The Role of Local Governments in Financing Safety Net Hospitals: Houston, Oakland, and Miami

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This report is part of the Urban Institute’s Assessing the New Federalism project, a multiyear effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs and their effects. In collaboration with Child Trends, the project studies child and family well-being.


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The authors would like to thank John Holahan and Susie Wallin for their helpful comments and suggested revisions. We also thank Ron Ruppel, Clifford Bottoms, Judge Robert Eckels and his staff, Peter Praetz, and David Keers for their assistance. The authors take full responsibility for any remaining errors.
Assessing the New Federalism

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.
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Background

Public hospitals that provide a substantial amount of care to the indigent usually collect patient revenues that fall short of their operating costs. The gap between internally generated—or operating—revenues and expenses has forced safety net public hospitals to rely on federal, state, and local subsidies to remain viable. Because the existence of these hospitals is considered critical to ensuring access to health care for uninsured and underinsured populations, it is important to learn how sizable and secure these subsidies are.

Most policy analysis on the financing of health care for lower-income households has focused on changes in the Medicaid program and on additional payments made by the federal government and the states for indigent care. Much less information has been collected on how localities (generally counties) support the safety net. This study examines how safety net hospital systems in three large urban areas—Houston/Harris County, Texas; Oakland/Alameda County, California; and Miami-Dade County, Florida—are struggling with how
to fund hospital care for people who lack health coverage. The study covered the Harris County Hospital District (HCHD) system in Houston/Harris County, composed of the Lyndon Baines Johnson and Ben Taub Hospitals; Highland Hospital in Oakland/Alameda County; and Jackson Memorial Hospital in Miami-Dade County. Each of these hospitals provides a significant portion of the safety net services within its local area. For example, the HCHD system provides more than 75 percent of all charity care in Harris County, Highland Hospital provides more than half of the charity care in Alameda County, and Jackson Memorial Hospital provides close to 80 percent of the charity care in Miami-Dade County.

The study sites were selected to reflect a mix of important challenges to the goal of providing affordable health care for the indigent. Previous Urban Institute analyses of safety net providers throughout the nation concluded that providers that simultaneously faced several threats to their viability were in the most serious trouble. The three county health systems chosen for more intensive analysis here are those that confronted most or all of the four forces identified as important in these earlier case studies: demand for safety net services, the shift to managed care in Medicaid, commercial market competition, and financial support from the federal and state governments (Norton and Lipson 1998).

**Demand for safety net services:** The demand for safety net services is growing in many communities for several reasons. The uninsured rate is climbing because of shifts in the mix of jobs (e.g., toward retail trade and part-time and temporary work, where health coverage is less prevalent) and increases in health insurance premiums. The problem of uninsurance is compounded by the needs of people with special health care problems arising from HIV/AIDS, homelessness, substance abuse, and other causes.

**Medicaid managed care:** Medicaid managed care is a threat to safety net providers as nontraditional providers expand into the Medicaid market, leaving safety net providers with fewer paying patients. Moreover, capitation payments—fixed monthly payments that cover the cost of all care stipulated in the contract—often exert more pressure to cut costs on Medicaid providers than a fee-for-service system does.

**Commercial market competition:** Increased penetration of managed care in the private market has resulted in heightened price and nonprice competition. This competition is both threatening the private-pay patient base of safety net providers, which is often small but is nevertheless important, and driving down payment rates.

**Federal and state financial support:** Federal and state assistance to safety net providers can help cover the revenue shortfall arising from the combination of below-market payments by Medicaid and the cost of serving the uninsured. Some states provide higher levels of support than others for hospitals through programs such as the Medicaid disproportionate share hospital (DSH) program.
Taken together, these factors suggest that the stress on safety net providers, and the need for local support for indigent care, will be greater where there are a large number of uninsured people, a substantial penetration of Medicaid managed care, a high level of market competition, and a relatively low level of federal and state support. The sites selected for this study meet all or most of these criteria.

**Study Methodology**

The authors relied on two methods of data collection for this study. One involved collecting information about the financial positions of the hospitals, using revenue bond issue books, proposed operating budgets for the hospitals, and actual budget sheets for past years. The authors conducted telephone interviews with hospital personnel and analyzed the financial data to determine five-year trends in the hospitals’ revenues and expenses, as well as sources of funding to cover operating deficits—the difference between operating costs and operating revenues.

The second method involved visiting the three sites in July and August 1998; interviewing hospital administrators, county budget officials, health department leaders, and other experts in the communities; and then conducting follow-up telephone interviews to clarify certain budget information.

The fact that this study covers only three sites makes generalizations to the nation as a whole unwarranted. All three sites are in large urban areas, so the findings may not be directly applicable to safety net hospitals in smaller cities or rural areas. This study covers only public hospitals; in some cities, the major safety net providers are private hospitals. Also, the study has no sites in certain areas of the country such as the Northeast. Further, the authors intentionally selected providers that are among the most vulnerable in terms of the pressures they face. With these important caveats in mind, the authors have searched for common patterns and experiences as well as notable differences across the three sites. They also have tried to draw some broader lessons from these sites that could have implications for other communities.

**Key Findings**

Hospital revenue sources can be divided into two broad categories: operating revenues and nonoperating revenues. The focus of this study is nonoperating revenues, specifically the scope and stability of public subsidies to safety net hospitals. This overview highlights some of the cross-cutting issues regarding subsidies, including the level of predictability, equity, and efficiency associated with these nonoperating revenues. Next, it compares sites’ operating revenues and their ability to cover costs, which largely determines the extent
to which hospitals must rely on subsidies. The section concludes with a description of the sources of nonoperating revenues for each of the three sites.

**Characteristics of Nonoperating Funds**

**Predictability**

Whether safety net hospitals rely on dedicated or discretionary government funding sources can be an important determinant of their financial viability. Obviously, discretionary funding is less stable than a dedicated funding source, but this study suggests that even dedicated funding sources are not sacrosanct. Political leaders can lower dedicated taxes if they perceive less need for funding, as occurred in Harris County in 1996. A dedicated source of funding for indigent care is more meaningful when coupled with a local maintenance-of-effort requirement, a requirement that the county subsidize its hospital at the same level in years when other sources of subsidy (DSH payments, perhaps) go up as well as in years when they go down. Safeguards against fungibility also are important. Revenues that are fungible are interchangeable; rather than funding health care services, they can be used for other public purposes.

Miami-Dade County has in place a maintenance-of-effort requirement, ensuring that the safety net hospital’s dedicated revenue source is a consistent addition to other revenues. In contrast, the Harris County Commissioners’ Court, which oversees HCHD, cut back in 1996 the ad valorem tax that underwrites HCHD and sustained the cut in 1997, putting the squeeze on the system. Similarly, Alameda County diluted the favorable effect of a federal and state infusion of funds by substantially reducing its own funding for indigent care. In effect, the federal government and the state bought out a sizable portion of the county’s commitment to ensure a viable safety net.

Even with a maintenance-of-effort requirement, no revenue source is beyond the reach of political leaders and voters. If Jackson Memorial Hospital continues to run substantial surpluses, at some point either the sales tax or the fixed local contribution will probably be scaled back. But any change of this nature would require altering a previously approved ballot initiative—it could not be undertaken by administrative action. In sum, simply having a dedicated revenue source does not provide a lock on continued funding.

**Equity**

In supporting safety net providers, localities generally rely on revenue sources (sales and property taxes) that are less fair to lower- and middle-income households than are revenue sources used at the national level (income tax). Sales taxes, for example, constitute a proportionally higher burden for lower-income households than for higher-income households. Applying the same sales tax rate to all creates a burden on those with less ability to pay.
Property taxes are somewhat more equitable than sales taxes. These tax collections rise with the value of property, which tends to be greater for higher-income families. In some cases, however, property taxes can create inequitable outcomes. Many elderly people with relatively low incomes own their homes and may pay more in property taxes than do higher-income younger people who are renting their housing.

In contrast, income tax financing is generally viewed as more progressive, taking more from those with a relatively greater ability to pay. Of course, income taxes, which are appealing on equity grounds, can be faulted on efficiency criteria because they create what economists refer to as an extra burden associated with adverse effects on incentives to work or save, and they are usually unpopular with voters.

It is generally agreed that the best way of raising revenues for redistributive purposes is at the national level. The problem of financing indigent care cuts across all state and local boundaries; it is truly national in scope. If the nation decides to tackle the challenge of raising money from the general populace to help those who cannot afford health care, the federal government possesses the best means of getting this job done through the federal income tax. A consistent national policy would also remove the incentives for state and locality border-crossing by persons seeking more generous publicly subsidized benefits.

A full analysis of the advantages and disadvantages of various financing mechanisms is beyond the scope of this report. The important point is that using a piecemeal approach with stop-gap financing mechanisms may result in a relatively unfair distribution of the cost. A fairer financing mechanism would spread the cost of meeting the health care needs of the indigent across a broad base of the populace and account for persons' abilities to shoulder these costs.

Hospital Efficiency

Another challenge related to direct public support of hospitals is striking a balance between providing a safety net for lower-income people that can withstand the political pressures and the ups and downs of the business cycle and at the same time providing incentives for safety net providers to be cost-conscious and efficient. If safety net hospitals have a virtually guaranteed revenue stream to make up their operating deficits, access for lower-income populations will be secure (at least for hospital care). But local governments will probably find themselves in the position of underwriting any inefficiency in the operation and management of the institution.

The challenge is to find a way of keeping safety net providers viable while simultaneously holding them accountable for excessive costs or inappropriate care. In today’s competitive environment in the health care industry, this means, among other things, strongly encouraging these hospitals to demonstrate that they offer managed care organizations an acceptable combination of
reasonable prices and good quality of care. Achieving this end requires structuring subsidies in a way that is consistent with the adoption of good management techniques.

Promoting hospital efficiency was very important in all three communities covered by this study. In Harris County, the county officials cut the ad valorem tax in 1996 in part to send a message to the hospitals that they needed to improve cost management. The theme seemed to be that necessity would prove to be the mother of invention. In Alameda County, the health department has undertaken a thorough review of its entire strategy of meeting the needs of the lower-income population. It has taken an inventory of all the resources flowing into the county for this purpose and developed a plan to reorganize the delivery system to help stretch limited dollars as far as possible. Part of this strategy is the creation of an independent Hospital Authority to operate the county hospital under contract to the county supervisors. The Authority receives a lump-sum payment from the county for the provision of indigent care and is expected to generate enough revenue and cut enough costs to operate without further subsidy from the county.

Finally, in Miami-Dade County there is considerable debate over the fact that virtually all of the county’s funding for health services goes to Jackson Memorial. All parties realize that Jackson is serving a large number of nonpaying patients who otherwise might have no place to go for hospital care. (Jackson receives many transfer patients whom other hospitals are reluctant to serve.) At issue is whether some of the funding could be used more efficiently if redirected into primary and preventive care and targeted to the relatively remote sections of the county where providers who serve highly vulnerable populations (e.g., migrant workers) are in serious financial distress.

Sources of Operating Revenues

The magnitude of the gap between a safety net hospital’s operating revenues (or internally generated funds) and its operating costs varies greatly across the three study sites. In other words, the financial problem facing safety net hospitals, while always substantial, can be of manageable size in one community and enormous and almost overwhelming in another. A recent study found that public hospitals need to retain a reasonable number of paying patients—Medicaid, Medicare, and privately insured—to have the financial ability to serve non-paying patients (Legnini 1999).

Medicaid

The amount of a safety net hospital’s internally generated funds depends partly on the generosity of the state’s Medicaid program. If Medicaid covers a relatively large proportion of the state’s lower-income population, a safety net hospital is likely to have less uncompensated care. Similarly, safety net hospi-
tals in states that make more generous payments per Medicaid beneficiary are likely to be in better shape financially. Both the breadth and the depth of Medicaid coverage are directly related to the amount of internally generated funds for hospitals serving an indigent population. The more a state supports these institutions through Medicaid, the less the need for state and local governments to provide them with direct subsidies.

Medicaid outlays per enrollee are low in Texas. The state spent $2,677 per enrollee in federal fiscal year (FFY) 1996, compared with a national average of $3,397. In addition, Texas Medicaid eligibility does not extend beyond the minimum criteria established by the federal government. As a result of limited Medicaid coverage, Medicaid spending per low-income person in Texas also was below the national average in FFY 1996 ($1,199 versus $1,690).

