PACIFIC HEALTH CONSULTING GROUP

72 Oak Knoll Avenue
San Anselmo, California 94960

Phone 415-459-7813 • Fax 415-459-1541
bwunsch@pachealth.org

# Medi-Cruz

## An Evaluation of Santa Cruz County's Program for Medically Indigent Adults

**Prepared for the**
**Santa Cruz County**
**Health Services Agency**

**By**

**Tim Reilly, MA**
**Pacific Health Consulting Group**
**September, 2005**

***This report was funded by the California HealthCare Foundation***

PACIFIC HEALTH CONSULTING GROUP

72 Oak Knoll Avenue
San Anselmo, California 94960

Phone 415-459-7813 • Fax 415-459-1541
bwunsch@pachealth.org

# Medi-Cruz

## An Evaluation of Santa Cruz County's Program for Medically Indigent Adults

## TABLE OF CONTENTS

Executive Summary ..... i

1. Introduction ..... 1
2. Medi-Cruz Program Overview ..... 2
3. Medi-Cruz Program Demographic Data ..... 3
4. Medi-Cruz Program Expenditures ..... 6
5. Review of Medi-Cruz Program Operations ..... 9
6. Similar Medically Indigent Programs in Other California Counties ..... 13
7. Opportunities and Challenges ..... 17
8. Recommendations ..... 21

Attachments ..... 23

Attachment I: Primary Care Clinic List

Attachment II: Indigent Health Care in Santa Cruz: The County Medical Services Program (CMSP) Option

Attachment III: California HealthCare Foundation County Indigent Studies

Attachment IV: Hospital Charity Care Guidelines

PACIFIC HEALTH CONSULTING GROUP

72 Oak Knoll Avenue
San Anselmo, California 94960

Phone 415-459-7813 • Fax 415-459-1541
bwunsch@pachealth.org

# Medi-Cruz

## An Evaluation of Santa Cruz County's Program for Medically Indigent Adults

### Executive Summary

The Santa Cruz County Health Services Agency retained the Pacific Health Consulting Group to perform an "audit" of its program for medically indigent adults referred to as "Medi-Cruz." The goal of the Medi-Cruz program is to provide eligible clients access to medically necessary services within the limits of the available County funds. The Medi-Cruz program clients are eligible adult residents of Santa Cruz County whose income does not exceed two hundred percent (200%) of the federal poverty level (FPL) income guidelines and who do not qualify for other public health care insurance programs, like Medi-Cal. The report that follows is an assessment of the major program elements, including an analysis of pertinent program data. The assessment considers how the County can optimize the care given to adult indigents given the availability and use of existing financial resources.

The "audit" found the basic structure of the Medi-Cruz program to be sound. Eligibility criteria, and benefits and exclusions under Medi-Cruz are consistent with similar county indigent programs elsewhere in the state.

Medi-Cruz program expenditures have shown only a slight growth over the last eight years. However, in reviewing the annual expenditures by type of provider, several trends are clear. Physician payments are declining as a percent of total health care expenditures. Hospital payments, particularly for outpatient services, are steadily increasing over time. This increase is directly related to the Medi-Cruz contract which includes the practice of reimbursing outpatient hospital services at a percent of billed charges. This is significantly above the reimbursement level adopted by similar county adult indigent programs elsewhere in the state.

The Medi-Cruz program is administered in a manner consistent with other county programs. However, if the goal is to maximize the use of current funding levels, the adoption of more sophisticated management techniques is necessary. Medi-Cruz program staffing has been downsized in recent years, jeopardizing its effective operation and development of needed administrative capability. However, it may not be feasible for a program the size of Medi-Cruz to support the administrative structure

necessary for effective management based on standards followed in the managed care insurance industry.

The management of a complex health care program requires sophisticated management expertise, effective information systems, well-articulated policies and procedures, and a trained staff. Most managed care companies struggle daily trying to meet these needs.

Based on the results of the assessment, we make the following recommendations:

**Recommendation #1** – Institute new provider reimbursement policies that are in line with the early diagnosis and treatment of clients and overall program financial prudence. Payment policies should be modified to encourage specialty physician participation (See Recommendation #4) and reduce expenses for hospital outpatient care. Consistent with this recommendation, payment policies which are linked to charge levels should be eliminated. A preferred policy would involve either fixed reimbursement rates or rates linked to some percentage of a recognized physician fee schedule like that of Medicare. It is recommended that the hospitals be paid at Medi-Cal rates for all services.

**Recommendation #2** - Expand administrative capabilities either by internal investment or through external partnerships. Features such as improved and integrated claims processing, utilization review, and tracking performance according to a consistent set of indicators, and taking corrective action on operating deficiencies are particularly important. Potential outside partners such as local managed care organizations should be approached to explore the possibilities.

**Recommendation #3** – Implement an intensive case management program for the 50 highest cost indigent client users of the program. All efforts should be made to coordinate the client's services and to manage their appropriate use of all services. Partnering with others to perform this function should be explored. Alternatively, the intensive case management program would require the redeployment of staff to this effort or the creation of at least 1.0 FTE new position. Nursing resources with case coordination or utilization review experience would be appropriate for this position. Capacity is needed 7 days per week at both hospitals for 2-3 hours per day.

**Recommendation #4** – Assess community, particular Hospital, recruitment efforts to ensure that needed physician specialists are recruited on a timely basis with contract obligations to provide indigent care. Reinvest funds saved from reforming hospital outpatient rates reform to institute rate increases and stipends for specialists.

**Recommendation #5** – Increase efforts to get other health insurance coverage, primarily Medi-Cal, for potential Medi-Cruz clients. The County Health Services Agency needs to partner with County Social Services Agency (SSA) to maximize outreach and enrollment resources, and increase their effectiveness in finding coverage for this

population. One measure to consider is adding a bilingual benefit advocate for SSI to South County

**Recommendation #6** – Monitor the State Hospital Financing Waiver. The State could be required to use $540 million of the $900 million of the waiver funding to provide healthcare coverage to the uninsured. The federal government has requested that the State include additional funds, over and above the $540 million, from other sources in the Pool for coverage expansions. This could be accomplished by using programs and services currently provided by public hospitals and clinics. It is not clear at this time how this will develop. However, it could present an opportunity to match existing Medi-Cruz funds with federal dollars to expand indigent services.

**Recommendation #7** – Explore the availability of new and alternative funding streams that may be adapted for use in Santa Cruz County. Flat and declining traditional revenue streams are clouding the future of programs to serve medically indigent adults regardless how efficiently programs can be managed. Other California counties and other public entities have studied and, in some cases, actively pursued innovative revenue generating measures such as tax-based arrangements through special districts, designated voter ballot propositions, and others.

