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Possible Options for the Relationship Between Ramsey County and St. Paul-Ramsey Medical Center

M E M O R A N D U M

TO: St. Paul-Ramsey Joint Study Committee

FROM: Margaret Thorpe
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DATE: July 20, 1983

RE: Possible Options for the Relationship Between Ramsey County and St. Paul-Ramsey Medical Center

At its meeting of May 23, 1983, the Joint Study Committee requested that staff provide further detail and review of three possible approaches to the relationship between the County and the Medical Center:

1) Direct control of the Center by the County Board;

2) Sale of the Center to a non-profit corporation;

3) Modifications of the present structure.

The Committee also asked that staff review Hennepin County's investigation into contract management for its Medical Center and determine if that approach presented any applications for Ramsey County.

In analyzing these options, David Gitch and Richard Culbertson, of the Medical Center, Michele Timmons, Assistant County Attorney, and I reviewed the information presented to the Study Committee to date, national reports and analyses concerning public hospitals, and the legal history of the relationship between the County and the Center. We also analyzed the financial statements of the Medical Center in comparison to those of other public and private hospitals in the Twin Cities area. We then sought to define the issues of concern to the Joint Study Committee and to determine the extent to which any or all of the options under consideration might assist in resolving those issues.

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CURRENT ORGANIZATIONAL RELATIONSHIP

The present relationship between Ramsey County and St. Paul-Ramsey Medical Center places limited responsibilities upon the County Board, and allows for considerable flexibility in operation of the Medical Center. The County Board is empowered to provide several forms of support to the Center but is not obligated to do so. The Commission, on the other hand, is mandated to perform specific roles in a specific

manner. The direct relationship between the County Board and the Medical Center Commission consists primarily of the fact that four of the fifteen members of the Commission must also be members of the County Board.

Under current statute, the County Board is required to do the following:

- -- Appoint four of its members to serve on the Commission;
- -- Appoint nine citizen members to the Commission from nine senate districts, selecting from nominees submitted by legislative members;
- -- Appoint two citizen members - at large from among nominees submitted by the Commission;
- -- Review and approve the budget of the public medical center and consult with the commission before approving the budget;
- -- Retire the general obligation debt which it previously contracted for construction of the present Medical Center facility.

The Medical Center Commission, however, must execute the following responsibilities:

- -- Operate, administer, manage and control the Center;
- -- Reimburse the County's Civil Service department for services for the Commission's classified employees;
- -- Submit an annual budget to the County no later than November 1 of each year;
- -- Submit requests for funds for facilities' construction to the City of St. Paul and Ramsey County;
- -- Control accounts and payrolls and establish and maintain a public depository;
- -- Establish and maintain all accounts;
- -- Provide hospital and medical services for the indigent of Ramsey County, the contagiously ill, and catastrophically injured and city and county prisoners, and maintain the hospital as a research and teaching institution;
- -- Reimburse the Ramsey County attorney for services;
- -- Implement all the powers and duties concerning institutional care of the sick and injured and the city and county prisoners which were previously vested in or

imposed on the Ramsey county welfare board and the Ramsey county sanatarium commission.

Among these responsibilities allocated under the present structure, the most notable is clearly the responsibility for the care of the indigent.

The current statute specifically assigns responsibility for care of the indigent to the Medical Center Commission, not to Ramsey County as a general government. Under the plain meaning of the statutes, the County has the authority to fund a portion of the budget of the Commission, as well as the authority to provide medical care for the indigent who do not meet the eligibility requirements of entitlement programs such as Medical Assistance and General Assistance Medical Care. While legal arguments can be made, on both sides of the question, as to whether these grants of "authority" are really discretionary or are in fact mandatory, it is clear as a practical matter that the County is the only source of governmental support for care provided to the indigent by the Medical Center which is not reimbursed by state or federal funds. (See Attachment #1.)

The present working relationship between the County and the Commission is based upon a reasonably longstanding willingness on the County's part to pay that portion of the Center's "uncollectibles" which is over and above the percentage of "uncollectibles"incurred by other hospitals in the area, with the Center and the County Attorney working together to determine which individual uncollectible accounts are appropriately assigned to the County. For the last couple of years, the County has also appropriated funds to the Center for the difference between charges incurred by persons receiving General Assistance-Medical Care and the percentage of those charges which the State of Minnesota is willing to pay.

Finally, in summarizing the present relationship between the County and the Commission, it may be useful to review not only the way in which responsibilities are allocated but also the way in which authorities are assigned. While the Commission is clearly mandated to handle most of the responsibilities of the Center, the County retains considerable authority over the Center. The following breakdown makes clear the significant descretion in the hands of the County Board:

Authorities Pertaining to the Medical Center

Center Commission	County Board
-- Elects Commission officers	-- Appoints Commission members
-- Adoption of By-Laws	-- Approval of budget
-- Carriage of malpractice insurance for medical and non-medical staff and pay premiums	-- Approval of borrowing of funds for operation and maintenance of Center

-- Appointment of chief executive officer and seven principal assistants

-- Employment of other personnel

-- Control of accounts and payrolls and establishment of public depository

-- Establishment and maintenance of all necessary accounts, including reserve, depreciation, and working capital accounts

-- Discretion to provide hospital and medical services to the general public

-- Entry into agreements it determines necessary (with other entities)

-- "....all powers necessary and convenient for the operation, administration, management and control of the medical center."

-- Control of purchasing, within the statutory limitations, including use of a nonprofit cooperative hospital service organization to which standard public bidding requirements shall not apply

-- Power to sue and be sued

-- Acceptance of land, money or other assistance from governmental and private sources for execution of its purposes

-- Purchase, holding and conveyance of personal property

-- Holding and conveyance of real property.

-- Control of civil service system under which all Center classified employees are placed

-- Decision as to whether or not debt may be issued for construction of new facilities

-- Approval to purchase real property

In summary, the Commission controls operations, administration, and the scope of services and has most of the necessary powers to operate the Center in a flexible and responsive manner. The County Board, however, determines the people in whom that authority shall be vested, controls basic, major financial transactions, and oversees the policies and systems pertaining to all classified employees at the Center. While the present structure is a hybrid of public and corporate models, it, nevertheless, closely approximates the ideal structure for governance of a public hospital as outlined in several national studies and analyses.

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APPLICABILITY OF NATIONWIDE APPROACHES TO ST. PAUL-RAMSEY MEDICAL CENTER

Since the three options under consideration, as well as the others outlined for the May 23 meeting, were largely drawn from approaches considered and adopted in other localities, the staff reviewed the situations of other public hospitals to identify those which might be applicable to the issues the Joint Study Committee has been considering. Included in this analysis was Hennepin County's investigation into the possible usefulness of contract management for its Medical Center.

What our review found is that "the crisis of the public hospital", which has been extensively discussed in publications ranging from academic journals to NACo's County News is not the "crisis" of St. Paul-Ramsey Medical Center. The public hospital problem, according to national writers, is comprised of institutions that:

-- have antiquated, incomplete facilities and services;

-- cannot attract top-flight physicians and, in some cases, cannot even obtain physicians considered competent;

-- receive the majority of their revenues from local tax dollars;

-- have become so bogged down in unimaginative, inflexible bureaucracy that they cannot respond to changes in community needs, new financing methods, or developments in medical knowledge,

-- have become the bottom half of a two-tiered medical care system in which those people with any financial resources for health care, including those with Medicare and Medicaid coverage, use other facilities than the "last resort" county hospital.

To the extent that criticisms of St. Paul-Ramsey have surfaced during the Joint Study Committee's review of the Medical Center, they have been the virtual opposite of this national picture. The Center, some have said, has: excessively sophisticated facilities and equipment and overly diverse and comprehensive services; too many high-powered,

high-salaried physicians, conducting research of international significance; complex management and financial systems, well advanced of the general medical community; programs that successfully compete with the private sector for patients with the ability to pay.

A brief comparison of St. Paul-Ramsey with other public hospitals throughout the country demonstrates that it is not typical of the "public hospital issue". Summarizing from data from the National Association of Public Hospitals previously reviewed by the Study Committee, the staff found that the Medical Center receives far less of its revenue from local government than does the typical public hospital. Moreover, it draws a well above average percentage of its clientele from among people with commercial health insurance rather than government assistance.

