

Santa Clara Valley Medical Center

Santa Clara Valley Medical Center (SCVMC) in San Jose, California is a large public hospital that uses Medicaid disproportionate share hospital (DSH) funding to offset low base Medicaid payment rates. Because California expanded Medicaid before 2014, the hospital serves few uninsured patients, but it is looking to expand the outpatient care that it provides to uninsured individuals through the state's new Section 1115 demonstration, which combines DSH and other Medicaid funding for uncompensated care into a global payment for care provided to the uninsured.

Hospital and Market Characteristics

SCVMC is a 574-bed tertiary medical center, owned and operated by the County of Santa Clara. The hospital is part of the Santa Clara Valley Health and Hospital System. SCVMC provides many services to its community, including a regional burn center, a regional rehabilitation center, a Level I Trauma Center, and an emergency and inpatient psychiatric facility.

SCVMC is also a teaching hospital that has its own residency program as well as a long-standing residency affiliation with Stanford University Medical School. In 2012, SCVMC received \$197 million in Medicaid DSH payments, which represented 32 percent of its total Medicaid revenue (\$625 million) and 12 percent of its total operating revenue (\$1.6 billion).

Role in the safety net

Medicaid-enrolled and low-income patients comprise a much higher share of SCVMC's patient population than they do in other hospitals in the hospital referral region (HRR) and in the state at large (Table 1). As a public safety-net hospital, SCVMC treats all patients regardless of ability to pay. SCVMC executives reported that other hospitals in the county often transferred Medicaid-enrolled or uninsured patients to SCVMC.

Types of services provided

Given its long history as the main provider of care for Medicaid-enrolled patients in Santa Clara County, SCVMC has developed expertise in caring for this population, according to system executives. Over the past several years, SCVMC has been building the infrastructure to handle the specific needs of Medicaid enrollees and other low-income populations, including forging partnerships with community-based organizations and negotiating contracts with local federally qualified health centers so they can join its network. For example, SCVMC has a large health care program for homeless individuals, which works closely with community partners and the local housing authority to connect homeless patients with stable housing.



TABLE 1. Medicaid and Low-Income Utilization Statistics for Santa Clara Valley Medical Center and Other Hospitals, 2014

| Comparison region | Medicaid inpatient utilization rate | Low-income utilization rate |
|--|-------------------------------------|-----------------------------|
| Santa Clara Valley Medical Center (San Jose, CA) | 68% | 81% |
| San Jose, CA, hospital referral region average | 26 | 22 |
| California average | 28 | 21 |
| National average | 18 | 13 |

Notes: The Medicaid inpatient utilization rate is the percentage of hospital inpatient days that are attributable to patients who are eligible for Medicaid. The low-income utilization rate is a measure of Medicaid and charity care utilization.

Source: MACPAC, 2017, analysis of 2014 Medicare cost reports.

SCVMC executives also reported that Santa Clara County has long recognized the value of investing in SCVMC to ensure certain services are available for the health and wellness of the community. For example, the county is currently funding an expansion of SCVMC’s emergency department and burn unit and the establishment of a new ambulatory care surgery center and a new clinic in downtown San Jose.

Market characteristics

Several hospitals operate in Santa Clara County, including Stanford Health Care, El Camino (a community hospital primarily serving commercially insured and Medicare-enrolled patients), and two for-profit hospitals. According to hospital executives, SCVMC provides the majority of Medicaid patient days in the county; they said, “to a large degree [local] hospitals do depend on us to accept their [Medi-Cal] transfers and patients.”

SCVMC executives acknowledged that the hospital was competing with other health plans to enroll beneficiaries in its Medicaid plan, the Santa Clara Family Health Plan. Executives reported that they were trying to expand the health plan’s market share of Medicaid-enrolled patients with new beneficiaries, as one executive said, to “diversify our risk pool . . . [so] we actually probably have a better chance of sustainability.”