This report was funded by the California HealthCare Foundation (CHCF). CHCF's Public Financing and Policy Program works to create solutions to problems in publicly funded health care and safety net programs.

PACIFIC HEALTH CONSULTING GROUP

72 Oak Knoll Avenue
San Anselmo, California 94960

Phone 415-459-7813 • Fax 415-459-1541
bwunsch@pachealth.org

# Medi-Cruz

## An Evaluation of Santa Cruz County's Program for Medically Indigent Adults

## 1. Introduction

The Santa Cruz County Health Services Agency retained the Pacific Health Consulting Group to perform an "audit" of its program for medically indigent adults referred to as "Medi-Cruz." The report that follows is an assessment of the major program elements, including an analysis of pertinent program data. The assessment considers how the County can optimize the care given to indigents given the availability and use of existing financial resources.

As the health care needs of the indigent population have changed and the diagnostic and treatment requirements have become more complicated, the cost to pay for health care services has increased significantly. Medi-Cruz program has operated with essentially flat State funding since 1983. Consequently, the program is under constant pressure to find ways to serve the medically indigent adult population without the expectation of added funding. This report reflects on ongoing effort by Santa Cruz County to make the Medi-Cruz program more efficient and effective. This assessment considers how the County can optimize the specialty and hospital care given to indigents given the availability and use of existing financial resources.

The focus of this report is on specialty and hospital care provided by providers under the Medi-Cruz program. Problems in access to specialty care are an on-going problem that is recognized by all involved, while primary care access is generally considered good.

Primary care services for uninsured adults which are provided by County and community Safety Net clinics. (See Attachment I for a list of community clinics that provide access to care for the uninsured.) These clinic services are not directly supported by the Medi-Cruz program. The clinics provide primary care for individuals under 200% of the Federal Poverty Level and use Medi-Cruz only for specialists and hospital care.

Other health care related services such as drug and alcohol related services, provided to the medically indigent adults through programs separate from Medi-Cruz, are outside the scope of this assessment.

This report was funded by the California HealthCare Foundation (CHCF). CHFC's Public Financing and Policy Program works to create solutions to problems in publicly funded health care and safety net programs. See www.chcf.org/programs/ for more information about CHCF and its programs.

## 2. Medi-Cruz Program Overview

Pursuant to its obligations under Section 17000 of the California Welfare and Institutions Code, Santa Cruz County uses the Medi-Cruz program to administer and arrange for the provision of health care services to medically indigent adult residents of the County. While Medi-Cruz funds most health services for indigents, other separate sources provide funding for emergency medical care and services for the homeless which target the medically indigent population. Additionally, Medi-Cruz provides fiscal intermediary services to other programs and departments that obtain health care services from the private sector, e.g. the Sheriff's Department for jail patients.

The goal of the Medi-Cruz program is to provide eligible clients access to medically necessary services within the limits of the available County funds. The Medi-Cruz program clients are eligible adult residents of Santa Cruz County whose income does not exceed two hundred percent (200%) of the federal poverty level (FPL) income guidelines and who do not qualify for other public health care insurance programs, like Medi-Cal.

Since Medi-Cruz began in 1983, it has been focused on paying for episodic medical needs of qualified individuals. Patients must have a presenting medical need to qualify for Medi-Cruz. Some medically indigents actually first 'enter' the Medi-Cruz program through the hospital emergency room as uninsured patients with an acute illness or trauma. If the patient applies and is eligible for coverage, Medi-Cruz pays for emergency outpatient services and the medically necessary inpatient care. However, most Medi-Cruz clients apply for coverage to access outpatient care in county-operated clinics located in Santa Cruz and Watsonville. Medi-Cruz also covers for medically necessary specialty consultations, tests, and scheduled hospitalizations and treatments. Medi-Cruz relies on County Clinics for primary care and a network of private community physicians and other providers for all specialty care. Other safety net clinics (Attachment I) also provide primary care for individuals under 200% of the Federal Poverty Level and use Medi-Cruz only for specialists and hospital care.

The Medi-Cruz program is exposed to financial risk under a set budget that faces the ongoing yearly strain of increasingly strict program limitations. State funding for Medi-Cruz has remained constant at $4.2 million per year since 1983. Meanwhile, County general funds for this program have increased from $500,000 to $1.2 million over the past 20 years.

The County has been exploring options to address two critical problems facing the Medi-Cruz program: financing and access to care. In CY 2004 the County commissioned a study, entitled, "Indigent Health Care in Santa Cruz County," to explore joining the County Medical Services Program (CMSP). (See Attachment II)) This is a program through which the smallest thirty-four California counties uniformly administer their Indigent programs. See Section 6 for more details about this program. The study concluded that based on current CMSP Board policy, Santa Cruz County might have to increase its current financial contribution level by as much as $14,000,000 annually to join. This would be in addition to a one time "buy-in fee" that also amounted to 14 million dollars. The CMSP program itself is undergoing its own ongoing evaluation and search for alternative methods to improve access and restrain cost increases. CMSP expenses have been rising at significant rates during the last several years. Santa Cruz County has concluded that joining the CMSP is not a viable option at this time.

Meanwhile, Santa Cruz County has instituted a number of changes over the last several years to improve the program. In order to remain fiscally solvent through two decades of no growth budgets, the Medi-Cruz program has become progressively more restrictive. The income cap on eligibility has been lowered to 200% of the federal poverty level. The maintenance need level has not been increased in fifteen years and stands at $600 for a single individual. This is a state-determined amount used by Medi-Cal, and adopted by Medi-Cruz, judged necessary for subsistence existence and used to establish the point at which a share of cost must be paid. A six-month residency requirement has been implemented to qualify for specialty and inpatient services. Non-married partners of applicants have their income included in the eligibility determination. Benefits have been reduced. Dental services were eliminated. Restrictive caps are in place for physical therapy. The medical directors review all specialty referrals from clinics. A medical review board must approve non-emergency surgeries and medical equipment purchases and rentals.

These efforts have been effective in limiting overall expenditures. However, there is continued financial pressure that is limiting access to specialty services.

## 3. Medi-Cruz Program Demographic Data

Medi-Cruz program demographic data for the period, July, 2003—June, 2004, are presented below. Data is also available on the number of patients that used services on a monthly basis from FY 1996-96 through FY 2000-01. Both of these data sets provide a profile of the client population and services that they use.

According to recent data from the Medi-Cruz program, during FY 03-04 there were 1,200 people receiving services through the program. According to program staff on average there are about 1,100 monthly eligibles for the program. In most months there were over 700 patients receiving direct care.

The most recent data available is from Medi-Cruz Registration files and provides demographic measures on the Medi-Cruz. There were 1,200 people who were registered in Medi-Cruz at some point in FY 2004-05. Fifty-three percent of the people were male while forty-six percent were female. (See Table 1.)

