CASE OF: CANIDA CASSAS

AND PARADISE VALLY HOSPITAL

1. INVESTIGATION REPORTS AND OTHER MATERIAL

SOURSE. HECTOR DIAZ

STATE DEPT. OF HEALTH L.A. CA.

SPRING 1978

2. INVESTIGATION OF COMPLAINT

CRUZ ROJA MEXICANA

JEFATURA DEL CUERPO DE SOCORRISTAS

DELEGACION TIJUANA

Tijuana, B.C., Abril 21 de 1978.

A QUIEN CORRESPONDA:

Por medio de la presente hacemos constar, que el día 26 de Enero del presente año, se recibió una llamada telefónica aproximadamente a las 19:30 horas; del Hospital -- Paradaise Valley, indicando que se encontraba en la sala de Urgencias del mencionado hospital una persona de sexo femenino con quemaduras en la espalda, su nombre era Cándida Casas Rangel con domicilio en la calle Fermina Rivera # 661 Col. Del Río en ésta ciudad.

La persona que se comunicó a ésta Institución solicitaba que si fuera posible se mandara a la Línea Internacional a una Ambulancia para que le fuera entregada la -- persona antes mencionada por personal del Servicio de Ambulancia Aaron de la ciudad de San Diego, California.

A las 21:45 se recogió a la persona y se le trasladó al Hospital General de Tijuana.

Se extiende la presente para los fines legales que a los interesados convenga.

A T E N T A M E N T E

SEAMOS TODOS HERMANOS

DELEGACION TIJUANA
COMANDANCIA
C. SOCORRISTAS

EL JEFE DEL CUERPO DE SOCORRISTAS.

LIONEL RIOS SAUCEDO.

c.c.p. Archivo

Facilities Development Section
107 South Broadway, Room 6015
Los Angeles, California 90012
(213) 620-4954

May 1, 1978

Dr. Frank
Burns Center #6400A
University Hospital
225 West Dickenson Street
San Diego, California 92103

Dear Dr. Frank:

Enclosed you will find the articles we were discussing by telephone. It is our understanding that your policy for patient admittance into the Burns Unit evolves around two questions: (1) Is the person a citizen, and (2) were the burns or injuries sustained in the community?

A yes on either of the two questions above would allow admission of the patient. The problems we discussed with respect to reimbursement will be discussed in a workshop to be scheduled June 9, 1978 at the Health Systems Agency of San Diego and Imperial Counties (Telephone 714-297-4721).

We would like to extend an invitation to you for the purpose of discussing problems and solutions of the indigent patients and hospitals serving such patients.

Very truly yours,

Hector J. Diaz
Construction Adviser

Enc.
cc: Sacto. File

HJD:dbs

The Superior Court
COUNTY OF SAN DIEGO
GRAND JURY
220 WEST BROADWAY, ROOM 7003
SAN DIEGO, CALIFORNIA 92101
(714) 236-2675

STATE DEPARTMENT
OF HEALTH
RECEIVED
FEB 2
FACILITIES CONSTRUCTION
SECTION - LOS ANGELES

February 11, 1980

Mr. L. Kent Corey, President
California Hospital Monitoring Association
831 N. Lucile
Los Angeles, California 90026

Re: Grand Jury File #80-35

Dear Mr. Corey:

The Health & Welfare Committee of the Grand Jury has discussed the factors involved with regard to Candida Cassas' admission to the Emergency Room of Paradise Valley Hospital on January 26, 1978, with the District Office of the Licensing Division of the State Department of Health Services.

It appears that while the physicians there were attempting to have her admitted to the only burn center services for this County, which are at the University Hospital where there was confusion (if that is the word) over her illegal alien status, her husband transferred her to Tijuana.

The Department of Health Services met with the responsible officials involved. It has taken steps to ensure that all patients with critical burns will be treated, regardless of illegal alien status or non-ability to pay. Hopefully, in the future there will be exact compliance with California Administrative Code Title 22, Section 70717(J).

We are informed that the Federal Government investigated this matter in May of 1979. You may want to obtain a copy of this report by writing Dr. Florence Fiori, Director Bureau of Health Facilities Finance Compensation and Conversion, 3700 East West Highway, Room 5-22, Hyattsville, Maryland, 20782.

Sincerely yours,

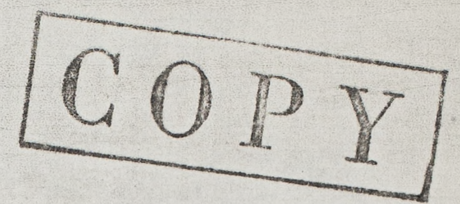
for the SAN DIEGO COUNTY GRAND JURY

ELVIN E. BINGER, Foreman

DR. PERRY E. NUSSBAUM, Chairman
Health & Welfare Committee

EEB/PEN:jml

The Superior Court
COUNTY OF SAN DIEGO
GRAND JURY
220 WEST BROADWAY, ROOM 7008
SAN DIEGO, CALIFORNIA 92101
(714) 236-2675



January 28, 1980

Mr. Dean Harthorne
Assistant Administrator
District Office
State Department of Health Services
Licensing Division
6150 Mission Gorge Road, Suite 119
San Diego, California 92120

Re: Grand Jury File #80-35

Dear Mr. Harthorne:

Re California Hospital Monitoring Association about Paradise Valley Hospital, San Diego, which the Health & Welfare Committee of the Grand Jury discussed with you on December 4, 1979, please advise us about the progress you have made to date in your investigation of the Hospital's emergency services as outlined in the complaint received.

With kind regards, I am

Sincerely,

for the SAN DIEGO COUNTY GRAND JURY

by ELVIN E. BINGER, Foreman

DR. PERRY E. NUSSBAUM, Chairman
Health & Welfare Committee

EEB/PEN:jml

STATE DEPARTMENT
OF HEALTH
RECEIVED

FEB 1 5 1980

FACILITIES CONSTRUCTION
SECTION-LOS ANGELES

TITLE 22. SOCIAL SECURITY

DIVISION 7. HEALTH PLANNING AND FACILITY CONSTRUCTION

CHAPTER 3. UNCOMPENSATED SERVICES AND COMMUNITY SERVICE

91135. Assurance. (a) Before an application for federal assistance under the program is recommended by the Department to the Secretary, the Department shall obtain an assurance from the applicant that there will be made available in the licensed facility, or portion to be constructed or modernized, a reasonable volume of services to persons unable to pay.

(b) The Department shall waive the requirement of an assurance if the applicant demonstrates to the satisfaction of the Department subject to subsequent approval of the Secretary, that this requirement is not financially feasible in accordance with Section 91149 of this Chapter.

91137. Presumptive Compliance Guideline. (a) An applicant shall be presumed to be in compliance if either of the following is met for the fiscal year:

(1) Budgets for the support of, and makes available on request, according to the requirements of this Chapter, uncompensated services at a volume not less than the lesser of 3 percent of operating costs or 10 percent of all federal assistance provided to or on behalf of the applicant under the program.

(2) Certifies that the applicant shall not exclude directly or indirectly any person from admission on the grounds that such person is unable to pay for needed services and that services provided by the facility shall be made available to each person admitted without charge or at a charge below reasonable cost which does not exceed any such person's ability to pay as determined in accordance with criteria established in Section 91145.

(b) Applicants shall, within 120 days after completing a fiscal year to each succeeding budget year for which the option is selected, submit an annual compliance report.

(c) If the estimated dollar volume of uncompensated services under option (a)(2) above is substantially less than the dollar volume that would have been provided under option (a)(1) above, the applicant shall submit sufficient justification for the estimated dollar volume of services. The justification shall describe how the estimated dollar volume was derived and why this dollar volume meets the applicant's assurance and the criteria for determination of the volume of uncompensated services required.

(d) If the Department finds the justification does not establish a reasonable expectation of fulfillment of the applicant's obligation, the Department shall require the applicant to choose one of the following:

(1) Elect another option.

(2) Submit a request to the Department to negotiate a volume of uncompensated services.

(e) If appropriate, the Department shall impose sanctions.

(f) In the case of a loan guarantee with interest subsidy or a direct loan to be sold by the Secretary with an interest subsidy, the amount of federal assistance, as used in option (a)(1) above, shall include:

(1) The total amount of the interest subsidy which the Secretary is, or will be, obligated to pay over the full life of the loan.

(2) Any other payments which the Secretary makes on behalf of the applicant in connection with the loan guarantee or the direct loan which has been sold.

91139. Annual Compliance Report and Annual Compliance Plan. (a) Each applicant shall, not later than 120 days after the end of a fiscal year, file with the Department an annual compliance report which shall set forth sufficient information and verification to indicate the applicant's compliance with this Chapter. This annual report shall include at least the following:

(1) The applicant's operating costs.

(A) Operating costs shall be determined for the applicant's entire facility and for all patients regardless of the source of payment for care.

(B) In determining such operating costs there shall be deducted the amount of all actual or estimated reimbursements, as applicable, for services received or to be received pursuant to Titles XVIII and XIX of the Social Security Act, 42 U.S.C. Section 1395 and Section 1396.

(2) The applicant's income from all sources.

(3) A breakdown of the dollar volume of all uncompensated services provided by the applicant to all persons within each eligibility category specified for persons unable to pay for services.

(4) The number of persons receiving uncompensated services within each eligibility category specified for persons unable to pay for services.

(5) A breakdown of the general category of the uncompensated services provided (emergency, inpatient, outpatient) by dollar amount and by number of persons.

(6) Such additional information and verification as the Department may reasonably request.

(b) This annual report shall be certified as correct by the administrator, officer, controller, treasurer, or other authorized representative of the applicant.

(c) For hospitals, this annual report may be an extract from the reports submitted annually to the State Health Facility Commission as required under the State Hospital Disclosure Act, Health and Safety Code, Section 440, provided all the above information is contained therein and is properly certified and identified as uncompensated services under this Chapter.

(d) Each applicant shall file with its annual report description of that portion of the applicant's adopted current fiscal year budget relating to the support of uncompensated services during the year.

(Exhibit 1)

(e) The budget for uncompensated services shall be based on the operating costs of the applicant for the preceding fiscal year and shall give due cognizance to probable increases in operating costs. If the report does not conform to the presumptive compliance guideline, the applicant shall submit with its plan the following:

(1) A justification therefor, based on the criteria in Section 91151(d).

(2) If necessary to meet the presumptive compliance guidelines or such other level of uncompensated services as may have been established by the Department, a proposal to increase such uncompensated services within the fiscal year.

(f) The applicant shall also submit with the annual report such additional information and verification as the Department may require.

(g) Based on the annual report, the Department shall determine in accordance with the procedures for the determination of the volume of uncompensated services required whether the applicant has been in compliance during the past fiscal year with the assurances made pursuant to this chapter.

(1) The provision of a dollar volume of uncompensated services which equals or exceeds the level established for the fiscal year shall constitute compliance with the assurance, provided there has been compliance with all other requirements of this Chapter.

(2) If the dollar volume of services provided was less than the level of uncompensated services established, the applicant shall submit with the annual report the following for Department approval:

(A) Justification, based on the criteria in Section 91151 (d).

(B) A description of the steps it proposes to take to assure the availability and utilization of the volume of uncompensated services to be established for the current fiscal year, which shall include a corrective action plan, utilizing press releases or other appropriate means as the Department shall direct to bring to the attention of the public the availability of such uncompensated services and the conditions of eligibility.

(h) The Department shall make a finding as to whether an applicant has complied with the requirement of this Article or has submitted adequate justification for a lack of compliance. Where appropriate, the Department shall require corrective action to be incorporated into the applicant's annual report or shall impose sanctions.

(i) Pending the establishment of a dollar volume of uncompensated services for an applicant for a fiscal year, the applicant shall provide a dollar volume of services that is the highest of the following:

(1) The dollar volume established for the preceding fiscal year.

(2) The dollar volume provided in the preceding year.

(3) The dollar volume proposed in its report for the current fiscal year.

91141. Determination of Qualifying Services. (a) In determining the dollar volume of uncompensated services provided by an applicant, there shall be included except under circumstances described in (b) thru (d) below, only those services provided to an individual who:

(1) Was notified in advance of services being rendered that uncompensated services may be available.

(2) Had a written determination of eligibility prior to the delivery of services that such individual was eligible to receive services according to the criteria established for persons unable to pay for services.

(3) Was notified in advance of services being rendered that such a determination was made.

(b) The determination of eligibility may be made after the provision of such services in the case of services provided on an emergency basis: provided, that only a first billing is made for the service, and the first billing must be accompanied by substantially the information required in the posted notice to the public of the availability of uncompensated services.

(c) The determination of eligibility may be made after the provision of services in the case of a change in financial circumstances as a result of the illness or injury occasioning such services or in case of insurance coverage or other resources being less than anticipated or the costs of services being greater than anticipated.

(d) In all cases where a determination was not made prior to the provision of services, such services may not be included as uncompensated services if any collection effort has been made other than the rendering of bills permissible in the above exceptions. A determination may be made at any time if the determination was substantially hindered or delayed by reason of erroneous or incomplete information furnished by or on behalf of the patient.

(e) The following shall be excluded from the computation of uncompensated services:

(1) Any amount which the applicant has received, or is entitled to receive, from a nongovernmental third-party insurer.

(2) The reasonable cost attributable to a service for which the applicant has received, or is entitled to receive, reimbursement from a governmental program (e.g., Medicare or Medi-Cal). If the facility has billed a governmental program for a service and has received or is entitled to receive any reimbursement for the reasonable cost of the service from the program, no amount attributable to the service shall be included in the computation of uncompensated services. However, if the facility has billed a governmental program for a service with the reasonable expectation of being reimbursed but the governmental program has denied coverage or reimbursement, the reasonable cost of the service may be included in the computation of uncompensated services except where denial was based upon determination that the services were not medically needed.

(3) Any amount attributable to a service for which payment in whole or in part would be available under a governmental program (e.g., Medicare and Medi-Cal) in which the applicant, although eligible to do so, does not participate, but only to the extent of the otherwise available payment.

(Exhibit 1)

91145. **Persons Unable to Pay for Services.** (a) Persons who shall incur liability for services rendered but from whom no compensation or reduced compensation shall be collected shall be determined from the following:

(1) All persons who request services and meet the resource and income eligibility standards of the Medi-Cal program, but who are otherwise ineligible for Medi-Cal.

(2) Any person whose income does not exceed 300 percent of the income eligibility standards of the Aid to Families with Dependent Children program, California Welfare and Institutions Code Section 11200 *et seq.*, including any person who is spending down their available income in order to qualify within the eligibility standards of the Medi-Cal program.

(b) In making services available, the applicant shall not discriminate in any way on the basis of race, ethnic origin, age, sex, physical or mental handicap, religious beliefs, or any other factor prohibited by law.

(c) The applicant shall not differentiate on the basis of medical diagnosis, or prognosis, except to the extent that such differentiations are made uniformly and equitably with respect to all persons without regard to the manner in which payment is to be made for services rendered.

(d) The applicant may exclude from needed services those items and services which generally enhance the personal comfort of the eligible person, but are not necessary in the diagnosis or treatment of an illness or injury.

(e) The applicant may on behalf of persons applying for uncompensated services seek certification or other proof from the local agency responsible for administration of eligibility standards under Medi-Cal that the person is or is not eligible for benefits under Medi-Cal. Local agencies shall cooperate with the applicant in determining the eligibility of any person.

(f) If within 6 months after the determinination that a person has incurred a liability for services rendered but no compensation or reduced compensation has been collected, the annual income of the person increases by 300 percent, the applicant may bill the person for the incurred liability provided that any compensation received from the person shall be deducted in computing uncompensated services for the year in which the compensation was received.

91147. **Notice to the Public of the Availability of Uncompensated Services.** (a) The applicant shall make available to any person, upon request, a copy of the criteria for eligibility to be considered for uncompensated services which shall include the name of the persons, department of the facility, or contracted agency responsible for establishing eligibility of the persons unable to pay for services and an explanation of the standards for eligibility determination. This information shall be multilingual where the applicant serves a multilingual community. A copy of this notice shall be filed with the Department for the Department's review and approval, which approval shall not be unreasonably withheld.

(b) The applicant shall post notices in substantially the following form which shall be multilingual where the applicant serves a multilingual community and which shall be posted in appropriate area within the applicant's facility, including but not limited to admissions offices, emergency rooms, and business offices.

Notice of Hill-Burton Obligation

Under the Hill-Burton program, this facility is obligated to render a reasonable dollar volume of services at no cost or less than full cost to persons who meet the eligibility standards established by the facility as required by the Hill-Burton program. Should you believe you may be eligible for such services, you should contact our business office (or designated person or other office). If you are dissatisfied with the determination in your case, you may contact the State Hill-Burton Agency at the State Department of Health, Facilities Construction Section, 744 "P" Street, Room 422, Sacramento, California 915814 (Telephone (916) 445-2603).