State Context

California fully expanded Medicaid to adults under age 65 with incomes at or below 138 percent of the federal poverty level in 2014. Prior to 2014, the state had expanded coverage to low-income adults in select counties, including Santa Clara County, through a Section 1115 demonstration. In 2014, the state’s uninsured rate (12.4 percent) was slightly higher than the national average (11.7 percent).



California targets its DSH payments to certain designated public hospitals, which account for about 11 percent of hospitals in the state. The non-federal share of DSH payments is provided by intergovernmental transfers (IGTs) from public hospitals.¹

Effects of the Affordable Care Act

SCVMC executives highlighted the importance of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) for individuals who gained insurance coverage under this law: “The fact [is] that we have another 30,000–40,000 individuals who are now connected with a primary care provider and have coverage versus them coming to our system on an episodic basis. That is a big deal.”

Executives further noted that the ACA “produced a boost for the financial performance at SCVMC,” which helped reduce the system’s reliance on Santa Clara County. For example, executives reported that they had originally projected they would need \$154 million in local subsidies for the fiscal year ending June 30, 2016, but wound up requiring only about \$64 million. Funds have been reinvested in SCVMC, primarily in one-time capital and critical infrastructure improvements.

SCVMC executives reported that gains in insurance coverage under the ACA resulted in a decline in uncompensated care but a rise in Medicaid shortfall. They estimated that Medicaid accounts for between 75 percent and 85 percent of SCVMC revenues but that Medicaid base payments cover only an estimated 55 percent of the costs of providing care. “The fact of the matter is that no matter what we do under the ACA in terms of providing coverage, unless the reimbursement keeps pace with what the market demands, there’s going to be a disproportionate reliance on the safety-net system.”

State policy changes affecting Medicaid supplemental payments

California has recently implemented several changes to Medicaid supplemental payments through its Medi-Cal 2020 Section 1115 waiver demonstration. Under Medi-Cal 2020, approved in December 2015, California’s federal Medicaid DSH allotment of \$1.2 billion was combined with federal funds paid through California’s Safety Net Care Pool (which gave funds to safety-net systems to provide care to uninsured patients under the state’s previous 1115 waiver) to create a new Global Payment Program (GPP) for public health care systems. Payments to hospitals participating in the GPP are delinked from hospital uncompensated care and are instead based on a point system that rewards public health systems when value-based care is provided to uninsured patients. For example, hospitals can earn points for providing traditional inpatient and outpatient services, such as dental care and mental health treatment, and they can also earn points for providing additional patient support services, such as health coaching and technology-based consultations. During the initial years of the demonstration, the point system is based on the relative costs of each service, but in later years of the demonstration, potentially avoidable services, such as emergency room visits, will earn fewer points to encourage hospitals to provide care in the most appropriate and cost-effective setting. GPP payments are made only to California public hospitals with counties providing the non-federal share of the payments through IGTs. GPP payments are not guaranteed but rather must be earned by the hospital. As one executive explained, the GPP is a “game changer,” with payments “based on services provided, not the cost of services provided.”



The Medi-Cal 2020 waiver also established the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, a successor program to the state's Delivery System Reform Incentive Payment program that was part of California's previous Section 1115 waiver. While GPP provides funds to care for uninsured patients, the purpose of PRIME is to improve care for patients enrolled in Medicaid. Under the Medi-Cal 2020 waiver, PRIME ties Medicaid supplemental payments to improvements in areas such as ambulatory care and care for high-risk populations to strengthen the capacity of public hospitals to meet performance targets in risk-based alternative payment models. To get PRIME funding, public hospitals must achieve year-over-year performance targets.

Another supplemental funding source available through the Medi-Cal 2020 waiver is Whole Person Care, an optional pilot program to integrate physical health, behavioral health, and social services for high-risk patients. Over the course of the waiver, \$1.5 billion in federal money is available through Whole Person Care across California, with the state share provided by county IGTs.

