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AN ANALYSIS OF ISSUES REGARDING THE SALE OF RIVERSIDE COUNTY REGIONAL MEDICAL CENTER OR A JOINT-VENTURE ARRANGEMENT

Henry W. Zaretsky, Ph.D.

December 15, 1999

Prepared for the County of Riverside under Purchase Order 28607. The findings and opinions presented herein are those of the author, and are not intended to represent those of the County of Riverside Board of Supervisors, Executive Office or the Health Services Agency.

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I. Introduction and Summary

The purpose of this report is to identify and discuss the major issues that must be addressed in considering the potential sale of, or joint-venture involving, Riverside County Regional Medical Center (RCRMC). The issues range from health delivery, to economic to political.

In 1998, RCRMC accounted for some $60 million in indigent-care expenditures (county indigent care plus bad debts and charity expenses) on behalf of patients with no private or public health coverage, 65 percent of all such expenditures borne by all hospitals located in Riverside County. The second-ranked hospital is Riverside General Hospital-Mental Health, also County sponsored, with a 6 percent share. Thus, the two county facilities combined account for over 70 percent of all indigent care provided in Riverside County. While accounting for 65 percent of all indigent care, RCRMC represents only 12 percent of total countywide hospital expenditures and 22 percent of countywide Medi-Cal expenditures. While at the present time there is, in general, countywide excess acute-care inpatient capacity, such is not the case with respect to ICU/CCU and neonatal intensive care. The excess capacity in the other services is less than in most other counties, and given the rapid population growth projected, does not appear to be a major consideration. Population is projected to nearly double to 2.8 million in 2020. Two disturbing trends include a near doubling in RCRMC's indigent-care costs from 1994 to 1998, coupled with a halving of Medi-Cal patient days. Since disproportionate share revenue is used to subsidize indigent care and is tied to Medi-Cal patient days, these opposing trends, which are not unusual for county hospitals, raise a red flag.

The key to preserving the financial viability of RCRMC is to prevent further erosion of its Medi-Cal and other-paying patient base. Four methods for maintaining viability are discussed — selling RCRMC, a public/private joint venture, cost cutting and reducing indigent care. None are viewed as solutions in themselves, and the last method (reducing indigent care) is not realistic or statutorily permissible.

The recent experiences of other counties point to the complexity, potential risks and benefits of selling a county hospital. Even if what appears to be an acceptable arrangement can be negotiated, unanticipated developments could place the county at risk several years after the sale. The potential benefits of such a sale are less apparent in Riverside County than in counties which have recently sold their hospitals because in those counties the aging hospital was not replaced, population growth was not expected to absorb excess hospital capacity and the buyers were local health systems which could integrate county-hospital programs with their own. A potential buyer for RCRMC must be sufficiently credit worthy to assume approximately $250 million in long-term debt.

A set of conditions to guide the sale decision is proposed, intended to assure maintenance of access and quality, financial viability of the new system, protection of county funds from future claims, and continued public accountability. The economic and political implications of such an arrangement are considerable, including substantial financial risk, potential litigation, reduced worker productivity, intense political pressure on Board members, and polarization within the Board and within the health care community. This makes it essential that, prior to embarking on this process, the Board be convinced that selling RCRMC is the preferred alternative.

An alternative approach is presented for consideration — providing increased flexibility to the Health Services Agency in administering its programs, which must compete with the private sector. Since protecting the Medi-Cal base is essential, competition for this patient base is intense and competitors have more flexibility than public agencies to respond to marketplace developments, granting increased flexibility to the Health Services Agency, for example, in the areas of personnel, contracting and equipment purchasing, may represent the most feasible, and least risky, opportunity available.

The report is structured as follows:

(1) An analysis of trends in the volume and distribution of indigent care and Medi-Cal among hospitals in Riverside County. Included in this analysis is a review of capacity and utilization on the part of individual hospitals.

(2) A discussion of the role of RCRMC in the local health delivery system, including the financial risks involved in maintaining continuing to operate the facility.

(3) A discussion of the "value" of the facility in terms of outstanding debt, revenue sources for debt-service, and its costs versus comparable hospitals.

(4) Other counties' experiences.

(5) A proposed set of conditions for contracting county indigent-care responsibilities to private-sector hospitals.

(6) The economic and political implications involved in selling RCRMC.

(7) An alternative approach.

