Close to the Edge:

An Analysis of the Financial Predicament of
San Francisco General Hospital

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The views expressed in this report are those of the author and not necessarily those of the institutions with which the author is affiliated.
Summary of Key Findings

1. Costs at SFGH have risen more slowly than hospital costs for the nation overall during the past decade.
   - Annual SFGH expenditures increased from $205.0M in fiscal year 1989/1990 to $315.8M in 1999/2000, representing an average annual increase of 4.4%.
   - During this same 10-year period, the annual average rate of increase in overall hospital expenditures in the US was 5.7%, a rate much greater than that experienced by SFGH.
   - If expenditures at SFGH had followed national trends over the past decade, 1999-00 expenditures would be $356.8M instead of the actual 1999/2000 expenditures of $315.8M. Stated another way, adjusting for the national rate of hospital cost inflation, in “constant 1989 hospital dollars” SFGH expenditures actually decreased from $205.0M in 1989 to $181.4M.

2. State and federal policies have precipitated the local budget crisis in safety net funding. Recent reductions in Medi-Cal revenues are the principal cause of the current budget predicament at SFGH.
   - Total net Medi-Cal revenues at SFGH have declined by $38.1M in the past 5 years, from $157.2M in 1994/1995 to $119.1M in 1999/2000. This represents a 24% decrease in Medi-Cal funds in nominal dollars (i.e., not adjusted for inflation).
   - Reductions in Medi-Cal revenues are due to two principal factors: 1. A change in payer mix among inpatients at SFGH, with more uninsured patients and fewer Medi-Cal covered patients admitted to the hospital; this parallels the statewide growth in the number of uninsured persons and decline in the number of Medi-Cal beneficiaries in California, and 2. Recent federal policy changes to reduce federal funding of the Medicaid Disproportionate Share Hospital payment program (DSH program, operating under SB 855 and 1255 statutes in California).

3. Increases in the early 1990s in Medi-Cal and other non-city/county sources of revenues to pay for indigent care relieved the City and County of San Francisco of much of the financial burden of paying for inpatient care for uninsured San Franciscans. The current withdrawal of federal and state support exposes the City to a much greater burden of the costs of health care costs for uninsured San Franciscans.
payments to SFGH had fallen to $7.9M, 3% of the SFGH budget. General fund support to SFGH in 1999/2000 is budgeted at $49.8M, 16% of the SFGH budget.

- If general fund support to SFGH had risen at the rate of overall national hospital expenditures in the past decade, the 1999/2000 general fund payments to SFGH would be $90.0 M—$40M more than the City budgeted for 1999/2000.

- If general fund support to SFGH had risen proportionate to the rate of increase of SFGH’s overall budget in the past decade, the 1999/2000 general fund payments to SFGH would be $79.7M. In other words, if the City had maintained general fund support equivalent to 25% of the overall SFGH budget (the percentage support in 1989-90), the City would be spending approximately $30M more in general funds for SFGH in 1999/2000.
I. INTRODUCTION

Health care for uninsured, low income, and other vulnerable populations in the United States is in crisis. A recent Institute of Medicine report, “America’s Safety Net – Intact but Endangered” concluded that health care trends in the US “are beginning to place unparalleled strain in the health care safety net in many parts of the country (page 139).” The report ominously observed that many safety net providers “may be unable to survive the current environment.”

These concerns are nowhere more valid than at San Francisco General Hospital. For more than a century, SFGH has been the cornerstone of the safety net system of health services for poor and uninsured residents of San Francisco. Together with independent community health centers and primary care neighborhood clinics and other facilities operated by the SF Department of Public Health, SFGH has contributed to a safety net system that has promoted access to quality health care for disadvantaged populations.

Economic forces threaten the future of SFGH and the City’s safety net health care system. Rising health care costs and diminishing federal and state support for SFGH have created a fiscal crisis. This crisis is apparent in the current debate over the 2000/2001 budget for SFGH. Lack of funding jeopardizes important services at SFGH, such as:

- Closure of 20 medical-surgical beds
- Closure of the outpatient pharmacy
- Cuts may also force some possible reductions in operating room time and medical specialty services and some radiology services such as mammography. Considered for closure, but temporarily reprieved, have been an inpatient psychiatric ward and a neighborhood-based primary care clinic.

This report provides an economic analysis of the current budgetary crisis at SFGH. It examines recent spending and revenue trends at SFGH, diagnosing the specific combination of factors that have created the present financial ills at this institution.
II. BACKGROUND ON SFGH

The Institute of Medicine defines the health care safety net as “those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations (page 3).” Like most public hospitals in the US, SFGH epitomizes this definition of a health care safety net provider. SFGH provides services to all San Franciscans irrespective of insurance status, income, immigration status, or other social factors. Uninsured, low-income residents are provided services free of charge or at nominal charge according to an income-based sliding scale billing policy.

