THE CALIFORNIA HEALTH SERVICE

PLAN

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Health Care Options Project

California Health and Human Services Agency

March 31, 2002

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ACKNOWLEDGEMENTS

The Health Care Reform Project was funded by the federal Health Services and Resources Administration (HRSA) to explore options for expanding health care coverage. The California Endowment provided some supplementary funding. As one of twenty states to receive a HRSA grant, the California Health and Human Services Administration (CHHSA) established a process that has been dynamic and invited public participation and visibility. Donald W. Light, Professor, Princeton University; and Tom Moore, Jr., consultant to organized labor, San Francisco, made substantial contributions to the original conception and drafting of this proposal. Tom Moore's work on preventable hospitalizations for ambulatory care-sensitive conditions is noted in Appendix A. Some of Professor Light's extensive publications on national health systems and universal health care are cited in the bibliography. Leonard Rodberg, Professor, Queens College, City University of New York; Deborah Socolar, Co-Director, Health Reform Program, Boston University School of Public Health; and Alan Sager, Professor and Co-Director, Health Reform Program, Boston University School of Public Health; have all provided important and ongoing comments on successive drafts, and on the financial modeling and qualitative analysis. Robert Isman, DDS, MPH, provided helpful background information on access to dental services. Jennifer Cho, Culture & Linguistic Specialist, L.A. Care Health Plan, offered important information about the unmet need for interpretation and translation services in California. Lynn Anne Mulrooney at the University of Hawaii offered observations and sources about the health professions. Ann Bossard, ESRI Health and Human Service Solutions, ran several iterations of a program exploring the geographic distribution of California hospitals. Michael Dimmitt at the California State Assembly Budget Committee for Health, Mental Health and Developmental Disabilities and several staff at the California Office of Statewide Health Planning and Delivery offered valuable assistance in accessing and formatting the information on hospital financing represented in Appendix C. My colleagues in the Medical Care Section of the American Public Health Association, and in the California Public Health Association-North, have provided organizational and intellectual support for considering the role of public health and a health service model in the U.S., although neither organization is formally associated with this proposal. U.S. Representative Barbara Lee and her present and former staff, particularly Lynnette Farhadian, Michael Rubiano, Roberta Brooks and Ying Lee have been graciously supportive of the present effort. Rep. Lee introduced the original legislation that created the Health Care Options Project, while a member of the California State Senate. She continues to update and introduce national legislation proposing a health service model for the U.S., including most recently H.R. 3080, the U.S. Universal Health Service Act of 2001. Her predecessor in the House of Representatives, Ronald V. Dellums, first introduced a national health service bill in 1977. The hundreds of Californians who gave their time and thought at a series of public symposia sharpened the issues. I thank and acknowledge them all, and take sole responsibility for the contents of this work, including any errors.

SUMMARY

The California Health Service Plan:

- **Reforms both delivery system and financing**
- **Publicly funded**
- **Public owns delivery system, trains and employs clinicians**
  - **Pay clinicians by salary**
  - **Pay hospitals by budget**
  - **Quality Improvement Initiatives**
- **Responsive administration**
- **Equitable allocation of services based on need**
- **Addresses California crises in financing, inequalities, clinician shortages**
- **Achieves universal coverage at lower cost than present system**

The California Health Service Plan (CHSP) is designed to rebalance the relationships of providers and users of health care services, payers, and the state, in the interests of high quality outcomes from personal health services, and improving population health.

The California Health Service Plan would create a publicly funded program that will provide universal and comprehensive coverage for all Californians. The program would also transfer responsibility for delivering health care to the public sector. Financing the system through a single government payer, and public ownership, would make it possible to implement effective policies to control costs, allocate health services based on population need, improve quality and outcomes, and organize the delivery system.

The state administration would aim to be flexible and responsive to emerging health needs, and to democratic participation by providers and users.

A focused public health system would collect data, set policies and implement programs to improve population health, including redressing inequalities.

The plan relies on macroeconomic incentives to providers to control expenditures, rather than microeconomic measures such as copayments that can reduce utilization but have inequitable effects on users and are less effective at controlling expenditures. Clinicians and other health care workers would be salaried and paid by the State, which would also sponsor their education and training. Physician education and employment policies would change the balance between primary care and specialty services, to improve quality of care and to control costs.

Savings from administrative simplicity, and the shift to primary care, would make it possible to cover all Californians at less cost than is currently spent to cover only 75% of residents. The program would achieve about $5 billion in savings in the first year of full implementation, and significantly more over time by controlling current inflation in health care expenditures. The vast majority of Californians and businesses would spend less than they do presently.

Current crises facing the California health care system require organizational as well as financial solutions. The need to rebuild substantial portions of the state's aging hospitals will place additional strain on many financially vulnerable hospitals. Preventable hospitalizations for conditions sensitive to timely ambulatory care are high and rising. Disparities in access to services for communities of color and immigrants undermine their health status. An imbalance in specialist to primary care physician supply, and inadequate distribution of clinicians in low income communities, communities of color, and rural areas, add to the cost of care and diminish outcomes. The shortage of nurses in California as in the rest of the U.S. calls for an examination of programmatic reforms in the workplace and in the training system. Accountable public authorities can and should take steps to resolve these problems.

The unique characteristics of California's large uninsured population render impractical expansions of insurance coverage through the workplace. Compared with the nation, uninsured Californians disproportionately encompass working non-citizens, "flex" or contingent workers who do not work full time for a single employer, and individuals earning more than 300% of the federal poverty level as well as low-income adults.

The proposal is designed to redress the limits of market-oriented approaches to controlling costs and expanding coverage, and the resulting inefficiencies in the health care delivery system. The proposal presents major features in the reorganization of a complex system. It incorporates lessons from the experiences of industrialized nations that provide universal coverage, with particular attention to those that operate a health service system, and builds on existing patterns in California of funding and providing health services.

OBJECTIVES

The proposal aims to:

- **Present a specific model for achieving universal health care coverage**
- **Broaden policy debate to address public financing, and organizational characteristics of high quality systems**

The objectives of this proposal are twofold. The first is to present a model for a universal health care system financed and operated by, and accountable to, the public. The plan is intended to be sufficiently specific to permit modeling of its likely expenditures and savings compared to the current system, and the outline of a feasible transition.

The second is to contribute to a policy debate about the elements of reform that will be required to effectively deliver affordable, high quality, and responsive health care, and to help build public support for such a goal. These elements include consensus on the relative responsibilities of the public and private sectors, and mechanisms (regulation and market forces) for controlling costs, allocating capital and services, organizing the delivery system, and creating accountability for outcomes.

Universal coverage in California is an important policy objective. A single payer financing mechanism would shift considerable funds from administrative savings to expanded coverage. In addition, long term cost control is likely to require reorganization of the delivery system, entailing a shift in the relationships among clinicians, health facilities, users of health care and the government to produce improvements in health status, the cost of which is generally considered justified by the value of the outcomes. (30)

An array of macroeconomic and microeconomic cost controls have been tested in California and elsewhere over the last thirty years, offering valuable policy lessons on methods to improve efficiency and responsiveness, and to control costs. A comprehensive program that integrates currently fragmented sources of financing, coordinates the delivery of services, and addresses pressing population health needs, will be critical to controlling costs in the long run. A comprehensive approach would also improve health status and the quality of care

U.S. health policy of the 1960s and 1970s combined government health planning with cost-plus reimbursement, leading to expenditure levels that became unacceptable to payers. Payers concluded that weak regulation of providers was not sufficient to control the effects of perverse financial incentives. Price competition was introduced in the 1980s to exert fiscal discipline over providers.

The social experiment with imposing market forces onto the health care system exhibits increasing problems over time. It is remarkable that it proceeds with so little consideration of alternatives in mainstream policy discussions. This regime has not provided a framework or a financial surplus sufficient to expand coverage or access. California has had a persistently high rate of uninsurance throughout the recent period of enormous prosperity, despite relatively low health care costs and utilization. The 9.5% increase in health insurance premiums suggests that market-driven competition to discipline providers, coupled with weak regulation of payers, is not a sustainable method of cost control. (17) Some attribute rising charges to the failure to sufficiently convert sick people into consumers doing their part to create Pareto optimality. Employers are expected to reduce or eliminate health coverage, shifting the financial burden to employees, and increasing the number of uninsured and underinsured residents. A continuing economic downturn may poise the state for a return to "a paradox of dramatic increases in health spending and diminished access to care." (54)

Meanwhile, clinicians report the routine tragedies that $1 trillion a year in national health care expenditures do not prevent. One such account was presented by Robert L. Ferrer, a Texas physician, in a recent issue of JAMA:

> "My waiting room … seats 228 and by mid-afternoon it is usually packed. On a good day patients will wait two to three hours to see me or one of the other clinicians who work here. On a bad day the wait can reach five or six hours. Not as many patients complain as you might think. Almost all are uninsured, and they have nowhere else to go. Our 'acute care' clinic is a large county-hospital walk-in

> clinic -- portal of entry to the public health care system in a county in which 360,000 of the 1.3 million inhabitants are uninsured. The numbers are alarming, but the stories underlying them are even worse.
>
> "A man in his early 20s with a worsening dental infection was unable to afford a dentist. He finally saw a physician who prescribed an antibiotic, but the patient was unable to pay for the prescription. He presented to our clinic with sepsis and spread of the infection to his mediastinum. He died soon after admission.
>
> "The egregious is commonplace in our setting.
>
> "Events such as these are the product of an increasingly coherent system of exclusion that denies care to the uninsured: the system of no-system…embedded within the national nonsystem of health care. Despite legislation to prohibit patient 'dumping,' it still occurs. Private hospitals are no longer shipping indigent patients off to public EDs in a taxicab. Instead, they now offer perfunctory treatment, forego any diagnostic procedures, and discharge patients with instructions to 'follow up tomorrow with your primary care physician.' They might as well be advised to see their personal banker.
>
> "It is time to rescue the 39 million Americans who are forced to seek care within the system of no-system. The need and the suffering are there, now, plain for all to see."

The abandonment of tens of millions to avoidable distress and death is not acceptable. We must scour our creativity to find a solution, and the political will to implement it. This must include an open policy debate about universal health care in the U.S. that includes consideration of government financed programs.

CENTRAL PRINCIPLES

This proposal describes a coordinated system that can provide appropriate, continuous and integrated health services, focused on improving individual and population health. The proposal rests on three central principles:

- **Central government role in setting goals for quality and cost, organizing the system, and holding the system accountable.**
- **Reliance on macroeconomic incentives for providers to control costs and utilization**
- **Engagement and participation by health care users and providers**

The first principle is that state government, and related health agencies at the state, county and local levels, can and should play a central role in setting goals for quality and cost, organizing the system so that these goals can be achieved, and holding the health care system accountable for meeting those goals. After nearly twenty years of activity focused on cost control, with decentralized for-profit insurance companies as the primary agents imposing financial discipline on the providers and users of the health care system, there is a pressing need for coordination. Not only are there almost innumerable

public and private payers. The service delivery system, fragmented to begin with, has become further Balkanized by competing provider networks, often frustrating the possibility for continuous relationships between caregivers and patients, as well as regional coordination of services. The role of establishing the vision and priorities of the health care system, and the responsibility for creating conditions in which the health of the population can flourish, are most effectively carried out by the government. To redress the present imbalance, this proposal favors mechanisms most likely to establish a central authority for guiding the financing and delivery systems. It also recognizes the importance of mechanisms to permit flexibility and course corrections.

Second, the proposal focuses on supply-side reforms to control costs, building on the conclusions of World Health Organization analysts that these have been most effective in Western Europe.(50) These ongoing reforms have been intended both to control costs and improve the delivery of care, and suggest several lessons. For purposes of cost control, utilization can be reduced either on the demand side (patients), or the supply side (providers). The WHO analysts conclude from comparing experiences over time that individual patient utilization is most effectively controlled via macroeconomic approaches: treating population health, and designating a public health authority to identify and address socioeconomic causes of disease. Microeconomic measures such as choice of health insurance plan are less effective on a systemwide basis. Copayments can reduce patient-driven utilization. However U.S. residents already have the lowest rate of physician visits in the industrialized world, and additional reductions are unlikely to be a key building block of cost containment.

On the provider side, however, they found that microeconomic factors are more important. That is, whether providers are reimbursed via fee for service (clinicians) or per diems (hospitals), or more globally via capitation, salary, or budget, it is the mix of incentives and organization of services that determines success. Microeconomic incentives such as payment incentives can be effective at directing the supply side, if coupled with a supportive authority enforcing patients' rights and quality.

The present proposal is designed to improve health by strengthening the public health system, and encouraging targeted community interventions in the delivery of clinical services.

The third pinciple is that engagement and involvement by health care users and health care workers is crucial to creating a functional health care system. The concerns and involvement of health care workers and professionals are important. Addressing the concerns of patients is the central goal of the enterprise. Engaging patients is key to keeping providers and the government accountable and responsive.

FEASIBILITY OF A HEALTH SERVICE SYSTEM FOR CALIFORNIA

This section identifies California health care problems that are best solved by a health service system. Beginning with the section on Target Populations and Eligibility, on page 16, further operating details of the proposal are presented.

California conditions and health care priorities call for a health service system:

- **California's uninsured not suited to employment based insurance: immigrants, flex workers, both high and low income residents**
- **Rebuilding California hospitals: allocation by financial vulnerability vs. need**
- **Reducing hospitalizations for ambulatory care sensitive conditions**
- **Reducing disparities in access to services for communities of color and immigrants**
- **Imbalance in physician/generalist supply, underserved communities of color and rural areas**
- **Time for a course correction**

Several conditions present in California today either call for concerted public sector intervention, or offer the opportunity for it, in order to assure that expansions of coverage will be affordable.

1. California's uninsured: numerous, immigrants, flex workers, at income poles

California is an ideal state to pilot an alternative to employment-based health insurance. It has the highest or close to the highest uninsurance rate in the U.S., according to various reports. Over 20% of Californians are uninsured, and in Los Angeles the rate is over 30%. Working adults are the vast majority of the uninsured, largely because of the structure of employment, and a workforce with insufficient leverage to compel employers to establish or fund health insurance. The uninsured workforce are disproportionately in "flex" jobs: temporary, part time, seasonal, or independent contractors; Lucien Wulsin et al. estimate that only about half work at full time, full year jobs. Marcelli estimates that 2.3 million of 16.6 million workers are employed in the "informal" sector including agriculture and personal services.(31) 25.6% of the population are "non-citizens;" 30% of California workers are Latino, compared to 8% in the U.S. as a whole. The rate of unionization is low, especially in the south. A focus group conducted in San Mateo County with unionized janitors who are uninsured illustrated the difficulties low-wage workers who are monolingual in Spanish encounter in initiating coverage after a waiting period for eligibility that may last from 12 to 36 months. (Available from the author.) Fewer California employers offer insurance, though the take-up rate is comparable here, including among immigrant and Latino workers. Only 51% of residents have employment based insurance, according to KFF State Health Facts Online, the seventh lowest in the nation; the UCLA Health Policy Center reports that 60.6% of the nonelderly had employer based coverage in 1999, compared with 69% nationally, and a high of 79% in Wisconsin.

Immigrant workers may have public charge concerns regarding enrolling for public services However, many come from countries where the government provides health care, and the concept of purchasing insurance is far more foreign. Public charge concerns can be addressed through easy enrollment and public policy measures. Public opinion regarding immigrants generally has become more positive in the last several years, due in part to the communities' exertion of political power.

The public sector already provides the bulk of services to uninsured adults. Explicit use of public funds to provide health care services for immigrants, both documented and undocumented, may continue to be a contentious issue, but it is being piloted in Alameda County and elsewhere, and is unavoidable if coverage is to be expanded meaningfully.

An additional and compelling factor that makes public sector coverage feasible is that a significant number of uninsured workers earn wages greater than 300% of the federal poverty level. Mark Smith, director of the California Health Care Foundation, estimated that 30% may fall in this category, in remarks to the California Association of Public Hospitals annual meeting in 2000. The San Mateo County Health Works project found that many low wage workers have two or more full-time or part-time jobs, in order to afford the high cost of living in the San Francisco Bay area; this drives up their total incomes. This population is unlikely to benefit from subsidies targeted to low income, but they cannot afford to buy health insurance independently.

The state's recent reluctance to fund health services and social programs adequately presents a barrier to feasibility, although its longer history of generous benefits, and the successful results of increases in MediCal funding for pregnant women, provide grounds for optimism.

2. Rebuilding California hospitals

California will be rebuilding a significant portion of its 2500 hospital buildings at 475 hospital campuses by 2030, to comply with seismic safety standards set by SB 1953. Significant repairs are required sooner, by 2008. Direct patient care facilities are usually the oldest parts of the hospital plant, and therefore most likely to require replacement. Cost estimates for the entire enterprise range from $5 billion to $40 billion, depending on whether buildings are retrofitted, or undergo more complete modernization. (33)

This raises the question of whether all existing hospitals should be rebuilt. If not, the further question is which ones, and why.

California inpatient hospital occupancy for actively staffed beds hovers at around 60%, as it has for decades, although 23 of 401 general acute hospitals closed between 1995 and 2000. (23) Lengths of stay have fallen, and many procedures are now performed on an outpatient basis. This could suggest that closing a number of hospitals, or failing to rebuild them, is a wise course. On the other hand, Sager et al. have suggested that demand for institutional care may increase for a number of reasons, including aging of the population. Even if new mechanisms contain costs, if resources are not adequate strains will manifest themselves in long waiting lists and declining quality of care. They propose that mothballing unused capacity, but not destroying it, will save building costs in the long run.(49)

Efforts to close hospital beds in the UK have shown that the process requires a planned approach that can achieve savings while maintaining access. (50) No such planning process, to match population need with facility rebuilding, exists in California.

The present study finds that 202 of 382 general acute hospitals reporting to OSHPD in 1999 had a negative operating margin, indicating that hospitals are losing money from operations (see Appendix C.1). The average operating margins for California hospitals were negative in 1997 and 1999, and the average over the three-year period 1997-1999 was -.71. (40) This degree of financial distress suggests that over half of hospitals will have trouble borrowing money for needed rebuilding and insuring their bonds, and likely will turn to the state for assistance. (Note: a one-year analysis is not considered a reliable reflection of a hospital's financial position. The information presented in the appendices is primarily for purposes of illustration. An analysis of data over three years would be more reliable, but could not be produced within the constraints of the current project.)