II. Hospital Industry Trends in Riverside County

A. The Current Situation

Table A1 in the Appendix presents data comparing indigent care volume and related information among all hospitals (with the exception of Kaiser) in Riverside County.[1] The data cover the 12-month period ending September 30, 1998. Riverside County Regional Medical Center (RCRMC) is the major Medi-Cal and indigent-care provider. RCRMC's expenditures on behalf of indigent patients (i.e., low-income patients not covered by any private or public health insurance programs) totaled $50.3 million. When bad debts are included, the total rises to $60 million. When indigent care is defined to include county indigent expenses plus charity costs, RCRMC's $50.3 million accounts for 78 percent of the total for all hospitals in Riverside County. When bad debts costs are added, RCRMC's $60 million represents 65 percent of the County total. Using the broadest definition of indigent care (i.e., including bad debts expenditures), only three other hospitals account for more than 4 percent of county-wide expenditures (Riverside General-Mental Health, Riverside Community, and Desert Regional Medical Center). While RCRMC accounts for 65 percent of indigent care, it accounts for only 12 percent of total expenses. With respect to Medi-Cal, RCRMC is also the major provider in the County, with a 22 percent share of Medi-Cal expenses. Note that revenue and net income data are misleading, since a large portion of RCRMC's revenue is derived from disproportionate share (DSH) Medi-Cal payments, which include transfer payments made by the County as revenue.[2] Such payments account for over two-thirds of DSH revenue, but are not reported in this data base. It also should be noted that the time period covered here does not yet include a full year of operations at the new RCRMC, but a blending of both facilities.

In terms of overall occupancy rates, most general-acute hospitals had occupancy rates at or below 60 percent on a licensed-bed basis, and, as expected, slightly higher on available-bed (available for occupancy) and staffed-bed bases. Table A2 provides calendar-year 1997 data on licensed beds and occupancy according to licensed-bed category, in addition to emergency-room

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[1] The data source is the Office of Statewide Health Planning and Development, Quarterly Hospital Financial and Utilization Reports. Kaiser is exempt from reporting requirements. While there may be more accurate and detailed data available for some hospitals, this data base covers all hospitals (with the exception of Kaiser). The purpose of the analysis presented here is not a detailed accounting of RCRMC's operations, but an analysis of RCRMC relative to other hospitals in Riverside County. This is the only publically-available data base permitting such an analysis on a timely basis.

[2] See Section III.A. below for a discussion of the disproportionate share programs.

volume and cardiac surgery volume for all hospitals in Riverside County (including Kaiser). Note that of all general-acute bed categories (i.e., excluding long-term care and psychiatric), the only areas where there may be shortages are in ICU/CCU and neonatal intensive care. With respect to emergency services, RCRMC, with over 45,000 emergency room visits, ranks second in volume. Other hospitals with over 30,000 visits include: Kaiser, Desert Hospital, and Hemet Valley Medical Center.

B. Population Growth

While most areas in California are characterized by excess hospital inpatient capacity, the extent of excess is less in Riverside County than in other areas. Moreover, Riverside County's population has been, and is projected to continue, growing at high rates. As shown in Table A3, the California Department of Finance projects County-wide population to nearly double from 1997 to 2020 — from 1.4 million to 2.8 million. In addition, there is likely to be some hospital "attrition" by 2008 due to enforcement of new seismic-safety standards.[3] Thus, excess inpatient hospital capacity does not appear to be a major factor in Riverside County.

C. Recent Trends

Table A4 portrays the variables in Table A1 in terms of hospital-specific five-year trends. "Annual %", displayed below each hospital's five years of data is the average annual rate of change in each variable, calculated through a linear regression equation. For example, for the first hospital listed (Betty Ford Center), bad debts cost grew at an average annual rate of 5.38 percent between 1994 and 1998. Where "ERR" is displayed, a rate could not be calculated since one or more years had a value of zero or less.[4] For RCRMC, note that indigent-care expenditures (defined to include bad debts) have grown at an annual rate of 16 percent, nearly doubling over the five-year period. At the same time, its Medi-Cal expenditures have dropped at an annual rate of 11 percent, and Medi-Cal patient days have dropped at an annual rate of 19 percent; over this five-year period they dropped by half.[5] Since DSH payments are tied to Medi-Cal patient days, and many public hospitals depend on these payments to subsidize indigent care, these opposing trends are troubling. They are fairly typical, however, for public hospitals, since more and more private hospitals are aggressively competing for Medi-Cal patients (particularly obstetrics patients) as other revenue sources are drying up, due to declining inpatient use rates and lower payment rates under managed-care programs. No other large-volume Medi-Cal provider in the

[3] By 2008, under SB 1953 (1994) all general acute hospitals must adhere to new seismic-safety standards or cease operating as inpatient institutions. It is likely most hospitals constructed prior to the mid-1970's will require substantial retrofitting, and many of these will elect to close.

[4] In calculating an average annual rate of change, the regression procedure uses logarithms, which cannot be calculated for zero or negative values.

[5] Sufficient data are not yet available to ascertain the impact of the new and relocated RCRMC on these trends.

County has experienced Medi-Cal declines of RCRMC's magnitude. On the other hand, the only hospital experiencing major increases in Medi-Cal patient days is Hemet Valley Medical Center. It is likely, however, that most, if not all of, this increase is in the long-term-care area.[6] Its total (from all payer sources) long-term-care patient days went from zero to 38,384 and its total Medi-Cal patient days went from 7,866 to 22,007. At the same time, its Medi-Cal expenses have grown only from $7.5 million to $10.6 million.

