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EVALUATION OF OPTIONS FOR THE FUTURE OF

ALAMEDA COUNTY MEDICAL CENTER

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I. INTRODUCTION AND SUMMARY

A. SCOPE

This study assesses three major models for the future role of Alameda County Medical Center (ACMC) over the intermediate term (i.e., the next five years). The three alternative models are as follows:

(1) ACMC as a "treat and transfer" facility, where the Highland campus hospital would maintain its trauma center designation and largely restrict its inpatient services to trauma and emergency patients. These patients would be transferred to other hospitals upon stabilization. County-obligation patients (County Medical Services Program -- CMSP) who are not emergency admissions would be treated in private hospitals under contract with the County;

(2) ACMC as a treat and transfer facility and as the CMSP hospital. Non-CMSP patients who are not emergency patients would in general be treated in other hospitals. ACMC's payor sources would primarily be CMSP and private and public sponsors of trauma/emergency patients admitted to ACMC; and

(3) ACMC maintaining its current role as a trauma center and the major CMSP provider, as well as a major Medi-Cal provider and source of care for patients of all payor sponsorships.

As part of the evaluation of the above alternatives, the study also addresses mechanisms for coordinating efforts with private hospitals, to minimize risks faced by both sectors of the Alameda County health-care community, and sets forth conditions for contracting with private hospitals.

Given existing payment mechanisms, where a major portion of state and federal funds used to subsidize county-indigent patients is derived through the Medi-Cal program in the form of disproportionate-share payments, it appears that the only feasible alternative is for ACMC to continue to be a high-volume Medi-Cal provider. Given the movement to Medi-Cal

managed care and competitive pressures in general, to maintain its Medi-Cal patient base will require ACMC to take initiatives (capital investments and programmatic changes) to be a competitive hospital. Failure to do so would result in Alameda County being unable to support its Section 17000 obligation without substantial general fund expenditures, either directly through operating its own hospital or indirectly through private-sector contracting.

B. THE ENVIRONMENT

ACMC, and many other county-operated health systems, are faced with a set of nearly bewildering pressures and challenges. Its major funding sources are shrinking. County general fund revenues are no longer a predictable source of funds. ACMC's ability to provide necessary care to unsponsored, county-indigent patients is dependent on its ability to draw a sufficient number of Medi-Cal patients. That ability is severely threatened by competition from private hospitals with increasing excess capacity. While county-hospital funding may be less secure, inevitable cuts in overall Medicaid funding, without establishment of a national health insurance program, will lead to an expansion in the number of county-indigent patients. The ability to successfully compete for Medi-Cal patients will in all likelihood require capital investments on the part of ACMC so that its facilities and services will attract Medi-Cal patients with private-sector choices. If ACMC is unsuccessful in its efforts to protect its funding sources, it is likely the County will not have sufficient resources to meet its indigent-care responsibilities through private-sector contracting. This shortfall in resources will largely be the result of the loss of ACMC's disproportionate-share (DSH) funds of approximately $30 million in the current fiscal year and an estimated $15 million in the coming fiscal year. These funds are not transferrable to other hospitals. (To qualify for DSH status requires high Medi-Cal and/or unsponsored patient loads, and there is an approximately two-year lag between achieving sufficient patient volume and attaining qualification.) Should ACMC cease to operate as a general-acute hospital, there will be a major tug-of-war between the County's indigent-care obligation and the private hospitals' abilities and willingness to accommodate large numbers of these patients without payment.

C. FINDINGS AND RECOMMENDATIONS

1. Treat and Transfer Facility

Under this scenario, ACMC would only be a trauma/emergency hospital. Once patients are stabilized, they would be transferred to other hospitals. Outpatient services would continue to be provided at both campuses. All inpatient services at the Fairmont campus would be discontinued. All inpatient services provided at either campus to CMSP patients who are not trauma/emergency or have been stabilized would be provided at other hospitals under contract. In addition, other county-obligation patients, such as jail patients, will have to be accommodated in private facilities.

Because of the low volume associated with this type of facility, its practicality is doubtful.

To be a trauma center, a hospital must provide a fairly comprehensive array of inpatient services, and have substantial back-up personnel and facilities. If volume falls between 38 and 86 percent (a midpoint of 62 percent), as projected here, an adequate patient base to support a full-service hospital would not exist. In general, hospitals of substantially less than 200 beds in urban areas do not make economic sense. Where geographic access is not a primary constraint, a population base is best served by fewer, and larger, hospitals, for both economic and quality reasons.

In addition to the problem of appropriate size is the loss of substantial DSH payments, which are tied to Medi-Cal patient days. Given that DSH revenue is vital for the support of CMSP, such losses would have to be offset by substantial county general fund appropriations to enable the County to meet its Section 17000 obligation through contracting with private hospitals. All non-trauma/emergency CMSP would have to be contracted to the private sector. With projected DSH losses of $12 million to $28 million in 1995-96, and $6 million to $14 million in 1996-97, private hospitals would be required to incur aggregate losses which could approach a similar magnitude, and which would be only partially offset by profits from receiving ACMC's former Medi-Cal patients.

Another ramification of this model is the loss of the ACMC teaching program, with its associated Medicare direct and indirect graduate medical education subsidies. According to a recent study, the teaching program earned surpluses of $3.3 million in 1994-95.

2. Trauma Center and a CMSP Hospital

Under this scenario, ACMC would remain a trauma center, treating all trauma patients, regardless of payor source, and be the primary hospital provider for CMSP patients. CMSP patients would be treated regardless of admission status. Non-CMSP patients, however, would only be treated if they were trauma patients, and once stabilized, transferred to other hospitals.

The implications of this scenario are similar to those pertaining to the treat and transfer model, with one exception. CMSP patients would continue to be treated at ACMC, rather than contracted to the private sector. The loss of virtually all DSH revenue, however, would have to be offset by considerable general fund contributions, nearly $30 million in the current year. DSH losses are projected at the higher level under the treat and transfer model since Medi-Cal patient days, which drive DSH payments, would only derive from trauma patients.

3. A Competitive Full Service Hospital

Under this scenario, ACMC would maintain its current payor base and take initiatives necessary to maintain that base through the remainder of this decade, and beyond. Given the movement of formerly inpatient services to the outpatient setting and the implementation of Medi-Cal managed care, private providers who, in the past, did not view Medi-Cal as a desired payor source, are increasingly competing for this market segment.

At this time, ACMC should expect to have to compete to retain its Medi-Cal patient base in the mandatory aid categories (the AFDC-related groups which will be required to enroll in a managed-care plan), a large portion of which is obstetrics-related. ACMC should capitalize on its competitive advantages in terms of a committed medical and support staff accustomed to dealing with hard-to-manage indigent populations, its considerable capabilities due to its extensive teaching program, its dependability at a time when the desirability of Medi-Cal patients to many private providers may be only a fad, and its integrated health system involving a network of county-operated and private clinics linked to ACMC.

It should be noted that Fairmont, given its orientation and lack of competition, at this time appears to be insulated from the type of competition discussed here.

Capital Investments

ACMC should consider reasonable efforts to improve its plant and equipment in a cost-effective manner over the next three-to-five years. The main Highland building, which houses the inpatient facilities, was completed in 1970 and should be adequate to meet the 2008 seismic-safety threshold. The inpatient facilities are generally adequate. There appear to be four major problems on the entire campus: (1) the emergency department is in need of major renovation; (2) the surgery facilities (in- and out-patient) are inadequate; (3) outpatient services are cramped in some areas and spread-out among several buildings in a confusing manner; and (4) parking space is inadequate.

These problems have been recognized in the capital plan adopted by ACMC, which includes construction of a parking structure and of an eight-story critical care building. The latter is to include, in addition to emergency/trauma and surgical facilities, intensive care beds and an imaging center. Architectural plans for the critical care building were filed with OSHPD in time to qualify for financial assistance under SB 1732. The total cost of this project was estimated to be approximately $90 million. Since the plans incorporated only shelled space for a portion of the building (which does not qualify for SB 1732), approximately $60 million in planned capital expenditures would qualify for SB 1732 assistance. Thus, assuming ACMC's Medi-Cal patient-days percentage is 50 percent, SB 1732 will yield $30 million in subsidies.