As a recent report notes, there is a wide disparity between financially stable hospitals and those that are weaker. (20) California hospitals in the top quartile, by operating margin, outperformed the nation's top quartile in 1999. However, California hospitals in the bottom quartile showed an operating margin of –7.76, compared with –5.1 nationally. There was a gap of 10.82% between the top and bottom quartile median California margins in 1995, a gap that widened to 13.48% in 1999. (20)

Hospitals that closed between 1995 and 2000 performed worse financially than other hospitals, and experienced declining reimbursements and income per bed the year before closure. Most were in Los Angeles. In some cases, communities lost reproductive health services, and in two cases, closures removed all hospital service from a 15-mile radius. (23) If hospitals close on the basis of financial weakness, there is no assurance that community health care needs will be met, including access to emergency and hospital outpatient services.

Appendix C.2 presents the 202 hospitals with negative operating margins in 1999 by ownership type and by designation as a small/rural or teaching hospital Those reporting negative margins include:

48 small/rural hospitals, out of 76 total such hospitals
11 teaching hospitals, out of 32 total such hospitals
33 district hospitals, out of 47 total such hospitals
5 county hospitals, out of 28 such hospitals

Appendix C.3 presents the 202 hospitals with negative operating margins in 1999 grouped by county.

Whether the cost of rebuilding is borne directly and immediately by the state, or financed through private lenders, the cost will be paid by users of health care services, either in the form of higher charges, or reduced expenditures on other items. Since staffing is the largest hospital budget item, further reduction of staff/patient ratios could be anticipated.

All of these factors suggest that planning is required to evaluate the distribution of hospital capacity, in the interests of serving the population's long and short-term health care needs that would not be addressed if market forces continue to dictate closures.

They will also lend feasibility to the state's exercise of eminent domain to acquire health care facilities.

3. Increasing number of hospitalizations for ambulatory care sensitive conditions

Preventable hospitalizations for ambulatory care-sensitive conditions cost a minimum of $4 billion annually in California, and are increasing. (See Appendix B) Effective medical care can maintain health and prevent hospitalizations, which are more costly. Ready access to primary care contributes to managing chronic diseases such as diabetes, prevents illness from immunizable conditions such as measles, and catches acute onset conditions like pelvic inflammatory disease before they worsen. Hospitalizations for such ambulatory care-sensitive (ACS) conditions are an indication of inefficiencies in the delivery system: either poor access to primary care, or poor quality of primary care.(5) The rate of preventable hospitalizations is higher in areas that are lower income and in communities of color, for people with private insurance. (18) However, there is no such difference among Medicare beneficiaries, suggesting that insurance makes a difference.(41)

Even among Medicaid patients, having a medical home protects health. Medicaid beneficiaries who were regular patients at a federally qualified health center, in 24 areas of 5 states, had 20% fewer hospital admissions due to ACS conditions, compared with similar patients with no regular source of care. FQHC patients had a modestly higher number of office visits, but this did not explain the differences in hospitalization rates. (15)

A United Hospital Fund review of health plans determined that an achievable and acceptable rate of hospitalizations for ACS conditions is 5 per 1,000 admissions.(37) In 1992 Portland, Oregon had a rate of 6.85/1,000, while New York City had a rate of 15.16. The California rate in 1998 was 13.96. Rates among counties ranged from 22 in Plumas to 4.3 in Mono. The rates are rising annually. Even in relatively affluent counties such as San Mateo, the rate rose from 8.66 in 1997 to 9.54 in 1998.

Effective organization of the delivery system is integral to reversing this substantially controllable trend. Expanded availability of primary care, and community outreach systems to connect high-risk individuals with regular sources of care, as proposed here, make a difference. Creating such a system from currently fragmented care will require a high degree of coordination of health care delivery, best accomplished through a health service.

The U.S. has the potential for the world's most sophisticated systems of information technology, capable of identifying incidence and location of treatable illness, and disseminating research on the most effective treatments. As the recent experience of a

dropped anthrax report in New York has demonstrated, the system's capacity to coordinate and respond to relevant information is dangerously low.

The CHS would have the capability not only to enhance collection and dissemination of data, between and among localities. By integrating information and clinical practice, the CHS will be able to respond effectively to immediate threats, as well as longer term concerns.

4. Disparities in health status and in access to services for communities of color and immigrants

Mirroring the nation, California health indicators for people of color (no long "minorities" in the state population) lag behind those of whites.(30) The state does an increasingly good job of documenting the problem. (8) The CHS will be able to target services more directly to populations at risk, and coordinate with other public health initiatives to improve health and reduce inequalities, such as community outreach and support, education, and economic development.

Latinos and African Americans in Los Angeles are less likely to have certain cardiac surgical procedures compared with whites, and distance from a hospital is associated with a significantly lower rate of angioplasty and of coronary artery bypass graft, according to one study. (9) Another recent study indicates that lack of access to primary care is also a significant predictor of poor health for African Americans, though the effect of race disappears when controlling for socioeconomic status. (55)

The percentage of African Americans and Latinos living in California communities correlated directly with the likelihood of a community being a physician shortage area, and correlated inversely with the number of physicians practicing in the community, according to another study. (26)

About 25% of the California population are immigrants, mostly from Latin America and Asia. Immigrants have both advantages and disadvantages in terms of health status, and culture may have a protective effect. To the extent that acculturation is associated with health education and use of preventive and screening services, it is beneficial to immigrants. Studies suggest that immigrants to Canada, which provides universal coverage, become acculturated in their use of health services and health status within 3 to 6 years, compared with 10 years in the U.S. (27)

5. Imbalance in physician generalist/specialist supply; maldistribution of MDs, particularly in low income/communities of color, and rural areas.

Contrary to anecdotal reports, California maintains a high doctor/patient ratio, ranking 14th in the nation at 280 doctors per 100,000 population as of 1999, just slightly below a US average of 285/100,000. (24) However, the state is 36th in the percent of primary care doctors, at 33%. The Center for the Health Professions similarly reports that California has a 20% higher supply of specialists than the upper bounds of requirements set by the

Council on Graduate Medical Education. Average annual income for specialists is twice that of primary care doctors, at $250,000 a year.(13)

As documented above, access to primary care can improve health status. Primary care is also cost effective, reducing expenditures on preventable hospitalizations.

While California clearly remains an attractive location for physicians, primary care doctors have difficulty affording the costs of both housing and opening a practice in many parts of the state. The National Health Service Corps, through state agencies, places between 30 and 40 physicians a year in underserved Medical Services Study Areas, (12) compared with practically 92,985 practicing nonfederal doctors in the state in 1999. (24)

The CHS would take three steps to address these problems:

a. Finance medical education. This is consistent with practice in most industrialized countries, which either heavily subsidize or completely pay for medical education. It would allow students more representative of the state population to become doctors. Minority and women doctors are more likely to prefer primary care.

b. Develop a plan for redistribution of physicians, primarily by directing the location of new graduates, and precluding most from locating in "overdoctored" areas.

c. Encourage the formation of group practices and multispecialty clinics, particularly in urban and suburban areas. This will facilitate providing care through teams of professionals, which will enhance care as well as balance distribution.

Public funding and organization of the delivery system also removes tremendous administrative burdens from physician practices and from other clinicians.

6. Shortage of nurses and dentists

California and the nation face a moderate to severe shortage of nurses, at the same time as an aging population is likely to increase demand for nursing care. RNs are far more disproportionately white and female than the state population. (13) The are also older; most are over the age of 40. Half of California registered nurses are trained outside of the state. 44% of qualified applicants to California State University nursing schools were denied admission in 1997 due to lack of capacity. (57) By sponsoring and coordinating health professional trainings, the CHS can take steps to increase training capacity in the state.

Working conditions could also be improved, beyond the critical issues of staffing and compensation. Studies show that autonomy is an important element of job satisfaction for nurses (1) as well as for doctors.

As the employer of the state's health care workforce, the CHS will be in a position to motivate and coordinate the redesign of clinical training, and also encourage the development of workforce teams to carry out the services needed to deliver optimal care.

Dentists are also in short supply, particularly in rural areas. 31 of 32 shortage areas for dentists are also rural areas.

7. Time for a course correction

California has vigorously pursued market-based health policy solutions. The achievements and sustained value of that approach are under scrutiny. California health care premiums are about median for the nation, and rising. Hospital per diem rates are high. Issues of capacity and quality are receiving renewed attention. Organized public and private systems of care exist in California, including some county systems and Kaiser, but are limited by fragmented financing and organization of services. These and other groups of providers that could find a productive role in a public system.

This is an important moment to consider alternative approaches. It is possible that health care reform may soon attract attention, in light of a faltering economy. Public health threats subsequent to the events of September 11 have renewed awareness of the nation's deteriorating public health system, and renewed interest in public sector solutions. It is time to re-examine the contribution of the public sector and public health to creating an accountable, affordable and coordinated health care system, that provides high quality care to all residents.

TARGET POPULATIONS AND ELIGIBILITY

- **All residents covered**
- **Three month waiting period for eligibility for new residents**
    - **Transitional services available in the interim**

All residents with a primary residence in California for three continuous months, newborns delivered in California, and newborns delivered elsewhere but whose parents are California residents, would be entitled to comprehensive covered services. New residents from other U.S. states previously insured elsewhere will be permitted to retain that insurance for the first three months of residence. Relocating residents from other U.S. states who are uninsured and visitors would have access to primary care and emergency services, through payment arrangements made in advance or at the point of service, during the three month waiting period.

> Several California counties offer similar payment programs for uninsured residents who present for health care at public clinics and hospitals, including Basic Adult Care in Contra Costa, and the WELL program in San Mateo.

Inter-governmental arrangements will provide reciprocal coverage for temporary visitors and workers from Canada, Mexico and other Central American nations. Targeted outreach services and clinics will provide social and health care services for relocating immigrants and for migrant farm workers.

The original CHSP proposal included a six month waiting period for eligibility for hospital and long term care services. The purpose of a waiting period is to discourage migration from bordering states by people needing expensive acute care, or long term care. A waiting period longer than six months could be discriminatory to new arrivals. In the opinion of the financial modeler, however, the difference between a three month and a six month waiting period was not considered to have a significant effect on program costs. Therefore this final proposal uses a three month waiting period.

MECHANISM FOR EXPANDING COVERAGE

All covered services would be financed and provided directly by the state. (Covered services and financing mechanisms are described below.) Individuals would be initially informed of their right to health care benefits, and enrolled in the program, through public announcements including:

- online outlets
- the media
- schools
- workplaces
- government offices
- health care delivery sites, and
- community based organizations.

Certified Application Assisters, trained to enroll applicants into the Healthy Families program, and others will conduct outreach and enrollment at least during the first two years of the CHSP program. Outreach will concentrate on currently underinsured populations. Culturally appropriate informational materials will be provided.

Newborns delivered in California will be automatically enrolled in the program. The CHSP administrator would subsequently establish efficient mechanisms for assuring enrollment by other eligible residents.

COVERED BENEFITS

The purposes of developing an initial list of covered benefits are to:

- Provide a basis for modeling projected expenditures under different scenarios
- Reflect the maximum possible coverage for services needed and valued by the community, and supported by evidence
- Allow for future expansion

The initial benefits program will cover:

- preventive, primary, and acute services, including services for reproductive health
- home health care
- long term care
- dental
- vision
- prescription drugs
- acupuncture and chiropractic care, if practitioners operate within group practices described below
- translation and interpretation services

Other alternative services may be provided in the future through group practices depending on available funding, evidence of efficacy, and community demand. Alternative services offered outside of group practices will be covered upon referral from a primary care provider.

The full range of MediCal benefits will remain available to present beneficiaries during the two-year transition period, and reviewed prior to the initiation of the California Health Service.

The original version of this proposal excluded orthodontia, for purposes of comparing the cost of these services in this plan and in two other HCOP proposals that are financed through a single government payer. A preliminary analysis by the Lewin Group, presented in Appendix A, illustrates the marginal effects of adding these services. It estimates that the annual cost of covering orthodontia would be $2.1 billion.

The original version also excluded long term care services, for two reasons. Primary was the issue of comparing cost, as described above. The preliminary Lewin analysis estimates that coverage for nursing home care under the CHSP would add $3.7 billion a year. The second consideration was the ability to model the conversion of long term care facilities to the public domain. However it appears that a model was feasible, and is included in the modeler's appendix.

Translation/interpretation services

Translation of written materials, and interpretation of oral communications, are clearly critical benefits to assure culturally and linguistically appropriate care for many

Californians with limited English proficiency. This includes residents who are monolingual in a language other than English, or only partially bilingual. California law and federal regulations strongly support provision of these services. The Dymally-Alatorre Act of 1973 provides for effective communication between state residents and their state, county and municipal governments, and requires that services be made available in any language spoken by 5% or more of a community that uses the services. Los Angeles has identified the need to provide bilingual staff and materials in 33 languages, with particular concentrations in Spanish, Cantonese, Russian, Armenian, Cambodian and Vietnamese.

California law further affirms the right of every state resident to basic health care services, including access to information:

> Chapter 2, Health Facilities, Article 1 General, Section 1259:
> "(a) The Legislature finds and declares that California is becoming a land of people whose languages and cultures give the state a global quality. **The Legislature further finds and declares that access to basic health care services is the right of every resident of the state,** and that access to information regarding basic health care services is an essential element of that right. Therefore, it is the intent of the Legislature that where language or communication barriers exist between patients and the staff of any general acute care hospital, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff. (b) As used in this section: (1) "Interpreter" means a person fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language. Interpreters shall have the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages. Interpreters may include members of the medical or professional staff. (2) "Language or communication barriers" means: (A) With respect to spoken language, barriers which are experienced by individuals who are limited-English-speaking or non-English-speaking individuals who speak the same primary language and who comprise at least 5 percent of the population of the geographical area served by the hospital or of the actual patient population of the hospital. In cases of dispute, the state department shall determine, based on objective data, whether the 5 percent population standard applies to a given hospital. (B) With respect to sign language, barriers which are experienced by individuals who are deaf and whose primary language is sign language. (c) To ensure access to health care information and services for limited-English-speaking or non-English-speaking residents and deaf residents, licensed general acute care hospitals shall: (1) Review existing policies regarding interpreters for patients with limited-English proficiency and for patients who are deaf, including the availability of staff to act as interpreters. (2) Adopt and review annually a policy for providing language assistance services to patients with language or communication barriers. The policy shall include procedures for providing, to the extent possible, as determined by the hospital, the use of an interpreter whenever a language or communication barrier exists, except where the patient, after being informed of the availability of the interpreter service, chooses to use a family member or friend who volunteers to interpret. The procedures shall be designed to maximize efficient use of interpreters and minimize delays in providing interpreters to patients. The procedures shall ensure, to the extent possible, as determined by the hospital, that interpreters are available, either on the premises or accessible by telephone, 24 hours a day. The hospital

> shall annually transmit to the state department a copy of the updated policy and shall include a description of its efforts to ensure adequate and speedy communication between patients with language or communication barriers and staff. (3) Develop, and post in conspicuous locations, notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter and the telephone numbers where complaints may be filed concerning interpreter service problems, including, but not limited to, a T.D.D. number for the hearing impaired. The notices shall be posted, at a minimum, in the emergency room, the admitting area, the entrance, and in outpatient areas. Notices shall inform patients that interpreter services are available upon request, shall list the languages for which interpreter services are available, shall instruct patients to direct complaints regarding interpreter services to the state department, and shall provide the local address and telephone number of the state department, including, but not limited to, a T.D.D. number for the hearing impaired. (4) Identify and record a patient's primary language and dialect on one or more of the following: patient medical chart, hospital bracelet, bedside notice, or nursing card. (5) Prepare and maintain as needed a list of interpreters who have been identified as proficient in sign language and in the languages of the population of the geographical area serviced who have the ability to translate the names of body parts, injuries, and symptoms. (6) Notify employees of the hospital's commitment to provide interpreters to all patients who request them. (7) Review all standardized written forms, waivers, documents, and informational materials available to patients upon admission to determine which to translate into languages other than English. (8) Consider providing its nonbilingual staff with standardized picture and phrase sheets for use in routine communications with patients who have language or communication barriers. (9) Consider developing community liaison groups to enable the hospital and the limited-English-speaking and deaf communities to ensure the adequacy of the interpreter services. (d) Noncompliance with this section shall be reportable to licensing authorities. (e) Section 1290 shall not apply to this section."

The work cited by J. Cho and B.M. Solis documents that these rules are not consistently applied currently. There would likely be both additional costs and substantial savings from provision of adequate translation and interpretation services, as well as other aspects of culturally competent care. Because these costs and savings should apply uniformly to all health plans, they are not modeled independently for any one plan as part of the HCOP.

STRUCTURE AND ADMINISTRATION

- California Health Service Administration sets policy, coordinates Departments, assures accountability and responsiveness
- California Health Service Program delivers most health care services
- California Department of Pubic Health monitors vital statistics, implements programs to address social and economic determinants of poor health
- California Office of Statewide Health Planning and Development collects data, supports strategic planning

Rationale

The California Health Service Plan would combine the functions of financing and providing services, through a state authority. The potential advantages of this arrangement include:

- Alignment of financial incentives with system goals: improving population health, access, quality, and equity
- Availability of good data
- Successful cost containment, because providers are managed by payors
- Efficiency: Less micromanagement and regulation than systems that rely on markets to set prices and control expenditures, and on regulation to protect quality and equity, and to reduce fraud

The potential challenges of such a system are:

- Politically driven decisions
- Decision-making at a central level may not reflect local needs
- Inflexibility

A successful health care system would implement shared, socially determined goals. Based on a common mission, one question is then at what levels should decisions be made about strategy and policy; allocation of funds and services; and public health priorities. State, regional and local levels each offer advantages and disadvantages. Local bodies may be more responsive to local conditions, but also more subject to parochial political pressures, while state and regional bodies have less stake in a local delivery system, but may be more removed from local concerns. The system needs to maximize the advantages of each level, recognizing the need to adjust over time based on experience.

Options may include at least five types or centers of control: technocratic command and control; physicians; markets; democratic processes that link populations with the formulation of priorities, and with the administration of the health care system; and control by the population, either directly or through elected representatives. Some systems rely on professional managers, with renewable contracts; others find success with elected officials.

The California Health Service Plan would link local and regional groups of health care providers and users with a state administration, which sets overall goals and strategies,, and holds the system accountable for outcomes. Regional authorities would control some decisions about allocations, with close attention to drawing regional boundaries sufficiently widely to minimize vested interests in locating services in politically powerful areas, as opposed to determinations based on need. Clinical group practices, as described below, would have considerable autonomy regarding aspects of clinical care. Advisory groups would offer regular guidance regarding local needs and conditions.

Regional authorities, clinical practices and their respective community advisory boards may wish to enact and measure the effects of various combinations of financial and non-financial incentives to induce productivity and create high quality outcomes, within the

framework described below. The state could support such experimentation by approving it, or additionally by funding demonstration programs.