Comparing these trends with the County-wide trends displayed in Table A5 suggests that while there has been some shifting of Medi-Cal volume from RCRMC to other hospitals, there has also been an overall decrease. Thus, RCRMC's decline in Medi-Cal volume is attributed to two causes: (1) a loss in market share; and (2) an overall decline in use rates.

RCRMC's revenue from treating Medi-Cal patients is derived from five major sources:

(1) Medi-Cal managed-care revenue, based on contracts negotiated with the Inland Empire Health Plan (and secondarily Molina Medical Centers) covering mainly the AFDC population. This accounts for approximately 20 percent of RCRMC's inpatient Medi-Cal patient days;

(2) For the remainder of the Medi-Cal inpatient caseload, per-diem payment rates negotiated with the California Medical Assistance Commission (CMAC) through the Selective Provider Contracting Program. For DSH hospitals, payment rates have experienced little, if any, adjustment since the early 1990's, since it has been CMAC policy to depend on DSH funding to compensate for cost increases not accounted for in the negotiated per-diem rates;

(3) For Medi-Cal outpatient services not covered through managed care, revenues are determined through a State-mandated fee schedule that, for the most part, has not been updated since 1982. Based on a recent law suit in which all California hospitals prevailed against the State, negotiations are underway to obtain payment rate increases;[7]

(4) DSH funding in the form of supplemental payments for each Medi-Cal patient day. This funding, for the most part, is provided through SB 855 (where supplemental payments are based on a statutory formula), SB 1255 (where supplemental payments are negotiated with the California Medical Assistance Commission) and Graduate Medical Education supplements (also based on negotiations); and

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[6] This data base (Office of Statewide Health Planning and Development Quarterly Financial and Utilization Reports) does not identify long-term patient days according to payer source.

[7] U.S. Court of Appeals, Ninth Circuit decision in Orthopaedic Hospital et al. v. Belshe, January 9, 1997.

(5) Payments pursuant through SB 1732, to assist in the debt service associated with the new hospital building.

Of these revenue sources, non-DSH Medi-Cal accounts for one third. This source, however, drives all the DSH and SB 1732 revenues.

It is essential that each of these revenue sources be exploited to the fullest. One source over which the Board of Supervisors has some control is the Inland Empire Health Plan (IEHP), an entity created through a joint powers agreement with San Bernardino County. IEHP has the ability to steer Medi-Cal patients to, or away from, RCRMC. It is essential the Board consider feasible mechanisms to assure IEHP's role as a resource for generating Medi-Cal managed-care revenue for RCRMC. The role of IEHP could become even more important in the future if Medi-Cal managed-care is expanded to require enrollment by additional beneficiaries in currently non-mandatory eligibility categories.

III. The Role of Riverside County Regional Medical Center

A. The Medi-Cal Disproportionate Share Funding Systems

Prior to discussing the role of RCRMC, it is useful to describe the Medi-Cal disproportionate share programs, on which most county hospitals depend for subsidizing indigent care. The revenue flowing through these programs is directly tied to Medi-Cal inpatient volume.

1. SB 855

Provision of care to Medi-Cal and other indigent patients is intertwined. This is evident by 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, DSH 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. The SB 855 program is funded through payments transferred by public entities into a statewide pool that is then matched with federal funds and distributed according to a statutory formula to all DSH hospitals (public and private).

2. SB 1255

These federal Medicaid funds are distributed to DSH hospitals on the basis of negotiations with the California Medical Assistance Commission (CMAC). While there is more flexibility with respect to this funding source, there is also less predictability. Moreover, these

allocations are applied against the "savings" attributed to the Medi-Cal Selective Provider Contracting Program. Since the Program's effectiveness is judged by its estimated savings, CMAC would be reluctant to be overly generous in its SB 1255 allocations. The funding source is voluntary transfer payments by public entities, matched with federal funds. Again, these funds are distributed to private DSH hospitals as well.

3. Graduate Medical Education

This program is based on two funds also supported by intergovernmental transfers matched with federal funds — the Medi-Cal Medical Education Supplemental Payment Fund and the Medi-Cal Large Teaching Emphasis Hospital and Children's Hospital Medical Education Supplemental Payment Fund. The purpose of this program is to recognize medical education costs associated with services rendered to Medi-Cal beneficiaries. This program is similar to the SB 1255 Program, in that payments are determined through negotiations with CMAC, and eligible hospitals must be Medi-Cal contracting hospitals under the Selective Provider Contracting Program. The Graduate Medical Education Program (GME), however, is limited to hospitals meeting certain teaching-hospital definitions. The GME Program is a short-term, temporary mechanism; it became operative in 1997, and is to be repealed January 1, 2001.