(c) An applicant that has selected a presumptive compliance guideline may do either of the following:

(1) Add to the notice language stating that the obligation is limited to a specified dollar volume of services and that the applicant has, during a specified period of time, already provided a volume of uncompensated services sufficient to satisfy this obligation.

(2) Post an additional notice stating that the applicant's obligation has been satisfied for the current period and stating when additional uncompensated services will be available. Any person inquiring about services will be given a written statement which shall state when additional uncompensated services may be available.

(d) The additional language of the notice shall be filed with the Department for its approval.

(e) The applicant shall also inform in writing all practitioners of the healing arts having staff privileges in the applicant's facility as to the existence of the program including criteria for eligibility of persons for uncompensated services, the amount of care available, and the applicant's method of conducting the program. The required notice to practitioners shall contain a statement as follows:

This hospital is required by law to provide a limited amount of service to persons unable to pay. The administration and enforcement of this law is the responsibility of the Department of Health, 744 "P" Street, Room 422, Sacramento, California 95814, Telephone (916) 445-2603. Persons desiring information concerning this law or who wish to file a complaint should contact the Department.

(f) The applicant shall provide a notice in substantially the same form as that required in this Section for posting in the county welfare office nearest to the applicant's facility.

(Exhibit 1)

91149. Waivers. (a) Before an applicant is recommended by the Department to the Secretary, the Department shall receive, consider, and make recommendations on requests for waivers from the obligation imposed by this Article on the basis of a review of the following documents:

(1) Audited financial statements for the past two fiscal years including at least the Balance Sheet, Statement of Income, and the Statement of Changes in Financial Position, Statement of Sources and Application of Funds.

(2) The budget adopted for the current fiscal year.

(3) Any additional information or verification reasonably required by the Department.

(b) The applicant may submit a written statement setting forth the reasons supporting a waiver.

(c) A waiver shall not be recommended unless to the satisfaction of the Department there is a clear and convincing evidence that the provision of uncompensated services as required by this Article is not financially feasible.

(d) Prior to recommending a waiver the Department shall publish in a newspaper of general circulation in the area served by the applicant a notice of the request for such waiver and shall invite public comment allowing not less than 30 days. All comments received shall be available for public inspection and shall be considered by the Department in arriving at its recommendation.

(e) Notice of the determination on the request for waiver shall be given to all interested persons and to the public before forwarding to the Secretary.

91151. Determination of the Dollar Volume of Uncompensated Services Required. (a) The Department shall for each fiscal year determine for each applicant what constitutes a reasonable dollar volume of uncompensated services in compliance with the obligation imposed by this Article. In no event shall the volume of uncompensated services established exceed the presumptive compliance guidelines except where sanctions have been imposed.

(b) The Department shall make determinations for each fiscal year of an applicant commencing 90 days after the effective date of these regulations. A determination shall be made within 60 days after receipt of the annual report.

(c) The Department shall, for the purpose of making a determination, review and evaluate the annual report, the annual plan, and related information submitted by each applicant and such additional information or verification as the Department may reasonably request.

(d) In making a determination, the Department shall consider the following:

(1) The financial status of the applicant, taking account of income from all sources, and financial ability to provide uncompensated services.

(2) The nature and quantity of services provided by the applicant in the primary geographic area from which the applicant draws its patients.

(3) The need within this area for the provision, without charge or at a charge which is less than reasonable cost, for services of the nature provided or to be provide by the applicant.

(4) The extent and nature of joint or cooperative programs with other facilities for the provision of uncompensated services, and the extent and nature of outreach services directed to the needs of underserved areas.

(e) A dollar volume of services less than that required by the presumptive compliance guidelines shall not be established unless the Department is satisfied that the reduced dollar volume is justified in accordance with the criteria listed in Section 91151 (d).

(f) In making a determination of a dollar volume of uncompensated services, the Department may consult persons who have knowledge and experience in the social aspects of health service, operation of health facilities, and general accounting procedures.

91153. Notification as to Level of Uncompensated Services; Public Notices; Review. (a) The Department shall notify the applicant in writing of the dollar volume of uncompensated services which has been established for the applicant for the fiscal year.

(b) At the time of notifying the applicant, the Department shall also publish as a public notice in a newspaper of general circulation within the community served by the applicant the dollar volume that has been establish and a statement that documents upon which the Department based its determination are available for public inspection at a location and time prescribed by the Department.

(c) In the case of the establishment by the Department of a dollar volume which is less than the presumptive compliance guideline, such notice shall also include a statement that persons wishing to object to the dollar volume established may do so by writing to the Department within 20 days after publication of the notice.

(d) The applicant may object to any level established which is greater than the level proposed in its annual plan.

(e) The applicant or any person or persons residing or located within the area served by the applicant, or any organization on behalf of such person may submit to the Department within 20 days of the publication of the notice objections to the dollar volume established by the Department. Objections may be supported in writing by factual information and argument.

(f) The Department shall give public notice of receipt of the objections and shall make the objections and the supporting documents available for public inspection and comment.

(g) The Department may set a public hearing on the objections and shall give notice of such hearing to all interested parties and to the public.

(Exhibit 1)

(1) A public hearing if held shall be in accordance with Chapter 5 (commencing with Section 11500), Part 1, Division 3 of Title 2, Government Code. The findings and recommendations determined by such public hearing shall be considered by the Department in making a final determination.

(2) The Department shall, within 60 days of the expiration of the period within which objections may be filed, rule upon the objections in writing, stating the reason for sustaining or overruling, in whole or in part, and establishing finally the dollar volume of uncompensated services either the same as, above, or below the dollar volume previously established, provided that justification for such altered level exists according to the criteria established under the determination of the dollar volume of uncompensated services required.

(3) Notice of the final determination shall be mailed to all parties who filed objections or who participated in the proceedings leading to the redetermination.

(h) Within 20 days of receipt of written notice of the Department's final determination, the applicant or any other interested person or organization may submit to the Secretary a written request for review of the Department determination in accordance with procedures provided by 42 C.F.R. Section 53.112 (h) (6) and related federal laws or regulations.

(i) The dollar volume of uncompensated services established for an applicant under this section for any fiscal year shall constitute a reasonable dollar volume of services to persons unable to pay during the fiscal year.

91155. Records of Uncompensated Services Provided; Availability to Department. (a) The applicant shall maintain accurate and adequate records to demonstrate the dollar volume of uncompensated services provided for the purpose of complying with this Chapter and shall make available such records to representatives of the Department. Summary reports shall be made available to any interested person upon request. The records shall be maintained at the facility where the services are provided.

(b) The applicant shall also make available to the Department such records as are necessary to verify the persons to whom services were provided under this Chapter, provided, that the Department and the applicant shall take all reasonable steps to protect the privacy of those persons and the confidentiality of records.

91157. Complaints. (a) The Department shall receive, consider and investigate where necessary all complaints alleging violations of this Chapter.

(1) The Department shall send a copy of the complaint to the challenged applicant together with an explanation of the complaint procedure under this Section within 20 days from the decision by the Department to investigate a complaint. The applicant shall have 20 days from the date of receipt in which to file with the Department a written explanation or response.

(2) Unless satisfied with the response of the applicant, the Department shall conduct an investigation of the complaint and shall conclude that investigation within 30 days of the receipt of the applicant's response or explanation.

(3) The Department shall notify the applicant and the complaining party of its conclusions and proposed remedies or sanctions, if any.

(4) The administrative remedies listed in this Section are not intended to preclude any other remedies in law or at equity which are contemporaneously available to a complainant.

91158. Departmental Evaluation. (a) The Department shall conduct, at least annually, an evaluation to determine compliance with this Chapter and shall report to the Secretary, in writing, each applicant's compliance the disposition of each complaint, the proposed corrective action to be taken by each applicant found not to be in compliance, and the status of such corrective action.

(b) If the Department determines that an applicant is not in compliance with this Chapter, the Department shall notify the applicant of its proposed sanctions.

91159. Sanctions. (a) The Department may impose appropriate remedies or sanctions against an applicant found to be in violation of this Chapter. The sanctions shall include, but are not limited to, the following:

(1) Withdrawal or revision of any approval given the applicant for the provision of uncompensated services.

(2) Rendering the applicant ineligible for federal and state financial assistance under the Hill-Burton Program or the California Health Facility Loan Guarantee Program.

(3) Requiring the applicant to take corrective action to ensure compliance with this Chapter, including but limited to filing a plan for corrective action or altering the applicant's procedures for making eligibility determinations and estimating uncompensated services.

(4) Requiring that the applicant increase the dollar volume of uncompensated services in a subsequent year. The increased dollar volume may exceed the presumptive compliance guidelines, and extend the obligations imposed by this Article for additional years past the durational limitations imposed until the obligation under this Article is fulfilled.

(5) Referring the violation to the Office of the Attorney General of California for legal action authorized under existing law or any other remedy at law or equity.

91161. Report by Department. The Department shall promptly report to the Regional Attorney and Regional Health Director of the Department of Health, Education, and Welfare the initiation of any legal action against a facility or against the Department involving compliance with the assurance.

(Exhibit 1)

Article 3. Community Service

91163. Applicability. The provisions of this Article apply to every applicant which heretofore has applied or shall hereafter apply for and receive funds which have been paid under Title VI of the Public Health Service Act, Assistance for Construction and Modernization of Hospitals and Other Medical Facilities, also known as the Hill-Burton Act, 42 U.S.C. 291 *et seq.*, or under Title XVI of the Public Health Service Act, 42 U.S.C. Section 3000, and has given or hereafter will give an assurance for community service.

91165. Duration of Obligation. The community service obligation shall be a continuing one without limited duration. The applicability of this provision shall not be governed by the 20-year limitation referred to in 42 C.F.R. Section 53.113(a).

91167. Assurance. Before an application for federal assistance under the program is recommended by the Department to the Secretary, the Department shall obtain an assurance from the applicant that the applicant will furnish a community service.

91169. Compliance. (a) Each applicant shall make services available to the general public. Each applicant may limit the availability of services to persons in the community served only on the basis of medical indigency, or type or kind of medical or mental disability.

(b) Each applicant shall make arrangements, if eligible to do so, for reimbursement for services with:

(1) Those principal state and local governmental third-party payers which provide reimbursement for services that is not less than the actual cost of such services, as determined in accordance with accepted cost-accounting principles, and

(2) Medicare and Medi-Cal.

(c) An applicant may refuse to provide services to a person requesting services on the basis of their medical indigency only after a determination has been made that the person is not:

(1) Eligible for Medicare, Medi-Cal.

(2) Likely, based on a reasonable estimate of length of stay and services to be received, to incur such liability as to become eligible for Medi-Cal during the planned course of treatment in the applicant's facility.

(3) Eligible for care under Article 2 of this Chapter.

(d) The applicant shall in cooperation with appropriate local agencies counsel each person seeking services at the applicant's facility as to the person's potential eligibility for Medi-Cal, Medicare, or benefits from other governmental third-party payers.

(e) No collection efforts shall be made against a person with regard to services that would be covered by Medi-Cal, Medicare, or a governmental third-party payer, until such counseling was provided and the person refused to cooperate in making application for such benefits. Applicants shall not refuse to accept assignment of Medicare claims pursuant to 42 U.S.C. Section 1395u (b) (3) (B) (ii).

(f) Persons in need of emergency treatment shall not be denied services on the basis of medical indigency unless the applicant reasonably determines that the person will be transferred and admitted to another facility without aggravation of medical condition.

(g) Unless the applicant operates an organized outpatient department, open daily and scheduled evening hours, and unless all physicians staffing the outpatient department have staff admitting privileges at the applicant's facility, the applicant shall make available to the Department and to any interested person a list of all physicians with staff privileges at the applicant's facility, which includes:

(1) Name.

(2) Specialty.

(3) Languages spoken.

(4) Business address and phone number.

(h) Each applicant shall take such additional steps as may be reasonably necessary to ensure that admission to, and the services of, the applicant's facility will be available to beneficiaries of the governmental programs specified in Section 91169(b) without discrimination. Steps may include requiring physicians with staff privileges to accept government programs beneficiaries who request treatment.

91171. Compliance Reports. (a) Each applicant shall, upon request, make available to the Department or a member of the public an annual report of compliance to this Article.

(b) The annual report shall set forth sufficient information and assurance to indicate the applicant's compliance with this Article. The report shall include at least the following:

(1) By category for inpatient admissions, emergency admission, and where the facility has a separately identifiable outpatient service:

(A) The total number of patients receiving services.

(B) The total number of Medi-Cal patients served.

(C) The total number of Medicare patients served.

(D) The dollar volume of services provided to each patient category listed in (A), (B), and (C) above.

(2) If the annual report of the applicant indicates that persons eligible for Medi-Cal and Medicare are not utilizing the applicant's facilities in a proportion that is reasonable when compared to the proportion of Medi-Cal and Medicare patients in the community served by the applicant, and if the Department determines that this low utilization is unreasonable, the Department shall require from the applicant an explanation therefor and a description of the steps to be taken in the next fiscal year to assure that an appropriate proportion of patients are persons eligible for Medi-Cal or Medicare.

(3) Such other information and assurance as the department may reasonably require.

(c) If the Department has reason to believe that the assurances required under this Chapter are not being complied with or has instituted an investigation of a complaint, the applicant shall make available to the Department adequate documentation of the applicant's compliance with this Chapter.

(Exhibit 2)

(d) Such documentation may include, if available, information concerning each person who without prior physician authorization has sought services at the applicant's facility and who has been referred to another facility or who is not otherwise provided with the requested services.

(e) The Department and the applicant shall take all reasonable steps to protect the privacy of patients and the confidentiality of all data utilized in the evaluation of an applicant's compliance.

91173. Notice to the Public. (a) The applicant shall post notices in substantially the following form which shall be multilingual where the applicant serves a multilingual community and which shall be posted in appropriate areas within the facility, including but not limited to admissions offices, emergency rooms, and business offices:

Notice of Community Service Obligation

This facility is required by law to make its services available to the general public and may limit the availability of such services only on the basis of age, indigency, or type or kind of medical or mental disability. This facility is prohibited by law from discriminating against Medi-Cal and Medicare patients. Should you believe you may be eligible for Medi-Cal or Medicare, you should contact our business office (or designated person or office) for information on applying. If you are in need of a physician to provide you with services at this facility, a list of physicians on the staff of this facility will be provided to you by our business office. If you believe that you have been refused services at this facility in violation of the community service obligation, you should inform (designated person or other office) of such complaint. You should also contact the State Department of Health, Facilities Construction Section, 744 "P" Street, Room 422, Sacramento, CA 95814, telephone (916) 445-2603. Persons desiring information concerning this law or who wish to file a complaint should also contact the Department.

(b) The applicant shall also inform in writing all practitioners of the healing arts having staff privileges in the applicant's facility as to the existence of the community service obligation. The required notice to practitioners shall contain a statement as follows:

This hospital is required by law to provide a community service and accepts Medi-Cal and Medicare patients. The administration and enforcement of this law is the responsibility of the Department of Health, 744 "P" Street, Room 422, Sacramento, CA 95814, telephone (916) 445-2603. Persons desiring information concerning this law or who wish to file a complaint should contact this Department.

(c) Copies of the notices required under this section shall be filed with the Department for the Department's review and approval.

(d) The applicant shall provide a notice in substantially the same form as that required in this section for posting in the county welfare office nearest to the applicant's facility.

91175. Compliance and Departmental Evaluation. (a) The Department shall receive and investigate all complaints alleging violations of this Chapter in accordance with the procedures and requirements of Section 91157.

(b) The Department shall conduct, at least annually, an evaluation of the records maintained by the applicant to determine compliance with this Chapter in accordance with the procedures and requirements of Section 91157.

91177. Sanctions. The Department may impose appropriate remedies or sanctions against an applicant found to be in violation of this Chapter which will include, but not be limited to, those sanctions listed in Section 91159.

(Exhibit 2

INDIGENT MEDICAL CARE
in San Diego & Imperial Counties

Report & Recommendations of
the INDIGENT MEDICAL CARE COMMISSION

of the Health Systems Agency of San Diego & Imperial Counties

March, 1980

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INDIGENT MEDICAL CARE

IN SAN DIEGO AND IMPERIAL COUNTIES

I. INTRODUCTION AND SUMMARY

A. Commission Charges and Composition. In response to reported problems in the provision of indigent medical care in our area, the Health Systems Agency (HSA) of San Diego and Imperial Counties established the Indigent Medical Care Commission in summer, 1979. The HSA Governing Body's charge to the Commission was that it "review and implement solutions to problems of indigent medical care in San Diego and Imperial Counties." The Governing Body also specified "that the Commission utilize existing research and information to the maximum extent possible so that it not duplicate previous research efforts, and that its main focus be on implementation." The Governing Body alloted the Commission six months to complete its work, and the Commission held to this time frame by beginning in September, 1979, and concluding its deliberations in March, 1980.