St. Paul-Ramsey derived 9% of its total revenue in 1982 from Ramsey County, including payment for "uncollectibles", payment of the reductions in State GAMC reimbursements, retirement of capital debt, and support of community services. Prior to the reduction in GAMC funds from the State, approximately 5% of revenue came from the County. According to the NAPH, the only one of 22 public hospitals with a similar link to county government that equalled this low percentage was Brackenridge of Austin, Texas. The average among all 22 hospitals, including those with substantial state support, was 31%. Three major public hospitals, in Chicago, Houston, and Dallas, receive over half of their revenue from city and/or county government. Only 2 of the 22 derive a higher percentage of revenue from people with private insurance than does St. Paul-Ramsey. The Center received 30% of its 1982 revenue from such people, while the national average was 13%.

Because St. Paul-Ramsey Medical Center does not resemble the public hospital for which model solutions and options have been proposed and developed throughout the nation, the staff found that the model approaches, for the most part, would do little to address the issues which concern the Study Committee. Contract management, for example, has received considerable publicity, from both articles and advertisements, in various publications directed to public officials and administrators. Studies undertaken thus far, according to County News, do not report substantial savings to local government from contract management, except where the contract has allowed the managers to reduce substantially the level of care provided to indigent people. In some situations where the hospital had been unable to respond quickly to change and opportunity because of its inability to bypass excessive bureaucratic restrictions, contract management did extricate the hospital from the complexity of the general government.

Hennepin County, whose Medical Center more closely resembles St. Paul-Ramsey than it does the national stereotype, undertook a detailed evaluation of the potential usefulness of contract management to its Center. Five private management firms worked with Hennepin County staff to determine if outside management might benefit the Center. Attachment #2 is the memorandum summarizing the findings for the Hennepin County Board of Commissioners, in which County Administrator Dale Ackmann states: "It does not appear likely that comprehensive

management of Hennepin County Medical Center via a contract with a hospital management firm would result in significant cost reduction, revenue increases or better health service management." Interestingly, the Medical Practice Plan referred to in Mr. Ackmann's memo is a proposal to create a structure closely resembling the relationship between St. Paul-Ramsey, Ramsey Clinic Associates, and the Medical Education and Research Foundation. The private firms, as noted, strongly encouraged such a system.

The Hennepin study analyzed the potential impact of contract management on twelve aspects of Medical Center operations: governance (change of structure); employee compensation and benefits; labor union agreements; community service programs; contractual relationships; financial performance; support services; relationship with the University of Minnesota; employee relations; high-tech services; community relations; market competition. While the five firms indicated that contract management could be implemented without basic disturbances in the current systems and relationships of the Center, they also did not find any areas in which a clear advantage would be provided by adoption of contract management.

Of particular relevance to Ramsey County's deliberations are the comments of the firms pertaining to financial performance and support services. Regarding financial performance, the County stated the issue to the firm as: "Currently, the County funds approximately 15% of Hennepin County Medical Center's financial requirements from local tax support. The County is interested in maintaining and improving the financial performance of Hennepin County Medical Center such that the reliance on local tax support is minimized." As noted below, St. Paul-Ramsey compares favorably with Hennepin County on key financial performance indicators, including a lower percentage of public support. The firms which reviewed Hennepin's Center concluded that "Hennepin County Medical Center is presently financially well-managed." One firm stated that it "would not anticipate any management company being able to demonstrate major financial improvements without undertaking major changes in the basic mission(s) of the institution." Given St. Paul-Ramsey's favorable performance, it appears likely that the same comments would apply to any likelihood of substantial savings from outside management at St. Paul-Ramsey.

In the support services area, because of the direct control of Hennepin County Medical Center by the County Board, the Center makes far greater use of County support services for its operations than does St. Paul-Ramsey. While the firms did not directly criticize the dependence of the Center on extensive in-house support, one did indicate that maximum benefit from private management would be obtained if the County "diminish(ed) the Medical Center's dependence on other County units and look(ed) to the contractor to provide these." The separation of St. Paul-Ramsey's support services from County system appears, therefore, to approximate more closely a private management system than does Hennepin's.

In summary, the Hennepin study of contract management substantiates the staff's conclusion that the national models for approaching the

county hospital are not particularly relevant to the issues under discussion in the Twin Cities. In fact, in reviewing eleven recommendations made by the Commission on Public-General Hospitals for developing a viable governing structure for public-general hospitals, the staff found that the present structure already closely resembles this ideal model developed after considerable study of problems in other communities. (See Attachment #3.) (If members of the Committee would like a full copy of the Hennepin study, please let me know.)

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IF RAMSEY COUNTY IS NOT SUFFERING FROM "THE PUBLIC HOSPITAL CRISIS", WHAT, THEN, ARE THE ISSUES WHICH DO NEED TO BE ADDRESSED?

In reviewing the minutes of the previous meetings of the Joint Study Committee, the staff found that the key issue of discussion is the amount of financial support which Ramsey County provides to the St. Paul-Ramsey Medical Center and the need of the County Board to assure itself and its constituency that it has a sufficient degree of information and control to ascertain that the amount expended is both justifiable and appropriate. As noted above, the percentage of the Medical Center's support which comes from Ramsey County is small in comparison to other public hospitals and even in comparison to Hennepin County. Nevertheless, the dollars involved have increased rapidly during the last two years, primarily as a result of the change in State funding of GAMC but also as a result of the recession. Elected officials must know, in some detail, and be able to explain any allocation of nearly $6,000,000 in property tax funds.

In order to ascertain if the appropriation to St. Paul-Ramsey is both appropriate and justifiable, the County Commissioners have requested further information concerning several items which appear to relate to the amount of the appropriation:

-- What are the characteristics of the people whose bills have been deemed "uncollectible"? In particular, are they Ramsey County residents, or is one County subsidizing medical care for people from a wider region?

-- Is "uncollectible" synonymous with "indigent"? Are these bills those of people who actually have no way to pay, or is the County picking up the charges for people who are simply irresponsible?

-- What are the characteristics of the GAMC recipients for whom the County is now paying a portion of the charges?

-- Is St. Paul-Ramsey as cost-effective an institution as possible? Could the amount required to support the indigent be reduced by either reducing overall costs at St. Paul-Ramsey or by providing indigent care in a different manner?

In analyzing the three options selected for further study, then, the staff gave particular attention to three basic questions:

-- Is the approach likely to reduce overall costs at St. Paul-Ramsey Medical Center?

-- Is the approach likely to reduce the need for property tax funds from Ramsey County for care of the indigent?

-- Will the approach provide the County Board with greater certainty that the funds appropriated to the Medical Center are justifiable and approppriate?

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DIRECT COUNTY BOARD CONTROL

The first of the three options chosen for further analysis was that of establishment of direct County Board control of the Medical Center. Commissioner Norgard prepared, a few months ago, draft legislation, based upon the current Hennepin County statute for governing its Medical Center, for assuming direct Board authority over St. Paul-Ramsey. This approach would treat the Medical Center just as Ramsey County's system treats the current County Departments. Instead of the present division of responsibilities and authorities between the Medical Center Commission and the County Board, all of the responsibilities and authorities currently vested in the Commission would be vested in the County Board. While the Commission currently has certain authorities that the County, as a general government, does not have, presumably those authorities could be vested in the County Board with respect to the Medical Center by the legislation that would be required to adopt this approach.

Establishment of direct control over the Medical Center by the County Board would require that the Center route the same types of decisions through the Board's policy and administrative process as do other County Departments. All contracts, agreements, grant applications, and reallocations of budgeted funds would be reviewed and acted upon by the Board, as would changes in various policies or services of the hospital. Clearly, integrating the operations of the Medical Center into the Board's regular processes would substantially increase the workload and paper supply of both the Board and its support staff. The Board might well elect to establish a new standing Committee to consider Medical Center business separate from the business of other Departments.

As with the merger of the Welfare Department into County government and, later, the merger of that Department with the Mental Health Department into the Human Services Department, the Board would have the discretion as to the extent to which the administrative and support units of the Center would be merged into the central County operations and the extent to which they would be left as separate units within the Medical Center. The practical aspects of integration would require substantial further study if this option were adopted.

In order to determine the likelihood of positive results from establishment of direct control by the Board over the Medical Center, the staff looked at Hennepin County as a working model of this

structure. As described above, Hennepin County has asked similar questions about its Medical Center and brought in five private firms to review the usefulness of another way of structuring its health care service. Hennepin's question as to whether or not its Center is as cost-effective as possible was largely answered affirmatively by the private health care management firms. It is worth noting that, given the fact that such a study was done, the direct control approach apparently has not provided the Hennepin County Commissioners with any greater assurance that the tax dollars appropriated to the Hennepin County Medical Center are both justifiable and appropriate.