4. SB 1732

Another source of funding is the SB 1732 program, which will subsidize nearly 50 percent of debt-service payments for RCRMC. 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 DSH 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 Medi-Cal patient days percentage for the year immediately preceding plan submittal to the Office of Statewide Health Planning and Development (OSHPD). For RCRMC, the floor is 44.9 percent.

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.

B. The Role of RCRMC

As it should be, RCRMC is the County's major indigent-care provider, accounting for 65 to 78 percent of all indigent-care expenditures incurred by hospitals located in the County during 1998, depending on how indigent care is defined (i.e., including or excluding bad debts expenditures). Regardless of the particular definition, no other general acute hospital accounts for more than 5 percent of County-wide indigent care. And the magnitude of indigent care provided by RCRMC has been growing over time; including bad debts, RCRMC's indigent-care expenditures have nearly doubled from 1994 to 1998 — from $32.4 million to $60 million. County-wide, such expenditures increased from $70 million to $92.6 million, indicating RCRMC's increasingly important role; from a 46 percent share to a 65 percent share.

While its indigent-care expenditures nearly doubled, its Medi-Cal patient days fell by half. These opposing trends have important implications due to funding sources for indigent care. The primary funding sources for County-provided indigent care are the following: (1) State Realignment ($23.5 budgeted for the current fiscal year); (2) California Health Care Indigent Program ($2.8 million budgeted for the current fiscal year); and (3) net DSH funds ($34.2 million expected during the current fiscal year).[8] Virtually all County General Fund appropriations for health are allocated to public health programs, not RCRMC.[9] It is clear that DSH is the major source of indigent-care funding. That this funding source is tied to Medi-Cal volume which has decreased markedly, while indigent-care responsibilities have increased correspondingly, raises concern.

Given the current funding mechanism for indigent care and the current allocation method for DSH funds, there appears to be only one feasible solution to this dilemma — increase (or at least, maintain) Medi-Cal inpatient volume at RCRMC.[10] Other potential solutions, such as selling RCRMC, joint-venturing with a private provider, otherwise cutting operating costs, or reducing indigent-care services, even if politically, economically and medically feasible, could not overcome the funding gap that could materialize should Medi-Cal volume continue to drop. Each of these potential solutions is discussed below.

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[8] Letter from John P. Logger, Director of Finance, Health Services Agency, to Henry Zaretsky, August 16, 1999.

[9] This allocation is at the discretion of the Board of Supervisors.

[10] This is obviously in addition to maintaining volume derived from other payment sources (i.e., Medicare and private insurance), which is largely generated by RCRMC's specialty programs, which are in turn driven by its teaching programs.

1. Selling RCRMC

If a buyer could be found, willing and able to assume the approximately $260 million in outstanding debt and willing and able to assume the County's indigent-care obligations (i.e., without worsening the status quo for the County's indigent population) in a manner that would limit the County's general fund contribution to an acceptable level, that buyer would still be as dependent on DSH revenue and other payer revenue as is RCRMC. It would thus also have to maintain Medi-Cal volume at a level that would generate sufficient DSH funds. The major advantage a private operator could have over a public operator is greater flexibility regarding operating and capital decisions (e.g., marketing expenditures, assuring that personnel resources are consistent with workload requirements, providing incentives to employees to be productive, acquisition of capital equipment, and acquisition of outpatient capacity in a timely manner). This flexibility could result in cost savings and greater ability to compete for Medi-Cal managed-care patients. A substantial degree of flexibility, however, could be granted to RCRMC should the Board of Supervisors choose, recognizing that RCRMC is most likely the only County-operated entity whose viability depends on its ability to compete with the private sector. If a potential buyer also operated a local hospital system, it could have further efficiencies potential through integrating programs on a regional basis.

2. Public-Private Joint Venture

Joint ventures, while having the potential for cost savings and improvements in market share, are not likely to be the "silver bullets" that can enable the County to avoid the risks involved in operating a major health system. A private entity will only be attracted to a joint-venture opportunity if there is a likely benefit. For a joint venture to work, both parties must benefit, and thus both must give up something. Certainly such opportunities are available, and must be evaluated on a case-by-case basis. The more limited the transaction, the more feasible its implementation; and, obviously, the more modest its payoff to all participants. A highly ambitious joint venture, such as joint ownership of health facilities, for example, would involve complex negotiations, complicated and costly transactions and joint governance. Moreover, larger joint ventures are likely to have tax consequences, especially if the partner is a for-profit organization. Even if the partner is tax exempt, the particular program subject to the joint venture could be viewed as a taxable business.

Should there be an interest in joint ventures, the following should guide the decision: (1) reasonable potential for cost savings and/or increased market share; (2) limited, and acceptable, downside risk for the County; (3) limited scope; and (4) no effect on County governance. Obviously, such constraints will limit the potential payoff.