In 1998/1999, SFGH had 18,399 acute care inpatient discharges accounting for 106,884 inpatient hospital days. The number of total annual acute inpatient discharges and inpatient days have both increased over the past five years. In addition to acute care hospitals episodes, in 1998/1999 SFGH had:

- nearly 50,000 inpatient days on long term Skilled Nursing Facility units
- over 100,000 visits to hospital-based primary care clinics
- over 150,000 visits to hospital-based specialty clinics, and
- over 60,000 visits to the Emergency Department and Psychiatric Emergency unit.
III. SFGH SPENDING TRENDS

One possible factor that might contribute to fiscal problems at SFGH is excessive increases in hospital spending. Have expenditures grown uncontrollably at SFGH?

Costs have increased at SFGH in recent years. Annual SFGH expenditures grew from $205.0M in fiscal year 1989-90 to $315.8M in 1999-00, representing an average annual increase of 4.4%.

However, costs at SFGH have actually risen more slowly than hospital costs for the nation overall during the past decade. During this same 10-year period, the annual average rate of increase in overall hospital expenditures in the US was 5.7%. Thus, annual increases in expenditures at SFGH have lagged behind the national trend in hospital spending by a substantial amount.
If expenditures at SFGH had followed national trends in hospital expenditures over the past decade, 1999-00 expenditures would have been $356.8M instead of the $315.8M actually spent in 1999-00. Stated another way, adjusting for the national rate of hospital cost inflation, in “constant 1989 hospital dollars” SFGH expenditures actually decreased from $205.0M in 1989/90 to $181.4M in 1999/2000.

Figure 3
SFGH Expenditures Adjusted for National Rate of Inflation in Hospital Costs
(Constant 1989 Hospital Dollars)

Source: Office of CFO, SFDPH; Health Affairs, Jan/Feb 2000

Note: SFGH expenditures in all years after 1989/1990 are deflated by annual rate of inflation in overall US hospital expenditures

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Like most hospitals, SFGH undoubtedly does not operate at optimal efficiency in terms of maximizing the services provided at its current level of spending. However, many of the factors contributing to rising costs at SFGH are not under the direct control of the hospital. Approximately 75% of expenses at SFGH are for labor costs. For most SFGH workers, wages are determined through labor negotiations between unions and the Mayor’s office and approved by the Board of Supervisors. SFGH must comply with wage increases agreed to by the Mayor and the Board of Supervisors. In addition to personnel costs, a large component of expenses at SFGH is the purchasing of pharmaceuticals and other biomedical supplies. Pharmaceutical prices have experienced unprecedented inflation in the US in recent years, and are growing more rapidly than any other component of national health expenditures. SFGH is subject to these inflationary pressures from expenditures for medications and related products.

In summary, unreasonable inflation in costs at SFGH does not appear to principally account for the current financial predicament at SFGH. Trends in revenues are a much more important factor.

IV. SFGH REVENUE TRENDS

A. Funding Sources

Funding for operating costs at SFGH derives from 4 major sources, listed in descending order of relative magnitude of funding:

1. **Medi-Cal** is the single largest source of funds for SFGH. Medi-Cal is the state’s Medicaid program, with the state and federal government sharing in program costs on an approximately 50:50 basis. Hospitals in California with Medi-Cal contracts negotiate with the state for a fixed daily fee for each Medi-Cal patient in the hospital.

   These basic Medi-Cal per diem fees are supplemented by Medi-Cal funds from special programs that support safety net hospitals. Medi-Cal Disproportionate Share Hospital (DSH) program funds are authorized under SB 855 (enacted in 1991) and SB 1255. Under these programs, the state is able to generate special extra federal contributions to the state Medi-Cal program and then disperse these additional DSH funds to California hospitals serving a “disproportionate” number of Medi-Cal and low income patients. DSH funds have supported over 130 hospitals in California, including many private hospitals. One additional, smaller Medi-Cal special hospital program is funding for graduate medical education (GME) at UC and some public teaching hospitals. The GME Medi-Cal program was implemented in 1997/1998.

2. **State subsidies** take the form of state realignment dollars transferred to county governments to support local social services including health care. In addition, the
state transfers Proposition 99 cigarette tax revenues to local governments to help subsidize health care services to the uninsured.

3. **Medicare**, the federal insurance program for the elderly and some disabled persons, pays for services provided to Medicare beneficiaries.

4. **County General Fund** revenues, derived from local tax revenues, also contribute to funding of services at SFGH.

5. Revenues from **direct patient payments, private health insurers, and other miscellaneous sources** contribute the balance of funds.