On the full $90 million project, annual debt-service payments (30 years at 6 percent interest) would be $6.5 million, with $2.2 million in SB 1732 subsidies, for a net county contribution of $4.3 million. If the project could be completed for $60 million, for example by eliminating the shelled floors and those earmarked for ICU and radiology, SB 1732 subsidies of $2.2 million might remain, but the net county contribution would drop to $2.2 million (on a total debt-service payment of $4.4 million).

It appears that to be able to retain a substantial portion of Medi-Cal patient days associated with managed-care enrollees, a significant portion of the construction discussed here will be necessary. These capital-investment decisions will not bear fruit overnight. In the

meantime (i.e., until the projects are available for patient use), ACMC will have to fully rely on its other, considerable attributes and attempt to make cosmetic appearance changes and minor renovations in the existing buildings as appropriate.

Non-Capital-Intensive Measures

Several measures not involving major capital investments are worthy of consideration. They mainly revolve around ACMC capitalizing on its major attributes.

ACMC has more experience in providing care to Alameda County's indigent residents than any other provider. The medical staff, nursing staff and social-services personnel are familiar with the indigent population's unique needs. Private-sector providers do not have this experience and many will find the adjustment difficult, not worth the effort, or impossible. Medical, cultural and linguistic characteristics of this population can best be accommodated by the ACMC staff resources.

ACMC has the potential to form the nucleus of an integrated health delivery system, including long-term-care facilities (Fairmont), mental-health facilities (John George Pavilion), public-health clinics, a network of county-operated and private-non-profit community clinics (community-based organizations [CBOs]), and extensive specialty resources through its teaching program. This system should provide the base to enable the necessary continuity of care and control mechanisms to be a successful health system. To take full advantage of this potential requires investments in necessary information systems to enable and coordinate the flow of data on individual patients and the medical care process among the various facilities and services.

Coordination among these components in ACMC's best interests requires at a minimum that the first choice for hospital and medical specialty referrals on the part of all affiliated clinics is ACMC. Unless there is a distance problem, or a clinic is located adjacent to another hospital, or ACMC does not have the required services (e.g., pediatrics, cardiovascular surgery), all clinics, including CBOs, should be required to refer within the ACMC system (i.e., hospital and specialty clinics). For such coordination to work in the patient's best interests requires the ability of ACMC's programs to accommodate the referring clinics through timely appointment scheduling.. Physicians representing ACMC, CBOs and other community physicians should be brought together to identify improvements needed at ACMC to facilitate establishment of an expanded referral base.

Reconfiguring some of the clinics to be more "patient friendly" could enhance ACMC's marketability. For example, obstetrics, gynecology and pediatrics clinics could be placed in close proximity and scheduling could be coordinated, to enable "one-stop" shopping on the part of mothers and children.

A mechanism being implemented in other public hospitals is establishment of two tracks for patient care, one for insured and Medi-Cal patients, and another for CMSP, since the latter are

not being enticed by private-sector providers. The feasibility of such a two-track system should be explored. While it may be controversial, to the extent it contributes to the financial viability of ACMC, it improves the latter's ability to maintain access for county-obligation patients.

The teaching program provides an opportunity for ACMC to enhance its reputation in various medical specialties, and to enhance its private patient base. For example, in cooperation with private hospitals, ACMC could develop certain "Centers of Excellence" (i.e., specific illnesses for which ACMC would have a regional reputation). One area for such a center could be disease management of cancer patients. Another area could be workplace injuries.

Efforts should be made to encourage county employees to use ACMC and its affiliated physicians through financial incentives, in terms of reduced health-insurance premiums, deductibles or coinsurance.

Another obvious mechanism to retain Medi-Cal managed-care patients is through the Local Initiative, in which ACMC, as the major DSH hospital in Alameda County, is the nucleus. Enrollees should be encouraged to select primary care providers (i.e., county clinics and CBOs) affiliated with ACMC. If they are unable to make a selection, they should be defaulted into the ACMC network.

Finally, consideration should be given to enlisting the support of the private hospitals in two regards -- protecting ACMC's Medi-Cal patient base and coordinating programs with ACMC.

The major private hospitals should be made aware that ACMC's ability to maintain its trauma center and to be the provider of last resort is contingent on its ability to maintain its Medi-Cal patient base. Without this payment base, DSH payments, which heavily subsidize ACMC's CMSP patients, will disappear. Without these subsidies, ACMC will be forced to discontinue its inpatient services at Highland. The County would then contract with private hospitals to provide care to CMSP patients at the level it could afford (e.g., realignment funds plus the current general fund contribution, which is zero!). The loss of tens of millions of dollars in DSH funds, which heavily subsidize the CMSP program, will require private providers to incur major losses from treating these patients. Such losses will only be ameliorated through dramatic cuts in service to this population, and accompanying deterioration in health status, which would be politically intolerable.

To protect the private hospitals from this scenario, mechanisms should be explored through, for example, Local Initiative policies to protect ACMC's Medi-Cal patient base.

In addition, under SB 697 (Torres), enacted in 1994, not-for-profit hospitals, either alone or through other organizational arrangements, are required to conduct a community needs assessment and to develop a community benefits plan. ACMC should initiate a process to enable all local hospitals to work together in this effort.

4. Coordinating Efforts with Private Hospitals

It appears there are only two feasible options: maintain ACMC as an institution capable of attracting a sufficient Medi-Cal revenue base, and related DSH subsidies, or cease inpatient operations altogether, in favor of private-sector contracting for county-obligation patients. Should the Board of Supervisors decide to close ACMC as an inpatient facility, and contract with private hospitals to fulfill its Section 17000 obligations, it should be guided by a policy based on the following:

1. The private hospitals should make a legally-binding, long-term (i.e., 25-30 years) commitment to provide mainstream care to all patients in need of such care.

2. The hospitals' track records in treating the indigent (especially Medi-Cal) should be established.

3. The general-fund exposure to the county should be reasonable and predictable. (It is currently zero.)

4. The private hospitals should coordinate and integrate services among themselves in their community's best interests, and should be financially viable.

5. There should be a maintenance of effort requirement regarding the hospitals' provision of charity care.

7. Given the unique nature of this patient population and given that the county's medical and nursing staff are accustomed to this population, maximum effort should be made to assure that the county medical staff will be given the same privileges at the private hospitals and that staffing increases at the private hospitals will be accommodated by former county employees.

8. The private hospitals should assure their seismic safety for the length of the long-term agreement.

5. Immediate Implementation Steps

Assuming Board authorization to proceed with the direction recommended here, several steps should be taken immediately to address urgent concerns that do not require substantial funding commitments (e.g., working with ACMC, CBO and other physicians to enhance referral potential and to improve ACMC operations to encourage referrals; to reassess the critical care building plans; and to streamline and reconfigure a portion of the clinic space to be more "patient friendly"). These immediate steps should be completed by July 1996.

II. SCOPE OF STUDY

A. Models

This study examines three major models for the future role of Alameda County Medical Center (ACMC) over the intermediate term (i.e., the next five years). The three alternative models are as follows:

(1) ACMC as a "treat and transfer" facility, where the Highland campus hospital would maintain its trauma center designation and largely restrict its inpatient services to trauma and emergency patients. These patients would be transferred to other hospitals upon stabilization. County-obligation patients (County Medical Services Program -- CMSP) who are not emergency admissions would be treated in private hospitals under contract with the County;

(2) ACMC as a treat and transfer facility and as the CMSP hospital. Non-CMSP patients who are not emergency patients would in general be treated in other hospitals. ACMC's payor sources would primarily be CMSP and private and public sponsors of trauma/emergency patients admitted to ACMC; and

(3) ACMC maintaining its current role as a trauma center and the major CMSP provider, as well as a major Medi-Cal provider and source of care for patients of all payor sponsorships.

As part of the evaluation of the above alternatives, the study also addresses mechanisms for coordinating efforts with private hospitals, to minimize risks faced by both sectors of the Alameda County health-care community, and sets forth conditions for contracting with private hospitals.

