White Paper – Future of San Joaquin General Hospital

Presented to the San Joaquin County Board of Supervisors

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I. Executive Summary

For nearly a decade, San Joaquin General Hospital (SJGH) has experienced persistent losses requiring a $70 million infusion of funds from Hospital reserves and the County General Fund. This year, (fiscal year 2009-10), due to continuing higher than anticipated losses, SJGH will require an additional $8 to $10 million above the $11.9 million County General Fund contribution already included in the budget; consequently, the County General Fund contribution could exceed $20 million this year alone.

In spite of several major initiatives that have reduced losses over the past two years, losses of this magnitude undermine the ability of the County to operate a county hospital. At this point in time, funding the losses at SJGH will occur at the expense of other County departments, programs, and services.

The factors which frame the recommendations contained in this White Paper are as follows:

- The State of California faces an estimated budget deficit of over $20 billion over the next 18 months. Continued major reductions in reimbursement, scope of services and eligibility for both Medi-Cal and other State medical services have been announced. These actions will simply shift the burden -- again-- from the State to the County.
- Unemployment in San Joaquin County is nearly 17 percent, which has led to an increase in uninsured persons in the County being seen at SJGH.
- Intense competition for paying patients among well-funded, well-capitalized corporate-supported hospital facilities and medical groups.
- San Joaquin County contains five private hospitals which are financially stable, and some have expanded their services and facilities this year.
- Continued increases are expected in salaries and benefits for scarce medical professionals.

The impacts on SJGH from these factors are:

- Reduction in the number of paying patients.
- Reductions in reimbursement from federal and State medical programs.
- Increasing numbers of uninsured, self–pay and indigent patients.
- Continued increases in costs for salaries, benefits and supplies.
- Under-financed infrastructure and information technology.

Making the challenge more daunting, there is no source of capital funds in the amounts necessary to address the demolition/replacement of the older tower, which is necessary for SJGH to compete for paying patients.

In light of the County's overall severe budget limitations, the increasing magnitude of SJGH's losses necessitates the re-examination of how the County can best meet its responsibility to provide care to the patients under California Welfare and Institutions Code Section 17000 (Section 17000). In the past, considerable effort has been placed on the continuing operation of SJGH. It is now necessary to shift the focus from operating a hospital toward how to best provide services for the 5,000 to 6,000 residents currently qualified as indigent in the County. It is for this population that that the County must legally provide or arrange medical services.

A strategic plan was presented to the Board of Supervisors in September 2009. The Plan identified a series of actions that are necessary to meet the County's mandate to provide for indigent care, limit the annual County General Fund contribution to $11 to $12 million, and require no capital investment. Specifically, it is necessary to convey SJGH, convert the SJGH clinics into a private Federally Qualified Health Centers ("FQHC"), and restructure the teaching program. All of the other strategic options will require continued County General Fund subsidies that will exceed $20 million annually. That level of subsidy will require that the County begin to divert funds from all other County departments. It is for all the above reasons that conveyance of any combination of the property and operations of SJGH, conversion of clinics, and restructuring of the teaching programs are recommended at this time.

This White Paper outlines the key factors for decisions that will need to be made regarding the future of SJGH. These recommendations are not made lightly, and management is conscious of the disruption that changes of this magnitude will have on the patients, employees and the community.

II. County Obligation – Defining Section 17000

A county's obligation for indigent care is outlined in Section 17000. Each county has the freedom to define its eligibility requirements and scope of services. SJC has periodically adjusted eligibility and scope, most recently in 2007. SJC has a current standard of 300 percent of the Federal Poverty Level (FPL) as its definition of indigent care. This is roughly $32,000 a year for a single person or $66,200 for a family of four. Individuals that meet the eligibility requirements (income, assets, and residency) are enrolled in the Medical Assistance Program (MAP). These patients receive medical care at county-operated clinics and at SJGH with a small or no copayments as long as they remain eligible. Medi-Cal covers most children and pregnant women, and Medicare covers the disabled and individuals over 65 years of age; by county policy, these patients are excluded from MAP. Counties are not required to pay for services of undocumented residents, nor do counties have an obligation to provide services to Medi-Cal or Medicare recipients.

Section 17000 does not require any county to operate a hospital, an emergency room, a clinic, or any other specific service. The law only requires that the medical services be provided for and available to Medically Indigent Adult (MIA) patients as defined by each county. Of the 58 counties in California, 46 do not operate a hospital. Every county has had to evaluate the cost to purchase services versus the cost to directly provide the service. The counties that do not operate hospitals have found willing private partners in their local area to provide services to their MIA patients. Counties that have most recently discontinued operation of their county hospital include Fresno, San Luis Obispo, Stanislaus, and Tuolumne.

There are only two counties smaller than SJC that still operate a hospital, Modoc and Monterey. Both counties have significantly different demographics than SJC. Modoc is a California Frontier county and receives additional federal funding to operate its hospital as a Critical Access Hospital. Monterey has one-fourth of the number of uninsured patients in its hospital and has fewer than half the number of unemployed residents in comparison to SJC. Monterey County will be discussed in more detail later in this document.

III. Financial Position of the Hospital

Over the past three years, SJGH has experienced significant losses from operations; however, improvements have been made in the past two years as shown in Table 1. These improvements have not been sufficient to cover increasing deficits.

Table 1: Revenue and Expenditure Summary
FY 2006-07 through FY 2008-09
(Dollars in Millions)

Fiscal year ending June 30	Audited FY 2006-07	Audited FY 2007-08	Draft Audit FY 2008-09
Revenue (including Sales Tax portion of Realignment)	$150.5	$166.8	$169.7
Realignment (related to Vehicle License Fees)	16.2	15.4	14.0
Non-Operating Revenue (primarily Interest Revenue)	(3.7)	(2.8)	(0.9)
Total Revenue	162.9	179.4	182.8
Total Expenses	188.0	197.8	197.1
Operating Loss	**($25.0)**	**($18.4)**	**($14.3)**
Annual Improvement		**$6.6**	**$4.1**

Source: Audited Financial Statements FY 2006-07 and 2007-08 and Draft Audit Financial Statements for FY 2008-09. Moss Adams, LLP, CPA Firm.

Without immediate corrective actions, it is estimated that SJGH operations will cost the County $20 to $21 million in this fiscal year. This represents an additional $8 to $9 million loss that was not anticipated in the budget. This increase is due primarily to a lower census and unfavorable payer mix. Plans to mitigate the losses, through reductions in services and programs are outlined in pages 22 to 25 of this document. If the losses are not mitigated within the next five months and in FY 2010-11, shortfalls must come from other resources within the County.

Impacts to County General Fund & Other Departments

In addition to funding the losses at SJGH, the County also serves as SJGH's bank to provide cash for operations. SJGH has constant cash flow shortfalls due to the timing for additional funding sources, payment lags from Medi-Cal, and extended collection periods for Medi-Cal Pending patients. The cash balance as of December 31, 2009 was negative $52.6 million. This consists of negative balances from prior years ($8.1 million), the budgeted shortfall for FY 2009-10 ($15.5 million), and the unbudgeted shortfall in FY 2009-10 ($29.0 million).

FY 2009-10 will not be the first year that the losses from SJGH have directly impacted other County departments. Since 1996 an additional $1.3 to $1.8 million annually in Realignment funds has been redirected from Behavioral Health Services to SJGH. In FY 2006-07, SJGH's operating losses required the final depletion of the $43 million Hospital Replacement Fund. Also, in FY 2007-08, $27 million from the County Capital Fund previously appropriated for healthcare facilities was redirected to SJGH to cover SJGH's operating losses and cash flow needs. A summary of SJGH losses and cash balances can be found on pages 28 and 29 in Exhibit 1.

Actions Taken to Improve Performance

In the past decade, the County has engaged national consulting firms on three different occasions to improve the financial position of SJGH. In FY 2000-01, Mercer was engaged to develop an operations improvement and strategic direction plan. PricewaterhouseCoopers was hired in FY 2005-06 to perform a hospital-wide operation assessment with an emphasis on billing, collection practices, and process improvement. This was followed by the hiring of The Camden Group to provide interim management and strategic business planning for SJGH in October 2007.