The state and its administrative bodies would consider separately and together the particular needs for resource allocation in particular types of California regions: rural, urban, inner-city urban, and suburban.

Administrative structure, Departments and Offices

The reconstituted California Health Service Administration (CHSA) will set policy for and coordinate the work of the Departments and Offices described below, in consultation with their directors, with organizations representing providers, and with appointed and elected boards representing users of health care.

Legislation will create the California Health Service Program (CHSP) as a department of the California Health Services Administration (CHSA), and will establish access to high quality health care for every eligible resident as a central goal. CHSP will be responsible for the delivery of most primary care, and for hospital and home health services.

In addition, the Department of Public Health (DPH) will conduct public health functions, and initiate and oversee efforts to improve population health.

The Office of Statewide Health Planning and Development (OSHPD) will collect and analyze data on utilization and expenditures for health services, and support strategic planning by the CHS and DPH.

Patient advisory boards will be elected at the community level, subject to conflict of interest rules. Community boards will nominate the members of the state advisory board, who will be selected and appointed by the Secretary of CHHSA. The boards will provide patient perspectives on organizational, access and quality issues, and will educate and communicate with patients. Elected members will be compensated for a half time position at the level of the county Board of Supervisors.

Veterans Administration and Indian Health Services would not be administered through CHSP during the transition period, but would be folded in subsequently. During the transition, mechanisms would be established to ensure coordinated care and financing for beneficiaries of those programs who may also use the state delivery system.

The intention of creating three Departments with equal standing – CHSP, DPH, and OSHPD - is to acknowledge the critical importance of each function for assuring quality and controlling costs: clinical services, public health, and data-based strategic planning. The further intention is to create a coordinating responsibility through the office of the Secretary of HHS, to reduce the prospect of fragmentation, and improve the likelihood of cross-communication.

Mission And Responsibilities Of The California Health Services Administration

The core goals of the CHSA will be to assure:

- Improvements in population health
- Access to health services
    - Reduction in inequalities in health status and equitable access to health services
- Fiscal responsibility
- An organized delivery system that produces safe, coordinated and high quality health care
- Productive and safe workplaces for Administration employees, with appropriate incentives for productivity, quality and financial efficiency
- Allocation of resources commensurate with population need
    - Responsiveness to changing and emerging health conditions
- Responsive and flexible administration, with democratic participation by users and providers
- Accountability for system performance

CHSA will conduct strategic planning and assure coordination among Departments, Offices and the public to achieve these goals.

Responsibilities Of The California Health Service Program

The California Health Service Program (CHSP) will make determinations about resource allocations, including the location of facilities and of clinical group practices.

The new Office of Accountability will assume the personnel and relevant functions of the current Department of Managed Care. It will develop operational standards for clinical group practices regarding access, and advocate for the rights of patients.

The new Office of Reimbursement will absorb the multiple state agencies currently involved with setting and providing payment for health care, including the health care division of the California Public Employee Retirement System, MediCal and Healthy Families payment and contracting offices, and the Major Risk Medical Insurance Board. It will negotiate salaries with clinicians and other health care workers, and set and monitor budgets for health care facilities. The Office would establish local, county and regional authorities, to assist in developing proposed budgets with service providers. Currently existing county health plans and organized health systems would be converted to this role.

Because California's present reimbursement and utilization rates are both so low, it is possible that the first year budget will anticipate an increase over the prior year's expenditures for personal health services. Subsequent budgets will be constant with total spending for personal health services in the prior year, adjusted for changes in the population, health care needs, and general inflation. In consultation with county and local administrators, and with organizations of providers and users described below, it

will establish subsequent health care budgets. It will also determine the distribution of funds and health care facilities.

The Office of Community Health Services will provide home health services and community outreach and health education.

Responsibilities Of The Department Of Public Health

The Department of Health Services will remain a separate department under the Health and Human Services Agency, but will change its title to the Department of Public Health (DPH), and will coordinate and set policy for population health and public health programs. DPH will maintain surveillance and monitoring, track vital statistics including outbreaks of infectious diseases, set and administer policy to reduce tobacco use, and implement programs to address social and economic determinants of poor health.

The DPH would retain current DHS functions regarding programs for specific populations, including an Office for Multicultural Affairs and an Office for Women's Health. These programs would continue to work to assure that cultural competence and other non-financial methods of promoting access to care for special populations receive attention at the levels of policy and service delivery.

Responsibilities Of The Office Of Statewide Health Planning And Development

The Office of Statewide Health Planning and Development will also report to the HHS. It will collect and report data on health care expenditures and utilization, population need, and quality of care. OSHPD will create reports required to inform strategic planning by HHS generally and by CHS and DPH. Specific reports will assist in targeting the distribution of personal health services by the CHSP, and public health services by DPH.

REIMBURSEMENT: GENERAL

- **Budgets by service category**
- **Greater allocation depending on case mix, and for underserved communities**
- **Financial and non-financial incentives**

The California Health Service Program would set and enforce annual Health Service budgets for specific categories of services (such as primary care, inpatient and outpatient hospital care, and pharmaceutical drugs), with separate funds for capital expenses, research, and training. Providers could not offer covered services privately. Salaries and facility budgets would be negotiated with providers in appropriate groups.

Reimbursement policies and levels will recognize the higher costs of caring for patients with more acute and complex chronic conditions, as well as for presently underserved communities and populations.

Financial and non-financial incentives will be implemented to encourage productivity and quality. These incentives may be altered over time as successful models are identified.

Within certain parameters, incentives may vary among clinical practices and regions. A description of reimbursement methods for clinicians and hospitals, and acceptable areas of variation, follows.

DELIVERY SYSTEM: MAJOR COMPONENTS

The major components of the delivery system are:

- **Clinician group practices**
- **Shift to primary care**
- **Clinicians paid by salary**
- **Financial and non-financial incentives for quality and productivity**
  - **Quality Improvement Institutes**
- **Hospital allocations: "base closure" commission**
- **Hospitals paid by budget**

CLINICIAN PRACTICES

Goals for clinician practices will include:

- Achieve a ratio of 55% primary care to 45% specialty care physicians (presently 33% to 67%)
- Distribution of clinicians sufficient to provide access to all residents
- Medical home for each covered resident
- Group practices consisting of multispecialty teams of clinicians as the core of primary care practice
- Respect for the autonomy for clinicians, within the bounds of professional standards, and teamwork in the interest of patient care
- Cost efficient practices
- Continually improving patient outcomes
- Maximize patient involvement in treatment decisions, and clinician responsiveness to patients
- Cultural competence in care delivery

Primary care physicians and other non-specialist clinicians will work in group practices. Primary care clinicians include advanced practice nurses and physician assistants. In urban and suburban areas, each group practice will be staffed at a minimum to serve a population of 2,000. Based on the U.S. average of 285 physicians per 100,000 population, each group practice would include at least 6 clinicians. The geographic boundaries of rural practices may vary. Clinical teams will include physicians, nurses, and ancillary staff, including mental health services, social services, and outreach workers where appropriate. Dentists, chiropractors, acupuncturists, and alternative health care practitioners who wish to be employed by the CHSP will also practice with a group practice.

Specialist MDs will have hospital appointments. They may choose to work exclusively as hospitalists, or may also participate in group practices with primary care clinicians. In

either setting, case managers/patient navigators will work with specialists and their patients to assure coordination of care.

Each user of services will have a primary caregiver. Specialists who participate in group practices may be primary caregivers for patients with complex conditions.

CHSP will finance the premises and equipment for each group practice. New practices will be located in areas of health care need. As aging physicians retire from areas with excess capacity, their offices will not be maintained. CHS will take definitive steps to assure sufficient staffing in underserved areas, with initial attention to the state's current 25 counties which are below the lower bound of physician supply recommended by the Council on Graduate Medical Education of 145 per 100,000, and the 153 Medical Services Study Areas (MSSAs) currently designated by OSHPD as Primary Care Health Professions Shortage Areas (109 rural, 28 urban, 16 facility-based). (13)

In addition, CHS will address shortages of nurses and dentists. In California as in the rest of the U.S., the nursing workforce is aging, and the number of nurses being trained and entering the workforce are inadequate to meet the need.(11) It is estimated that 97 of 487 Medical Services Study Areas, or 20%, are at or below the federal Health Professional Shortage Area ratio of primary care dentists to population of 1:5000. (34) Sixty-six of these shortage MSSAs, and 31 of 32 MSSAs with no dentists, are rural. The 31 dental shortage MSSAs in urban areas include almost 9% of the state's population.

Community clinics, including federally qualified health centers and look-alikes, will be funded in the same manner as group practices. Funding levels will be increased as needed to the extent that the patient population requires a broader range of services, and presents with more complex conditions, than the average.

Clinician reimbursement by salary

All staff will be paid a salary, at rates negotiated by their representative organizations with the Office of Reimbursement. Most clinicians and health care staff, except physicians, are already paid by salary. There are several reasons for advocating salaries for physicians as well.

Microeconomic incentives can calibrate physician activity, particularly productivity and induced utilization. They can also be used to encourage quality objectives, in the context of a system with defined goals. These incentives include the primary form of reimbursement, which generally includes either capitation, fee for service, or salary. Each has advantages and limitations in inducing productivity and quality. Capitation may encourage undertreatment to a packed roster of enrolled patients. In the United Kingdom this problem is addressed by ratcheting down capitated fees as more patients are added, and the physician/patient ratio is set low. Fee for service rewards induced demand, and controlling this incentive requires substantial regulation. While fee for service complements and rewards physician autonomy, it is increasingly unclear to what degree the current level of autonomy serves quality objectives or a trusting relationship

with patients. Salary keeps physicians at the greatest remove from a link between productivity and financial reward, permitting them to make clinical decisions about treatment based on quality and the patient's best interest. Absent other financial and/or non-financial incentives, salary systems offer no motivation to see patients quickly, and productivity may suffer.

U.S. physicians are excessively conditioned to respond to financial incentives. They practice in organizational environments that are also focused on cost savings rather than quality. An important objective for proposing salaried physician reimbursement at present is to separate clinical decisions from financial ones, and to reinforce physicians' sense of professionalism and fiduciary responsibility to the interests of the patient. Reimbursement by salary also places them as part of a team with other clinicians.

Half of California general practitioner physicians, and 30% of specialists, are already paid by salary. (13) Other health care workers are also generally salaried.

Other financial incentives

The state will authorize a mechanism for testing the effectiveness of additional financial incentives for clinicians to provide evidence-based, cost-efficient care, and to maintain productivity. Such mechanisms could include grants to group practices or regional authorities.

Financial incentives can include additional reimbursement in the form of bonuses or other adjustments for meeting goals for quality, utilization or cost, or withholding reimbursement for failure to meet those goals. For example bonuses may be offered for meeting preventive care goals, for care planning, or for providing effective care for chronic conditions. Because financial incentives have a powerful effect on quantity of work, they must be designed in a way to avoid performance to the narrow goal of the bonus, to the detriment of other important aspects of care.

Non-financial incentives: Group and patient accountability

Non-financial incentives can be powerful motivators for quality of work. The CHSP will focus on non-financial incentives for quality: teamwork among coworkers, and strengthened relationships with patients. Since quality and productivity will be monitored, responsible feedback and reporting to peers and the public will be possible.

Quality improvement programs will draw on sources including the work of the Institute for Clinical Systems Improvement, (22) and the Patient Care Groups and Patient Care Trusts under development in the United Kingdom. (6)

A clinician-led Quality Improvement Initiative will maintain standardized evidence-based guidelines to provide a framework for the provision of common types of care, with financial and technical support from OSHPD. QII staff will provide inservice education for group practice clinicians and staff.

Patient advisory groups in each community will help guide program objectives, particularly regarding quality of care, outreach, and cultural competence of services. "Community" will be defined by population, and may include one or more neighborhoods in urban and suburban areas, or multi-county regions in rural areas.

Group practices in a community will consult regularly with OSHPD and QII staff about clinical outcomes, and choose one or more indicators for improvement in a defined time period. QII staff will assist clinicians in accessing relevant guidelines, setting targets for improvement, and evaluating the success of alternative approaches. In the first two years of the program financial incentives will not be permitted as a reward for attaining quality improvement goals, but results will be reported publicly and among peers. At the end of two years the role of financial incentives may be revisited by the CHS, in consultation with the QII, OSHPD, clinicians, and patient advisory groups.

HOSPITALS

Goals for hospitals will include:

- Regional distribution to assure sufficient and appropriate access for all residents
- Continually improving patient outcomes
- Operating within or below annual budget
- Improve working conditions for nurses, including meeting legal nurse/patient ratios, and job redefinition, to achieve sufficient job satisfaction to reduce shortage of nurses
- Responsiveness to community

Organization

The CHSP will periodically assess the changing population need for inpatient and outpatient hospital services. During the two-year transition period, an appointed commission will consult with OSHPD to assess future facility needs through 2030, based on upper and lower bounds of projected population demographics, consideration of the role of hospitals in providing access to emergency and outpatient care and community stability, and other relevant factors. At the end of two years the commission will present a plan for the regional distribution of secondary and tertiary hospitals, including emergency rooms. Based on this plan, it will recommend to the legislature which hospitals will remain open and be financed for retrofitting, and which areas if any will receive new inpatient and outpatient facilities. The legislature will be able to accept or reject the proposal, but not amend it.

This proposal builds on the success of the independent base closure commission in the early 1990s. Though the need for military bases had been greatly reduced, the bases were important sources of jobs and revenue in Congressional districts. The determination by a respected independent body of which bases to close, and in what order, which could not be amended, made it politically possible for a majority of members of Congress to take action, despite initial negative consequences in some districts.

Hospitals will participate in QII programs, initially focused on improving processes to protect patient safety, as well as improvements in clinical outcomes.

Regionalized distribution of some specialized services such as neonatal intensive care is already in place in California and many other states, resulting in improved outcomes and lower costs.

Hospital reimbursement

The CHS will determine the distribution of hospital budgets, in consultation with OSHPD and DPH. Each hospital will receive a prospective annual budget, disbursed monthly. Budget shortfalls will result in subsequent reductions. Budgets will account for population need and community demographics, to reflect case mix.

The administrator would be authorized to negotiate contracts with groups of clinicians and/or health care facilities that wish to assume a limited degree of financial risk for the purpose of encouraging innovative practices that reduce costs or improve quality, access, or outcomes, with the limitations that: 1. Financial surpluses would be used for service enhancement; 2. The development and existence of provider networks would be consistent with the rational and equitable allocation of health care services.

PRESCRIPTION DRUGS AND DURABLE MEDICAL EQUIPMENT

To the extent that the program remains state-based, not national, it is assumed that the pharmaceutical industry would remain proprietary. There will be a separate budget for prescription drugs. The CHS will act as a group purchaser, negotiating rates for prescription drugs bought in bulk using the federal supply schedule (FSS). Formulary and generic drugs will be encouraged, subject to override by a prescribing clinician. QII programs will track and encourage appropriate ordering. Having a statewide plan permits statewide data analysis to assess which drugs are most cost-effective and to shape formularies.

Durable medical equipment would also be purchased using the federal supply schedule.

FINANCING MECHANISM

- **Payroll tax: 7.41% employer contribution, 2.5% employee contribution**
- **Tobacco tax: $1 a pack**
- **Most families save about $1,500 a year**
- **Employers who currently provide coverage spend less**
    - **Employers not currently providing coverage spend about $169 a month extra**

The state would establish regular sources of funding for the Health Service, and create mechanisms for assuring sufficient funding in years when some sources of revenues may

fluctuate. The health service would consolidate current public and private contributions to health care services, which would be contributed to a dedicated CHSP Trust Fund. The balance would be derived from an increase in the payroll tax with neither a floor nor a ceiling, the tobacco tax, and supplemented if necessary by an increase in the personal income tax. The modeler's preliminary estimate suggests that an income tax would not be necessary. (An earlier version of this proposal suggested an increase in the corporate tax rate; since it could not be modeled, it is not included in this iteration.) The system would be fully implemented after the two-year transition period, and public health measures to mitigate demand among the currently uninsured would be sufficiently effective to prevent a surge in expensive care.

Public sources of funding would include Medicare, California MediCal, AIM, and Healthy Families; the state/federal disproportional share hospital (DSH) program; county funds for the uninsured; local initiatives such as the Alameda Alliance plan and Healthy Kids in Santa Clara County; and current funds from realignment in the County Health and Welfare Trusts, generated from sales tax and vehicle license fees.

Financing options are often characterized as drawing primarily on general revenues, as the United Kingdom does; or depending on more specified taxes, often a payroll-based contribution, as in Germany. There is little consistency in whether either type of funding successfully controls costs, though it is known that more complex systems incur higher administrative costs. A political advantage of drawing from the general fund for a new program is that it is relatively invisible. It may require reducing funding for other programs, but this may be a less politically difficult project than asking the electorate to approve a new earmarked tax. However, to the extent that ongoing funding depends on general funds, health care services would compete directly with other priorities. Users and provider would have to generate sufficient advocacy power to both protect spending levels, and counterbalance potential pressure from providers to inflate spending.

This proposal suggests using earmarked taxes to capture current private sources of contributions, particularly from employers, in order to assure that funding for the system is both transparent and stable. It would begin with a payroll tax on aggregate payroll (as opposed to a tax based on each individual's paycheck), without either a floor or a ceiling. (This draws on the example of the Health Insurance portion of the Social Security tax, which funds Medicare, does not have a ceiling.) This is intended to be progressive, since subjecting all levels of payroll to taxation generates sufficient revenue at a relatively low tax rate, thereby protecting lower wage workers. This proposal also does not differentiate by firm size, as small businesses would be protected by the imposition of these taxes across a level playing field including all of their competitors. This would capture significant revenues from the 25% of California employers who do not offer insurance. If needed, additional funds would be generated from increases in the income tax, including unearned income.

The modeler's estimate to date shows that a payroll tax of 7.41% for employers, and 2.5% for employees, plus an increase in the tobacco tax of $1 per pack, would raise sufficient revenue to fund the program. At this level, employers that currently offer coverage would

spend on average slightly less than they do now, while employers that do not currently offer insurance would pay about $169 a month. Families would spend about $1,055 less per year, on average, than they do now, with significant savings for families with household income under $150,000 a year.

A sensitivity analysis of financing options by the Lewin Group indicates that while average household spending is lower on average if the system if financed using a payroll tax, compared with financing by income tax, savings are somewhat greater for households earning $74,999 or less if income taxes are used. The differences are due in part to the wage effects of each method. Because payroll taxes are considered a more stable source of funding than an income tax, and the overall savings to households are greater, the present proposal relies primarily on the payroll tax, using the income tax only as a backup in the event of revenue shortfalls.

