy Network: Neighborhood-based disaster preparedness and planning infrastructure to increase individual preparedness, and provides coordination in immediate response to disaster.	$100,000	$100,000	$100,000

Detail of Sequoia Healthcare District Grants for 06-07
Focus Areas: Youth Access to Fitness & Nutrition, Senior Access to Health Services and Disaster Preparedness: Prevention, Preparedness & Response

Program/Agency: Program Detail	Year & Funding		
	1	2	3
	2006-07	2007-08	2008-09
Rosener House Adult Day Services/Peninsula Volunteers, Inc.: Occupational, physical and speech therapies for individuals with Alzheimers, Parkinson's, stroke, or other age-related cognitive disabilities to support for caregivers including education in areas of physical assistance, adaptive equipment, safety and communication.	$60,000	$50,000	$40,000
Youth Health and Wellness/Second Harvest Food Bank: Expansion of nutrition services to 11 children's programs to provide fruits and vegetables and nutrition workshops.	$30,000	$30,000	$30,000
Disaster Preparedness Plan/Shelter Network: Development of an agency-wide preparedness plan and training of staff and shelter residents to carry it out.	$65,000	$12,500	$12,500
Disaster Preparedness Plan/Thrive Alliance for Nonprofits: Collaboration of nonprofits, faith-based organizations and government agencies committed to working together to respond effectively to disaster.	$40,500	$0	$0
Youth Development Health and Wellness High School Action Plan/Youth and Families Enrichment Services (YFES): Expansion of Latina Curves program in Sequoia Union High School District, a culturally competent program to improve health among at-risk teens. This program has been successfully piloted at Sequoia High School.	$100,000	$100,000	$100,000
Tracey's Place of Hope/Women's Recovery Association: Fitness and nutrition activities at the only residential treatment program in San Mateo County for girls ages 14-18 with co-occurring mental health and substance abuse problems.	$37,000	$0	$0
Totals	**$1,152,809**	**$981,778**	**$878,638**

PENINSULA HEALTH CARE DISTRICT
RESPONSE TO THE CIVIL GRAND JURY REPORT
Re: PROVISION OF INDIGENT HEALTH CARE IN SAN MATEO COUNTY
Report Filed July 17, 2007
District Response Submitted October 5, 2007

The Peninsula Health Care District Board agrees with the vast majority of the findings included in the Civil Grand Jury's Report and commends the Grand Jury for their efforts in analyzing the complex issue of providing healthcare to the indigent population of San Mateo County.

General Comments/Observations:

The health care system of this country has been under considerable strain for many years because of increasing medical costs due to new technology, increased demand driven by the changing demographics, and the "medicalization" of all aspects of contemporary life. All of these have contributed to the financial burden placed on the San Mateo Medical Center (SMMC).

The four proposals explored by the Grand Jury addressed the increasing operating losses experienced at SMMC over the past six years and concluded that they were primarily due to the number of indigent patients treated at the County facility. The report then pointed out that SMMC has "historically treated 95% of the indigent population" (pg 4) of the County, but does not provide a reference as to how this number was determined.
The report focused on dollars spent rather than patients served. To fully analyze indigent care as a part of SMMC's operating costs, it would be important to know how many indigent patients are new to the system versus repeat admissions or visits, the cost per admission, cost per day of hospital care, cost per episode of illness, etc. Another factor is the impact of the increased depreciation costs on the operating performance of SMMC due to the opening of the new hospital. These are important numbers when analyzing the problem and identifying possible solutions and omitting or misunderstanding them could result in short term, unsustainable solutions and missing an opportunity for broader, systemic changes that could reduce the cost burden experienced by SMMC for the long term.

The data provided in the tables on pages 10 and 11 further support this concern. The actual year-to-year percentage increases in costs to SMMC to provide healthcare to the indigent population as shown in Table 2 are in single digits, which is consistent with the hospital industry at large. The only exception is the ~23% change between FY 02-03 to FY 03-04, which is when the new hospital came on line and therefore suggests the impact of the increase in depreciation costs. It is also significant that Table 3 shows that nearly $22 million of SMMC's operating deficit, or 37% of SMMC's draw on the General Fund in FY 05-06, was for "non-indigent" care. Of that, ~$13 million or 59% was from patients covered by HMO's, Insurance, and Medicare. This is also consistent with the

general hospital industry's experience and symptomatic of much bigger systemic problems relative to costs out pacing reimbursements across all payer types.