**Table 1**
**Unduplicated Medi-Cruz Patients**
**By Sex**
**July 2004 – June 2005**

| Sex/Eligibles | Count | Percent |
|---|---|---|
| **Male** | 642 | 53% |
| **Female** | 558 | 47% |
| **Total** | 1,200 | 100.0% |

*Source: Medi-Cruz Registrations.*

The average age for program registrants was 45 years old; the average male was 43 and the average female was 47 years old. The largest age band of female patients was 55-64 year olds, while the largest band for the males was 44-54. (See Table 2.)

**Table 2**
**Medi-Cruz Patients**
**By Age and Sex**
**July 2004 – June 2005**

| Age Band | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| | *Patients* | *Percent* | *Patients* | *Percent* | *Patients* | *Percent* |
| **18-34** | 142 | 25.4% | 201 | 31.3% | 343 | 28.6% |
| **35-44** | 82 | 14.7% | 123 | 19.2% | 205 | 17.1% |
| **45-54** | 143 | 25.6% | 207 | 32.2% | 350 | 29.2% |
| **55-64** | 147 | 26.3% | 97 | 15.1% | 244 | 20.3% |
| **> 64** | 44 | 7.9% | 14 | 2.2% | 58 | 4.8% |
| **Total** | 558 | 100.0% | 642 | 100.0% | 1,200 | 100.0% |

*Source: Medi-Cruz Registrations.*

The population was primarily English speaking with almost 64% of the total having English as their primary language. Spanish was second with almost 36%. (See Table 3.)

**Table 3**
**Medi-Cruz Patients**
**Primary Language**
**July 2004 – June 2005**

| Language | Count | Percent |
|---|---|---|
| **English** | 761 | 63.9% |
| **Spanish** | 425 | 35.7% |
| **Other** | 4 | 0.0% |
| **Total** | 1,190 | 100.0% |

*Source: Medi-Cruz Registrations.*

Over eighty-sex (86) percent of the population was at 100% of the Federal Poverty Level (FPL) or below. (See Table 4.)

**Table 4**
**Medi-Cruz Patients**
**Patient by % FPL**
**July 2004 – June 2005**

| % FPL | Count | Percent |
|---|---|---|
| **100% & below** | 1,041 | 86.8% |
| **101-150%** | 58 | 4.8% |
| **151-199%** | 16 | 1.3% |
| **> 200%** | 12 | 0.0% |
| **Blank** | 73 | 6.1% |
| **Total** | 1,200 | 100.0% |

*Source: Medi-Cruz Registrations.*

There has been a modest growth in the average number of users per month, according to Medi-Cruz data reported for the past several years. (See Table 5.)

**Table 5**
**Medi-Cruz Patients**
**Annual Average Monthly Service Users**
**June 1995 – July 2002**

| Users/FY | 1995-1996 | 1996-1997 | 1997-1998 | 1998-1999 | 1999-2000 | 2000-2001 | 2001-2002 |
|---|---|---|---|---|---|---|---|
| **Average Monthly Count** | 627 | 635 | 628 | 651 | 650 | 705 | 709 |

*Source: Medi-Cruz Utilization Data Files.*

## 4. Medi-Cruz Program Expenditures

Medi-Cruz program expenditures have shown only a slight growth over the last eight years. For example, expenditures under Medi-Cruz for specialty care and hospital inpatient and outpatient services have been relatively stable for years. Reductions in the program discussed above have contained aggregate growth in expenses for the program. (See Table 6.)

(With respect to primary care services, Medi-Cruz capped payments to the two county operated health centers several years ago at $1.4 million. This figure was not adjusted for several years and was eventually incorporated into the clinic budget. So Medi-Cruz no longer makes payments to the county clinics except for orthopedic services which are paid on a fee for service basis at the same rates paid to other community specialists. The transfer of funds to the clinics has made the increased cost of providing primary care a problem outside of the Medi-Cruz budget, although ultimately, all programs within the Health Services Agency compete for scarce county dollars. Pharmaceutical costs were included with the transfer of funds to the clinics. So importantly, the growth of pharmaceutical costs, which could have had a significant potential impact on Medi-Cruz program costs, have also been shifted to County's clinic budget.)

**Table 6**
**Medi-Cruz Expenditure Trends**
**For Specialty & Hospital Services**
**July 1996 – June 2003**

| | 1996-1997 | 1997-1998 | 1998-1999 | 1999-2000 | 2000-2001 | 2001-2002 | 2002-2003 |
|---|---|---|---|---|---|---|---|
| **Annual Expenditures** | $3,529,229 | $3,282,387 | $3,463,218 | $3,544,627 | $3,520,107 | $4,216,904 | $3,544,965 |

*Source: Medi-Cruz Expenditure Data Files.*

Data on Medi-Cruz program annual expenditures by type of provider reflects that while overall expenditures vary little, there have been obvious shift in expenditures from one provider type category to another. Physician payments are declining as a percent of total dollars expended. Hospital payments, particularly for outpatient services, are steadily increasing over time. (See Table 7 and Chart 1.)

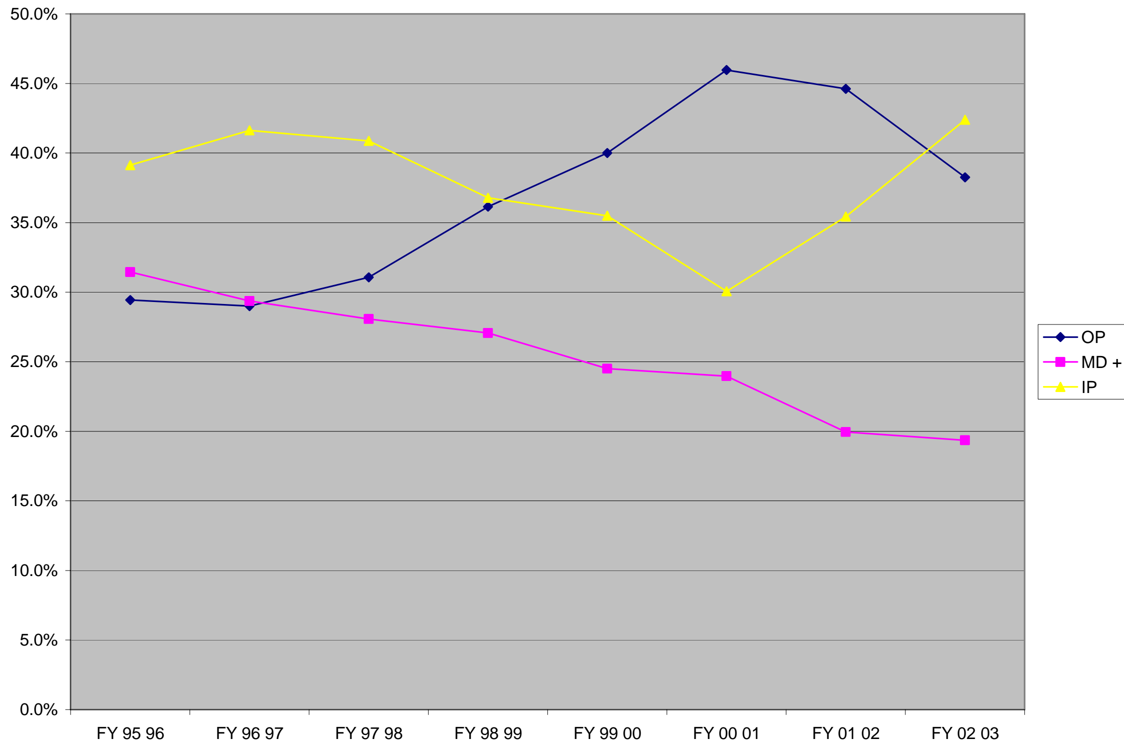
**Table 7**
**Medi-Cruz Expenditure Trends**
**By Health Care Provider Type**
**July 1995 – June 2003**