Hospital Financial Information

Uncompensated care

In 2014, bad debt and charity care made up less than 1 percent of SCVMC's operating expenses, a share that was lower than the proportion reported in California and in other hospitals nationally, but similar to other hospitals in its HRR (Figure 1). Medicare cost report data show that the hospital's charity care and bad debt fell substantially between 2011 and 2014.

Medicaid payment shortfall

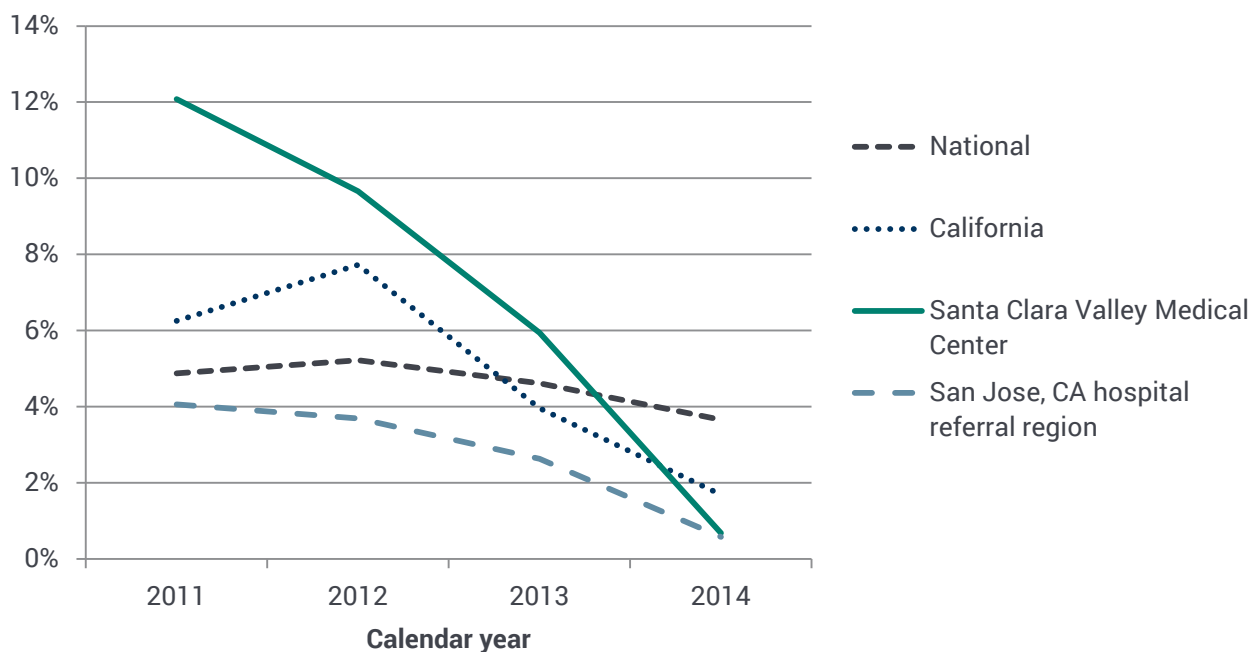
According to California's 2012 DSH audit, Medicaid base payments covered 91 percent of SCVMC's Medicaid costs. However, because Santa Clara County (and other California counties) provide the state share for base payments on many services through IGTs, SCVMC's net Medicaid payments are much lower. For example, hospital executives noted that for inpatient fee-for-service (FFS) Medicaid services, SCVMC was paid an average per diem rate of about \$5,900, but after accounting for the IGT that the county provides, the net payment "averages \$2,800, \$2,900, and unfortunately that's a fraction of the cost."

Medicaid DSH payments

According to DSH audits, SCVMC received \$197 million in DSH payments in 2012; and according to hospital executives, SCVMC reported \$128 million in net DSH funding after accounting for the IGT that it provides to cover the state share of DSH payments.² Gross DSH payments accounted for about one-third of Medicaid payments to the hospital in 2012. In fiscal year (FY) 2016, SCVMC's net GPP payments through the Medi-Cal 2020 waiver totaled \$136 million, which includes DSH payments as described above.