As specified by the Governing Body, the Commission memberships was broadly representative of the individuals and groups within the community with a particular interest and concern in the area of indigent medical care. The thirty-seven members included representatives of low income and ethnic groups, area hospitals, medical societies, emergency room physicians, dentists, local government, and business. A list of members with brief biographic sketches is at Attachment A.

B. Summary of Findings. The Commission defined "indigents" as (1) low-income persons who are ineligible for Medi-Cal, such as undocumented aliens; (2) Medi-Cal recipients; and (3) those persons slightly above the Medi-Cal income cut-offs who cannot afford necessary medical care (the working poor). The Commission determined that there are, indeed, significant problems in access to necessary health care for all three groups.

The Commission spent most of its time examining the necessary role of all the responsible parties in what should properly be a system of shared responsibilities for indigent medical care. The first such responsibility, and the one least fulfilled at present, rests with the Federal Government. The strong conclusion of the Commission was that the Federal Government should provide the main share of funding of health care of indigent undocumented aliens. The Commission also decided to pursue a Federal demonstration grant to provide health services to indigents who do not qualify for Medi-Cal (Medicaid) in our area.

The Commission next turned to the State level of Government and determined that it, too, is not living up to its appropriate responsibility for indigent medical care. The State passes the buck to the County Governments by assigning them all such responsibility, but then does not provide any standards, oversight or funding for the indigent care provided by the counties. The result is enormous variation among counties in the availability of indigent medical care, with San Diego and Imperial Counties being among the lowest in the amount of County-funded care provided per indigent. The

Commission recommended that the State Government open up Medi-Cal to the participation of more indigents, and discontinue its procedure of notifying the Immigration and Naturalization Service whenever an undocumented alien applies for Medi-Cal -- a procedure which constitutes the main deterrent to necessary health care for such persons.

The Commission made an extensive set of recommendations to the San Diego County Government concerning its policies on indigent medical care, and endorsed the proposed new indigent care policies for Imperial County developed by a county government task force there.

The Commission recognized the appropriate responsibility of private physicians, hospitals and clinics in the provision of indigent medical care, as part of the overall system of shared responsibilities of government and the private sector. The Commission recommended actions to safeguard against discriminatory or inadequate treatment of indigents by private providers.

The eleven Hill-Burton hospitals in HSA 14 have a special responsibility in the provision of indigent medical care, and the Commission developed a detailed plan for assuring that this responsibility is fulfilled.

If approved by the voters in June, Jarvis II promises to have a devastating effect on not only indigent care in our area, but also health services across the board. Accordingly, the Commission recommended that combatting Jarvis II be the top priority of this HSA in the coming months.

The Commission concluded that significant problems remain in the provision of indigent medical care in our area, but the mechanisms and recommendations the Commission has set in motion should go a long way toward resolving those problems in the future.

II. STATEMENT OF PROBLEMS

Indigent persons in San Diego and Imperial Counties have significant problems in obtaining necessary medical care. These problems are manifest both in terms of denials of care -- providers who refuse to accept new Medi-Cal patients, for example, or who refuse to treat indigent persons who are not eligible for Medi-Cal such as undocumented aliens -- and in terms of delays in obtaining necessary care. There is no question that access to health care for indigent people in San Diego and Imperial Counties is limited and insufficient to meet the needs of such people.

Such limited access leads to not only more serious illnesses and more costly care over the long term for the indigent person, but threats to the well-being of society at large in the case of communicable diseases. In Orange County, for example, when a new citizenship screening procedure was instituted that dissuaded many undocumented aliens from seeking necessary care, the annual tuberculosis rate for the county went up 47 percent, the rubella rate increased 53 percent, the syphillis rate 153 percent, and the infectious hepatitus rate 14 percent.[1]

[1] California Dept. of Health Services, Office of Statewide Health Planning and Development, Draft, California State Health Plan, 1980-85, pp. 47 and 50.

On the other hand, numerous studies have shown that the low-income have more serious health problems and a greater need for health services than the population at large.[2] The death rate for low-income people in the United States, for example, is 60 percent higher than for high-income people, the infant mortality rate is 90 percent higher, and the number of disability days each year is 220 percent higher.[3]

The Commission on Indigent Medical Care determined that there are three main groups of indigent persons in our area affected by problems in obtaining necessary medical care:

1. Persons within the Medi-Cal income limits who are not eligible for Medi-Cal, such as undocumented aliens;

2. Medi-Cal recipients; and

3. The working poor, or those persons slightly above the Medi-Cal income cut-off who cannot afford necessary care.

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[2] See, for example, U.S. Department of Health, Education, and Welfare, "Towards a Comprehensive Health Policy for the 1970s -- A White Paper", Washington, D.C., U. S. Government Printing Office, 1971, p.2.
Cambridge Research Institute, Trends Affecting the U. S. Health Care System, U. S. Department of Health, Education and Welfare, Publication No. (HRA) 76-14503, Germantown, Md.: Aspen Systems Corp., January, 1976, pp. 20-30.
U. S. Department of Health, Education and Welfare, Office of Health Resources Opportunity, Health of the Disadvantaged: Chartbook, U. S. DHEW, September, 1977, pp. 18-48.
U. S. Department of Health, Education and Welfare, National Center for Health Services Research, Health United States: 1976-77, U. S. DHEW Publication No. (HRA) 77-1232, Hyattsville, Md.; U. S. DHEW, 1977, pp. 133-217.

[3] U. S. Department of Health, Education, and Welfare, Health of the Disadvantaged: Chartbook, op. cit., p. 2.

A. Low-Income Persons Ineligible for Medi-Cal. The largest group within this category in San Diego and Imperial Counties is undocumented aliens. Other such persons appear to be transients, residents of other states, those who refuse to complete the Medi-Cal application process, or other low-income persons for whom establishing eligibility for Medi-Cal or Medicaid in another state is extremely difficult or time consuming for the health provider.

In terms of undocumented aliens, a 1977 study by the San Diego County Government estimated that about 92,000 such people reside in San Diego County and about the same number in Imperial County.[4] Even though these figures were based on estimates from the U. S. Border Patrol, Immigration and Naturalization Service (INS) and the Customs Bureau, the 92,000 figure for Imperial County seems much too high since the total population for that County was estimated to be 87,500 in 1977. The discrepancy may be explained in part by the fact that many of the undocumented aliens in Imperial County are migrant farm workers, who move to other areas during different times of the year.

There are many types of "undocumented aliens" depending on the amount of time they have been in the U. S. and the particular circumstances under which they entered the country. The health services utilized and needed by such persons vary somewhat accordingly. Green card holders, or those with temporary work permits, are not eligible for Medi-Cal, and neither are those with 72 hour passes or other temporary official papers for being in the U.S. Pregnant women with 72 hour passes often come across the border when labor begins so that their children may be born in this country as U. S. citizens.

Most undocumented aliens in this area seek health services only when absolutely necessary, and that usually means in the case of a severe emergency. One undocumented woman suffered third-degree burns over more than 50 percent of her body in 1978 and yet refused to go to a health facility for four days despite her excruciating pain and life-threatening condition. Her case came to light later because she was refused treatment at an area hospital when she finally sought care and had to be transported to Mexico for treatment.

There is some evidence that the longer undocumented aliens remain in the U. S., the less reluctant they are to seek necessary health services. Most such persons are also more likely to be able to pay for necessary care and, indeed, the repayment rate for Mexican nationals without any form of health insurance is significantly higher than the repayment rate for similar American citizens, according to the San Diego County Government and other health providers. The problem of undocumented aliens is more often that they are unable to pay because of their particularly low incomes. A 1977 study by the California State Government estimated that the average wage of an undocumented alien is only $2 to $3 per hour[5], and that only 65 percent of undocumented aliens are employed.[6]

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[4]County of San Diego, Human Resources Agency, A Study of the Socioeconomic Impact of Illegal Aliens on the County of San Diego, January, 1977, p. 44.

[5]California Dept. of Health Services, Office of Planning and Program Analysis, The Impact of Undocumented Aliens Upon Health Care Programs Within California, Oct., 1977, p. 8

[6]Op.Cit., p. 41.

In addition to their frequent inability to pay, other important barriers to health care for undocumented aliens are the California State procedure of notifying INS whenever such persons apply for Medi-Cal, and their reluctance to incur any form of "public debts" (such as unpaid medical bills) that would later be held against them when they apply for official residency status. The INS notification fuels the fear of undocumented aliens that seeking health services will lead to their arrest and deportation. Another barrier to care is their frequent inability to speak English or communicate effectively in English.

Most importantly, some providers of health care in San Diego and Imperial Counties are reluctant to treat undocumented aliens because of their frequent inability to pay. The provision of emergency services to such people -- and indeed all people -- is mandated by California law, but elective hospital care is almost impossible to obtain if the undocumented alien cannot pay. Primary care outside community clinics and public health programs is also difficult to secure.

This reluctance to treat undocumented aliens affects not only such people, but many other Hispanics in our area. The frequent suspicion when an Hispanic person enters a hospital or other health facility is that he is an undocumented alien, and that suspicion can have serious consequences if the person is unconscious or unable to prove his status.

An unconscious 16-year old boy with a gunshot wound in the head was not authorized transfer to an area hospital for necessary neurosurgery in April 1979. The receiving neurosurgeon thought he might be an undocumented alien. The boy was a full-fledged American citizen but his skin was the wrong color and he could have died for it.

An important fact about undocumented aliens that bears on their right to obtain necessary health care is that they contribute enormous funds to all levels of government in the form of taxes and other payments. The 1977 California State Study concluded that the 1.5 million undocumented aliens in California pay about $1.5 billion a year to the Federal, State, and local governments. About 60 percent of this goes to the Federal Government in the form of Federal income and social security taxes. Another 30 percent goes to the State Government in the form of State income tax, sales tax, and disability insurance, workman's compensation and unemployment insurance contributions; and the last approximately 10 percent goes to the County Government in the form of sales and property taxes.[7]

Many of these tax contributions are "windfall profits" to the Federal and State Governments since they would have to be rebated at the end of the year if the undocumented aliens filed tax returns. The incomes of undocumented aliens are generally so low that they would owe little or nothing in taxes if they filed returns, but they usually do not out of fear that it will lead to their discovery and deportation.

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[7] Op. Cit., p. 43. Based on other studies, the State Study concluded that taxes are withheld from the paychecks of about 80 percent of the undocumented aliens who are employed (p. 41).

In contrast to their tax contributions, undocumented aliens do not seek or receive many public services. One study, for example, showed that only 4 percent had ever collected unemployment insurance, 4 percent had children in U. S. schools, 1 percent had received food stamps, and .5 percent had ever been on welfare.[8]

The overall conclusion of the California State study was that undocumented aliens contribute more than three times the amount to government in taxes that they receive in public services.[9] The San Diego County Government study reached the same conclusion, but even more strikingly. It estimated that the undocumented aliens in San Diego County contribute almost $50 million a year to government, but receive only about $2 million a year in public services.[10]

A number of Commission recommendations concerning health care for undocumented aliens are contained in later sections of this report on the roles of the Federal, State and County Governments in indigent health care.

In addition, it is this Commission's RECOMMENDATION that the Health Systems Agency co-sponsor with community groups a conference on the provision of health care to undocumented aliens in this area. This conference would be a practical workshop, particularly aimed at those agencies and individuals who help guide undocumented aliens toward available sources of care, and emphasizing the current existing health care resources for such persons both in this area and, when transfers are necessary and appropriate, adjoining areas of Mexico.

B. Medi-Cal Recipients. Medi-Cal patients in our area can have difficulty in finding physicians who will treat them, particularly as new patients. Data comparing the area of residency of Medi-Cal patients in HSA 14 with the area in which they receive hospital services (Attachment A) indicate Medi-Cal access problems in Coastal North San Diego County (SAC II) and East San Diego County (SAC VI). Significantly fewer Medi-Cal patients received services in SACs II and VI than lived there in 1978.

The low Medi-Cal reimbursement rates no doubt affect this reluctance of some physicians to accept Medi-Cal patients. Currently, Medi-Cal pays only about 20-60% of usual charges for services, and this proportion will probably decline even more if Jarvis II passes in June and Medi-Cal reimbursement rates are again frozen as after Jarvis I. For this and a number of other reasons affecting indigent health care, the Commission later recommends that combatting Jarvis II be the top priority of this Health Systems Agency in the next three months.

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[8] David S. North and Marion T. Houston, "The Characteristics and Role of Illegal Aliens in the U. S. Labor Market: An Exploratory Study", cited in the 1977 California State study, Op. Cit. pp. 32-33. The North and Houston findings were based on interviews with 793 apprehended undocumented aliens.

[9] California Department of Health Services, Op. Cit., pp. 5 and 48.

[10] County of San Diego, Op. Cit., pp. 57 and 173.

C. The Working Poor. Many of those slightly above the Medi-Cal income cut-offs can have serious problems in obtaining necessary care because of their inability to pay. Such persons are often self-employed or do not have health insurance through their employers. Particularly when serious illness or a need for hospitalization arises, necessary health care may force them into virtual bankruptcy. Their utilization of preventive or primary care, moreover, is the lowest of all income groups, which means that they are more likely to let an illness or injury progress to a serious state before seeking treatment.

One recommendation proposed to the Commission was that the County Governments could help pay the Medi-Cal "spenddowns" of such persons to make them eligible for Medi-Cal. A working poor person could then pay back the County over a period of time and in small increments that would not decimate his monthly budget. Such an arrangement was instituted by Santa Clara County several years ago, but was later discontinued because of high overhead costs and a drop in the Medi-Cal eligible population in that county.

As a result of its proposal by a Commission task group, the San Diego County Government is now considering implementation of such a proposal on a pilot basis in an area of the county. The outcome of Jarvis II will undoubtedly be decisive in terms of whether the County Government continues to pursue the proposal.

III. ROLES OF RESPONSIBLE PARTIES

A. Federal Government. The strong conclusion of the Commission is that the Federal Government should bear the main responsibility for funding health services for indigent undocumented aliens. The reasons are, first, that the main bulk of tax revenues of such people go to the Federal Government. Secondly, it is the Federal Government -- not the State or local governments -- that has responsibility for the border and for the presence of undocumented aliens in this country. Neither the state nor local governments have control over the border and are reluctant to accept responsibility for health care or other services for such people as a result. Lastly, health care is a service essential to life itself and should not be tied to citizenship status. Not only can denials of care lead to disability or death of undocumented aliens themselves, but letting health problems go unchecked and untreated can pose a danger to the entire community.

The Federal Government now funds health care for aliens only on a very limited basis through Federal grants to certain community health centers, migrant health programs, and rural health programs. Such centers and programs that receive Federal funds must offer services to all persons in need regardless of citizenship status, but they are limited both in terms of geography and types of services covered. No Federal funding is available for hospital care of indigent undocumented aliens.

Legislation has been introduced in Congress annually for the past 20 years or more proposing that the Federal Government provide specific funding for medical care of undocumented aliens. Currently, such bills are H.R. 820 (H.R. 4708), H.R. 1871, H.R. 3628, and H.R. 3888. The legislation has never proceeded far in Congress, however, and its chances of passage have always been slim to nonexistent. The main reason it has not received much consideration is that medical care for undocumented aliens is perceived as a California - New York - Texas problem, and those three states are greatly outnumbered by the rest of the country in Congressional votes.

Two key Federal officials attended the January 1980 meeting of the Commission and offered two suggestions of ways in which this area could attempt to obtain Federal funding for undocumented alien health care. These suggestions are in addition to our continuing to strongly advocate Federal legislation that would add such persons to Medicaid (Medi-Cal) or provide other comprehensive solutions.

The first suggestion is to attempt to get the number of undocumented aliens in an area included as a factor in the determination of the amount of Federal 314(d) formula grant funds for health care allocated by the Federal Government to the States and the States in turn to the County Governments.

Subsequent investigation of this proposal proved it not promising or feasible for the following reasons:

1. The amount of 314(d) formula grant funds is relatively small and would not go far in addressing the problems of undocumented alien health care, even if they were all expended for such a purpose in areas such as San Diego and Imperial Counties. (Given the other current uses of the 314(d) funds and groups who would lobby against any reductions in those current uses, major shifts of funds to undocumented alien health care at either the State or local levels would be difficult to accomplish politically). Imperial County received only $21,196 in 314(d) funds in the 1978-79 fiscal year and San Diego County received $213,584. The State of California will receive $5,139,070 in 314(d) funds next year, compared to an estimated cost of $80 million for providing health care to undocumented aliens in Los Angeles County alone last year.

