

## **Appendix IX**

### **Public Support: Funding Options**

The hospital system operated in Prince George's County by Dimensions Healthcare System (Dimensions) is the dominant Medicaid and indigent care provider in both the County and the State. As such, it is a critical component of the County's health care safety net for which public support is appropriate and essential. A variety of mechanisms have been used in Maryland and elsewhere to provide public support of safety net hospitals. These include rate relief, direct public grants, and special tax districts.

#### *HSCRC special rate order.*

Over the past several years, Maryland's Health Services Cost Review Commission (HSCRC) has issued a series of special rate orders to provide additional revenues to the system over the past several years. The special rate orders now in effect provide an upward rate adjustment of 3.2 percent, or approximately \$10 million in system revenues for the year ending February 13, 2005, when the special rate orders expire.

The HSCRC's special rate orders provide the system a significant financial benefit by increasing reimbursement from all payors, including Medicaid - a substantial element of the system's case mix. However, the higher reimbursement rate also has the negative effect of eroding the system's competitive position and market share, as higher payment rates make the system less attractive to commercially insured patients and managed care plans that purchase services for both public-pay and commercial patients.

#### *Direct public grants.*

While under Dimensions' management, the system has received significant financial assistance from both the County and the State. In the Memorandum of Understanding (MOU) between the State and Prince George's County (initially executed on February 20, 2004), the State and County pledged a total of \$45 million in public support over five years. In addition to the rate adjustment orders worth \$10 million, the State has committed to a capital grant of \$5 million through the State bond program during FY 2005. The County's \$30 million commitment ("subject to appropriations") consists of \$10 million to be paid on or before June 30, 2004. Five

million dollars of that pledge remains outstanding. The MOU also includes the County's agreement to make subsequent grants of \$5 million annually through FY 2008.<sup>1</sup>

Both the County and the State may continue to contribute directly to the system or to its constituent County-owned/Dimensions-operated facilities in the future. The MOU anticipates this form of public funding. But direct grants, especially those established as yearly installments, have the serious limitation of being discretionary. With each new budget cycle, grant funding must compete with other budgetary priorities. Moreover, direct grants can fall into the pattern (seen in previous attempts to address the system's problems) of repeated short-term cash infusions to avert looming crises.

*Special tax district.*

The creation of a special tax district offers an additional alternative that acknowledges the system's public mission and avoids some of the problems of other financing alternatives. In Maryland, charter counties such as Prince George's can establish special tax districts to raise local revenues for specific purposes through a property tax surcharge. It is not unusual for Maryland counties to use the special tax district mechanism to finance public projects and services. In 1998, 14 Maryland counties and Baltimore City had special tax districts in place to support various types of public works: roads, fire and rescue, water projects, and other community benefits. Prince George's County has used special tax districts to support countywide transit, storm drain projects, and the Maryland National Capital Parks and Planning Commission. Although in Maryland there are currently no special tax districts supporting hospitals, other states regularly use them under circumstances very similar to those of the safety net hospital system currently operated in Prince George's County by Dimensions.

Nationally, the financial stability of safety net hospitals depends largely on local factors, including local attitudes about a hospital's value to the community. Community attitudes towards a safety net hospital are determined by the amount of uncompensated and under-compensated care the community requires; the importance the community places on local access

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<sup>1</sup>The County's commitment in the MOU is "subject to appropriations." The 1992 lease between Prince George's County and Dimensions Healthcare System provides, subject to the same limitation, that the County would provide \$2.5 million of financial support to the system in 1992, and consider renewal of the grant annually during the pendency of the lease.

to services the hospital provides; the hospital's capacity relative to the demand for services in the area; and the level of competition among area hospitals to attract privately insured patients.

The value a community places on its safety net hospitals is important because of its crucial role as a source of external support. The stability and predictability of such support is critical. Many local communities outside Maryland use special tax districts successfully to provide consistent sources of revenue to support safety net hospitals that serve those communities. A few examples follow.

*Jackson Memorial Hospital.* Jackson Memorial is a 1,567-bed public hospital in Miami-Dade County, Florida. It is the primary hospital services provider for indigent patients in the county, delivering Medicaid and charity care at a level comprising 44 percent of its gross patient charges. Patient revenues cover only two thirds of the hospital's operating costs. In 1991, county voters enacted a local ½ cent sales tax increase dedicated to the hospital's support. This has provided a fairly constant level of support for the hospital in subsequent years. In 1997, county support (\$191 million, including \$112.8 from sales tax) exceeded the hospital's operating loss of \$157 million. For 2003 (the most recent annual report available), county-provided support amounting to \$257 million (including \$150 million from sales tax and \$107 from local ad valorem property tax revenues) fell short by \$23 million of covering the hospital's operating loss for the year.

*Harris County Hospital District.* In Texas, the Harris County Hospital District (HCHD) owns and operates two public general hospitals: Ben Taub Hospital (510 beds) and the Lyndon Baines Johnson Hospital (233 beds), along with 12 community clinics. HCHD was financially healthy from 1990-95, in spite of providing over 75 percent of hospital services to the county's indigents. Although patient revenues covered only 48 percent of operating costs in 1995, HCHD could count on local property tax subsidies and disproportionate share hospital (DSH) revenues, which together constituted 55 percent of HCHD's total revenue. After HCHD had reported a subsidy-dependent "surplus" for four years (1992-94), the County reduced the ad valorem property tax rate that had funded subsidies to HCHD. The consequent revenue reduction contributed to combined losses of nearly \$88 million during FY 1996-98. HCHD's county tax revenues have increased each year since 1998, and have been sufficient to cover the hospital's operating losses

for FY 1999-2004. Most recently, for FY 2004, HCHD reported net ad valorem tax revenues of \$346 million (double that collected in 1998) offsetting operating losses of \$318 million.