Medicaid spending per enrollee ($2,645) and per low-income person ($1,075) in Florida was similar to spending in Texas and was also below the national average in 1996. But even though Medicaid spending in Florida and Texas are comparable, local officials in Miami-Dade County start off in a somewhat better position than their counterparts in Harris County do. In Florida, the state funds Florida Healthy Kids, which provides coverage to low-income children with age and income limits above the federally mandated Medicaid levels (Bruen and Ullman 1998).

In California, Medicaid coverage is more extensive than in Florida and Texas, as reflected in part in the state’s higher expenditures per low-income person ($1,338). However, California spends less per Medicaid enrollee than the other two states ($2,295) do, which is attributed in part to its relatively low provider payment rates.

The push by most states to enroll large numbers of Medicaid beneficiaries in managed care plans is reducing the Medicaid revenues of many safety net hospitals, exacerbating their financial problems. Between 1991 and 1997, the proportion of Medicaid beneficiaries enrolled in managed care rose from 9.5 percent to 47.8 percent, according to data from the Health Care Financing Administration. With the shift to Medicaid managed care, safety net providers are placed at greater financial risk as they lose Medicaid patients to private providers but keep uninsured patients. Another factor reducing Medicaid payments to providers is a decrease in Medicaid enrollment caused by a drop in the number of people receiving Temporary Assistance for Needy Families, the cash assistance program that confers Medicaid eligibility. But many people still rely on these providers, and hospitals such as those studied here must have a stable base of paying patients in order to serve those with no health coverage.

**Medicare and Private Insurance**

Another way to compare the three hospitals is to examine the proportion of their operating costs covered by commercial payers and Medicare, payers
that are avidly sought by all hospitals. Table 1 shows that while the sum of these payments covered more than a third of operating costs at Jackson Memorial Hospital, the corresponding figures were about 15 percent for HCHD and 22 percent for Highland Hospital.

### Table 1 Selected Hospital Revenues as a Proportion of Costs, FY 1997

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Medicare + Commercial Payments to Hospital as a Proportion of Hospital's Operating Costs</th>
<th>Medicaid Payments to Hospital as a Proportion of Hospital's Operating Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCHD (Harris County)</td>
<td>14.9%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Highland (Alameda County)</td>
<td>22.2%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Jackson Memorial (Miami-Dade County)</td>
<td>38.3%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

*Source: Economic and Social Research Institute (ESRI) calculations based on data collected from the hospitals.*

### Operating Deficits

As table 1 shows, third-party payments are far from sufficient to cover the hospitals’ operating costs. Other operating revenues, including self-payments, also contribute to the hospitals’ bottom line but still leave a deficit.

The size of the operating deficit varies greatly. In 1997, internally generated funds covered 80 percent of operating costs at Jackson Memorial Hospital but only 48 percent of operating costs in the HCHD hospital system. At Highland Hospital, the corresponding figure is 58 percent (see table 2).

### Table 2 Magnitude of Hospital’s Operating Deficit, FY 1997

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Proportion of Hospital’s Operating Costs Covered by Hospital’s Internally Generated Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCHD (Harris County)</td>
<td>48.4%</td>
</tr>
<tr>
<td>Highland (Alameda County)</td>
<td>58.2%</td>
</tr>
<tr>
<td>Jackson Memorial (Miami-Dade County)</td>
<td>79.9%</td>
</tr>
</tbody>
</table>

*Source: ESRI calculations based on data collected from the hospitals.*

### Sources of Nonoperating Revenues

Safety net providers historically have served primarily Medicaid patients and uninsured patients. Medicaid reimbursements have typically been lower than payments by Medicare and commercial payers, but taken together these revenues have enabled safety net providers to cross-subsidize charity care patients. As commercial payers and Medicare have lowered payment rates and
placed more emphasis on utilization management, financing through cross-subsidies has become more difficult to achieve. Thus, safety net providers have had to rely more heavily on other sources of funding, including federal, state, and local subsidies.

**Federal and State Funding Programs**

Safety net institutions receive supplemental payments from federal and state governments to help defray the costs of uncompensated care patients (primarily DSH payments). The DSH program was added to Medicaid in the early 1980s. In many cases, states collected money from localities and/or their hospitals and used this money to obtain federal matching payments. The funds were then redistributed to hospitals based primarily on their indigent care case-load, with the intent to compensate hospitals for seeing a high volume of Medicaid and uninsured patients. States used a variety of distribution formulas, however, and some funds flowed to hospitals providing relatively little uncompensated care. Many states did not begin to make substantial DSH payments until the early 1990s, at which time many hospitals began to rely heavily on DSH revenues. DSH payments as a percentage of total Medicaid spending rose from 1.2 percent in 1991 to 19.3 percent in 1995 in California and from 4.9 percent to 17.4 percent for the same period in Texas (Coughlin and Liska 1998, table 1). Payments also rose in Florida, although not nearly to the same degree: from 1.2 percent in 1991 to 5.4 percent in 1995.

The rapid increase in DSH spending was attributable in part to the use of hospital “donations,” which states used to draw down larger federal matching payments, and in part to the increased use of provider taxes and intergovernmental transfers. The federal government imposed limits on DSH spending in 1991 and 1993 legislation. The 1991 law essentially banned the use of provider donations and capped DSH payments. The 1993 law sought to target DSH funds to hospitals’ actual needs by limiting these funds to the unreimbursed costs of providing inpatient hospital care to Medicaid patients and uninsured patients. In 1997, the federal Balanced Budget Act further restricted DSH payments over the 1998–2002 period. A study by the Urban Institute estimated the impact of these changes on federal DSH spending over the 1998–2002 period relative to 1995 spending levels. For California, the estimated reduction is 9 percent, equal to a loss of $461 million in DSH revenues over the five-year period; for Texas, an 11 percent reduction, equal to a $546 million loss, is predicted; and in Florida, a 3 percent reduction, equal to $28 million, is estimated (Coughlin and Liska 1998, table 2). As DSH payments are limited, many safety net hospitals will see an important revenue stream reduced and will be looking for other sources of funding.

The federal government contributes to safety net hospitals in other ways. For example, through graduate medical education (GME) payments, it adds to Medicare reimbursements for teaching hospitals. (States also make GME payments to hospitals.) The federal Ryan White program assists providers, including hospitals, serving substantial numbers of patients with AIDS.
The extent to which states directly subsidize safety net providers varies greatly across the country. Whereas state governments in Texas and Florida spend relatively little on indigent care beyond Medicaid, California has more or less taken over the financing of indigent hospital care from its counties, using funds generated by a vehicle license fee, a sales tax, and a tobacco tax. None of the hospitals in our study is located in states that have established statewide indigent care pools that collect funds from providers across the state and redistribute them to safety net hospitals, an approach used in Massachusetts and Maryland. Because the three localities studied do not have access to this type of “automatic” funding stream, they must develop alternative means of financing. Just as the willingness or the ability to assist safety net providers varies greatly across localities, the amount and security of local funding for indigent care also varies, as discussed below.

Local Funding

In each of the three sites, by statute, the localities are the providers of last resort for the indigent population. And, in each site, the primary method by which the county discharges its duty is by operating a local public hospital. The actual amount of fiscal responsibility taken by Harris, Alameda, and Miami-Dade Counties for public hospitals, however, differs dramatically. These differences are driven by two factors. First, the county must have the authority to collect tax revenue in order to be in a position to fund the safety net. Second, if the county has taxing authority, the county must choose to spend discretionary revenue on the hospitals or create dedicated revenue streams to fund the hospitals. County spending on health care, while significant, is not the dominant item in the county budget of any of the sites studied. In Miami-Dade County, for example, county outlays for Jackson Memorial account for a little more than one dollar of nine in the countywide service area budget and about 7 percent of the overall budget, which includes fire and rescue, libraries, and services to unincorporated areas. Similarly, in Harris County, outlays for HCHD account for about one dollar in ten of the total county budget. These local funds are critical to the survival of the hospitals in these two counties, as discussed below.

Harris County, Texas

Although the roles of the state and the county in Harris County are similar to those in Miami-Dade County, the medical facilities that constitute HCHD are not nearly as securely funded. Similar to Jackson Memorial, HCHD provides three-quarters or more of the charity care in Harris County; and like Florida, the state of Texas has little involvement in funding the safety net directly. Instead, HCHD relies heavily on DSH funds and—even more so—on a county ad valorem property tax. This funding was sufficient for the early 1990s, when ample DSH money was available and the property tax was high. However, during a period when the hospitals were running a surplus, the county chose to cut back the property tax. At the same time, Medicaid revenues to the hospitals fell, and
costs continued to increase. Now, despite continued inflows of DSH money, HCHD is facing large projected deficits without a clear idea of how to fund them. The county has the ability to fund HCHD’s current operating deficit, but the county has not chosen to restore the property tax to its previous level. Figure 1 demonstrates that in the early part of the decade HCHD was able to cover its operating deficit with DSH and tax revenue but in the past three fiscal years those sources of revenue have not been sufficient to cover the deficit.

As figure 1 illustrates, HCHD must either find other sources of funding for the hospitals or cut costs to reduce its operating deficit. The county has authorized HCHD to receive additional funding from the state’s tobacco settlement when the distribution of those funds is finally determined, which could generate approximately $32.5 million per year. But projected net losses are estimated to be in the $60–90 million range annually over the next few years, again because of continued rising costs and a fall in Medicaid revenues. Thus, while it may be beneficial to a hospital to be located in a county that can generate tax revenue and use that revenue to fund the hospital, unless the tax revenue is dedicated and nondiscretionary, the hospital is still vulnerable to policy changes by county government.

Figure 1  Harris County Hospital District Funding

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>DSH Funds</th>
<th>Ad Valorem Tax Revenue</th>
<th>Operating Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>92–93</td>
<td>$150</td>
<td>$200</td>
<td>$50</td>
</tr>
<tr>
<td>93–94</td>
<td>$150</td>
<td>$200</td>
<td>$50</td>
</tr>
<tr>
<td>94–95</td>
<td>$150</td>
<td>$200</td>
<td>$50</td>
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<tr>
<td>95–96</td>
<td>$150</td>
<td>$200</td>
<td>$50</td>
</tr>
<tr>
<td>96–97</td>
<td>$150</td>
<td>$200</td>
<td>$50</td>
</tr>
<tr>
<td>97–98</td>
<td>$150</td>
<td>$200</td>
<td>$50</td>
</tr>
</tbody>
</table>

Source: ESRI calculations based on data from the Harris County Hospital District.

Alameda County, California

Highland Hospital provides the majority of charity care in Alameda County. The situation in Alameda County is different from that of the counties in Texas and Florida because California counties have limited taxing authority. These limits are the result of ballot initiatives, including most recently the passage of Proposition 218 in 1996, which forced counties to obtain the approval of two-thirds of the voters in order to raise county taxes. In addition, as a result of the fiscal realign-
ment that occurred in the early 1990s, the county does not have direct control over its own streams of funding for its safety net hospitals, and it directly provides very little money to Highland and the other county safety net hospitals.

Instead, Highland must rely on federal and state revenue to fund its operating deficit. The federal money comes to the hospital primarily via the DSH program, which provided about two-thirds of the money needed to cover Highland’s operating deficit in 1997–98. The other federal money the hospital receives is for special categories of patient care (e.g., Ryan White funding for AIDS care). Although substantial state revenues are dedicated to health and social services in Alameda County, the county may choose to spend that money to meet needs other than funding Highland’s operating deficit. For example, state dollars are also used to support mental health, public health, and outpatient clinics—services that the county may perceive as more cost-effective from the perspective of overall health status in Alameda County.

As is evident in figure 2, over the past five years Highland has not been able to cover its operating deficit even with county, state, and federal monies. Highland has instituted some cost-cutting to address the deficit, and it also has been allowed by the county to carry over some of the deficit from year to year, which results in an implicit county subsidy. Again, Highland clearly is in a very tenuous position.

Figure 2  Highland Hospital Funding

![Graph showing Highland Hospital Funding](image)

Source: ESRI calculations based on data from Highland Hospital.