ERISA

It is unlikely that this financing scheme would present problems with the federal Employment Retirement Income Security Act (ERISA), which reserves to the federal government (as opposed to the states) the power to enact laws "related to" employee benefits. Court decisions have expanded the opportunity for states to levy fees on providers to finance health care for low income populations. Several Congressional proposals in the 106th Congress (HR 4412 -Tierney and S 2888 - Wellstone) would explicitly grant states expanded authority to increase health care coverage, and it is expected that these will be reintroduced. HR 3080 (Lee) would explicitly institute a national health service, and is currently pending in Congress.

Copayments

The Lewin Group, which modeled the costs of the HCOP proposals, credits copayments with reducing both utilization and expenditures. Their analysis, shown in Appendix A, shows that the CHSP could achieve additional savings by imposing a $5 copayment for all services. However, the CHSP would achieve significant savings without incurring the negative consequences of copayments.

Saltman and Figueras interpret the evidence from Europe to indicate that copayments at the point of service are far less effective in controlling demand than macroeconomic approaches such as improved public health programs. Strong evidence suggests that copayments discourage the use of necessary as well as unnecessary care, including primary care; and that sliding scale arrangements designed to offset this effect on low-income individuals are cumbersome, costly, and do not achieve any long-range policy objectives including overall budget savings.(43)

The modeler has raised the additional argument that in a system where the supply and income of clinicians are constrained, as this plan proposes, financial incentives on users to reduce utilization are necessary to prevent overwhelming clinicians' workload. The CHSP proposes a different approach to limiting demand, by providing support for both

users and clinicians to recognize and practice evidence-based care. A variety of educational tools have proven successful at dissuading patients from pursuing high tech treatments of dubious efficacy. Californians have historically used less hospital days than residents of most other states, even prior to widespread managed care. These are debatable points, and it is not possible to predict with certainty how utilization demands and workforce capacity would balance out in the proposed system. These trends would be monitored and could be addressed under the proposed system, something that cannot be done effectively in the current fragmented system.

The modelers would also credit additional savings for imposing a $25 copayment for specialty services provided without referral by a primary care provider. The CHSP proposal supports the use of a primary care gatekeeper, though there is not definitive evidence that this is the best model for accessing specialty care; it also recognizes that for some complex or chronic conditions, specialists are the best primary care providers. The proposed change in the ratio of specialty to primary care physicians from 67%/33% currently to 45%/55%, as well as the establishment of multidisciplinary group practices with strong support for evidence-based care, would arguably achieve equal savings to a copayment, with better effects on equity.

TRANSITION

The system of financial coverage would be implemented through legislation authorizing the collection of funds and establishing eligibility and benefits. Initial enrollment would be accomplished as described above. The timetable would take into consideration areas where the stabilization and integration of outpatient and inpatient services most likely to benefit the public immediately, and where public services are already strong.

Transferring the delivery system

- **Buying out hospitals**
- **Contracts vs. buyout for state, county and district hospitals**
- **Establishing hospital districts**

The transfer of the delivery system to public control would be accomplished over two years. After accounting for present debt, and with the use of long term bond financing,, the acquisition of all facilities and clinical practices would add only marginally to overall system costs, which would likely be offset by administrative savings.

Both the state and federal government are empowered by the Constitution and by statute to take private property for the public good, very broadly defined. The Uniform Relocation Act of 1970, United States Code Title 42, Chapter 61, describes actions the government should take to deal fairly with displaced owners. The federal Declaration of Taking Act enables the government to acquire property immediately, while it pursues settlement with the owner. California Government Code Chapter 16, describes similar obligations incurred by the state. Article 6, Section 1263.510, describes compensation to business owners for goodwill, and provisions for subtracting that compensation from

other parts of a settlement. It is questionable whether any payment for goodwill would be required for a business that is in debt. California Health and Safety Code Section 32121-32138(d) imparts to local districts the power to "exercise the right of eminent domain for the purpose of acquiring real or personal property of every kind necessary to the exercise of any of the power of the district." The present analysis assumes that the present owners of non-profit and for-profit businesses would have to be compensated for the fair market value of their enterprises.

As discussed below in the section on feasibility, there are compelling reasons to consider the conversion of many California hospitals to public ownership, particularly those in financial distress.

To reduce the cost of acquiring hospitals, and also to take advantage of a natural experiment, during the transition period the state would contract with existing public facilities, including city/county hospitals, district hospitals, and University of California hospitals. District hospitals already operate with elected boards, and these may prove to be viable administrative structures in the long term

Conversion to district hospitals may also be a viable interim option for financially vulnerable hospitals in underserved areas, as several hospitals in northern California have done. Most recently a failing hospital won the required vote of the electorate to establish a hospital district, including a new parcel tax. Based on the credit of prospective tax revenues, the hospital was able immediately after the election to borrow money from a bank at a favorable rate to reduce its debt and sustain operations. In the long term the new tax revenues, added to existing sources of funds, are expected to keep the hospital open. The administration has chosen to experiment with the addition of respite services at minimal charge to the community.

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APPENDIX A. COMPARISON BY LEWIN GROUP OF PLAN FEATURES AMONG HCOP PROPOSALS FINANCED THROUGH A SINGLE GOVERNMENT PAYER

MEMORANDUM March 21, 2002

To: Ellen R. Shaffer, PhD, Judy Spelman, and James Kahn, MD

From: John F. Sheils

CC: Genie Chough, Gary Claxton

Subject: Benefits and Co-payments

The purpose of this analysis was to show how costs under the three single-payer programs would be affected by selected changes in covered services and co-payment requirements.

Much of the difference in cost among these plans is attributed to differences in covered services and patient co-payment requirements. All three of these plans provide comprehensive coverage for a "core" set of benefits including hospital care, physician services, mental health and prescription drugs. The major differences in covered services were for dental care, vision, eyeglasses and long-term care.

For example, the California single-payer program would cost about $119.8 billion in 2002 (***Figure 1***). Adding coverage for general dentistry (excluding orthodontia) would add $9.9 billion to the cost of the program. Coverage for vision and eyeglasses would cost an additional $1.3 billion. The Cal Care proposal and the CHSP proposal already cover these services.

Another major area of difference is in coverage for long-term care. All three plans would maintain at least the current level of coverage under Medi-Cal for nursing home and home health services. However, both the Cal Care and the California Single-Payer plans would also cover all nursing home expenses other than room and board. These plans would also provide home health services to all persons with three or more limitations in Activities of Daily Living (ADL). The cost of adding these services under CHSP would be $3.7 billion for nursing home care and $1.2 billion for home health care.

The California single-payer proposal is unique among the three proposals in that it requires patient co-payments for all services ($5.00 per visit, $5.00 per prescription). Studies have shown that eliminating patient cost sharing can increase utilization of physician services by up to 30 percent and increase the use of hospital care by 10 percent. Based upon these studies, we estimate that eliminating co-payments under the California Single-Payer plan would increase costs by about $8.3 billion.

Benefits design can be used as a means of encouraging the use of primary care. For example, the Cal Care program would require all individuals to select a primary care provider. It would also impose a co-payment of $25 for physician specialist services received without a referral from their primary care physician. This is designed to reduce unnecessary use of costly specialist services and to improve quality by assuring that care is coordinated for patients receiving care from multiple providers. Including this provision reduced the cost of the Cal Care program from $138.5 billion without these primary care requirements to our current Cal Care estimate of $134.8 billion (***Figure 2***).

The plan could further reduce costs by requiring a co-payment for all services. As discussed above, the presence of a co-payment requirement can significantly reduce the use of health services. For example, with a co-payment requirement of $5.00 per visit and $5.00 per prescription, the total cost of the Cal Care program would be reduced to $127.7 billion. ***Figure 2*** shows how costs for all three single-payer proposals would change under these alternative benefits designs.

Figure 1
Cost of Selected Expansions in Covered Services Under Single-Payer Proposals

	Cal-Care	Single-Payer for California a/	California Health Service Program (CHSP)
Costs Under Current Proposal	$134.8	$119.8	$129.0
Added Cost of Selected Benefits			
General Dental Care			
Dental Services	-- b/	$9.9	-- b/
Orthodontia	$2.1	$1.8	$2.1
Vision			
Vision Exams	-- b/	$0.2	-- b/
Eyeglasses	-- b/	$1.1	-- b/
Increased Long Term Care c/			
Nursing Home (except room and board)	-- b/	-- b/	$3.7
Home Health	-- b/	-- b/	$1.2
Eliminate Co-payments	-- d/	$8.3	-- d/

a/ Reflects presence of Co-payments under the Single-Payer Program for California.
b/ Services Already Covered by Plan.
c/ Includes only expansions in long-term care services in excess of the current Medi-Cal covered amounts, which would continue to be covered under all three proposals.
d/ These plans require no co-payments in most or all cases.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

Figure 2
Total Program Costs (Net of Offsets) for the Single-Payer Proposals Under Alternative Co-payment and Benefits Designs a/

	Cal Care	Single-Payer for California	California Health Service Program (CHSP)
Costs Under Current Proposals	$134.8	$119.8	$129.0
Costs Under Alternative Benefits Designs			
No Co-payments for All Services	$138.5	$128.1	$129.0 b/
$25 Co-payment Only for Specialty Care Provided Without Primary Care Provider Referral	$134.8 b/	$125.3	$126.1
$5.00 Co-pay for All Services	$127.7	$119.8 b/	$120.7
$5.00 Co-pay for All Services with $25.00 Co-pay for Services Without Primary Care Provider Referral	$124.0	$116.3	$117.2

a/ Estimates assume that covered services for each plan are the same as under the current proposals. Cost changes reflect only the impact of varying co-payments and benefits design.
b/ Cost sharing and benefits design used under current proposals.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

APPENDIX B. CALIFORNIA RATES AND COSTS OF PREVENTABLE HOSPITALIZATIONS

OSHPD CALIFORNIA DISCHARGE DATA 1998

TOTAL DISCHARGES for ambulatory care sensitive conditions (ACS): 460,772

PREVENTABLE ACS DISCHARGES: Total less 5% (irreducible minimum): 437,733

AVERAGE CHARGE per ACS admission: $14,996

ACTUAL PAYMENT per ACS admission (30-40% below charge shown on discharge record)= $8998
(highly conservative estimate)

TOTAL PREVENTABLE CHARGES = $4 billion for ACS admissions

RATES:

5 ACS admissions per 1,000 population is considered an achievable and reasonable rate for an effectively organized health system
(John Billings, United Hospital Fund report, based on national survey of best practices)

Statewide rate:13.96/1000 residents

County with highest age/gender adjusted rate: Plumas 22/1000 residents

Lowest: Mono 4.3/1000 residents

Zip code with highest adjusted rate: 90013 – Los Angeles County – with 129.35/1000

Lowest: 93458 Santa Maria with 2.67/1000

County with highest rate of cases charging more than $100,000: Shasta

Lowest: Mono

Prepared by: Tom Moore, Jr. California Works Foundation, and Ellen R. Shaffer
Source: Codman Research Group

Total California Hospitalizations for Ambulatory Care Sensitive Conditions, 1998
Adjusted Rate for Age and Sex Population Size: 171,665 *($ in thousands)*

County/State	ACS Rate/1,000	Charged amount
Plumas County	21.94	$178,864
Yuba County	21.68	$286,945
Trinity County	19.67	$188,417
Sutter County	18.85	$194,904
Imperial County	17.76	$207,011
San Bernardino County	17.11	$236,948
Kings County	17.04	$121,405
Colusa County	16.95	$141,999
Los Angeles County	15.95	$261,257
Tulare County	15.90	$144,961
San Joaquin County	15.30	$247,377
Kern County	15.11	$174,665
Stanislaus County	14.99	$369,916
Riverside County	14.97	$192,235
Lake County	14.94	$188,241
Shasta County	14.64	$327,369
Amador County	14.40	$166,466
Tehama County	14.33	$181,661
Merced County	14.24	$206,287
Mariposa County	14.20	$124,474
Mendocino County	14.17	$117,356
Butte County	14.02	$131,398
Humboldt County	13.96	$161,707
Alameda County	13.93	$200,874
Sacramento County	13.80	$265,736
Modoc County	13.65	$136,985
Fresno County	13.27	$135,803
Solano County	12.92	$234,328
San Francisco County	12.75	$184,283
Monterey County	12.57	$179,459
San Benito County	12.57	$161,066
Contra Costa County	12.56	$223,600
Madera County	12.50	$112,686
Tuolumne County	12.50	$129,194
Nevada County	12.44	$128,710
Sierra County	12.36	$86,618
Glenn County	12.28	$144,444
Yolo County	12.10	$183,648
Del Norte County	12.09	$126,087
Napa County	11.82	$149,266
El Dorado County	11.26	$130,852
Orange County	10.98	$168,034
Siskiyou County	10.96	$86,088
Placer County	10.81	$165,487
Ventura County	10.78	$149,954

Calaveras County	10.69	$129,983
San Diego County	10.60	$145,332
Sonoma County	10.20	$107,325
Santa Clara County	10.11	$148,755
San Luis Obispo County	10.08	$148,282
Santa Cruz County	9.54	$142,660
San Mateo County	9.54	$158,260
Santa Barbara County	9.47	$113,254
Lassen County	9.29	$110,616
Marin County	8.51	$125,046
Inyo County	8.34	$98,717
Alpine County	7.83	$84,228
Mono County	4.31	$42,984

INCREASE IN AMBULATORY CARE SENSITIVE HOSPITALIZATIONS, RATE PER 1,000 ADMITS, TOTAL CALIFORNIA 1997-1998

CaseType	Admits 1997	Rate/1000 1997	Admits 1998	Rate/1000 1998
ACS-ALL ACS CONDITIONS	449,702	**13.62**	460,772	**13.96**
ACS-PREVENTABLE	2,574	0.08	2,938	0.09
Congenital Syphillis	38	0.00	24	0.00
Immunization Preventable Conds	558	0.02	700	0.02
Iron Deficiency Anemia	1,355	0.04	1,632	0.05
Nutritional Deficiency	314	0.01	314	0.01
Failure to Thrive	309	0.01	268	0.01
ACS-RAPID ONSET	237,291	7.19	248,569	7.53
Convulsions	13,550	0.41	13,635	0.41
Severe ENT Infection	4,810	0.15	4,307	0.13
Bacterial Pneumonia	86,854	2.63	95,703	2.90
Cellulitis	30,565	0.93	31,516	0.95
Hypoglycemia	7,714	0.23	8,526	0.26
Diabetes w/Ketoacidosis	10,805	0.33	10,857	0.33
Gastroenteritis	10,908	0.33	11,247	0.34
Kidney/Urinary Infection	37,077	1.12	38,134	1.16
Dehydration/Vol Depletion	30,599	0.93	30,656	0.93
Pelvic Inflammatory Disease	4,409	0.13	3,988	0.12
ACS-CHRONIC	209,837	6.36	209,265	6.34
Grand Mal & Epil Convulsion	5,591	0.17	4,977	0.15
Pulmonary Tuberculosis	1,427	0.04	1,442	0.04
Other Tuberculosis	481	0.01	459	0.01
COPD	42,287	1.28	44,808	1.36
Asthma	39,254	1.19	36,178	1.10
Congestive Heart Failure	82,315	2.49	86,685	2.63
Hypertension	5,322	0.16	5,480	0.17
Angina	20,090	0.61	16,290	0.49
Diabetes w/Complications	903	0.03	806	0.02
Diabetes w/o Complications	5,274	0.16	5,318	0.16
Skin Grafts	5,209	0.16	5,063	0.15
Dental Conditions	1,684	0.05	1,759	0.05

DETAIL: SAN MATEO COUNTY - INCREASE IN CASES AND COSTS FOR AMBULATORY CARE SENSITIVE HOSPITALIZATIONS, RATE PER 1,000 ADMITS, 1997-1998

($ in thousands)

CaseType	Adms 1997	Charged amt	Adms 1998	Charged amt
ACS-ALL ACS CONDITIONS	**8.66**	**$122,858**	**9.54**	**$158,260**
ACS-PREVENTABLE	0.06	$1,906	0.07	$2,306
Congenital Syphillis	0.00	$52	0	$0
Immunization Preventable Conds	0.01	$66	0.02	$673
Iron Deficiency Anemia	0.02	$166	0.02	$202
Nutritional Deficiency	0.03	$1,589	0.02	$1,285
Failure to Thrive	0.01	$50	0.01	$184
ACS-RAPID ONSET	4.67	$60,689	5.22	$78,683
Convulsions	0.31	$3,064	0.27	$3,468
Severe ENT Infection	0.08	$504	0.09	$709
Bacterial Pneumonia	1.69	$28,830	2.09	$41,622
Cellulitis	0.68	$6,415	0.72	$7,763
Hypoglycemia	0.16	$2,818	0.16	$2,615
Diabetes w/Ketoacidosis	0.24	$3,548	0.23	$3,436
Gastroenteritis	0.16	$1,247	0.19	$1,423
Kidney/Urinary Infection	0.61	$6,095	0.7	$8,545
Dehydration/Vol Depletion	0.66	$7,139	0.68	$7,857
Pelvic Inflammatory Disease	0.09	$1,012	0.09	$1,220
ACS-CHRONIC	3.94	$60,401	4.25	$77,346
Grand Mal & Epil Convulsion	0.09	$1,605	0.11	$1,804
Pulmonary Tuberculosis	0.02	$1,346	0.04	$1,604
Other Tuberculosis	0.01	$348	0.01	$238
COPD	0.62	$12,238	0.71	$13,449
Asthma	0.80	$7,903	0.82	$9,261
Congestive Heart Failure	1.86	$30,039	1.97	$40,205
Hypertension	0.08	$711	0.07	$865
Angina	0.24	$2,412	0.25	$2,773
Diabetes w/Complications	0.01	$67	0.01	$46
Diabetes w/o Complications	0.06	$606	0.08	$854
Skin Grafts	0.13	$2,960	0.16	$5,855
Dental Conditions	0.02	$162	0.03	$494