The report also made the point that the amount coming from the County General Fund from 2001-2002 to 2006-2007 "has remained roughly constant" as a percentage of the overall County fund. This suggests escalation in total County operating costs, not just SMMC's, which would certainly be understandable given the growth of the economy and increasing tax revenues.

Based on the information provided in the report, the Grand Jury's conclusion to keep SMMC and to explore a possible change in the mix of services seems the best of the four options presented.

Comments Related to the Peninsula Health Care District (PHCD):

There seems to be an inaccurate underlying assumption in the report that the Districts and County health service mandates and missions overlap, entirely, without distinction. The audience is left with the impression that the purpose and intent of County Health Services provided by SMMC are the same as the purpose and intent of the Health Care Districts. ***The legal mandates for SMMC and PCHD are different and distinct.*** The County Section 17000 mandate from the State defines SMMC's responsibility to cover health needs as the "provider of last resort" to indigent patients. The broader Health District authority established by the State Legislature is quite clear that Health Districts do not exist as providers of last resort or duplicate the role of Counties. This is manifest in the Legislative directive that Health Districts "not subsidize County patients" (Health & Safety Code Section 32125 (b)).

PCHD received $3.6 million in tax revenues in fiscal year 2006-2007 and has as its legislated mandate to serve the health care needs of all residents within the District –not just those of the "indigent". Given both its legislated mandate and the 50-year Master Lease Agreement achieved between the District and Sutter/Mills-Peninsula Health Services (MPHS), the Board must be prudent in how it allocates its annual tax revenues.

The PHCD Board successfully negotiated and received an overwhelming 92% voter support of **a 50-year, (**not 30-year as the report says on page 8), Master Lease Agreement with MPHS. This unique, well-conceived deal provides for a seismically sound, modern hospital replacement for Peninsula Medical Center at ***no cost to the tax payers – PHCD reserve funds will not be used to build the new hospital as suggested at the top of page 16.*** However, the Lease Agreement defines significant financial obligations over the 50-year term that will require the Board to manage assets with foresight in order to be prepared for the potential of "paramount default" by Sutter and the inevitability of its taking back ownership at the end of the term.

In 2004 the Healthy Community Collaborative of San Mateo reported that 86% of the County's adults have at least one risk factor for heart disease and that 50% of the premature deaths in the County "are because of alcohol, tobacco, drug use, poor diet…and other health risk behaviors." These findings span across all socio-economic

demographics. Indicators for a Sustainable San Mateo County, published this year by a collaborative group of sponsors called "Sustainable San Mateo County", makes the critical point that a healthy society is inextricably linked to a healthy environment and healthy economy. This report delineated many health-related priority areas such as childhood obesity, child abuse, adult risk behaviors, and homelessness. Both of the reports make the point that to achieve a healthy community, the County must take a broad approach.

It is appreciated that the Grand Jury Report acknowledged the PHCD's grant program and that it cited a few of the organizations that have been supported. We agree with the Report's statement that PCHD does not give money "directly to SMMC" for indigent care. However, the funding provided to Samaritan House and the Children's Health Initiative does ***directly provide services to the indigent population for whom SMMC responsible.*** The District has provided more than $1.5 million a year to the two programs cited above, as well as, the Youth and Family Assistance Crisis Center and Insights Program, Senior Focus Alzheimer's and Wellness Clinics, Women's Recovery Center, the College of San Mateo Nursing Program and an RN Loan Forgiveness Program to encourage graduates to remain in the District - ***all contribute indirectly to the operating costs at SMMC through access to primary care, crisis intervention, and prevention.***

Grand Jury Recommendations and PCHD Responses

Recommendation 1: Review the funding for community health care initiatives and consider increasing contributions for direct indigent health care.