Miami-Dade County, Florida

In Miami-Dade County, Jackson Memorial Hospital is by far the largest safety net provider, providing approximately three-quarters of all the charity care in
the county. Patient revenues cover about 80 percent of operating costs. The bulk of the funds covering the operating deficit are provided by the county. The county enacted a one-half cent sales tax in 1991, which provides a dedicated source of revenue for Jackson. In addition to the sales tax, there is a law mandating that the county continue to contribute the same proportion of its countywide budget to Jackson as it contributed the year the sales tax was enacted. In combination, Miami-Dade County provides some $190 million a year in funding to Jackson, and that funding is not subject to administrative changes but instead is mandated by law. As a result, Jackson Memorial Hospital is fully and securely funded. Figure 3 illustrates how the two locally generated sources of revenue not only cover the operating deficit at Jackson but also enable it to run a sizable surplus.

### Figure 3  Jackson Memorial Hospital Funding

![Jackson Memorial Hospital Funding Graph](image)

Source: ESRI calculations based on data from Miami-Dade 1998b, p. 38.

The state and federal governments provide some additional support to Jackson Memorial. Whereas the state funds very little indigent care directly, the federal government provides fairly significant support through the DSH program. In 1997, net DSH payments to Jackson totaled $32 million, or about one-sixth of the total amount contributed by the county.

**Conclusion**

It is clear that each of the hospitals studied would not be economically viable without large subsidies, because of the large gap between operating revenues and operating expenses. The size of the gap varies substantially across the three sites, as does the extent to which the gap is covered by local versus state or federal funding. In one location (Miami-Dade County), local funds completely cover the operating deficit. In another site (Alameda County), state and
federal money fills the bulk of the gap between operating costs and patient revenue. Harris County lies somewhere in between the other two counties: it relies on both DSH and local taxes to subsidize its public hospitals. Further, the funding sources for the operating deficit are far more secure in some localities than in others. In Miami-Dade County, for example, the combination of a dedicated sales tax and a maintenance-of-effort requirement have locked in funding for Jackson Memorial Hospital. In contrast, in Harris County, where the county also provides most of the funding, policy changes and maintenance-of-effort issues may jeopardize the financial stability of the public hospital system.

The three case studies illustrate the geographic differences in the U.S. health care system. For lower-income Americans, access to affordable health care often depends heavily on where they live. In some communities, that access is rather secure, even though it may be tilted in the direction of institutional care rather than a medical home in a managed care environment. In other communities, access to care is more tenuous. Moreover, some communities obtain a very large degree of outside help from higher levels of government in meeting their obligation to provide health care for the indigent. Other communities pay most of the tab locally. Some communities have locked in a commitment to indigent care and largely insulated this commitment from local politics. In other localities, a secure safety net is subject to the vicissitudes of local politics and changing local priorities.

The next sections present a more in-depth review and analysis of each of the three sites.
Harris County, Texas

Introduction

Harris County, which includes Houston, has a long tradition of financing health care services for the county’s indigent population. After the Texas legislature passed legislation in 1963 authorizing the establishment of hospital taxing districts, Harris County voters approved the creation of the Harris County Hospital District (HCHD), a public organization with taxing authority that has the primary responsibility for providing health services to the indigent. Voters also authorized the imposition of an ad valorem property tax earmarked for HCHD. The Harris County Commissioners’ Court approves HCHD’s budget each year and appoints HCHD’s nine-member board of managers, which has responsibility for overseeing the operations of HCHD. The court is a collection of five elected officials—the county judge and four county commissioners, each of whom represents one of four districts in the county. An administrator manages the day-to-day operations of HCHD and reports to the board of managers.

HCHD owns and operates two public general hospitals—the 510-bed Ben Taub Hospital and the 233-bed Lyndon Baines Johnson (LBJ) Hospital. These facilities offer a wide variety of general medical and surgical services. Ben Taub is also home to a Level I trauma center, and LBJ operates a Level III trauma center. Along with the two general hospitals, HCHD owns the 73-bed Quentin Mease Hospital, a community hospital that has inpatient psychiatry, physical medicine, and skilled nursing units. HCHD also runs a network of 12 community clinics throughout the area.

HCHD is obligated to provide services to the low-income population in Harris County, home to some 3.2 million people. Although statistics are not available for Harris County, an estimated 23.9 percent of nonelderly people were
uninsured in 1995 in Texas as a whole, compared with 15.5 percent nationwide (Wiener et al. 1997). The large uninsured population is explained in part by a sizable undocumented alien population, who for the most part are ineligible for Medicaid. Other factors that contribute to the state’s high uninsurance rate are its strict eligibility criteria for Medicaid and its rate of employer-sponsored coverage, which is lower than the rate in many other states.

As of 1998, approximately 900,000 residents of Harris County were eligible to receive services at HCHD, of whom 400,000 to 500,000 are covered by Medicaid and the remainder have no (or extremely limited) health insurance. Some of these individuals receive care completely free of charge, and others pay a modest amount depending on their income levels. Roughly 341,000 people received services at HCHD last year.

HCHD provides the vast majority (more than 75 percent) of inpatient and outpatient hospital services to the indigent population within Harris County. While other not-for-profit hospitals in Harris County must provide a minimum amount of charity care (equivalent to 4 percent of net patient revenues) to maintain their not-for-profit status, some community health care leaders question whether many of these institutions are seriously committed to the provision of indigent care. That said, there are a few hospitals outside of HCHD facilities, such as Hermann Hospital, the Memorial System, and St. Luke’s Episcopal, that community health care leaders hold out as being committed to serving the indigent.

HCHD is not alone in providing outpatient clinic services (e.g., prevention and screening services) to the indigent. HCHD’s 12-clinic network is supplemented by a network of clinics operated by the Houston City Health Department, which has 8 or 9 clinics within the city limits, and the Harris County Health Department, which runs 5 clinics in Harris County outside the city limits. In addition, Harris County has formed partnerships with public and private organizations (e.g., the March of Dimes, Baylor School of Medicine, the local school district, local corporations) to provide various outpatient services for the indigent.

Financial Situation of Harris County Hospital District

The Early Part of the Decade: Relative Prosperity

In the first half of this decade, HCHD was on sound financial footing. Two forces combined to yield a rosy financial picture. First, as figure 4 shows, patient revenues increased steadily and substantially between 1990 and 1995. (All years in the text, figures, and tables refer to HCHD’s fiscal year, March 1 to February 28.) Indeed, net patient revenues nearly tripled over this period (see table 3). This increase in patient revenues is probably attributable to several
significant changes in HCHD facilities. In 1989, HCHD opened LBJ Hospital in a low-income area to serve as an obstetric hospital. In 1990, HCHD, which had relied solely on Baylor University to staff its hospitals, brought in the University of Texas to provide additional medical staff. This increased the number of available physicians, which led to a decision by HCHD to use LBJ Hospital as a general hospital rather than just an obstetric hospital. In addition, Ben Taub was rebuilt in 1989–90, thereby improving its facilities substantially.

A second factor contributing to HCHD’s solid financial situation is that net patient revenues were supplemented by substantial local subsidies, along with smaller but steadily growing contributions from Medicaid’s DSH program (see figure 4). In 1995, for example, ad valorem tax revenues accounted for 43 percent of HCHD’s total revenues. When DSH payments are added to this tax rev-

**Table 3 Relative Prosperity in Early Part of Decade (in millions of dollars)**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>SOURCES OF INCOME (CASH)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient revenues</td>
<td>64.7</td>
<td>91.7</td>
<td>112.3</td>
<td>157.4</td>
<td>185.4</td>
<td>187.9</td>
</tr>
<tr>
<td>Ancillary revenue</td>
<td>1.8</td>
<td>7.0</td>
<td>8.9</td>
<td>8.3</td>
<td>11.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Interest income</td>
<td>9.1</td>
<td>7.8</td>
<td>5.5</td>
<td>7.8</td>
<td>9.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Ad valorem tax</td>
<td>170.0</td>
<td>176.3</td>
<td>214.5</td>
<td>215.6</td>
<td>212.3</td>
<td>205.7</td>
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<tr>
<td>DSH funds</td>
<td>38.6</td>
<td>55.9</td>
<td>50.0</td>
<td>57.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL INCOME</td>
<td>245.6</td>
<td>282.8</td>
<td>379.8</td>
<td>445.0</td>
<td>468.4</td>
<td>476.9</td>
</tr>
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<td>EXPENSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating costs</td>
<td>226.6</td>
<td>284.6</td>
<td>282.2</td>
<td>316.7</td>
<td>350.8</td>
<td>391.2</td>
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<td>Capital expenditures</td>
<td>45.0</td>
<td>22.0</td>
<td>13.6</td>
<td>6.8</td>
<td>20.1</td>
<td>19.1</td>
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<td>Debt service</td>
<td>7.6</td>
<td>13.0</td>
<td>16.4</td>
<td>26.2</td>
<td>25.3</td>
<td>25.4</td>
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<td>Transfer to county</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>30.0</td>
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<td>TOTAL EXPENSES</td>
<td>279.2</td>
<td>319.6</td>
<td>312.2</td>
<td>349.7</td>
<td>396.2</td>
<td>465.7</td>
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<tr>
<td>Net Profit or Loss (on Cash Basis)</td>
<td>–33.6</td>
<td>–36.8</td>
<td>67.6</td>
<td>95.3</td>
<td>72.2</td>
<td>11.2</td>
</tr>
</tbody>
</table>

Source: Harris County Hospital District.

**Figure 4 HCHD Revenues, FY 1990–1998**

Source: Harris County Hospital District.
Major external support was sufficient to allow HCHD to enjoy four straight years of significant surpluses from 1992 to 1995, following deficits in 1990 and 1991 (see table 3). The infusion of funds also enabled the district to more than double its cash reserves, from $156.6 million to $386.2 million. This buildup in reserves occurred despite rising costs (resulting primarily from increased demand for services), as the increase in revenues significantly exceeded the increase in expenditures.

### The Latter Part of the Decade: A Serious Decline in Fortunes

Beginning in 1996, HCHD’s financial situation began a marked downturn. Three forces combined to bring about this change: (1) net patient revenues moved downward after several years of increases; (2) operating costs continued to escalate after a small dip in 1996; and (3) the county slashed the subsidy by cutting ad valorem taxes. Specifically, ad valorem tax revenues, at $154.7 million in 1998, were more than $60 million below their peak in 1993. Patient care revenues declined to $153.3 million in 1998, nearly $35 million below the peak in 1995. In 1998, net patient revenues covered only 37 percent of total operating costs, down from the peak of 48 percent in 1995. Increased DSH funding over this period was insufficient to offset these other revenue and cost developments. These combined forces led to losses of $8.8 million in 1996, $32.8 million in 1997, and $46.3 million in 1998 (see table 4).
Forces Underlying the Reversal of Fortune

To understand the changes in HCHD’s financial situation over the past decade, it is helpful to evaluate the three major components of its income statement: operating revenues, expenses, and external financial support.

Operating Revenues

HCHD’s operations generate revenues from three sources:

- Patient care revenues, including reimbursement by Medicare, Medicaid, and commercial insurance;
- Non-patient-care revenues, such as fees generated from parking or cafeteria services; and
- Interest income on accumulated cash reserves.

As noted earlier, these three sources combined have never been enough to cover more than half of HCHD’s operating expenses in the past decade.

As table 5 shows, HCHD almost completely depends on Medicare and Medicaid for its patient revenues. In 1998, for example, Medicare and Medicaid provided 79.3 percent of net patient revenues. Commercial payments accounted for only 8.7 percent of revenues (see table 5).