2. The current Federal-to-State allocation formula is determined by Federal legislation, and it would take an act of Congress to change that formula. The current formula is based on only two factors, population and the net State revenue devoted to health care. California uses the same Federal formula in its allocation of 314(d) funds to the counties, and State officials feel the State formula could not be changed without a change in the counterpart Federal formula.

3. Hard and consistent data on the number of undocumented aliens residing in any area does not exist, and so any figures that could be plugged into a revised 314(d) allocation formula would be questionable at best.

The second suggestion offered by the Federal officials was that San Diego and Imperial Counties attempt to obtain a Federal grant under Section 1115 of the Medicaid law (Title XIX) to provide health services to undocumented aliens on a demonstration basis in order to study the exact magnitude of the problem and the national implications of including care for such persons in the national health insurance proposals now under consideration in Congress. The Federal officials recommended that both health and social services be included in such a proposal since Title XIX covers both. They also recommended that the proposed project be aimed at (a) identifying the population of undocumented aliens in terms of numbers, particular health and social problems, and general characteristics; (b) determining how and to what extent they would utilize health and social services if the services were offered under Federal sponsorship; and (c) identifying the national consequences of including such persons in Medicaid or national health insurance proposals.

Between $1 and $4 million will be available for Section 1115 grants throughout the country in the next fiscal year. Grants are not awarded on the basis of a State-by-State allocation, but all applications compete nationally on the basis on merit.

One important specification is that the application must be filed by the "single State agency for Medicaid", which in California's case is the Department of Health Services. A key official of that Department attended our February 1980 meeting and discussed with us in informal sessions the prospects of the State forwarding such a proposal on our behalf. He felt the Department of Health Services would be favorably inclined to such a proposal -- if Jarvis II does not pass. Jarvis II would so undermine other health programs that the State's time and attention would have to be turned to them if Jarvis II passes.

In addition, a factor which considerably helps a Section 1115 application's chances of being approved by the Federal Government is whether it includes commitments from the State Government, local government and community groups to help in its funding, on a matching or other basis. The Department of Health Services' official stated that the chance of any State match for the proposed project would be nil if Jarvis II passes, but is a distinct possibility if it does not pass. Similarly, a contribution of local government toward the project is believed to be impossible unless Jarvis II fails.

For the above reasons, it is this Commission's RECOMMENDATION that, if Jarvis II fails, this Health Systems Agency should take the lead in developing a Medicaid Section 1115 proposal for funding of health care of undocumented aliens in San Diego and Imperial Counties on a demonstration basis. The HSA would attempt to enlist the assistance and financial support of concerned community groups, the two County governments, and the State Government in such a proposed project. The

actual application for the project would be filed through the State Department of Health Services, as required by the Federal Government.

In October 1979, the HSA provided testimony to the National Democratic Party Committee advocating Federal financing of health care for indigent undocumented aliens. The HSA similarly testified before the Federal Select Commission of Refugee and Immigration Policy in February 1980. It is this Commission's
RECOMMENDATION that the HSA, the San Diego and Imperial County Governments, and the California State Government should continue to strongly advocate Federal funding of health care for indigent undocumented aliens, both in Congress and at every available opportunity.

B. State Government. The California State Government does not provide any funding for the medical care of indigents who do not qualify for Medi-Cal, but assigns any such responsibility to local governments in Section 17000 of the State Welfare and Institutions Code:

> "Every county and every city shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accidents, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

Section 17001 adds:

> "The board of supervisors of each county, or the agency authorized by county charter, shall adopt standards of aid and care for the indigent and dependent poor of the county of city and county, and such standards shall be open to public inspection."

The State assigns this responsibility for indigent medical care to the counties and then sets no standards, makes no specific requirements, nor provides any oversight of what the counties do. The result is an enormous variation among counties in how they interpret and attempt to comply with Section 17000. As pointed out by a recent San Diego County Government survey of all California counties, some counties do absolutely nothing and other counties have extensive indigent medical care programs in response to Section 17000. The foremost of these counties is Los Angeles, which provided almost $200 million in medical services for indigents this year. About $80 million of that was estimated to be for the care of undocumented aliens. Half of the counties that responded to the survey reported that they provide services to undocumented aliens under their Section 17000 programs.

In February 1979, the State Attorney General issued an opinion[11] that California counties are not authorized to provide non-emergency (elective) services to undocumented aliens under Section 17000. The

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[11] California State Attorney General, Attorney General's Opinions, Volume 62, Opinion No. CV-78-38, February 9, 1979, pp. 70-77.

opinion also held that counties may provide non-emergency services to such persons if they apply for Medi-Cal and, in the course of applying, claim legal residency status. Lastly, the opinion held that counties may require proof of citizenship prior to providing non-emergency services. This last provision resulted in a number of counties instituting citizenship screening procedures prior to the delivery of health services. To the extent that Spanish surname or language is used as a reason to screen, civil rights violations may be occurring, according to the Statewide Office of Health Planning and Development.[12] As noted earlier, these citizenship screening procedures resulted in a dramatic rise in communicable diseases in at least Orange County. Two important points concerning the Attorney General's opinion are that is being challenged in court by Chicano and other groups, and that it refers only to elective -- not emergency -- health services.

In addition to the Section 17000 mandate on the counties, the State assigns some responsibility for indigent medical care to hospitals with emergency rooms. Section 1317 of the Health and Welfare Code requires that all such hospitals provide emergency care to any person needing such services, regardless of their ability to pay.

California is unusual within the country in that it includes within Medi-Cal a category of "medically indigent" persons. Most other states limit their Medicaid programs to only those persons mandated by Federal law, namely those qualifying for other public assistance programs such as welfare, aid to families with dependent children, or aid to the aged, blind or disabled. The "medically indigent" category of Medi-Cal recipients is comprised of those persons who qualify solely because of their low incomes. All the rest of Medi-Cal is paid for jointly by the Federal and State Governments on a 50-50 matching basis, but the full cost of the "medically indigent" category would appear to be the first to go -- at least for adult medically indigent persons -- if Jarvis II passes.

In January 1979, the State Department of Health Services proposed to the Governor that all undocumented aliens except those under warrant for deportation be made eligible for Medi-Cal. In January 1980, the Governor rejected this proposal because of cost, which was estimated to be at least $90 million a year.

California requires as a standard procedure the notification of INS whenever anyone applies for Medi-Cal who is suspected of being an undocumented alien. The purpose of the procedure is for INS to verify the residency status of the person so that California can comply with the Federal requirement that all persons receiving Medicaid be residing in this country "under the color of law".[13] The Federal officials present at the Commission's January meeting stated that the INS notification procedure is not a specific requirement of the Federal Government, and California could use any procedure it might choose to certify compliance with the general "color of law" requirement. Such alternative procedures

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[12]California Department of Health Services, Offices of Statewide Health Planning and Development, <u>Op</u>. <u>Cit</u>., p. 49.

[13]Title 42, Section 435.402, <u>Federal Code of Regulations</u>.

could include the simple declaration recommended by the Department of Health Services that the applicant and his spouse are not under warrant for deportation. Only if a subsequent Federal audit revealed significant false disclosures under such a procedure would it be disallowed by the Federal Government.

Currently, the INS notification procedure takes a number of months, and the Medi-Cal applicant is eligible for Medi-Cal during that entire time. Even if his application is later denied because of INS non-verification, the Medi-Cal payments for medical services received during that time remain in effect.

The problem with the INS notification procedure is that it acts as a strong deterrent to the seeking of health services by undocumented aliens or those who have any doubts as to their residency status. Most such persons are convinced that the INS notification will result in their arrest and deportation, no matter how severe their need for health services. Consequently, it is this Commission's
RECOMMENDATION that the State immediately discontinue its procedure of notifying INS whenever someone applies for Medi-Cal who is suspected of being an undocumented alien. Instead, the State should adopt the recommendation of the Department of Health Services that the Medi-Cal application form merely ask whether a person or his spouse is "under warrant for deportation." If the response to that question is negative, the applicant would be eligible for Medi-Cal if he meets the income and other criteria for the Medi-Cal program.

Another State procedure that seems to have little justification concerns Medi-Cal "sticky labels", which verify the patient's Medi-Cal eligibility for reimbursement purposes. County and University of California health facilities can obtain verification of a patient's Medi-Cal eligibility without "sticky labels" and on their own in order to file for Medi-Cal reimbursement, but private providers cannot, according to State regulations. If a Medi-Cal patient forgets or does not bring a sticky label when he seeks services from a private provider, there is little incentive for him to return later with the label once the services have been rendered. The result is that the private provider is unable to obtain Medi-Cal reimbursement. This procedure seems to unfairly discriminate against private providers, and so it is this Commission's
RECOMMENDATION that State Medi-Cal regulations be changed so that private providers, at least in emergency rooms, can obtain rapid verification of a patient's Medi-Cal eligibility if he fails to bring in a "sticky label" when requesting services.

There are strong grounds on which to argue that the State Government should provide more assistance in indigent medical care. In terms of undocumented aliens, the State received 30 percent of all tax contributions of such persons, which amounted to $300-$500 million in 1977. In addition, the State sets the general 17000 requirement on counties to provide indigent medical care but does not assist in any way in doing so or establish any consistency or minimal standards of such care across the State. Accordingly, it is this Commission's
RECOMMENDATION that the State establish uniform standards of health care to

be provided by counties under Section 17000, and share the cost of such programs with counties on a 50-50 basis.

C. County Government. San Diego County currently responds to its Section 17000 responsibility by funding some indigent care at University Hospital. The County has had a contract with University Hospital to provide such care since 1966, when the former County Hospital became University Hospital. The contract provides for reimbursement of University at a set rate per patient day if the patient's application is approved by the County. Two sample studies by University Hospital covering about a three month period showed that the County certified for reimbursement less than half of the indigent patients for whom applications were filed and for whom there was no Medi-Cal or other insurance coverage. The County denied applications for reimbursement on such grounds as that the patient had been transferred to University from another hospital, previous care at University had been given to another member of the patient's family and was paid for in part or in whole by the University's Clinical Teaching Fund, or the patient was a minor without parental consent.

San Diego County Government began reevaluating its indigent care health policies about the time this Commission was established. The County Department of Health Services proposed changes in those policies that would reimburse University Hospital for the care of indigent patients transferred there if the transferring hospital did not have the medical capability to treat the patients.

The Commission examined these County proposals at meetings in October 1979, and made an extensive set of recommendations to the San Diego County Board of Supervisors concerning the proposals. Those recommendations are contained at Attachment C and include proposals that the County,

- adopt a system of reimbursing other hospitals besides University for indigent care, namely those hospitals that provide more than a certain "threshold level" of indigent care in any year, exclusive of Hill-Burton obligations;

- incorporate in the County's own proposal on reimbursing for "medically necessary" transfers to University Hospital a system for facilitating such transfers by placing on the transferring hospital the onus of proof that it did not have the medical capability to treat the patient;

- develop a comprehensive plan for indigent medical care in San Diego County, specifying the exact responsibilities of and linkages among all the responsible parties, and providing for a continuum of care from primary to hospital services. This comprehensive plan should be part of the County's A.B. 8 (post-Proposition 13 county bail-out funding) submission to the State in 1980; and

- drop its proposal to require Department of Immigration documents from all applicants for County reimbursement, as well as its proposed dual system of care whereby emergency services for undocumented aliens would be reimbursed at University Hospital but not non-emergency services.

- These recommendations of the Commission are slated to be considered by the San Diego County Board of Supervisors at a meeting in spring 1980. The HSA and Commission members will testify in support of the proposals at that time.

The Imperial County Government does not currently provide any reimbursement for indigent care in response to its Section 17000 obligation except for emergency ambulance transport of indigents and care of jail inmates. A County Government task force began reevaluating this policy more than a year ago and developed a set of proposed new policies that were examined by the Commission at a meeting in Imperial County in December, 1979. These policies (Attachment D) would make eligible for County reimbursed emergency care those indigents who are: a) legal County residents and within the Medi-Cal income limits but have been denied Medi-Cal; b) documented resident aliens who provide proof of their status; and c) undocumented aliens who provide certification of legal residency to the INS. No County reimbursement would be provided for non-resident aliens such as those with Work Visas, Tourist Visas, etc., or "illegal" aliens.

The Commission adopted a motion at its December meeting to endorse these proposed new policies, while at the same time setting up a group to monitor their implementation and make recommendations concerning future improvements in the policies based on the experiences gained through implementation. This monitoring group is to be convened under the auspices of Subarea Council VII and is to include representatives of concerned community groups, area hospitals and physicians.

It is this Commission's
RECOMMENDATION that the Health Systems Agency support the Commission recommendations to both San Diego and Imperial County Governments concerning indigent health care in those counties.

D. Private Sector. All hospitals with emergency rooms are required to treat any emergency patient regardless of his ability to pay, provided the patient assumes financial responsibility once care is provided. Twenty-three of the thirty-one civilians hospitals in San Diego County have emergency rooms and must meet this requirement, as well as all three hospitals in Imperial County.

The State requirements are that an emergency condition must be assumed to exist when a patient enters a hospital if the patient himself says so. No questions concerning financing can be asked until after a physician sees the patient and confirms whether or not his condition is a true emergency. If it is, no questions concerning financing can be asked until treatment to stabilize the patient is rendered. Violations of these State licensing requirements have been reported to the Health Systems Agency, such as when patients are questioned in the emergency room concerning insurance coverage or asked for a deposit before seeing a physician. The HSA has referred all such potential violations to the local office of the State Bureau of Licensing and Certification for follow-up inspection, which the State is committed to undertake. It is this Commission's
RECOMMENDATION that this HSA continue to forward all cases of potential violations in State Licensing Requirements concerning emergency hospital

treatment of patients who are unable or suspected of being unable to pay to the State Bureau of Licensing and Certification for follow-up inspection, verification or non-verification of the violation, and appropriate action.

Non-emergency hospital care is not generally available to patients who are not eligible for Medi-Cal in HSA 14. A limited amount of such care is provided through the County reimbursement system and Clinical Teaching Fund at University Hospital, and through the Hill-Burton obligations of eleven area hospitals to provide a specified amount of uncompensated care each year.

In their annual financial report to the California Health Facilities Commission, hospitals are required to report the amount of "charity care" they provide each year. This care is defined as excluding Hill-Burton obligations, subsidies for such care (from charitable, public or other sources), and bad debts (care provided to persons who would not pay rather than could not pay). The reports for 1977 -- the latest year for which the reports of all hospital are available -- showed wide variation in the amount and level of "charity care" reported among the hospitals (Attachment E). Indeed, many hospitals failed to report any amount in this column and told the HSA on a recheck that their accounting system did not allow the identification of such a figure.

Even though the exact accuracy of the reported figures may be questionable given the difficulties in determining when a patient could not and would not pay, they probably give a good indication of the range of charity care provided in this area. The hospitals that provided the highest amounts and levels of charity care (such amounts proportionate to total revenue of the hospital) among those reporting in 1977 were University, Mercy, Sharp, Children's, Centre City, and Paradise Valley. The amount of care reported ranged from $1,320 and .006% of total hospital revenue at one hospital, to $796,624 and almost 5% of total revenue at other hospitals (excluding University Hospital for which the figures are even higher as a result of its indigent care contract with the County and the non-reimbursement of significant amounts of such care by the County).

There is no question that the private sector -- both hospitals and physicians -- have a responsibility to help in the provision of necessary health care to indigent persons, and that this responsibility is not being fully effectuated in some instances. Hospitals argue that the costs of charity care must be passed on to their paying patients and result in even higher overall hospital charges. Physicians note that charity care was more willingly and freely rendered before Medicaid went into effect in 1966. Since that time, most indigent patients are treated through the Medicaid (Medi-Cal) program, for which the reimbursement rates are so low that it dampens physicians' willingness and ability to see more than a certain number of other indigent patients. The physician problem is reported to be particularly acute in hospitals and areas with large numbers of Medi-Cal and indigent patients.

Nevertheless, it is this Commission's
RECOMMENDATION that the HSA, County Governments, Medical Societies, Hospital Council and other responsible parties help make physicians and hospitals in HSA 14 aware of and compliant with their proper responsibilities in rendering indigent medical care.

F. Hill-Burton Hospitals. Ten general acute hospitals and one acute psychiatric hospital in HSA 14 have special and specific obligations in the provision of indigent medical care as a result of previous Federal grants to help in the construction or modernization of their facilities. These hospitals have two types of obligations:

(1) Uncompensated Care Obligation - to provide a certain specified amount of free or below-cost care to poor persons. This obligation generally remains in effect for 20 years after the Federal grant was received.

(2) Community Service Obligation - to assure through affirmative actions that hospital services are fully accessible to all people in the area, particularly poor people. Such affirmative actions include assuring that an adequate number of physicians on staff accept Medi-Cal patients and that community patients can be admitted to the hospital even if their physician is not on staff. This obligation remains in effect throughout the life of the institution.