SJGH has improved in multiple areas over the past three years. In FY 2007-08 and FY 2008-09, improvements in operations and additional funding more than covered inflation and labor cost increases. **However, no more action items that could generate multi-million dollar savings or revenues without requiring a major redesign of the delivery system have been identified.**

Major changes that could potentially improve SJGH's payer mix (such as restructuring the medical staff or significant capital improvements) can be perceived as too disruptive, too expensive, too risky, or a departure from a teaching emphasis. Without the ability to make capital investments, SJGH has a limited ability to alter the payer mix and compete with the private sector.

In addition, recent capital investments by other hospitals in the County will enhance their ability to attract the Medicare and Medi-Cal patients currently being seen at SJGH. The loss of a significant number of insured patients to competitors will continue to increase the losses at SJGH in the coming years.

IV. Reducing the Losses

This section addresses issues that were incorporated into the analysis including operating revenue, expenses, clinic services, capital, and governance.

Patient Revenue

At SJGH the revenue per adjusted patient day (APD) has increased consistently over the past three years. Table 2 shows the changes in net revenue (collections) per APD.

Table 2: Changes in Collections per APD

	FY 2007-08	FY 2008-09	YTD 2009-10
Medi-Cal Fee for Service	$1,327	$1,696	$2,003
Medi-Cal Managed Care	$1,012	$1,238	$1,277
Medicare	$1,965	$2,344	$2,505
Self-pay	$814	$634	$1,030
Insurance	$1,506	$2,475	$2,598
Indigent	$18	$18	$35

SJGH has increased collections in all payer categories in the past two years. This is due to a combination of improved revenue capture in all areas, the addition of credentialed coders, increases in contract rates, improved physician collections, temporary increases in Medi-Cal per diems from Federal Medical Assistance Percentage (FMAP), and increases in charges. Table 2 does not include all additional funding sources that are received for being a safety net and Disproportionate Share Hospital (DSH) as they are not influenced by county policy and collection performance. Additional funding sources will be discussed later in this document.

Comparison to Other Hospitals

In addition to comparing the net revenue to previous years, management tracks net revenue per APD compared to other county hospitals in California. The Office of Statewide Health Planning and Development OSHPD) collects information from all hospitals in California every year, and the most recent full-year detail information is as of June 30, 2008. The county hospitals most comparable to SJC are Contra Costa, Ventura, San Mateo, and Kern. Monterey County was added to the analysis because its hospital (without the clinics) is budgeted to be self-sufficient this year, after being reimbursed by the county for MIA patients treated at its hospital.

The net revenue per APD, including additional funding, is shown in Table 3 along with some relevant demographic information to put the revenue information in perspective.

Table 3: SJGH Compared to Five Similar County Hospitals

	SJGH	Monterey	Other Counties *
Average Daily Census (acute only)	115	78	124
Average Length of Stay (acute only)	4.6	3.9	5.1
Case Mix Index (acuity)	1.0	0.84	0.97
Population (CY 2009)	692,406	417,125	850,821
Unemployed Residents	117,017	50,472	98,953
Residents with Income under $25,000	161,161	71,616	133,798
Percent Indigent (Patient Days)	14.0	5.2	13.4
Net Revenue per APD (acute, excluding clinics)	**$2,755**	**$3,184**	**$2,310**
Inpatient Gross Revenue per Discharge (acute only)	$23,905	$44,750	$27,093

** Averages of Contra Costa, Ventura, San Mateo, and Kern counties*
Source: OSHPD as of June 30, 2008, Claritas, Inc., and California Employment Development Department (November 2009)

Despite the higher gross revenue in the other county hospitals, the **net revenue** (cash collections) of the other hospitals is actually lower. Monterey, like the private hospitals in SJC, has a commercial patient base of 30 to 40 percent and can increase charges and improve collections immediately. By contrast, an increase in charges has little impact on SJGH collections as only 10 to13 percent of the patients have insurance payments that are linked to charges.

It is evident that 1) SJGH has increased patient collections over the past three years for insured patients and 2) collections compare favorably to other county hospitals.

This is important information because it frames expectations about what can be accomplished in terms of increasing revenue at SJGH given the demographics of SJC and the resulting payer mix at SJGH. Dramatic improvements in collections are not likely, as a number of operational efficiencies have already been implemented in the past three to five years. The data shows that current performance is quite favorable.

There are always opportunities for improvement, but improving patient collections will not generate the $8 to $10 million incremental revenue that is necessary to achieve budgeted targets of $10 to $12 million loss on a sustained basis.

Volume and Payer Mix

SJGH's volume is near budget in clinic visits, emergency room visits, and other outpatient activities. However, in the inpatient areas, the average daily census (ADC) year-to-date (YTD) is below budget by 3.9 ADC compared to the YTD budget of 106.2 ADC. Table 4 shows the change in ADC over the past three years.

Table 4: Average Daily Census at SJGH

	Actual FY 2008	Actual FY 2009	Dec. 2009 YTD Actual FY 2010	Budget FY 2010	Variance
Average Daily Census					
Medicare	17.4	16.5	11.4	16.7	(5.3)
Corrections System	-	2.3	2.0	2.4	(0.4)
All Other (incl. Commercial)	12.1	6.6	6.6	6.5	0.1
Subtotal Best Payment	**29.5**	**25.4**	**20.0**	**25.7**	**(5.7)**
Medi-Cal (FFS)	43.3	40.2	46.1	38.4	7.7
Medi-Cal (HMO)	14.1	14.3	11.2	13.4	(2.2)
Subtotal Medi-Cal	**57.4**	**54.5**	**57.3**	**51.8**	**5.5**
Pending	**12.4**	**16.7**	**11.4**	**16.9**	**(5.5)**
Indigent	3.2	3.2	6.3	3.3	3.0
Self Pay	12.6	8.3	7.3	8.6	(1.3)
Subtotal Lowest or No Payment	**15.8**	**11.4**	**13.6**	**11.9**	**1.7**
Total	**115.1**	**108.0**	**102.3**	**106.2**	**(3.9)**
			Percent Variance		**-3.7%**

The lower volume combined with the deteriorating payer mix is responsible for a $3.5 million shortfall in net revenue for the first six months of the current fiscal year.

Expenses

On a YTD basis expenses are over budget by $3.3 million or 3.4 percent. The variances are due to the following:

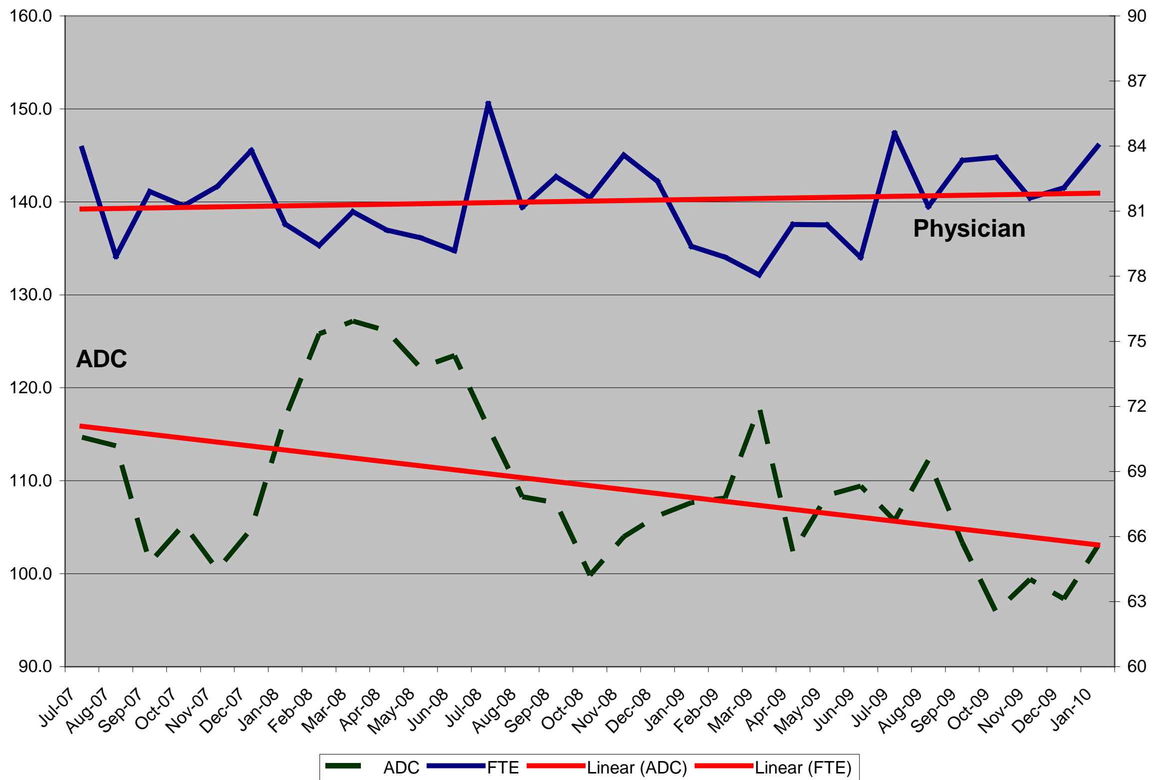
1) Physician's services and other professional services are over budget by $1 million and $400,000 more than last year. The FY 2009-10 SJGH budget anticipated improvements in this fiscal year but reductions have not been achieved. Most of the physician positions are fixed due to the nature of a