B. Approach

The three models are evaluated in terms of their likely impact on volume, revenue, expenses (operating and capital), and service capability. The primary data source is ACMC data on volume and charges for calendar-year 1995, broken out according to service, payor source and admission source (e.g., trauma, emergency). Because the data were generated in early January 1996, the data pertaining to services provided in late 1995 may be incomplete. This should not create a problem, however, since the analysis focuses on the differences among the three model scenarios at the same point in time, and the extent of "incompleteness" is minor.

The primary focus of the analysis is on the Highland campus, for the following reasons:

(1) The trauma center is at Highland;

(2) Highland accounts for over 95 percent of ACMC's CMSP inpatient gross revenue, and 90 percent of CMSP patient days. Fairmont, through its emphasis on rehabilitation and long-term care, fills a major gap in treating sponsored patients that is not addressed by the private sector;

(3) Given Fairmont's emphasis, its high Medi-Cal volume is not threatened by the implementation of the Two-Plan Model for Medi-Cal managed care, which is directed to the AFDC population. On the other hand, Highland is highly vulnerable to competition for Medi-Cal patients;

(4) The only major capital-expenditure plan for ACMC relates to the Highland campus. A go-no-go decision on this plan is imminent, resting on a determination of the facility's future role; and

(5) Under current law, inpatient facilities at the Fairmont campus will have to be completely rebuilt by 2008, to comply with seismic safety standards. A decision on that campus' future can be postponed beyond the next few years, pending the willingness of the private sector to provide the level of long-term care offered at Fairmont.

The data analysis is combined with an assessment of the health-care environment in Alameda County and likely future developments in public financing for health care services.

III. THE ENVIRONMENT

A. Funding

Funding for ACMC is derived through a wide variety of sources, all of which are becoming more and more restrictive. Major sources of funds include:

(1) State funds, which are mainly "Realignment" funds earmarked for counties, derived from a portion of vehicle license fees and sales-tax revenue. For the current fiscal year, this source is expected to provide approximately $24.8 million, down from $32.8 million the previous year;

(2) Direct payments for patient care (e.g., Medi-Cal, Medicare, insurance, self-pay). Of approximately $100 million budgeted for the current year, $57.1 million is expected from Medi-Cal (excluding disproportionate-share payments);

(3) Disproportionate-share hospital payments, estimated at $30 million for the current year. These are federal Medicaid funds matched against transfer payments from public hospitals and distributed to qualifying hospitals based on a statutory

formula. They are expected to be cut in half in the next fiscal year; and

(4) County general fund contributions. No general fund expenditures are budgeted for this year. This traditional source of funding for county-obligation patients has been sharply reduced in many counties as county revenues have been diverted to the state, and disproportionate-share (DSH) revenue, which is tied to Medi-Cal volume, has become a major source of funding for county-indigent patients. With expected reductions in DSH payments, however, there will be few alternatives in the future to increased general fund support in many counties.

B. Payment Pressures and the Impact of Managed Care

Payment levels for health-care services have tightened considerably in recent years. While Medi-Cal payment rates have always fallen short of costs, they have fallen considerably short in recent years. In particular, hospital outpatient payment rates (generally frozen since 1982) now average less than 50 percent of costs, and few hospitals have received inpatient payment rate increases in recent years, under the Selective Provider Contracting Program. Medi-Cal and Medicare payment shortfalls have traditionally been off-set by inflated charges to private payors (cost shifting). This ability has largely evaporated with the proliferation of managed care; and it never was a viable option for county hospitals, which have a low mix of private-paying patients.

Besides severely restricting the hospital's ability to cost shift, managed-care payors have aggressively pursued alternatives to inpatient care. Complimented by advancements in medical science, inpatient utilization is dropping universally. Tight payment rates combined with shrinking volume is resulting in intense competition by hospitals for a shrinking pool of patient-care dollars. That competition has recently spread to Medi-Cal patients, notwithstanding that program's low payment rates.

Three managed-care models are being implemented by the Medi-Cal program in the State's urban areas.[1] The models are as follows:

(1) County Organized Health Systems (COHS), where designated county governments assume responsibility, on a capitation basis, for the entire Medi-Cal population within their jurisdictions. Four COHSs are currently operational -- Santa Barbara, San Mateo, Solano and Orange -- and one is scheduled for implementation later this year -- Santa Cruz. Under current federal law, no additional COHSs can be designated in California;

(2) The two-plan model being pursued in 12 counties. Under this model, all Aid to Families with Dependent Children (AFDC), and no-share-of-cost Medically-Needy Families and Children will be required to sign up with one of two local HMOs. The major HMO is envisaged as a consortium of each county's safety-net

providers -- the "local initiative" -- organized by the county boards of supervisors. The other HMO is to be a single, mainstream HMO selected by the State. The former is to be comprised of disproportionate-share hospitals. This model was intended to protect disproportionate-share hospitals, the most important of which in terms of Medi-Cal volume are county hospitals, and other safety-net providers that are dependent on Medi-Cal revenue. Local initiative health plans are to be Knox-Keene-licensed HMOs, and as such must eventually have an enrollee mix that is at least 25 percent non-Medi-Cal, non-Medicare.[2] Alameda County's Local Initiative, implemented January 1, 1996, is the first to become operational. Blue Cross has been awarded the Mainstream contract. In Alameda County, the beneficiary population covered under the two-plan model accounts for approximately 65 percent of total Medi-Cal beneficiaries, and approximately 30 percent of Medi-Cal patient days; and

(3) Geographic Managed Care (GMC) is being pursued in two counties -- Sacramento and San Diego. In Sacramento, it was implemented in April 1994. Implementation in San Diego is scheduled for 1996. While GMC covers the same beneficiary mix as the two-plan model, here beneficiaries choose from among a variety of mainstream plans -- seven in Sacramento. While neither of these counties has county hospitals, approved health plans are required to include safety-net providers (disproportionate-share hospitals, community clinics and major Medi-Cal physicians).

Notwithstanding the above-mentioned "safeguards", implementation of Medi-Cal managed care, combined with the inability of hospitals to be reimbursed for their excess capacity, is expected to place county hospitals at major risk of losing significant portions of their Medi-Cal patient loads. Protection of Med-Cal revenue is vital to the survival of most, if not all, county hospitals. One major factor that could ameliorate the competition for Medi-Cal patients in Alameda County is the decision (which is not yet final) by Kaiser-Permanente to close its Oakland hospital, and contract with other hospitals to provide inpatient care to Plan members.

C. Disproportionate-Share Funds

1. SB 855

Provision of care to Medi-Cal and other indigent patients is intertwined. This is evident in the manner in which supplemental funds are distributed to hospitals with high Medi-Cal and indigent patient loads. These hospitals are defined as Medi-Cal disproportionate-share hospitals (DSH) in SB 855. The DSH definition and payment formula are based on both Medi-Cal and indigent patient percentages. To compensate DSH hospitals for unreimbursed charity and county-indigent costs, disproportionate-share payments flow through the Medi-Cal payment mechanism, in terms of supplemental payments for every Medi-Cal inpatient day. Thus, for example, a hospital with no Medi-Cal patient days and a high proportion of unsponsored indigent

patients would receive no Medi-Cal disproportionate-share payments. This relationship is reinforced by the manner in which Medi-Cal managed care is being implemented in various counties, as discussed above.

As indicated above, ACMC expects to receive approximately $30 million in DSH funds in the current year, and $15 million in fiscal-year 1996-97. This reduction reflects new federal limits, a growing list of qualifying hospitals and a "pay-back" for increased payments in earlier years due to alignment of state and federal payment periods. A drop in DSH payments by this amount next year will create a major shock that will have to be dealt with through extensive cost cutting. Alameda County is not alone in facing such severe reductions; it will be joined by all counties currently dependent on DSH revenues. These counties will be working with the State Administration and Legislature and the federal government to attempt to minimize the reductions. To the extent major reductions remain, they will have to be dealt with through a combination of cost cutting, county general fund appropriations and new revenue sources.

2. SB 1732

Another source of future funding for ACMC is the SB 1732 program, should a decision be made to proceed with the planned building project on the Highland campus. This project is comprised of a parking structure and a critical care building, including a replacement emergency department and inpatient and outpatient services.