Medicaid is particularly important to HCHD, accounting for twice the amount of revenues from Medicare. Because of the hospitals’ dependence on

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Table 4  Significant Shortfalls in Recent Years (in millions of dollars)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>1996 (11 months)</th>
<th>1997</th>
<th>1998</th>
<th>1999 (projected)</th>
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<tr>
<td>SOURCES OF INCOME (CASH)</td>
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<td></td>
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<tr>
<td>Net patient revenues</td>
<td>165.9</td>
<td>163.0</td>
<td>153.3</td>
<td>133.4</td>
</tr>
<tr>
<td>Ancillary revenue</td>
<td>12.8</td>
<td>10.9</td>
<td>10.4</td>
<td>10.3</td>
</tr>
<tr>
<td>Interest income</td>
<td>24.8</td>
<td>19.8</td>
<td>16.3</td>
<td>18.4</td>
</tr>
<tr>
<td>Ad valorem tax</td>
<td>140.8</td>
<td>154.6</td>
<td>154.7</td>
<td>152.0</td>
</tr>
<tr>
<td>DSH funds</td>
<td>56.8</td>
<td>68.3</td>
<td>76.5</td>
<td>82.7</td>
</tr>
<tr>
<td>TOTAL INCOME</td>
<td>401.1</td>
<td>416.6</td>
<td>411.2</td>
<td>396.8</td>
</tr>
<tr>
<td>EXPENSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating costs</td>
<td>367.4</td>
<td>400.5</td>
<td>410.0</td>
<td>389.1</td>
</tr>
<tr>
<td>Capital expenditures</td>
<td>18.1</td>
<td>18.4</td>
<td>21.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Debt service</td>
<td>24.4</td>
<td>26.2</td>
<td>25.2</td>
<td>23.8</td>
</tr>
<tr>
<td>Transfer to HMO</td>
<td>4.3</td>
<td>1.0</td>
<td>1.1</td>
<td>—</td>
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<tr>
<td>TOTAL EXPENSES</td>
<td>409.9</td>
<td>449.4</td>
<td>457.5</td>
<td>430.2</td>
</tr>
<tr>
<td>Net Profit or Loss (on Cash Basis)</td>
<td>–8.8</td>
<td>–32.8</td>
<td>–46.3</td>
<td>–33.4</td>
</tr>
</tbody>
</table>

Sources: Harris County Hospital District; Harris County Budget Office.
Medicaid, recent changes to the program are of concern. While Harris County is a relatively immature market with respect to commercial and Medicare managed care, it is rapidly becoming a mature Medicaid managed care market. Beginning December 1, 1997, all Temporary Assistance for Needy Families Medicaid beneficiaries in Harris County and elsewhere in Texas were required to enroll in a managed care arrangement (health maintenance organization [HMO] or primary care case management). On March 1, 1998, all aged and disabled Medicaid beneficiaries in Harris County also had to enroll in a managed care arrangement as part of a pilot project authorized for the county. Those who did not choose a plan were automatically assigned to one of the six HMOs in the area, including HCHD’s own Medicaid HMO. The state initially denied a contract to HCHD’s HMO but later awarded one when legislation was enacted requiring the state Medicaid agency to contract with public hospital district HMOs. The same legislation required the other approved Medicaid HMOs to offer a contract to all “significant traditional providers” of services to the indigent, as measured by Medicaid volumes. Naturally, HCHD qualified under the act, as did a number of other hospitals, physicians, and health care providers throughout the state.

As Medicaid moved both young parents and their children and the elderly and disabled populations into managed care, enrollees’ use of health care services became less concentrated at HCHD facilities and more dispersed throughout the community. As enrollees obtained a medical home and were assigned to a primary care physician, the use of both HCHD clinics and the emergency rooms at Ben Taub and LBJ Hospitals began to decline. In addition, the combination of better Medicaid rates paid under managed care contracts and lower commercial payments reduced prior differences in reimbursement for labor and delivery between Medicaid and commercial payers, making Medicaid payments for deliveries more attractive to private hospitals. As a result of these trends, Medicaid revenues plummeted from $117.8 million in 1994 to $81.0 million in 1998, a drop of 31 percent. Medicaid revenues are projected to fall further to $54.1 million in 1999, or less than half of the 1994 level (see table 5).

Non-patient-care revenues have declined roughly in step with patient care revenues, while interest income has declined as accumulated cash reserves are depleted.
Operating Expenses

Part of the reason for HCHD’s accumulated deficits has been a steady and relatively rapid increase in operating costs over the past several years. These costs have risen by 29.5 percent since 1993. As table 6 shows, the increase is certainly not being driven by the volume of inpatient care. Admissions and patient days have declined by 10.7 percent and 13.3 percent, respectively. Moreover, emergency room visits appear to be stable. While outpatient visits have risen by 26.7 percent over the period, this increase cannot account for all of the growth in operating costs. Ruling out these explanations could lead to the conclusion that costs per patient day have risen sharply. This rise may be attributable to several factors, including the increasing costs of new technologies, inefficient management, and sicker, more expensive patients. Because there is no clear explanation for the increase in costs, the county commissioners have renewed concern about HCHD management.

Table 6 Patient Volumes and Operating Costs, FY 1993–FY 1998

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</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>56,280</td>
<td>54,838</td>
<td>52,971</td>
<td>52,692</td>
<td>52,655</td>
<td>50,243</td>
<td>–10.7%</td>
</tr>
<tr>
<td>Patient days</td>
<td>255,095</td>
<td>255,359</td>
<td>245,913</td>
<td>238,322</td>
<td>235,136</td>
<td>221,163</td>
<td>–13.3%</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>621,000</td>
<td>673,000</td>
<td>753,000</td>
<td>762,000</td>
<td>787,000</td>
<td>26.7%</td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>188,000</td>
<td>196,000</td>
<td>201,000</td>
<td>200,000</td>
<td>198,000</td>
<td>5.3%</td>
<td></td>
</tr>
<tr>
<td>Operating costs (in millions)</td>
<td>$316.7</td>
<td>$350.8</td>
<td>$391.2</td>
<td>NA</td>
<td>$400.5</td>
<td>$410.0</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

Source: Harris County Hospital District.

External Sources of Support to Finance the Deficit

As the trends in the previous two sections make clear, HCHD relies heavily on external sources of funding to help cover its costs. This section examines each of these sources.

County Funds

The ad valorem property tax is the main source of external funding for HCHD. For the first half of the decade, the tax more than covered the costs of indigent care, thanks in part to a 3-cent increase in the tax, from roughly 15 cents per $100 in value to 18 cents in 1993–94.

By 1995, however, the equation began to change. Seeing the annual surpluses, building cash reserves, and rapidly rising costs as an indication that HCHD was more than adequately funded and had little incentive to operate efficiently, the Commissioners’ Court in 1996 rolled back the ad valorem tax rate by
roughly one-third, from more than 18 cents per $100 in valuation to 12.4 cents per $100 in valuation. The tax cut took roughly $60 million annually out of HCHD's revenues. Figure 6 shows the bulge in total income relative to total expenses that developed over the 1992–95 period. This “surplus” presented local officials with a tempting opportunity for a tax cut.

The change in external funding illustrates three recurrent themes in this study. First, the abrupt change of course by county officials in response to what they perceived as an overfunding situation illustrates the vulnerability that safety net providers experience even when local revenue sources are dedicated. Even a dedicated tax can be cut by political leaders, and a short-term surplus provides a tempting target for such action. In Harris County, officials have more leeway to make such cuts than in Miami-Dade County because the Harris County tax can be cut through administrative action.

Second, the tax cut illustrates the challenge to the long-term viability of safety net providers posed by maintenance-of-effort issues. As local leaders perceive that revenue sources other than county funding are growing, they are tempted to scale back their own contributions. In this case, the sharp increase in patient revenues, coupled with the onset and growth of DSH payments, may have led county officials to believe that they could reduce their own commitment without jeopardizing the financial position of the provider.

Third, county officials were motivated by a desire to cap revenues in order to spur providers to reduce costs and improve their management of facilities. Officials feared a situation in which county funds rode up in tandem with costs. Thus, if county officials were to restore funding, they would probably want to see some effort on the part of HCHD to become a more efficient provider.

While the intent of the tax cut may have been to avoid underwriting inefficiency, property tax revenues no longer appear to be sufficient to cover the costs
of indigent care services. By HCHD’s calculations, after indigent care had been overfunded by $217.8 million between 1992 and 1995, the reduction in revenue from the ad valorem tax resulted in an indigent care financing shortfall of $80 million in 1996 and 1997 and a projected shortfall of $422 million between 1998 and 2002.

A majority of the members of the County Commissioners’ Court do not share HCHD’s view that the tax rate is too low. To foster efficiency, the county commissioners in recent years have begun to scrutinize HCHD operations closely. Until a few years ago, the commissioners tended to approve HCHD budgets without much debate. Today, there is significant discussion back and forth, with pressure from the various commissioners to reduce budget items they see as unnecessary.

**Funds from DSH**

HCHD began to collect DSH funds in 1990. However, in the first two years of Texas’s DSH program the state was not aggressive in going after DSH funds, and they accounted for only 4.9 percent of total Medicaid spending in the state (Coughlin and Liska 1998, table 1). Thus, in 1990 and 1991 HCHD received only a few million DSH dollars each year, a figure so low that HCHD did not even track DSH funds in its financial statements. Beginning in 1992, however, Texas began to receive significantly more in DSH payments, and DSH funds accounted for 24.2 percent of total Medicaid spending for the state in that year. HCHD in turn began to receive more in DSH money, collecting nearly $39 million in 1992, $56 million in 1993, and $50 million in 1994. HCHD was able to use DSH payments not only to help cover costs but also to bolster its cash reserves. The $57 million in DSH funds received in 1995 turned what could have been a $46 million loss into an $11 million surplus. DSH payments to HCHD in the past several years have continued to increase, and they have helped reduce the size of the deficits in 1996, 1997, and 1998.

Part of the reason for the high levels of DSH funding for HCHD in recent years is the passage of federal legislation mandating that no hospital could receive more in DSH funding than it provided in uncompensated care. As a result, many hospitals qualified for less DSH funding than before, meaning that even with DSH cuts at the federal level, more money was available for those hospitals, such as HCHD, that provide substantial amounts of uncompensated care.

**Projections**

HCHD is projected to run increasingly larger operating deficits and deplete its cash reserves within the next few years. A court-ordered study conducted by the Harris County Budget Office in mid-1997 estimated that without major changes HCHD would experience net losses of $65 million in 1999 (HCHD projections suggest that with aggressive cost-cutting its net loss will be only $33.4 million), $76.5 million in 2000, and $88.9 million in 2001. The study assumes that up until 2001, existing cash reserves could be used to cover these losses.
By 2002, however, the study concludes that no cash reserves will be left to cover what could be a loss of more than $90 million that year. A similar analysis conducted by HCHD shows a near-zero cash balance by the end of 2000. These projections largely assume that the ad valorem property tax revenues will not be reduced further and that the growth in the indigent care load will not significantly increase. Both could occur should the local economy slip into recession.

Discussion

Given the unfavorable trends and projections, it is clear that HCHD operations cannot survive as currently financed and configured. There are a number of options on the horizon, however, that could improve HCHD's financial picture, some more likely than others.

Increasing Participation in Medicaid Managed Care

Patient revenues are projected to continue falling in 1999, and hospital management holds out little hope that they will turn around in a meaningful way in the next few years. The big problem is the drop in Medicaid revenues. Beneficiaries enrolled in managed care have been voting with their feet by leaving district facilities for private hospitals and clinics. Even people enrolled in HCHD’s HMO are using other providers; for example, only 20 percent of HCHD’s enrollees signed up for an HCHD physician. In July 1998, HCHD’s HMO had 5,511 enrollees, not even half the number of its nearest competitor, which had 12,073 enrollees, and well behind the two market leaders, which had more than 24,000 and 29,000 enrollees.

Nevertheless, HCHD is optimistic that it can win back enrollees—and patients—over the long term, as HMOs continue to exit the Medicaid market. Hospital management also is hopeful that newly signed contracts with existing Medicaid HMOs might bring business back to the clinics and hospitals.

Reallocating Tax Revenues

In part because of a strong local economy that has generated increased tax revenues, the county’s general fund has been running a modest surplus for the past four years, and the 1998–99 budget is projected to be in balance (see table 7).

The health of the county’s general fund budget generates little political appetite for any sort of a tax increase, including raising the ad valorem tax. However, the county budget office, on the basis of the work of a task force evaluating HCHD,\(^2\) has recommended a modest reallocation of taxes to HCHD, equivalent to 1.25 cents per $100 in property valuation (or roughly $15 mil-
lion annually), with funds to be released after HCHD develops appropriate managed care contracts and obtains budget approval for the new fiscal year beginning in March 1999. If the recommendation is adopted as proposed, the revenue increase to HCHD would not result in higher taxes for Harris County residents, because the funds for HCHD would come out of taxes now earmarked for the county’s general fund budget, which presumably would be reduced to remain in balance. After reviewing the proposal, the County Commissioners’ Court has, at least for now, rejected the idea of transferring these funds to HCHD in March 1999. The general view is that HCHD must get its house in order before any additional funding will be provided by Harris County.