3. Cost Cutting

Cutting costs, without compromising the scope and quality of care or indigent access, most likely also has limited potential. Table 1 below compares cost per patient day and per discharge for RCRMC and its hospital peer group (defined by the Office of Statewide Health Planning and Development [OSHPD] as non-university teaching hospitals). Note that in all years shown, RCRMC's costs were below that of its comparable hospitals' peer group, on both per patient day and per discharge bases. Note also that for the most recent period, which reflects most of the annual capital costs of its new facility, the cost differentials are reduced. From the data displayed here, it appears that if there are opportunities for cost cutting, they are not likely to result in major savings.

TABLE 1
COST PER PATIENT DAY AND PER DISCHARGE
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER
AND NON-UNIVERSITY HOSPITALS PEER GROUP

Year	Cost per Patient Day		Cost per Discharge	
	RCRMC	Non-University Teaching	RCRMC	Non-University Teaching
1994	$1,345	$1,559	$6,721	$9,168
1995	$1,410	$1,672	$7,379	$9,532
1996	$1,414	$1,633	$6,991	$9,411
1997	$1,525	$1,691	$7,287	$9,927
1998	$1,700	$1,711	$8,667	$10,231

Source: OSHPD Hospital Quarterly Financial and Utilization Reports, 12-month periods ending September 30.

4. Reducing Indigent Care

Assessing the degree of indigent access provided by the County health system is beyond the scope of this study (i.e., the "generosity" of Riverside County relative to other counties' health systems). For our purposes, it is reasonable to set a constraint that any changes in the County health system should not be implemented if they are likely to worsen the status quo for the indigent population. Given the relatively large and growing uninsured population in California, the likely future impact of Welfare Reform in terms of restricting Medi-Cal eligibility, and the overall population growth projected for Riverside County, reducing indigent care does not appear to be a viable option.

IV. The Economic Value of Riverside County Regional Medical Center

A potential buyer of RCRMC would at a minimum be expected to assume the outstanding debt, which is in excess of $260 million (including a $20 million debt-service reserve fund). Since a non-governmental entity could not simply assume the outstanding lease revenue bonds, the latter would have to be defeased, and new bonds issued by the buyer. Defeasance costs would be approximately $269 million.[11] In addition, the net book value of capital equipment transferred from the old facility to the new facility is $6.7 million, although the market value may be significantly less. Further, a financial dispute with the general contractor was recently settled for $4.7 million.

Average annual debt service on the outstanding lease revenue bonds is approximately $19.7 million, over the 30-year life of the debt. Approximately 46.5 percent of this debt-service expense ($9.2 million) is offset by the SB 1732 program. At current patient volume levels, this SB 1732 subsidy is worth $192 per patient day. Thus, if a buyer could not maintain SB 1732 eligibility, it would have to find an additional $192 per patient day in net revenue, unless it could cut operating costs by a corresponding amount, which is doubtful given the data in Table 1, above. To maintain SB 1732 eligibility, the new owner would have to be not-for-profit, so that it could obtain tax-exempt financing, would have to maintain the hospital as a disproportionate share hospital and would have to continue the hospital's status as a Medi-Cal contractor under the Selective Provider Contracting Program. Even if it met all these conditions, eligibility is not assured.

Assuming the County would transfer all RCRMC's Realignment and County general fund revenues to the new owner, and SB 1732 eligibility is maintained, the new owner would expect to earn a profit on operations and/or integrate RCRMC's programs with other programs operated by the owner (e.g., a nearby hospital), so that the new "system" would be profitable. At the same time, the County would need strong, long-term assurances that its general fund is protected and that indigent access is maintained at current levels on a per-capita basis.

V. Experiences of Other Counties

Of all large, urban counties in California, only four do not have county-operated hospitals. In three of these counties, Sacramento, Orange and San Diego, the county hospitals were taken over by University of California hospitals, which in turn assumed the county responsibilities under contract. Given the teaching mission and public ownership of University of California hospitals, at least some degree of public accountability has been maintained in these arrangements. These transactions occurred during the 1970's. They have not absolved the

[11] Memorandum from Salomon Smith Barney, August 20, 1999.

affected counties from their indigent-care responsibilities, and have been subject to renegotiations over the years that have often been contentious. This type of arrangement is not a model for Riverside County since, among other things, the University of California is no longer considering acquiring county hospitals. The University has its hands full with its own hospitals.

A. Fresno County

The fourth large county to sell its hospital is Fresno. In 1996, the county hospital, Valley Medical Center (VMC) was acquired by Community Hospitals of Central California, a not-for-profit hospital system operating a nearby major medical center (Fresno Community Hospital and Medical Center). VMC was an aging facility, in need of major renovation. Community Hospital is consolidating VMC's services into its own facility, which has been renamed "University Medical Center" (UMC). (That name reflects a teaching affiliation with University of California San Francisco.) The new UMC is also responsible for operating ambulatory-care clinics throughout the County. The merger occurred at an opportune time, given VMC's need for costly renovation or outright replacement. The agreement involves three components, among other things: (1) transfer of Realignment funds, including a cost-of-living escalator to UMC; (2) a $50 million appropriation from the State Legislature for construction of a trauma center; and (3) receipt of all DSH funds that would have been received by VMC had it remained under County ownership. This last provision, which will not be available to future acquisitions of public hospitals due to legislation enacted after this transaction, enables UMC to receive all SB 855 revenues, without transferring funds into the program. The value of this provision is illustrated as follows:

In the fiscal year proceeding the sale, VMC received $61.4 million in SB 855 payments, paid transfer payments of $46.9 million, and thus received net SB 855 revenues of $14.5 million.[12] Under private ownership, the same hospital would have received the full $61.4 million, with no offsetting transfer payments. This is a net gain to the hospital of $46.9 million (and an equivalent net loss to all other SB 855 hospitals). It later became apparent to the Legislature that if these types of arrangements would be repeated in other counties, the SB 855 program would no longer be viable, as it depends on a pool of transfer payments by public entities to leverage against federal matching funds. In future acquisitions of this type, if any, the new private owner's SB 855 revenues will be limited to approximately the net SB 855 funds it would have received as a public hospital.

[12] California Medical Assistance Commission, *Annual Report to the Legislature*, January 1997, Appendix C.

The situation facing RCRMC is far different: (1) it is no longer an aging facility in need of capital investment; (2) it is doubtful the Legislature would appropriate anything approaching $50 million as an additional subsidy[13]; and (3) the SB 855 "loophole" has been closed.

B. Contra Costa County

After literally decades of debate, in 1992 the Board of Supervisors approved construction of a hospital to replace its aging and dilapidated facility (Merrithew Memorial Hospital). In 1993, however, a lawsuit was filed by the National Association for the Advancement of Colored People (NAACP) Legal Defense Fund to block construction on the grounds that its location was not accessible to the two areas in the County with concentrations of low-income people. During the hiatus that occurred prior to the suit being dismissed, the Board was approached by the three hospital districts located within Contra Costa County with a proposal to take over all County indigent responsibilities for an aggregate fee not to exceed current general fund plus Realignment appropriations. After extensive negotiations (including highly spirited and acrimonious Board meetings) it was determined by the Board's consultant that this was a risky proposition for the following reasons:

(1) Only one of the districts was financially viable, and this hospital did not have a favorable track record with respect to treating low-income patients. If the deal were consummated and later proved not to be feasible, the County would be trapped. It would have given up its claim to necessary SB 1732 construction subsidies, so a new county hospital would no longer be feasible, and it is likely the Board would have been approached by the districts to provide additional funds. The Board would have been left with no other realistic options;

(2) Only one of the district hospitals qualified for disproportionate share funds, and only for a small amount. Without sufficient DSH funds, the deal was not expected to be financially feasible;

(3) Given that system-wide viability was essential, it was proposed that the three districts and the County form a Joint Powers Authority for governance of the entire health system, to create a fully integrated health system. This was not acceptable to the districts;

(4) There were strong doubts that all of the district hospitals would remain part of the arrangement after some district residents and medical staff members realized the complexities and negative consequences involved in treating some segments of the indigent population (e.g., homeless, AIDS, psychotics). There appeared to be a feeling among the districts' administrators that these patients are analogous to "capitated lives".

[13] It is possible, however, that SB 1732 eligibility could be maintained if the new owner would be a not-for-profit hospital.

Moreover there was even disunity between some district administrators and district board members; and

(5) There is a provision in State law prohibiting district hospitals from contracting to care for county patients at below cost.[14] The districts' representatives alleged that this provision would not be enforced. It is easy, however, to imagine a scenario where a disgruntled district resident or medical staff member would bring a law suit on this basis, with unpredictable consequences.

Realizing the riskiness of the proposed venture, the Board elected to pursue construction of the replacement hospital under County sponsorship. County staff estimates the direct costs to the County of this process (i.e., that occurring during the two-year hiatus) to be approximately $750,000. Non-quantifiable costs include the opportunity costs of new programs and initiatives during this period. The new hospital, Contra Costa Regional Medical Center, opened in 1997, and has been operating successfully. On the other hand, for all practical purposes, the three district hospitals no longer exist. One hospital, Los Medanos, which had already closed and was in bankruptcy proceedings during the County deliberations, sold its building to the County, which is reconfiguring it as an outpatient facility. Another hospital, Mount Diablo, was acquired by a nearby not-for-profit hospital (John Muir). And the third hospital, Brookside, is being leased by Tenet, and consolidated into its regional operations.