SB 1732 (1988) established the Construction/Renovation Reimbursement Program (CRRP), administered by the Department of Health Services as part of the Medi-Cal program. CRRP is intended to provide supplemental debt-service payments to disproportionate-share hospitals for eligible projects. Eligible projects are limited to construction and acquisition of fixed equipment. Medi-Cal's share of debt service payments is determined by the hospital's Medi-Cal percentage of inpatient days. The Medi-Cal debt-service share would vary from year to year based on the Medi-Cal patient days percentage, but would be subject to a floor. This floor, or lower limit, is 90 percent of the base-year percentage. The latter is determined by the weighted average Medi-Cal patient days percentage for the three years immediately preceding plan submittal to the Office of Statewide Health Planning and Development (OSHPD). Thus, if a hospital's three-year average is 60 percent, the Medi-Cal funding floor would be 54 percent of debt-service payments.

Eligible projects must be available to Medi-Cal hospital patients, must be on behalf of Medi-Cal contracting hospitals (through the Selective Provider Contracting Program), must be financed through tax-exempt debt, and must involve at least $5 million in capital expenditures (construction and fixed equipment), unless they are for the purpose of correcting licensing or accreditation deficiencies. With some exceptions, plans for eligible projects must have been filed with OSHPD between July 1, 1989 and June 30, 1994. Thus, the "window" is now closed and costs to the program are predictable. Since the bill's enactment in 1988, the program has become more expansive through several amendments that, for the most part, extended the plan-

submittal window for specific, narrowly-defined projects (up to June 30, 1995).

Under the statute, the state pledges to bond holders that until debt service is fully paid, the state will not limit or alter the rights vested in the hospital to receive supplemental reimbursement.[3]

D. Medicaid Reform

It is likely that the Medicaid program will undergo significant change within the next few years. While Congress intends to drastically curtail growth in the program and convert this federal entitlement into a block-grant program with few restrictions on states, the President insists on maintaining federal guarantees and lower cuts in growth. The likely result is increased state flexibility coupled with decreased federal and state funding in terms of real dollars. It is possible the increased state flexibility could decouple Medicaid funding for county-indigent care (through DSH payments) from Medi-Cal volume, enabling Medi-Cal funds to directly support county-indigent care. It is also possible the advantages of this new flexibility would be more than off-set by Medi-Cal funding reductions in general.

At the same time, the need for a viable network of safety-net providers may be increasing. Given the already growing uninsured population and the lack of political will to enact universal health coverage, future Medi-Cal and Medicare funding cuts are likely to swell the uninsured ranks even further.[4] First, cutting Medi-Cal funding will directly reduce Medi-Cal access and remove beneficiaries from the Medi-Cal rolls. Second, cutting Medi-Cal and Medicare payments will, to some extent, lead to a cost-shift to some private payers (e.g., insurance carriers, HMOs, self-insured employers) who will in turn be forced to increase their health-insurance premiums, which will result in a reduction in health-insurance coverage in terms of both benefits and insured lives. Thus, greater strains will be placed on safety-net providers to treat unsponsored patients.

E. Summary

ACMC, and many other county-operated health systems, are faced with a set of nearly bewildering pressures and challenges. Its major funding sources are shrinking. County general fund revenues are no longer a predictable source of funds. ACMC's ability to provide necessary care to unsponsored, county-indigent patients is dependent on its ability to draw a sufficient number of Medi-Cal patients. That ability is severely threatened by competition from private hospitals with increasing excess capacity. While county-hospital funding may be less secure, inevitable cuts in overall Medicaid funding, without establishment of a national health insurance program, will lead to an expansion in the number of county-indigent patients. The ability to successfully compete for Medi-Cal patients will in all likelihood require capital investments on the part of ACMC so that its facilities and services will attract Medi-Cal patients with private-sector choices. If ACMC is unsuccessful in its efforts to protect its funding sources, it is likely the County will not have sufficient resources to meet its indigent-care responsibilities through

private-sector contracting. This shortfall in resources will largely be the result of the loss of ACMC's DSH funds of approximately $30 million in the current fiscal year and an estimated $15 million in the coming fiscal year. These funds are not transferrable to other hospitals. (To qualify for DSH status requires high Medi-Cal and/or unsponsored patient loads, and there is an approximately two-year lag between achieving sufficient patient volume and attaining qualification.) Should ACMC cease to operate as a general-acute hospital, there will be a major tug-of-war between the County's indigent-care obligation and the private hospitals' ability and willingness to accommodate large numbers of these patients without payment.

IV. EXAMINATION OF THE THREE MODELS

A. Treat and Transfer Facility

Under this scenario, ACMC would only be a trauma/emergency hospital. Once patients are stabilized, they would be transferred to other hospitals. Outpatient services would continue to be provided at both campuses. All inpatient services at the Fairmont campus would be discontinued. All inpatient services provided at either campus to CMSP patients who are not trauma/emergency or have been stabilized would be provided at other hospitals under contract. In addition, other county-obligation patients, such as jail patients, will have to be accommodated in private facilities.

1. Volume, Necessary Capacity, Revenue and Expenses

The primary data source is the ACMC billing records for calendar-year 1995.[5] To assess this option, data on both inpatient and outpatient volume and charges are analyzed for patients identified as trauma or emergency (i.e., treated as a trauma or emergency patient). As a treat and transfer facility, ACMC's patient base may not be limited to "pure" trauma patients, but would most likely include some non-trauma emergency patients as well. The analysis presented here uses two definitions -- trauma and all emergency patients. The latter provides inflated estimates since many patients treated in the emergency room and subsequently admitted may not be in need of emergency care, and once admitted, these patients are not subsequently transferred to other facilities once they are stabilized. On the other hand, the former (i.e., trauma patients only) may be too restrictive.

Table 1 provides data on gross revenue and inpatient volume (discharges, length of stay, patient days and average daily census) for inpatient trauma according to service. Note that there is a service identified as "trauma", which is a division of the surgery department. These patients were not subsequently assigned to a "regular" service. Note that for this restrictive definition of trauma/emergency, an average daily census (i.e., occupied licensed beds) of 12 results. Accommodating this census would require approximately 20 beds, to allow for daily census fluctuations. Average charge per patient day is $5,472. Note that average daily censuses (ADC) of one or more appear in only two regular services (neurosurgery and orthopedic surgery). The

largest ADC (8) is in the unassigned trauma classification. While there is very low volume in many services, to maintain its trauma-center designation would require ACMC to maintain most of its service capabilities.

Table 2 shows equivalent data for emergency inpatients. Here the average daily census rises to 87, and charge per patient day drops to $2,386. This census would require 125-145 beds. ADCs of greater than one appear in most major services.

Table 3 presents inpatient trauma data according to source of payment, and cost per discharge and patient day. Costs are estimated by applying the Highland campus' cost-to-charge ratio of 68.5 percent to gross revenue for each payor. Note the largest payor for inpatient trauma is Medi-Cal. Note also that the estimated Medi-Cal per diem cost is $3,287. With Medi-Cal payments negotiated on a competitive basis, and with average per diems below $1,000 for even the most sophisticated hospitals, achieving payment rates even approaching $3,000 from Medi-Cal (or any other payor) is unlikely.

Table 4 provides equivalent data for all emergency patients (including outpatient data, which is discussed below). Again, Medi-Cal is the major payor, with an estimated per diem cost of $1,672.

In projecting costs for these options, it should be noted that adequate adjustments have not been made for the fixed cost component. What is presented here are estimates of average costs attributed to these patients within the context of the current programs and overall volume of the Highland campus. Should the non-trauma/emergency patients volume be eliminated, the fixed costs would remain. While staffing could be reduced, the reductions would be far from proportional to the patient volume loss. Supply purchases may be cut proportionally, but current capital expenditures (i.e., depreciation and interest on existing plant and equipment) would remain fairly constant. Thus, the unit costs (e.g., per discharge, per patient day, per outpatient encounter) would be substantially above those presented here.