### Changing the Disproportionate Share Hospital Formula

The steady increase in DSH funding that HCHD has enjoyed for a number of years could end soon, unless efforts to change the formula for payments are successful. HCHD’s DSH funding is at risk because of reduced overall funding at the federal level and because DSH funds in Texas are distributed based on inpatient Medicaid days, which have been declining rapidly at HCHD. Whether and how to change the formula for distributing DSH funds is under debate; HCHD and other public hospitals are lobbying the state for a formula based on indigent care days, inpatient Medicaid days, and the volume of outpatient indigent and Medicaid services. The County Commissioners’ Court also is lobbying hard for a change; in its view, the current formula based on inpatient days creates a disincentive for HCHD to move patients into the lower-cost outpatient setting as rapidly as possible. It should be kept in mind that by federal law DSH spending on a particular hospital cannot exceed its losses on Medicaid inpatient days or its uncompensated care costs, a provision that benefits HCHD relative to other hospitals that provide less uncompensated care. Without a change in the state’s formula, however, HCHD will lose a significant amount of DSH funds in the year 2000, when funds will be distributed based on HCHD’s 1998 Medicaid volumes, which were down significantly from prior years. In addition, one study estimated that because of changes at the federal level, Texas will experience between 1998 and 2002 an 11 percent decline in DSH spending relative to 1995 spending levels, which will likely affect HCHD’s DSH allotment (Coughlin and Liska 1998, table 2).

## Table 7 Harris County General Fund Operating Budget (in millions of dollars)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>93–94</th>
<th>94–95</th>
<th>95–96</th>
<th>96–97</th>
<th>97–98</th>
<th>98–99 (projected)</th>
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</thead>
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<tr>
<td>Revenues</td>
<td>511.5</td>
<td>586.8</td>
<td>598.7</td>
<td>627.5</td>
<td>636.9</td>
<td>621.4</td>
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<td>Expenses</td>
<td>566.7</td>
<td>569.5</td>
<td>584.0</td>
<td>593.2</td>
<td>619.9</td>
<td>621.4</td>
</tr>
<tr>
<td>Balance</td>
<td>–55.2</td>
<td>17.3</td>
<td>14.6</td>
<td>34.3</td>
<td>17.0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Office of the Harris County Judge.
Allocating Funds from the Tobacco Settlement

It is the intention of the Commissioners’ Court to allocate Harris County’s share of the tobacco settlement funds to HCHD. The chairman of the board of managers of HCHD estimates that Harris County will receive $50 million in January 1999, $19 million in January 2000, and $9.5 million in January 2001. In addition, a separate $1.8 billion endowment could generate roughly $24 million annually for the county in perpetuity. If this money goes to HCHD without a mandate to increase services, these funds could make a meaningful dent in the operating deficit. The county budget office, on the basis of the work of the task force developing a long-range plan for HCHD, has recommended that these tobacco funds (less $10 million for attorney fees and $10 million for children’s health programs) be allocated to HCHD. HCHD officials estimate this funding, plus accumulated interest, to be approximately $325 million in total over 10 years.

Providing Funds from the Children’s Health Insurance Program Pool

The state of Texas has set up a corporation to apply for and manage the Children’s Health Insurance Program (CHIP) pool funds being made available by the federal government to provide coverage to children without health insurance. Texas has elected to use CHIP funds to expand eligibility for Medicaid, enrolling the children in managed care plans. Over the 1998–2002 period, Texas is eligible to receive more CHIP funds ($2.5 billion) than any other state. HCHD has the potential to benefit from CHIP as its young patients who lack coverage enroll in the program. Of course, to the extent that children newly enrolled in managed care plans under CHIP use other hospitals, this potential benefit may not be realized. Nonetheless, HCHD will either be receiving some reimbursement for the care it provides to CHIP enrollees or at the very least be providing less uncompensated care.

Cutting Costs and Increasing Efficiency

An analysis conducted by HCHD suggests that, given current revenue projections, operating costs would have to be trimmed by roughly $75 million (about 19 percent) from 1998 levels in order to bring HCHD’s operating budget into balance on a cash basis by 2000 (see table 8).

A majority of the five members of the County Commissioner’s Court believe that there are significant opportunities for increased efficiencies in HCHD operations, including a downsizing to reflect the decline in Medicaid volume and a more rapid movement of care from the inpatient to the outpatient setting. Other opportunities to reduce operating costs involve privatizing or contracting out certain services to other providers in the county. The pressure on the HCHD budget may also lead to setting priorities on services, raising cost-sharing requirements, or restructuring eligibility for charity care.
Consolidating County and City Health Programs into HCHD Operations

Many community leaders are touting the possibility of creating enhanced efficiencies through the consolidation of the county and city health department clinics with those run by HCHD. This proposal has been made a number of times over the past 25 years but has always been politically unacceptable to one or more parties. The proposal recently resurfaced when the county judge floated the idea of moving several county health programs into HCHD’s budget as a means of maximizing Harris County’s share of tobacco settlement funds (because the tobacco funds in Texas will be allocated based on county spending for the local hospital districts).

Radically Redesigning the Financing and Organization of Indigent Care Services

A few leaders in the community are intrigued by the idea of creating an insurance pool to pay for health care services for the indigent in Harris County. In other words, rather than giving the ad valorem tax revenues to HCHD as direct payment for the provision of services, they propose that the money be used to create managed-care-like coverage for the indigent. A variety of providers, including HCHD, might participate in this managed care organization’s network. This proposal is not being considered seriously, primarily because for political reasons it would be very difficult to implement. In addition, even if it were possible politically, ad valorem tax revenues would not be a sufficient source of income to create a pool of money that could provide managed-care-like coverage for the indigent.

| Table 8 Cutting Costs to Break Even (in millions of dollars) |
|-----------------|--------|--------|--------|--------|
| Fiscal Year     | 1998   | 1999   | 2000   | 2001   |
| Projected cash revenues | 409.7  | 396.8  | 379.9  | 378.7  |
| Cash costs      |        |        |        |        |
| Operating costs | 404.5  | 389.1  | 330.8  | 328.3  |
| Other costs     | 47.4   | 41.1   | 49.1   | 50.4   |
| Cash profit (or loss) | –44.0  | –33.4  | 0.0    | 0.0    |

Source: Harris County Hospital District.
Introduction

Alameda County, which includes Oakland, is located on the east side of San Francisco Bay. It had a population of approximately 1.4 million as of January 1997, making it California’s seventh most populous county.

For general acute care hospitalization, the safety net in Alameda County consists of two institutions: Highland Hospital, the largest component of the Alameda County Medical Center (the county public hospital system, which includes freestanding clinics and long-term care and inpatient psychiatric facilities) and Children’s Hospital Medical Center of Northern California, a private pediatric facility. Although other hospitals admit Medi-Cal (California’s Medicaid program) patients, these two institutions are the principal providers for patients without health insurance coverage and also the largest Medi-Cal providers. This section of the report concentrates on Highland Hospital, because Highland provides most of the uncompensated hospital care in Alameda County. Less than 10 percent of patients at Children’s Hospital do not eventually qualify for Medi-Cal or some other source of funding for children with special needs; Children’s Hospital receives very little in direct public subsidies.

Funding for California’s county hospitals, including Highland, has evolved such that since the 1990s the counties themselves have only a small role in funding the institutions they own and operate and upon which the most vulnerable of their citizens depend. State and federal funding keeps these hospitals open; while this removes a thorny fiscal issue from the counties’ political agenda, it also leaves the fate of these institutions largely outside county control. To illustrate the
flow of funds to Highland Hospital, it is necessary to describe the state and federal funding programs that provide the bulk of the hospital’s revenue.

## Funding Overview

### Shifts in State-County Relationship

The state of California’s current financial relationship to its counties, especially with respect to the health care safety net, was shaped to a great extent by the following events:

- *The California taxpayers’ revolt of 1978, embodied in Proposition 13*, which limited the ability of counties to raise property taxes and allocate property tax revenues.

- *The removal of funding for medically indigent adults (MIAs) from the Medi-Cal program.* Before 1983, California’s Medi-Cal program received one-fourth of its funding from counties, one-fourth from the state, and one-half from the federal government. In 1983, the county portion was dropped, as was MIA eligibility. As a result, county governments, not the state via Medi-Cal, became the providers of last resort for indigent patients.

- *The recession of the early 1990s,* which necessitated a “realignment” of funding and responsibilities between state and county governments in 1991. This realignment was the name given to a shift of responsibility from the state to the counties for health, mental health, and some social services programs, coupled with several designated state tax revenues to support the delivery of these services at the county level (although not necessarily at pre-recession levels of funding). Designated revenues include a half-cent state sales tax and an increase in the state’s vehicle license fee. These revenues augmented the existing California Healthcare for the Indigent Program begun in 1988, which continues to provide counties with a portion of the revenues from a state surtax on tobacco products.

- *The transfer, starting in FY 1992–93, of local property tax revenues from counties (where they are levied and collected) to state coffers.* This is perhaps the most significant change at this time, from the perspective of county governments. Without the ability to directly expend local property tax revenues, counties are extremely dependent on this “realignment” of funding from the state.

- *Most recently, the passage of a ballot initiative in 1996 (Proposition 218),* which forces counties to obtain the approval of two-thirds of voters in order to raise county taxes.

Combined, these changes have effectively removed California’s counties from the role of key decisionmakers and major financiers of indigent care.

### Medi-Cal and DSH

Approximately 90 percent of Medi-Cal reimbursement for inpatient care is provided via selective contracts negotiated between hospitals and the Califor-
nia Medical Assistance Commission (CMAC). CMAC assesses the state’s needs for hospital beds to serve the Medi-Cal population in a given market, then negotiates per diem or case-specific reimbursement rates with as many hospitals as it needs in that market to provide the necessary number of beds. CMAC has been very successful in negotiating low reimbursement rates on behalf of the state; in part because of this success, various other programs have been created to augment the contract rates CMAC pays certain classes of hospitals.

Medi-Cal reimbursement was described by one respondent as “a little cake with lots of icing,” and that icing is mostly federal DSH funding. Safety net providers in California have depended on a succession of fixes to stay afloat through the 1990s, and first and foremost among these fixes is California’s DSH program. Referred to as SB 855 (after the authorizing legislation), DSH, in the absence of dedicated county revenues, is the salvation of most safety net hospitals in California. (Currently, Children’s and Highland Hospitals are the only Medi-Cal DSH hospitals in Alameda County.) To qualify for this program, a hospital must have either (1) a Medi-Cal inpatient utilization rate greater than or equal to one standard deviation above the mean for all hospitals receiving Medi-Cal reimbursement, or (2) a utilization rate by low-income patients that is 25 percent or more of the hospital’s patient revenue.

In addition to DSH, CMAC administers a DSH-like program, SB 1255, that uses federal funds to augment the contract rates it pays DSH hospitals. To be eligible for SB 1255 payments, a hospital must agree to maintain its Medi-Cal contract and provide emergency services for the life of the contract. SB 1255 payments to hospitals were initially add-ons to per diem rates but are now separate supplemental payments, made quarterly. The state share or matching for this federal program is funded through intergovernmental transfers, and the reality of the program is that public hospitals get most of the money so that the transferring entities “get their money back.”

The most recent of the safety net hospital fixes comes from temporary (two-year) legislation that allows CMAC to subsidize graduate medical education (GME) at certain contracting hospitals. This pilot program will be followed, it is hoped, by longer-term state legislation that continues support for GME through the Medi-Cal program.

The SB 1255 and GME programs were developed in part to better focus money through the Medi-Cal program on particular issues or classes of hospitals. SB 1255 took its present form during a crisis involving access to emergency rooms (ERs) in Los Angeles County, so it focuses on keeping ERs open in hospitals that need more help than is provided by Medi-Cal’s relatively low contract rates. Today, hospitals in Los Angeles County still receive most of the SB 1255 funding. The GME program was developed in response to federal Medicare cutbacks in funding for GME. Although California’s total federal DSH funds are twice the amount of the SB 1255 and GME programs, these DSH-like programs can target public safety net providers for additional funds as more private hospitals collect SB 855 money.
As one respondent characterized it, the state of California and its counties have created a “state/federally funded system of county hospitals.” The state can avoid raising Medi-Cal rates because it can distribute so many DSH dollars, and counties can use DSH dollars instead of county general fund monies to support their responsibilities as providers of last resort (specified under Section 17000 of the California Welfare and Institutions Code), unfettered by any maintenance-of-effort requirements with respect to DSH versus county subsidy. Thus, the state can cap its commitment to Medi-Cal, and the counties can cap their commitment to indigent health care services, while substantial funding continues to flow to the county hospitals.