C. Stanislaus County

Stanislaus County was also faced with an aging county hospital in need of major renovation, but without the funding for such renovation. After extensive study, it reached agreement with Doctors' Medical Center of Modesto (DMC), the largest and most sophisticated hospital in the County, to assume all inpatient and emergency-room indigent care responsibilities. In 1998 the county hospital (Stanislaus County Medical Center) closed. The County maintained responsibility for operating its clinics. Three major problems remain unresolved: (1) The County has lost approximately $7 million in DSH funds since DMC is not a DSH hospital; (2) The County has lost $1.5 million in Tobacco Tax (Proposition 99) revenue; (3) There is a problem in physician coverage since some DMC specialists refuse to treat Medi-Cal patients; and (4) There is a possibility the County clinics may no longer be eligible for Medi-Cal reimbursement for the facility fee since they are no longer under a hospital license. The costs (legal and accounting) for this transaction borne by the County were approximately $2 million to $3 million. If County staff could start the process over again, they would have attempted to generate better dialogue between County and DMC physicians, and pursued joint-venturing arrangements.

D. San Joaquin County

[14] Section 32125 (b), Health and Safety Code.

In June 1998, San Joaquin County issued a request for proposal (RFP) for a health care system to joint-venture all health agency functions (including health care delivery, public health, mental health and substance abuse) with the County Health Services Agency. The intent was to create an entity that would share in all health care assets and risks. Two systems submitted proposals — Sutter Health and Catholic Healthcare West (CHW) in association with University of California Davis Medical Center. Both Sutter Health and CHW operate hospitals in the service area of the county hospital (San Joaquin General Hospital). San Joaquin General had recently completed a major replacement project, but additional construction will be necessary in the future. After about six months of negotiations, it was determined that neither proposal was sufficient in terms of ability and willingness to be a true partner with the County with respect to all its health care and public health functions.

E. San Luis Obispo County

San Luis Obispo County was scheduled to close its aging county hospital (San Luis Obispo General Hospital) in 1998. It had negotiated contracts for the care of indigent patients with local hospitals. A change in Board composition, however, resulted in hiring a management company to attempt a "turnaround" of the county hospital. If, in the next two years, the turnaround cannot be accomplished, the closure will again be considered.

Of recent county hospital closure or joint-venture proposals summarized here, substantial similarities with the Riverside County hospital situation are not apparent — i.e., sale of a new replacement hospital being considered. Many of the issues, however, faced by these counties would be faced by Riverside County — e.g., joint-public-private ownership and management, consolidation of facilities, labor-management relations, the ability to continue competent management during transition periods and periods of uncertainty, maintenance of DSH funds, and financial viability of the private entity and its indigent-care track record.

VI. A Proposed Set of Conditions for Contracting Indigent-care Responsibilities to Private-sector Hospitals

Based on recent experiences in other counties and the nature of health-care competition, financing and delivery present now and expected to evolve in the 21st Century, the following conditions are proposed to guide the Board in considering hospital sale or major joint ventures:

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 no longer owns its hospital, it is unlikely ever to do so again.

4. The general-fund exposure to the county should be reasonable, predictable and acceptable. The county's costs to defease bonds, if any, should be part of the cost equation, as should any potential liability.

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, if separate hospitals and systems are proposing to assume the county responsibilities, 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 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. 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. It is essential that in assessing the financial feasibility of the proposed arrangement, sophisticated sensitivity analyses be performed at differing levels of disproportionate share funding.

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:

> (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.

8. 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.[15]

9. The Board of Supervisors should establish a permanent public process to monitor the provision of care by the new private entity. Either the full Board or a special committee should hold hearings on a regular and frequent basis to enable public input. While the provision of

[15] Data are not yet available on the seismic status of hospitals in Riverside County.

indigent care should be the primary consideration, the overall behavior of the private entity within the local health system should also be under public scrutiny.

VII. The Economic and Political Implications of Selling Riverside County Regional Medical Center

A. Assumptions

The following assumptions underlie the economic and political implications set forth below.

- The private entity will assume all county inpatient and outpatient health care services (i.e., the hospital and all clinics)
- All Realignment and other county revenues currently allocated to RCRMC and county clinics will be assigned to the private entity
- The private entity will have a favorable track record regarding provision of care to all low-income groups
- There will be no worsening in the status quo regarding indigent care (i.e., level of access, quality and cultural sensitivity)
- The county general fund exposure will be acceptable and predictable
- The transaction will otherwise conform to the conditions set forth in Section VI above.

B. Economic Implications

Based on the above assumptions, it is reasonable to expect the following economic implications:

- The level of DSH funding is a major determinant of the financial viability of the arrangement
- The buyer must have the financial strength to assume additional debt of approximately $250 million
- To assume this debt, the buyer will have to be a not-for-profit entity, so that it can issue tax-exempt bonds to be eligible for SB 1732 debt-service subsidies. Even then, SB 1732 eligibility is not assured

- To realize economies, the buyer must be able to consolidate operations of RCRMC with other local hospitals under its control

- The County System is highly integrated, including public health, mental health and juvenile-and-adult-justice-system care. Maintaining this integration may not be possible if the system is divided into different ownership entities, which could increase costs for these components. Moreover, the County Mental Health facility is licensed as part of RCRMC. If it is not licensed as part of a general-acute hospital, there could be major repercussions involving Medicare and Medi-Cal reimbursement for inpatient mental health services. In addition, the County General Fund benefits from RCRMC overhead contributions

- Acceptable arrangements will have to be implemented to deal with the transfer of public employees to private employment

- Employee morale problems will adversely affect productivity and management decision making

- There will be substantial transaction costs that will have to be borne by the County; well into the millions of dollars, in addition to inevitable litigation expenses (including legal fees and potential awards). Some of these costs could continue well beyond the date of transfer of ownership, and could be incurred even if the transaction falls through.