The staff reviewed financial and service data comparing St. Paul-Ramsey Medical Center with the Hennepin County Medical Center to determine if the direct control model provides any advantages from the perspective of reducing overall costs and reducing costs of indigent care. Since the two institutions and the communities they serve are not identical, it is not possible to assume that the structural relationship between the Centers and the respective Counties is the only variable which might account for differences. However, the comparison of basic financial and service data did not identify any areas in which the Hennepin County Medical Center appears to function more effectively than St. Paul-Ramsey. Had we identified such areas, we would then have sought to determine the cause of the results found.

Because of differing formats in the financial statements of the two Medical Centers, with St. Paul-Ramsey's more closely resembling those of private hospitals, a line-by-line comparison of the revenues and expenses of the two operations is not possible. However, using data from both the 1982 financial statements of the two Centers and from the Minnesota Association of Public Teaching Hospitals, it is possible to determine that:

-- In 1982, of total gross patient revenues of $83,739,329, St. Paul-Ramsey received support from the County of $5,395,000 to cover both uncollectibles and "contractual adjustments" (difference between charges and state and federal reimbursements). Hennepin County Medical Center, of total gross patient revenues of $98,481,440, received $11,251,907 in County dollars for the same items. Hennepin County's subsidy of patient charges is 11%, while Ramsey County's is 6%. (The 9% figure cited earlier includes debt service and community services. Hennepin's total contribution to its Center is 15%.)

-- In 1982, St. Paul-Ramsey was able to absorb $10,670,528 in uncollectibles and contractual adjustments within its own budget, while Hennepin County Medical Center absorbed only $1,823,854.

-- St. Paul-Ramsey obtained 47% of its net patient revenues from patients not on Medicare, Medicaid, or GAMC, while Hennepin County Medical Center received only 32% from "able-to-pay" patients, suggesting that St. Paul-Ramsey has more successfully marketed itself to the community-at-large.

-- The amount which Hennepin County pays to its Center for care of the indigent is a slightly smaller percentage of the County's total budget, 2.2%, than is the amount which Ramsey County pays to St. Paul-Ramsey, 2.6%. However, when the population of the two Counties is taken into account, Ramsey County residents pay slightly less per capita, $11.60, for subsidy, than do Hennepin County residents, at $11.86. More significant, perhaps, is that the revenues of St. Paul-Ramsey are, per capita, substantially higher, at $180.12, than the revenues per capita of Hennepin, at $103.83. The difference appears to be in the fact that St. Paul-Ramsey has a substantially higher ratio of people served compared to its population than does Hennepin County Medical Center (.57 to .26, including admissions and outpatient visits) and that, as noted above, it has a substantially higher percentage of patients not receiving governmental assistance. The preliminary conclusion from this data is that a full-service medical center, reaching all sectors of the community, is a less expensive vehicle for indigent care than is an institution with more limited services and programs targeted more specifically toward care of the indigent.

-- St. Paul-Ramsey had only 5.74 staff per occupied bed in service, while Hennepin County Medical Center had 6.29.

-- Hennepin County Medical Center spent more per staff person than did St. Paul-Ramsey, with Hennepin's cost per staff person at $30,307 and St. Paul-Ramsey's at $26,010.

-- Neither of the County Medical Centers spent a greater percentage of its total budget on personnel than other hospitals in the area. Of seven hospitals for which information was available, all used between 61% and 68% of their expenditures for personnel. St. Paul-Ramsey was high at 68%, with St. Joseph's next at 67%, Hennepin County Medical Center at 65%, United at 63%, and the UM Health Center low at 61.2%.

-- St. Paul-Ramsey achieved more inpatient days per staff person than did Hennepin County Medical Center, at 62 to 58. Including both outpatient visits and hospital admissions, each St. Paul-Ramsey staff person served 138 patients to 116 at Hennepin County Medical Center.

-- St. Paul-Ramsey also had lower expenditures per patient served (both in and out) and per admission than Hennepin County Medical Center. For each patient served, St. Paul-Ramsey spent $278 and Hennepin County Medical Center spent $401; for each admission, St. Paul-Ramsey spent $4,915 and Hennepin spent $5,655. It should be noted that these

expenditures per admission are significantly higher than two community hospitals, United and St. Joseph's, which spent $3,571 and $2,913, respectively. The Medical Center has previously presented data to the Study Committee indicating that this difference is due to the number of complex high-cost cases seen at Hennepin County Medical Center and St. Paul-Ramsey as compared to the other hospitals.

-- St. Paul-Ramsey appears to have been more successful than Hennepin County Medical Center in getting outpatients to use the lower cost outpatient clinics for service rather than the high-cost emergency room, with 77% of St. Paul-Ramsey's outpatients using the clinics compared to 73% of Hennepin County Medical Center's.

In conclusion, the Hennepin County Medical Center, which functions under direct County Board control, was found financially efficient by the five private health care management firms that reviewed it. St. Paul-Ramsey, judging from several different criteria, is either as cost-effective or more cost-effective than Hennepin County Medical Center. While there are, no doubt, numerous variables that create the differences between the two facilities, Hennepin County's direct control structure has not enabled it to achieve lower tax support or greater productivity nor, apparently, has it given the County Board greater assurance that its funds are well spent. Thus, as Hennnepin found with its investigation of contract management, it would be possible to implement direct County Board control but no obvious advantages to that structure have been identified. The disadvantage of considerable additional time and process for both the Board and its support staff, however, does exist.

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SALE OF MEDICAL CENTER TO NON-PROFIT CORPORATION

The second option chosen for further review is the possibility of selling the medical center to a non-profit corporation. The presumed potential benefits of this approach would be: 1) To establish clearly to the community the separation of the Medical Center from the County government (as well as City government, since the public perception of St. Paul-Ramsey appears to be based upon its historical evolution from Ancker Hospital in which the City had an active, integral role). The extent to which the community holds the County Commissioners responsible for the Medical Center appears, in part, to be generated by a conception of the Center that was once true but is no longer -- that it is operated directly by government and that the primary source of funds at St. Paul-Ramsey is the local tax dollar. Sale to a non-profit corporation would mark a clear separation of the Center from County government. 2) To generate revenue which might then be used to reduce the amount taken from the tax levy for indigent care. This is akin to the approach which the City intends to use to obtain funds for repair and improvement of the Civic Center complex, except that the City plan involves a profit purchaser, which, as originally planned, would be able to utilize various tax incentives to maximize the

financial benefit to both parties of the transaction. County News has described at least one community which sold its public hospital and then used the proceeds of the sale to establish a trust fund from which the earnings were then used to support care of the indigent.

The first potential benefit would require some public opinion research to determine how likely it is that such a sale would generate the desired improved understanding of the relationship between government and the Center. Unknown at this time is the actual reaction of the community to sale of what is perceived as the public hospital. While it would be quite possible to retain some County control over the direction and policies of the non-profit, it is also possible that the sale of the public hospital would be equally misperceived as the present relationship may be and that the community would react strongly to the idea that its elected officials had deprived the community of a "public hospital". The other, less extreme possibility, is that the community's understanding of the St. Paul-Ramsey Medical Center would not be significantly changed by such a sale and that the public would continue to see the County as responsible, even though it clearly divested itself of any direct role.

The second potential benefit requires an actual "walk" through the numbers to determine what actual advantage might be achieved. What the County clearly owns that it could sell is 72½% of the land, land improvements and buildings, excluding construction and improvements undertaken with Commission funds. The remaining 27½% is owned by the City of St. Paul. The facilities, improvements and equipment developed and purchased with Commission and MERF funds are assets of the Commission rather than the County. To what entity these assets or proceeds from the sale therefrom, would go would be decided by the Legislature if it were to vote to dissolve the Commission and authorize sale of the facilities.

The Department of Property Taxation estimates the current market value of the land, land improvements, and buildings at the Medical Center at $37,879,400. The portion actually owned by the County and the City cannot be separated out from improvements made with Commission funds. Therefore, we have used the full value for the following analysis, recognizing that it is somewhat higher than the actual maximum the County might derive from sale.

72½% of the current market value is $27,462,565.