hospital's 24/7 operations and the faculty required for the teaching programs. In other words, the residency program and fixed 24/7 physician models result in the same number of physicians as prior years, even though the inpatient census is lower. In prior years, when the census was in the range of 108 to 115, the residency infrastructure was equal to or less than the physician resources that SJGH needed. This was the case in August 2008 when SJGH management completed an analysis of the residency program compared to alternate structures. The August 2008 report concluded that the cost of the residency program was similar to alternative structures unless ADC dropped to the range of 100.

The following chart shows the changes in physician full-time equivalents (FTEs) and census over the past two and a half years. Management's recommendations regarding the residency program are outlined on page 24 and Exhibit 2 includes a brief summary of the residency programs.

Average Daily Census and Physician Full Time Equivalents

July 2007 through January 2010



1) Supply costs are over budget by $538,000 compared to a budget that was established at $1 million less than last year's experience. Although the supply costs

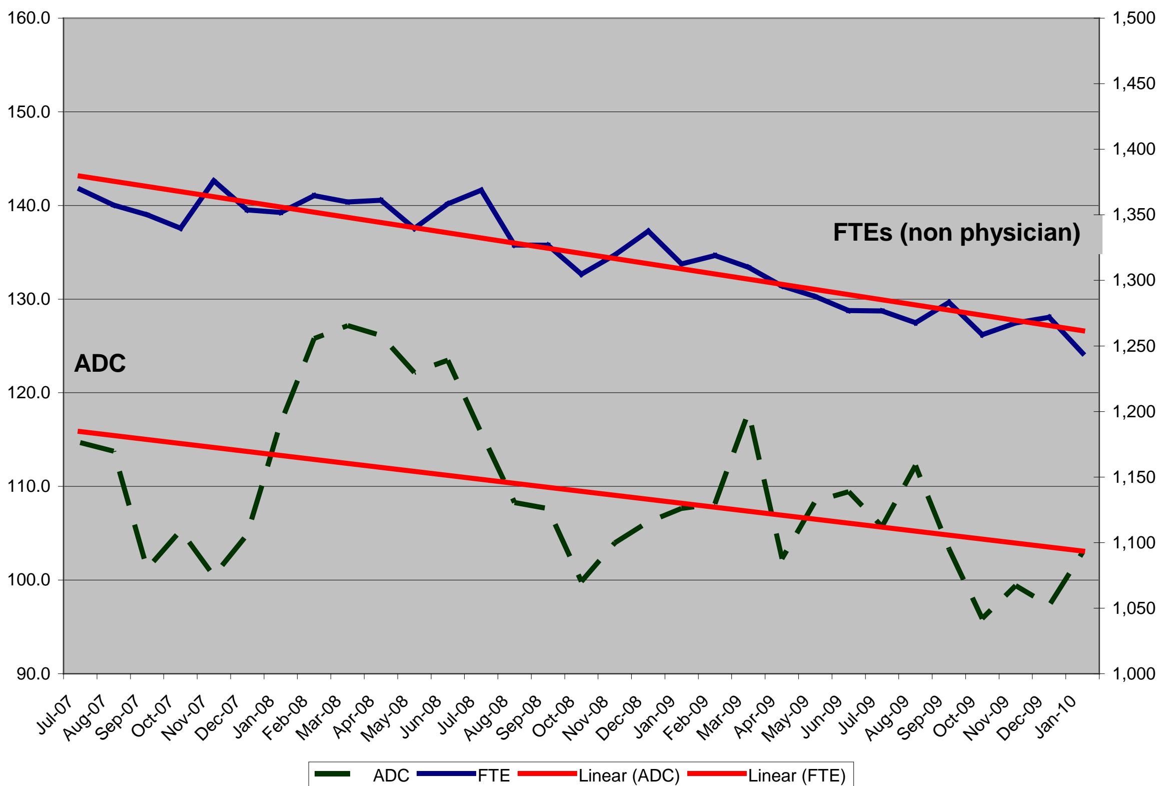
have decreased from prior years, SJGH has not achieved the savings anticipated in the budget.

2) Expenses for outside services for MIA patients are over budget by $365,000 YTD. The variance is primarily related to three patients who required transfers to academic medical centers for services that are not available at SJGH or St. Joseph's Hospital.

3) The highest budget variances are in the area of salary expenses and benefits which are over budget by $1.3 million or 2.3 percent. The variance is not due to increased FTEs, as FTEs have been under budget in every month of the fiscal year and have been reduced by 110 since October 2007. The following chart shows changes in non-physician FTEs and census.

Average Daily Census and Hospital Employee Full Time Equivalents (excluding physicians)

July 2007 through January 2010



Management is continuing to work with staff and physicians to implement efficiencies through reduced length of stay, improved work processes, cross-training, flexing for volume and closing some low volume clinics. These efforts have been successful in reducing the FTEs over the past two years, but there are few opportunities to continue

reducing FTEs without significant targeted program changes. Several opportunities for increasing, decreasing, combining or eliminating services have been implemented already or are being recommended in this document. The most significant program changes are outlined in pages 22 through 26.

During the second quarter of FY 2009-10, SJGH continued to have 30 to 40 vacancies in the nursing area and support areas that require expensive overtime and registry usage. The nursing ratios mandated in the state of California require a certain level of staffing, despite the availability of staff employed by SJGH. Additionally, like all hospitals in the area this year, there is an increase in the number of highly complex high acuity patients requiring ventilators and 1:1 nursing care due to influenza-related illnesses and H1N1. This is responsible for an additional 8.2 FTEs YTD in respiratory therapy and increased nursing staffing in the Intensive Care Unit (ICU).

Clinic Services

One other issue that was identified in the analysis of other county hospitals in California is that only San Bernardino County and SJC operate hospital-based clinics as their primary access point for primary care physicians.

Most counties operate or contract with Federally Qualified Health Clinics (FQHCs) for all or most of their primary care clinic patients. FQHCs receive higher rates than hospital-based clinics for Medi-Cal and Medicare patients. Thus, subsidies (to offset losses) paid for by other counties to operate or contract for clinic services are not recorded in the hospital's financial statements; they are covered elsewhere in the county's budget. In Counties that contract with private FQHCs, the losses are not borne by the County, rather, the County pays the FQHC for the medical care provided to their MAP patients, typically on a per visit basis.

The cost to SJC could be reduced by $3 to $4 million annually if the clinics were federally-funded or contracted with another community provider.

The SJGH management team is actively looking at the steps required to convert SJGH's existing clinics to FQHC status and preferably, contracting with an established FQHC that would be interested in contracting with SJC to provide primary care services to patients currently seen in the clinics.

Capital – Old Tower Building

The Business Plan presented to the Board of Supervisors (BOS) on September 29, 2009 included five options for the future of SJGH. All five options included a major assumption that the Old Tower Building (Tower), built in the 1930s, would be vacated by 2013. Four of the five options are to continue to operate a hospital, and that some or all

the services housed in the Tower that generate significant revenue would be moved to a new building or repositioned in the main building (1997 Building). Option 2, which

required moving essential services to the 1997 Building, would require a capital investment of at least $45 million including demolition and a parking lot (added after the Business Plan was presented). Without this investment, the ability of SJGH to compete with private hospitals with modern facilities will be limited.