The latest year for which all Hill-Burton hospital reports are available is 1978 (Attachment F). Those reports show that all Hill-Burton hospitals except Paradise Valley and Heartland met their requirements to provide uncompensated care that year. Heartland was purchased during the year by Kaiser, and its Hill-Burton obligations have to be assumed by Kaiser. Any obligations for uncompensated care not fulfilled within a year by a hospital are carried forward to future years.

A total of $1.1 million in uncompensated care was reported to be rendered in 1978. About 64% of that was for inpatient care, 36% for outpatient care (virtually all at Mercy Hospital), and 5% for emergency care. A total of 676 inpatients, 12,548 outpatients (virtually all at Mercy) and 1,007 emergency patients were reported as treated under the Hill-Burton program that year.

New Federal regulations governing the Hill-Burton program were put into effect in May, 1979, and identify special roles for the HSA in helping to monitor the compliance of hospitals with Hill-Burton requirements. One particular HSA responsibility is to review the annual hospital plans to provide uncompensated services, and provide comments to the hospitals on the extent to which their plans meet community needs. The HSA can also be an active participant in other areas of monitoring Hill-Burton compliance.

The Commission has developed an overall plan for the HSA's role in the Hill-Burton compliance (Attachment G), and it is this Commission's RECOMMENDATION that the Governing Body adopt this proposed plan for HSA monitoring of Hill-Burton obligations.

F. Health Systems Agency (HSA). The HSA is not a direct provider or financier of care, as are all other responsible parties discussed in this section. Nevertheless, the HSA does have responsibilities in monitoring the overall performance of the health system in providing indigent care, advocating necessary systems changes to improve the provision of indigent care, and disseminating important information concerning indigent care. Specific responsibilities of the HSA are outlined in the sections on low-income persons eligible for Medi-Cal, the Federal Government, and the private

sector. In addition, the previous section on Hill-Burton assigns to the HSA a major responsibility in monitoring the Hill-Burton obligations of hospitals. All of the recommendations concerning the HSA are summarized in the last section of this report, "List of Recommendations."

IV. EFFECTS OF JARVIS II

A key official of the State Department of Health Services attended the Commission's February 1980 meeting and emphasized the devastating effect passage of Jarvis II is likely to have on health programs across the board in California and indigent care programs in particular. The State is now preparing an alternative 1980-81 budget based on a 30% or $852 million reduction in funds for health programs. Such an alternative budget will go into effect if Jarvis II passes.

A likely inclusion in this alternative budget will be the entire adult "medically indigent" category of Medi-Cal. The cost of that program is estimated to be $537 million in 1980-81, so such a cut would provide 63% of the overall funding reduction required in the alternative health budget. The main reason this program is a likely target is that, unlike the rest of Medi-Cal, there is no Federal match for the "medically indigent" category and the entire costs of that program are borne by the State.

About 12,374 persons in San Diego County and 6,049 in Imperial County qualified for Medi-Cal under the "medically indigent" category in 1979. If our area has problems now in the provision of indigent health care, they pale by comparison with the post-Jarvis II situation in which so many new indigent patients will be added to the scene.

For this and reasons concerning overall health needs, it is this Commission's RECOMMENDATION that combatting Jarvis II be the top priority of the Health Systems Agency in the next three months. The HSA should help in disseminating information on the exact impact of Jarvis II on health programs in this area, and coordinate its campaign with other groups and individuals working for the voters' rejection of Jarvis II in June.

V. CONCLUSION

Even with the work and recommendations of this Commission, many problems in indigent medical care remain to be resolved in San Diego and Imperial Counties. The Commission recommendations address the main such problems, however, and set into motion mechanisms that will help resolve additional problems in the future. For this reason, the Commission believes it has complied with the Governing Body's mandate to provide a six-month review of indigent medical care in this area and implement solutions to problems in such care.

Accordingly, we respectfully submit this final report and recommendations.

VI. LIST OF RECOMMENDATIONS

II.A. Low-Income Persons Ineligible for Medi-Cal:

The Commission recommends that the Health Systems Agency co-sponsor with community groups a conference on the provision of health care to undocumented aliens in this area. This conference would be a practical workshop, particularly aimed at those agencies and individuals who help guide undocumented aliens toward available sources of care, and emphasizing the current existing health care resources for such persons both in this area and, when transfers are necessary and appropriate, adjoining areas of Mexico. (page 6)

III.A. Federal Government:

The Commission recommends that, if Jarvis II fails, this Health Systems Agency should take the lead in developing a Medicaid Section 1115 proposal for funding of health care of undocumented aliens in San Diego and Imperial Counties on a demonstration basis. The HSA would attempt to enlist the assistance and financial support of concerned community groups, the two County governments, and the State Government in such a proposed project. The actual application for the project would be filed through the State Department of Health Services, as required by the Federal Government. (page 9)

The Commission recommends that the HSA, the San Diego and Imperial County Governments, and the California State Government should continue to strongly advocate Federal funding of health care for indigent undocumented aliens, both in Congress and at every available opportunity. (page 10)

III.B. State Government:

The Commission recommends that the State immediately discontinue its procedure of notifying INS whenever someone applies for Medi-Cal who is suspected of being an undocumented alien. Instead, the State should adopt the recommendation of the Department of Health Services that the Medi-Cal application form merely ask whether a person or his spouse is "under warrant for deportation." If the response to that question is negative the applicant would be eligible for Medi-Cal if he meets the income and other criteria for the Medi-Cal program. (page 12)

The Commission recommends that State Medi-Cal regulations be changed so that private providers, at least in emergency rooms, can obtain rapid verification of a patient's Medi-Cal eligibility if he fails to bring in a "sticky label" when requesting services. (page 12)

The Commission recommends that the State establish uniform standards of health care to be provided by counties under Section 17000, and share the cost of such programs with counties on a 50-50 basis. (page 12)

III.C. County Government:

The Commission recommends that the Health Systems Agency support the Commission recommendations to both San Diego and Imperial County Governments concerning indigent health care in those counties (see Attachments C and D). (page 14)

III.D. Private Sector:

The Commission recommends that this HSA continue to forward all cases of potential violations in State Licensing Requirements concerning emergency hospital treatment of patients who are unable or suspected of being unable to pay to the State Bureau of Licensing and Certificaiton for follow-up inspection, verification or non-verification of the violation, and appropriate action. (page 14)

The Commission recommends that the HSA, County Governments, Medical Societites, Hospital Council and other responsible parties help make physicians and hospitals in HSA 14 aware of and compliant with their proper responsibilities in rendering indigent medical care. (page 15)

III.E. Hill-Burton Hospitals:

The Commission recommends that the Governing body adopt the proposed plan for HSA monitoring of Hill-Burton obligations of hospitals (Attachment G). (page 16)

III.F. Health Systems Agency:(repetition of above recommendations involving HSA):

The Commission recommends that the Health Systems Agency co-sponsor with community groups a conference on the provision of health care to undocumented aliens in this area. This conference would be a practical workshop, particularly aimed at those agencies and individuals who help guide undocumented aliens toward available sources of care, and emphasizing the current existing health care resources for such persons both in this area and, when transfers are necessary and appropriate, adjoining areas of Mexico. (page 6)

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IV. Effects of Jarvis II:

The Commission recommends that combatting Jarvis II be the top priority of the Health Systems Agency in the next three months. The HSA should help in disseminating information on the exact impact of Jarvis II on health programs in this area, and coordinate its campaign with other groups and individuals working for the voters' rejection of Jarvis II in June.

HEALTH
SYSTEMS
AGENCY
OF
SAN DIEGO
AND
IMPERIAL
COUNTIES

ATTACHMENT A

A
PUBLIC
REGIONAL
HEALTH
PLANNING
BODY

INDIGENT MEDICAL CARE COMMISSION
November 7, 1979

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Vice-Chairperson

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RES: 344-4021

NP:kmf

COMPARISON OF WHERE MEDI-CAL ELIGIBLES RESIDE
AND WHERE THEY RECEIVE HOSPITAL CARE

AREA	% of Medi-Cal Eligibles (7/77)	% of Medi-Cal Hospital Patient Discharges(1978)	% of Medi-Cal Hospital Patient Days (1978)	% of Medi-Cal Hospital Revenue (1975-1976)
SAC I ---Inland North San Diego County	7.3%	6.3%	N/A[a]	2.5%[g]
SAC II---Coastal North San Diego County	7.5	5.9	5.3	4.0
SAC III--North San Diego City	10.6	17.9	19.2[b]	17.1
SAC IV --Central San Diego City	34.4	32.9	41.8[c]	48.1
SAC V ---South San Diego City	15.5	18.3	11.2[d]	15.6
SAC VI --East San Diego County	16.8	11.7	17.5[e]	9.3
SAC VII--Imperial County	7.8	6.9	5.1[f]	3.3

[a] Neither hospital in this area (Palomar and Pomerado) reported data on Medi-Cal patient days.

[b] One hospital (Scripps Memorial) reported data for only three quarters.

[c] Three of the nine hospitals in this area (Cabrillo, Centre City and Hillside) did not report data, and another hospital (Alvarado) reported data for only three quarters

[d] One of the four hospitals in this area (Community of Chula Vista) did not report data,.and another hospital (Bay General) reported data for only three quarters.

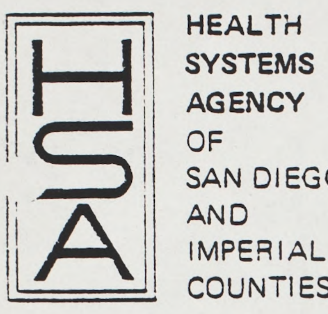
[e] One of the four hospitals in this area (Mt. Helix) did not report data.

[f] One hospital (Calexico) reported data for only two quarters.

[g] Data reported for only one of two hospitals in area (Palomar).

SOURCES: California Center for Health Statistics
PSRO telephone survey of hospitals
Acute Hospital Quarterly Utilization Report
Series A California Health Facilities Commission Financial Report

ATTACHMENT B



HEALTH
SYSTEMS
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OF
SAN DIEGO
AND
IMPERIAL
COUNTIES

ATTACHMENT C

A
PUBLIC
REGIONAL
HEALTH
PLANNING
BODY

M E M O R A N D U M
****
October 29, 1979

TO: San Diego County Board of Supervisors

FROM: HSA Commission on Indigent Medical Care

SUBJECT: Commission Comments on "Policies for Medically Indigent and Indigent Undocumented Alien Care"

The Commission appreciates the opportunity to review and comment on the policy options and analysis submitted by the San Diego County Department of Health Services to the Board of Supervisors regarding medical care for indigent persons (memorandum dated September 17, 1979). We have spent considerable time listening to the points of views of various provider, consumer, and County representatives who have examined the proposed policies.

It is our conclusion that none of the proposed options can be accepted in its entirety. We recommend that modified forms of Options III and VI be approved by the Board of Supervisors, along with an additional policy option that would help assure necessary and nondiscriminatory health care for indigent persons. In addition, we strongly endorse the Department of Health Services' recommendation that County policy on indigent medical care apply to all such persons "regardless of whether the patient is a resident of the County or a non-resident, present legally or illegally" (see Addendum). The reasons for our various recommendations follow.

The Commission firmly believes that both emergency and non-emergency health care must be provided to indigent persons needing such services in San Diego County. First, our national ethic dictates that we cannot close the door to the plight of those less fortunate, particularly when it concerns a service such as health care that is essential to life itself. Second, because of the physical proximity of persons of all economic strata, inadequate health care for indigents directly impacts the health of the population at large. Third and least important in light of the foregoing, the laws of the State and Federal governments require that necessary health care be provided to indigent persons.

<u>Amendment to Option VI</u>. We will discuss first our proposed modification to Option VI since it sets the context for the other recommendations that follow.

The Commission supports the concept that the County should prepare an indigent health care plan under the requirements of AB-8. The Commission strongly recommends, however, that this indigent health care plan be comprehensive in the sense of covering all providers of such care, not just the

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County Government. The plan can thus draw the necessary linkages among all such providers, and clearly delineate responsibilities in what should properly be a system of shared responsibilities. The plan should also cover the whole continuum of health services from primary care to inpatient care. We recognize the time limits under which the A.B.-8 plan must be prepared, and therefore offer the assistance and resources of the HSA and the Commission in developing this necessary comprehensive plan.

In the past, many of our problems in indigent health care have stemmed from the fact that the field is a complex maze of differing and undelineated responsibilities. The effect is that, with so many different parties bearing responsibility, no one is responsible; each party looks to the others as the source and solution of problems, and the resulting chaos of counter-claims and demands resolves nothing.

The role of delineating and establishing this system of shared responsibility is properly that of the County since the County's obligation under the State law in the field of indigent medical care is residual. The County is obligated to provide care only when no other party is responsible or, as stated in Section 17000 of the Welfare and Institutions Code, when indigent persons "are not aided by relatives, friends, or state and private institutions." It is significant to note that the County's responsibility applies to all types of medical care, not just emergency services.

The first important responsibility of another party is that of all hospitals with emergency rooms (23 of the 31 civilian hospitals in San Diego County). Section 1317 of the California Health and Safety Code requires such hospitals to provide care to any person needing emergency services regardless of their ability to pay. This same responsibility is imposed on other hospitals in the county by the Federal Regulations governing Hill-Burton hospitals (hospitals that in the past have received Federal construction funds). Under its Community Service Requirement, a Hill-Burton hospital must provide necessary emergency services to any person who resides in the facility service area whether or not the person is able to pay (42 Code of Federal Regulations, Section 124.603(b)(1)). In addition, the Joint Commission on Accreditation of Hospitals, by which all hospitals in San Diego County are accredited, specifies that the hospital's responsibility extends through the necessary course of treatment and that, "Unless extenuating circumstances are documented in the patient's record, no patient shall be arbitrarily transferred to another hospital if the hospital where he is initially seen has the means for providing adequate care" (lines 43-46, page 20 of "Emergency Services" section of JCAH Accreditation Manual for Hospitals). Thus virtually all of the hospitals in San Diego County have an obligation to provide emergency care to indigent patients.

In addition, nine hospitals in San Diego County have a Hill-Burton obligation to provide a certain level of uncompensated care to indigent patients each year. That care can include non-emergency services, and does include such services unless specifically exempted in the hospital's annual Plan for Uncompensated Care that is approved after a period of community and HSA review. After the plan is finalized, the hospital is required to "provide uncompensated services to all persons eligible under the plan who request uncompensated services" (42 Code of Federal Regulations, Section 124.507(a)(5)). The Plans for Uncompensated Care for the nine Hill-Burton hospitals can also include

outpatient or primary care services, and the HSA will stress these elements as well as non-emergency services in its annual review of the hospitals' Plans.

The main areas, therefore, in which indigent medical care is only minimally covered in San Diego County appear to be non-emergency services and outpatient or primary care services. In addition, one of the most significant problems in San Diego County appears to be that only a few of the hospitals in the county bear the main load of providing emergency indigent care, and this has sometimes resulted in discriminatory and inadequate treatment of such persons. All of these problems are addressed in the Commission's proposed additional County policy on indigent medical care.

Amendment to Option III. The Commission endorses Option III as a necessary element in the adequate provision of indigent medical care in this county. Clearly, indigent patients have had to be transferred to University Hospital in the past for medical reasons and will have to be in the future.

The problem with the proposal is that it gives the County sole right to determine after the fact whether the transfer was justified and, therefore, whether care will be reimbursed by the County. The County's non-reimbursement for the care of individual indigent patients at University Hospital has often been questioned by that hospital in the past, and many would interpret the County's past performance on reimbursement as being extremely conservative or restrictive at best.

It is easily conceivable that the County's continued role as the sole after-the-fact arbiter would result in further discriminatory and inadequate treatment of indigent patients. After several County denials for reimbursement of transferred patients, University Hospital could become extremely cautious in its own approach and be very reluctant to accept the word of the transferring hospital that it does not have the medical capability to treat a patient. Intensive screening by University Hospital and debates back and forth between it and the transferring hospital could result in lengthy delays that would be seriously detrimental to the patient's condition.

The solution to this problem is to place the onus of proof on the original hospital. That could be done by having the original hospital certify that it does not have the capability to treat a patient it is proposing to transfer. The County would reimburse University Hospital automatically for the care, but then make its own determination of whether the transfer was justified. If the County determined the transfer was not justified, it could require the original hospital to reimburse the County in turn for the care at University Hospital. The County should also report any such incident of an unjustified transfer to (1) the local office of the State Bureau of Licensing and Certification as a violation of the original hospital's Title 22 licensing requirements; (2) the Joint Commission on Accreditation of Hospitals as a violation of JCAH accreditation requirements; and (3), if the hospital is a Hill-Burton hospital, the United States Department of Health, Education and Welfare as a violation of Federal Hill-Burton requirements.