County Funding

In Alameda County’s 1998–99 budget, health care services receive the third-largest budget appropriation, both from all sources and from the county general fund. From the county general fund, public assistance receives the largest share ($473.2 million, or 38.1 percent), followed by public protection ($346.9 million, or 28.0 percent) and health care services ($317.7 million, or 25.6 percent). (The allocations for FY 1993–94 were $416.7 million, or 43.0 percent, for public assistance; $233.5 million, or 24.1 percent, for public protection; and $208.3 million, or 21.5 percent, for health care services.) Respondents concerned about the health care safety net mentioned how much easier it is politically for county policymakers to dedicate tax revenue to public protection programs rather than to health care programs for the underserved, the former being more popular with the local electorate than the latter. The only health care program with dedicated county tax revenue behind it is the emergency medical system because, as one respondent put it, any voter can imagine needing an ambulance someday. As the next section documents, even though the county spends a substantial amount on health services, it provides very little of Highland Hospital’s budget.

Financial Situation of Highland Hospital

The services Highland Hospital provides in fulfillment of the county’s Section 17000 responsibilities are funded by the vehicle license fee, sales tax, tobacco tax, SB 855 (DSH), and a subsidy from the county general fund. Table 9 shows the sum of these sources, which defines the total amount of funding available for charity care delivered by the hospital in a given year.

Calculated in this manner, the annual amount of indigent care delivered at Highland Hospital over the period 1993–98 averaged $124 million. (All figures used in this section on Alameda County are for fiscal years. The fiscal year for Highland runs from July 1 to June 30.) Over that same period the hospital’s direct subsidy from the county general fund averaged $2.6 million, or just over 2 percent. Not only is this subsidy very small when compared with the amount
of charity care the hospital provides, it also varies greatly from year to year, reflecting the lack of maintenance of effort on the county’s part in funding Highland Hospital. (There is no maintenance of effort with regard to the county’s matching funds for SB 855 either.)

Another perspective on Highland’s funding is provided by an analysis of the hypothetical situation in which Highland is forced to survive only on money generated from seeing patients (excluding SB 855 [DSH] and GME) plus miscellaneous revenues (small grants, gifts, etc.). If this situation were real, the resulting annual operating shortfalls would be as shown in table 10.

As noted above, the funds available to make up this deficit come from four sources: federal aid (excluding DSH), state aid (including vehicle license fees, sales tax, and tobacco tax), subsidy from the county general fund, and the federal portion of DSH (total DSH minus the matching funds put up by the state and county governments through intergovernmental transfers). As figure 7 shows, a combination of federal DSH payments and state aid makes up more than 95 percent of the shortfall, reinforcing the notion that what California has is, in essence, a state/federally funded system of county hospitals.

The net county cost for Highland Hospital is the gain or loss after total hospital revenues (including subsidy from the county general fund) have been applied to total hospital expenditures. In any given year, a positive net county cost (that is, a net loss) could be attributed in whole or in part to the cost of providing uncompensated care, but it could also be attributed to revenue shortfalls

**Table 9 Funding for Charity Care**

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<td>Vehicle license fee (state)</td>
<td>$19,681,011</td>
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<td>Sales tax (state)</td>
<td>$6,200,381</td>
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<td>Tobacco tax (state)</td>
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<td>SB 855 (DSH) (federal)</td>
<td>100,646,616</td>
<td>104,967,368</td>
<td>72,894,888</td>
<td>93,330,510</td>
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<td>County subsidy</td>
<td>879,691</td>
<td>4,950,486</td>
<td>0</td>
<td>4,136,081</td>
<td>3,027,392</td>
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<tr>
<td><strong>Total Charity Care</strong></td>
<td><strong>$132,249,729</strong></td>
<td><strong>$139,709,709</strong></td>
<td><strong>$98,506,768</strong></td>
<td><strong>$119,765,899</strong></td>
<td><strong>$130,275,874</strong></td>
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</table>

Source: Highland Hospital.

**Table 10 Hypothetical Budget Shortfalls**

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<tr>
<td>Patient fees + other</td>
<td>$76,581,183</td>
<td>$74,956,552</td>
<td>$71,840,976</td>
<td>$79,619,081</td>
<td>$82,949,573</td>
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<td>Operating expenses</td>
<td>$210,606,040</td>
<td>$236,933,712</td>
<td>$196,377,649</td>
<td>$202,264,002</td>
<td>$232,059,921</td>
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<tr>
<td><strong>Assumed shortfall</strong></td>
<td><strong>−$134,024,857</strong></td>
<td><strong>−$161,977,160</strong></td>
<td><strong>−$124,536,673</strong></td>
<td><strong>−$122,644,921</strong></td>
<td><strong>−$149,110,348</strong></td>
</tr>
</tbody>
</table>

Source: Highland Hospital.

*Assuming revenues were limited to patient fees and other miscellaneous revenues.
from Medi-Cal, Medicare, or commercial payers; higher operating costs; or a
number of other factors that the authors of this paper are unable to assess. But
regardless of its source, Alameda County’s policy has been that when the net
county cost is positive, it has been funded by cutting costs at the hospital, not
by additional contributions from the county general fund. This policy allows
the county to cap its general fund commitment to Highland at the amount of its
budgeted subsidy payment. The policy has not been strictly enforced, however.
Highland was allowed to roll over approximately $1.3 million in operating deficit
accumulated over the past three years, without making commensurate budget
cuts. Also, one-time revenue strategies have been employed in prior years, in lieu
of spending cuts, to deal with deficits. The county, however, was never involved
in payments beyond the budgeted subsidy.

Discussion

Limited County Control

As Alameda County’s situation illustrates, California’s counties do not play
a significant role in funding their own county hospitals when compared with,
for example, counties in Florida or Texas. As a consequence, they can be rela-
tively passive with respect to the organization and financing of safety net insti-
tutions. An outside observer might conclude that in Alameda County there is
little political will to set and fund different priorities for safety net institu-
tions. Local officials, however, blame the county’s inability to generate local tax
revenues on constraints beyond its control, such as the shift of property tax rev-
enues from counties to the state and Proposition 218, which requires a two-
thirds majority to pass any tax increase that goes before the electorate. Even
though “realignment” was supposed to give counties ultimate responsibility for
indigent health care as well as dedicated funds to discharge that responsibility,
because very little of the money that supports California’s county hospitals comes from inside the county, the scope and nature of the safety net are determined by the availability and level of state and federal funding. Since their county hospital is, to a great extent, paid for by someone else, county governments can avoid politically volatile issues such as new tax revenues to pay for indigent health care services, or funding trade-offs among health care and other public services in annual budgets.

In one respondent’s view, the most significant long-term implication of California’s state/federally funded county hospital arrangement is that it perpetuates county safety net institutions as they now exist. This view holds that if California’s counties and the state bore more responsibility for raising tax revenues to fund these institutions, they might be forced to consider alternative institutions, programs, and funding arrangements to serve vulnerable populations in ways that might be more cost-effective or of higher quality.

For example, although the board of supervisors has been supportive of the hospital, from time to time in other quarters some sentiment has been expressed for closing Highland Hospital and contracting with private-sector hospitals, which currently have significant excess capacity, for the services required to care for indigent patients. The feeling has been that other hospitals can deliver the care more cost-effectively—and possibly deliver higher-quality care than Highland can. Public perception of the quality of care at Highland is mixed, based to some extent on its ambiance and also on views of public versus private institutions. Given that several respondents expressed a low opinion of the perceived quality of care at Highland, many patients might themselves choose a different hospital if they could. But this reasoning has met with strenuous opposition from many quarters, including organized labor, which has been a vocal opponent of change at Alameda County Medical Center. The approximately 3,500 unionized employees of Highland Hospital constitute what was characterized as a politically influential group of voters. As suggested elsewhere in this study, there is a genuine concern about job loss in public-sector hospitals, as well as fear that the mission and character of public institutions, reflected in issues such as access to care and advocacy for safety net patients, can be lost when private-sector hospitals take responsibility for public-sector patients (Legnini et al. 1999).

Although DSH is currently the salvation of California’s public hospitals, approximately half of the DSH money distributed in California now goes to private hospitals, which qualify for DSH because of their Medi-Cal, not their uncompensated care, utilization rates. The growing private-sector share (at the expense of public hospitals) of a shrinking SB 855 pie is a volatile issue in California. It is often noted that private hospitals do not contribute matching funds to the DSH program; however, the matching funds that the state and counties put up are intergovernmental transfers, which are fully replaced by DSH funds when received. Private hospitals’ Medi-Cal volumes have risen, in part because Medi-Cal managed care has been directing patients away from traditional safety net providers. Even the county’s own Medi-Cal managed care
The Alameda Alliance for Health, has begun to contract with other local hospitals (not exclusively Highland) for services. In addition, private hospitals have significant numbers of empty beds and see Medi-Cal as an increasingly important source of patient care revenue. The bulk of uncompensated or charity care, however, is still delivered by county and University of California hospitals. Several respondents noted that the Medi-Cal populations most avidly sought by private hospitals, namely, pregnant women and children, are relatively healthy, low-cost patients—that is, patients who generate higher net revenues. The charity care patients seen by public hospitals, in contrast, not only do not have insurance but also may cost much more to serve. Charity patients, unlike Medi-Cal patients, often do not have a regular source of care and suffer from more acute and complicated medical problems.

Recent Changes

At the beginning of this decade, when Highland Hospital became more dependent on state and federal money, little attention was paid to the efficiency or cost-effectiveness of safety net providers. But in the latter part of the decade, conditions have changed:

- Federal and state funding programs, namely DSH, have leveled off and might decline. Even though the federal Balanced Budget Act of 1997 contained a special provision that softened the reduction in California’s DSH payments, this offers only temporary protection to the state’s public hospitals.
- The vehicle license fee, a major source of state revenue under realignment, is being cut.
- The local economy has improved, but a shift in priorities has more funding going to services such as public protection.

One could compare the last decade of financing for public hospitals in California to crossing a dangerous stream by stepping from one stone to the next. At each point when public hospitals saw no solution in sight for their financial troubles, a new stepping stone appeared in the form of SB 855 or SB 1255. An extension of the current two-year GME funding might be the next stepping stone, taking up some of the slack from DSH and vehicle license fee cuts. What does not seem probable, however, is a significant increase in support from county government. In Alameda County government, only one supervisor remains on the board from pre-DSH years; that is, only one member has ever had to vote on the higher, pre-DSH levels of funding for Highland Hospital. With the bulk of Highland’s funding coming from state and federal sources, the county supervisors have been able to avoid the larger trade-offs between funding health care services programs or public protection, for example, or possibly raising tax revenues to increase funding for both.

The county does continue to help the hospital by, for example, putting its excellent credit rating (Moody’s: Aaa; S&P: AAA) behind a $116 million bond issue to finance construction of a new trauma and clinics building, parking...
garage, and related facilities on the hospital campus. Its most recent approach to Highland Hospital and the inpatient component of its Section 17000 responsibilities involves creation of the Alameda County Medical Center Hospital Authority, which will manage the hospital and sink or swim financially on its own.

Under the new (as of July 1, 1998) Hospital Authority arrangement, the county supervisors contract with the Authority, which is an 11-member board appointed by the supervisors, to operate Highland Hospital. The Hospital Authority leases the hospital (for a token fee) from the county supervisors, holds the relevant operating licenses, and employs the staff. The county will forgive Highland’s accumulated deficits of approximately $3 million, to allow the Authority to start with a clean slate, but the county does not see itself contributing any last-dollar support to Highland under the Authority. The Authority will be responsible for building up operating reserves to fund any future deficits. The county subsidy to Highland will be discontinued, and in its place will be a revenue stream from the county to the Authority of approximately $82 million, made up of a pass-through of state vehicle license fee, sales tax, and tobacco tax revenues, plus $18 million in county general fund revenues. This $82 million will constitute the revenue stream from the county to the hospital to cover the cost of the county’s Section 17000 responsibilities.
Introduction

Miami-Dade County includes the city of Miami but extends well beyond the city’s borders and includes many unincorporated areas. The county has a large indigent population, many of whom are recent immigrants. Some of these people are unemployed or working in low-wage jobs, such as migrant farm work, that provide no health coverage.