The Tower houses post-partum, Neonatal ICU (NICU), and pediatrics patients. These services generate significant Medi-Cal and supplemental payments in support of SJGH. The Tower also houses a medical/surgical unit. The Tower is functionally and structurally obsolete and, without recent extensions, would be out-of-compliance with California SB1953 seismic requirements. The seismic regulations originally required that the Tower must discontinue general acute care services by 2008. The operation of the Tower has been extended on two separate occasions by legislative actions including SB1953 to allow access until 2020.

No hospitals in SJC, nor any of the five comparable county hospitals, have inpatient beds in a building of this age and obsolescence. Due to the age of the Tower and its operating systems, the Tower requires a significant amount of maintenance, repair, and replacement of worn out systems estimated to be $1.0 million annually above the costs of a newer facility. Additionally, there is the increasing risk that major repairs will be needed.

The County also faces the risk that future inspections may deem SJGH to be out-of-compliance with hospital fire/life safety requirements, potentially requiring the closure of the entire structure. SJGH staff estimated that just the repair and renovation costs to add a sprinkler system in the Tower could range from $1.5 to $2.0 million.

Governance & Leadership

SJGH is accountable to the BOS through the Health Care Services Agency (HCS), which is one of the 29 County departments. Some counties have the hospital report directly to the BOS, or to the County Administrator who reports to the BOS. One county, Monterey, has an advisory board, which is established by its BOS to provide oversight of medical staff, quality, and selected committees.

It is important to note that only a change in legal structure, such as the creation of a Hospital District or Health Authority (Alameda County), would relieve the BOS from the liabilities associated with running a county hospital. More importantly, only through the creation of a Hospital District or Health Authority can the flexibility to operate more like a private hospital be obtained. Such flexibility is imperative to financially and operationally compete in today's environment. No alternative structure can relieve a county of its Section 17000 obligation, and in no county that operates a hospital has the BOS been able to insulate itself from the financial liability of operating an inpatient facility.

Changes in governance do not have a direct impact on operational inefficiencies resulting from a civil service system. The Civil Service system in SJC governs many aspects of employment including rules on how to recruit, how qualifications are interpreted, how candidates are referred for positions, how many interviews are required, how employees are promoted, how jobs are described and classified, how discipline is administered, and how layoffs occur.

A civil service system can be cumbersome and bureaucratic in a hospital environment that needs to react flexibly to changes in patient census, as well as the need to respond to the organizational staffing needs in real-time. Private sector hospitals do not have this same constraint, and some counties in California, such as Monterey County, do not have a civil service system that governs and restricts their employment processes.

V. Risks of Relying on Additional Funding Sources

FMAP & Bed Tax

A significant fiscal augmentation for this year and next is the enhanced FMAP. The American Recovery and Reinvestment Act authorized an enhanced federal contribution ratio for the cost of Medi-Cal (from roughly 50/50 to 60/40). This has augmented revenue to SJGH by $4.4 million in FY 2009-10. Based on current authority, FMAP will sunset in December 2010.

This opportunity for an enhanced FMAP ratio also fueled the greatest unknown in funding for SJGH and all public hospitals in California this year: the timing of the hospital fee or "Bed Tax" (AB1383). When final federal approval is granted, the payments to SJGH could be $12 to $16 million, spanning three fiscal years. This complicates the outlook on the *immediate* future of SJGH since the payments would cover a portion of the deficit (including the deficit related to prior years) through June 2012, but the payments may not be received this fiscal year.

Under AB1383, fees are assessed against all **non**-public hospitals based on their volume of Medi-Cal business. Funds are redistributed via a higher Medi-Cal rate augmented by federal funds. Hospitals must continue to admit Medi-Cal patients in order to reap the benefits of AB1383. As the largest provider of healthcare to Medi-Cal patients in the County, this is positive for SJGH. However, it creates an incentive for other hospitals in the community to continue to compete with SJGH for Medi-Cal patients as they did earlier in this decade when Medi-Cal managed care became an attractive payer.

The Bed Tax will sunset in December 2011. There is a proposed ballot initiative (not yet certified) for November 2010 to extend this financing mechanism, but it is uncertain if such ballot measure will pass and, therefore, should not be relied on for future revenues.

State Budget & Issues

In general, SJC operates a hospital in a state that does not have a balanced and approved budget. This adds to the burden of the counties in three significant areas.

1) Cuts in state health and human services programs increase the number of uninsured patients that come to county hospitals.

2) When state employees are reduced, state audits (such as Medi-Cal cost reports) and reviews are slowed down or not completed at all. This results in payment lags for state-administered additional funding sources and cost report settlements. The FY 2006-07 Medi-Cal Audit has been in process for over a year, which should result in a $3.3 million payment to SJGH. Settlements outstanding for FY 2006-07 through FY 2008-09 are $8 million as of November 30, 2009. Most of these should have been completed in FY 2008-09.

3) The state typically uses payments to hospitals as a strategy to balance the state budget. For example, in June 2009, two Medi-Cal payments were withheld until this fiscal year. This left SJGH with a $2 million shortfall in FY 2008-09. At one point in FY 2005-06, SJGH experienced a $24.3 million shortfall caused by delayed payments of the Medi-Cal Waiver for public hospitals. The funding was delayed for nine months.

For FY 2009-10, cash receipts are estimated to be $202 million. Additional funding is estimated to be $85 million, which is 42 percent of total receipts. Of that $85 million, over half is related to programs that do not have funds authorized to replace them. Table 5 shows the additional funding sources budgeted for SJGH in FY 2009-10 and the end dates for the temporary funding sources.

Table 5 also shows the expected payments on a quarterly basis. It is apparent that cash is not received on a regular basis; rather, several sources of funding are loaded toward the end of the fiscal year. The irregular cash flow at SJGH is a feature of the payer mix, especially the large number of Medi-Cal Pending patients and the heavily leveraged funding from state and federal sources, including DSH and Certified Public Expenditures. Because of its reliance on state and federal funds, the County is continually at risk from a cash flow basis to provide operating funds for SJGH.

Through December 2009, additional funding payments have not been received as budgeted. The hospital has a cash flow shortfall of $17.6 million due to the timing of additional funding receipts alone. As noted earlier in this document, the cash flow position of SJGH as of November 30, 2009 was negative $52.6 million, which was $23.6 million worse than expected. The shortfall in additional funding was responsible for most of the cash flow budget variance.

Table 5: Additional Funding for Budget FY 2009-10 by Quarter

(Dollars in Millions)

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total	Comment
County	**$4.6**	**$3.1**	**$0.0**	**$4.2**	**$11.9**	**Ongoing**
Waiver Related (CPE)	1.1	3.7	3.7	5.3	13.8	Most likely will extend in some form
Waiver Related IGT	1.0	2.6	2.6	5.8	12.0	Uncertain, subject to negotiation between State and CMS
Managed Care IGT	-	7.7	-	5.8	13.5	Subject to annual agreement
Health Plan Safety Net	-	-	0.7	2.0	2.7	Ongoing
FMAP (included in Medi-Cal rate)	1.1	1.0	1.1	1.2	4.4	Sunsets December 2010
Realignment	4.6	4.6	4.6	4.6	18.5	Ongoing
SB 1732 and AB915	-	3.0	-	4.7	7.7	Ongoing
Total Each Quarter	**$12.5**	**$25.8**	**$12.7**	**$33.7**	**$84.6**	
		Total amount subject to change			$43.8	**52%**

VI. Uninsured & Charity Care Obligations in the Private Sector

All nonprofit hospitals have a charity care obligation. In exchange for Federal and State tax-exempt status, nonprofit hospitals are expected to provide charity care to the community in which they are based.

This obligation to provide charity care is not well defined, and there is no threshold or ratio to which nonprofit hospitals are held accountable or must meet in order to retain their nonprofit status. The state has attempted to define the obligations of nonprofit hospitals under "community benefit" legislation (SB697). However, this legislation does not define a specific level of charity care. Charity care is self-reported by these hospitals on an annual basis to OSHPD.