| | Physician+ | Inpatient | Outpatient | Total |
|---|---|---|---|---|
| **FY 95 96** | $ 1,032,596 | $ 1,284,775 | $ 966,592 | $ 3,283,963 |
| **FY 96 97** | $ 1,036,595 | $ 1,469,075 | $ 1,023,559 | $ 3,529,229 |
| **FY 97 98** | $ 921,190 | $ 1,341,490 | $ 1,019,707 | $ 3,282,387 |
| **FY 98 99** | $ 937,366 | $ 1,274,200 | $ 1,251,652 | $ 3,463,218 |
| **FY 99 00** | $ 868,567 | $ 1,257,955 | $ 1,418,105 | $ 3,544,627 |
| **FY 00 01** | $ 843,625 | $ 1,058,240 | $ 1,618,242 | $ 3,520,107 |
| **FY 01 02** | $ 841,244 | $ 1,493,960 | $ 1,881,700 | $ 4,216,904 |
| **FY 02 03** | $ 686,059 | $ 1,502,930 | $ 1,355,976 | $ 3,544,965 |

*Source: Medi-Cruz Expenditure Data Files.*

In FY 1995-96, physician services were slightly more expensive than hospital outpatient services By FY 2002-03 hospital outpatient services were twice as expensive as physician. There is a steady increase in the expenditures at Dominican (DSCH) and Watsonville (WCH) hospitals, while at Sutter (SMSC) and all other hospitals have remained relatively stable.

**Chart 1**
**Medi-Cruz Expenditures**
**By Health Care Provider Type**
**July 1995 – June 2003**




There is a steady increase in expenses at both Dominican and Watsonville hospitals. The increase is increasing at a faster rate in the later years. The expenses at Dominican Hospital rose 146%, while those at Watsonville Hospital rose 121% during this period. In theory the accelerating rate of increase could be due to increased utilization of services, rising cost per service, or a combination of both. From the available data it appears that the number of services has not increased over time. A significant portion of the increase is due to increases in payments per service. Payments for emergency room visits nearly tripled from $332 per visit in FY 94-95 to $961 in FY 02-03. A large portion of that increase can be attributed to the ancillary service component. (See Table 8.)

**Table 8**
**Medi-Cruz**
**Hospital Outpatient Expenditures**
**By Hospital**
**July 1995 – June 2003**

| | DSCH | WCH | SMSC | OTHERS | TOTAL |
|---|---|---|---|---|---|
| **FY 1995- 1996** | $ 408,335 | $ 336,601 | $ - | $ 112,262 | $ 857,198 |
| **FY 1996- 1997** | $ 446,979 | $ 389,961 | $ 6,370 | $ 123,282 | $ 966,592 |
| **FY 1997- 1998** | $ 450,167 | $ 394,959 | $ 34,519 | $ 143,914 | $ 1,023,559 |
| **FY 1998- 1999** | $ 455,317 | $ 407,942 | $ 44,106 | $ 112,342 | $ 1,019,707 |
| **FY 1999- 2000** | $ 560,040 | $ 539,413 | $ 36,565 | $ 115,634 | $ 1,251,652 |
| **FY 2000- 2001** | $ 508,288 | $ 776,850 | $ 27,762 | $ 105,205 | $ 1,418,105 |
| **FY 2001- 2002** | $ 617,067 | $ 847,473 | $ 28,769 | $ 124,933 | $ 1,618,242 |
| **FY 2002- 2003** | $ 1,003,500 | $ 743,000 | $ 11,200 | $ 124,000 | $ 1,881,700 |

*Source: Medi-Cruz Expenditure Data Files.*

## 5. Review of Medi-Cruz Program Operations

In reviewing a health care program, there are a number of factors that need to be addressed. The goal of any health care program should be to provide the necessary services to the target client population. Is the program operating effectively and efficiently? Are the medical needs of the clients being met? Are funds being spent wisely? These questions are pertinent when considering public program aimed at serving a vulnerable and often underserved population. This section generally looks at the operations of the Medi-Cruz program in light of effectiveness and efficiency through:

- Eligibility;
- Benefits/Services;
- Provider Fee Schedules;
- Member and Provider Incentives;
- Service Authorization Requirements;
- Member Case Management; and
- Program Administration

**Eligibility** - According to program documents the primary eligibility criteria for this program is that the patient must be between 21-64 years of age, and have a medical need, be a resident of Santa Cruz County, and have an income below 200% of the Federal Poverty Level (FPL). Prospective eligibles must also not be covered by an existing health insurance program, such as Medi-Cal. The Medi-Cruz program staff does verify these key elements. These eligibility requirements are consistent with most similar county indigent health programs. The major difference between the counties is

that some require proof of legal residence. Medi-Cruz Cruz covers undocumented residents of Santa Cruz County. See the next section for more detailed comparisons.

Stricter FPL requirements would result in fewer eligibles, and probably fewer expenses, but since the vast majority (87%) of the Medi-Cruz clients were at 100% of FPL or below, it must be assumed that there is no significant room for improvement in cost containment in the FPL eligibility requirements. However, for the purposes of this analysis, there was no data on the costs to the program stratified by FPL. It is possible that a disproportionate share of Medi-Cruz expenditures are attributable to the 13% of the client population above 100% of the FPL.