**B. Funding Trends**

In the past decade, major shifts have occurred in the relative contribution of these various funding sources towards paying for operating costs at SFGH. As the following figure shows, sources of revenues other than City and County of San Francisco general funds rose steadily throughout the past decade until this trend reversed in 1999/2000. Conversely, general fund contributions declined in the early 1990s and began to rise again in the late 1990s.

![Figure 4: San Francisco General Hospital Revenues, Expenditures and General Fund History FY 1989/1990 to FY 1999/2000 (in millions)](source: Office of CFO, SFDPH)
The following section analyzes these revenue trends in more detail.

**B.1. Trends in Medi-Cal Revenues**

The single most important financial change at SFGH in recent years has been the decrease in Medi-Cal revenues. After peaking in the mid-1990s, Medi-Cal revenues have plummeted at SFGH.

Total net Medi-Cal revenues at SFGH declined by $38.1M in the past 5 years, from $157.2M in 1994/1995 to $119.1M in 1999/2000. This represents a 24% decrease in Medi-Cal funds in nominal dollars (i.e., not adjusted for inflation).

The following figure shows the decrease in Medi-Cal revenues at SFGH, by specific component of the Medi-Cal program.
Basic Medi-Cal hospital per diem payments have shown a steady decrease across the years shown, declining from a peak of $126.1M to only $57.6M estimated for 1999/2000. Medi-Cal DSH payments under the SB 855 program grew between 1994/1995 and 1995/1996 before decreasing in 1999/2000.

Causes of Decreases in Medi-Cal Revenues

What accounts for this large decrease in Medi-Cal revenues at SFGH? The first factor is the change in payer mix among inpatients at SFGH, with more uninsured patients and fewer Medi-Cal covered patients admitted to the hospital. Uninsured patients accounted for 27% of inpatient hospital days at SFGH in 1993/1994. By 1999/2000, uninsured patients accounted for 38% of inpatient days.

![Figure 6: Uninsured Patients as a Percent of Inpatient SFGH Hospital Days](source: Office of Planning & Marketing, SFGH)

The decrease in Medi-Cal patients and increase in uninsured patients at SFGH mirrors trends in insurance coverage for Californians overall. Although Medi-Cal enrollment grew in the early 1990s with liberalization of eligibility policies, Medi-Cal enrollment in the state began to decline in the late 1990s. Between January 1996 and January 1998 the total number of Medi-Cal enrollees in California decreased from 5.4 million to 4.9 million, a 10% reduction. During this same period, the number of uninsured Californians increased from 6.5 million to 7.3 million.
The decrease in Medi-Cal enrollment has been attributed to welfare reform and the uncoupling of Medi-Cal eligibility from welfare benefits. In addition, federal policies have become more restrictive for immigrants to qualify for Medi-Cal, and state policies such as Proposition 187 may have also created a climate in which some immigrants eligible for Medi-Cal have been deterred from applying for benefits.

Exacerbating the financial impact on hospitals of the decline in Medi-Cal enrollment in California has been the stagnation of Medi-Cal reimbursement rates. Medi-Cal per diem hospital fees have been virtually frozen for the past decade.

A final factor potentially contributing to decreasing core Medi-Cal revenues at SFGH may be a shift of some Medi-Cal patients away from SFGH to other hospitals due to the advent of Medi-Cal managed care. In 1996, the California Department of Health Services expanded its implementation of mandatory Medi-Cal managed care for AFDC (now TANF) eligibles to many of its largest urban counties, including San Francisco. State-wide data suggest this policy change may have resulted in a change in the type of hospitals serving pregnant Medi-Cal beneficiaries, with more births occurring in private hospitals in California and fewer in public hospitals such as SFGH. (CAPH data)

Other policy changes are affecting Medi-Cal payments under the DSH program. In the early 1990s, states discovered how to capitalize on DSH policies using creative
approaches to generating required state “matching dollars” to increase federal DSH payments to state Medi-Cal programs. Congress responded to this development by changing DSH legislation in the Balanced Budget Act of 1997, resulting in a projected $10.4 billion decrease in federal DSH funding between 1998 to 2002 (IOM report). The DSH program has been controversial, with many analysts questioning whether this program effectively targeted funds to hospitals caring for the most underserved and vulnerable populations. Nonetheless, DSH funds have been an important component of revenues for SFGH, partly offsetting decreases in core Medi-Cal per diem payments. The current reductions in DSH funding will further destabilize the financial status of SFGH.