Unlike Option III as currently proposed, such a system would place strong financial and regulatory incentives on the original hospital to treat an indigent patient whenever possible. Because of these deterrents to unnecessary transfers, we do not believe the proposed system would be an administrative burden on the County.

At least in the short term until such a system of financial and regulatory incentives could be set up, an impartial committee should be established as an appellate body in cases of dispute between the County and University Hospital concerning whether particular transfers were medically necessary and should be reimbursed by the County. The Health Systems Agency would be glad to assist in the formation of such a committee, which could also review complaints by indigent patients that their medical needs were not met under the current system of providing hospital indigent care in San Diego County.

Proposed Additional County Policy on Indigent Medical Care. The Commission recommends that the County adopt a policy whereby hospitals that provide more than an established threshold level of unreimbursed indigent care can qualify for County assistance in providing further indigent care. Any hospital providing less than the threshold level in a year would receive nothing in reimbursement from the County. Any hospital providing more than the threshold level would be reimbursed for all indigent care over the threshold level at the same daily rates as University Hospital is reimbursed by the County.

The threshold level could be established as a certain percentage of the hospital's total costs (i.e., total care) for the year. In calculating the threshold amount, hospitals would not be allowed to include Hill-Burton free service obligations, charitable care paid for by fund raisers or outside sources, or bad debts. Statistics on such indigent care are now supposedly kept by all hospitals to comply with requirements of the California Health Facilities Commission.

Some physician reimbursement would be provided by this sytem. After the threshold level had been reached by a hospital, the hospital would have to pay part of the County's reimbursement amount to its physicians rendering indigent care, according to a negotiated agreement between the hospital and such physicians.

The main reason for this proposal is that several hospitals, generally located in low-income areas, bear the major load of providing indigent care in this county. Discriminatory and inadequate treatment of indigents is more of a possibility in such situations since it is more difficult to recruit physicians to provide necessary services to indigents when, on a continuous basis, they are not compensated for such care and the amounts of such care are significant.

One of the main advantages of the system proposed here is that is would not help all hospitals but only those hospitals and physicians providing the main bulk of indigent care. The proposal would provide an "escape valve" in a sense when and where particular problems in indigent care may arise.

Moreover, this proposal responds to the County's obligation under Section 17000 to be the residual provider of indigent care by filling the gaps in the current provision of indigent care in this county. In a sense, the hospitals and County would be trading off some of their responsibilities. As part of their indigent care, the hospitals should provide non-emergency and outpatient services as well as emergency care. By furnishing some reimbursement once the threshold level had been reached, the County would be picking up some of the hospital's responsibility to furnish emergency indigent care; but in turn the hospitals would be picking up part of the County's residual responsibility to provide non-emergency and outpatient care.

Finally, the proposal has the advantates of not being onerous administratively for the County since arrangements would have to be made with only a few hospitals. The proposal would also not be especially costly to the County given the threshold level; and the additional County funds that would be required would be spent in the most effective manner, targeted only on those areas of particular need.

In summary, the Commission is proposing a system of shared responsibilities with minimal County involvement and funding - but only at those critical junctures where inadequate and discriminatory treatment of indigents may occur.

HEALTH
SYSTEMS
AGENCY
OF
SAN DIEGO
AND
IMPERIAL
COUNTIES

A
PUBLIC
REGIONAL
HEALTH
PLANNING
BODY

November 1, 1979

TO: San Diego County Board of Supervisors

FROM: HSA Commission on Indigent Medical Care

SUBJECT: Commission Comments on "Policies for the Medically Indigent and Medically Needy" (October 12, 1979 draft memorandum to the Board of Supervisors).

We appreciate the Department of Health Services giving the Commission an opportunity to comment on this draft memorandum to the Board. The October 12 memorandum is basically an elaboration on the Options III & VI for new County policies on indigent medical care that the Department of Health Services recommended to the Board in a September 17 options paper.

The Commission's general comments concerning Options III & IV outlined in the preceding memorandum apply to the October 12 memorandum. In addition, we strongly support innovative approaches in the October 12 memorandum such as the establishment of appropriate linkages between the Community Clinics and other primary care providers with providers of inpatient care; expansion of joint purchasing, service sharing, service integration, and other methods to increase efficiency and effectiveness of ambulatory care programs; and establishment of a quality assurance mechanism for the provision of health services to the indigent and working poor.

The Commission strongly objects, however, to another provision in the October 12 memorandum, namely the establishment of a dual system of County indigent care whereby indigent undocumented aliens would receive emergency services but not non-emergency services like other indigents. Such a dual system would not only deny necessary health care to such persons, but would seriously jeopardize their receipt of even emergency services. The screening mechanism in the County proposes to set up to identify undocumented aliens would strongly deter such persons from seeking any form of health care.

The October 12 memorandum proposes to require a,"Department of Immigration document which is pertinent to the.patient's status" whenever University Hospital files an application for County reimbursement of an indigent patient's care (2.b.4 on page 2 of "Administrative Procedures" section). As a number of studies have concluded, such requests for documentation confirm the suspicion of aliens that their seeking of health care will result in their arrest and deportation. According to the 1977 State Government study on "The Impact of Undocumented Aliens Upon Health Care Programs within California", the "testimony of INS officials, health department officials, persons studying undocumented aliens, and community based organizations" support the existence of this "barrier which severely

limits the use of medical services by undocumented aliens" (page 29).

Such a requirement of documentation and dual system of indigent care was not alluded to whatsoever in the September 17 options paper from the Department of Health Services to the Board of Supervisors. That Options paper, quite commendably, recommended that new County policies for indigent care apply to all such persons "regardless of whether the patient is a resident of the County or a non-resident,present within the County legally or illegally."

Moreover, the County's requirement of documentation is unjustified given the attached opinion from the U.S. Department of Justice. That July 6, 1978 opinion holds that County hospitals have no requirement under Federal law, or more specifically the Immigration and Naturalization Act, to collect documentation on the immigration status of Hispanics. The opinion goes on to state that, "Nevertheless, if such information is generated and there is evidence that prospective patients are illegal aliens, the hospital at least arguably must report that to the proper authorities should those authorities request the information." What more is needed to convince undocumented aliens that if they seek health care they will be deported?

In conclusion, the requirement of documentation and the dual system of indigent care proposed in the October 12 memorandum would constitute a major barrier to the provision of necessary health care to indigent perons in San Diego County, and the HSA Commission on Indigent Medical Care strongly opposes these proposed County policies.

ATTACHMENT TO ADDENDUM

DEPARTMENT OF JUSTICE
Washington, D.C. 20530

July 6, 1978

MEMORANDUM

TO: John E. Huerta
Deputy Assistant Attorney General
Civil Rights Division

FROM: Leon Ulman
Deputy Assistant Attorney General
Office of Legal Counsel

SUBJECT: County Hospital Admissions Procedures as Related to Illegal Aliens

Assistant Attorney General Harmon has asked me to respond to your memorandum of May 23, 1978, concerning the above matter. The factual background, as we understand it, appears to be as follows: The Bernallilo County Medical Center (BCMC), a county hospital in Albuquerque, New Mexico, has attempted to address the problem of providing services to Mexican illegal aliens by requesting proper immigration or birth certificate documentation from those patients applying for non-emergency treatment who are "suspected" of being Mexican illegal aliens. Thereafter, these aliens are required to pay in advance. Local Hispanic-Americans have attempted to have this policy changed, but local counsel for the hospital has advised the hospital that failure to report on a regular basis information concerning illegal aliens disclosed in the hospital admissions process would be a violation of federal criminal statutes.

The issue seems to be whether a county hospital violates federal statutes by failing to report information on illegal aliens disclosed in the admissions process. Our conclusion is that a county hospital would not violate the criminal sanction provisions of the Immigration and Nationality Act by failing to require documentation of immigration status from Hispanics.

Nevertheless, if such information is generated and there is evidence that prospective patients are illegal aliens, the hospital at least arguably must report that to the proper authorities should those authorities request the information.

Local counsel has advised the hospital that consistent failure to report information concerning illegal aliens could be termed one of three criminal violations: aiding and abetting a crime; harboring or concealing aliens; or part of a conspiracy in violation of the criminal statutes of the United States. It appears hospital counsel sought advice from the local United States Attorney and the local official of the Immigration and Naturalization Service concerning these questions. Those two officials stated that should the hospital cease to report on a regular basis information concerning illegal aliens who apply to them for health care, they would recommend bringing some kind of action against hospital personnel.

The statute which applies here is 8 U.S.C. § 1324(a)(3) (1970). It provides that any person who willfully or knowingly conceals, harbors, or shields from detection, or attempts to conceal, harbor, or shield from detection, any alien who is not duly admitted by an immigration officer or not lawfully entitled to enter or reside within the United States shall be guilty of a felony. 8 U.S.C. § 1324(a)(3)(1970). It seems clear that from the willfully and knowingly requirements that were the hospital to elicit no information, and ask no questions concerning immigration status there would be no violation. But if such information is generated there may be grounds for arguing that hospital personnel are knowingly harboring illegal aliens.

Older cases on the definition of harboring held that to harbor meant to conceal surreptitiously or to clandestinely shelter, succor, and protect improperly admitted aliens.

United States v. _Mack_, 112 F.2d 290 (2d Cir. 1940); _Susnjar v. United States_, 27 F.2d 223 (6th Cir. 1928). A new line of cases, however, has expanded the definition of harboring. It now means to afford shelter to such aliens, and is not limited to clandestine sheltering only. _United States_ v. _Acosta De Evans_, 531 F.2d 428 (9th Cir. 1976). The purpose of § 1324 is to keep unauthorized aliens from entering or remaining in the country. Harboring need not be a part of the chain of transaction involving the smuggling of aliens into the United States, since the statute is aimed at the prevention of illegal aliens remaining as well. _United States_ v. _Lopez_, 521 F.2d 437 (2d Cir. 1975). The words "in any place" in the statute are broadly inclusive not restrictive; it prohibits not only smuggling-related activity but also activity which substantially facilitates an alien's remaining in the United States illegally. _United States_ v. _Cantu_, 557 F.2d 1173 (5th Cir. 1977). We have, however, found no case that extends the definition of harboring to include the type of behavior described in the instant matter. Presumably, counsel is basing his advice that such non-action is a violation of the criminal statute on this line of cases and the expansive reading of the definition of harboring. It is at least arguable that the expansive current concept of harboring would include failure to report such information concerning illegal aliens. But there is authority that a person informed of the smuggling of aliens has no duty to inform the authorities. _United States_ v. _Driscoll_, 449 F.2d 894, 896 (1st Cir. 1971); _See also_ _Scales_ v. _United States_, 367 U.S. 203 (1961); _United States_ v. _Dellaro_, 99 F.2d 781, 783 (2d Cir. 1938); _Boyett_ v. _United States_, 48 F.2d 482 (5th Cir. 1931). In conjunction with the requirement that the violation be willful or knowing, it is doubtful that failure to report information after receiving it could be deemed a violation of section 1324. In addition, being in the United States without proper immigration documents is not a crime per se and therefore notice of such is not notice of the violation of a law in particular.

That crime seems to involve the clandestine crossing of the border and eluding the authorities, and the first offense is generally a misdemeanor in any case. 8 U.S.C. § 1325 (1970).

A second problem involving the hospital conduct is whether it can be classified as aiding and abetting the commission of a crime. To "aid and abet" means to assist the perpetrator of the crime while sharing in the requisite intent. United States v. Jackson, 526 F.2d 1236, 1238 (5th Cir. 1976). For a person to aid and abet another to commit a crime, it is necessary that he associate himself with the unlawful venture, that he participate in it with the desire of accomplishment, and that he seek by his action to make it succeed. Peterson v. United States, 405 F.2d 102, 109 (8th Cir. 1968); Mays v. United States, 261 F.2d 662, 664 (8th Cir. 1958). The emphasis in most cases seems to be on the active element rather than mere negative acquiescence, in conjunction with criminal intent, knowledge, or purpose. E.g., People v. Needer, 16 Cal. App. 3d 846, 94 Cal. Rptr. 364 (1971); State v. Myers, 158 N.W. 2d 717, 720 (Iowa Sup. Ct. 1968); State v. Trocodaro, 36 Ohio App. 2d 1, 301 N.E. 2d 898 (1973).

It seems absurd to argue that a failure to report information about illegal aliens aids or abets the actual crossing of the border. Nevertheless, that failure may assist an alien to elude examination by immigration officers, which is also an offense under 8 U.S.C. § 1325 (1970). Maintenance of a benign silence on information as to illegal immigrant status would certainly seem to hinder enforcement activities by the Immigration and Naturalization Service by allowing illegal aliens to move through a neutral population and use available social services with no fear of detection. But failure to volunteer that information probably does not, in our opinion, cross the line from inaction to action. On the

other hand, systematic refusal to transmit information which has already been compiled on request by the immigration authorities arguably is action especially if done with knowledge of an alien's illegal status.

Aiding and abetting within the meaning of 18 U.S.C. § 2 (1970), which provides that whoever commits an offense against the United States or aids or abets it is a principal, assumes some furtherance of the common design either before or at the time a criminal act is committed and implies some conduct of an affirmative nature; again, mere negative acquiescence is not sufficient. United States v. Moses, 122 F. Supp. 523, 526 (E.D. Pa. 1954). There is no further language of description as to what aid or abet means within section 1324.

A third problem is whether nonaction on the hospital's part could be a conspiracy in violation of the laws of the United States. The applicable statute is 18 U.S.C. § 371 (1970), which makes it a crime for two or more persons to conspire to commit any offense against the United States and to do any act to effect the object of the conspiracy. Therefore, a conspiracy is an agreement between two or more persons to do an unlawful act plus an overt act in furtherance of that agreement. Castro v. United States, 296 F.2d 540, 542 (5th Cir. 1961). But mere knowledge, approval of, or acquiescence in the object or purpose of a conspiracy without an intention and agreement to cooperate in the crime is insufficient to constitute one a conspirator. Colosacco v. United States, 238 F.2d 766, 711 (10th Cir. 1956). To be a party to a conspiracy one must actually participate in it by aiding or abetting it in some way. Mere acquiescence or standing by and watching others conspire does not suffice to impose conspiratorial responsibility. United States v. American Precision Products Corp., 115 F. Supp. 823 (D.N.J. 1953). In order to be an aider or abetter or co-conspirator, a person must associate himself with the criminal venture in some fashion, participate

in it as something that he wished to bring about, or seek by his action to make it succeed. Absent evidence of purposeful behavior, mere presence at the scene of the crime even when coupled with knowledge that a crime is being committed is insufficient to prove aiding or abetting or membership in a conspiracy. United States v. Johnson, 513 F.2d 819 (2d Cir. 1975).

We do not believe that the BCMC admissions process involves the required components of conspiracy to harbor illegal aliens. An overt act is an outward act done in pursuance of crime, and a manifestation of an intent or design looking toward accomplishment of a crime. Chavez v. United States, 275 F.2d 813 (9th Cir. 1960). There is clearly no intent to do a criminal act on the part of BCMC, and the alleged "overt act" seems to be the inaction of not disclosing information on possible illegal aliens. The cases listed above emphasize the positive nature of an "overt act"; although there may be a civic duty to disclose information, failure to do so is not prohibited by federal law. Indeed, that is no sure way for BCMC employees to find out that a suspected applicant is in fact an illegal alien unless the information is volunteered, since a person may be unable to produce proper citizenship or immigation papers for any number of legitimate reasons.

Our conclusion is that should BCMC not disclose its admissions records to the immigation authorities, no criminal liability will result unless there is both a systematic creation of information specifically involving illegal aliens and a systematic denial of requests by INS for its disclosure. In that case it is at least arguable that BCMC is actively assisting illegal aliens in remaining in the United States by escaping detection.

ATTACHMENT D

DRAFT PROPOSAL
11/15/79

IMPERIAL COUNTY
MEDICAL INDIGENTS PROGRAM

I. POLICIES AND PROCEDURES PERTAINING TO COUNTY RESPONSIBILITIES FOR PROVIDING MEDICAL CARE FOR "COUNTY MEDICAL INDIGENTS"

A. Definition: "County Medical Indigent".

A "county medical indigent" is a person or family member who meets each of the following requirements:

(1) is a resident of the County; (2) meets the standards for need, personal property and real property as established by the Director of the State Department of Health for a medically indigent person or family under the California Medical Assistance Program (Welfare and Institutions Code Sections 14000 et seq., hereinafter, "the State Medi-Cal Program" or "Medi-Cal"); and (3) has made application for and been denied benefits under Medi-Cal, or has not applied for Medi-Cal because the subject person or family member clearly does not qualify for Medi-Cal.

B. Scope of Care and County Reimbursement of Costs of Hospitals.

A "county medical indigent" shall be entitled to necessary non-emergency and emergency medical care, which care shall be provided only by hospitals as designated by the Board of Supervisors.

