Contra Costa Regional Medical Center: $55,000,000 (On-going)

The Contra Costa Regional Medical Center (CCRMC) is a 167-bed general acute care safety-net hospital that provides a full range of services that include emergency care, psychiatric care, newborn labor and delivery, medicine, and surgery. Ten ambulatory care health centers throughout Contra Costa County provide comprehensive, personalized, patient-centered health care with a full range of specialty services. The medical center is the training ground for our family practice residency program.

As a general acute care teaching facility, CCRMC provides a full range of diagnostic and therapeutic services including medical/surgical, intensive care, emergency, prenatal/obstetrical, and psychiatric services. Ancillary services include pharmacy, rehabilitation, medical social work, laboratory, diagnostic imaging, cardiopulmonary therapy and ambulatory care surgery service. The licensed basic emergency room provides medical and psychiatric evaluation and treatment.

The ten ambulatory care Federally Qualified Health Centers in East, West and Central Contra Costa County are licensed as an outpatient department of CCRMC. The clinics provide family practice oriented primary care, geriatrics, dental, rehabilitation, prenatal, pediatric and adult medical services, as well as medical and surgical specialty clinical services. Specialty clinics include podiatry, infectious disease, eye, dermatology, orthopedics, urology, Ear, Nose and Throat (ENT), gynecology, general surgery, plastic surgery, nephrology, neurology, rheumatology, and other services. All age groups are served. The ambulatory care centers serve as an integrated care delivery system with the hospital, behavioral health clinics, detention health centers, and all of the other ambulatory clinics. The delivery system is served by an electronic medical record that allows for communication between all sites and providers.

The interdisciplinary medical staff at Contra Costa Regional Medical Center and Health Centers (CCRMC/HCs) includes a wide range of generalist and specialty physicians and nurse practitioners to serve the patients of the County. The active staff numbers nearly 400 providers. The Family Medicine Residency Program provides clinical experience for 39 residents who rotate through all inpatient acute services, the emergency department and ambulatory care centers.

Patient Population

CCRMC/HCs is the primary medical and dental network provider for Medi-Cal beneficiaries in Contra Costa County. CCRMC/HCs supports the most vulnerable and low-income population in the County, including a high number of homeless and immigrant residents and others who traditionally have a high prevalence of mental health and co-occurring conditions.

As an organization CCRMC/HCs strives to create optimal health for all through respectful relationships and high-quality service. Our goals to achieve optimal community health include:

- Being patient and family centered
- Fostering continuous improvement
- Delivering value and safe care

Contra Costa County is experiencing rapid population growth and rising poverty. Many patients face food and housing insecurity and transportation issues as they struggle to earn living wages. These daily stressors manifest themselves as poor health among the population we serve. Our community members face a myriad

of chronic health conditions that are worsened by the growing poverty rate and deepening health disparities in our county. We recognize that collaborative and integrated care methods are required to help improve health outcomes in our population.

The following list summarizes some of the high intensity patient needs that increase complexity of the care provided by CCRMC/HCs:

1. 34% our patients have behavioral health needs requiring interventions
2. 57% of adults reported experiencing COVID-19 related adversity or trauma requiring resources and support
3. Nearly 50% of our patients utilize interpreter services in at least 45 different languages to communicate with their provider in a language other than English
4. We have a higher proportion of late-stage cancer diagnoses. 27% of women newly diagnosed with breast cancer at our health system had localized disease, compared to the national benchmark of 62.6%. Late-stage colon cancer diagnoses were higher at our health system than the average of 30 other community hospitals in California (48% vs. 40% of stage III and IV colon cancer at diagnosis). The most common cancer deaths are lung, colorectal, breast and pancreatic.
5. Our award-winning cancer center provides chemotherapy infusions using state of the art research protocols at a cost of $500,000 per month. Our patients who utilize these services often have difficulty with transportation to/from care and require significant support in the home post chemotherapy infusion.
6. In the Pre-COVID period, heart disease accounted for 23% of the non-cancer-related deaths in the county.
7. Nearly 50% of pediatric patients cared for in our system have a body mass index (BMI) of 85th percentile or higher. Similarly, 39% of our adult population are overweight.
8. About 8% of our population is diabetic with another 47% pre-diabetic
9. 19% of children ages 1 to 14 have an asthma diagnosis in our county, compared to 13.8% statewide
10. More than 1,400 children in foster care are under the supervision of Contra Costa County
11. Approximately 11,000 individuals annually receive medical services in Detention while incarcerated
12. Transitions in care from incarceration to community health services are coordinated upon release from jail
13. Greater than 70% of our patients qualify for Medi-Cal insurance based on poverty level income requirements
14. At least 11% of our patients report food insecurity, approximately 10% have unmet transportation needs, and approximately 30% of our patients are at least somewhat socially isolated
15. 95% of babies delivered at CCRMC are covered by Medi-Cal. Black mothers are more likely to have caesarean sections, have pre-term labor, and have lower birth weight babies.
16. African American residents have a shorter life expectancy and are more likely to die from heart disease and cancer than other racial groups
17. The opioid epidemic has resulted in more drug overdose mortality and driven staff and resources to delivering increased access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives
18. The Human Rights Campaign Foundation recognized our system as a leader in healthcare equality. Our equity team reviews data to identify and implement plans to reduce disparities