Charity care is generally defined as care provided to those individuals who cannot pay for care (as opposed to bad debt, where someone does not pay for care), and the individual does not have coverage from any other source. These uninsured individuals are often undocumented persons, or those who do not qualify, either due to assets or income, for any other county, state, or federal program. The OSHPD charity care definition does not allow nonprofit or public hospitals to report the contractual differences between Medi-Cal and Medicare payments and a hospital's charges as charity care.

In California, in those counties that operate public hospitals, uninsured patients historically are concentrated in the public sector, like SJGH, where 60 percent of services to the uninsured in SJC are provided. The private sector hospitals in San Joaquin County provide care to the other 40 percent (spread unevenly among the other five hospitals). These uninsured persons seen at SJGH add significantly to the fiscal burden of the County.

VII. Impacts of Reductions in Services or Closure under Option 5

A poor state and local economy, high local unemployment, high uninsured population, severe cuts to the State budget, a looming county deficit, and increasing hospital operating costs have significantly increased the potential liability of operating a county hospital. All of these factors have gotten worse since the issuance of the Business Plan in September 2009.

Based upon these significantly negative factors, it is incumbent upon the County to very closely examine and strongly consider Option 5 (closure or sale) identified in the September 2009 Business Plan for SJGH. The short-term impact on patient access in the community and on SJGH patients should not be understated; however, they could be largely mitigated if a sale or lease with an appropriate business partner can be found.

In September 2009, The Camden Group presented the Business Plan for SJGH to the BOS. It included five options, including: growth, three downsizing options, and an outright closure or sale. Key operational and financial summaries from the Business Plan are included in this document under Exhibit 1. Four of the five options propose to continue operating a hospital and have the following themes:

- Capital building/renovation costs for the four Options were estimated to be between $14 and $115 million. The building programs ranged from Option 3, where only NICU would be moved to the 1997 Building, significantly downsizing SJGH, to Option 1 that called for a new building with full replacement of the services in the Tower.
- The annual cost to the County exceeded the targeted $10 to $12 million each year for all four options.
- All four options assumed the Tower would be vacated by no later than FY 2012-13.
- All four options required changes in the organization structure and executive and director compensation packages, so that a permanent, experienced SJGH hospital administrative team could be hired to implement and maintain the strategies in the Business Plan.
- Option 1 included the teaching program as the backbone of the physician strategy. Options 2 through 4 assumed the teaching programs would remain and be supplemented by a teaching consortium and contracted physician groups.
- All four scenarios assumed the physicians would form or join an IPA or other vehicle necessary to secure commercial and managed care contracts in conjunction with SJGH.

The only option that resulted in County General Fund support of less than $10 to $12 million was Option 5, which called for a complete reorganization of the delivery system where the County provides directly very few services and contracts for all medical care services for MAP patients.

If SJGH and its Emergency Department did not exist, the uninsured would be distributed among the other hospitals, as is the case in most other counties. The County would pay other hospitals and physicians for providing medical services to MAP patients. Generally, the economics of Option 5 in FY 2009-10 are summarized in Table 6:

Table 6: Option 5 – Projected Revenues and Expenses in FY 2009-10
(Dollars in Millions)

Revenue Likely to Continue (without a county hospital)		
Realignment	$18.0	
Health Plan of San Joaquin Safety Net Payments	5.0	
Lease and Other Income	1.3	
Total	***$24.3***	
Expenses	***Low***	***High***
Medical Care – Inpatient and Emergency Room	$23.0	$28.7
Administrative and Other Costs	4.5	4.5
Ongoing Debt Services for the 1997 Building	8.0	8.0
Total	***$35.5***	***$41.2***
Cost to the County	**($11.2)**	**($16.9)**

The Business Plan projections noted in Table 6 for Option 5 were recently tested using information from the first quarter of FY 2009-10. Hospital staff summarized the actual inpatient, outpatient, and physician utilization of County MAP patients during the first quarter and applied prevailing Medicare and Medi-Cal rates to the number of visits and patient days for this same time period. This resulted in estimated inpatient and outpatient costs of $23.0 to $28.7 million, which is in the range of the $24.5 million projected in the Business Plan.

The County would need to expand the existing MAP office, and utilization review functions within HCS would become a claims administrator strictly for MAP patients. The costs for ongoing administration of the MAP program and others to be absorbed by HCS after the closure of SJGH are included in the "Administrative and Other Costs" noted above. SJGH management consulted with other counties for information regarding their infrastructure and costs in making these estimates.

The costs of winding down the services at SJGH were estimated in the Business Plan to be $9.5 million and are generally related to:

- Severance and unemployment costs
- Vacation payout
- Legal fees
- Business interruption
- Dismantling teaching programs

Some excerpts from the Business Plan are included in Exhibit 1. Pages 32 and 34 in Exhibit 1, shows the impact of the Business Plan projections without the Hospital Tax. All other pages are taken directly from the Business Plan.

VIII. Midyear Strategies & Action Items

Revenue Increases

1. The hospital-wide Charge Master was updated effective January 1, 2010 to maintain charges at 85 percent of market charges (the maximum per BOS policy) at comparable hospitals. This midyear increase is expected to yield an additional $150,000 in the remainder of FY 2009-10 and $300,000 next fiscal year. In addition, a request will be made to the BOS to increase the rates to 100 percent of the market median during the midyear adjustment request. It is estimated that this change in policy, if approved, will yield an additional $250,000 this year and $400,000 next year. Charges were also increased in July 2008 and July 2009.

2. A program to capture more admissions from community physicians began in January 2010. This effort focused on communicating patient progress and outcomes more consistently has been developed by the medical staff, admitting department, and nursing departments. If this outreach is successful, the incremental net revenue from this effort is estimated to be $2 to $3 million next fiscal year.

3. Despite recent efforts to expand SJGH's commercial patient base, the managed care contracts have yielded few elective admissions and visits.

   Both physicians and hospital contractors need to be in place to benefit from commercial contracts. Unless these arrangements provide a significant volume of patients to SJGH, they actually cost SJGH more than the net revenue generated. The existence of health plan contracts will not result in either an immediate or sustained number of patients choosing SJGH over its competitors. The commercial and Medicare-supplement insurance plans in the SJC area are heavily reliant on established physician groups to provide professional services. The area's two biggest medical groups, Sutter/Gould and Hill Physicians, currently work closely with other private hospitals. It is not anticipated that health plans, their contracted and affiliated physicians, or the community will switch affiliation to SJGH for their inpatient services. In addition, the SJGH's ambulatory clinic system is not conducive to attracting a large number of insured patients away from the well-established physician organizations. In this market, there are several physician joint ventures where physicians can be owners of ancillary services such as outpatient surgery and imaging centers. As such, there is little ability to provide a significant increase in insured patients to SJGH in the near future.

   Medi-Cal managed insurance contracts should be continued and expanded. Selected private commercial contracts should be cancelled. Without a contract, the insurance companies will pay billed charges instead of discounted rates. For

example, the cancellation of the Blue Shield contract, to be effective April 1, 2010, will yield an additional $45,000 of net revenue in FY 2009-10 and an estimated $100,000 next fiscal year. The loss of Blue Shield business, currently running eight admissions annually through SJGH's emergency room, will not result in a significant volume change to the inpatient or clinic services.

Several counties, including Monterey and San Mateo, have aggressively worked to add commercial HMO and PPO contracts since they have a more favorable payer mix. However, in counties with a high level of competition and unfavorable demographics, it is not unusual for the county hospitals to operate without some major commercial contracts.

Expense Savings

1. Supplies

   The renegotiation of large maintenance and supply contracts, effective at the end of 2009, will yield savings of $250,000 in the current fiscal year and $500,000 next fiscal year. The two largest contracts that have been modified are with Beckman/Coulter, Inc. for maintenance and reagents for several of the laboratory analyzers and with AmerisourceBergen for distribution of SJGH's pharmaceutical supplies.

2. Overtime and Registry

   The reduction of overtime and nursing registry staff was implemented in December 2009 and will continue throughout the current year. The loss of approximately eight FTEs will save $250,000 during the remainder of the current year.