Such medical care coverage shall be limited to the types of medical care provided for by the State Medi-Cal Program. The County's costs for such care shall be limited to the rates paid for the same medical services by the State pursuant to the State Medi-Cal Program.

C. Eligibility Determination.

(1) The County Welfare Department shall be responsible for determining the eligibility of all persons or families as "county medical indigents", with the exception of inmates of non-medical institutions, whose eligibility shall be determined by the County Health Officer.

(2) Persons who do not fully cooperate with the County's hospitals and/or the County's Welfare Department in the eligibility determination process for the State Medi-Cal Program and/or for care as a "county medical indigent" shall not be "county medical indigents."

Persons whose Medi-Cal applications are denied because of "lack of cooperation" (i.e., failure to return the MC210 "Statement of Facts" form; failure to provide essential eligibility determination information; voluntary withdrawal of the Medi-Cal application by the applicant; failure to sign required releases to obtain eligibility verification information; etc.), shall not be "county medical indigents".

(3) A person or family member shall be deemed to be a "resident of the County" if such person or family member is a "lawful resident of the county" as defined in Welfare and Institutions Code Section 17105. Said section provides that such person must be: (a) a resident of California; and (b) one who has resided in Imperial County continuously for one year immediately preceding application for assistance, or who has not resided continuously within any California county for one year continuously within the three years preceding the application and has not been present in any other county for a longer time during the three year period than present in this county.

(4) Persons whose Medi-Cal applications are denied because of "excess property", or property transfers, or "lack of residence", shall be deemed to be either non-indigents or non-residents, and therefore are not "county medical indigents".

(5) Persons whose Medi-Cal applications are denied because of eligibility to another public assistance program shall receive benefits under said other public assistance program, and shall not be "county medical indigents".

(6) In instances involving a Medi-Cal applicant with whom the Imperial County Welfare Department has lost contact before eligibility verification can be completed by the Department, the department shall attempt to determine indigency and/or residence on the basis of information contained on the application form and will approve said person for Medi-Cal if the statement of facts by the applicant so warrants. If Medi-Cal benefits are denied to such an applicant by the Imperial County Welfare Department due to "loss of contact", such applicant shall be deemed to be a "county medical indigent".

D. Special Provisions: Persons Who Are Inmates of Non-Medical Facilities, Institutions for Tuberculosis, and Institutions for Mental Diseases.

The State Medi-Cal Program does not provide eligibility for certain types of persons as enumerated herein. Medical care for these types of persons shall be provided as follows:

1. Persons Who Are Inmates In A Non-Medical Institution. "Non-medical institution" means any institution providing nonmedical residential care, custodial care, custody or restraint, including penal institutions. The County thus is responsible for the medical care of its County jail inmates and for inmates of its Juvenile Hall, whether or not such persons meet the definition of "county medical indigent."

2. Persons Who Are Patients In An Institution For Tuberculosis. If such persons are under 65 years of age, they are not included within State Medi-Cal Program coverage. If such persons otherwise meet the definition of "county medical indigents", the County shall be responsible for such medical care as authorized by the County Health Officer.

3. Persons Who Are Patients In An Institution For Mental Diseases. If such persons are over 21 years of age but under 65 years of age, they are not included within State Medi-Cal Program coverage. Such persons shall be aided under the County's mental health program, whether or not such persons meet the definition of "county medical indigent."

E. Documented Resident Aliens.

1. Documented resident aliens shall be entitled to benefits as "county medical indigents" on the same basis as other residents of the County of Imperial, upon meeting all of the eligibility requirements, as follows:

a. An alien who has entered the United States under an immigration quota (i.e., with a Resident Alien Visa) has been given permission to reside permanently in this country. He/she, therefore, has the ability to establish residence by virtue of physical presence and intent to remain here permanently or indefinitely.

b. A person who has entered the United States lawfully and who is entitled to remain indefinitely, such as certain "parolees" (i.e., certain Cuban Refugees, Indochinese Refugees, etc.) if otherwise eligible, may be aided until such time, if ever, that the United States Immigration and Naturalization Service (hereinafter, the "INS") revokes his/her indefinite parole.

2. Documented resident aliens must provide proof of such status. Acceptable verification of lawful permanent resident status or entitlement to remain indefinitely in this country shall consist of an Alien Registration Receipt Card or other appropriate official documents establishing such resident status.

F. "Undocumented" Aliens.

1. If a person is an alien who cannot substantiate lawful presence in the United States (i.e., an "undocumented" alien), such person may be eligible for both nonemergency and/or emergency health care services under the State Medi-Cal Program--provided such person provides the certification prescribed by Welfare & Institutions Code Section 11104. Said section provides that any alien who is otherwise eligible for aid shall be eligible for Medi-Cal if he/she certifies under penalty of perjury that to the best of his/her knowledge he/she is in the country legally and is entitled to remain indefinitely, or he/she is not under order for deportation, or that he/she is married to an individual not under order for deportation, or, if such person has been residing in the United States for five years or more, he/she provides the affidavits of two U.S. citizens attesting to such continuous residence. Said section further provides that such certification by the alien shall, upon receipt, be forwarded to the INS for verification, and Medi-Cal eligibility shall continue pending such verification.

2. The County Welfare Department shall use its best efforts to obtain Medi-Cal eligibility for all undocumented aliens at hospitals by attempting to obtain the requisite certifications of such persons' legal rights to reside in the United States, and forwarding the same to the INS for verification.

If such undocumented aliens refuse to provide the required certification, such persons shall not be eligible for assistance as "county medical indigents".

3. If any undocumented alien has previously been or is discontinued from or denied State Medi-Cal Program eligibility because of reporting of illegal status by or failure to appear for an interview with the INS, such person shall <u>not</u> be eligible for assistance as a "county medical indigent."

G. <u>Non-Resident Aliens</u>.

A person who is legally in the United States for a temporary period, such as with a visa containing time limitations (e.g., Student Visa, Tourist Visa, Work Visa, etc.), does not have the ability to establish intent to reside permanently or indefinitely in Imperial County since he/she has been given permission to remain in the United States for a temporary period only. He/she is not eligible to become a "county medical indigent." (See Policy II.B., below, for provisions concerning <u>emergency</u> medical care for such persons).

H. <u>"Illegal" Aliens</u>.

Foreign nationals who are in the United States illegally are incapable of establishing "intent" to reside permanently or indefinitely in Imperial County, even though they may have physical presence in this county, since they are subject to deportation at any time. They are ineligible to become "county medical indigents." (See Policy II.B., below, for provisions concerning <u>emergency</u> medical care for such persons).

II. <u>POLICIES AND PROCEDURES PERTAINING TO COUNTY RESPONSIBILITIES FOR EMERGENCY CARE FOR NON-RESIDENT INDIGENTS</u>.

A. <u>Definition: "Emergency Medical Care"</u>.

For purposes of this program, "emergency medical care" shall mean those services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to disability or death.

The County Health Officer shall monitor medical care provided as emergency medical care, and, in cases of dispute, make final determinations as to whether particular medical treatment or procedures shall be deemed to be "emergency medical care" as herein defined.

(38)

B. Residents of Other States.

Residents of other states may qualify for medical care benefits under medical programs in such States. The County Welfare Department will assist the County's hospitals in determining whether the costs of care for such persons may be recovered from such other state's programs. If such recovery is not available, and such person meets all the requirements for a "county medical indigent" other than the county residency requirement, the County will provide for the costs of necessary emergency medical care on the same basis as it would have provided for such emergency care for a "county medical indigent".

C. Residents of Foreign Countries (Non-Resident Aliens).

1. If a non-resident alien (see Policy I.G., definition) meets all the requirements for a "county medical indigent" other than the county residency requirement, and such person is lawfully in the United States, the County will provide for the costs of necessary emergency medical care on the same basis as it would have provided for such emergency care for a "county medical indigent."

2. If non-resident aliens are not lawfully in the United States, or cannot document lawful presence, the County Welfare Department will attempt to provide for emergency medical care for such persons under the State Medi-Cal Program as undocumented aliens, at least during the period of time that status in the United States is being verified by the INS (see Policy I.F., above). If such Medi-Cal assistance is not available, such persons shall not be eligible for emergency medical care as "county medical indigents."

D. Residents of Other California Counties.

Such persons may be eligible for the State Medi-Cal Program and for county medical programs of their counties of residence. The County Welfare Department will assist the County's hospitals in determining eligibility of such persons for such medical care benefits in their counties of residence.

CHARITY CARE BY HOSPITAL, CHARITY CARE AS PERCENTAGE OF GROSS REVENUE OF HOSPITAL, AND CHARITY CARE AS PERCENTAGE OF TOTAL CHARITY CARE OF ALL HOSPITALS

HSA 14, 1977 (Table to be Revised)

HOSPITAL	CHARITY CARE ($)	CHARITY CARE AS % OF GROSS REVENUE OF HOSPITAL	CHARITY CARE AS % OF TOTAL CHARITY CARE OF ALL HOSPITALS	REPORTING PERIOD
SAC I				
Palomar	0	-----	-----	7-76/6-77
SAC II				
Fallbrook	$ 13,345	0. 36%	0.54%	7-76/6-77
North County	2,552	0. 09	0.05	1-77/12-77
Tri-City	83,245	0. 46	1.52	7-76/6-77
SAC III				
Children's	440,656	3. 91	8.04	7-76/6-77
Clairemont	0	-----	-----	1-77/12-77
Mission Bay	0	-----	-----	2-77/1-78
Scripps Encinitas	0	-----	-----	1-77/12-77
Scripps Memorial	1,320	0.006	0.02	10-76/9-77
Sharp	593,435	1. 95	10.82	11-76/10-77
SAC IV				
Alvarado	0	------	-----	6-77/5-78
Cabrillo	7,434	0. 16	0.32	7-76/6-77
Centre City	176,227	2. 27	3.21	1-77/12-77
College Park	0	-----	-----	12-75/11-77
Community of San Diego	0	-----	-----	7-76/6-77
Hillside	17,549	0. 20	0.32	4-77/3-78
Mercy	796,624	2. 01	14.53	7-76/6-77
University	3,269,000*	10. 98	59.62	7-76/6-77
Villa View	8,283	0. 14	0.15	7-76/6-77
SAC V				
Bay General	15,241	0. 10	0.28	7-76/6-77
Community of Chula Vista	0	------	-----	1-77/12-77
Coronado	13,027	0. 29	0.24	10-76/9-77
Paradise Valley	136,830	0. 77	2.50	1-77/2-78
SAC VI				
Carroll's	0	------	-----	4-77/12-77
El Cajon Valley	0	------	-----	9-76/8-77
Grossmont	33,275	0. 19	0.61	7-76/6-77
Mt. Helix	0	------	-----	1-77/12-77
SAC VII				
Calexico	1,343	0. 08	0.02	7-76/6-77
El Centro	39,568	0. 46	0.72	7-76/6-77
Pioneers	0	------	-----	7-76/6-77

Source: California Health Facilities "Series A" Cost Reports (filed by each hospital for their 1977 fiscal year).

*Includes $2,821,000 in straight "Charity Care" and $448,000 in underpayments by the County of San Diego under the indigent care contract with University Hospital (charges that were not paid in full for patients the County accepted as its responsibility). Most of the total $3,269,000 in charity care at University Hospital was covered by the Clinical Teaching Fund but is included here since charity care per se is not the designated purpose of the Clinical Teaching Fund.

ATTACHMENT E

HILL-BURTON OBLIGATIONS AND UNCOMPENSATED CARE PROVIDED BY HSA 14 HOSPITALS, 1978

Facility	Obligation Amount	Actual Care Provided							Obligation Option Chosen 1978[a]
		Total Amount	Emergency		Inpatient		Outpatient		
			$ Amount	No. Patients	$ Amount	No. Patients	$ Amount	No. Patients	
Children's	$ 7,867	$ 10,116	---	---	$ 10,116	1	---	---	10%
Coronado	---[b]	33,278	$ 225	2	32,570	19	$ 483	2	Open Door
El Centro	No report filed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Open Door
Fallbrook	12,881	13,126	1,441	4	11,943	12	41	1	10%
Grossmont	---[b]	38,865	17,665 (inc. outpatient)	152	21,200	44	---	---	Open Door
Heartland	22,503	9,137	647	7	8,415	9	74	1	3%
Mercy	241,546	554,160	15,375	663	175,051	268	363,734	12,397	10%
Mesa Vista Acute Psychiatric Hospital	68,271	103,868	---	---	157,888	221	---	---	10%
Paradise Valley	137,487	118,882	2,712	N/A	116,170	N/A	---	---	10%
Sharp's	74,361	112,808	inc. in other two categories	70	89,374	55	23,434	140	10%
Tri-City	88,018	95,768	18,273	109	72,157	47	5,338	7	10%

SOURCES: Annual Hill-Burton Compliance Reports filed by each hospital with the State Hill-Burton Enforcement Unit, Department of Health Services.

[a] Each hospital can choose one of four options for calculating its annual Hill-Burton obligation for uncompensated care. The three choosen by HSA 14 hospitals are (1) 10%--taking 10% of the total Hill-Burton grant and loan money received in the previous 20 years; (2) Open Door--adopting a policy that no person will be denied service because of an inability to pay (no specific "obligation" amount is then calculated); and (3) 3%--taking 3% of the operating costs of the hospital minus Medi-Cal and Medicare requirements.

[b] Since open door option was chosen by both hospitals, there is no set "obligation amount". If Coronado selected the 10% option, its obligation amount would have been $80,311; and if it had selected the 3% option, its obligation amount would have been $75,645. With Grossmont, the 10% option would have meant a $62,657 obligation and the 3% option would have meant a $349,621 obligation.

ATTACHMENT F

HEALTH SYSTEMS AGENCY OF SAN DIEGO AND IMPERIAL COUNTIES

ATTACHMENT G

A PUBLIC REGIONAL HEALTH PLANNING BODY

PROPOSED PLAN FOR HSA MONITORING OF HILL-BURTON OBLIGATIONS OF HOSPITALS

All HSA activities would be coordinated through the Community Development and Implementation Committee, which would have the lead HSA responsibility in the area of Hill-Burton.

I. ALLOCATION PLANS

A. Request required plans from all HSA 14 Hill-Burton Hospitals.

B. Provide technical assistance to hospitals in developing plans.

1) Sponsor seminar on new Hill-Burton regulations for hospital administrators, trustees, and key personnel.

2) Sponsor a meeting of facilities to share and coordinate allocation plans and to maximize available services.

C. Review Plans

1) Preliminary staff review.

2) HSA task force review of all plans.

3) Subarea Advisory Council review of plans from their area:

a. Public hearing on plan if particularly needed or appropriate.

4) Transmittal to hospitals of HSA recommendations on plans within 60 day alloted time frame.

II. COMMUNITY SERVICE OBLIGATION COMPLIANCE

A. Develop data on each Hill-Burton hospital in following areas:

1) Bilingual staffing (dependent upon availability of HSA funding for such a survey).

2) Pre-admission deposit policy.

3) Percent of hospital patients who are Medi-Cal recipients.

4) Number of patients transferred to University Hospital for whom County denies payment based on determination of inappropriate transfer (dependent upon future County data collection).

5) Number of physicians with staff privileges who accept Medi-Cal patients for initial care for the different services available at the hospital (dependent upon availability of HSA funding for such a survey).

2831 CAMINO DEL RIO SOUTH, SUITE 204 / SAN DIEGO, CALIFORNIA 92108
714 / 297-4721

(41)

6) Ask Medical Society assistance in determining if hospitals are complying with community service obligation.

B. Collect statements of compliance with community service non-exclusionary admission policy.

III. PROGRAM MONITORING

A. Develop Subarea Advisory Council monitoring mechanism, coordinated through the Community Development and Implementation Committee.

1) On-site spot checks of facility compliance.

2) Investigative body for specific complaints (personnel of a hospital cannot sit on such a body when that hospital is being investigated).

B. Report all non-compliance findings and complaints to State/Federal authorities.

C. Request any Affirmative Action Plans that hospitals have developed to correct deficiencies in their community service programs.

IV. CERTIFICATE OF NEED (CON), APPROPRIATENESS AND PROPOSED USE OF FEDERAL FUNDS (PUFF) REVIEW

A. Investigate Hill-Burton compliance as part of staff CON reports relevant to criteria:

1) #7, compliance with laws and regulations,

2) #8, responsiveness to community need,

3) #11, obligation of facility to enhance accessibility, and

4) #15, facility's effect on indigent population.

B. When Appropriateness Review and PUFF Review become operational, investigate and evaluate Hill-Burton compliance whenever Hill-Burton facilities are subjects of such reviews.