Medi-Cruz must continue its efforts to get patients on to other available public insurance programs, where possible. Exploring Medi-Cal coverage will continue to be the most productive option. Significant cost savings occurred when the Medi-Cal program opened up to undocumented aliens for pregnancy and emergency related services. Emergency Medi-Cal has been helpful in relieving Medi-Cruz of some of the costs associated with serving undocumented residents of the county although Medi-Cal has narrowly defined such assistance. Additional relief has also come from state coverage of disease specific programs such as better Medi-Cal access for HIV patients, the Aids Drug Assistance Program and the Breast and Cervical Cancer Treatment Program.

Medi-Cruz has always placed a strong emphasis on being the “payer of last resort” by making sure Medi-Cal eligible individuals gain access that program. From initial screening to assisting people with the disability determination process, moving people into Medi-Cal is a high priority. Success in these efforts has relieved Medi-Cruz of the expense of numerous high cost cases and contributed substantially to the financial stability of the program over time.

The development of new programs which benefit indigents, like coverage for In-Home Supportive Services (IHSS) population, provide an opportunity to meet service needs while securing categorical funding that doesn’t burden the Medi-Cruz program.

**Benefits/Services -** The scope of benefits for the Medi-Cruz program include primary and specialty physician services, laboratory and x-rays, pharmaceuticals, medical equipment and supplies, and inpatient and outpatient hospital care, including emergency care. Primary care services are obtained from the two county health centers, as well as other safety net clinics. Emergency care is only covered at Dominican and Watsonville hospitals.

Excluded services include routine physicals, preventive services, dental care, skilled nursing, psychiatry, optometry, and non-traditional or alternative medical services.

Benefits and exclusions under Medi-Cruz are consistent with similar county indigent programs elsewhere in the state.

**Provider Fee Schedules** - The provider fee schedule is the most straightforward element in this equation. Access to providers, particularly physicians, and expenses are directly and inversely related to payment rates for services. Low rates may appear to keep expenses down, but reduce the participation of providers—often impeding access to needed services. However, when provider reimbursement is too low, and problems are not handled on timely basis, more costly emergency and inpatient care may result.

Community physicians participating in Medi-Cruz are paid at the level of reimbursement of Medicare rates, which while about 40% above Medi-Cal rates, they are still not sufficiently high to attract an adequate supply of specialists.

In-county hospitals in Medi-Cruz are paid on a per inpatient day basis. The inpatient rates by hospital are:

| | |
|---|---|
| Watsonville - | $1,000 |
| Dominican - | $955 |
| Sutter - | $950 |

These appear to be rates that benefit the Medi-Cruz program. In CY 2003, the average statewide negotiated Medi-Cal CMAC rate was $1,141 a day. The average cost-based Medi-Cal rate for the same period was $ 1,445 a day. The difference between the two Medi-Cal Statewide averages is that in geographic areas with multiple hospitals, the California Medical Assistance Commission, authorized to negotiate hospital rates on the state's behalf, can count on competition to drive rates down. In areas where there is no competition the State pays a rate based on what they determine is a hospital's "allowable costs." Hospitals will "negotiate" a rate below their costs because not all costs would disappear if Medi-Cal business were to disappear.

Outpatient hospital services (including ER)

- Watsonville – $57,000 fixed monthly price for ER; Eighty (80) % of billed charges for other outpatient services
- Dominican – 70% of Billed Charges for all outpatient services
- Sutter – Services are free for the first $100,000; seventy percent (70%) of billed charges for other hospital outpatient services.

In CY 2003, the average statewide Medi-Cal outpatient visit, including emergency room and surgeries was $140.98. Because of the payment methodologies used, there is incomplete data on the price per service at the hospitals. However, the data show that Medi-Cruz payments in FY 02-03 averaged $941 for an emergency room visit, plus an additional $557 for surgeries and ancillary services. This is obviously, and significantly, above Medi-Cal payment levels.

**Member and Provider Incentives** – All health care programs should be structured so that both members and provider have incentives are focused on achieving program goals.

Methods used for paying health care providers, like paying a percent of billed charges, can encourage the ordering of unnecessary services. This contributes to higher health care expenditures. By using similar methods of reimbursing hospital outpatient services Medi-Cruz is not structuring incentives toward containing program costs.

An overall reimbursement structure can be designed to couple reimbursement for specific services with additional financial incentives to accomplish budgetary goals. For example, under some health insurance arrangements, physicians are paid bonuses for programs staying within budget or for meeting quality of care objectives. Medi-Cruz does not use any of these mechanisms.

**Service Authorization Requirements** – Health insurance programs typically use controls to limit the access to expensive services. Medi-Cruz does require authorizations for all non-primary care services. All non-emergency care services outside of the county clinics must be authorized by Medi-Cruz before services are provided. Emergency services are reviewed for medical necessity retrospectively. However, review functions are not systematic and integrated with other program functions.

**Client Case Management** – Case management can be a technique used by health programs to give special attention to clients with more complicated and costly medical conditions. This can be a way to assure coordination of multiple providers, reinforce patient compliance with treatment regimens, and identify problems early in their development. Medi-Cruz does not employ such management practices. Timely client information to identify client candidates is required to implement such systems, but is beyond the administrative capability of Medi-Cruz. The primary example is identifying high cost cases. Medi-Cruz does not regularly produce reports that identify high cost cases. Much of the data is not available in any case. Other counties have found a data-driven case management function to help contain costs and use health care services more efficiently and effectively. For example, Marin County's analysis of paid claims revealed that 3% of the patients account 47% of expenditures, and 5% account for 66% of the expenditures.

**Program Administration –** The overall management of the program should ensure that services are managed and properly processed, and data is collected and analyzed to support goals and objectives Policies and procedures should be developed that train and guide current and new staff in program operations.

The claims processing program and claims database is the heart of any system that pays claims. In order to limit payments to appropriate services and maintain management of the program, you must be able to properly process claims and maintain accurate and appropriate records of all transactions.

All claims should be logged in by claim type and date of receipt. A claims inventory should be maintained that details the numbers of claims received by type and date of

receipt. The system should be able to provide the same information on the numbers of claims processed, including their status as paid, suspended or denied.

All reference files used in the system should be maintained properly. This means that eligible client information and provider fee schedules should be accurate and updated, as necessary.

The system should be able to apply basic edits to all claims during the adjudication process. Has the correct amount been paid for the service? The claims processing system should also be capable of identifying the submittal of more than one claim for the same service by the same provider. Unintentionally, providers can bill twice for the same service unintentionally.

The Medi-Cruz program does meet the general level of management see in other county programs. However, the program does not meet the standards of the managed care industry, noted above, for the functions of claims processing or management information reporting and analysis.