APPENDIX C. 1. ALL CALIFORNIA HOSPITALS, BY OPERATING MARGIN, 1999

FACILITY NAME	COUNTY	TYPE OF CONTROL	TEACHING OR RURAL	DSH HOSP	OPERATING MARGIN
CITY OF ANGELS MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(6.103)
VALLEY PLAZA DOCTORS HOSPITAL	RIVERSIDE	INVESTOR		non-DSH	(1.707)
WARRACK MEDICAL CENTER HOSPITAL	SONOMA	INVESTOR		non-DSH	(1.141)
CHILDRENS RECOVERY CTR OF NO CALIF	SANTA CLARA	INVESTOR		non-DSH	(0.663)
HERITAGE HOSPITAL	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.641)
MOTION PICTURE & TELEVISION HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.577)
SAN VICENTE HOSPITAL	LOS ANGELES	INVESTOR		DSH	(0.534)
SHARP CABRILLO HOSPITAL	SAN DIEGO	NON-PROFIT		non-DSH	(0.524)
SAN LUIS OBISPO GENERAL HOSPITAL	SAN LUIS OBISPO	CITY/COUNTY		DSH	(0.379)
GLENN MEDICAL CENTER	GLENN	NON-PROFIT	SMALL/RURAL	non-DSH	(0.375)
LOS ANGELES CO HIGH DESERT HOSPITAL	LOS ANGELES	CITY/COUNTY		DSH	(0.356)
AVALON MUNICIPAL HOSPITAL & CLINIC	LOS ANGELES	NON-PROFIT	SMALL/RURAL	non-DSH	(0.343)
ORANGE COAST MEMORIAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.338)
COLUMBIA SOUTH VALLEY HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.336)
VILLA VIEW COMMUNITY HOSPITAL	SAN DIEGO	NON-PROFIT		DSH	(0.332)
ST. LOUISE HEALTH CENTER	SANTA CLARA	NON-PROFIT		non-DSH	(0.331)
SAN DIEGO HOSPICE ACUTE CARE CENTER	SAN DIEGO	NON-PROFIT		non-DSH	(0.323)
MOUNTAINS COMMUNITY HOSPITAL	SAN	DISTRICT	SMALL/RURAL	non-DSH	(0.320)

CHOWCHILLA DISTRICT MEMORIAL HOSPITAL	BERNARDINO MADERA	DISTRICT	SMALL/RURAL	DSH	(0.319)
ALTA HOSPITAL DISTRICT	TULARE	DISTRICT	SMALL/RURAL	non-DSH	(0.313)
LA PALMA INTERCOMMUNITY HOSPITAL	ORANGE	NON-PROFIT		non-DSH	(0.304)
BREA COMMUNITY HOSPITAL	ORANGE	INVESTOR		non-DSH	(0.298)
SAN MATEO GENERAL HOSPITAL	SAN MATEO	CITY/COUNTY		DSH	(0.296)
SCRIPPS HOSPITAL - EAST COUNTY	SAN DIEGO	NON-PROFIT		non-DSH	(0.286)
TUSTIN HOSPITAL MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.278)
PARKVIEW COMMUNITY HOSPITAL	RIVERSIDE	NON-PROFIT		non-DSH	(0.230)
UCSF/MT ZION	SAN FRANCISCO	NON-PROFIT	TEACHING	non-DSH	(0.221)
SETON MEDICAL CENTER - COASTSIDE	SAN MATEO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.213)
SELMA DISTRICT HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.210)
SANTA MARTA HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.208)
GOOD SAMARITAN HOSPITAL-BAKERSFIELD	KERN	INVESTOR		DSH	(0.208)
GOOD SAMARITAN HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.205)
HUNTINGTON MEMORIAL HOSPITAL	LOS ANGELES	NON-PROFIT	TEACHING	non-DSH	(0.202)
SANTA YNEZ VALLEY COTTAGE HOSPITAL	SANTA BARBARA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.193)
JEROLD PHELPS COMMUNITY HOSPITAL	HUMBOLDT	DISTRICT	SMALL/RURAL	DSH	(0.191)
VICTOR VALLEY COMMUNITY HOSPITAL	SAN BERNARDINO	NON-PROFIT	SMALL/RURAL	DSH	(0.189)
SENECA HOSPITAL	PLUMAS	DISTRICT	SMALL/RURAL	DSH	(0.186)
VALLEY COMMUNITY HOSPITAL	SANTA BARBARA	INVESTOR		non-DSH	(0.183)
KPC GLOBAL MEDICAL CENTER	SAN BERNARDINO	INVESTOR		non-DSH	(0.179)
LONG BEACH COMMUNITY MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.177)

HANFORD COMMUNITY HOSPITAL	KINGS	NON-PROFIT	SMALL/RURAL	non-DSH	(0.177)
IRVINE MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.173)
MAMMOTH HOSPITAL	MONO	DISTRICT	SMALL/RURAL	non-DSH	(0.172)
DANIEL FREEMAN MARINA HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.165)
VENTURA COUNTY MEDICAL CENTER	VENTURA	CITY/COUNTY		DSH	(0.164)
MEMORIAL HOSPITAL AT EXETER	TULARE	DISTRICT	SMALL/RURAL	non-DSH	(0.164)
HUNTINGTON EAST VALLEY HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.163)
METHODIST HOSPITAL OF SACRAMENTO	SACRAMENTO	NON-PROFIT		non-DSH	(0.162)
CHINO VALLEY MEDICAL CENTER	SAN BERNARDINO	INVESTOR		non-DSH	(0.157)
SOUTHERN INYO HOSPITAL	INYO	DISTRICT	SMALL/RURAL	non-DSH	(0.155)
SANTA TERESITA HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.152)
FRENCH HOSPITAL - SAN LUIS OBISPO	SAN LUIS OBISPO	NON-PROFIT		non-DSH	(0.152)
PETALUMA VALLEY HOSPITAL	SONOMA	NON-PROFIT		non-DSH	(0.146)
COALINGA REGIONAL MEDICAL CENTER	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.139)
DOWNEY COMMUNITY HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.136)
SURPRISE VALLEY COMMUNITY HOSPITAL	MODOC	DISTRICT	SMALL/RURAL	DSH	(0.135)
SIERRA VALLEY DISTRICT HOSPITAL	SIERRA	DISTRICT	SMALL/RURAL	DSH	(0.135)
ST. MARY'S MEDICAL CENTER SAN FRANCISCO	SAN FRANCISCO	NON-PROFIT	TEACHING	non-DSH	(0.132)
HUNTINGTON BEACH HOSP & MED CTR	ORANGE	INVESTOR		DSH	(0.129)
TEHACHAPI HOSPITAL	KERN	DISTRICT	SMALL/RURAL	DSH	(0.129)
TRI-CITY REGIONAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.128)
CENTRAL VALLEY GENERAL HOSPITAL	KINGS	INVESTOR		DSH	(0.128)
PACIFIC ALLIANCE MEDICAL CENTER	LOS ANGELES	INVESTOR		DSH	(0.127)
MARTIN LUTHER HOSPITAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.126)
SAN CLEMENTE HOSPITAL & MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.125)

ST. AGNES MEDICAL CENTER	FRESNO	NON-PROFIT		non-DSH	(0.124)
VERDUGO HILLS HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.124)
SANTA BARBARA COTTAGE HOSPITAL	SANTA BARBARA	NON-PROFIT		non-DSH	(0.122)
COLUMBIA GOOD SAMARITAN HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.117)
TRI-CITY MEDICAL CENTER	SAN DIEGO	DISTRICT		non-DSH	(0.116)
JOHN C FREMONT HEALTHCARE DISTRICT	MARIPOSA	DISTRICT	SMALL/RURAL	non-DSH	(0.111)
SONOMA VALLEY HOSPITAL	SONOMA	DISTRICT		non-DSH	(0.111)
SIERRA KINGS DISTRICT HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.110)
OROVILLE HOSPITAL	BUTTE	NON-PROFIT		non-DSH	(0.109)
ST. BERNARDINE MEDICAL CENTER	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.106)
LINDSAY DISTRICT HOSPITAL	TULARE	DISTRICT	SMALL/RURAL	DSH	(0.106)
INLAND VALLEY REGIONAL MEDICAL CENTER	RIVERSIDE	INVESTOR	SMALL/RURAL	non-DSH	(0.105)
HEALDSBURG GENERAL HOSPITAL	SONOMA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.103)
MARSHALL HOSPITAL	EL DORADO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.095)
EAST LOS ANGELES DOCTOR'S HOSPITAL	LOS ANGELES	INVESTOR		DSH	(0.093)
ST. DOMINIC'S HOSPITAL	SAN JOAQUIN	NON-PROFIT		non-DSH	(0.092)
CHILDREN'S HOSPITAL AT MISSION	ORANGE	NON-PROFIT		non-DSH	(0.091)
STANFORD UNIVERSITY HOSPITAL	SANTA CLARA	NON-PROFIT	TEACHING	non-DSH	(0.090)
EISENHOWER MEDICAL CENTER	RIVERSIDE	NON-PROFIT		non-DSH	(0.090)
ST. ROSE HOSPITAL	ALAMEDA	NON-PROFIT		DSH	(0.088)
SUTTER MERCED MEDICAL CENTER	MERCED	NON-PROFIT		DSH	(0.086)
CONTRA COSTA REGIONAL MEDICAL CTR	CONTRA COSTA	CITY/COUNTY		DSH	(0.083)
VENCOR HOSPITAL - SAN LEANDRO	ALAMEDA	INVESTOR		non-DSH	(0.082)
FRESNO SURGERY CENTER	FRESNO	INVESTOR		non-DSH	(0.081)
FOOTHILL PRESBYTERIAN HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.081)

MEDICAL CENTER AT THE UCSF	SAN FRANCISCO	NON-PROFIT	TEACHING	non-DSH	(0.079)
BEAR VALLEY COMMUNITY HOSPITAL	SAN BERNARDINO	DISTRICT	SMALL/RURAL	non-DSH	(0.079)
FRANK R HOWARD MEMORIAL HOSPITAL	MENDOCINO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.078)
PALM DRIVE HOSPITAL	SONOMA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.077)
COLUSA COMMUNITY HOSPITAL	COLUSA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.075)
KINGSBURG MEDICAL HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	DSH	(0.075)
LOMPOC HEALTHCARE DISTRICT	SANTA BARBARA	DISTRICT	SMALL/RURAL	non-DSH	(0.075)
PIONEERS MEMORIAL HOSPITAL	IMPERIAL	DISTRICT	SMALL/RURAL	DSH	(0.073)
NORTHRIDGE HOSPITAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.072)
METHODIST HOSPITAL OF SOUTHERN CAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.071)
WEST HILLS HOSPITAL & MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.071)
MORENO VALLEY COMMUNITY HOSPITAL	RIVERSIDE	DISTRICT		non-DSH	(0.071)
REGIONAL MEDICAL CENTER OF SAN JOSE	SANTA CLARA	INVESTOR		DSH	(0.070)
SCRIPPS MEMORIAL HOSPITAL - CHULA VISTA	SAN DIEGO	NON-PROFIT		DSH	(0.070)
HENRY MAYO NEWHALL MEMORIAL HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.070)
ALAMEDA HOSPITAL	ALAMEDA	NON-PROFIT		non-DSH	(0.068)
CITRUS VALLEY MEDICAL CENTER-QV CAMPUS	LOS ANGELES	NON-PROFIT		DSH	(0.066)
SUMMIT MEDICAL CENTER	ALAMEDA	NON-PROFIT		non-DSH	(0.065)
PALOMAR MEDICAL CENTER	SAN DIEGO	DISTRICT		non-DSH	(0.062)
DESERT VALLEY HOSPITAL	SAN BERNARDINO	INVESTOR		non-DSH	(0.062)

SHARP MARY BIRCH HOSPITAL FOR WOMEN	SAN DIEGO	NON-PROFIT		non-DSH	(0.061)
LODI MEMORIAL HOSPITAL	SAN JOAQUIN	NON-PROFIT		non-DSH	(0.060)
TRINITY GENERAL HOSPITAL	TRINITY	CITY/COUNTY	SMALL/RURAL	DSH	(0.060)
ST. FRANCIS MEMORIAL HOSPITAL	SAN FRANCISCO	NON-PROFIT		non-DSH	(0.058)
RIDGECREST COMMUNITY HOSPITAL	KERN	NON-PROFIT	SMALL/RURAL	non-DSH	(0.058)
GRANADA HILLS COMMUNITY HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.057)
BAY HARBOR HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.057)
SAN JOAQUIN COMMUNITY HOSPITAL	KERN	NON-PROFIT		non-DSH	(0.057)
GOOD SAMARITAN HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.056)
SANTA PAULA MEMORIAL HOSPITAL	VENTURA	NON-PROFIT		non-DSH	(0.056)
DANIEL FREEMAN MEMORIAL HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.055)
SANGER GENERAL HOSPITAL	FRESNO	INVESTOR	SMALL/RURAL	DSH	(0.054)
BAKERSFIELD MEMORIAL HOSPITAL	KERN	NON-PROFIT		non-DSH	(0.053)
MIDWAY HOSPITAL MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.052)
MERCY WESTSIDE HOSPITAL	KERN	NON-PROFIT	SMALL/RURAL	DSH	(0.049)
SAN JOSE MEDICAL CENTER	SANTA CLARA	INVESTOR	TEACHING	non-DSH	(0.048)
MODOC MEDICAL CENTER	MODOC	CITY/COUNTY	SMALL/RURAL	DSH	(0.047)
SAN GORGONIO MEMORIAL HOSPITAL	RIVERSIDE	DISTRICT	SMALL/RURAL	non-DSH	(0.046)
POMERADO HOSPITAL	SAN DIEGO	DISTRICT		non-DSH	(0.046)
ANAHEIM MEMORIAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.045)
MISSION BAY HOSPITAL	SAN DIEGO	INVESTOR		non-DSH	(0.045)
NORTHRIDGE HOSPITAL MEDICAL CTR - SHERMAN	LOS ANGELES	NON-PROFIT		DSH	(0.044)
ST. VINCENT MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.044)
ST. FRANCIS MEDICAL CTR - SANTA BARBARA	SANTA BARBARA	NON-PROFIT		non-DSH	(0.042)
MENDOCINO COAST DISTRICT HOSPITAL	MENDOCINO	DISTRICT	SMALL/RURAL	non-DSH	(0.042)
SIMI VALLEY HOSP & HLTH SVCS - SYCAMORE	VENTURA	NON-PROFIT		non-DSH	(0.040)

MENIFEE VALLEY MEDICAL CENTER	RIVERSIDE	DISTRICT		non-DSH	(0.040)
MAD RIVER COMMUNITY HOSPITAL	HUMBOLDT	INVESTOR		non-DSH	(0.040)
VALLEY PRESBYTERIAN HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.039)
WOODLAND MEMORIAL HOSPITAL	YOLO	NON-PROFIT		non-DSH	(0.039)
PARADISE VALLEY HOSPITAL	SAN DIEGO	NON-PROFIT		DSH	(0.037)
SOUTH COAST MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.036)
SANTA MONICA - UCLA MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.036)
SONORA COMMUNITY HOSPITAL	TUOLUMNE	NON-PROFIT	SMALL/RURAL	non-DSH	(0.035)
REDLANDS COMMUNITY HOSPITAL	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.035)
MERCY SAN JUAN HOSPITAL	SACRAMENTO	NON-PROFIT		non-DSH	(0.034)
SPECIALTY HOSPITAL OF SOUTHERN CAL	LOS ANGELES	INVESTOR		non-DSH	(0.033)
SAN GABRIEL VALLEY MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.033)
ST. JOSEPH HOSPITAL - EUREKA	HUMBOLDT	NON-PROFIT		non-DSH	(0.032)
TULARE DISTRICT HOSPITAL	TULARE	DISTRICT		non-DSH	(0.031)
MT DIABLO MEDICAL CENTER	CONTRA COSTA	NON-PROFIT		non-DSH	(0.030)
CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	NON-PROFIT	TEACHING	DSH	(0.030)
ST. JOSEPH'S MEDICAL CENTER OF STOCKTON	SAN JOAQUIN	NON-PROFIT		non-DSH	(0.030)
GLENDALE ADVENTIST MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.030)
COMMUNITY HOSPITAL OF GARDENA	LOS ANGELES	INVESTOR		non-DSH	(0.029)
WEST ANAHEIM MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.029)
NATIVIDAD MEDICAL CENTER	MONTEREY	CITY/COUNTY	TEACHING	DSH	(0.028)
EASTERN PLUMAS HEALTH CARE	PLUMAS	DISTRICT	SMALL/RURAL	DSH	(0.028)
O'CONNOR HOSPITAL	SANTA CLARA	NON-PROFIT		non-DSH	(0.027)
MERCY HOSPITAL - BAKERSFIELD	KERN	NON-PROFIT		non-DSH	(0.027)
FEATHER RIVER HOSPITAL	BUTTE	NON-PROFIT		non-DSH	(0.025)
SHARP CORONADO HOSPITAL & HEALTHCARE CTR	SAN DIEGO	NON-PROFIT		DSH	(0.025)

LOMA LINDA UNIVERSITY MEDICAL CENTER	SAN BERNARDINO	NON-PROFIT	TEACHING	DSH	(0.021)
ENCINO TARZANA REGIONAL MED CTR - ENCINO	LOS ANGELES	INVESTOR		non-DSH	(0.021)
RIVERSIDE COMMUNITY HOSPITAL	RIVERSIDE	INVESTOR		non-DSH	(0.019)
SUTTER DAVIS HOSPITAL	YOLO	NON-PROFIT		non-DSH	(0.019)
PACIFICA HOSPITAL OF THE VALLEY	LOS ANGELES	INVESTOR		DSH	(0.019)
SETON MEDICAL CENTER	SAN MATEO	NON-PROFIT		non-DSH	(0.018)
KERN VALLEY HEALTHCARE DISTRICT	KERN	DISTRICT	SMALL/RURAL	DSH	(0.018)
ST. HELENA HOSPITAL & HEALTH CENTER	NAPA	NON-PROFIT		non-DSH	(0.017)
MARK TWAIN ST. JOSEPH'S HOSPITAL	CALAVERAS	NON-PROFIT	SMALL/RURAL	non-DSH	(0.017)
WESTERN MEDICAL CENTER - ANAHEIM	ORANGE	INVESTOR		DSH	(0.017)
CHILDREN'S HOSPITAL MED CTR OF NO CAL	ALAMEDA	NON-PROFIT	TEACHING	DSH	(0.017)
CHAPMAN MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.016)
GOLETA VALLEY COTTAGE HOSPITAL	SANTA BARBARA	NON-PROFIT		non-DSH	(0.016)
SCRIPPS MEMORIAL HOSPITAL - ENCINITAS	SAN DIEGO	NON-PROFIT		non-DSH	(0.015)
PROVIDENCE HOLY CROSS MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.014)
BROTMAN MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.014)
SUTTER GENERAL HOSPITAL	SACRAMENTO	NON-PROFIT		non-DSH	(0.014)
TUOLUMNE GENERAL HOSPITAL	TUOLUMNE	CITY/COUNTY	SMALL/RURAL	DSH	(0.013)
SANTA ROSA MEMORIAL HOSPITAL	SONOMA	NON-PROFIT		non-DSH	(0.013)
HOLLYWOOD COMMUNITY HOSP OF HOLLYWOOD	LOS ANGELES	INVESTOR		non-DSH	(0.013)
CHILDREN'S HOSPITAL OF ORANGE COUNTY	ORANGE	NON-PROFIT		DSH	(0.012)
SAN LEANDRO HOSPITAL	ALAMEDA	INVESTOR		non-DSH	(0.011)