Table 5 shows inpatient and outpatient gross revenue and average daily census data according to payer, for all Highland patients and for trauma and emergency patients only. Total gross revenue for all patients is $223 million, falling to $94 million (a 58 percent drop) if only emergency patients (inpatient and outpatient) are served, and falling further to $31 million (an 86 percent drop from total) if only trauma patients are served. The ADC falls from 222, to 87, to 12, respectively.

2. Implications

The practicality of this type of hospital is doubtful. To be a trauma center, a hospital must provide a fairly comprehensive array of inpatient services, and have substantial back-up personnel and facilities. If volume falls between 38 and 86 percent (a midpoint of 62 percent), an adequate patient base to support a full-service hospital would not exist. In general, hospitals of

substantially less than 200 beds in urban areas do not make economic sense. Where geographic access is not a primary constraint, a population base is best served by fewer, and larger, hospitals, for both economic and quality reasons.

In addition to the problem of appropriate size is the loss of substantial DSH payments, which are tied to Medi-Cal patient days. Under the restrictive definition of treat and transfer, nearly all DSH payments would be eliminated. Table 5 suggests that Medi-Cal patient days (and, hence, DSH payments) would drop by 94 percent. For the current year that would cost ACMC approximately $28 million in net revenue. In 1996-97, assuming DSH net revenue of $15 million at current total volume, $14 million would be lost. Under the expansive definition of treat and transfer (i.e., retaining all emergency patients), DSH net revenue would fall from $30 million to $18 million in the current year (a $12 million loss), and from $15 million to $9 million in the 1996-96 fiscal year (a $6 million loss).

Because of the cuts being considered in Congress, the continued availability of DSH funds at approximately current levels is being called in to question. At this time, however, there is no proposal on the table which would specifically eliminate such funds. The SB 855 program accounts for approximately $1.1 billion in federal Medicaid funds flowing to California annually. Of this, the State Department of Health Services receives over $250 million to partially support its administrative functions. Should this source of revenue be significantly curtailed without replacement from another source, all counties operating hospitals (in addition to the State of California) will be placed in severe jeopardy, to the extent that a major reduction would not be politically feasible. If there are aggregate reductions, they are likely to be complemented by a shifting of the remaining funds away from private disproportionate-share hospitals, to county hospitals through greater weight being given to outpatient services and to services provided to unsponsored patients.

Thus, while not a certainty, DSH funds at some level should be available for the intermediate term at least. To the extent increased flexibility results in decoupling DSH from Medi-Cal volume, the DSH losses projected here could be reduced. Under current law, however, DSH payments are fully driven by Medi-Cal volume.

Given that DSH revenue is vital for the support of CMSP, such losses would have to be offset by substantial county general fund appropriations to enable the County to meet its Section 17000 obligation through contracting with private hospitals. All non-trauma/emergency CMSP would have to be contracted to the private sector. With projected DSH losses of $12 million to $28 million in 1995-96, and $6 million to $14 million in 1996-97, private hospitals would be required to incur aggregate losses that could approach a similar magnitude, which would be only partially offset by profits from receiving ACMC's former Medi-Cal patients. In fact, as discussed in Section C below, private hospitals contracting to care for ACMC's CMSP patients would incur costs of $42.4 million, receive realignment revenue of $24.8 million and, thus, incur losses of $17.6 million from this arrangement.

Another ramification of this model is the loss of the ACMC teaching program, with its associated Medicare direct and indirect graduate medical education subsidies. A recent study suggests the teaching program earned $3.3 million in profits in fiscal-year 1994-95.[6]

In terms of necessary capital expenditures, while a substantial portion of the main Highland building would become empty, the emergency department would still have to be replaced. Rather than moving to the new planned critical care building, the remodeled emergency facility could most likely be accommodated in the main building, and the planned parking structure may not be necessary. These capital expenditures, however, would not be eligible for SB 1732 assistance.

A component of the treat and transfer model is discontinuance of inpatient services at the Fairmont campus, and thus contracting for Fairmont's CMSP inpatient services at private hospitals. The CMSP inpatient volume at Fairmont is low, a 1995 ADC of 2.5. Thus, virtually the entire patient load has a payor sponsor, and is not an obligation of Alameda County. Fairmont, with its rehabilitation and high-acuity, long-term care role, fills a major gap in the local health system. While an integral and valuable component of the ACMC integrated health system, discontinuance of Fairmont's inpatient services should not cause the County significant legal problems with regard to its Section 17000 obligation. Since, however, the private sector has elected not to compete for Fairmont's sponsored patients, closing its inpatient program would not appear to benefit the private hospitals. Unless major Medi-Cal payment shortfalls are projected, decisions on the future of that facility should be based on the costs and benefits of its replacement prior to 2008 to meet new seismic-safety standards, under SB 1953 (1994).[7] This law will require inpatient facilities to be in reasonable conformance with at least 1960s building codes by 2008.

B. Trauma Center and a CMSP Hospital

1. Volume, Necessary Capacity, Revenue and Expenses

Under this scenario, ACMC would remain a trauma center, treating all trauma patients, regardless of payor source, and be the primary hospital provider for CMSP patients. CMSP patients would be treated regardless of admission status. Non-CMSP patients, however, would only be treated if they were trauma patients, and once stabilized, transferred to other hospitals.

Table 6 provides data for Highland and Fairmont on CMSP inpatient and outpatient gross revenue and estimated costs per discharge and per patient day. Note that of $62 million in gross CMSP revenue (in-and out-patient) for both campuses, $54 million (87 percent) is accounted for by Highland. Of the CMSP combined ADC of 24, 22 (90 percent) occurred at Highland. Note also the high length of stay (and relatively low per diem cost) at Fairmont, reflecting the long-term-care nature of the Fairmont patient load.

Table 7 compares, for Highland, inpatient volume and gross revenue according to service

for three categories of patients -- all inpatients, emergency admissions, and trauma admissions. The bottom row in the table excludes discharges and patient days in the nursery since some of that volume is in unlicensed bassinets and is not normally counted as discharges and patient days, and excludes volume and revenue for the John George Pavilion, which is on the Highland license. (On the other hand, neonatal intensive care [NICU] discharges and patient days should be included.) This data base does not permit identification of NICU patients. With these exclusions, the total ADC of 126 drops to 22 for CMSP patients only, and 33 for trauma and CMSP combined. Table 8 provides a calculation of ADC for CMSP plus trauma, excluding the CMSP patients that are already included in trauma. That ADC is 32. Accommodating this ADC would require a hospital with approximately 50-55 beds. Again, maintenance of the trauma center would require maintenance of most services, although ENT, obstetrics, nursery, ophthalmology and urology most likely could be eliminated.

Table 9 provides CMSP inpatient data for Highland, including gross revenue per discharge and per patient day. The per diem charge of $2,933 is close to that for all patients. Thus, it appears that CMSP patients have acuity levels (on a per-diem basis) similar to those of other Highland patients.

2. Implications

The implications of this scenario are similar to those pertaining to the treat and transfer model, with one exception. CMSP patients would continue to be treated at ACMC, rather than contracted to the private sector. The loss of virtually all DSH revenue, however, would have to be offset by considerable general fund contributions, nearly $30 million in the current year. DSH losses are projected at the higher level under the treat and transfer model since Medi-Cal patient days, which drive DSH payments, would only derive from trauma patients.

C. A Competitive Full Service Hospital

1. Volume, Necessary Capacity, Revenue and Expenses

Under this scenario, ACMC would maintain its current payor base and take initiatives necessary to maintain that base through the remainder of this decade, and beyond. Given the movement of formerly inpatient services to the outpatient setting and the implementation of Medi-Cal managed care, private providers who, in the past, did not view Medi-Cal as a desired payor source, are increasingly competing for this market segment. In the last year, ACMC has experienced a drop in its Medi-Cal obstetrics patients due to competition from private providers. To effectively compete for this vital market segment will require efforts on the part of ACMC to emulate private-sector providers in terms of service and amenities.