- The County's bond rating could be affected if the investment community perceives the decision to sell as an indication of expected financial difficulties, whether or not the hospital is sold. Any action along these lines is likely to trigger a review by the rating agencies.

C. Political Implications

If the Board decides to sell the hospital or to consider a major joint venture arrangement, the opportunity will have to be extended to all health systems that could potentially qualify. There is reasonable potential for polarization within the Board of Supervisors and within the health care community. Board members will be lobbied strongly by the affected interests, including: unions, other health department employees, consumer advocates, private health interests, property owners and developers, tax-payer groups, and other elected officials. In addition, the working environment at RCRMC will be adversely affected. Recruitment of new personnel will obviously be hampered.

There is a relationship with the City of Moreno Valley through the Redevelopment Authority, predicated on the County building and operating RCRMC in exchange for redevelopment funds. Obviously this relationship will be strained if a sale or major joint venture

is even considered. And this could have an adverse effect on the availability of redevelopment funds and could result in litigation.

Prior to reducing county health services, a county is required to hold public hearings ("Beilenson Hearings"), providing the community an opportunity to testify. These hearings are likely to be contentious, provoking passionate concern on the part of low-income groups believing they will be adversely affected. Furthermore, if the potential buyer is a for-profit entity, the Attorney General is likely to get involved through his authority to approve not-for-profit conversions to for-profit status.

Prior to setting in motion this chain of events, the Board should be convinced that the sale of RCRMC is by far the preferred alternative.

VIII. Another Approach

Maintaining Medi-Cal volume and associated DSH funds is the key to RCRMC's long-term financial viability, assuming mechanisms for financing indigent care do not change drastically and assuming County general fund appropriations to RCRMC are restrained at current levels.

Maintaining Medi-Cal volume requires the ability to compete with private providers and health plans. Effectiveness as a competitor requires a provider network desired by consumers. Clinics and hospitals should be geographically accessible, provide the services needed by Medi-Cal beneficiaries, and should be attractive to consumers, both in terms of physical attributes and responsiveness to consumer needs (e.g., acceptable waiting times and appointment scheduling). In addition, physicians and other health personnel should be skilled at treating this population. And, the provider network must have the ability to manage its patient population within relatively low payment rates.

While private ownership and management is generally viewed as a plus in terms of effectiveness as a competitor, it is possible to build on the County health system's attributes to provide the latter a competitive edge. For example, RCRMC, the hub of the County provider network, is a new, attractive facility; and County physicians and other providers are experienced in treating low-income populations. What may be lacking is the flexibility inherent in some private organizations. To be able to respond to market pressures, the Health Services Agency needs sufficient administrative discretion to change its programs in response to changes in the private market. Questions that need to be addressed would include such issues as:

(l) Does the Agency have adequate flexibility under the civil service rules to maximize the productivity of its workforce in the delivery of health care?

(2) Does the Agency have the flexibility to enter into private sector partnerships (which may be an important factor in maintaining competitiveness) in a timely manner?

(3) Does the Agency have the budgetary flexibility to move funds to where they are most needed (e.g., contracting, purchasing, marketing, facility improvements)?

These are all management questions where centralized control could be relaxed in order to allow the Health Services Agency to function in a manner similar to its private sector competitors, under broad guidelines set by the Board.

The Board and the Health Services Agency should develop a strategic plan addressing how the public delivery system functions in a competitive environment (i.e., an environment with a profit-and-loss mentality, as opposed to a traditionally government controlled environment). By considering the actions necessary for the delivery system's long-run economic viability, this would be a good starting point for assessing the degree of flexibility necessary. Since the County Health System is most likely the only County-operated resource in direct competition with the private sector, there should be little risk that granting the Health Services Agency greater flexibility would lead to similar proposals by other County departments. After the plan is submitted, the Board may wish to consider creating a pilot program, where for a limited time period (e.g., two to three years) increased administrative discretion is given to the Agency in specific areas such as personnel, contracting or equipment purchasing. The pilot would then be evaluated in terms of whether or not the Agency's efficiency was enhanced in a manner that did not compromise the Board's ultimate public policy responsibility. Alameda County recently established a quasi-independent authority to govern its county hospital, Alameda County Medical Center. Under this structure, the Board decides on the overall size of the hospital system budget, but leaves the detailed decision-making regarding system policy and the expenditure of dollars to the health authority. The results in terms of operating flexibility and effectiveness are not yet in.

APPENDIX