MARIAN MEDICAL CENTER	SANTA BARBARA	NON-PROFIT		non-DSH	(0.010)
WATSONVILLE COMMUNITY HOSITAL (NEW)	SANTA CRUZ	INVESTOR		non-DSH	(0.010)
LAUREL GROVE HOSPITAL	ALAMEDA	NON-PROFIT		non-DSH	(0.009)
VALLEY CHILDREN'S HOSP & GUIDANCE CLINIC	MADERA	NON-PROFIT		DSH	(0.008)
MERCY GENERAL HOSPITAL	SACRAMENTO	NON-PROFIT		non-DSH	(0.008)
HEMET VALLEY MEDICAL CENTER	RIVERSIDE	DISTRICT		non-DSH	(0.006)
EMANUEL MEDICAL CENTER	STANISLAUS	NON-PROFIT		non-DSH	(0.006)
DOS PALOS MEMORIAL HOSPITAL	MERCED	NON-PROFIT	SMALL/RURAL	non-DSH	(0.006)
ANAHEIM GENERAL HOSPITAL	ORANGE	INVESTOR		DSH	(0.005)
LAKEWOOD REGIONAL MEDICAL CENTER - SOUTH	LOS ANGELES	INVESTOR		non-DSH	(0.005)
CENTURY CITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	(0.005)
SAN ANTONIO COMMUNITY HOSPITAL	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.004)
POMONA VALLEY HOSPITAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		DSH	(0.004)
COLUMBIA SAN LEANDRO HOSPITAL	ALAMEDA	INVESTOR		non-DSH	(0.003)
UKIAH VALLEY MEDICAL CENTER-HOSPITAL DR	MENDOCINO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.002)
BARSTOW COMMUNITY HOSPITAL	SAN BERNARDINO	INVESTOR	SMALL/RURAL	DSH	(0.001)
CEDARS-SINAI MEDICAL CENTER	LOS ANGELES	NON-PROFIT	TEACHING	non-DSH	(0.000)
SIERRA VIEW DISTRICT HOSPITAL	TULARE	DISTRICT		non-DSH	0.001
MILLS-PENINSULA MEDICAL CENTER	SAN MATEO	NON-PROFIT		non-DSH	0.001
SUTTER MEDICAL CENTER OF SANTA ROSA	SONOMA	NON-PROFIT	TEACHING	DSH	0.001
HI-DESERT MEDICAL CENTER	SAN BERNARDINO	DISTRICT	SMALL/RURAL	DSH	0.001

LANCASTER COMMUNITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	0.002
SHARP MEMORIAL HOSPITAL	SAN DIEGO	NON-PROFIT		non-DSH	0.002
SAN PEDRO PENINSULA HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	0.002
PROVIDENCE SAINT JOSEPH MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	0.002
MAYERS MEMORIAL HOSPITAL	SHASTA	DISTRICT	SMALL/RURAL	DSH	0.003
PLUMAS DISTRICT HOSPITAL	PLUMAS	DISTRICT	SMALL/RURAL	non-DSH	0.003
SHERMAN OAKS HOSPITAL & HEALTH CENTER	LOS ANGELES	NON-PROFIT		non-DSH	0.004
EL CAMINO HOSPITAL	SANTA CLARA	NON-PROFIT		non-DSH	0.004
ENLOE MEDICAL CENTER-ESPLANADE CAMPUS	BUTTE	NON-PROFIT		non-DSH	0.005
ST. JOHN'S PLEASANT VALLEY HOSPITAL	VENTURA	NON-PROFIT		non-DSH	0.005
LUCILE S PACKARD CHLDRN HOSP AT STANFORD	SANTA CLARA	NON-PROFIT		DSH	0.006
ST. LUKE'S HOSPITAL - SF	SAN FRANCISCO	NON-PROFIT		DSH	0.006
ST. JOSEPH HOSPITAL - ORANGE	ORANGE	NON-PROFIT		non-DSH	0.007
REDBUD COMMUNITY HOSPITAL	LAKE	NON-PROFIT	SMALL/RURAL	non-DSH	0.008
FAIRCHILD MEDICAL CENTER	SISKIYOU	NON-PROFIT	SMALL/RURAL	non-DSH	0.009
COMMUNITY MEM HOSP - SAN BUENAVENTURA	VENTURA	NON-PROFIT		non-DSH	0.009
ALTA BATES MEDICAL CENTER - ASHBY CAMPUS	ALAMEDA	NON-PROFIT		non-DSH	0.009
ST. LUKE MEDICAL CENTER - LA	LOS ANGELES	INVESTOR		non-DSH	0.009
CLOVIS COMMUNITY HOSPITAL	FRESNO	NON-PROFIT		non-DSH	0.010
BEVERLY HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	0.010
DOMINICAN SANTA CRUZ HOSPITAL - SOQUEL	SANTA CRUZ	NON-PROFIT		non-DSH	0.010
MERCY HOSPITAL OF MT. SHASTA	SISKIYOU	NON-PROFIT	SMALL/RURAL	non-DSH	0.010
CALIFORNIA HOSPITAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		DSH	0.011

GROSSMONT HOSPITAL	SAN DIEGO	NON-PROFIT		non-DSH	0.011
DAMERON HOSPITAL	SAN JOAQUIN	NON-PROFIT		non-DSH	0.012
ARROYO GRANDE COMMUNITY HOSPITAL	SAN LUIS OBISPO	NON-PROFIT		non-DSH	0.012
CHINESE HOSPITAL	SAN FRANCISCO	NON-PROFIT		non-DSH	0.013
EL CENTRO REGIONAL MEDICAL CENTER	IMPERIAL	CITY/COUNTY		non-DSH	0.013
BARTON MEMORIAL HOSPITAL	EL DORADO	NON-PROFIT	SMALL/RURAL	non-DSH	0.014
U S FAMILY CARE MED CTR - MONTCLAIR	SAN BERNARDINO	INVESTOR		non-DSH	0.016
RANCHO SPRINGS MEDICAL CENTER	RIVERSIDE	INVESTOR		non-DSH	0.016
VENCOR HOSPITAL - SAN DIEGO	SAN DIEGO	INVESTOR		non-DSH	0.016
ANTELOPE VALLEY HOSPITAL MEDICAL CTR	LOS ANGELES	DISTRICT		non-DSH	0.016
SUTTER MEMORIAL HOSPITAL	SACRAMENTO	NON-PROFIT		non-DSH	0.017
CHILDREN'S HOSPITAL - SAN DIEGO	SAN DIEGO	NON-PROFIT		DSH	0.018
SCRIPPS MEMORIAL HOSPITAL - LA JOLLA	SAN DIEGO	NON-PROFIT		non-DSH	0.018
MISSION HOSPITAL REGIONAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	0.018
OJAI VALLEY COMMUNITY HOSPITAL	VENTURA	INVESTOR	SMALL/RURAL	non-DSH	0.018
DOCTORS HOSPITAL OF MANTECA	SAN JOAQUIN	INVESTOR		non-DSH	0.018
GENERAL HOSPITAL THE	HUMBOLDT	INVESTOR		non-DSH	0.019
PATIENT'S HOSPITAL OF REDDING	SHASTA	INVESTOR		non-DSH	0.020
SCRIPPS MERCY HOSPITAL	SAN DIEGO	NON-PROFIT	TEACHING	DSH	0.025
HOAG MEMORIAL HOSPITAL PRESBYTERIAN	ORANGE	NON-PROFIT		non-DSH	0.025
CALIFORNIA PACIFIC MEDICAL CENTER	SAN FRANCISCO	NON-PROFIT	TEACHING	non-DSH	0.025
KAWEAH DELTA DISTRICT HOSPITAL	TULARE	DISTRICT		non-DSH	0.025
GEORGE L. MEE MEMORIAL HOSPITAL	MONTEREY	NON-PROFIT	SMALL/RURAL	DSH	0.025

ROBERT F. KENNEDY MEDICAL CENTER	LOS ANGELES	NON-PROFIT		DSH	0.025
INDIAN VALLEY HOSPITAL	PLUMAS	DISTRICT	SMALL/RURAL	non-DSH	0.026
LONG BEACH MEMORIAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT	TEACHING	non-DSH	0.026
COMMUNITY HOSPITAL OF MONTEREY PENINSULA	MONTEREY	NON-PROFIT		non-DSH	0.026
MONROVIA COMMUNITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	0.026
OAK VALLEY DISTRICT HOSPITAL	STANISLAUS	DISTRICT	SMALL/RURAL	non-DSH	0.029
SUTTER COAST HOSPITAL	DEL NORTE	NON-PROFIT	SMALL/RURAL	non-DSH	0.029
SADDLEBACK MEMORIAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	0.031
TAHOE FOREST HOSPITAL	NEVADA	DISTRICT	SMALL/RURAL	non-DSH	0.031
SEQUOIA HOSPITAL	SAN MATEO	NON-PROFIT		non-DSH	0.032
HAZEL HAWKINS MEMORIAL HOSPITAL	SAN BENITO	DISTRICT	SMALL/RURAL	non-DSH	0.033
VALLEY MEMORIAL HOSPITAL	ALAMEDA	NON-PROFIT		non-DSH	0.033
PACIFIC HOSPITAL OF LONG BEACH	LOS ANGELES	INVESTOR		DSH	0.034
VENCOR HOSPITAL - SACRAMENTO	SACRAMENTO	INVESTOR		non-DSH	0.035
PRESBYTERIAN INTERCOMMUNITY HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	0.038
ST. MARY REGIONAL MEDICAL CENTER	SAN BERNARDINO	NON-PROFIT	SMALL/RURAL	non-DSH	0.038
MEMORIAL HOSPITAL MODESTO	STANISLAUS	NON-PROFIT		non-DSH	0.038
JOHN MUIR MEDICAL CENTER	CONTRA COSTA	NON-PROFIT		non-DSH	0.040
NORTHERN INYO HOSPITAL	INYO	DISTRICT	SMALL/RURAL	non-DSH	0.040
SCRIPPS GREEN HOSPITAL	SAN DIEGO	NON-PROFIT		non-DSH	0.041
UCLA MEDICAL CENTER	LOS ANGELES	NON-PROFIT	TEACHING	non-DSH	0.041
LITTLE COMPANY OF MARY HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	0.041
CORCORAN DISTRICT HOSPITAL	KINGS	DISTRICT	SMALL/RURAL	non-DSH	0.042
SAN RAMON REGIONAL MEDICAL CENTER	CONTRA COSTA	INVESTOR		non-DSH	0.042

GLENDALE MEMORIAL HOSPITAL & HEALTH CTR	LOS ANGELES	NON-PROFIT		non-DSH	0.043
NOVATO COMMUNITY HOSPITAL	MARIN	NON-PROFIT		non-DSH	0.043
EDEN MEDICAL CENTER	ALAMEDA	NON-PROFIT		non-DSH	0.044
SAN DIMAS COMMUNITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	0.045
SALINAS VALLEY MEMORIAL HOSPITAL	MONTEREY	DISTRICT		non-DSH	0.048
REDWOOD MEMORIAL HOSPITAL	HUMBOLDT	NON-PROFIT	SMALL/RURAL	non-DSH	0.048
MARIN GENERAL HOSPITAL	MARIN	NON-PROFIT		non-DSH	0.049
QUEEN OF THE VALLEY HOSP	NAPA	NON-PROFIT		non-DSH	0.049
TORRANCE MEMORIAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	0.050
FALLBROOK HOSPITAL DISTRICT	SAN DIEGO	DISTRICT	SMALL/RURAL	non-DSH	0.050
BIGGS-GRIDLEY MEMORIAL HOSPITAL	BUTTE	NON-PROFIT	SMALL/RURAL	non-DSH	0.052
ST. MARY MEDICAL CENTER - LONG BEACH	LOS ANGELES	NON-PROFIT		DSH	0.053
DELANO REGIONAL MEDICAL CENTER	KERN	NON-PROFIT		DSH	0.054
SUTTER AUBURN FAITH HOSPITAL	PLACER	NON-PROFIT		non-DSH	0.055
RIDEOUT MEMORIAL HOSPITAL	YUBA	NON-PROFIT		non-DSH	0.055
MADERA COMMUNITY HOSPITAL	MADERA	NON-PROFIT		non-DSH	0.057
DOCTORS HOSPITAL OF WEST COVINA	LOS ANGELES	INVESTOR		DSH	0.059
DOCTORS MEDICAL CENTER - SAN PABLO	CONTRA COSTA	INVESTOR		DSH	0.059
WASHINGTON HOSPITAL - FREMONT	ALAMEDA	DISTRICT		non-DSH	0.059
MERCY MEDICAL CENTER-REDDING	SHASTA	NON-PROFIT		non-DSH	0.061
SHARP CHULA VISTA MEDICAL CENTER	SAN DIEGO	NON-PROFIT		non-DSH	0.063
ALHAMBRA HOSPITAL - ALHAMBRA	LOS ANGELES	INVESTOR		DSH	0.063
MERCY HOSPITAL & HLTH SVCS - MERCED	MERCED	NON-PROFIT		non-DSH	0.069
MISSION COMMUNITY HOSPITAL - PANORAMA	LOS ANGELES	NON-PROFIT		DSH	0.071
SUTTER LAKESIDE HOSPITAL	LAKE	NON-PROFIT	SMALL/RURAL	non-DSH	0.072
ST. JOHN'S HOSPITAL AND HEALTH	LOS ANGELES	NON-PROFIT		non-DSH	0.072

CENTER					
TEMPLE COMMUNITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	0.073
WESTERN MEDICAL CENTER - SANTA ANA	ORANGE	INVESTOR		DSH	0.075
SUTTER TRACY COMMUNITY HOSPITAL	SAN JOAQUIN	NON-PROFIT		non-DSH	0.075
LOS ANGELES METROPOLITAN MEDICAL CENTER	LOS ANGELES	INVESTOR		DSH	0.075
FREMONT HOSPITAL - YUBA CITY	SUTTER	NON-PROFIT		non-DSH	0.075
UNIVERSITY OF CALIFORNIA IRVINE MED CTR	ORANGE	NON-PROFIT	TEACHING	DSH	0.075
SUTTER ROSEVILLE MEDICAL CENTER	PLACER	NON-PROFIT		non-DSH	0.076
NORTH BAY MEDICAL CENTER	SOLANO	NON-PROFIT		DSH	0.077
ST. JOHN'S REGIONAL MEDICAL CENTER	VENTURA	NON-PROFIT		non-DSH	0.079
SANTA ANA HOSPITAL MEDICAL CENTER	ORANGE	INVESTOR		DSH	0.080
VENCOR HOSPITAL - ORANGE COUNTY	ORANGE	INVESTOR		non-DSH	0.080
THE HEART HOSPITAL	RIVERSIDE	INVESTOR		non-DSH	0.083
SUTTER DELTA MEDICAL CENTER	CONTRA COSTA	NON-PROFIT		non-DSH	0.083
DOCTORS MEDICAL CENTER	STANISLAUS	INVESTOR		non-DSH	0.084
COMMUNITY HOSPITAL OF SAN BERNARDINO	SAN BERNARDINO	NON-PROFIT		DSH	0.087
DOCTORS MEDICAL CENTER - PINOLE	CONTRA COSTA	INVESTOR		non-DSH	0.088
BELLFLOWER MEDICAL CENTER	LOS ANGELES	INVESTOR		DSH	0.088
PALO VERDE HOSPITAL	RIVERSIDE	INVESTOR	SMALL/RURAL	non-DSH	0.088
CORONA REGIONAL MEDICAL CENTER - MAGNOLIA	RIVERSIDE	NON-PROFIT		non-DSH	0.089
ST. JUDE MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	0.090
LOS ALAMITOS MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	0.090
CENTINELA HOSPITAL MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	0.091
MERCY HOSPITAL OF FOLSOM	SACRAMENTO	NON-PROFIT		non-DSH	0.091

UNIVERSITY OF CALIFORNIA DAVIS MED CTR	SACRAMENTO	NON-PROFIT	TEACHING	DSH	0.095
SUTTER AMADOR HOSPITAL	AMADOR	NON-PROFIT	SMALL/RURAL	non-DSH	0.096
DESERT REGIONAL MEDICAL CENTER	RIVERSIDE	INVESTOR		non-DSH	0.097
SIERRA NEVADA MEMORIAL HOSPITAL	NEVADA	NON-PROFIT	SMALL/RURAL	non-DSH	0.098
ST. FRANCIS MEDICAL CENTER - LYNWOOD	LOS ANGELES	NON-PROFIT		DSH	0.099
MEMORIAL HOSPITAL LOS BANOS	MERCED	NON-PROFIT	SMALL/RURAL	non-DSH	0.104
VENCOR HOSPITAL - LOS ANGELES	LOS ANGELES	INVESTOR		non-DSH	0.105
SUTTER SOLANO MEDICAL CENTER	SOLANO	NON-PROFIT		DSH	0.105
COASTAL COMMUNITIES HOSPITAL	ORANGE	INVESTOR		DSH	0.106
ST. ELIZABETH COMMUNITY HOSPITAL	TEHAMA	NON-PROFIT	SMALL/RURAL	non-DSH	0.106
WHITTIER HOSPITAL MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	0.109
ARROWHEAD REGIONAL MEDICAL CENTER	SAN BERNARDINO	CITY/COUNTY		DSH	0.111
VENCOR HOSPITAL - BREA	ORANGE	INVESTOR		non-DSH	0.112
MEMORIAL HOSPITAL OF GARDENA	LOS ANGELES	INVESTOR		DSH	0.112
LINCOLN HOSPITAL MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	0.114
COLLEGE HOSPITAL COSTA MESA	ORANGE	INVESTOR		DSH	0.114
ORANGE COUNTY COMM HOSP - BUENA PARK	ORANGE	INVESTOR		non-DSH	0.121
FRESNO COMMUNITY HOSP AND MEDICAL CENTER	FRESNO	NON-PROFIT		non-DSH	0.123
LOS ROBLES HOSPITAL MEDICAL CENTER	VENTURA	INVESTOR		non-DSH	0.126
RIVERSIDE COUNTY REGIONAL MED CTR	RIVERSIDE	CITY/COUNTY	TEACHING	DSH	0.126
COAST PLAZA DOCTORS HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	0.130
USC UNIVERSITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	0.130
LASSEN COMMUNITY HOSPITAL	LASSEN	NON-PROFIT	SMALL/RURAL	non-DSH	0.134
SAN JOAQUIN GENERAL HOSPITAL	SAN JOAQUIN	CITY/COUNTY		DSH	0.139
SIERRA VISTA REGIONAL MEDICAL	SAN LUIS	INVESTOR		non-DSH	0.143