## 6. Similar Medically Indigent Programs in Other California Counties

Section 17,000 of the California Welfare and Institutions Code requires counties to provide medical assistance to the poor:

> ***Sec. 17000****. Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.*

This seemingly vague law is the basis for the operation of county hospitals and clinics and indigent care financing programs in California. The counties' responsibility for the provision of medical care has not been further defined in statute though there have been a number of court cases, which have clarified the obligation. In fact, the counties have widely differing standards of support for indigent health services. San Diego, and other counties, do not pay for services for indigents who are not "lawfully" resident in the county (thus excluding the undocumented from their "section 17000" population). Other counties provide open access through their hospital and clinic systems.

There are three basic "models" used by Counties to fulfill their Section 17000 obligations. These models include:

- County Medical Services Program (CMSP);
- County Hospitals; and
- Payor Counties.

The thirty-four smallest counties participate in the CMSP program. It is administered like the Medi-Cal program through a statewide contractor. Practically, the county has limited operational responsibility for these programs.

All other counties participate in the California Healthcare Indigent Program (CHIP) and Rural Health Services (RHS) programs. These programs require counties to maintain a certain level of county expenditure to be able to receive Proposition 99 funds. These funds have significantly been reduced in recent years. Medi-Cruz initial allocation was $1,200,000 and is now $72,000. This precipitous decline is not unique among California counties. Similar consequences have spawned efforts elsewhere to investigate the availability of new funding streams for programs to serve the medically indigent adult. It is widely viewed that even increases in program efficiency will not allow programs to keep pace with the population's future needs. In some cases, the imperative of additional funding has brought the issue before voters in the form of ballot measures seeking special tax assessments.

Twelve counties own and operate hospitals, with ancillary clinics, which serve as the principal sites for indigent services in the county. These counties essentially fulfill their obligations under Section 17000 by holding open publicly operated clinics and hospitals.

The remaining twelve counties have indigent care programs in which the county services in the role of a "payor" for services provided to indigents. These counties are further defined into counties that operate clinics and those who do not. These clinics are usually primary care clinics in focus. Both types of counties pay community providers for the majority of care provided.

For a more complete description of County Indigent programs refer to Attachment III. Two studies funded by CHCF and authored by Deborah Reidy Kelch do an excellent job of describing the variety of programs, including how they are funded, and how they have evolved over time.

The three counties closest to Santa Cruz are all "County Hospital" counties. San Mateo, Santa Clara, and Monterey counties each have County Hospitals. Consequently, these counties are substantially different than Santa Cruz. For purposes of comparison, selected California county health departments without county-operated hospitals were also contacted to understand the contractual relationships maintained with community hospitals for the provision of indigent care. Table 9, Table 10 and Table 11 present the comparisons.

Table 9 presents the number of adults in the target population age band (18-64), the number who have incomes below 100% of FPL, and the number of unduplicated CHIP clients. Unduplicated CHIP clients refers to the number of unique individuals that used services.

Santa Cruz has a relatively high rate of adults that are below 100% of FPL. There are more low-income adults proportionately in Santa Cruz (17%) than there are in Placer

(4%), Santa Clara (11%), and Stanislaus (15%). Merced (19%) and Monterey (20%) have slightly higher rates of low-income adults.

The last two columns present a perspective on how many CHIP clients there are based on adult population figures and low-income figures. The percentage of Santa Cruz Adults that are CHIP users is relatively low in this group of counties. The proportion of people with incomes below 100% FPL that are unduplicated CHIP users is also relatively low for Santa Cruz.

These measures can provide some insight into access to services for low-income residents. Santa Clara and Stanislaus counties have high rates for both measures of CHIP users. Both programs had County Hospitals with extensive outpatient clinic departments that provide multiple access points. (Stanislaus has closed its inpatient services) Monterey County also has a County hospital, but it does not have the same clinic capacity, and does not include undocumented persons in its regular indigent program. In contrast Placer County is a relatively wealthy county with a small number of low-income adults that apparently has provided good access for that population.

**Table 9**
**Medically Indigent Adults as a % of the County Adult Population For Selected California Counties**

| | (1)* | (2)* | **(2)/(1)** | (3)** | **(3)/(1)** | **(3)/(2)** |
|---|---|---|---|---|---|---|
| | **Adults (18-64)** | **0-99 % FPL** | **FPL %** | **CHIP** | **% CHIP** | **%CHIP of FPL** |
| **Santa Cruz** | 166,000 | 28,000 | 17% | 4,304 | 3% | 15% |
| **Merced** | 133,000 | 25,000 | 19% | 2,960 | 2% | 12% |
| **Placer** | 172,000 | 7,000 | 4% | 4,181 | 2% | 60% |
| **Stanislaus** | 288,000 | 42,000 | 15% | 20,765 | 7% | 49% |
| | | | | | | |
| **Monterey** | 283,000 | 57,000 | 20% | 6,063 | 2% | 11% |
| **Santa Clara** | 1,089,000 | 115,000 | 11% | 75,124 | 7% | 65% |

*Source: *UCLA 2001 California Health Interview Survey.*
***CA Dept. of Health Services - Medically Indigent Care Reporting System (MICRS).*

The financial provisions for most of the counties that do not have a County hospital are similar in that the county has partnered with local hospitals. It is important to note that the local hospital either provides inpatient care for free or provides services for a fixed dollar amount. Merced and Stanislaus counties each have long term agreements related to a fixed amount of money. In these two counties, the fixed dollar amount is tied to a fixed percentage of state Health Care Realignment Funds.

**Table 10**
**Medically Indigent Programs**
**For Selected California Counties**

| | Santa Cruz | Merced | Placer | Stanislaus |
|---|---|---|---|---|
| **Hospital** | 1) Dominican<br>2) Watsonville<br>3) Sutter | Mercy Medical | 1) Sutter Roseville<br>2) Sutter Auburn | Doctors Medical |
| **Hospital Payment** | Negotiated Per Diem OP % of Charges | 19% of Realignment for both IP & OP | Medi-Cal Rates for both IP & OP | 2,200 Free Days, Then Medi-Cal Rates |
| **County Primary Care Clinics** | Yes | Yes | Yes | Yes |

Comparisons can be made to other indigent programs by using CHIP data available from the State. The most recent available reporting period is FY 00 – 01. Santa Cruz County has a higher than average per patient expenditure rate overall, and particularly for outpatient hospital services. This is consistent with the findings regarding payment rates.

The inpatient figures show a different picture with Santa Cruz being below the average. However, much of that is explained by County hospitals. Those counties like Monterey, Kern, and Santa Clara tend to have higher rates of inpatient expenditures because all of the costs of their facilities are also reflected in these reports. The "Average" and "Median" figures are greatly impacted by Los Angeles County, which has a large and costly hospital system.