The largest provider of hospital care to indigent patients in Miami-Dade County is Jackson Memorial Hospital. Jackson is a public hospital with 1,567 licensed beds and is affiliated with the medical school at the University of Miami. While the rest of the university is in nearby Coral Gables, the medical school has its own campus in the central part of Miami that surrounds Jackson Hospital. The hospital–medical school complex includes burn and trauma care units, the internationally recognized Bascom Palmer Eye Institute, and a pediatric center, among other specialty care departments. Jackson also owns and manages a network of community health centers and nursing homes and owns and manages a small HMO.

More than 20 other hospitals in the county offer some charity care. But in all of these cases, charity care is a very small percentage of total patient revenue. For example, Cedars Medical Center and Baptist Hospital provide more charity care than any of the other hospitals in the county do, except Jackson, but their total combined outlays for charity care were only about 7 percent of those incurred by Jackson Memorial. The combination of Medicaid and charity care accounts for 44 percent of Jackson Memorial’s
gross patient charges, compared with 14 percent at Cedars and 6 percent at Baptist. At other hospitals in Miami-Dade County, charity care is negligible. Indeed, the sum of the charity care provided by all of the 35 hospitals in the county other than Jackson in one year was only 29 percent of the amount provided by Jackson.

Financial Situation of Jackson Memorial

Jackson Memorial Hospital is fully funded at present to serve the mission of providing the bulk of charity hospital care in Miami-Dade County. This is the case despite a shortfall in internally generated funding needed to cover costs. The funding situation at Jackson Memorial Hospital is described in detail below.

Internal Funding

Like public hospitals across the country, Jackson does not fully cover its operating costs through patient revenue, as a result of its mission to serve as a provider of last resort for people who lack health insurance. Unlike many public hospitals, where patient revenue is declining relative to operating costs, Jackson’s patient revenue has provided a constant proportion of the hospital’s outlays over the past five years. Net patient revenue at Jackson Memorial covered 65.8 percent of operating costs in 1993, 63.8 percent in 1995, and 68.1 percent in 1997. (All figures used in this section on Miami-Dade County are for fiscal years. The fiscal year for Jackson runs from October 1 to September 30.) Thus, patient revenues cover only two-thirds of operating costs, but that figure, for now at least, appears stable. (The possible exception, developed more fully below, is Medicaid payments, which have tapered off in recent years.) Moreover, revenues other than from patient billings are not insignificant at Jackson. When this additional source of internal funding is taken into account, Jackson covered 80 percent of its operating costs in 1997.

External Funding

Most of the funding that covers the shortfall between operating costs and operating revenues is generated locally. In 1997, Jackson had a loss from operations totaling $157 million. But the hospital received $191 million in county support. Under state enabling legislation, counties are permitted to put a sales tax on the ballot to generate money to fund public hospitals in the county. In 1991, Miami-Dade County voters approved a half-cent sales tax increase, with all of the proceeds to go to Jackson Memorial Hospital and its clinics. Combined with county general funds, a small amount of interest, and miscellaneous income, this significant boost in county funding has yielded a surplus of revenues from all sources, relative to expenses, since the tax was instituted. The
surplus reached $56 million in 1997, which amounted to about 10 percent of Jackson’s net patient revenue (see table 11).

### County Support: Dedicated Sales Tax and General Revenue Funding

The support from Miami-Dade County consists of two major components, and they are linked. First, the half-cent sales tax revenue is dedicated to the Public Health Trust (PHT), the governing board for Jackson Memorial Hospital. Under the terms of its charter, PHT may use the proceeds of the tax to support only public hospitals, in addition to certain nonhospital programs. These terms tie most of the funds to Jackson, the only public hospital in the county. Thus, there is virtually no chance of Jackson following the lead of many other public hospitals by converting to private status, because this action would jeopardize its substantial county support. As table 11 shows, the dedicated sales tax generated $112.8 million in revenue for Jackson in 1997. The table also shows the stability of this revenue over the past five years.

When the dedicated sales tax was enacted, there was concern that the county would respond by scaling back the contributions it had been making to charity care out of county general revenues. To avoid this problem, the sales tax law established the second component of support, a maintenance-of-effort requirement for Miami-Dade County. The county was required to contribute the same proportion of its countywide budget (11.87 percent) to Jackson that it contributed in the base period of 1991, when the sales tax law was enacted. As a result, Miami-Dade County funding for PHT (over and above the sales tax) has also remained steady and substantial over the 1993–97 period (see table 11). More recent data obtained from Miami-Dade County show that this financial commitment is rising—to an estimated $89.4 million in 1998 and a projected $92.3 million in 1999 (Miami-Dade 1998a, p. 9).

### Table 11  Revenues and Expenses: Jackson Memorial Hospital, FY 1993–FY 1997
(in millions of dollars)

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<th>Budget Categories</th>
<th>FY 92–93</th>
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<th>FY 94–95</th>
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<tr>
<td>Total Operating Expenses</td>
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<td>717.3</td>
<td>744.5</td>
<td>772.6</td>
<td>781.4</td>
</tr>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>465.6</td>
<td>475.2</td>
<td>474.8</td>
<td>512.5</td>
<td>532.6</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>69.1</td>
<td>77.3</td>
<td>81.2</td>
<td>90.0</td>
<td>91.9</td>
</tr>
<tr>
<td>Total Operating Revenues</td>
<td>534.7</td>
<td>552.5</td>
<td>556.1</td>
<td>602.5</td>
<td>624.5</td>
</tr>
<tr>
<td>LOSS FROM OPERATIONS</td>
<td>–172.0</td>
<td>–164.8</td>
<td>–188.4</td>
<td>–170.1</td>
<td>–157.0</td>
</tr>
<tr>
<td>Miami-Dade County funding</td>
<td>73.8</td>
<td>77.7</td>
<td>84.2</td>
<td>84.1</td>
<td>77.9</td>
</tr>
<tr>
<td>Sales tax revenue</td>
<td>100.5</td>
<td>97.0</td>
<td>103.9</td>
<td>111.0</td>
<td>112.8</td>
</tr>
<tr>
<td>Other revenue incl. interest income</td>
<td>13.1</td>
<td>10.4</td>
<td>19.0</td>
<td>16.2</td>
<td>22.7</td>
</tr>
<tr>
<td>Total Nonoperating Revenues</td>
<td>187.4</td>
<td>185.1</td>
<td>207.1</td>
<td>211.3</td>
<td>213.4</td>
</tr>
<tr>
<td>EXCESS REVENUES OVER EXPENSES</td>
<td>15.4</td>
<td>20.3</td>
<td>18.7</td>
<td>41.1</td>
<td>56.4</td>
</tr>
</tbody>
</table>

The county’s budget for PHT ($89.4 million) was 11.8 percent of its $761 million countywide operating budget in 1998, as required by law. The county is spending twice this amount on corrections ($192.1 million), which is by far the largest expenditure category in the budget. When outlays for police and courts are included, a total of $291.2 million is allocated to the justice system, law enforcement, and corrections, or 38.2 percent of the county’s total 1998 operating budget (see table 12).

### Table 12 Operating Budgets for Countywide Services, FY 1997–98 and FY 1998–99 (in millions of dollars)

<table>
<thead>
<tr>
<th>Service Area</th>
<th>1997–98</th>
<th>1998–99*</th>
<th>Percent Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>41.3</td>
<td>77.4**</td>
<td>87.6</td>
</tr>
<tr>
<td>Courts</td>
<td>57.8</td>
<td>55.9</td>
<td>-3.3</td>
</tr>
<tr>
<td>Corrections</td>
<td>192.1</td>
<td>196.4</td>
<td>2.2</td>
</tr>
<tr>
<td>Fire, rescue</td>
<td>4.7</td>
<td>5.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Transit</td>
<td>102.3</td>
<td>103.2</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>PHT</strong></td>
<td>89.4</td>
<td>92.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Other</td>
<td>273.0</td>
<td>289.7</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>760.8</td>
<td>819.9</td>
<td>7.8</td>
</tr>
</tbody>
</table>


*Proposed budget.

**Increase primarily a result of a cost allocation review of police services and cost between countywide and unincorporated area budgets.

Property taxes underwrite about 62 percent of Miami-Dade County’s outlays in the communitywide budget, and a mixture of fees, other taxes, and state contributions makes up the rest of the revenue base (see table 13).

### Table 13 Countywide Revenue for FY 1997–98 and FY 1998–99 (in millions of dollars)

<table>
<thead>
<tr>
<th>Source</th>
<th>1997–98</th>
<th>1998–99*</th>
<th>Percent Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property tax</td>
<td>470.6</td>
<td>513.9</td>
<td>9.2</td>
</tr>
<tr>
<td>Fees</td>
<td>58.2</td>
<td>58.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Gas tax</td>
<td>55.6</td>
<td>55.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Carryover</td>
<td>14.7</td>
<td>31.7</td>
<td>115.9</td>
</tr>
<tr>
<td>Interest</td>
<td>8.0</td>
<td>7.0</td>
<td>-12.8</td>
</tr>
<tr>
<td>Misc. state revenue</td>
<td>28.9</td>
<td>34.2</td>
<td>18.1</td>
</tr>
<tr>
<td>Limited-term revenue</td>
<td>50.0</td>
<td>45.0</td>
<td>-10.0</td>
</tr>
<tr>
<td>Sales tax</td>
<td>20.1</td>
<td>20.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Other</td>
<td>54.7</td>
<td>53.2</td>
<td>-2.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>760.8</td>
<td>819.9</td>
<td>7.8</td>
</tr>
</tbody>
</table>

The County Board of Commissioners has been faced with a strict limit on millage rates (the rate of taxation that is applied to property values to generate necessary revenue to pay for services proposed in the budget), which has constrained its capacity to meet rising costs. After remaining steady over the 1991–95 period, the millage rate declined over the 1995–98 period (see figure 8). Because property taxes account for nearly two-thirds of total revenue, this cut in the millage rate has forced certain trade-offs in the overall budget. Over the 1995–98 period, the board adopted an “aggregated roll-back millage-rate” budget in response to perceived citizen concerns about “unneeded bureaucracy and waste.” Millage rate cuts over this period offset the growth in property values, leaving aggregate property tax revenue roughly unchanged. This amounted to a cut in revenues in real terms of an estimated $120 million over three years, relative to revenues that would have been realized if millage rates had been held constant.

![Countywide Millage History](image)

**Figure 8 Countywide Millage History**

With county contributions set at a fixed proportion of the countywide budget and that budget held roughly constant in absolute dollars, the nominal value of the county’s contribution to Jackson has remained roughly constant—so the inflation-adjusted contribution has edged down slightly. Nevertheless, compared with the situation faced by most other public hospitals, the dual sources of county revenues have been very stable over time, and this stability occurs at a very high level of effort.

**Federal and State Support**

Jackson is also the recipient of federal and state government support, but these contributions are not nearly as large as county payments. The principal source of federal/state support for serving uninsured patients is the DSH component of the Medicaid program. Three counties in Florida—Dade, Duvall,
and Hillsborough—put up 92 percent of the money that the state of Florida uses to obtain a federal match under DSH. These county contributions amounted to about $90 million in 1998. Jackson contributed about $60 million of this amount. Of the total amount the state received in federal DSH money, Jackson received $92 million back in 1998. Thus, by “putting up” $60 million, Jackson realized a net return of $32 million, as the state leveraged the local contributions to obtain the federal match.

DSH payments have been a secure source of revenue for Jackson, even though the amount has bounced around somewhat from year to year in the 1990s. Yet DSH payments, at a little more than $30 million a year, are less than one-sixth of the combined revenue that Jackson receives from the two stable sources of county revenues described above.

Another source of both federal and state funding involves payments for graduate medical education (GME). Federal GME contributions are embedded in Medicare diagnosis-related group (DRG) rates. Thus, Jackson’s Medicare revenues are higher than they would otherwise be. State GME outlays are separate payments, totaling $6.2 million in 1998, and are included in the category “other revenue incl. interest income” in table 11.

Local Contributions to the State

While the state of Florida is contributing to indigent care through DSH and GME payments, it is also collecting money from local sources in two ways. First, PHT contributes directly to the Florida Medicaid program to help it meet its match requirements. In 1998 this contribution was $10 million, but the proposed 1999 county budget calls for this amount to triple to $30 million. If this occurs, the net return from DSH received by Jackson in 1998 would be roughly offset.