Table 10 shows Highland inpatient volume, gross revenue and estimated costs according to payor. (Note that in this data base, Medi-Cal-sponsored mental health patients are not identified as such. All mental health is classified as a distinct payor source.) Of total inpatient

gross revenue of $136 million, $75 million (55 percent) is accounted for by Medi-Cal (excluding Medi-Cal mental health patients). A clearer picture is provided by Table 11, which shows total and Medi-Cal inpatient volume and gross revenue according to service, enabling the exclusion of mental health (John George Pavilion). This shows Medi-Cal (excluding mental health and nursery) accounting for 57 percent of total patient days. The total ADC, excluding mental health and nursery, is 126. Cost per patient day for Medi-Cal patients is estimated to be $1,961.

This ADC of 126 is consistent with needed capacity of 175 beds or less. Licensed beds at the Highland campus (excluding the John George Pavilion [JGP]) are 236. Many of these beds, however, do not exist, as the space has been converted to other functions (i.e., administration and outpatient use). According to the Office of Statewide Health Planning and Development (OSHPD) Quarterly Financial and Utilization Reports covering the 12-month period ending June 30, 1995, the Highland campus (including the John George Pavilion) has 274 available beds. Subtracting the 83 licensed beds at the John George Pavilion leaves 191 available beds at Highland, reasonably close to the 175-bed requirement.

Table 13 provides comparative data on the all hospitals in Alameda County. It shows that on the basis of available beds, Highland (including JGP) has the second highest occupancy rate among all general-acute hospitals (77 percent). It shows that both ACMC campuses combined account for 47 percent of all Medi-Cal patient days and 45 percent of all county-indigent patient days. (Thunder Road Chemical Dependency Hospital accounts for 49 percent of county-indigent patient days, but only 4 percent of county-indigent expenses. ACMC accounts for 90 percent of such expenses.)

Table 14 presents 1992 Medi-Cal paid-claims data on beneficiaries residing in Alameda County, identifying patient days on behalf of those aid categories that will be required to enroll in a managed-care plan. While these data are not current, they are shown here to provide a perspective on the relative market shares of Medi-Cal patient days and each hospital's dependence on those beneficiaries that will be required to enroll in one of the two managed-care plans.[8] Individual data are shown for hospitals with 1,000 or more non-cross-over Medi-Cal patient days. Since California Children's Services (CCS) patients will be covered under fee-for-service, these patient days on behalf of beneficiaries in the mandatory aid codes are subtracted to arrive at net mandatory patient days. As a percent of total non-cross-over patient days, net mandatory patient days are 28 percent for the county as a whole and 29 percent for Highland. Thus, over 70 percent of Highland's 1992 Medi-Cal patient days would not be covered under the two-plan model. The more than 8,000 patient days that will be covered, however, are significant. Given the county-wide patient-day utilization rate for this population (265 days per 1,000 beneficiaries), these 8,319 patient days translate into 31,358 enrollees. This projection does not account for the likely drop in per-capita utilization that should accompany movement to a capitated system. In Alameda County, approximately 170,000 Medi-Cal beneficiaries are in the mandatory aid codes. Approximately 75,000 are "targeted" for the Local Initiative plan.[9]

This suggests that to protect Highland's 8,319 mandatory patient days (that occurred in

1992), the ACMC system will have to enroll over 30,000 beneficiaries. While this would be an ambitious task, it may not be enough. Since Highland does not have an inpatient pediatrics service, ACMC may have to enroll even more beneficiaries to protect its patient-day base. Approximately 60 percent of the mandatory beneficiary population is 15 years of age or less. This group, however, has a lower utilization rate than the older cohorts, approximately one-third the adult rate. Thus, in terms of adult enrollees, approximately 19,000 would be required for Highland. Beneficiaries in the mandatory categories, however, are families and children. It is unlikely, for example, that a mother and her children would enroll in different plans. If they enroll in the ACMC system, the children would not be hospitalized at Highland; they would be treated in the ACMC clinics and presumably hospitalized at Children's Hospital. Highland's Medi-Cal patient base would be protected through a combination of enrolling a sufficient number of adults through both the Local Initiative and the Mainstream plans, and through subcontracting with the Mainstream plan for inpatient care for those enrollees assigned to non-ACMC physician groups for primary care.

Equivalent paid-claims data for Highland for 1995 indicates a similar number of total Medi-Cal patient days (27,824), but substantially fewer mandatory patient days (5,933). According to the 1995 data, mandatory patient days represent only 21 percent of total Medi-Cal days. And of these 5,933 mandatory patient days, 29 percent are in obstetrics. Enrollee equivalents based on 1995 data would be 22,364 and 13,423 for total enrollees and adult enrollees, respectively. These represent far more attainable enrollment targets. Table 15 presents these Medi-Cal paid-claims data for Highland by service.

2. Appropriate Strategies

The Setting

Competing for Medi-Cal patients is a relatively new phenomenon. Given Medi-Cal's relatively low payment rates (on average, 50 to 60 percent of allowable costs for hospitals) and the belief by some providers that a high Medi-Cal load is not conducive to attracting private patients, most private hospitals did not try to expand their Medi-Cal patient base. That situation has changed for some hospitals. First, for those hospitals that have always had a high proportion of Medi-Cal patients, the availability of DSH payments has made Medi-Cal a profitable business line. In Alameda County, however, this is not a competitive factor since only Children's Hospital Medical Center and ACMC qualify as DSH providers. Second, in the late 1980's, to deal with a shortage of physician and hospital capacity available to Medi-Cal patients in the obstetrics area, Medi-Cal payments to physicians for prenatal care and deliveries were increased to levels comparable to private payors, and the California Medical Assistance Commission (CMAC) began to negotiate separate inpatient rates for obstetrics. This has served to make Medi-Cal obstetrics patients far more desirable than previously, to both hospitals and physicians, especially the latter. Third, the proliferation of managed care in the private sector and advancements in medical science (e.g., orthoscopic and laser surgery) have resulted in a dramatic reduction in inpatient utilization, leaving hospitals with more and more empty beds, with fewer charge-paying

purchasers to subsidize them. And fourth, with the movement to Medi-Cal managed care, many hospitals and physicians believe they manage this population in a cost-effective and profitable manner.

It is far from certain, however, that this line of business will remain profitable or desirable to a large number of private-sector providers in the long run. Alameda County presents a unique circumstance. While the private-sector hospitals have been competing aggressively for Medi-Cal patients, especially obstetrics patients, Kaiser-Permanente has recently announced tentative plans to close its Oakland hospital, in favor of contracting with other hospitals. Should these plans be implemented, competitive pressures for Medi-Cal patients may ease. A final decision has not yet been made.

At this time, ACMC should expect to have to compete to retain its Medi-Cal patient base in the mandatory aid categories, a large portion of which is obstetrics-related. It should not be forced, however, to make considerable capital investments for purely marketing reasons, but to remedy current deficiencies. ACMC should capitalize on its competitive advantages in terms of a committed medical and support staff accustomed to dealing with hard-to-manage indigent populations, its considerable capabilities due to its extensive teaching program, its dependability at a time when the desirability of Medi-Cal patients to many private providers may be only a fad, and its integrated health system involving a network of county-operated and private clinics linked to ACMC.

It should be noted that Fairmont, given its orientation and lack of competition, at this time appears to be insulated from the type of competition discussed here.

Capital Investments

ACMC should consider reasonable efforts to improve its plant and equipment in a cost-effective manner over the next three-to-five years. The main Highland building, which houses the inpatient facilities, was completed in 1970 and should be adequate to meet the 2008 seismic-safety threshold. The inpatient facilities are generally adequate. There appear to be four major problems on the entire campus: (1) the emergency department is in need of major renovation; (2) the surgery facilities (in- and out-patient) are inadequate; (3) outpatient services are cramped in some areas and spread-out among several buildings in a confusing manner; and (4) parking space is inadequate.

These problems have been recognized in the capital plan adopted by ACMC, which includes construction of a parking structure and of an eight-story critical care building. The latter is to include, in addition to emergency/trauma and surgical facilities, intensive care beds and an imaging center. Architectural plans for the critical care building were filed with OSHPD in time to qualify for financial assistance under SB 1732. The total cost of this project was estimated to be approximately $90 million. Since the plans incorporated only shelled space for a portion of the building (which does not qualify for SB 1732 since this space would not be accessible to

Medi-Cal patients), approximately $60 million in planned capital expenditures would qualify for SB 1732 assistance. Thus, assuming ACMC's Medi-Cal patient-days percentage is 50 percent, SB 1732 will yield $30 million in subsidies.