However, given an asset of $27,462,565, at the end of 1982, Ramsey County still had $8,754,400 in debt outstanding for the facility. Thus, the actual County equity is only $18,708,165. In this most conservative scenario, then, assuming the existing debt could be liquidated at par as a result of the sale, the County could realize $18,708,165 from sale of its equity in St. Paul-Ramsey Medical Center, less whatever portion of this amount has been developed with non-County funds. The 1983 average rate of return on the County's investments is about 9%. If $18,708,165 were then placed in a trust fund, at current rates, it would earn $1,683,735, or 66% of the amount paid for uncollectibles at St. Paul-Ramsey in 1982. When the

appropriation to St. Paul-Ramsey for GAMC rateable reductions in 1982 is included, the interest earned on such a trust fund would produce only 31% of the amount required. If the City of St. Paul participated in this transaction, which would probably be necessary to create a workable new structure, the equity which could be realized, less value of the improvements generated with other funds, would be $26,889,000. This would earn, at current rates, $2,420,010 per year, or 95% of the amount expended for uncollectibles and 45% of the total amount appropriated for uncollectibles and GAMC reductions. In other words, had this plan been in effect in 1982, $2,979,942 would still have been required from the County's tax levy to support care of the indigent at St. Paul-Ramsey Medical Center.

Looking at the concept of sale to a non-profit corporation from another direction, how much would need to be derived from the sale of the facility and placed in a trust fund in order to earn a sufficient amount to remove all property tax dollars from support of St. Paul-Ramsey? In order to cover the 1982 appropriations, $54,000,000 would need to be placed in trust. If existing County and City debt is to be retired, the facility must be sold for $64,990,400, or nearly twice its current market value.

However, the retirement of the new debt incurred by the non-profit corporation to purchase the facility must now be added to the annual expenses of the Medical Center. St. Paul-Ramsey currently pays no debt service, as the existing debt is being retired by the County and the City. Assuming that one of the governmental or quasi-governmental bodies issued revenue bonds for the non-profit corporation, or that it was enabled by legislation to issue its own, it would now include the cost of amortizing that debt in its operating budget. If the revenue bonds could be sold at 2 points above the most recent cost of general obligation bonds for Ramsey County, the corporation could obtain the $64,990,400 at 9%. The retirement of this debt over 15 years would add approximately $7,911,000 to the annual operating costs of the Center, or over $5,000,000 more than the County would save. If the debt would be amortized over 20 years, it would still add $7,018,000 to the operating costs of the Center, still $4,600,000 more than the County would save. At the 20-year amortization rate, the annual expenses of the Center would be increased 10%, with no corresponding vehicle for increasing revenue except rate increases. $62 per day would need to be added to current rates to cover this increase.

The financial benefits of sale to a non-profit corporation do not appear to exist with St. Paul-Ramsey Medical Center. The situations in which such a transaction does work for the parties involved have different factors than exist in this case. Localities where sale of the public hospital has worked have generally been communities where the facility was older and where little or no outstanding debt existed. In addition, they are smaller communities where the dollars required to provide care for the indigent are not as great as those required in Ramsey County. The Civic Center proposal gained financial feasibility through the use of tax incentives available to the private purchaser. Recent introduction of legislation in Congress, which would substantially reduce the tax benefits available for such projects, has

virtually halted plans for any similar transactions. In addition, the Civic Center, unlike St. Paul-Ramsey Medical Center, is an entity which does not have its ability to generate revenues through increased charges and substantially expanded activities restricted through state and federal requirements and rate reimbursement ceilings. Nor is there major competition for the Civic Center in its immediate vicinity as there is with the Medical Center.

Finally, there is no clear indication in the data reviewed that non-profit corporations necessarily produce lower cost medical care than any other form of organization. Rather, as the Medical Center has suggested in earlier presentations to the Joint Study Committee, differences in expenditures, charges, and productivity appear to correlate most closely to the type of patients and severity of conditions treated, as well as to the teaching function, than to organizational form.

As noted above, St. Paul-Ramsey compares favorably with Hennepin County Medical Center on several productivity and cost criteria. Likewise, it performs better than University of Minnesota Hospitals on most of the same criteria, except that the University does draw a higher percentage of revenue from people with commercial insurance and ability to pay.

When compared with non-profit hospitals in Ramsey County, St. Paul-Ramsey achieves noticeably less in-patient days per staff person than do United and St. Joseph's. However, St. Paul-Ramsey does not spend any greater percentage of its total budget for personnel than do the two non-profits. In addition, United's expenditure per staff person is actually slightly higher than St. Paul-Ramsey's. Nor are top staff at St. Paul-Ramsey earning salaries higher than those of non-profit hospitals. In a 1982 survey of 15 Minnesota and Wisconsin hospitals, of which 12 were non-profits, St. Paul-Ramsey's salary rank for surveyed key positions was:

Chief Executive Officer	7/13
Chief Operating Officer	6/9
Associate Administrator	6/8
Assistant Administrator	7/12
Chief Fiscal Officer	10/14

In all cases, the St. Paul-Ramsey salaries were below average, even though most of the institutions surveyed, including, for example, Sacred Heart Hospital in Eau Claire and St. Agnes Hospital in Fond du Lac, are considerably smaller.

The Medical Center also has a greater expenditure per admission than do United and St. Joseph's. Yet, St. Paul-Ramsey's average billed charges for psychiatric care, according to Blue Cross/Blue Shield were, in 1982, well below the average for all Minnesota metropolitan hospitals, at $3,839 per case as compared to the $4,475 average. Average psychiatric length of stay was also slightly shorter at St. Paul-Ramsey, at 11.8 days compared to 12.2. This comparison is particularly important, as the greatest GAMC "rateable reduction", 45%

in 1983, is for psychiatric treatment, and a significant portion of St. Paul-Ramsey's GAMC cases were psychiatric patients.

Children's Hospital provides the clue that these differences relate more to the type of patient cared for than to organizational structure. In working exclusively with seriously ill children, who, because of their immaturity, require more intensive supervision and attention than adults, Children's Hospital is able to achieve only 44 in-patient days per staff person, as compared with 62 at St. Paul-Ramsey, 58 at Hennepin County Medical Center, and 94 and 96 at United and St. Joseph's, respectively. In addition, while Children's has a lower expenditure per admission than do the 3 teaching hospitals, it, nevertheless, has a noticeably higher expenditure per admission than do the two non-profits that treat primarily adults.

Even in the 1981 report of Metropolitan Council on hospital Medicare charges, which has been criticized for not taking into account the skewing of aggregated data by the severity of patient condition, St. Paul-Ramsey is not consistently rated more expensive than the seven non-profits in the east metro area. Of ten diagnoses analyzed by the Council, St. Paul-Ramsey's middle charge was highest for only three conditions, cerebrovascular disease, inguinal hernia, and ischomic heart disease. For two conditions, breast cancer and myocardial infarction (heart attack), St. Paul-Ramsey ranked fifth of the eight institutions and below the east metro average.

The most conclusive form of data with regard to charges would be a comparison of charges billed by several institutions for treatment of the same condition for the same patient, which is virtually impossible to obtain. Even data regarding charges for treatment of the same condition is not conclusive, as the characteristics and health factors of different patients can vary significantly. Removal of a gall bladder, for example, from a 75-year-old diabetic will be more expensive than removal of the gall bladder from a 30-year-old with no other health problems. Even less obvious differences, such as patient sensitivity to anesthetic agents, can vary the charges for two different persons. Nevertheless, the data which is available strongly suggests that organizational structure is not the critical factor in the cost differences among hospitals.

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MODIFICATIONS OF THE PRESENT STRUCTURE

As noted above, the various national models for changes in public hospital organization do not appear to have great relevance to the issues concerning St. Paul-Ramsey Medical Center because the issues here are not the same as elsewhere. In fact, the present structure meets most of the criteria set forth by a 1978 national commission which recommended improvements for all public hospitals. Nevertheless, some improvements and fine tuning of the present structure might well benefit both Ramsey County and St. Paul-Ramsey Medical Center. Four options which the Joint Study Committee may wish to consider include:

1) Change in the Composition and Appointment Process for the Commission.

At present, the Medical Center Commission is comprised of four County Commissioners, nine citizens appointed from specific legislative districts, and two citizens-at-large - a change added in the last session of the Legislature. The final appointments are made by the County Board from nominees submitted by legislators, and, for the at-large positions, by the Commission. The two at-large positions were created to enable the placement of people with desired special expertise on the Commission.