CCRMC/HCs are on the front lines of social and racial disparities of our society. The combination of complex disease, low income, high social needs, language barriers, behavioral health issues, drug use, inequities, and increasing regulatory pressure has led to CCRMC/HCs development into a highly skilled care coordinated health delivery system. Longer and more numerous care visits are needed to coordinate services with other

agencies and community resources. Providing adequate support services for high utilizers of the healthcare system can be very costly. This work also requires investment in a diverse workforce that can meet the needs of our patients in a culturally and psychosocially appropriate manner. As one example, hiring and training Community Health Workers to support patients with social needs allows us to offer standard social needs screenings at all healthcare entry points and on-site assistance with digital disparities (subsidized cell phones, low-income internet, and MyChart enrollment), assistance with food insecurity and health care enrollment.

CCRMC/HCs is committed to the families of our community and will continue to innovate and amplify our coordinated approach to health care delivery. Clearly our whole person care model, though more resource intense, is the way to succeed in providing services to a highly complex and underserved community where historic inequities require we think past the simple fee-for-service (FFS) structures of the commercial health care market.

Cost/Revenue

Providing the needed medical to care to CCRMC's patient population is costly. The current annual budgeted cost of this population is $693 million. Approximately 90% of the cost of care provided to these individuals is offset by revenue, i.e. Medi-Cal, Medicare, etc.; the remaining 10% is funded by County General Purpose revenues.

CCRMC provides care to individuals with a variety of insurance coverage. Medi-Cal is the primary coverage and revenue source representing 70%-75% of the patient population. For Medi-Cal payment purposes the State has identified CCRMC as a Designated Public Hospital (DPH). As a DPH CCRMC must **self-finance** the vast majority of the Medi-Cal revenue streams utilizing Intergovernmental Transfers (IGTs) or Certified Public Expenditures (CPEs)

Medi-Cal is jointly funded by states and the federal government. States can fund the non-federal share from a variety of sources. In California, the state relies heavily on public hospitals/counties to help fund the non-federal share for Medi-Cal. Public hospitals/counties provide billions of dollars of non-federal share each year, the vast majority of which fund supplemental payments to the public hospitals that are critical to the financial viability of these systems. The methods of financing the non-federal share by the public hospitals/counties fall into two categories: IGTs and CPEs.

IGTs

An IGT is a transfer of funds from another governmental entity (e.g., public hospital/county) to the state Medi-Cal agency. The Medi-Cal agency then uses those transferred funds as the source of non-federal share to draw down matching federal funds and pay the total amount of funds as a Medi-Cal payment to a Medi-Cal provider. In California there have been numerous IGT-based payment programs that fund public hospital systems such as Medi-Cal managed care supplemental payments and payments under the 1115 Waiver.

A simple example of how the funding works is as follows:

- Public Hospital A is eligible for a payment of $1 million
- The required non-federal share of that payment (assuming 50% matching rate) is $500K
- The hospital will send to the state $500K.
- The state will then use that to draw down the federal matching funds of $500K.
- The state then pays Public Hospital A the total $1 million (basically returning the hospitals initial $500K plus the $500K in federal money)

- The net payment to Public Hospital A is the $500K even though from the federal government perspective the total Medicaid payment is the $1 million.

Additional examples of programs funded in this manner are the Global Payment Program, Whole Person Care, Prime, Enhanced Payment Program and the Quality Improvement Program.

CPEs

CPEs are a mechanism where a public entity, such as a public hospital, certifies its actual cost of providing Medicaid services to the Medicaid agency. The Medicaid agency then uses that cost certification to draw down the federal share of the certified costs and then passes those dollars to the certifying entity as a Medicaid payment. Unlike IGTs, there is no transfer of money from the public entity to the state. In California there have been numerous CPE-based payments that fund public hospital systems, most notably it is the method of payment for inpatient hospital services in FFS where there is no state general fund support, and in addition is used in some additional supplemental payment programs as well.

A simple example of how the funding works is as follows:

- Public Hospital A submits cost reports documenting that it experienced $1 million is Medi-Cal costs for Medi-Cal services to the state.
- The state uses that cost report and certification to draw down the applicable federal share of funding (assuming a 50% matching rate) of $500K.
- The state then pays Public Hospital A the $500K.
- The net payment to Public Hospital A is the $500K even though from the federal government perspective the total Medicaid payment is the $1 million.

Additional examples of programs funded in this manner are Supplemental Outpatient services, Inmate care and the Construction and Renovation Program.

The use of the IGT/CPE process limits the revenue growth. Because of the Federal match requirement revenue does not keep pace with the inflationary rise in medical care cost, the increasing cost of specialized services, the increasing morbidity of the CCRMC patient population, the housing of “hard to place” individuals, without payment, or the replacement cost of needed medical equipment. The annual unfunded component of projected cost for the 2022/23 fiscal year and on-going is currently estimated at approximately 5% of the operating budget or $40 million. An annual request of $55 million for growth is not unreasonable.

Recommendation:

The County Administrator’s recommendation is to fund CCRMC in the amount of $40,000,000 annually, which will provide operational stability for the foreseeable future.