On the full $90 million project, annual debt-service payments (30 years at 6 percent interest) would be $6.5 million, with $2.2 million in SB 1732 subsidies, for a net county contribution of $4.3 million. If the project could be completed for $60 million, for example by eliminating the shelled floors and those earmarked for ICU and radiology, SB 1732 subsidies of $2.2 million might remain, but the net county contribution would drop to $2.2 million (on a total debt-service payment of $4.4 million). On the other hand, it may be cost-effective in the long term to include some shelled space for clinic space. The cost implications of these alternatives will have to be assessed. While it may be less costly overall to make extensive alterations in the current main building than to move ahead with the critical care building (or a portion of that building), such a project will not qualify for SB 1732 matching funds and would in all likelihood be more costly to the County.

It appears that to be able to retain a substantial portion of Medi-Cal patient days associated with managed-care enrollees, a significant portion of the construction discussed here will be necessary. These capital-investment decisions will not bear fruit overnight. In the meantime (i.e., until the projects are available for patient use), ACMC will have to fully rely on its other, considerable attributes and attempt to make cosmetic appearance changes and minor renovations in the existing buildings as appropriate. To the extent these capital expenditures (or other initiatives) require general-fund subsidies, it should be noted that of all departments of county government ACMC is unique in that its viability depends on its ability to compete with the private sector.

Non-Capital-Intensive Measures

Several measures not involving major capital investments are worthy of consideration. They mainly revolve around ACMC capitalizing on its major attributes.

ACMC has more experience in providing care to Alameda County's indigent residents than any other provider. The medical staff, nursing staff and social-services personnel are familiar with the indigent population's unique needs. Private-sector providers do not have this experience and many will find the adjustment difficult, not worth the effort, or impossible. Medical, cultural and linguistic characteristics of this population can best be accommodated by the ACMC staff resources. This should be communicated to the ACMC patient base.

ACMC has the potential to form the nucleus of an integrated health delivery system, including long-term-care facilities (Fairmont), mental-health facilities (John George Pavilion), public-health clinics, a network of county-operated and private-non-profit community clinics (community-based organizations [CBOs]), and extensive specialty resources through its teaching program. This system should provide the base to enable the necessary continuity of care and

control mechanisms to be a successful health system. To take full advantage of this potential requires investments in necessary information systems to enable and coordinate the flow of data on individual patients and the medical care process among the various facilities and services.

Coordination among these components in ACMC's best interests requires at a minimum that the first choice for hospital and medical specialty referrals on the part of all affiliated clinics is ACMC. Unless there is a distance problem, or a clinic is located adjacent to another hospital, or ACMC does not have the required services (e.g., pediatrics, cardiovascular surgery), all clinics, including CBOs, should be required to refer within the ACMC system (i.e., hospital and specialty clinics). For such coordination to work in the patient's best interests requires the ability of ACMC's programs to accommodate the referring clinics through timely appointment scheduling.. Physicians representing ACMC, CBOs and other community physicians should be brought together to identify improvements needed at ACMC to facilitate establishment of an expanded referral base.

A mechanism being implemented in other public hospitals is establishment of two tracks for patient care, one for insured and Medi-Cal patients, and another for CMSP, since the latter are not being enticed by private-sector providers. While the level and quality of patient care would be equivalent between the two tracks, the former would have more amenities, including improved scheduling, more attractive facilities and greater participation by private physicians. The feasibility of such a two-track system should be explored. While it may be controversial, to the extent it contributes to the financial viability of ACMC, it improves the latter's ability to maintain access for county-obligation patients.

Better use of existing clinic space would greatly improve the marketability of ACMC. For example, obstetrics, gynecology and pediatrics clinics could be placed in close proximity and scheduling could be coordinated, to enable "one-stop" shopping on the part of mothers and children.

The teaching program provides an opportunity for ACMC to enhance its reputation in various medical specialties, and to enhance its private patient base. For example, in cooperation with private hospitals, ACMC could develop certain "Centers of Excellence" (i.e., specific illnesses for which ACMC would have a regional reputation). One area for such a center could be disease management of cancer patients.[10] Another area could be workplace injuries, as the following quote of Quentin Young, M.D., former director of medicine at Cook County Hospital, illustrates:

> *"My job was to attract young doctors to the place. They came and worked their butts off. Occupational medicine was introduced into a public hospital. The county board objected: 'It's a hospital for indigents. They don't work.' We pointed out that our wards were full of people who were victims of the workplace; lead poisoning, brain damage, injuries. Today, Cook County has the largest*

occupational training program in the country."[11]

The ability to capitalize on the teaching program in this manner, besides enabling the building of a private patient base, will also facilitate competition for Medi-Cal patients.

Efforts should be made to encourage county employees to use ACMC and its affiliated physicians through financial incentives, in terms of reduced health-insurance premiums, deductibles or coinsurance.

Another obvious mechanism to retain Medi-Cal managed-care patients is through the Local Initiative, in which ACMC, as the major DSH hospital in Alameda County, is the nucleus. Enrollees should be encouraged to select primary care providers (i.e., county clinics and CBOs) affiliated with ACMC. If they are unable to make a selection, they should be defaulted into the ACMC network.

The importance of marketing the ACMC system to the Medi-Cal population cannot be over-emphasized. In this regard, the recent managed-care experience of University of California, Davis Medical Center (UCDMC) should be noted. In April 1994, Geographic Managed Care (GMC) was implemented in Sacramento County. Under that program, all Medi-Cal beneficiaries in the AFDC, Medically-Needy Families (no-share-of-cost) and Medically Indigent Children categories are required to select from seven managed care plans (excluding four dental plans) to receive all their Medi-Cal covered health services. One of those plans is a Primary Care Case Management (PCCM) plan sponsored by UCDMC. While the largest Medi-Cal provider in Sacramento County prior to implementation of GMC, the UCDMC plan has secured the smallest market share of GMC enrollees, approximately 7 percent (11,000 enrollees out of a population of 150,000).[12] According to Department of Health Services (DHS) representatives, this poor experience is the direct result of UCDMC's refusal to market its plan to the Medi-Cal population. While UCDMC, as a trauma center and the former county hospital, has a public-hospital image, it also has unique capabilities that should be valued by the Medi-Cal population (e.g., extensive tertiary-care facilities, an abundance of highly qualified physicians, cultural sensitivity and transportation programs serving the indigent population). It elected not to exploit its positive attributes during the early stages of enrollment, and has been unable to recover.

Finally, consideration should be given to enlisting the support of the private hospitals in two regards -- protecting ACMC's Medi-Cal patient base and coordinating programs with ACMC.

The major private hospitals should be made aware that ACMC's ability to maintain its trauma center and to be the provider of last resort is contingent on its ability to maintain its Medi-Cal patient base. Without this payment base, DSH payments, which heavily subsidize ACMC's CMSP patients, will disappear. Without these subsidies, ACMC will be forced to discontinue its inpatient services at Highland. The County would then contract with private hospitals to provide care to CMSP patients at the level it could afford (e.g., realignment funds plus the current general

fund contribution, which is zero!). The loss of tens of millions of dollars in DSH funds, which heavily subsidize the CMSP program, will require private providers to incur losses approaching that level from treating these patients. Such losses will only be ameliorated through dramatic cuts in service to this population, and accompanying deterioration in health status, which would be politically intolerable, and through profits from the shifting of ACMC's Medi-Cal patients to the private hospitals (which, in all likelihood, would not be sufficient to offset these losses). In such a scenario, the County may be able to recover some costs (to sweeten the contracting pot) by selling the Highland facility to a private for-profit or non-profit hospital chain, which would operate it as a private hospital, competing for private, Medicare and Medi-Cal patients. The new entity would be free to discontinue the trauma center and would be under no obligation to contract to care for CMSP patients.