District Response: ***This recommendation has been implemented.***

The PHCD Board reviews its community health care initiatives annually and strives to optimize both the amounts and the impact of its contributions. This past year, the Board's review was augmented by a 10-month strategic planning process that resulted in its 2007-2010 Strategic Plan, which was approved at the August 23, 2007 regular Board Meeting. The process was facilitated by health care planning experts. Plan development was driven by data and findings from a number of recent community reports (E.g. Healthy Communities of San Mateo County, the Board of Supervisor's Blue Ribbon Task Force, MPHS strategic planning data, LAFCo Report, etc.), as well as, Board Director participation on the Blue Ribbon Task Force, and input from the community-at-large through five Town Hall Meetings. The Board's Vision, Mission, Values and Goals are summarized below and confirm our achievement of Recommendation 1.

> **Our Vision:** That all residents of the District live in an environment that contributes to optimal health through education, prevention, and access to needed health care services.
>
> **Our Mission:** We will preserve Peninsula Hospital, ensure that needed core services are maintained, support programs that share our vision, and do so in

collaboration with public and private service providers and the members of our community.
Our Values: Stewardship, collaboration, inclusion, shared responsibility, and transparency.

Our Goals:

- Preserve Peninsula Hospital as a community asset.
- Achieve measurable improvements in identified health problems
- Improve availability of and access to health information and services for all residents in the District.
- Ensure sufficient resources to achieve the Board's vision, mission, strategic initiatives, and financial obligations.

As further example of the Board's work in funding community health initiatives it should be noted that the PHCD FY 07-08 grants budget was increased to $2 million and a new ad hoc Advisory Committee has been established to increase community input into the PHCD's grant review process.

Recommendation 2: Work with the San Mateo Medical Center to promote proactive, preventative health care initiatives to WELL Program participants and to the broader community.

District Response: ***This recommendation has been implemented.***

The Peninsula Health Care District is geographically located in San Mateo County and has always collaborated with others who share the PHCD's commitment to preventive health care. Board representatives have actively served, along with SMMC leadership, on committees and work groups focused on health issues of this community. In addition to the strategic plan goals delineated above and the activities that went into the development of that plan, the addition of a new Executive Director in May 2007 will extend the PHCD's opportunity to actively participate in county-wide collaborative activities.

COUNTY OF SAN MATEO
Inter-Departmental Correspondence

County Manager's Office

DATE: October 5, 2007
BOARD MEETING DATE: October 16, 2007
SPECIAL NOTICE: None
VOTE REQUIRED: Majority

TO: Honorable Board of Supervisors

FROM: John L. Maltbie, County Manager

SUBJECT: 2006-07 Grand Jury Response – Indigent Health Care

Recommendation

Accept this report containing the County's responses to the following 2006-07 Grand Jury report: Provision of Indigent Health Care in San Mateo County.

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. To that end, attached is the County's response to the Grand Jury report regarding the Audit and Review of County Financial Statements, issued on July 17, 2007.

Provision of Indigent Health Care in San Mateo County

Findings:

Staff is in general agreement with the Grand Jury's findings.

Recommendations:

The Grand Jury recommends that the San Mateo County Board of Supervisors:

1. Decide prior to May 2008 what level of indigent health care San Mateo County can provide given the available funds and demands of other San Mateo County programs.

Response: Concur. The County has been in the process of determining the cost of indigent healthcare services, and has hired the consulting firm of Health Management Associates (HMA) to review a financial analysis prepared by the Medical Center for its major service lines and payers. The County will use this information to develop the FY 2008-09 recommended budget for General Fund contributions related to (1) the County's financial obligation under Section 17000 and (2) contributions in excess of the County's Section 17000 mandate. The County will need to decide, as part of addressing its structural budget deficit, whether it will pay for a portion or all costs that exceed its Section 17000 obligation. The County is using HMA to help guide the decision making process by developing various options for the County to consider in determining the mix of services and payers that would create a financially viable system of care for indigent and uninsured residents. This work should be done in early 2008. It is anticipated that any decisions involving changes in the configuration of services or funding mix will be implemented over the course of several years.

2. Work with the County Manager to communicate a shared vision and message to the public concerning San Mateo County's policy on subsidized health care.

Response: Concur. Before a vision on subsidized health care can be shared, the County must first have a clear understanding of what is currently being subsidized and at what cost. The County is mandated to provide health care for indigent residents under Section 17000 of the Welfare and Institutions Code. The cost to fund this mandate represents the "subsidy", and any excess amount should be allocated at the Board's discretion, either toward more health care services or toward other County programs and services. The County should not subsidize costs that can be funded by other payers, such as the state and federal government, and commercial payers. A shared vision on subsidized health care will be communicated as part of the January 2008 final recommendations from the Blue Ribbon Task Force on adult healthcare coverage, which will take into consideration the financial

implications on existing County programs and General Fund contributions.