3. Staff Reduction

   An additional 60 to 100 FTEs should be reduced within the next 60 days following the appropriate Meet and Confer process. These reductions will include program reductions and adjustments expected for lower volume throughout the entire hospital and clinic system and will affect physicians, nursing, ancillary, and support staff. The impact of these reductions will be approximately $1.5 million for the remainder of the current fiscal year and $4.8 million on an annual basis.

4. Contract Services

   The security service should be moved to a contract organization. Staff has initiated this effort and anticipates that it will be completed within 90 days. This change will yield a savings of $80,000 this year and $250,000 next year. This action will affect 12.4 FTEs.

5. Closure of Services

Additional savings in clinical areas are currently under study. A definitive estimate of the savings from closure and redirection of the service to community providers is expected to be completed by January 31, 2010. The first two services under evaluation are the Infectious Disease/Oncology Clinic and Outpatient Surgical Services.

6. Residency Programs

The most disruptive recommendation for reducing costs is related to restructuring the residency programs.

In the long-term, in order to continue hospital services at SJGH, the Internal Medicine, Family Medicine and General Surgery programs should be restructured. The Transitional Year residency, a one-year program, will be eliminated as of June 30, 2009 and discussions are underway with other hospitals and residency programs in the Central Valley regarding how to integrate with and provide funding for the SJGH residency programs.

Internal Medicine, Family Medicine and Surgery Residencies may affiliate with other programs and/or find other funding sources so that SJC is only paying for services that are needed for the volume of services at SJGH. If other partners are not found, the number of residents, faculty and support staff will need to be reduced. In this model, SJGH would purchase hospitalist and clinic staffing from the teaching program as long as the cost is comparable to purchasing services from community non-teaching physicians.

It is essential that the SJGH General Surgery Residency program continue its ongoing discussions with hospitals in Modesto and finalize an affiliation. This is necessary to provide the residents a full scope of clinical cases during their five year residency program.

Management continues to hold discussions with the Medical Staff Leadership on an on-going basis in order to produce a cost effective physician services program that includes the full scope of training for the Residency programs.

If SJGH purchases only the physician services needed for patient care services at the Hospital, the SJGH budget will be reduced by $1.5 million to $2.0 million.

IX. Recommended Next Steps

Midyear Budget Adjustments & Beilenson Hearings

In light of SJGH's deteriorating payer mix, increasing number of uninsured patients, low census, and the likelihood of achieving sustainable multi-million dollar improvements in billing, collections, and operational efficiencies, beyond what has already been implemented, is limited without systemic, even radical, change. In order to achieve a level of budget savings commensurate with the County's overall goal of maintaining a County General Fund contribution at $10 to $12 million annually, the BOS will be asked to consider significant indigent healthcare delivery system changes.

The following recommended action items require a Beilenson Hearing in order to curtail services. SJGH will pursue these reductions, prepare the required legal notices, and set the items for hearing before the BOS.

a. Reduce the MAP eligibility from 300 to 200 percent of FPL.

   By reducing eligibility for the MAP program, approximately 400 of current recipients will no longer be eligible for reduced cost care under this program, nor will they be entitled to the scope of benefits as adopted by the BOS. These patients would be considered uninsured and as such may still be eligible for state required discounts for services either at SJGH or at any hospital. They will no longer be entitled to services under the MAP program, nor will they be the County's obligation under Section 17000. The majority of counties in California have a 200 percent FPL threshold, or lower, for their indigent programs. If this change does not yield the necessary annual fiscal benefit, further reductions in the level of FPL or increased cost sharing for MAP enrollees may need to be considered.

b. Reorganize SJGH's clinic system into FQHC model.

   The County should reorganize SJGH hospital-based clinics as an FQHC model in conjunction with an existing private sector FQHC. This recommendation is based upon the urgency to reduce SJGH losses associated with operating the clinics and to immediately improve federal reimbursement that is only achievable as an FQHC. It will take three times as long and considerably more effort to create a county FQHC look-alike (and achieve federal approval) as compared to partnering with an existing FQHC. This will require shifting patients from existing clinics to the care of another community provider. Most FQHCs have multiple sites within SJC and may be willing to expand a partner's sites further. SJGH may retain a small clinic for MAP and self-pay patients (staffed by non-teaching, family medicine physicians, and mid-levels), the employee health clinic, and certain critical specialty services for MAP patients.

c. Close low volume specialty clinics.

   The provision of certain medical services for MAP patients can be contracted through the private sector at less cost than the current hospital-based clinic setting. Medi-Cal patients (a state responsibility) will need to seek providers in the community. SJGH is currently reviewing the fiscal losses of two clinics that primarily serve Medi-Cal patients and will recommend these for closure.

d. Discontinue neuro-trauma receiving center status.

   The lack of neurosurgeons in the community, and SJGH's inability to recruit this high cost specialty has left a void for these services in the community. Traditionally, SJGH's Emergency Department was designated as the receiving facility for neuro-trauma, leaving SJGH's medical staff (once the patient is admitted) to care for certain types of head injuries, mostly subdural hematomas, whether the patients were Section 17000 patients or not. Approximately 50 patients a year access these services at SJGH. This change will defer patients to a higher level of care elsewhere, and the County will only be financially responsible for MAP patients. To accomplish this, the County Emergency Medical Services Agency will need to work within a broad geographic area of hospitals to ensure that there is adequate neurosurgery coverage.

The following further budget actions require BOS approval, but do not require a Beilenson Hearing. These actions are necessary to immediately begin to mitigate operating losses that are estimated to exceed the budgeted loss by nearly $8 million this fiscal year. SJGH must obtain BOS authority to proceed with the administrative steps necessary to implement the following:

a. Change BOS policy to allow SJGH to raise fees from 85 percent of the market median to 100 percent.

b. Reduce the number of resident physician positions and/or eliminate those teaching programs that are no longer economically sustainable with the current low volume of inpatients.

c. Reduce staff by 60 to 100 FTEs.

d. Contract out Security functions for the SJGH campus.

e. Authorize SJGH and HCS management to begin meeting with local hospitals and other stakeholders to manage the impact of SJGH reductions on their operations.

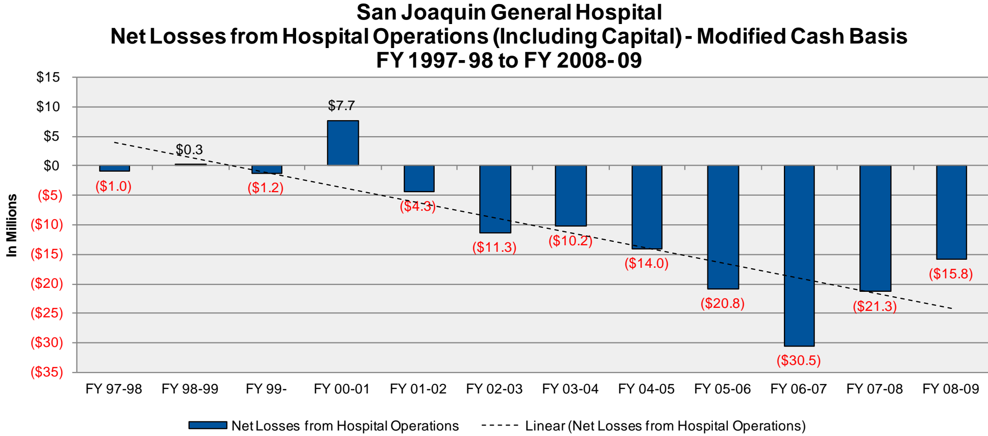
f. Authorize inquiries by staff to sell or lease SJGH to another organization in such a manner that can reduce the County's financial liabilities. Should a potential purchaser or lessee be identified, a Beilenson Hearing will be required to complete the transaction or change of ownership.