The Joint Study Committee might consider further change in the composition of the Commission. At present, most of the citizen members are still qualified for appointment by virtue of their geographical location. While district representation is still considered the most democratic way to choose those who direct general governments that decide policy on a broad range of public issues, it may no longer be the most appropriate way to select policy-makers for a health care institution, given the sophisticated specialization of that field and the numerous non-geographically-defined sectors of the community which are impacted by the institution.

For example, the community's understanding of the current role of the Medical Center and of its relationship to County government might be enhanced if one or more Commission members were also active leaders in neighborhood organizations. The financial community, as well as the insurance industry, have expertise that may be valuable to the Center.

There are numerous other possibilities of sectors of the community which might be brought into the operations of the Medical Center through service on the Commission. The primary goals of such a redirection of Commission composition, which could be phased in over time, would be to achieve greater community knowledge and understanding of the Center, provide greater assurance that the Center is addressing the goals and needs of the entire Ramsey County community, and obtain valuable expertise for the Center's policy board. Legislative action and agreement would be required to implement such redirection.

2) Changes in the Process of Managing Payments for the Indigent.

As noted in the description of the present structure, Ramsey County has provided for care of the indigent by St. Paul-Ramsey Medical Center by appropriating funds annually to pay that percentage of "uncollectibles" incurred by the Center which is above the percentage incurred by other

area hospitals. In 1980, the County Board adopted a one mill levy to be applied to this appropriation, with the understanding that the Center would absorb all uncollectibles that exceed the amount to be raised through one mill.

St. Paul-Ramsey distributes its uncollectibles to several funds -- those to be paid by Ramsey County, those which the Center absorbs generally, and those which meet the Center's obligation under the Hill-Burton Act. The uncollectibles include only hospital charges and, according to the Center, never include physicians' fees billed by Ramsey Clinic Associates. RCA absorbs all losses on unpaid physicians' fees. By state statute, no uncollectibles for elective abortions are billed to Ramsey County.

The Center has a well-defined process for pursuing all avenues to assure that any charges which can be collected are collected. It also, on occasion, denies non-emergency, optional treatment to persons with no apparent means of paying the charges who cannot be qualified for any assistance program.

However, no formal guidelines from the County exist for deciding which uncollectibles should be assigned to Ramsey County and which to other accounts. Further, at present, the only County representative who participates in reviewing the individual accounts deemed uncollectible is one Assistant County Attorney.

The Joint Study Committee might consider a revised approach to County payment for indigent care that would give the County Board significantly greater on-going knowledge of the use to which its appropriations for the indigent go. This approach could include:

1) Adoption by the County Board, in consultation with the Commission, of formal, specific, policy guidelines regarding the types of indigent cases that should be billed to the County;

2) Addition of other County representatives, such as a representative from the Office of the Executive Director, the Human Services Department, and/or the Public Health Department, to the bad debt review committee that assigns the individual accounts;

3) Revision of the Center's format for providing information on the cases to the review committee so that the circumstances and conformance with the policy guidelines to be established are easily discussed;

4) Regular reports to the County Board for review of all

indigent cases assigned to the County appropriation, described in a manner similar to the summaries currently used for "case consideration", or waiver of requirements for various forms of assistance from the Human Services Department; the reports might be limited to cases over a minimum amount, such as $100, in order to reduce the length of the reports;

5) Elimination of the use of the term "uncollectible", which has negative connotations and which implies, to the casual observer, people who won't pay rather than those who can't. The term "indigent" more accurately describes the people whom the County intends to serve.

Similar review and reports could be undertaken with respect to GAMC cases, so long as the "rateable reductions" remain in force and generate the need for additional County support of the Medical Center. It should be noted that the current discounting of 45% for psychiatric charges, 35% for in-patient charges, and 25% for out-patient charges will be reduced in 1984 for 30%, 20%, and 10%, respectively. Thus, some indication is present that the State may not continue this shift of charges to the Counties on a permanent basis. However, the Joint Study Committee may wish to consider more intensive, organized efforts with other affected Counties and institutions to change this State policy back to its original 10% local requirement. Legislative action is not required to implement any of the other sections of this option.

3) Negotiations to Obtain Payment from Place of Residence for Non-Ramsey County Indigents.

One issue which has been of concern to the Joint Study Committee, and which the County Board may wish to consider further, if it chooses to adopt guidelines for assignment of indigent accounts, is that of responsibility for payment of charges incurred at the Center by indigent people from outside of Ramsey County. The statute was changed in 1982 to give the Medical Center Commission responsibility only for care of the indigent of Ramsey County rather than the indigent in general.

In earlier sessions of the Joint Study Committee, the Medical Center presented data which indicated that 88.4% of the charges billed to the County for indigent accounts and GAMC discounts in 1982 were charges incurred by Ramsey County residents. However, $1,161,120 in County funds were used to cover charges incurred by people from other locations. This amount included:

-- $251,716 for residents of Hennepin, Anoka, Scott and Carver Counties;

-- $244,131 for residents of non-metro Minnesota counties;

-- $276,874 for residents of other states and nations;

-- $388,399 for residents of Washington and Dakota Counties.

The issue of place of residence with respect to whether or not it is appropriate for Ramsey County taxpayers to absorb the charges is somewhat complex. Is it appropriate for Ramsey County to provide such funds, since, presumably, its overall tax base benefits from the fact that people who reside in other areas also contribute to its revenues by locating their businesses here, spending funds here to obtain goods and services not available outside of major urban centers, and traveling to the County to use its entertainment and recreation facilities? Might it be appropriate for the County to pick up the costs for people who were injured or became ill while visiting Ramsey County but not costs for people sent here from other places because no facility in that location could treat their condition? How often do persons residing in Ramsey County incur medical bills they cannot pay at other facilities, particularly Hennepin County Medical Center and Univeristy of Minnesota Health Center?

It is probable that a reasonable trade-off exists between Ramsey and Hennepin Counties; in any case, the number of Hennepin indigents at St. Paul-Ramsey is quite small. Collection from other states and other nations is probably impractical, given the effort required in comparison to the amount involved. The primary areas which appear to achieve some advantage from the existence of the Center, by virtue of the fact that they have no comparable medical facilities, and from which about $500,000 of the 1982 charges appear to have come, are Washington and Dakota Counties and western Wisconsin. Looking at all of the people who were admitted to the Center in 1981, not just those who become "uncollectibles", the percentage of total population from all localities except Ramsey County, Washington County, and western Wisconsin, is less than .1% of the locality's total population. However, 2.6% of the Ramsey County population was admitted to the Center in 1981, and .5% of Washington County's, and .6% of the population from Pierce, Polk, and St. Croix Counties in Wisconsin.

The Joint Study Committee could begin discussions with officials of these areas to determine if the possibility of obtaining agreements to cover the charges of their indigent residents at St. Paul-Ramsey exists. The staff

has not researched Wisconsin law to determine if legislative action would be required to obtain reimbursement from western Wisconsin. However, the Wisconsin welfare system, in general, places greater responsibility and authority upon counties rather than the state than does Minnesota's, so it may well be that the three primary Counties involved could negotiate directly with the Commission and/or Ramsey County without State involvement. If the Joint Study Committee chooses to pursue this modification, staff could quickly determine what discretion exists and what parties would need to be involved.

4) Streamlining of Civil Service System at the Medical Center.

The staff sought to determine whether or not the civil service system, as presently structured, affects either costs or productivity at the Medical Center. As noted above, the percentage of expenditures at St. Paul-Ramsey that go for personnel is not significantly greater than those at other hospitals in the area. However, at 68% of total expenses, the personnel costs are slightly higher than at Hennepin County. Given that with most other indicators that were examined, St. Paul-Ramsey compared favorably with Hennepin County Medical Center, it is possible that there may be some room for improvement in the cost of personnel, although the actual expenditure per staff person was lower at St. Paul-Ramsey and the St. Paul-Ramsey staff was more productive, in terms of people served per staff person. (It should be noted that, of course, Hennepin County also functions under a civil service system.) The Medical Center's administrators indicated that the Civil Service Department has been highly cooperative in working with them to maintain salary and wage rates that are consistent with other medical facilities in the community but that, in some classifications, particularly those which are shared with other County departments, the rate at which an individual's pay increases over length of service is more rapid than at other Ramsey County hospitals.