In addition, the state of Florida imposes a 1.5 percent tax on hospitals throughout the state. The state has used the proceeds of this tax to draw down a federal match for the purpose of financing Medicaid expansions (e.g., covering people with household incomes above the levels federally mandated). The rationale for the tax is that providers will gain from such Medicaid expansions by seeing relatively fewer charity patients.

Thus, when funding flows between the state and Jackson in both directions are “netted out,” the state does not appear to be making a significant direct contribution to the indigent care load. Instead, Florida has chosen to help localities, such as Miami-Dade County, with a high indigent care load both by expanding Medicaid and by operating the state’s own children’s health program.

Florida Healthy Kids is a school-based program established in 1992. Healthy Kids provided coverage to an estimated 60,000 children in 1998. Under the state’s approved CHIP program, the coverage has been expanded statewide to children in families with incomes up to 185 percent of the federal poverty level, with
sliding-scale family contributions to the premium cost. Under a 1998 proposal, coverage would have expanded further to include children in families with incomes up to 200 percent of the federal poverty level (Bruen and Ullman 1998).

Discussion

Jackson has unusually secure sources of external funding to cover an operating loss that is relatively small to begin with, at about 25 percent of expenses. Some public hospitals are covering a much smaller proportion of operating costs with internal revenue sources (e.g., about half) and must rely on much more discretionary and volatile sources of external funding to cover the larger shortfall.

The Threat from Medicaid Managed Care

The main source of uncertainty for Jackson at this point is the threat of losing Medicaid revenues as a result of the push to enroll beneficiaries in managed care—which often leads to more enrollees receiving care from private providers. Jackson’s Medicaid revenues fell steadily over the 1993–96 period but recovered in 1997. Yet this source of funds remains substantially below the 1993 level (see table 14). Not only has Florida moved the majority of its Temporary Assistance for Needy Families population (i.e., younger adults and children) into Medicaid managed care, but the state has been among the leaders nationwide in moving elderly and disabled Medicaid enrollees into managed care. An estimated 205,000 nonelderly people with disabilities were in Medicaid managed care in Florida in 1998, or 66.4 percent of the total caseload of nonelderly persons with disabilities. This is the largest number of nonelderly people with disabilities enrolled in Medicaid managed care of any of the states.

Until recently, about two-thirds of Florida’s Medicaid managed care caseload has been in primary care case management (PCCM) models, under which a primary care physician is paid a small fee to manage the care of the patient and try to ensure that use of such resources as specialists or diagnostic tests is appropriate. This is a substantially lighter form of managed care than HMOs are

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Medicaid Revenues (in millions of dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>182.4</td>
</tr>
<tr>
<td>1994</td>
<td>162.6</td>
</tr>
<tr>
<td>1995</td>
<td>156.8</td>
</tr>
<tr>
<td>1996</td>
<td>140.4</td>
</tr>
<tr>
<td>1997</td>
<td>153.8</td>
</tr>
</tbody>
</table>

Source: Jackson Memorial Hospital.
and is much less likely to change patients’ patterns of using the health care system. Florida is shifting this balance between PCCM and HMO models of managed care in the direction of HMOs. As this shift occurs, it holds the potential to shift more patients away from Jackson toward lower-cost facilities.

The Challenge of Achieving an Efficient, Communitywide Strategy

Although the stability of the financing of the health care safety net in Miami-Dade County is not in any serious jeopardy, some controversy exists over the way the funding is distributed. The solution to the indigent care problem selected by Miami-Dade County represents one end of a continuum, in which the government starts by ensuring that existing safety net providers are adequately funded, with the main focus on the hospital. At the other end of the spectrum, government starts with an inventory of community public health needs—and available dollars from all sources—and figures out what mix of providers can best meet those needs.

Critics of the Miami-Dade County approach make two arguments. First, the community will achieve better health outcomes and more bang for the buck if no one provider has an “entitlement” to the money. When the county makes clear that it will underwrite a specific provider’s revenue shortfall, according to this view, the likelihood is reduced that this provider will take the necessary and sometimes painful steps to reduce costs and improve its management. Any inefficiencies that such a provider generates can be “frozen in” by funding that is not made contingent upon management reforms.

Second, a cost-effective health care strategy features early intervention, outreach, and primary care. Thus, the logical starting point, according to this argument, is to put together a communitywide strategy to improve public health first and then determine which providers can help achieve the goals. In Miami-Dade County, this would mean that Jackson, in effect, would have to compete for funds by responding, along with other institutions, to a request for proposals (RFP) developed by the county. Jackson would have to make its case for how it would help Miami-Dade County fulfill its public health goals. This RFP would challenge providers to develop outreach strategies reflecting the fact that many of the most vulnerable residents of Miami-Dade County live in remote areas of the county, where distance to a doctor’s office or clinic, combined with a lack of public transportation and language problems, are significant barriers to care. Although Jackson Memorial runs a network of clinics and is involved in community outreach, as described below, critics note that Jackson still is not reaching certain remote areas of Miami-Dade County.

Miami-Dade County has programs designed to address access barriers and public health threats, and it receives a small amount of funding from PHT to assist with these initiatives. This funding currently is an annual grant of less than half a million dollars a year, which is a small fraction of the PHT budget. Although funding for PHT continues to expand, many of the public health ini-
tiatives operated by the Miami-Dade County Health Department are running on a budget that is relatively small and that has been subjected to stringent limits in recent years. In addition, although the county historically has funded community health activities, last year it decided that Jackson should take over those responsibilities. Thus in 1997, Jackson dedicated $1.5 million of its revenues to community health activities. And, of the $89.4 million in PHT funding targeted to Jackson Memorial in 1998, about $5 million flowed to two Jackson-run health clinics, CHI-South Dade and North Dade Primary Care (Miami-Dade 1998a). Therefore, Jackson is contributing to the community’s public health needs in several ways—management of clinics, a grant to the county health department, and community outreach. At issue is whether additional efforts to redirect funding and develop new primary and preventive care strategies should be considered.

The Challenge of Providing Access to Care on an Equitable Basis

In addition to arguments over the efficiency of Miami-Dade County’s indigent care financing strategy, there are concerns about the equity of this approach. The largest source of revenue for charity care in Miami-Dade County is a sales tax, which, as noted earlier, is a regressive approach to financing. Moreover, because Florida, like most states, lacks a mechanism for financing indigent care for all in need across the state, each county is left to its own devices. This creates inequities across the state as families that are similarly situated are treated differently from one county to another.

Substantial differences exist in access to care for many lower-income households ineligible for Medicaid across Florida’s counties. Access to care for these households will depend on such factors as the generosity of local taxpayers and the priorities placed on indigent health care, vis-à-vis such needs as law enforcement and transportation. Thus, while Miami-Dade County has chosen to step up and tax its residents to meet the health care needs of the indigent, at least for hospital care, other counties with substantial indigent care burdens leave proportionally more of their residents without access.
Conclusion

The study’s preliminary conclusion, based on these three sites, is that the system of providing hospital care to the lower-income population is neither disastrous, as some claim, nor fully viable and secure, as others maintain. The safety net hospitals in these three sites are resourceful and resilient. They have weathered some rough storms and remained afloat. They are able to patch holes and make needed repairs in the system of providing services to needy populations.

Nevertheless, the concern about the adequacy of the safety net is not misplaced. In two of the three study sites, safety net hospitals are running operating deficits that are likely to cause some major problems in the future. In Harris County, DSH money stockpiled from prior years has been drawn down to make ends meet, but this stock is dwindling. In Alameda County, operating deficits are relatively small, but they are persistent. The county’s willingness up to now to restructure the hospital’s debt or roll it over to the next year is a helpful palliative but not a long-term cure. In Miami-Dade County, the hospital is running a surplus and faces no near-term fiscal crisis. Yet even this hospital’s Medicaid revenues are on a downward trend, as enrollment of Medicaid patients in managed care draws these patients to other institutions. Moreover, the county supervisors are subject to pressure from voters for tax reductions. Although so far there has been no move to lower the sales tax or alter the maintenance-of-effort requirement, pressure to meet other local needs may lead voters to reconsider their support of the hospital system in the future.

Another threat emerges from the combination of ongoing, if not rising, needs of the lower-income population and an increase in the number of uninsured. Hospitals in each of the sites are grappling with meeting the needs of a substantial population of recent immigrants, AIDS patients, and the homeless.
And it is possible that changes in welfare rules (e.g., time limits on coverage) will lead, in a series of steps, to a reduction in Medicaid coverage. A slight decline in Medicaid enrollment is already detectable nationwide.

An economic downturn would exacerbate the financial problems of safety net hospitals. In Miami-Dade County, for example, the principal source of funding for Jackson Memorial Hospital is a local sales tax. Revenues from this source would fall automatically in a recession. Property taxes might also be affected by an economic downturn, although the relationship is less direct.

The study’s tentative conclusion, hedged by the limited sample of localities covered, is that while safety net hospitals are bumping along and surviving so far, they are not well positioned for an uncertain future. Their base of paying patients is dwindling, and their reliance on subsidies to cover operating deficits is rising. Their success will be determined in large measure by the political skills of their leaders in coaxing local authorities to make up the revenue shortfall, as well as their business management skills needed to help bring costs in line with revenues.

This analysis highlights the need to look beyond a hospital’s current-year budget to the future implied by recent trends. An examination of the most recent annual budgets in the three institutions studied reveals that two health care delivery systems are running net losses and one is running a healthy surplus. The small losses in one system, Alameda County, are accumulating year by year and will eventually have to be addressed. In another system, Harris County, the losses are being covered by cash reserves, but the trend shows that annual losses are growing and cash reserves will be depleted in a few years if no corrective action is taken.

Looking ahead to the next few years, public safety net hospitals will be forced to make some very tough choices and to undergo some important transformations. First, they must position themselves to be included in managed care networks. This will require both a sharpening of their skills as contract negotiators and a demonstration of long-term cost control. The latter may necessitate the type of effective management of emergency department use that remains difficult for some hospitals with large indigent populations.

Second, safety net hospitals may need to take some unpleasant steps that they understandably hope to avoid. These include charging more than nominal fees for certain services, which could make it very difficult for some patients to afford them, as well as cutting back on some services that are not financially viable.

In summary, widespread closures of safety net hospitals are not likely in the near future. Terms such as “dire” and “drastic” do not seem appropriate, based on this preliminary assessment. Yet complacency is also unwarranted, and safety net institutions do not appear to be on a stable or secure long-term path. A number of important threats to their financial viability are looming.
In each of the study sites, local officials are struggling to find a balance between the extremes of letting safety net providers fail and underwriting their costs regardless of their efficiency. The prevailing mood seems to be one of structuring and adjusting subsidies in a way that holds these providers accountable for cost and quality while at the same time recognizing that they are not playing on a level field because of their high incidence of nonpaying patients. As efforts to strike this balance play out over the next several years, there will be some painful adjustments, some ongoing access problems, and a few casualties among the providers.
References


Notes

1. Urban Institute unpublished data, 1998, based on Health Care Financing Administration (HFCA) 2082 and HCFA 64 data. These figures do not include disproportionate share hospital (DSH) dollars.


3. The Harris County judge appointed a 12-member task force charged with the preparation of a long-range plan for HCHD. The work of the task force was carried out by study groups, composed of more than 100 stakeholders and experts. The County Budget Office recently reviewed the work of the task force study groups, and in the fall of 1998 it developed an initial set of recommendations for consideration by the County Commissioners’ Court and the HCHD board of directors.

4. The countywide budget consists of four parts, the largest of which is the communitywide budget. The communitywide budget funds all services except for fire and library services in the incorporated sections of the county. The three remaining sections of the countywide budget cover fire services, library services, and services provided to unincorporated municipal service areas (UMSAs). Each of these budgets is funded by its own property tax component—there is a separate millage rate for each one. Miami-Dade County provides police, parks, public works, and other services to these areas that are not part of any municipality—and this amounts to a population of more than 1 million people, or more than in any city in Florida. In effect, the taxpayers of the incorporated areas are paying for services to a cluster of areas that, taken together, are the size of the cities of San Diego and Dallas. The proposed 1999 budget, reflecting this concern, calls for a 15.7 percent cut in the millage rate that supports the UMSA (in contrast to a request for a 7.8 percent increase in the countywide budget). The total combined millage rate in 1998 is 11.672, below the 1994 peak of 12.374.
The Economic and Social Research Institute (ESRI) is a nonprofit, nonpartisan organization in Washington, D.C., that conducts research and policy analysis in health care and social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.
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