Exhibit 1

September 2009 Business Plan Excerpts

History of Hospital's Funding and Financial Performance

Net Losses from Hospital Operations



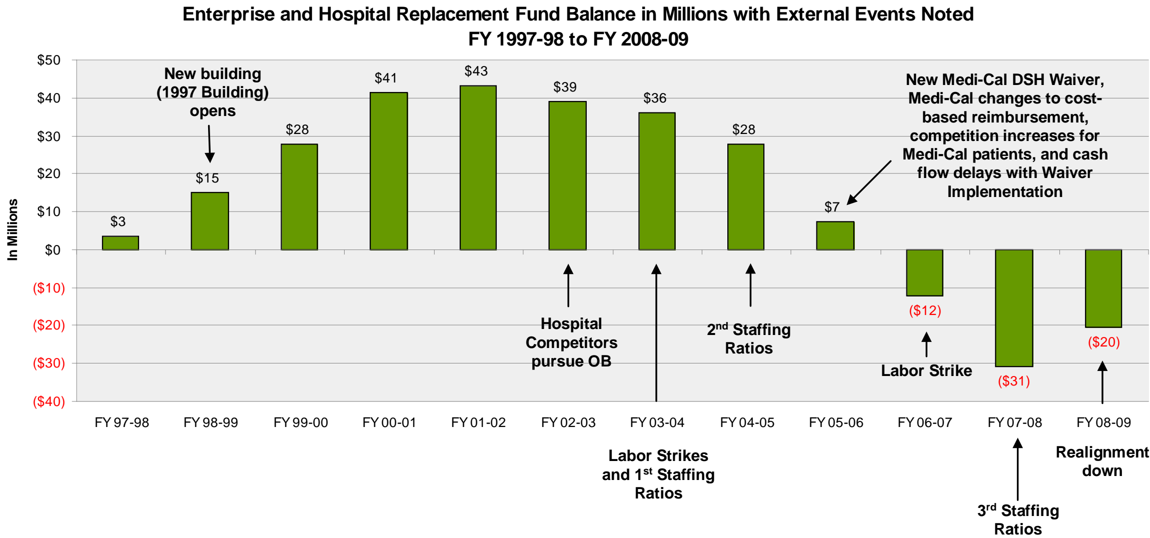
- The net losses at SJGH has improved somewhat over the last two years. The earlier losses have been absorbed by utilizing previously built-up reserves and by a substantial infusion of funds available by diverting essential Capital Improvement funds. More recently, there has been greater reliance on the County's General Purpose Revenue.
- Note that page 64 provides more detail for the last four years and includes FY 2009-10 Budget.

Cash Balances in the Hospital Related Funds

History of Hospital's Funding and Financial Performance

Cash Balances in the Hospital Related Funds

- SJGH has two funds within the County: the Enterprise Fund and the Hospital Replacement Fund. The balance of the two funds combined has decreased by $63 million since FY 2001-02. The table below shows the decline in the balance and significant external events.



Summary of Future Options – Original Version

Future Options

Option	Description	Management Structure	Physician Strategy	Routine Capital	Major Capital	Available Beds
Option 1 Replacement with Growth	Replace the services in the Old Tower building with a new building with growth (implement new services with capital investment).	Contract CEO, CFO, CNO, and Key Directors	Faculty/ Resident Model	$4 million annually (estimate)	$115 million (estimate)	177
Option 2 Replacement of OB and NICU	Replace essential services, Post Partum and NICU, in the Old Tower building by expanding adjacent to the 1997 Building to house these units.	County Employees or Contract	Residency Programs Consortium or Contract Physician Groups		$35 million (estimate)	135
Option 3 Replacement of NICU Only	Replace NICU only by renovating the 1997 Building to house this unit.				$14 million (estimate)	125
Option 4 No Replacement	None of the services in the Old Tower building are replaced and it is closed to inpatients. The services in the 1997 Building continue.				None	107
Option 5 Delivery System Reorganization	County no longer operates hospital and contracts for indigent at current 300% FPL (A) or at proposed 200% FPL (B). Lease Buildings (1) vs. Sell Buildings (2) options.	Oversight by HCS	Contract with Community Physicians	None		None

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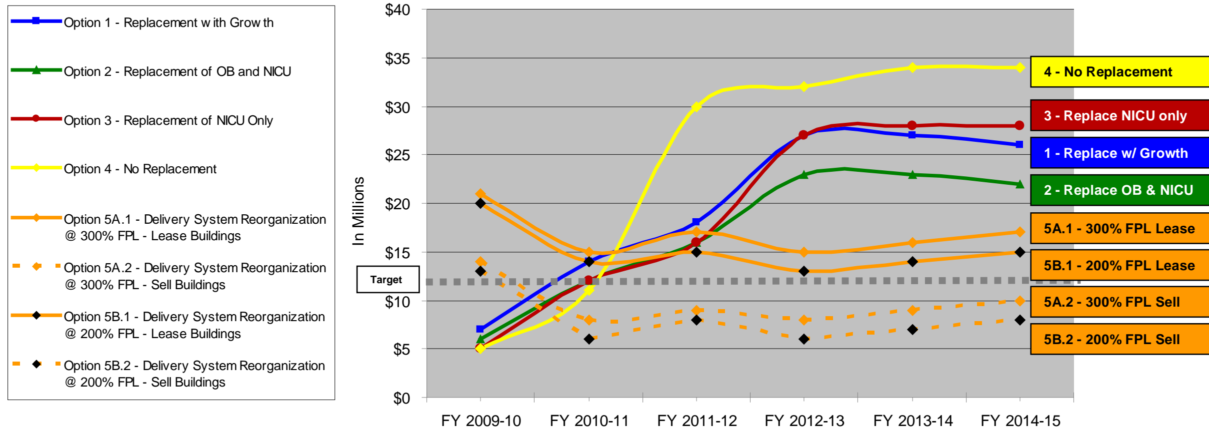
Annual Net Cost to County – Original Version

Future Options

Annual Net Cost to County in Millions for FY 2009-10 to FY 2014-15

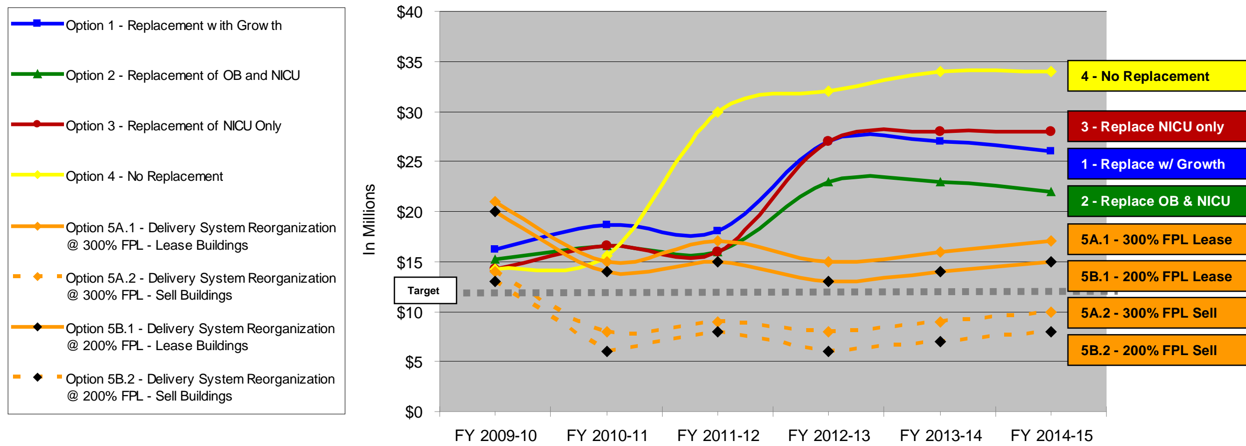


Annual Net Cost to County and Major Capital in Millions	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	Total over Six Years	Major Capital
Option 1 - Replacement with Growth	$7	$14	$18	$27	$27	$26	$119	$115
Option 2 - Replacement of OB and NICU	6	12	16	23	23	22	102	35
Option 3 - Replacement of NICU Only	5	12	16	27	28	28	116	14
Option 4 - No Replacement	5	11	30	32	34	34	146	-
Option 5A.1 - Delivery System Reorganization @ 300% FPL - Lease Buildings	21	15	17	15	16	17	102	-
Option 5A.2 - Delivery System Reorganization @ 300% FPL - Sell Buildings	14	8	9	8	9	10	59	-
Option 5B.1 - Delivery System Reorganization @ 200% FPL - Lease Buildings	20	14	15	13	14	15	91	-
Option 5B.2 - Delivery System Reorganization @ 200% FPL - Sell Buildings	13	6	8	6	7	8	48	-