Santa Cruz's average expenditure per patient ($1,323) is thirty-one (31%) percent higher than the State average ($1,011). This higher than average cost is driven by the outpatient costs. Santa Cruz's average expenditure per outpatient patient ($1,068) is one hundred and seven (107%) percent higher than the State average ($517).

**Table 11**
**Medically Indigent Adult**
**Average Expenditures Per Unduplicated Patient**
**For Selected Counties**
**FY 2000-2001**

| CHIP Counties | Expenditures per Patient | Expenditures Per Inpatient | Expenditures per Outpatient | Expenditures per Emergency Services Patient |
|---|---|---|---|---|
| Fresno | $ 929 | $ $5,412 | $ 525 | $ 237 |
| Kern* | $ 2,076 | $ $11,281 | $ 1,031 | $ 453 |
| Merced | $ 1,264 | $ $6,879 | $ 820 | $ 199 |
| Placer | $ 615 | $ $5,721 | $ 511 | $ 121 |
| ***Santa Cruz*** | ***$ 1,323*** | ***$ $5,433*** | ***$ 1,068*** | ***$ 262*** |
| Stanislaus | $ 626 | $ 4,944 | $ 584 | $ 139 |
| Yolo | $ 909 | $4,360 | $ 628 | $ 347 |
| Median* | $ 1,118 | $8,253 | $ 628 | $ 293 |
| **Average*** | **$ 1,011** | **$ 10,742** | **$ 517** | **$ 355** |
| "*" Contains Public Hospital(s) | | | | |
| **Local County Hospital Programs** | | | | |
| Santa Clara* | $ 727 | $6,706 | $ 371 | $ 551 |
| Monterey* | $ 1,633 | $12,653 | $ 1,553 | $ 148 |

*Source: CA Dept. of Health Services - Medically Indigent Care Reporting System (MICRS).*
*Note: Data relate to total Indigent Care Program expenditure and are not confined to CHIP dollars.*

## 7. Opportunities and Challenges

The Medi-Cruz program faces increasing demands to pay for health care without any corresponding increase in funding. This will present to Santa Cruz County an on-going challenge to maintain an effective health care program. These challenges also present opportunities for change and improvement. Several of these opportunities areas are discussed below. Specific recommendations follow in the next section.

**Provider Payment Rates and Participation** – The design of payment arrangements with community providers are always sensitive and complex. Community providers participate in indigent programs for both business and professional reasons. Many hospitals see service to indigents as a means to fulfill a mission to provide community benefits or charity care. This latter motivation explains why some hospitals in other

counties agree to provide potentially unlimited care for a fixed amount of funding (e.g. % of Realignment funding from the state). Local hospitals are often the key to the financing of indigent care programs since they can provide a substantial portion of the costly and needed services through an infrastructure more capable of absorbing unprofitable business. This capacity of absorbing unprofitable business is not true for private community physicians, often in sole or smaller group practices.

To consider what is fair compensation for hospitals is a difficult task. Certainly hospitals would not seek to build their financial base on indigent care. One approach is to analyze the payment level for indigent care on an "incremental business" basis that considers contributions to "direct fixed" costs. The "incremental business" methodology is performed where fixed costs approximations are calculated and costs are broken into "direct fixed" (usually approximating 13% of charges) and "indirect fixed" (approximating 13% of charges). In this manner, a "contribution to overhead" statistic could be calculated. (Typically in inpatient settings, "direct fixed" plus "indirect fixed" costs approximate 26% of billed charges. In an outpatient setting, the "indirect fixed" costs percentages are slightly higher). Any payment beyond covering "direct fixed" can be considered a contribution to overhead. This approach views the patient volume associated with the indigent care as "incremental business" contributing to indirect fixed costs. If a provider is able to cover the direct fixed cost portion or more, there is a contribution to overhead ("indirect fixed costs") and, in this context, the services provided can be considered "profitable incremental business." Clearly, the Medi-Cruz program is paying outpatient rates that are significantly above this contribution to overhead scenario.

Another approach asserts that the hospitals should not receive any compensation for these patients. According to earlier reports in Santa Cruz County, the National Health Law Program concluded that while counties have a duty to provide for the health care needs of the poor, this duty does not require counties to reimburse private providers for expenses incurred in treating indigent residents. A duty only arises, according to the National Health Law Program, when the poor are not supported or relieved by others. This position reflects a strict interpretation of Section 17000 of the California Welfare and Institutions Code.

This interpretation of the county's financial responsibility as only what other providers won't pay for, is not widely embraced. However, when this strict interpretation is combined with the recent adoption of expanded "Charity Care" guidelines by most hospital systems, there does emerge a conceptual agreement about limitation that should be placed on what County Indigent programs should pay to participating hospitals. (See Attachment IV for Charity Guidelines for the hospitals.) For example, all three local hospitals have policies that individuals with family incomes at or below 200% of the poverty level can qualify for free, or charity care. By definition, all of the Medi-Cruz program patients meet this criterion. Many counties have adopted a compromise position that requires local hospitals to cover the indigent population for a percentage of available funding (i.e. % of Realignment Funds). Alternatively a number of counties have adopted a more generous approach that establishes Medi-Cal rates as the basis

for compensation for care provided to the medically indigent. In Merced County the local hospital would be paid approximately 50% MORE if the County Indigent Program there paid providers on a Medi-Cal basis.

The long-term nature of the county's contracts with the local hospitals presents a different picture in Santa Cruz. Outpatient reimbursement has been based on a percentage of charges. This was reasonable for many years when outpatient charges were competitively priced and inpatient services were considered the "big-ticket" item. However, because of trends in the diagnosis and treatment of disease, hospital outpatient payments now drive a major portion of Medi-Cruz cost increases.

On the other hand, the Medi-Cruz cost of inpatient services at our local hospitals has held steady for several years, as the rate structures have not been renegotiated. Medi-Cruz pays the hospitals a rate that is undoubtedly lower than Medi-Cal rates.

In the event that the reform of outpatient service reimbursement levels results in savings when compared to current expenditure levels, the additional funding should be redirected into improving physician services. More specifically, these redirected funds can be invested in a combination of such enhancements as:

- Rate increases to selected specialties;
- Investment with hospitals in physician recruitment; and
- Development of direct stipends for selected specialties.

**Administrative Capabilities and Case Management** – The management of a complex health care program requires sophisticated management expertise, well-articulated policies and procedures, and a trained staff. Professionally run managed care companies struggle with these responsibilities every day. Medi-Cruz program staffing has been downsized in recent years, jeopardizing its effective operation and development of needed administrative capability.

Does Santa Cruz County currently have the administrative capabilities in-house to administer the program including claims, information systems, membership, quality assurance and utilization review, provider relations, contracting procurement and monitoring and evaluation?