The staff has not gone into detail to identify precisely areas in which adjustments of civil service classifications and pay scales might reduce costs at the Medical Center, since the overall performance of the Center, in comparison with other facilities, does not suggest that any major savings might result. However, the Medical Center has expressed its concern that the proposed reform of the civil service system into a personnel system take the needs of St. Paul-Ramsey into account and assure that appropriate flexibility and control, according to the statutory responsibilities of the Commission, be provided. As the County proceeds with development of a personnel

system, the Joint Study Committee may wish to undertake further, more detailed, study of the structure and impact of the civil service system at the Medical Center.

MT/gb
Attachments (3)

Attachment #1

OFFICE OF THE COUNTY ATTORNEY
RAMSEY COUNTY
200 LOWRY SQUARE
ST. PAUL, MINNESOTA 55102

TOM FOLEY
COUNTY ATTORNEY

TELEPHONE
(612) 298-4421

TO: David Gitch, Executive Director
St. Paul-Ramsey Medical Center
Margaret Thorpe, Assistant Executive Director
Ramsey County

FROM: Michele L. Timmons
Assistant County Attorney

DATE: July 25, 1983

RE: Financial Obligation or Authority of Ramsey County for Medical Care Provided to Indigents by St. Paul-Ramsey Medical Center Commission

At our last staff meeting in preparation for the joint Study Committee meeting, an opinion was requested on the following issue:

> What is the legal responsibility or authority of Ramsey County to provide funding for medical care provided by the St. Paul-Ramsey Medial Center Commission to persons who are indigent but do not qualify for entitlement programs such as Medical Assistance or General Assistance Medical Care?

The answer to this question is based in history as well as law.

The current St. Paul-Ramsey Medical Center Commission was originally established by Minn. Laws 1969, Ch. 1104. The "Ramsey County Hospital and Sanitarium Commission" created by that law was charged with the following responsibilities:

> The commission shall take all measures necessary and proper to provide hospital and medical services for the indigent, and contagiously ill, catastrophically injured, and city and county prisoners, and may take all measures necessary and proper to maintain the hospital as a research and teaching institution.

Minn. Laws 1969, Ch. 1104, Sec. 4, Subd. 4. That same law granted to Ramsey County the following authority:

> Notwithstanding any law to the contrary the Ramsey county board of commissioners is authorized to provide all funds, except those required for the purpose of funding prior construction indebtedness which shall be as heretofore provided, it approves pursuant to budgets duly submitted to it by the commission. The Ramsey county board of commissioners is further authorized to provide emergency funds for the commission for the purpose of operating facilities for the benefit of the indigent for civil defense, catastrophes, epidemics, and acts of war when operational income is insufficient to meet operational expenses.

Minn. Laws 1969, Ch. 1104, Sec. 6, Subd. 1. Thus, the original special law which created the Commission placed the responsibility for care of the indigent on the Commission, gave the County the authority to appropriate funds to support the budget of the Commission, and simply recited the care of the indigent as one of several purposes for which emergency operating funds could be granted.

The current special law provides essentially the same delineation of responsibilites and authority with respect to the indigent as did the original law. The current responsibility of the St. Paul-Ramsey Medical Center Commission has been reduced somewhat to serve the "indigent of Ramsey County" rather than the "indigent":

> The commission shall provide hospital and medical services for the indigent of Ramsey county, the contagiously ill, and catastrophically injured and city and county prisoners, and maintain the hospital as a research and teaching institution. It may provide hospital and medical services for the general public.

Minn. Stat. §383A.41, Subd. 9 (1982). This amendment was made in 1982 by Minn. Laws 1982, Ch. 418, Sec. 1. In the 1974 codification of the Ramsey County special laws, the authority to fund the hospital was removed from the hospital section and placed in the taxation section:

> Notwithstanding any law to the contrary, Ramsey

> county may provide all funds, except those required for the purpose of funding prior construction indebtedness which shall be as heretofore provided, that it approves pursuant to requests duly submitted to it by the Ramsey county hospital and sanitarium commission. Ramsey county may also provide emergency funds for the commission for the purpose of operating facilites when operational income is insufficient to meet operational expenses

Minn. Stat. §383A.03, Subd. 1(c) (1982). Although the above language has been streamlined to remove the various purposes for which emergency funds can be granted, including the specific recitation of the word "indigent", it is my opinion that the authority of Ramsey County to fund the Commission budget has not been reduced.

The current status of the Ramsey County special law, on its face, is that the Commission has the responsibility to provide services to the indigent of Ramsey County, as well as the contagiously ill, catastrophically injured and city and county prisoners, while Ramsey County has the authority to provide funds to the Commission. It would be possible to argue, however, that the discretionary language which gives the county authority to provide funds to the Commission should be construed to achieve a mandatory result.

The general laws relating to poor relief and General Assistance Medical Care provide additional statutory sources related to county support of medical care for the indigent. The general law relating to hospitalization of indigent persons reads as follows:

> The county board of any county in this state is hereby authorized to provide for the hospitalization in hospitals within the county or elsewhere of indigent residents of such county who are afflicted with a malady, injury, deformity, or ailment of a nature which can probably be remedied by hospitalization and who are unable financially to secure and pay for such hospitalization or, in the case of an unemancipated minor, whose parent, guardian, trustee, or other person having lawful custody of his person, as the case may be, is

unable to secure or provide such hospitalization.

Minn. Stat. §261.21, Subd. 1 (1982).

On its face, this statute gives the county discretionary authority to provide for hospitalization of the indigent. An opinion of the Attorney General written in 1942 found that the above statute was discretionary rather than mandatory. Op. Atty. Gen. 1942, No. 275, p. 392. The only Minnesota Supreme Court case to construe this statute did not reach the issue of whether it was discretionary or mandatory in general, but did hold that a county board was prohibited under a predecessor version from paying a medical bill for a state resident who received care from an out-of-state hospital. Dakota Hospital v. County of Clay, 280 Minn. 531, 160 N.W.2d 246 (1968). The holding in that case consequently seems consistent with the interpretation that the statute provides discretionary authority, but does not mandate the provision of care in the sense that the various entitlement programs do. On the other hand, the opinion in Dakota Hospital recited the policy behind the statutory general relief provisions:

> It has long been the unequivocal policy of our state, as declared by our statutes and decisions, that any person living in Minnesota and in need of the commonly recognized necessities of life, who for any reason is unable to earn a livelihood . . . shall be cared for at public expense.

Id., at 160 N.W.2d 248. This general policy language is more consistent with the imposition of a responsibility upon the county.

Additional relevant statutory provisions include those relating to General Assistance Medical Care which provide in pertinent part:

> Any county may, from its own resources, provide medical payments for which state payments are not made.

Minn. Stat. §256D.03, Subd. 4(d) (1982). This statutory language, which has not been interpreted by any case law, appears to give the county futher authority to supplement the entitlement programs with county funds.

While both sections 261.21 and 256.03, Subd. 4(d) are stated in discretionary terms, one caveat must be noted. Only the county, and no other governmental entity, is granted this authority to provide supplemental assistance to the medically indigent. In the sense that, if supplemental assistance is to be provided to the medically indigent, it must be done by the county, the county does have a responsibility to the medically indigent.

With respect to the Ramsey County special law, a similar caveat exists. If the St. Paul-Ramsey Medical Center Commission, because of its duty to provide medical care for the Ramsey County indigent, requires financial support for the Medical Center to remain economically competitive and viable, only Ramsey County has authority to provide it. In this practical sense, Ramsey County does have a responsibility to provide funding for medical care provided to the indigent by the St. Paul-Ramsey Medical Center Commission.

If you have further questions on this matter, please feel free to contact me.

cc: Richard L. Brubacher
Opinion File

JUN 3 1983

Attachment #2

HENNEPIN

DATE: January 31, 1983

TO: Hennepin County Board of Commissioners

FROM: Dale A. Ackmann, County Administrator

SUBJECT: Evaluation of Contract Management for Hennepin County Medical Center

County Board Resolution #82-9-711 directed that an evaluation be made of the applicability of contract management to Hennepin County Medical Center. The attached report details the evaluation process, the findings and my recommendation.