Future Medi-Cal Revenue Trend Projections

The recent adverse trends in Medi-Cal revenues at SFGH will deteriorate further in the coming fiscal year 2000/2001 due to factors such as the growing number of uninsured patients and reductions in Medi-Cal DSH funding. The SF Department of Public Health projects the following decreases in Medi-Cal revenues at SFGH relative to 1999/2000 levels:

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<th>Projected Declines in Medi-Cal &amp; Medicare SFGH Revenues for 2000/2001* (in millions)</th>
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<tr>
<td>Basic Medi-Cal</td>
<td>$6.6M decrease</td>
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<tr>
<td>Medi-Cal DSH SB 855</td>
<td>$10.0 decrease</td>
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The SFDPH also projects a $4.4M decrease in Medicare revenues at SFGH in 2000/2001.

*Compared to 1999/2000 revenues

✓ A $6.6M decrease in basic Medi-Cal per diem payments
✓ A $10.0 decrease in Medi-Cal DSH SB 855 payments.

In summary, SFGH is experiencing a major decline in Medi-Cal and Medicare revenues—and this trend is getting worse.
B.2. Trends in SF City and County General Fund Support for SFGH

Increases in the early 1990s in Medi-Cal and other non-city/county sources of revenues to pay for indigent care relieved the City and County of San Francisco (CCSF) of much of the financial burden of paying for inpatient care for uninsured San Franciscans. The current withdrawal of federal and state support exposes the City to a much greater burden of the costs of health care costs for uninsured San Franciscans.

CCSF general fund payments to SFGH peaked at $61.3M in 1990/1991, representing 27% of SFGH’s overall budget. By 1992/1993, general fund payments to SFGH had fallen to $7.9M, 3% of the SFGH budget. General fund support to SFGH in 1999/2000 is budgeted at $49.8M, 16% of the SFGH budget. The following figure shows trends in general fund payments to SFGH as a percent of SFGH’s annual operating budget.

Figure 8
General Fund Revenues as % of SFGH Budget

Source: Office of CFO, SFDPH
If general fund support to SFGH had risen proportionate to the rate of increase of SFGH’s overall budget in the past decade, the 1999/2000 general fund payments to SFGH would have been $79.7M. In other words, if the City had maintained general fund support equivalent to 25% of the overall SFGH budget (the percentage support in 1989-90), the City would have spent approximately $30M more in general funds for SFGH in 1999/2000 relative to the actual 1999/2000 general fund contribution.

If general fund support to SFGH had risen at the rate of overall national hospital expenditures in the past decade (a 5.7% annual increase), the 1999-00 general fund payments to SFGH would be $90.0M—$40M more than the City budgeted for 1999/2000.
Medi-Cal revenues have been a key subsidy for provision of health care to uninsured and indigent patients at SFGH, allowing the SFDPH to prioritize use of CCSF general funds for traditional public health activities within the Department. General fund spending by the SFDPH on activities in its Population Health and Prevention Division, including services such as substance abuse treatment and counseling, infectious disease surveillance, and community-based HIV prevention, grew from $96.1M in 1995/1996 to $160.4M in 1999/2000, a 60% increase. Some analysts have argued that traditional prevention-oriented public health activities should be the key emphasis of local departments of public health, rather than delivery of clinical services—especially acute care hospital services.

V. Conclusions and Recommendations

**Key Findings**

1. Costs at SFGH have risen more slowly than hospital costs for the nation overall during the past decade.

2. State and federal policies have precipitated the local budget crisis in safety net funding. Recent reductions in Medi-Cal revenues are the principal cause of the current budget predicament at SFGH.

3. Increases in the early 1990s in Medi-Cal and other non-city/county sources of revenues to pay for indigent care relieved the City and County of San Francisco of much of the financial burden of paying for inpatient care for uninsured San Franciscans. The current withdrawal of federal and state support exposes the City to a much greater burden of the costs of health care costs for uninsured San Franciscans.

4. Absent a renewal of state and federal revenues supporting safety net providers, the City and County of San Francisco faces the prospect of critical reductions in health care services at SFGH and of compromised ability to prioritize general fund support for public health and prevention activities.

**Recommendations**

1. State and federal policymakers should recognize that policy changes are shifting an unsupportable economic burden to counties such as San Francisco for financing hospital care for indigent and uninsured patients.

2. The state should increase basic Medi-Cal per diem payments rates to hospitals, with increases potentially targeted to hospitals caring for large numbers of Medi-Cal and uninsured patients.

3. The state and federal governments should broaden Medi-Cal eligibility criteria and enhance outreach efforts to enroll more uninsured Californians in Medi-Cal.
4. The federal government should reconsider reforms of the Medicaid Disproportionate Share Hospital Payment program enacted in the Balanced Budget Act of 1997. Future reforms of this program should maintain overall DSH funding levels at their 1998 level, with increases indexed to rates of overall health care inflation, and should ensure that DSH funds are more effectively targeted to hospitals serving the largest numbers of poor and uninsured patients. Alternatively, the federal government should replace the DSH program with a new program that commits these funds to a more focused initiative to support key safety net systems.