Annual Net Cost to County – Updated for White Paper without Hospital Tax

Future Options – Updated for White Paper without Hospital Tax

Annual Net Cost to County in Millions for FY 2009-10 to FY 2014-15

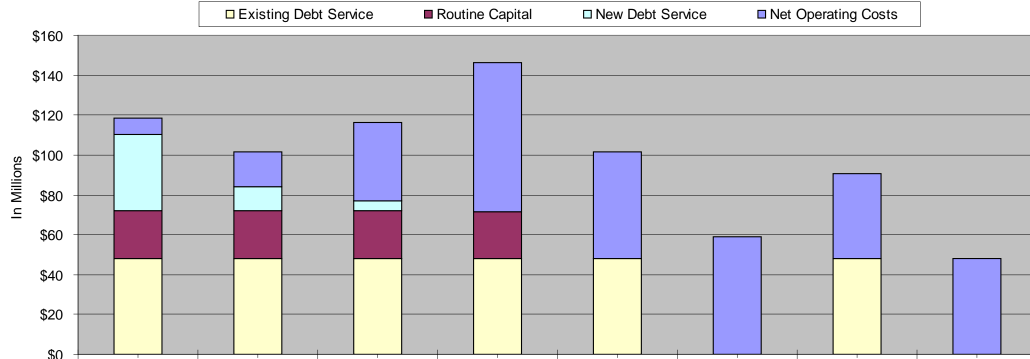


Annual Net Cost to County and Major Capital in Millions	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	Total over Six Years	Major Capital
Option 1 - Replacement with Growth	$16	$19	$18	$27	$27	$26	$133	$115
Option 2 - Replacement of OB and NICU	15	17	16	23	23	22	116	35
Option 3 - Replacement of NICU Only	14	17	16	27	28	28	130	14
Option 4 - No Replacement	14	16	30	32	34	34	160	-
Option 5A.1 - Delivery System Reorganization @ 300% FPL - Lease Buildings	21	15	17	15	16	17	102	-
Option 5A.2 - Delivery System Reorganization @ 300% FPL - Sell Buildings	14	8	9	8	9	10	59	-
Option 5B.1 - Delivery System Reorganization @ 200% FPL - Lease Buildings	20	14	15	13	14	15	91	-
Option 5B.2 - Delivery System Reorganization @ 200% FPL - Sell Buildings	13	6	8	6	7	8	48	-

Total Net Cost to County over Six Years – Original Version

Future Options

Net Cost to County over Six Years in Millions for FY 2009-10 to FY 2014-15



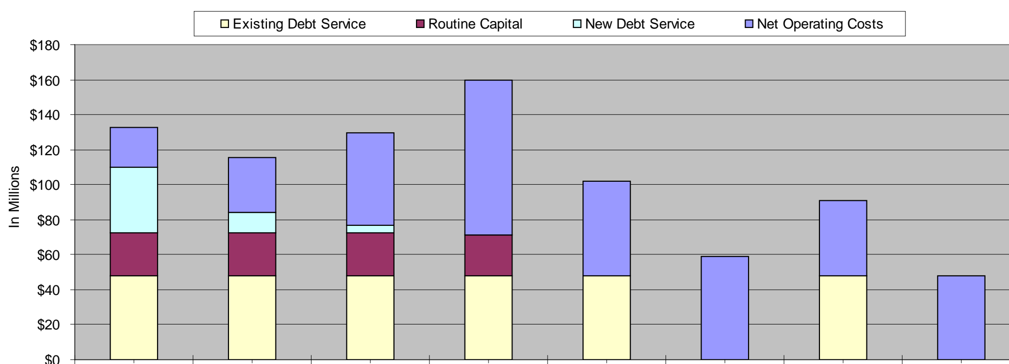
In Millions	Option 1 Replacement with Growth	Option 2 Replacement of OB and NICU	Option 3 Replacement of NICU Only	Option 4 No Replacement	Option 5A.1 Delivery System Reorganization @ 300% FPL - Lease Buildings	Option 5A.2 Delivery System Reorganization @ 300% FPL - Sell Buildings	Option 5B.1 Delivery System Reorganization @ 200% FPL - Lease Buildings	Option 5B.2 Delivery System Reorganization @ 200% FPL - Sell Buildings
Net Operating Costs	$8	$18	$39	$75	$54	$59	$43	$48
New Debt Service	38	12	5	-	-	-	-	-
Routine Capital	24	24	24	24	-	-	-	-
Existing Debt Service	48	48	48	48	48	-	48	-
Net Cost to County over Six Years	**$119**	**$102**	**$116**	**$146**	**$102**	**$59**	**$91**	**$48**
Remaining New Debt	$250	$77	$31	-	-	-	-	-
Remaining Existing Debt	$23	$23	$23	$23	$23	-	$23	-

See Appendix C for detail regarding financial projections for Options 1-4 and in Section IX for Option 5

Total Net Cost to County over Six Years – Updated for White Paper without Hospital Tax

Future Options – Updated for White Paper without Hospital Tax

Net Cost to County over Six Years in Millions for FY 2009-10 to FY 2014-15



In Millions	Option 1 Replacement with Growth	Option 2 Replacement of OB and NICU	Option 3 Replacement of NICU Only	Option 4 No Replacement	Option 5A.1 Delivery System Reorganization @ 300% FPL - Lease Buildings	Option 5A.2 Delivery System Reorganization @ 300% FPL - Sell Buildings	Option 5B.1 Delivery System Reorganization @ 200% FPL - Lease Buildings	Option 5B.2 Delivery System Reorganization @ 200% FPL - Sell Buildings
Net Operating Costs	$23	$32	$53	$88	$54	$59	$43	$48
New Debt Service	38	12	5	-	-	-	-	-
Routine Capital	24	24	24	24	-	-	-	-
Existing Debt Service	48	48	48	48	48	-	48	-
Net Cost to County over Six Years	**$133**	**$116**	**$130**	**$160**	**$102**	**$59**	**$91**	**$48**
Remaining New Debt	$250	$77	$31	-	-	-	-	-
Remaining Existing Debt	$23	$23	$23	$23	$23	-	$23	-

See Appendix C for detail regarding financial projections for Options 1-4 and in Section IX for Option 5

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Business Goals and Requirements – Original Version

Business Goals and Requirements

Business Goals and Requirements Applied to Options 1-5 (all)

Business Goals and Requirements	Option 1 Replacement with Growth	Option 2 Replacement of OB and NICU	Option 3 Replacement of NICU Only	Option 4 No Replacement	Option 5A.1 Delivery System Reorganization @ 300% FPL - Lease Buildings	Option 5A.2 Delivery System Reorganization @ 300% FPL - Sell Buildings	Option 5B.1 Delivery System Reorganization @ 200% FPL - Lease Buildings	Option 5B.2 Delivery System Reorganization @ 200% FPL - Sell Buildings
Meet the obligation for Section 17000 patients	✓	✓	✓	✓	✓	✓	✓	✓
Do not exceed an annual cost to the County's General Fund of $11-12 million						✓		✓
Do not exceed capital expenditures of $3-4 million (included in $11-12 million above)					✓	✓	✓	✓
Exit the non-seismic compliant Old Tower building	✓	✓	✓	✓	✓	✓	✓	✓

Exhibit 2

Overview of Residency Programs

Internal Medicine

There are 21 Internal Medicine Residents who provide around the clock coverage for inpatients in the hospital and in the ambulatory clinics. The residency program requirements call for each resident to participate in 130 half-day clinic sessions during the entire 3-year residency program.

Family Medicine

The Family Medicine Department is budgeted for five full-time teaching faculty and 5.5 service (non-teaching) physicians to cover outpatient clinics, including Employee Health Services, and inpatient coverage to the Medical/Surgical floor. There are 21 Family Medicine residents who provide extensive coverage of the outpatient clinics. In addition, the Family Medicine residents perform a small number of deliveries and assist the faculty or service physicians in the Pediatrics and Neonatal units.

General Surgery

There are currently 13 Residents in the General Surgery program who are supervised by 2.5 faculty physicians. SJGH receives reimbursement for the salaries of three of the Surgery Residents from St. Joseph's Hospital and from Saudi Arabia.

Transitional Medicine

SJGH currently has four Transitional Medicine Residents who assist with coverage on the inpatient floors and ambulatory clinics and rotate through other clinical sites during their one year assignment in the program.