CENTER	OBISPO				
VENCOR HOSPITAL - ONTARIO	SAN BERNARDINO	INVESTOR		non-DSH	0.144
COMMUNITY HOSPITAL OF LOS GATOS	SANTA CLARA	INVESTOR		non-DSH	0.146
SUBURBAN MEDICAL CENTER	LOS ANGELES	INVESTOR		DSH	0.148
UNIVERSITY MEDICAL CENTER	FRESNO	NON-PROFIT	TEACHING	DSH	0.149
WHITE MEMORIAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT	TEACHING	DSH	0.152
COMMUNITY & MISSION HOSPS-HTG PARK	LOS ANGELES	INVESTOR		DSH	0.160
PLACENTIA-LINDA COMMUNITY HOSPITAL	ORANGE	INVESTOR		non-DSH	0.160
COLORADO RIVER MEDICAL CENTER	SAN BERNARDINO	INVESTOR	SMALL/RURAL	non-DSH	0.161
ENCINO TARZANA REGIONAL MED CTR - TARZANA	LOS ANGELES	INVESTOR		non-DSH	0.162
MONTEREY PARK HOSPITAL	LOS ANGELES	INVESTOR		DSH	0.163
FOUNTAIN VALLEY REGL HOSP & MED CTR - EUCLID	ORANGE	INVESTOR		DSH	0.167
LOS ANGELES CO ML KING JR DREW MED CTR	LOS ANGELES	CITY/COUNTY	TEACHING	DSH	0.170
VACA VALLEY HOSPITAL	SOLANO	NON-PROFIT		non-DSH	0.178
RECOVERY INN OF MENLO PARK	SAN MATEO	INVESTOR		non-DSH	0.181
ALVARADO HOSPITAL MEDICAL CENTER	SAN DIEGO	INVESTOR		non-DSH	0.182
KERN MEDICAL CENTER	KERN	CITY/COUNTY	TEACHING	DSH	0.183
SAN FRANCISCO GENERAL HOSP MED CTR	SAN FRANCISCO	CITY/COUNTY	TEACHING	DSH	0.187
JOHN F. KENNEDY MEMORIAL HOSPITAL	RIVERSIDE	INVESTOR		DSH	0.194
TWIN CITIES COMMUNITY HOSPITAL	SAN LUIS OBISPO	INVESTOR	SMALL/RURAL	non-DSH	0.196
UCSD/SAN DIEGO - UNIVERSITY MEDICAL CTR	SAN DIEGO	NON-PROFIT	TEACHING	DSH	0.226

GARDEN GROVE HOSP & MEDICAL CENTER	ORANGE	INVESTOR		DSH	0.244
LOS ANGELES COMMUNITY HOSPITAL	LOS ANGELES	INVESTOR		DSH	0.250
GREATER EL MONTE COMMUNITY HOSPITAL	LOS ANGELES	INVESTOR		DSH	0.257
SAN BERNARDINO COUNTY MEDICAL CENTER	SAN BERNARDINO	CITY/COUNTY	TEACHING	DSH	0.259
LOS ANGELES CO OLIVE VIEW MED CTR	LOS ANGELES	CITY/COUNTY	TEACHING	DSH	0.262
SANTA CLARA VALLEY MEDICAL CENTER	SANTA CLARA	CITY/COUNTY	TEACHING	DSH	0.262
REDDING MEDICAL CENTER	SHASTA	INVESTOR		non-DSH	0.272
LOS ANGELES CO USC MEDICAL CENTER	LOS ANGELES	CITY/COUNTY	TEACHING	DSH	0.278
GARFIELD MEDICAL CENTER	LOS ANGELES	INVESTOR		DSH	0.289
QUEEN OF ANGELS-HOLLYWOOD PRESB MED CTR	LOS ANGELES	INVESTOR		DSH	0.298
LOS ANGELES CO HARBOR+UCLA MEDICAL CTR	LOS ANGELES	CITY/COUNTY	TEACHING	DSH	0.309
ALAMEDA COUNTY MEDICAL CENTER	ALAMEDA	CITY/COUNTY	TEACHING	DSH	0.410

Source: OSHPD Hospital Annual Financial Data

Notes:
1. Blank columns represent data from which operating margins were computed (Net from operations / [Net patient revenue + Other operating revenue])
2. Most financial analysts recommend consulting 3 to 5 years of data to get an accurate picture of a hospital's financial position. Because of the way OSHPD data files are presented, and some of the data are calculated, it was impossible within the time frame of this project to transpose three years of data accurately. The information presented here is intended to convey a general trend, and not a definitive assessment of any particular hospital's financial condition.

C.2. CALIFORNIA HOSPITALS WITH NEGATIVE OPERATING MARGIN, 1999
BY OWNERSHIP TYPE

FAC_NAME	COUNTY NAME	TYPE_CNTRL	TEACH_RURL	DSH HOSP	OP MARGIN
SAN LUIS OBISPO GENERAL HOSPITAL	SAN LUIS OBISPO	CITY/COUNTY		DSH	(0.379)
LOS ANGELES CO HIGH DESERT HOSPITAL	LOS ANGELES	CITY/COUNTY		DSH	(0.356)
SAN MATEO GENERAL HOSPITAL	SAN MATEO	CITY/COUNTY		DSH	(0.296)
VENTURA COUNTY MEDICAL CENTER	VENTURA	CITY/COUNTY		DSH	(0.164)
CONTRA COSTA REGIONAL MEDICAL CTR	CONTRA COSTA	CITY/COUNTY		DSH	(0.083)
TRINITY GENERAL HOSPITAL	TRINITY	CITY/COUNTY	SMALL/RURAL	DSH	(0.060)
MODOC MEDICAL CENTER	MODOC	CITY/COUNTY	SMALL/RURAL	DSH	(0.047)
NATIVIDAD MEDICAL CENTER	MONTEREY	CITY/COUNTY	TEACHING	DSH	(0.028)
TUOLUMNE GENERAL HOSPITAL	TUOLUMNE	CITY/COUNTY	SMALL/RURAL	DSH	(0.013)
MOUNTAINS COMMUNITY HOSPITAL	SAN BERNARDINO	DISTRICT	SMALL/RURAL	non-DSH	(0.320)
CHOWCHILLA DISTRICT MEMORIAL HOSPITAL	MADERA	DISTRICT	SMALL/RURAL	DSH	(0.319)
ALTA HOSPITAL DISTRICT	TULARE	DISTRICT	SMALL/RURAL	non-DSH	(0.313)
SELMA DISTRICT HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.210)
JEROLD PHELPS COMMUNITY HOSPITAL	HUMBOLDT	DISTRICT	SMALL/RURAL	DSH	(0.191)
SENECA HOSPITAL	PLUMAS	DISTRICT	SMALL/RURAL	DSH	(0.186)
MAMMOTH HOSPITAL	MONO	DISTRICT	SMALL/RURAL	non-DSH	(0.172)
MEMORIAL HOSPITAL AT EXETER	TULARE	DISTRICT	SMALL/RURAL	non-DSH	(0.164)
SOUTHERN INYO HOSPITAL	INYO	DISTRICT	SMALL/RURAL	non-DSH	(0.155)
COALINGA REGIONAL MEDICAL CENTER	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.139)
SURPRISE VALLEY COMMUNITY HOSPITAL	MODOC	DISTRICT	SMALL/RURAL	DSH	(0.135)
SIERRA VALLEY DISTRICT HOSPITAL	SIERRA	DISTRICT	SMALL/RURAL	DSH	(0.135)
TEHACHAPI HOSPITAL	KERN	DISTRICT	SMALL/RURAL	DSH	(0.129)

TRI-CITY MEDICAL CENTER	SAN DIEGO	DISTRICT		non-DSH	(0.116)
JOHN C FREMONT HEALTHCARE DISTRICT	MARIPOSA	DISTRICT	SMALL/RURAL	non-DSH	(0.111)
SONOMA VALLEY HOSPITAL	SONOMA	DISTRICT		non-DSH	(0.111)
SIERRA KINGS DISTRICT HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.110)
LINDSAY DISTRICT HOSPITAL	TULARE	DISTRICT	SMALL/RURAL	DSH	(0.106)
BEAR VALLEY COMMUNITY HOSPITAL	SAN BERNARDINO	DISTRICT	SMALL/RURAL	non-DSH	(0.079)
KINGSBURG MEDICAL HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	DSH	(0.075)
LOMPOC HEALTHCARE DISTRICT	SANTA BARBARA	DISTRICT	SMALL/RURAL	non-DSH	(0.075)
PIONEERS MEMORIAL HOSPITAL	IMPERIAL	DISTRICT	SMALL/RURAL	DSH	(0.073)
MORENO VALLEY COMMUNITY HOSPITAL	RIVERSIDE	DISTRICT		non-DSH	(0.071)
PALOMAR MEDICAL CENTER	SAN DIEGO	DISTRICT		non-DSH	(0.062)
SAN GORGONIO MEMORIAL HOSPITAL	RIVERSIDE	DISTRICT	SMALL/RURAL	non-DSH	(0.046)
POMERADO HOSPITAL	SAN DIEGO	DISTRICT		non-DSH	(0.046)
MENDOCINO COAST DISTRICT HOSPITAL	MENDOCINO	DISTRICT	SMALL/RURAL	non-DSH	(0.042)
MENIFEE VALLEY MEDICAL CENTER	RIVERSIDE	DISTRICT		non-DSH	(0.040)
TULARE DISTRICT HOSPITAL	TULARE	DISTRICT		non-DSH	(0.031)
EASTERN PLUMAS HEALTH CARE	PLUMAS	DISTRICT	SMALL/RURAL	DSH	(0.028)
KERN VALLEY HEALTHCARE DISTRICT	KERN	DISTRICT	SMALL/RURAL	DSH	(0.018)
HEMET VALLEY MEDICAL CENTER	RIVERSIDE	DISTRICT		non-DSH	(0.006)
CITY OF ANGELS MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(6.103)
VALLEY PLAZA DOCTORS HOSPITAL	RIVERSIDE	INVESTOR		non-DSH	(1.707)
WARRACK MEDICAL CENTER HOSPITAL	SONOMA	INVESTOR		non-DSH	(1.141)
CHILDRENS RECOVERY CTR OF NO CALIF	SANTA CLARA	INVESTOR		non-DSH	(0.663)
SAN VICENTE HOSPITAL	LOS ANGELES	INVESTOR		DSH	(0.534)
COLUMBIA SOUTH VALLEY HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.336)
BREA COMMUNITY HOSPITAL	ORANGE	INVESTOR		non-DSH	(0.298)
TUSTIN HOSPITAL MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.278)
GOOD SAMARITAN HOSPITAL-BAKERSFIELD	KERN	INVESTOR		DSH	(0.208)

VALLEY COMMUNITY HOSPITAL	SANTA BARBARA	INVESTOR		non-DSH	(0.183)
KPC GLOBAL MEDICAL CENTER	SAN BERNARDINO	INVESTOR		non-DSH	(0.179)
IRVINE MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.173)
CHINO VALLEY MEDICAL CENTER	SAN BERNARDINO	INVESTOR		non-DSH	(0.157)
HUNTINGTON BEACH HOSP & MED CTR	ORANGE	INVESTOR		DSH	(0.129)
CENTRAL VALLEY GENERAL HOSPITAL	KINGS	INVESTOR		DSH	(0.128)
PACIFIC ALLIANCE MEDICAL CENTER	LOS ANGELES	INVESTOR		DSH	(0.127)
SAN CLEMENTE HOSPITAL & MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.125)
COLUMBIA GOOD SAMARITAN HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.117)
INLAND VALLEY REGIONAL MEDICAL CENTER	RIVERSIDE	INVESTOR	SMALL/RURAL	non-DSH	(0.105)
EAST LOS ANGELES DOCTOR'S HOSPITAL	LOS ANGELES	INVESTOR		DSH	(0.093)
VENCOR HOSPITAL - SAN LEANDRO	ALAMEDA	INVESTOR		non-DSH	(0.082)
FRESNO SURGERY CENTER	FRESNO	INVESTOR		non-DSH	(0.081)
WEST HILLS HOSPITAL & MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.071)
REGIONAL MEDICAL CENTER OF SAN JOSE	SANTA CLARA	INVESTOR		DSH	(0.070)
DESERT VALLEY HOSPITAL	SAN BERNARDINO	INVESTOR		non-DSH	(0.062)
GOOD SAMARITAN HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.056)
SANGER GENERAL HOSPITAL	FRESNO	INVESTOR	SMALL/RURAL	DSH	(0.054)
MIDWAY HOSPITAL MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.052)
SAN JOSE MEDICAL CENTER	SANTA CLARA	INVESTOR	TEACHING	non-DSH	(0.048)
MISSION BAY HOSPITAL	SAN DIEGO	INVESTOR		non-DSH	(0.045)
MAD RIVER COMMUNITY HOSPITAL	HUMBOLDT	INVESTOR		non-DSH	(0.040)
SPECIALTY HOSPITAL OF SOUTHERN CAL	LOS ANGELES	INVESTOR		non-DSH	(0.033)
COMMUNITY HOSPITAL OF GARDENA	LOS ANGELES	INVESTOR		non-DSH	(0.029)
WEST ANAHEIM MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.029)

ENCINO TARZANA REGIONAL MED CTR - ENCINO	LOS ANGELES	INVESTOR		non-DSH	(0.021)
RIVERSIDE COMMUNITY HOSPITAL	RIVERSIDE	INVESTOR		non-DSH	(0.019)
PACIFICA HOSPITAL OF THE VALLEY	LOS ANGELES	INVESTOR		DSH	(0.019)
WESTERN MEDICAL CENTER - ANAHEIM	ORANGE	INVESTOR		DSH	(0.017)
CHAPMAN MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.016)
BROTMAN MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.014)
HOLLYWOOD COMMUNITY HOSP OF HOLLYWOOD	LOS ANGELES	INVESTOR		non-DSH	(0.013)
SAN LEANDRO HOSPITAL	ALAMEDA	INVESTOR		non-DSH	(0.011)
WATSONVILLE COMMUNITY HOSITAL (NEW)	SANTA CRUZ	INVESTOR		non-DSH	(0.010)
ANAHEIM GENERAL HOSPITAL	ORANGE	INVESTOR		DSH	(0.005)
LAKEWOOD REGIONAL MEDICAL CENTER - SOUTH	LOS ANGELES	INVESTOR		non-DSH	(0.005)
CENTURY CITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	(0.005)
COLUMBIA SAN LEANDRO HOSPITAL	ALAMEDA	INVESTOR		non-DSH	(0.003)
BARSTOW COMMUNITY HOSPITAL	SAN BERNARDINO	INVESTOR	SMALL/RURAL	DSH	(0.001)

C.3. CALIFORNIA HOSPITALS WITH NEGATIVE OPERATING MARGIN, 1999
BY COUNTY

FAC_NAME	COUNTY NAME	TYPE_CNTRL	TEACH_RURL	DSH hosp	OP MARGIN
ST. ROSE HOSPITAL	ALAMEDA	NON-PROFIT		DSH	(0.088)
VENCOR HOSPITAL - SAN LEANDRO	ALAMEDA	INVESTOR		non-DSH	(0.082)
ALAMEDA HOSPITAL	ALAMEDA	NON-PROFIT		non-DSH	(0.068)
SUMMIT MEDICAL CENTER	ALAMEDA	NON-PROFIT		non-DSH	(0.065)
CHILDREN'S HOSPITAL MED CTR OF NO CAL	ALAMEDA	NON-PROFIT	TEACHING	DSH	(0.017)
SAN LEANDRO HOSPITAL	ALAMEDA	INVESTOR		non-DSH	(0.011)
LAUREL GROVE HOSPITAL	ALAMEDA	NON-PROFIT		non-DSH	(0.009)
COLUMBIA SAN LEANDRO HOSPITAL	ALAMEDA	INVESTOR		non-DSH	(0.003)
OROVILLE HOSPITAL	BUTTE	NON-PROFIT		non-DSH	(0.109)
FEATHER RIVER HOSPITAL	BUTTE	NON-PROFIT		non-DSH	(0.025)
MARK TWAIN ST. JOSEPH'S HOSPITAL	CALAVERAS	NON-PROFIT	SMALL/RURAL	non-DSH	(0.017)
COLUSA COMMUNITY HOSPITAL	COLUSA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.075)
CONTRA COSTA REGIONAL MEDICAL CTR	CONTRA COSTA	CITY/COUNTY		DSH	(0.083)
MT DIABLO MEDICAL CENTER	CONTRA COSTA	NON-PROFIT		non-DSH	(0.030)
MARSHALL HOSPITAL	EL DORADO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.095)
SELMA DISTRICT HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.210)
COALINGA REGIONAL MEDICAL CENTER	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.139)
ST. AGNES MEDICAL CENTER	FRESNO	NON-PROFIT		non-DSH	(0.124)
SIERRA KINGS DISTRICT HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	non-DSH	(0.110)
FRESNO SURGERY CENTER	FRESNO	INVESTOR		non-DSH	(0.081)
KINGSBURG MEDICAL HOSPITAL	FRESNO	DISTRICT	SMALL/RURAL	DSH	(0.075)
SANGER GENERAL HOSPITAL	FRESNO	INVESTOR	SMALL/RURAL	DSH	(0.054)
GLENN MEDICAL CENTER	GLENN	NON-PROFIT	SMALL/RURAL	non-DSH	(0.375)