I believe certain findings and conclusions of the management firms deserve special emphasis:

- It does not appear likely that comprehensive management of Hennepin County Medical Center via a contract with a hospital management firm would result in signifcant cost reduction, revenue increases or better health service management. From the report:

  > "Perhaps the single most interesting findings of all management firms' responses is the lack of specific problem areas within Hennepin County Medical Center where substantial and immediate benefits would be realized by contract management. To the contrary, each of the firms commended the County and its Medical Center for being in a good financial position and apparently running within accepted normal standards for the hospital industry. Four of the five firms strongly suggested that a full management contract would not be appropriate for Hennepin County Medical Center and could actually cost the County more in the long run. The other firm did not comment specifically on the applicability of full contract management to Hennepin County Medical Center."

- All of the management firms involved in the evaluation process were familiar with the Medical Practice Plans and none identified any reasons why it should not be implemented. Several firms strongly encouraged the development of a practice plan at the Medical Center.

- The evaluation process did identify some opportunities for management improvements and it is my recommendation that we review these. They include: expanded relationships with other facilities such as the Metropolitan Medical Center, ensuring that the Medical Practice Plan has necessary

computer, administrative and marketing support at the time of its implementation, and the purchase of certain specialized services from contract management firms.

Although the County did not incur any "out of pocket" costs, the evaluation process was rigorous, with the involvement of many County staff and management firms employees. In addition, I believe it was a fair and open process.

I think it is important to thank the five management firms who assisted us in this evaluation. They provided objective and comprehensive expertise at no cost to Hennepin County. They are:

Fairview Community Hospitals, Minneapolis, Minnesota
The Health Central System, Minneapolis, Minnesota
Hospital Corporation of America, Nashville, Tennessee
Hyatt Medical Management Services, Inc., Encino, California
Intermountain Health Care, Inc., Salt Lake City, Utah

In summary, I believe the evaluation of contract management was beneficial for Hennepin County. It assures us that the Medical Center is well managed, endorses the concept of the Medical Practice Plan, and provides direction for possible further improvements.

vjv

ATTACHMENT #3

EXCERPT FROM

THE FUTURE OF THE PUBLIC-GENERAL HOSPITAL

AN AGENDA FOR TRANSITION

Report of the
Commission on Public-General Hospitals

HOSPITAL RESEARCH AND EDUCATIONAL TRUST

1978

Members of the Commission

Russell A. Nelson, M.D., *Chairman;* President Emeritus, The Johns Hopkins Hospital, Baltimore.

*Nelson H. Cruikshank, President, National Council on Senior Citizens, Washington, DC.

Thomas L. Hooker, Deputy Secretary for Family Assistance, Department of Public Welfare, Harrisburg, PA.

Odell H. Huffman, State Senator, West Virginia; Counsel, Princeton Community Hospital, Princeton, WV.

Mamie Hughes, Member, County Legislature of Jackson County, Kansas City, MO.

Barry Keene, Chairman, Health Committee, California State Assembly, Sacramento, CA.

Julius R. Krevans, M.D., Dean, School of Medicine, University of California, San Francisco.

Henry E. Manning, President, Cuyahoga County Hospital, Cleveland.

Richard B. Ogilvie, Partner, Isham, Lincoln and Beal, Chicago; former Governor, State of Illinois.

Beverly Phillips, Commissioner, Metropolitan Dade County, Miami, FL.

†David Rosenbloom, Commissioner, Department of Health and Hospitals, Boston.

Albert W. Snoke, M.D., Consultant in Hospital and Health Administration, Hamden, CT; former Coordinator of Health Services, State of Illinois.

Nathan J. Stark, Vice Chancellor, Schools of the Health Professions, University of Pittsburgh; President, University Health Center of Pittsburgh.

William H. Stewart, M.D., Acting Head, Department of Preventive Medicine and Public Health, Louisiana State University School of Medicine, New Orleans.

Joseph V. Terenzio, President, United Hospital Fund of New York.

R. Zach Thomas Jr., Executive Director, Charlotte-Mecklenburg Hospital Authority, Charlotte, NC.

John H. Westerman, General Director, University of Minnesota Hospitals and Clinics; Associate Professor, School of Public Health, University of Minnesota, Minneapolis.

Kevin H. White, Mayor, City of Boston.

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*Resigned, effective June 1977, to become Counselor to the President on Aging

†Alternate to Kevin H. White

many of the controls on standards for the institution and for the professionals who work in it, including accreditation, certification, and qualification for payment, are external to the hospital and its government sponsor. In short, the public hospital is not a department of government with conventional lines of authority and methods of allocating resources. Therefore, it cannot be managed properly through the identical controls applied to other functions of general-purpose municipal and county government.

All of these factors argue strongly for a governing structure for the public-general hospital that promotes efficient day-to-day professional management specifically suited to meet the operational needs of a complex health care delivery system and that has accountability appropriate to the concerns of public ownership.

Governance is not simply a management mechanism, however. Rather, it is a set of capabilities, or functions, that the hospital must be endowed with if it is to be a viable health service resource in the future. These capabilities include policymaking leadership within the community, with authority to advocate and implement hospital programs, and responsiveness to community needs, as well as management flexibility and accountability.

Governance also is not simply a matter of structure. Too often, localities considering changes in public hospital governance limit themselves to discussion of structural options only, such as transfer of operating control to a voluntary corporation, management company, or university; establishment of a public benefit corporation or hospital authority; charter of a hospital district with taxing authority; or appointment of an independent or autonomous board of directors. However, each governance structure that has been tried has met with both successes and failures, depending on local personalities, financial conditions, and politics in the community, as well as on the functions and capabilities that the structure was endowed with. For these reasons, the Commission has not attempted to describe or recommend any particular models of governance. There are many current developments across the country, which, when taken together with the experience of past changes in governance, suggest that the essential choices must be made on a community-by-community basis, with the deep involvement of local community leadership in assessing the options available.

The following governance functions or capabilities are those that the Commission believes are necessary to the viability of a public-general hospital.

1. *Policymaking capability.* As regulatory and planning pressures for a more rationally organized health system increase, the viability of the public-general hospital will depend increasingly on its ability to provide decisive policymaking leadership within its community. It must have a governing structure that can develop long-range goals and programs for the hospital that are responsive to community need and to areawide planning goals and objectives.

2. *Ability to assess and respond to community needs and expectations.* As a governmental entity supported in part by local taxpayers' dollars, the public-general hospital has a responsibility to identify and understand community needs and concerns and to take them into account in developing policy and programs. This is especially important if the hospital is to have community support for its programs and policies, for its requests for operating monies, and for the raising of capital by issuing bonds through public referendum. The public-general hospital's governing structure, therefore, should allow for community involvement in hospital policymaking processes. An independent body composed of experienced and influential members of the community can be a mechanism for obtaining information from

the community on unmet needs. It also can be an important resource for coalescing community support for hospital programs.

3. *Ability to establish short-range programmatic priorities for the hospital.* The inflation in health care costs and the growing demand for services have produced in most communities a widening gap between available resources and consumer expectations. The public-general hospital's governing structure should have the expertise to establish priorities for the use of limited resources and the authority to order the development of programs that reflect these priorities. This capability is extremely important for the public university hospital, which has to reconcile community needs with those of its long-term education and research programs.

4. *Ability to advocate hospital policy before the community, local government, and planning and regulatory authorities.* Decisions regarding public hospital programs often are made by public officials who are far removed from actual hospital operations and who are responding to interests in the community that also are remote from the hospital. The public-general hospital's governing structure should have the capability to mediate conflicting interests and to effect compromises in order to attain a consensus on health care needs and priorities that should be met with available resources. It must be able to generate broad community support for the goals and programs of the institution in order to withstand the volatile impact of local considerations affecting these goals or the support of the hospital. This capability is extremely important for the large urban public-general hospital, which frequently represents a constituency that has little organized influence on local government. It also is important for the public university hospital, which must generate public support for its education and research programs.

5. *Ability to establish effective administrative procedures.* The administrative controls applied by local government frequently create staffing and recruitment problems for the public-general hospital and impede efficient hospital operations. For example, civil service requirements may preclude the hospital's offering competitive salaries to managerial and technical staff, and governmentwide union contracts may make labor-management dealings more difficult. Elaborate approval mechanisms may inhibit staff attempts to initiate new programs. Also, the dependence of the hospital on central government support services, such as purchasing, personnel, maintenance, and data processing, often hinders efficient, responsive hospital operations. The governing structure of the public-general hospital must have the capability to establish administrative practices that provide hospital management with adequate authority and incentive to operate the hospital efficiently.