Table 16 represents an attempt to simulate the impact of CMSP contracting on the private hospitals. It starts with total CMSP gross revenue at Fairmont and Highland, then applies the weighted cost-to-charge ratio at both facilities (69.7 percent) to estimate CMSP costs. Thus, gross revenue of $61.7 million implies costs of $42. 4 million.[13] When these costs are compared to ACMC's 1995-96 realignment revenue of $24.8 million and the zero county general fund allocation, there is a payment shortfall of $17.6 million. ACMC has been able to offset this shortfall with DSH funds. DSH funds, however, would not directly transfer to the private hospitals. To the extent one or more private hospitals became eligible for DSH funds in the future due to the transfer of CMSP and Medi-Cal patients, there is an approximate two-year lag between the new patient volume and DSH qualification. Along with the new CMSP volume would come Highland's Medi-Cal volume. Table 15 also estimates Highland's costs for these patients and Medi-Cal net revenue. Note that net revenue is 60 percent of costs. (This shortfall has also been offset by DSH funds.) It is highly unlikely that the incremental costs to the private hospitals of the new CMSP and Medi-Cal volume would be sufficiently below the total costs estimated here to offset the expected payment shortfalls to an acceptable extent.

To protect the private hospitals from this scenario, mechanisms should be explored through, for example, Local Initiative policies to protect ACMC's Medi-Cal patient base.

In addition, under SB 697 (Torres), enacted in 1994, not-for-profit hospitals, either alone or through other organizational arrangements, are required to conduct a community needs assessment and to develop a community benefits plan. These plans are to be filed with OSHPD. ACMC should initiate a process to enable all local hospitals to work together in this effort. This mechanism could be used to jointly plan future programs and to establish an organized, public process for assessing the respective roles of each hospital in the best interests of the community. This would create an ideal forum, for example, for planning the Centers of Excellence programs discussed above.

V. COORDINATING EFFORTS WITH PRIVATE HOSPITALS

From the analysis discussed above, it appears there are only two feasible options: maintain ACMC as an institution capable of attracting a sufficient Medi-Cal revenue base, and related DSH subsidies, or cease inpatient operations altogether, in favor of private-sector contracting for county-obligation patients. After weighing the risks of the latter scenario, should the Board of Supervisors decide to close ACMC as an inpatient facility, and contract with private hospitals to fulfill its Section 17000 obligations, the elements listed below should form the foundation of such a policy.

Conditions for Delegating County Responsibilities to Private Hospitals

1. The private hospitals should make a legally-binding commitment to provide mainstream care to all patients in need of such care, regardless of diagnosis (e.g., AIDS, psychiatric), social status (e.g., homeless, jail patient), or payer source (e.g., Medi-Cal, unsponsored).

2. The hospitals' track records in treating the indigent (especially Medi-Cal) should be established, and generally accepted by the area's indigent advocates. Many of these patients are not simply a new line of business or a collection of capitated lives. They have a myriad of social and medical problems that are difficult to manage, requiring medical and allied-health personnel with particular sensitivities.

3. The hospitals' commitment should be for the long run (i.e., 25-30 years). Once the county hospital is closed, it is unlikely ever to open again.

4. The general-fund exposure to the county should be reasonable and predictable. (It is currently zero.) The private hospitals will be the beneficiaries of substantial incremental revenue and patients to fill their empty beds, especially from the county hospital's former Medi-Cal patients. The incremental costs of this new volume are likely to be below current average costs.

5. If a major rationale for closing the county hospital is that services should be consolidated, coordinated and integrated in the private system, there should in fact be a private "system." That is, the private hospitals should coordinate and integrate services among themselves in their community's best interests. This will improve care, contain costs and increase the financial viability of the local health system. Consideration should be given to their forming a not-for-profit joint-venture corporation to coordinate provision of care, collect funds from the county and disburse funds to the member hospitals. The viability of this entity should be guaranteed by its members.

6. There should be a maintenance of effort requirement regarding the hospitals' provision of charity care, so that the county will not be charged for services previously provided at no charge.

7. The hospitals should be financially viable, so that they will not come back to the county a few years later to change the terms of the agreement, after the county has lost all its leverage.

8. Given the unique nature of this patient population and given that the county's medical and nursing staff are accustomed to this population, maximum effort should be made to:

(1) Assure that the county medical staff will be given the same privileges at the private hospitals; and

(2) Assure that the staffing increases at the private hospitals made necessary by the incremental volume will be accommodated by former county employees.

9. The private hospitals should assure their seismic safety for the length of the long-term agreement. Those hospitals with plants that are likely to be determined out of compliance with seismic codes, should establish a sufficient reserve account to make the necessary corrections when required by OSHPD.

VI. IMMEDIATE IMPLEMENTATION STEPS

Efforts necessary to gear up ACMC to be a full-service, competitive hospital should begin immediately after authorization by the Board of Supervisors. Assuming such action takes place in mid-March, the following implementation schedule for the near term should be considered:

Activity	Commence	Complete
Convene group of ACMC, CBO and other physicians to identify short-term and long-term actions to expand referral base	March 15	April 30
Develop groundrules for CBO referrals	May 1	June 28
Reassess plans for Highland critical care building	March 15	June 3
Negotiate changes in plans with OSHPD	June 4	June 28
Reassess Local Initiative default procedure	March 15	April 15
Develop plans for reorganizing and streamlining clinic space	April 15	June 14

Activity	Commence	Complete
Develop marketing plan for ACMC for Local Initiative and Mainstream	May 1	June 28
Develop plans for encouraging county employees to use ACMC and its clinic network	April 15	June 28
Implement above plans and procedures	July 1	As appropriate

The above matrix identifies the steps needed to address the most urgent needs that do not require major expenditure commitments. The urgency with respect to the critical care building is based on the need to meet potential OSHPD concerns regarding modifications to final plans submitted in 1994 that will not trigger a new submittal (so that SB 1732 eligibility can be protected). The activities identified above should generally be pursued concurrently. Under this schedule, by the start of the next fiscal year, ACMC should have policies in place and plans in place to enhance its competitive position. Other initiatives proposed in this report (e.g., centers of excellence) should be pursued on a timely basis, but do not appear to be as urgent as the need to immediately accommodate the CBOs and secure an essential referral base.

END NOTES

1.See the Legislative Analyst's Analysis of the 1995-96 Budget, for a summary of these programs.

2.Expanding Medi-Cal Managed Care, California Department of Health Services, March 31, 1993, p. 56.

3.Welfare and Institutions Code, Section 14085.5 (b)(5)(A).

4.The number of Californians with no health insurance, Medicare or Medi-Cal coverage increased by 273,000 between 1992 and 1993, to over 6.5 million individuals. See E. Richard Brown, "Health Insurance Coverage in California, 1993," UCLA Center for Health Policy Research Policy Brief, April 1995.

5.Reliance on billing data for trauma/emergency patients is likely to cause an undercount since during 1995 bills were apparently not produced for a significant number of emergency patients. (Letters from Gary P. Young, MD to Henry Zaretsky, December 21, 1995 and February 2, 1996.)

6.Study to Identify and Quantify Utilization Differences Attributable to The Alameda County Medical Center GME Program, Carlson Price Fass & Co., Inc., January 1996.

7.The Governor's Budget for fiscal-year 1996-97 calls for a 20 percent reduction in distinct-part/skilled-nursing facility rates for Medi-Cal. This could have a major impact on Fairmont.

8.As will be shown below, Highland's dependence on Medi-Cal beneficiaries in the mandatory aid categories has dropped significantly between 1992 and 1995. Thus, ACMC will be required to enroll fewer beneficiaries than suggested by the data in Table 14, as discussed below.

9.Memorandum to local initiatives from Joseph A. Kelly, Chief, Medi-Cal Managed Care Division, California Department of Health Services, April 27, 1995.

10.See, for example, Frederick C. Lee, "Disease Management in the Treatment of Cancer'" Medical Interface (December 1995), 126-131.

11.Quoted in Studs Terkel, Coming of Age: The Story of Our Century by Those Who've Lived It, New York: The New Press, 1995.

12.California Medical Assistance Commission, Update to the Annual Report to the Legislature, Sacramento, May, 1995, p. 9.

13.It should be noted that the actual costs of the CMSP program could be greater, since this data source is the billing system. Since ACMC does not get reimbursed for these patients it is likely that bills are not produced for all CMSP patients.