Does Santa Cruz County have the ability to implement the appropriate utilization and cost controls as well as the evaluation of the quality of services necessary to manage an independent health services program for the indigent?

It is only fair to say that Medi-Cruz does not, and that further, it may not be reasonable to expect a small program to every support an effective and efficient program. The Medi-Cruz program is administered in a manner consistent with other county programs. However, if the goal is to maximize funding a more sophisticated management may be necessary.

Partnership HealthPlan of California recently conducted a pilot program with Solano County and the state-CMSP program. PHC enrolled 75% of the Solano County CMSP population in its managed care program to better control costs and utilization. It only enrolled those that "fit" a managed care program. For example, it excluded those indigent clients whose care was retroactively covered by the program. While the results of the pilot project are not fully analyzed, program costs declined on a per eligible basis. However, enrollment increased during the pilot project. The net result was an increase in total program costs. The Solano County pilot project was less a test of enrolling the indigent population in a managed care program, but more about whether, certain managed care administrative capabilities might result in administrative program improvements. It is clear that they did.

The state CMSP is trying to build on this experiment by contracting with Blue Cross to administer the entire program statewide. Blue Cross brings substantial amounts of administrative capabilities at what is hoped to be marginal costs. It is too early to determine the success of this approach of contracting out all administrative services.

Medi-Cruz should be able to explore new ways of partnering with local experienced managed care organizations or third party administrators without contracting out all services.

One approach that might be the most appropriate, given the concern for attracting specialty physicians, would be to partner with local physician groups that currently provide managed care administrative services. The physicians in the community are already dealing with the entity for claims and utilization management services. Opportunities for developing new supportive relationships might develop more easily within a communities own physician organizations.

Existing partnerships with the hospitals and clinics should also be continued to look for opportunities to secure additional specialty services, or make better use of existing specialty services. Medi-Cruz and the Clinics should continue to work to ensure that they make appropriate referrals and explore the possibility of new arrangements like phone consultations from specialists. The development of a "Hospitalists" program should provide the opportunity to explore new working relationships.

In addition Medi-Cruz should increase its management capabilities where possible. A management program should be established to monitor the program monthly. Management should develop and apply an appropriate set of indicators, measure the indicators on a regular basis, track performance over time, make regular reports on the results of the measurements, and draft corrective action plans, and make recommendation on improvements in the program. A "Team" should meet monthly and mark progress with consistent data on the agreed upon indicators. The following indicators should be considered in monitoring performance in quality and access for the collaboration:

- Conditions avoidable through primary prevention (e.g. immunizations):
- Conditions with acute course and window for intervention (e.g. dehydration):
- Conditions with chronic course and amenable to self-management (e.g. asthma):
- Preventable hospitalization rates:
- Waiting time for appointment for primary care:
- Waiting time for appointment for specialty care:
- Number of patients with existing primary care provider: and
- Physicians by specialty available to provide indigent care in clinic settings.

Patients and services that would response to care and case management services should be identified. Policies and Procedures should be developed to establish appropriate care guidelines.

## 8. Recommendations

Based on our assessment, we propose the following seven recommendations:

**Recommendation #1** – Institute new provider reimbursement policies in line with the early diagnosis and treatment of clients and overall program financial prudence. Payment policies should be modified to encourage specialty physician participation (See Recommendation #4) and reduce expenses hospital outpatient care. Consistent with this recommendation, payment policies which are linked to charge levels should be eliminated. A preferred policy would involve either fixed reimbursement rates or rates linked to some percentage of a recognized physician fee schedule like that of Medicare. It is recommended that the hospitals be paid at Medi-Cal rates for all services.

**Recommendation #2** - Expand administrative capabilities either by internal investment or through external partnerships. Features such as improved and integrated claims processing, utilization review, and tracking performance according to a consistent set of indicators, and taking corrective action on operating deficiencies are particularly important. Potential outside partners such as local managed care organizations should be approached to explore the possibilities.

**Recommendation #3** – Implement an intensive case management program for the 50 highest-cost indigent client users of the program. All efforts should be made to coordinate the client's services and to manage their appropriate use of all services. Partnering with others to perform this function should be explored. Alternatively, the intensive case management program would require the redeployment of staff to this effort or a joint partnership with other organizations already doing utilization review at the hospitals. Nursing resources with case coordination or utilization review experience would be appropriate for this position. Capacity is needed 7 days per week at both hospitals for 2-3 hours per day.

**Recommendation #4** – Assess community, particular Hospital, recruitment efforts to ensure that needed physician specialists are recruited on a timely basis and promote contract obligations to provide some level of indigent care. Reinvest funds saved from reforming hospital outpatient rates to institute rate increases and/or stipends for specialists. It is important for safety net clinics to optimize specialty physician services.

**Recommendation #5** – Increase efforts to get other health insurance coverage, primarily Medi-Cal, for potential Medi-Cruz clients. The County Health Services Agency needs to partner with County Social Services Agency to maximize outreach and enrollment resources, and increase their effectiveness in finding coverage for this population. One measure to consider is adding a bilingual benefit advocate for SSI to South County

**Recommendation #6** – Monitor the State Hospital Financing Waiver. The State could be required to use $540 million of the $900 million of the waiver funding to provide healthcare coverage to the uninsured. The federal government has requested that the State include additional funds, over and above the $540 million, from other sources in the Pool for coverage expansions. This could be accomplished by using programs and services currently provided by public hospitals and clinics. It is not clear at this time how this will develop. However, it could present an opportunity to match existing Medi-Cruz funds with federal dollars to expand indigent services.

**Recommendation #7** – Explore the availability of new and alternative funding streams that may be adapted for use in Santa Cruz County. Flat and declining traditional revenue streams are clouding the future of programs to serve medically indigent adults regardless how efficiently programs can be managed. Other California counties and other public entities have studied and, in some cases, actively pursued innovative revenue generating measures such as tax-based arrangements through special districts, designated voter ballot propositions, and others.

## Attachments

Attachment I: Primary Care Clinic List

Attachment II: Indigent Health Care in Santa Cruz: The County Medical Services Program (CMSP) Option

Attachment III: California HealthCare Foundation County Indigent Studies

Attachment IV: Hospital Charity Care Guidelines

# Attachment I:

## Primary Care Clinic List

## Attachment II:

## Indigent Health Care in Santa Cruz: The County Medical Services Program (CMSP) Option

**A study conducted by the Santa Cruz Health Care Agency**

## Attachment III:

### California HealthCare Foundation County Indigent Studies

Deborah Reidy Kelch. *The Crucial Role of Counties in the Health of Californians: An Overview.* July 2004.

Deborah Reidy Kelch. *Caring for Medically Indigent Adults in California: A History.* June 2005.

## Attachment IV:

## Hospital Charity Care Guidelines