6. *Ability to require fiscal practices to maximize third-party revenues.* Traditionally, many public-general hospitals financed services for most of their patients through appropriations from local government. Since the enactment of the Medicaid and Medicare programs in the 1960s, however, the public-general hospitals have been serving many patients who have financial sponsorship. The tradition of financing care through public appropriation, however, and the practice of crediting third-party payments to central government accounts rather than to the hospital's revenues have created an atmosphere in many public-general hospitals that downplays the importance of such fiscal practices as internal budgeting, strong accounting systems, and aggressive billing and collection procedures. The public-general hospital's governing structure must ensure that the hospital is operated as an enterprise, with the capacity to account on an "enterprise basis" for its income and expenditures. Businesslike fiscal practices should be required as a standard of

public accountability. Arrangements should be made for all third-party reimbursements to go directly to the hospital rather than to a central government fund, and every effort should be made to maximize revenues from Medicaid and other financing programs outside local government.

7. *Authority to establish new relationships with other community providers.* Increasingly, there will be pressures on health care institutions to seek economies and efficiencies through the sharing of services or facilities among institutions within a community. Some public-general hospitals are precluded from participating in multi-institutional arrangements, however, because of local government prohibitions against public agency commitments to private institutions. The public-general hospital's governing structure must have the capability to develop hospital policy regarding relationships with other community providers and the authority to establish mutually productive arrangements that will both ensure efficiency and protect the public interest. It should have the authority to make commitments to other organizations and should be held accountable for the practices that result.

8. *Ability to require new standards of accountability.* Local government's traditional annual budgeting process for the public hospital is basically a prospective audit that provides no opportunities for the government to determine whether the hospital is operating efficiently and no discretion on the hospital's part to adjust to changes in workload during the year. The process tends to focus on the structure and programs of the institution rather than on outcomes. The governing structure of a public-general hospital must provide for improved accountability for the hospital by requiring that adequate information systems be established so that programs can be documented and justified on the basis of need and evaluated on the basis of performance in meeting these needs. Use of such systems will enable public officials to base their appraisal of the hospital not only on its conformance to a budget but also on its performance in conducting programs established to meet policy goals.

9. *Ability to develop affiliation agreements.* Affiliation with a medical or other health science school has important implications for the types and modes of services to be provided in the hospital, for the types and numbers of physicians and other professionals who will make up the hospital staff, and for the costs, quality, and quantity of the hospital's services. The public-general hospital's governing structure must have the ability to develop effective affiliation agreements that are supportive of institutional goals, that are beneficial to patients and to taxpayers, and that meet the needs of the schools involved. These agreements should spell out clearly all arrangements for financing and providing services.

10. *Ability to involve medical staff in policy development.* In developing broad institutional goals for the hospital, its governing structure must take into account the structure and practices of the medical staff and of the other professional groups in the hospital. To provide leadership that will be acceptable and responsive to the medical staff, the hospital's governing structure must have a close working relationship with these groups. It must provide for strong, focused leadership that can relate to the influential physician community with an authoritative voice and ensure that professional commitments made by physicians will be reinforced by consistent and stable hospital policies. The governing structure of the hospital must have the influence and authority to approve medical staff bylaws that contribute to the goals of the hospital and that benefit both patients and physicians.

11. *Ability to establish new criteria for physician attending privileges that will encourage use of the public-general hospital by private patients.* If the public-

general hospital is to be an essential component within an organized community health system, it must serve all members of the community. It cannot increase the range of patients it serves, however, unless it grants admitting privileges to qualified private practitioners who will bring their patients into the hospital. The governing structure of the public-general hospital should encourage changes that will permit physicians who are qualified under the standards of the Joint Commission on Accreditation of Hospitals to join the medical staff without becoming medical school faculty members or salaried physicians.

FINANCING THE SERVICES OF THE PUBLIC-GENERAL HOSPITALS

III. The financial problems that threaten the ability of the public-general hospitals to serve their communities must be resolved. Immediate fiscal relief must be provided to those hospitals that serve large numbers of poor and unsponsored patients. At the same time, the programs for providing funding and/or care for persons unable to pay must be reformed and restructured.

All hospitals, public and private, share a myriad of financing problems, whether related to inadequate reimbursement, the costs of complying with federal and state regulations, high labor costs, or systems and management inefficiencies. However, those hospitals that serve large numbers of poor and unsponsored patients are especially prone to financial problems. Although there are hospitals in the private sector that play this important role, the public-general hospitals that operate under a mandate to serve community residents regardless of their ability to pay for care bear the brunt of this responsibility. As a result, they suffer such debilitating financial difficulties that the quality and quantity of services that they provide are compromised and their ability to continue operating is threatened.

The problems of caring for the poor and unsponsored have been exacerbated in recent years by general economic conditions and, particularly for the public-general hospitals in our major cities, by local fiscal problems. As local governments beset by increased demands on tax revenues and unprecedented inflation have found themselves unable to keep up with the cost of health care, their public-general hospitals have suffered with appropriations that do not meet the difference between revenues and operating expenses. Some of these hospitals also have experienced revenue losses resulting from cutbacks in state support for Medicaid and other public assistance programs.

The effects of inflation and cost containment on private hospitals also are having repereussions in the public hospital sector. As costs rise and cost containment efforts increase, the private hospital's ability to absorb bad debts for personal health care services furnished to the poor or the underserved is becoming more limited. The diversion of nonpaying and part-paying patients to public-general hospitals for care is a long-standing phenomenon that could easily be accelerated in the present financial climate.

Therefore, it is imperative that we take immediate steps to provide short-term fiscal relief to those institutions that serve large numbers of poor and unsponsored patients to enable them to survive their current financial problems and to begin to adapt their missions and governance and to restructure their services and programs in accordance with other planned health system changes in their communities. While recognizing that tax revenues and other income cannot support all of the demands placed on government, the Commission is concerned that the urgent problems of these hospitals not be ignored simply because resources are scarce and their reallocation is painful. The implications of procrastination while people fail

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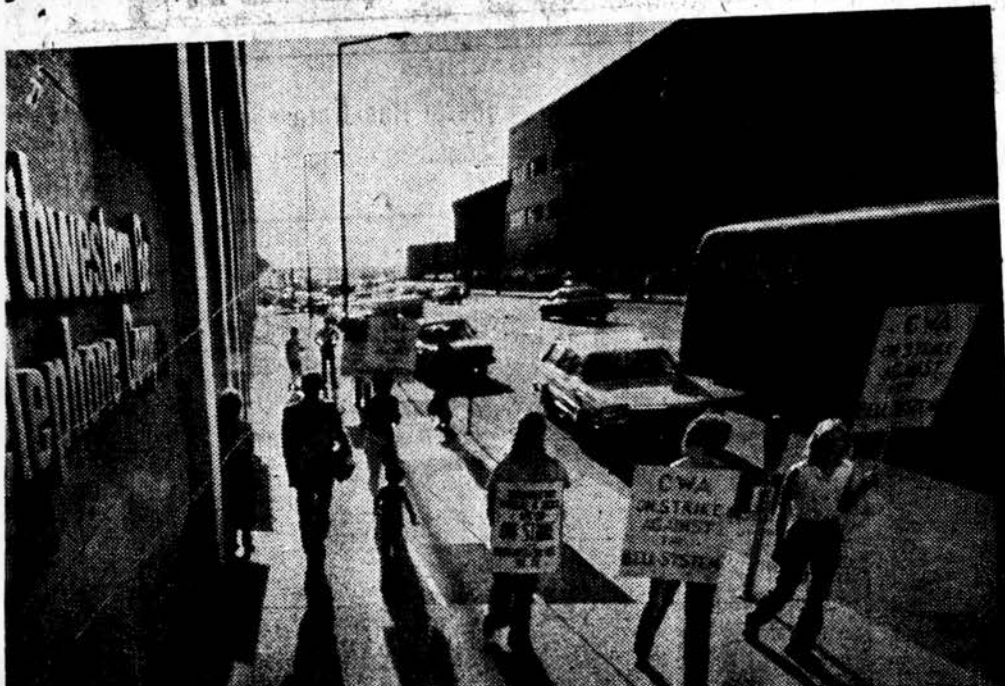

Dispatch 8/8/83

Medical center study is positive

By Steven Thomma
Staff Writer

St. Paul-Ramsey Medical Center is well-managed and draws a smaller percentage of its budget from county taxpayers than similar hospitals in 20 other cities, according to a study released today.

The study was prepared by a joint committee of Ramsey County

Partially Scanned Material

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