3. Commission a formal legal opinion as to San Mateo County's minimum legal requirements under California's Welfare and Institutions Code Section 17000 to provide medical care to the indigent. Once such minimum legal requirements are ascertained, the Board of Supervisors can knowingly decide whether San Mateo County should satisfy only the legal minimum or whether and to what extent it should exceed it.

Response: Agree. The County is currently in the process of revising its financial assistance policies for services provided by the San Mateo Medical Center. The Board approved the policies in December 2005. Subsequent changes in legislation, as well as identified improvements from the screening and verification pilot, need to be incorporated into the policies, which will be brought to the Board in December 2007. County Counsel will be requested to provide a formal legal opinion on minimum legal requirements under Section 17000 of the Welfare and Institutions Code, which will be included in the policy revision process and presented to the Board in December.

4. Withhold implementation of any Blue Ribbon Task Force recommendation until the full financial implications, including impacts on other County programs, are well developed and understood. If any such recommendation is adopted, consideration should be given to its implementation initially as a pilot program so that no long-term commitment is made before its financial feasibility is established.

Response: Agree. Prior to the completion of Blue Ribbon Task Force final recommendations, County staff will incorporate information regarding the financial implications of proposed recommendations for County programs such as our current indigent care program and other health care programs that address the needs of residents with incomes below 400% of the Federal Poverty Level. The Blue Ribbon Task Force preliminary recommendations incorporate consideration of phased enrollment in accordance with available resources, as well as learning from local experiences, such as pilot projects aimed at improving access to healthcare and improving population health. The Blue Ribbon Task Force final recommendations will be completed in January 2008.

5. Issue a request for proposal (RFP) by October 1, 2007, to review public health care services provided by San Mateo County with particular emphasis on indigent care. Qualified proposals should demonstrate a high level of experience and active involvement with indigent care models in California. The RFP should include but not be limited to the following tasks:

- **(a) Ascertain the financial strengths and weaknesses of the San Mateo Medical Center, including identifying all cost efficiencies, sources of revenue and consideration of the impact that any proposed change would have on such revenue sources.**
- **(b) Identify the advantages and disadvantages of different payer or hybrid models as compared to San Mateo County's provider health care**

system, including the fiscal, medical, and social effects of each.

(c) Consider the impact of shortages of primary care physicians, nurses, dentists and specialist physicians amid increasing demand for medical services.

(d) Estimate the number of uninsured and under-insured patients and plan for future increases in the cost of health care services for an aging population.

(e) Review how other public agencies are delivering service and where true efficiencies can be obtained.

(f) Determine how other communities have reduced costs and improved services, or at the very least, maintained a level of service.

(g) Consider how current and evolving state health care initiatives may impact any San Mateo County proposal.

(h) Consider the impact of health care issues that affect the whole San Mateo County community, such as the obesity epidemic, disparities in access to prenatal care, and a lack of access to preventative dental care.

Response: Concur. On June 11, 2007, the County entered into Phase 1 of an agreement with Health Management Associates (HMA) for the purpose of reviewing the internal financial analysis conducted by the Medical Center on its major service lines and payers, and preparing five-year financial projections, assuming no changes to the configuration of services at SMMC. The County Manager and executive management of SMMC, Health Department, and Health Plan of San Mateo selected HMA after proposals were solicited and interviews were conducted with HMA and another consulting firm with healthcare expertise. HMA specializes in public hospitals and the uninsured population, and has recent experiences in San Francisco and Los Angeles counties that were more relevant to the complex issues facing the County.

On September 25, 2007, the Board approved a contract amendment with Health Management Associates (HMA) for Phase 2 of the project. The firm will be interviewing and gathering information from County leadership, members of the Blue Ribbon Task Force on Adult Healthcare Coverage, County departments, other local hospitals and health care providers, community groups, physician groups, and others, and will develop various options for the County to consider in determining the mix of services and payers that would create a financially viable system of care for indigent and uninsured residents. Phase 2 should be completed in January 2008.