JEROLD PHELPS COMMUNITY HOSPITAL	HUMBOLDT	DISTRICT	SMALL/RURAL	DSH	(0.191)
MAD RIVER COMMUNITY HOSPITAL	HUMBOLDT	INVESTOR		non-DSH	(0.040)
ST. JOSEPH HOSPITAL - EUREKA	HUMBOLDT	NON-PROFIT		non-DSH	(0.032)
PIONEERS MEMORIAL HOSPITAL	IMPERIAL	DISTRICT	SMALL/RURAL	DSH	(0.073)
SOUTHERN INYO HOSPITAL	INYO	DISTRICT	SMALL/RURAL	non-DSH	(0.155)
GOOD SAMARITAN HOSPITAL-BAKERSFIELD	KERN	INVESTOR		DSH	(0.208)
TEHACHAPI HOSPITAL	KERN	DISTRICT	SMALL/RURAL	DSH	(0.129)
RIDGECREST COMMUNITY HOSPITAL	KERN	NON-PROFIT	SMALL/RURAL	non-DSH	(0.058)
SAN JOAQUIN COMMUNITY HOSPITAL	KERN	NON-PROFIT		non-DSH	(0.057)
BAKERSFIELD MEMORIAL HOSPITAL	KERN	NON-PROFIT		non-DSH	(0.053)
MERCY WESTSIDE HOSPITAL	KERN	NON-PROFIT	SMALL/RURAL	DSH	(0.049)
MERCY HOSPITAL - BAKERSFIELD	KERN	NON-PROFIT		non-DSH	(0.027)
KERN VALLEY HEALTHCARE DISTRICT	KERN	DISTRICT	SMALL/RURAL	DSH	(0.018)
HANFORD COMMUNITY HOSPITAL	KINGS	NON-PROFIT	SMALL/RURAL	non-DSH	(0.177)
CENTRAL VALLEY GENERAL HOSPITAL	KINGS	INVESTOR		DSH	(0.128)
CITY OF ANGELS MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(6.103)
MOTION PICTURE & TELEVISION HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.577)
SAN VICENTE HOSPITAL	LOS ANGELES	INVESTOR		DSH	(0.534)
LOS ANGELES CO HIGH DESERT HOSPITAL	LOS ANGELES	CITY/COUNTY		DSH	(0.356)
AVALON MUNICIPAL HOSPITAL & CLINIC	LOS ANGELES	NON-PROFIT	SMALL/RURAL	non-DSH	(0.343)
SANTA MARTA HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.208)
GOOD SAMARITAN HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.205)
HUNTINGTON MEMORIAL HOSPITAL	LOS ANGELES	NON-PROFIT	TEACHING	non-DSH	(0.202)
LONG BEACH COMMUNITY MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.177)
DANIEL FREEMAN MARINA HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.165)
HUNTINGTON EAST VALLEY HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.163)
SANTA TERESITA HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.152)

DOWNEY COMMUNITY HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.136)
TRI-CITY REGIONAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.128)
PACIFIC ALLIANCE MEDICAL CENTER	LOS ANGELES	INVESTOR		DSH	(0.127)
VERDUGO HILLS HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.124)
EAST LOS ANGELES DOCTOR'S HOSPITAL	LOS ANGELES	INVESTOR		DSH	(0.093)
FOOTHILL PRESBYTERIAN HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.081)
NORTHRIDGE HOSPITAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.072)
METHODIST HOSPITAL OF SOUTHERN CAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.071)
WEST HILLS HOSPITAL & MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.071)
HENRY MAYO NEWHALL MEMORIAL HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.070)
CITRUS VALLEY MEDICAL CENTER-QV CAMPUS	LOS ANGELES	NON-PROFIT		DSH	(0.066)
GRANADA HILLS COMMUNITY HOSPITAL	LOS ANGELES	NON-PROFIT		non-DSH	(0.057)
BAY HARBOR HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.057)
DANIEL FREEMAN MEMORIAL HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.055)
MIDWAY HOSPITAL MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.052)
NORTHRIDGE HOSPITAL MEDICAL CTR - SHERMAN	LOS ANGELES	NON-PROFIT		DSH	(0.044)
ST. VINCENT MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.044)
VALLEY PRESBYTERIAN HOSPITAL	LOS ANGELES	NON-PROFIT		DSH	(0.039)
SANTA MONICA - UCLA MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.036)
SPECIALTY HOSPITAL OF SOUTHERN CAL	LOS ANGELES	INVESTOR		non-DSH	(0.033)
SAN GABRIEL VALLEY MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.033)
CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	NON-PROFIT	TEACHING	DSH	(0.030)
GLENDALE ADVENTIST MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.030)
COMMUNITY HOSPITAL OF GARDENA	LOS ANGELES	INVESTOR		non-DSH	(0.029)
ENCINO TARZANA REGIONAL MED CTR - ENCINO	LOS ANGELES	INVESTOR		non-DSH	(0.021)

PACIFICA HOSPITAL OF THE VALLEY	LOS ANGELES	INVESTOR		DSH	(0.019)
PROVIDENCE HOLY CROSS MEDICAL CENTER	LOS ANGELES	NON-PROFIT		non-DSH	(0.014)
BROTMAN MEDICAL CENTER	LOS ANGELES	INVESTOR		non-DSH	(0.014)
HOLLYWOOD COMMUNITY HOSP OF HOLLYWOOD	LOS ANGELES	INVESTOR		non-DSH	(0.013)
LAKEWOOD REGIONAL MEDICAL CENTER - SOUTH	LOS ANGELES	INVESTOR		non-DSH	(0.005)
CENTURY CITY HOSPITAL	LOS ANGELES	INVESTOR		non-DSH	(0.005)
POMONA VALLEY HOSPITAL MEDICAL CENTER	LOS ANGELES	NON-PROFIT		DSH	(0.004)
CEDARS-SINAI MEDICAL CENTER	LOS ANGELES	NON-PROFIT	TEACHING	non-DSH	(0.000)
CHOWCHILLA DISTRICT MEMORIAL HOSPITAL	MADERA	DISTRICT	SMALL/RURAL	DSH	(0.319)
VALLEY CHILDREN'S HOSP & GUIDANCE CLINIC	MADERA	NON-PROFIT		DSH	(0.008)
JOHN C FREMONT HEALTHCARE DISTRICT	MARIPOSA	DISTRICT	SMALL/RURAL	non-DSH	(0.111)
FRANK R HOWARD MEMORIAL HOSPITAL	MENDOCINO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.078)
MENDOCINO COAST DISTRICT HOSPITAL	MENDOCINO	DISTRICT	SMALL/RURAL	non-DSH	(0.042)
UKIAH VALLEY MEDICAL CENTER-HOSPITAL DR	MENDOCINO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.002)
SUTTER MERCED MEDICAL CENTER	MERCED	NON-PROFIT		DSH	(0.086)
DOS PALOS MEMORIAL HOSPITAL	MERCED	NON-PROFIT	SMALL/RURAL	non-DSH	(0.006)
SURPRISE VALLEY COMMUNITY HOSPITAL	MODOC	DISTRICT	SMALL/RURAL	DSH	(0.135)
MODOC MEDICAL CENTER	MODOC	CITY/COUNTY	SMALL/RURAL	DSH	(0.047)
MAMMOTH HOSPITAL	MONO	DISTRICT	SMALL/RURAL	non-DSH	(0.172)
NATIVIDAD MEDICAL CENTER	MONTEREY	CITY/COUNTY	TEACHING	DSH	(0.028)
ST. HELENA HOSPITAL & HEALTH CENTER	NAPA	NON-PROFIT		non-DSH	(0.017)
ORANGE COAST MEMORIAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.338)
LA PALMA INTERCOMMUNITY HOSPITAL	ORANGE	NON-PROFIT		non-DSH	(0.304)

BREA COMMUNITY HOSPITAL	ORANGE	INVESTOR		non-DSH	(0.298)
TUSTIN HOSPITAL MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.278)
IRVINE MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.173)
HUNTINGTON BEACH HOSP & MED CTR	ORANGE	INVESTOR		DSH	(0.129)
MARTIN LUTHER HOSPITAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.126)
SAN CLEMENTE HOSPITAL & MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.125)
CHILDREN'S HOSPITAL AT MISSION	ORANGE	NON-PROFIT		non-DSH	(0.091)
ANAHEIM MEMORIAL MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.045)
SOUTH COAST MEDICAL CENTER	ORANGE	NON-PROFIT		non-DSH	(0.036)
WEST ANAHEIM MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.029)
WESTERN MEDICAL CENTER - ANAHEIM	ORANGE	INVESTOR		DSH	(0.017)
CHAPMAN MEDICAL CENTER	ORANGE	INVESTOR		non-DSH	(0.016)
CHILDREN'S HOSPITAL OF ORANGE COUNTY	ORANGE	NON-PROFIT		DSH	(0.012)
ANAHEIM GENERAL HOSPITAL	ORANGE	INVESTOR		DSH	(0.005)
SENECA HOSPITAL	PLUMAS	DISTRICT	SMALL/RURAL	DSH	(0.186)
EASTERN PLUMAS HEALTH CARE	PLUMAS	DISTRICT	SMALL/RURAL	DSH	(0.028)
VALLEY PLAZA DOCTORS HOSPITAL	RIVERSIDE	INVESTOR		non-DSH	(1.707)
PARKVIEW COMMUNITY HOSPITAL	RIVERSIDE	NON-PROFIT		non-DSH	(0.230)
INLAND VALLEY REGIONAL MEDICAL CENTER	RIVERSIDE	INVESTOR	SMALL/RURAL	non-DSH	(0.105)
EISENHOWER MEDICAL CENTER	RIVERSIDE	NON-PROFIT		non-DSH	(0.090)
MORENO VALLEY COMMUNITY HOSPITAL	RIVERSIDE	DISTRICT		non-DSH	(0.071)
SAN GORGONIO MEMORIAL HOSPITAL	RIVERSIDE	DISTRICT	SMALL/RURAL	non-DSH	(0.046)
MENIFEE VALLEY MEDICAL CENTER	RIVERSIDE	DISTRICT		non-DSH	(0.040)
RIVERSIDE COMMUNITY HOSPITAL	RIVERSIDE	INVESTOR		non-DSH	(0.019)
HEMET VALLEY MEDICAL CENTER	RIVERSIDE	DISTRICT		non-DSH	(0.006)
METHODIST HOSPITAL OF SACRAMENTO	SACRAMENTO	NON-PROFIT		non-DSH	(0.162)
MERCY SAN JUAN HOSPITAL	SACRAMENTO	NON-PROFIT		non-DSH	(0.034)

SUTTER GENERAL HOSPITAL	SACRAMENTO	NON-PROFIT		non-DSH	(0.014)
MERCY GENERAL HOSPITAL	SACRAMENTO	NON-PROFIT		non-DSH	(0.008)
HERITAGE HOSPITAL	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.641)
MOUNTAINS COMMUNITY HOSPITAL	SAN BERNARDINO	DISTRICT	SMALL/RURAL	non-DSH	(0.320)
VICTOR VALLEY COMMUNITY HOSPITAL	SAN BERNARDINO	NON-PROFIT	SMALL/RURAL	DSH	(0.189)
KPC GLOBAL MEDICAL CENTER	SAN BERNARDINO	INVESTOR		non-DSH	(0.179)
CHINO VALLEY MEDICAL CENTER	SAN BERNARDINO	INVESTOR		non-DSH	(0.157)
ST. BERNARDINE MEDICAL CENTER	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.106)
BEAR VALLEY COMMUNITY HOSPITAL	SAN BERNARDINO	DISTRICT	SMALL/RURAL	non-DSH	(0.079)
DESERT VALLEY HOSPITAL	SAN BERNARDINO	INVESTOR		non-DSH	(0.062)
REDLANDS COMMUNITY HOSPITAL	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.035)
LOMA LINDA UNIVERSITY MEDICAL CENTER	SAN BERNARDINO	NON-PROFIT	TEACHING	DSH	(0.021)
SAN ANTONIO COMMUNITY HOSPITAL	SAN BERNARDINO	NON-PROFIT		non-DSH	(0.004)
BARSTOW COMMUNITY HOSPITAL	SAN BERNARDINO	INVESTOR	SMALL/RURAL	DSH	(0.001)
SHARP CABRILLO HOSPITAL	SAN DIEGO	NON-PROFIT		non-DSH	(0.524)
VILLA VIEW COMMUNITY HOSPITAL	SAN DIEGO	NON-PROFIT		DSH	(0.332)
SAN DIEGO HOSPICE ACUTE CARE CENTER	SAN DIEGO	NON-PROFIT		non-DSH	(0.323)
SCRIPPS HOSPITAL - EAST COUNTY	SAN DIEGO	NON-PROFIT		non-DSH	(0.286)

TRI-CITY MEDICAL CENTER	SAN DIEGO	DISTRICT		non-DSH	(0.116)
SCRIPPS MEMORIAL HOSPITAL - CHULA VISTA	SAN DIEGO	NON-PROFIT		DSH	(0.070)
PALOMAR MEDICAL CENTER	SAN DIEGO	DISTRICT		non-DSH	(0.062)
SHARP MARY BIRCH HOSPITAL FOR WOMEN	SAN DIEGO	NON-PROFIT		non-DSH	(0.061)
POMERADO HOSPITAL	SAN DIEGO	DISTRICT		non-DSH	(0.046)
MISSION BAY HOSPITAL	SAN DIEGO	INVESTOR		non-DSH	(0.045)
PARADISE VALLEY HOSPITAL	SAN DIEGO	NON-PROFIT		DSH	(0.037)
SHARP CORONADO HOSPITAL & HEALTHCARE CTR	SAN DIEGO	NON-PROFIT		DSH	(0.025)
SCRIPPS MEMORIAL HOSPITAL - ENCINITAS	SAN DIEGO	NON-PROFIT		non-DSH	(0.015)
UCSF/MT ZION	SAN FRANCISCO	NON-PROFIT	TEACHING	non-DSH	(0.221)
ST. MARY'S MEDICAL CENTER SAN FRANCISCO	SAN FRANCISCO	NON-PROFIT	TEACHING	non-DSH	(0.132)
MEDICAL CENTER AT THE UCSF	SAN FRANCISCO	NON-PROFIT	TEACHING	non-DSH	(0.079)
ST. FRANCIS MEMORIAL HOSPITAL	SAN FRANCISCO	NON-PROFIT		non-DSH	(0.058)
ST. DOMINIC'S HOSPITAL	SAN JOAQUIN	NON-PROFIT		non-DSH	(0.092)
LODI MEMORIAL HOSPITAL	SAN JOAQUIN	NON-PROFIT		non-DSH	(0.060)
ST. JOSEPH'S MEDICAL CENTER OF STOCKTON	SAN JOAQUIN	NON-PROFIT		non-DSH	(0.030)
SAN LUIS OBISPO GENERAL HOSPITAL	SAN LUIS OBISPO	CITY/COUNTY		DSH	(0.379)
FRENCH HOSPITAL - SAN LUIS OBISPO	SAN LUIS OBISPO	NON-PROFIT		non-DSH	(0.152)
SAN MATEO GENERAL HOSPITAL	SAN MATEO	CITY/COUNTY		DSH	(0.296)
SETON MEDICAL CENTER - COASTSIDE	SAN MATEO	NON-PROFIT	SMALL/RURAL	non-DSH	(0.213)

SETON MEDICAL CENTER	SAN MATEO	NON-PROFIT		non-DSH	(0.018)
SANTA YNEZ VALLEY COTTAGE HOSPITAL	SANTA BARBARA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.193)
VALLEY COMMUNITY HOSPITAL	SANTA BARBARA	INVESTOR		non-DSH	(0.183)
SANTA BARBARA COTTAGE HOSPITAL	SANTA BARBARA	NON-PROFIT		non-DSH	(0.122)
LOMPOC HEALTHCARE DISTRICT	SANTA BARBARA	DISTRICT	SMALL/RURAL	non-DSH	(0.075)
ST. FRANCIS MEDICAL CTR - SANTA BARBARA	SANTA BARBARA	NON-PROFIT		non-DSH	(0.042)
GOLETA VALLEY COTTAGE HOSPITAL	SANTA BARBARA	NON-PROFIT		non-DSH	(0.016)
MARIAN MEDICAL CENTER	SANTA BARBARA	NON-PROFIT		non-DSH	(0.010)
CHILDRENS RECOVERY CTR OF NO CALIF	SANTA CLARA	INVESTOR		non-DSH	(0.663)
COLUMBIA SOUTH VALLEY HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.336)
ST. LOUISE HEALTH CENTER	SANTA CLARA	NON-PROFIT		non-DSH	(0.331)
COLUMBIA GOOD SAMARITAN HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.117)
STANFORD UNIVERSITY HOSPITAL	SANTA CLARA	NON-PROFIT	TEACHING	non-DSH	(0.090)
REGIONAL MEDICAL CENTER OF SAN JOSE	SANTA CLARA	INVESTOR		DSH	(0.070)
GOOD SAMARITAN HOSPITAL	SANTA CLARA	INVESTOR		non-DSH	(0.056)
SAN JOSE MEDICAL CENTER	SANTA CLARA	INVESTOR	TEACHING	non-DSH	(0.048)
O'CONNOR HOSPITAL	SANTA CLARA	NON-PROFIT		non-DSH	(0.027)
WATSONVILLE COMMUNITY HOSITAL (NEW)	SANTA CRUZ	INVESTOR		non-DSH	(0.010)
SIERRA VALLEY DISTRICT HOSPITAL	SIERRA	DISTRICT	SMALL/RURAL	DSH	(0.135)
WARRACK MEDICAL CENTER HOSPITAL	SONOMA	INVESTOR		non-DSH	(1.141)
PETALUMA VALLEY HOSPITAL	SONOMA	NON-PROFIT		non-DSH	(0.146)
SONOMA VALLEY HOSPITAL	SONOMA	DISTRICT		non-DSH	(0.111)

HEALDSBURG GENERAL HOSPITAL	SONOMA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.103)
PALM DRIVE HOSPITAL	SONOMA	NON-PROFIT	SMALL/RURAL	non-DSH	(0.077)
SANTA ROSA MEMORIAL HOSPITAL	SONOMA	NON-PROFIT		non-DSH	(0.013)
EMANUEL MEDICAL CENTER	STANISLAUS	NON-PROFIT		non-DSH	(0.006)
TRINITY GENERAL HOSPITAL	TRINITY	CITY/COUNTY	SMALL/RURAL	DSH	(0.060)
ALTA HOSPITAL DISTRICT	TULARE	DISTRICT	SMALL/RURAL	non-DSH	(0.313)
MEMORIAL HOSPITAL AT EXETER	TULARE	DISTRICT	SMALL/RURAL	non-DSH	(0.164)
LINDSAY DISTRICT HOSPITAL	TULARE	DISTRICT	SMALL/RURAL	DSH	(0.106)
TULARE DISTRICT HOSPITAL	TULARE	DISTRICT		non-DSH	(0.031)
SONORA COMMUNITY HOSPITAL	TUOLUMNE	NON-PROFIT	SMALL/RURAL	non-DSH	(0.035)
TUOLUMNE GENERAL HOSPITAL	TUOLUMNE	CITY/COUNTY	SMALL/RURAL	DSH	(0.013)
VENTURA COUNTY MEDICAL CENTER	VENTURA	CITY/COUNTY		DSH	(0.164)
SANTA PAULA MEMORIAL HOSPITAL	VENTURA	NON-PROFIT		non-DSH	(0.056)
SIMI VALLEY HOSP & HLTH SVCS - SYCAMORE	VENTURA	NON-PROFIT		non-DSH	(0.040)
WOODLAND MEMORIAL HOSPITAL	YOLO	NON-PROFIT		non-DSH	(0.039)
SUTTER DAVIS HOSPITAL	YOLO	NON-PROFIT		non-DSH	(0.019)