FIGURE 1. Uncompensated Care as a Share of Hospital Operating Expenses, Santa Clara Valley Medical Center versus Other Hospitals, 2011–2014



Note: Medicare cost reports define uncompensated care as charity care and bad debt.

Source: MACPAC, 2017, analysis of Medicare reports.

Other Medicaid supplemental payments

SCVMC executives expected the hospital to receive about \$56 million in net PRIME payments in 2015 in addition to DSH payments. Executives, however, did not consider PRIME funding as guaranteed and expressed concern about meeting the performance targets required to earn payments. SCVMC executives also reported submitting an application for a gross payment of at least \$43 million (roughly \$22 million net after accounting for IGT payment) in Whole Person Care funding.

Role of DSH Funding

According to SCVMC executives, DSH and other Medicaid supplemental payments are a vital source of revenue that help cover the cost of care for uninsured patients but also help the system's bottom line. "Every dollar that we earn for the uninsured makes up for losses on Medicaid and other segments of the population we serve," one executive explained. SCVMC executives further observed that they rely heavily on supplemental payments because California's base Medicaid payment rates have not kept up with the growing cost of providing care and because Medicaid-enrolled patients account for about 65 percent of the hospital's patients.



Because SCVMC is so reliant on DSH payments, hospital executives reported that receiving DSH payments on a retrospective basis rather than prospectively is not ideal. One executive noted that retrospective payments make it “very hard as a system to plan on what kind of money you’re going to have to spend.”

Even with Medicaid supplemental payments, SCVMC executives noted, the hospital still relies on a subsidy from Santa Clara County to fund operations given that it cares for a fairly large group of people who are not eligible for full Medicaid benefits. Hospital executives are concerned that an economic downturn in the local area could affect the availability of these local funds.

SCVMC executives supported California’s policy of targeting DSH payments to safety-net hospitals. Executives said that this payment policy enabled the state to support the development of a large, relatively viable, public health system in many areas of California. One SCVMC executive described the benefit of a public hospital system this way: “If what you hope to do is get [Medicaid patients] in a medical home, get them primary care, try to improve their health status, reduce the incidence of diabetes, [address] all the things that will limit their ability to support themselves over time, I think the only way that you will make progress on those things is to give people access to care.” This executive felt that the targeting of DSH payments to safety-net hospitals was appropriate and beneficial to Medicaid-enrolled patients. Otherwise, the executive continued, in states that do not target DSH payments in this way, these “institutions become challenged to continue and they end up being converted to for-profit institutions which to me is also reducing people’s access. I really think there is an ongoing need for DSH payments and there may be a need for a redesign of the program.”

Data and Methods

The information in this profile comes from interviews with hospital executives during the summer and fall of 2016 and MACPAC’s analysis of Medicare cost reports, DSH audits, and other publicly available data. For a summary of the findings from all seven DSH hospitals that we profiled and more information about our methods, please see MACPAC’s issue brief, [Profiles of Disproportionate Share Hospitals](#).

MACPAC would like to thank Teresa Coughlin and Christal Ramos at Urban Institute for designing and conducting the interview with Santa Clara Valley Medical Center that was the basis for this profile. The interview was one of seven interviews with executives from safety-net hospitals across the country that occurred between June and October of 2016.

Endnotes

¹ An IGT is a transfer of funds from another governmental entity (e.g., a county or other state agency) to the Medicaid agency before a Medicaid payment is made. IGTs may also be contributed directly by governmental providers themselves, such as hospitals operated by state or local government. The ability of states to use IGTs to finance their Medicaid programs is recognized in both federal statute and regulation (§1903(w)(6) of the Social Security Act; 42 CFR 433.51).

² SCVMC executives reported that their hospital’s total 2012 DSH payment was approximately \$180 million, which is less than the \$197 million reported on California’s 2012 DSH audit.