*Other Texas Safety Net Hospitals.* Eight hospital districts in Texas receive funding from local sales tax (\$17 million in FY 1998). Many more (132) are funded with the proceeds of local property taxes (\$730 million in FY 1998).

*Maricopa Integrated Health System.* Maricopa Integrated Health System (MIHS) consists of Maricopa Medical Center, the Arizona Burn Center, a specialty care clinic, the McDowell Healthcare Clinic (for HIV/AIDS), two mental health facilities, 10 community-oriented family health centers, and a home health program. Located in Maricopa County, Arizona, Maricopa Medical Center is a 482-bed public teaching hospital that provides health care services principally to the county's indigent population. In 2003, a citizens' task force appointed by the county supervisors determined that MIHS' financial crisis stemmed from four factors: the amount of uncompensated care provided by its facilities, a lack of capital improvement funding, the loss of disproportionate share hospital (DSH) funding, and lost income due to a shift to competitive bidding for long-term care contracts. The task force recommended creating a special health care district to which MIHS would transfer its assets and liabilities. The district would establish its own human resources, merit system, and procurement policies to operate the system, and would receive revenues collected by the county (with voter approval) from secondary property taxes and a bond issue. Last March, county voters approved legislation creating the district and establishing a 20-year period of county taxing authority to support it.

The legislation specifies the district's mission to provide medical education, emergency and other services, including services to the medically underserved, mandates ongoing responsibilities, and prohibits certain other activities. The law also includes a specific maintenance of effort requirement: the district must operate a general hospital for the full 20 years of taxing authority. For 10 years, it may not build, acquire, or lease a hospital outside the three-mile radius surrounding Maricopa Medical Center's current location. During the same 10-year period and within the same three-mile radius, the district must continue to operate a general hospital and burn center, and must provide emergency and trauma services, all at historic levels, and must provide maternity services at the levels required to qualify as a DSH public hospital.

Voters approved the measure in March 2004. Revenues from the tax levy (projected to yield \$40 million per year) will be allocated primarily to Medical Center renovations and ongoing support of the burn and trauma center.

*Alameda County Medical Center.* The Alameda County Medical Center's Highland campus includes a 236-bed acute care teaching hospital and trauma center that play a key role in the county's health services safety net. The hospital provides 90 percent of all inpatient days and emergency room visits for indigent patients in Alameda County, California. Its outpatient population (in 1997) was 70 percent uninsured, 23 percent Medicaid, and 7 percent Medicare. At the end of 2000, Alameda County transferred its oversight responsibility for the Alameda County Medical Center (ACMC) to the ACMC Hospital Authority as part of a transaction that included a one-time county grant of \$29.4 million, lease of certain County-owned hospital and clinic facilities, and the county's agreement to purchase health care services from ACMC in the future. Although at the time this deal was seen to establish long-term financial stability for ACMC, by 2003 state budget shortfalls and federal reduction of DSH funding made the center's financial condition precarious. In March 2004, Alameda County voters approved a one half-cent increase in the county sales tax to provide a 15-year subsidy for ACMC. The dedicated sales tax revenues are projected to provide \$90 million per year in support to the Medical Center.

*Grand River Medical Center.* During the first six months of 2004, the Garfield County, Colorado Hospital District raised \$1.2 million in county property tax revenues for the Grand River Medical Center.

*Southwest General Health Center.* The 340-bed Southwest General Health Center, located in Cleveland, Ohio's West Side, funds its capital expenses with property tax proceeds collected in surrounding areas. The taxes are authorized by the six communities served by the hospital. Voters renew the tax authorization every few years.

*Harborview Medical Center.* In Seattle, Washington, Harborview Medical Center is a 368-bed facility that needed to raise a substantial amount of capital to fund necessary seismic, health, and public safety improvements. These included demolition, new construction, and renovation and upgrading of existing facilities. The County approved a property tax In September 2000 to support 20-year general obligation bonds issued for the benefit of the hospital. The bond sale,

completed in August 2004, yielded \$193 million.

*Parkland Health and Hospital System.* Last year in Dallas County, the tax rate to support Parkland Health and Hospital System was 25.4 cents per \$100 assessed valuation. Parkland, a 990-bed teaching hospital, is Dallas County's only public hospital. It receives ad valorem property tax proceeds to subsidize the cost of services provided to uninsured patients. The hospital's tax proceeds for FY 2003 was \$321 million. This was sufficient to substantially offset the hospital's \$328 million operating loss for the period.

*Brackenridge Hospital.* Brackenridge is a 451-bed facility serving the city of Austin and Travis County. It operates a regional level II trauma center that serves 11 counties. The cost of serving publicly insured and uninsured patients is about \$125 million annually. Over the last few years, the number of indigent patients served by Brackenridge has doubled, with most using the emergency department. This caused serious overcrowding and extended waits for emergency services. The indigent patient load overtaxed the hospital's financial and physical resources. Although Brackenridge received financial support from both city and county property tax revenues, the support was unequal: city residents paid seven cents per \$100 assessed property value, while county residents paid only one cent per \$100. Even though the result would be higher tax bills (an additional \$92 per year for the average homeowner), Travis County residents voted in May 2004 to support the hospital by establishing a new Travis County Hospital District with an increased property tax rate equivalent to the city's.