C. Consider all findings in review reports, and report any deficiencies in compliance to State/Federal authorities.

V. HEALTH SYSTEMS PLAN/ANNUAL IMPLEMENTATION PLAN

A. Explain Hill-Burton program and obligations in HSP and AIP.

B. Include in HSP inventory of Hill-Burton obligations and available services by facility and subarea.

1) Annual dollar amount of obligation.

2) Years of obligation.

3) Allocation plan - what services will be available and when in year.

4) Languages that notices must be posted in and bilingual staffing available.

C. Include full implementation of Hill-Burton obligations as AIP goal.

1) Include full implementation of uncompensated care obligations as AIP objective.

2) Include full implementation of community service obligations as AIP objective.

3) Include implementation of Hill-Burton community education programs as AIP objective.

VI. COMMUNITY EDUCATION

A. Sponsor community forum addressing Hill-Burton regulations and impact.*

B. Issue media releases concerning allocation plans and general obligations of hospitals.

C. Train HSA volunteers about Hill-Burton.

*The Orange County Legal Services Assocaition has a Federal grant to undertake Hill-Burton community education, including some in our area. Such a public forum could be a joint project with that Legal Services Association.

from the desk of—

HECTOR DIAZ

Herman—

Enclosed is the report on Paradise Valley in addition to:

1. Other attachments related to the Paradise Valley case
2. Hill-Burton regulations
3. Signs that are given to Hill-Burton hospitals for posting in Emergancy Rooms, Admission Office, Bussiness Office and Outpatient clinic (if any)
4. Hill-Burton pamphlets (available in quantity to your organization)

Please call me if you have any questions

Thanks, Hector

INVESTIGATION OF COMPLAINT
PARADISE VALLEY HOSPITAL

PREPARED BY: HECTOR DIAZ, A.I.A.
STATE DEPARTMENT OF HEALTH
LOS ANGELES, CALIFORNIA

BACKGROUND

Complaint submitted by Community Crisis Center via California Public Interest Research Group (Attachment A). Letter of complaint forwarded to Paradise Valley Hospital (Attachment B) with the copy of the complaint letter. Hospital Administrator response to complaint (Attachment C). Reading of these attachments is necessary prior to reading the results of the investigation.

RESULTS OF INVESTIGATION

A field visit was made on April 12 and 13, 1978. The following persons were interviewed:

April 12, 1978

1. Emergency Supervising Nurse - Paradise Valley Hospital

   I inquired about the case of Candida Casas and it was indicated that the patient came in shortly before the 7 a.m. to 3 p.m. shift ended. Patient was in great pain and steps were taken to admit patient who had received prior treatment at a local community clinic. The nurse left her shift thinking that the patient would be admitted. The nurse appeared to have been disappointed to hear the following day that the 3 to 11 p.m. shift had not admitted the patient. She demonstrated compassion for the patient since there was a definite need to admit the patient for treatment.

2. Hospital Administrator - Paradise Valley Hospital

   I interviewed the medical records together with Mr. Friesen and questioned him about the comment entered in the emergency service record, "Hospitalization needed - turned over to Border Patrol". The administrator could not understand the comment since the Border Patrol will not come into a hospital and take a patient because he or she is an illegal alien. He indicated that efforts were made to admit the patient to the Burn Unit at University Hospital, but the patient was refused at University Hospital because she was an illegal alien. The emergency room backup surgeon also refused to treat the patient because of inability to pay. A general practitioner physician was persuaded to accept

the patient. It was at this point, according to the hospital administrator, that the husband of the patient made arrangements with a Tijuana hospital and requested that his wife be transferred to that hospital. The administrator indicated that the hospital had no option but to respect the husband's request.

3. Mr. Rios - Mexican Red Cross, Tijuana

Mr. Rios indicated that Paradise Valley Hospital contacted him by telephone between 7 and 9 p.m. on January 26, 1978 and indicated that a Tijuana resident needed hospitalization and made the arrangements to have a Mexican Red Cross ambulance meet an ambulance operated by Aaron Ambulance Service at the border. Records kept there confirm the fact that the patient's husband was not involved in the arrangement. Mr. Rios will be mailing a deposition on this matter.

4. Patient's Aunt and Uncle - Mr. and Mrs. DeEstrada (Living in Tijuana)

The patient, Candida Casas, spent several weeks at their home after release from the Tijuana hospital. According to their story, the patient had initially restrained herself in seeking medical treatment because there was no money and because of the fear of being deported. After 3 or 4 days of receiving burns, the patient could no longer tolerate the pain and sought medical assistance. The course of events that followed are partly explained in Attachment A. What is not reflected in Attachment A was the fact that both the patient and her husband were burned and the husband refused to be treated at the clinic because he could better tolerate the pain and was expecting to escape in case they were reported to the Border Patrol. The clinic did not report them, but the

hospital did and he left quickly. I requested that Mrs. DeEstrada write her niece for a deposition. Mailing time is approximately 10 days each way. A delay of 4 weeks should be expected in receiving this statement. This statement was read to Candida Casas in Spanish in Mr. Rios's office 5/11/78. Ms. Casas confirms statements — Read by Hector Diaz and witnessed by Lionel Rios

5. Mr. Gabriel Arce - Administrator, San Ysidro Community Clinic

   Mr. Arce accompanied me after working hours to pursue the story gathered from the Mexican Red Cross and the patient's family in Tijuana. His deposition will be mailed shortly.

Signatures
1. Hector Diaz
2. Lionel Rios ← Director Mexican Red Cross (letter attached)
3. Candida Casas

April 13, 1978

1. U.S. Border Patrol, Richard L. Jones, Assistant Chief

   He checked for any possible involvement his office may have had with respect to this case on January 26, 1978. Mr. Jones checked with a couple of his offices and found no record of having apprehended or taken into custody any person by the name of Casas. Any calls that may have been initiated on January 26, 1978 would not be traceable after February 26, 1978 since the recording tapes are recycled after 30 days. Mr. Jones indicated that if a call was made in connection with this case, his office would not have been involved since the health of that person would then become the responsibility of the Border Patrol. The Border Patrol automatically pays for the health and medical care of an illegal alien even if it means admission into one of our private hospitals.

2. Mr. Elias Gutierrez, Administrator, Tijuana Civil Hospital

   With Mr. Gutierrez's help I was able to determine from the patient's medical record that the Mexican Red Cross brought the patient to his hospital and that pre-arrangements were not made to admit the patient. It was stated that his hospital receives all persons that cannot pay or that cannot qualify for admission into the

better Social Security Hospitals in Tijuana. His hospital, however, cannot adequately treat a burn patient. Of interest in the medical records was a copy of Paradise Valley Hospital's emergency service record which did not appear to be the same as the record seen at Paradise Valley Hospital. I asked for and received a copy of this record (Attachment D).

3. <u>Ann Grogan - Office of Civil Rights, Department of Health</u>
I called Ms. Grogan and asked for a legal opinion in requesting copies of medical records. I was informed that Sections 91155(b) and 91171(c) gives the Department the right to ask for copies of medical records.

4. <u>Raquel Voght, Medical Records Supervisor - Paradise Valley Hospital</u>
I asked Ms. Voght for the medical records of Candida Casas. The record could not be found and no one in her office knew of the records whereabouts. She appeared puzzled since there is an established policy that no one takes records out of medical records with the exception of the hospital administrator, but only with their knowledge. She proceeded to call the administrator and was put on hold for approximately 5 minutes. Afterwards she took me to the emergency room where the medical record for Candida Casas was found on top of the nurse's counter. Ms. Voght retrieved the record and we returned to her office where I proceeded to review the emergency service record. I noted that the emergency service record was different and that additional entries were made. I suspected tampering of medical records and proceeded to request a copy of the emergency service records for the purpose of taking the copies to our medical professionals for their opinion.

Ms. Voght asked if I would step outside and wait while she proceeded to telephone the administrator and the hospital attorney for clearance in furnishing a copy of the record. I waited for approximately 30 minutes while she was on the phone and finally advised her that I would contact the administrator directly.

5. Mr. Friesen, Administrator, Paradise Valley Hospital

Mr. Friesen indicated that he could not furnish me copies of medical records because of State regulations requiring that the hospital protect the privacy of the patient by having the patient's consent prior to release of any information. It was pointed out that our regulations allowed the Department to retrieve any records needed for an investigation and that I would further provide a signed written statement that I would take the responsibility for the privacy of the patient as required by State regulations. The offer was rejected on the advice of their attorney, who suggested the State use its power of subpoena. Other issues that were discussed with Mr. Friesen are listed separately in this report.

6. Ted Bradt, Aaron Ambulance Service (National City)

Mr. Bradt was the ambulance driver that was called to take the patient to the border. When he first saw the patient, he remembers asking the question as to why the patient was not being transferred to the Burn Center at University Hospital instead of the border. He believes it was the nurse in charge who told him that the patient was not seriously burned to admit to University Hospital Burn Center and that they were transferring her to a Tijuana hospital. He was advised that the Border Patrol had been called in advance and to ask for the sargeant or lieutenant (does not remember exactly) when

he got to the border. He refused to provide the ambulance service unless the service was paid in advance. He indicated that the patient was by herself and that nobody accompanied the patient on the trip to the border for which he was paid in advance by the hospital. Mr. Bradt will sign a deposition if required to substantiate his statements.

7. Miss Maudester E. George, R.N., Community Crisis Center
   I discussed the case with Ms. George and verified that the husband and wife had both been burned but that the husband insisted that only his wife be treated. She verified her statements as outlined in her letter (Attachment A). Ms. George will provide us with a deposition to indicate her sentiments and opinion on the way the patient was handled by the hospital.

CONCLUSION OF COMPLAINT REGARDING CANDIDA CASAS

It appears that the hospital is in violation of the following sections of Articles 2 and 3, Chapter 3, Divison 7, Title 22, California Administrative Code:

1. Section 91145(b). Discriminating against a person unable to pay and arranging for the transporting, and in effect, deporting of an illegal alien in dire need of hospitalization. This is prohibited by Federal laws and policy in handling or deporting illegal aliens and is in direct conflict with the human rights issue being actively pursued by the Federal government.
2. Section 91155(b) and 91171(c) & (d). Failure to provide copies of records to the Department in the investigation of a complaint.

3. Section 91169(c)(3). Refusing health services to a person unable to pay.

4. Possible Violations of Other Laws

   Tampering with medical records and falsifying facts and statements to cover up Code violations. Transporting a patient without consent.

FOLLOW-UP RECOMMENDATIONS

1. Proceed in undertaking an indepth audit of hospital records with respect to compliance with Uncompensated Care and Community Service obligation under the Hill Burton Act.
2. Subpoena the medical records of Candida Casas for review by medical professionals to verify possible tampering, altering or falsifying of medical records.
3. Contact appropriate Federal agencies for opinion on patient's human rights to health care in this country when that paitent is here illegally.
4. Prepare appropriate documentation for initiation of legal sanctions.

OTHER COMPLAINTS

California Public Interest Research Group also indicated that their recent survey of this hospital resulted in finding noncompliances with other sections of the Code (Attachment E). My findings are as follows:

1. Section 91147(b)(f) and 91172(a)(d). Signs on Hill Burton obligation were posted in english only. The spanish version of the Hill Burton obligation as distributed by the Department were not posted. The requirement for posting signs publicizing the hospitals obligation in the nearest welfare office had not been complied with at the time of my visit. Complaint verified.
2. I interviewed several In-Take Receptionists in the emergency, admitting and cashier areas and found that they knew of the hospital's Hill Burton obligation. They appeared to know when and how to introduce the

application for Hill Burton Assistance. No violation found with respect to staff failing to volunteer information or not knowing about their Hill Burton obligation. This type of violation is difficult to verify when staff is aware that the person asking the question is from the Department of Health. For a copy of the hospital's application on Hill Burton assistance, see Attachment E.

3. Section 91169(g). List of doctors was not available for distribution to the public. The hospital staff did not know which of their doctors accepted Medicare or Medical patients. Complaint verified.
4. Section 91147(a) and 911559(a). The hospital does not provide the public with eligibility criteria which includes the type of information required by Code. The Hospital does not have summary reports available to the public. Complaint verified.

OTHER ISSUES DISCUSSED WITH THE ADMINISTRATOR - PARADISE VALLEY HOSPITAL

Mr. Friesen indicated that any sanction applied by the State would adversely affect the hospital's ability to serve the indigent because doctors would leave the hospital. I mentioned the alternatives that could have been available to the hospital in admitting the patient, Candida Casas.

Alternative No. 1 - The hospital could have paid the fee required to have a doctor admit the patient and write off the cost to their Hill Burton account. This action would have been possible if a pre-determination was made that the patient could not receive health services because of inability to compensate the doctor for his or her services. Mr. Friesen felt that this would "open up a can of worms" because doctors would start billing the hospital in all cases where indigent patients were not covered by Medicare.

Alternative No. 2 - The hospital could have paid University Hospital in order to assure the patient's admittance to the Burn Center. The

cost could have been assigned to the Hill Burton account. Mr. Friesen felt that the practice of one hospital paying another was out of order. Alternative No. 3 - Arrange for the Emergency Room Physician (under contract to the hospital) to admit patient. Mr. Friesen indicated that hospital bylaws do not allow this practice because of the competition that non E.R. doctors would have in getting their share of in-patient business.

Alternative No. 4 - Change the bylaws to allow the use of Alternative No. 3 in cases where a patient was refused by all staff doctors because of patient's inability to pay. Mr. Friesen's response was negative since he felt E.R. doctors were not as qualified as their regular staff doctors in following up with the treatment of an in-patient.

Mr. Friesen also indicated that unethical methods were used in questioning the hospital staff and compared this investigator to Calpirg surveyors who in the future will not receive "the time of day". I pointed out to Mr. Friesen that when the community relies on a group outside of the hospital to voice their complaints, it signifies that the hospital is not communicating or has a credibility gap with the community with respect to health delivery being equally given to the public. I also pointed out that our Code and our hospital licensure laws authorize the State Department of Health to initiate an investigation whenever it is justified and to enter the facility without asking the permission of the hospital administrator. The administrator was interested in knowing when this report would be released and was advised that my report would be a matter of public record. Further, that Sacramento would initiate whatever action is necessary.

3000 E STREET
SAN DIEGO, CALIFORNIA 92102
(714) 236-1508

CALIFORNIA PUBLIC INTEREST RESEARCH GROUP

February 22, 1978

Washio Terada
State Department of Health
744 P Street
Sacramento, California 95814

Dear Wash:

Please find enclosed three complaints against Hill-Burton Facilties in San Diego. Since I have had communication with each of the complainants, I will elaborate on their written statements where necessary.

I. SHARP HOSPITAL: Complainant, Robert Stinson

Mr. Stinson's wife was an emergency patient who incurred over $19,000 in hospital bills. At no time during her hospitalization, at the first billing or after, did the Stinson's receive any information about Hill-Burton or MediCal. Mr. Stinson told the financial counselor he would pay the bill if he could get a loan from his mother who would have to sell her stocks. He conveyed his inability to pay the bill to the business office as well. The response was that the bill would be turned over to a collection agency at the end of February.

The extraordinary bill and the apparent lack of his own financial resources would indicate the necessity of financial aid counseling. The lack of such counseling violated the community service obligation. Similarly, the patient should have received notice of the Hill-Burton program with his first billing which he did not. Nor did he see a posted notice in the emergency room indicating the Hill-Burton obligation (no sign was evident to CalPIRG's researcher in December, 1977) violating the uncompensated care provisions.

Unless the hospital had fulfilled its dollar volume for the fiscal year by August 30, 1977, it appears that the hospital was deficient in not notifying Mr. Stinson of the program and determining his wife's eligibility after she was admitted for emergency care. It is ultimately the responsibility of the hospital to inform the patient (or family) about financial assistance when the ability to pay is in question. The complainant presently cannot pay the bill.

Attachment "A"
page 1 of 3

II. PARADISE VALLEY HOSPITAL Complainant: Maudester George, R.N.
for Candida Casas

This case raises the question of the hospital's responsibility to have physician's on staff who will treat indigent patients. I believe Candida Casas, the patient, was an undocumented alien. She was admitted in the emergency room of the facility, but the hospital social worker was unable to find a surgeon who would accept the patient. Thus, in her very serious condition, she was transported to Mexico.

The Question and Answer sheet prepared by your department indicates that it is the "hospital's responsibility to recruit community orientated physicians. The burden is not on the individual patient". "The privacy of contract theory operates to protect a patient's right to the benefits of a Hill-Burton contractual obligation" (Question 45). Clearly, the Hill-Burton obligation as it applies to undocumented persons is meaningless if these individuals are unable to receive a doctor's care in the facility. The barrier to care appears to violate the community service and uncompensated care provisions.

III. CORONADO HOSPITAL Complainant: Kathleen Abrantes

The complainant has attempted to place her mother in the extended care unit of Coronado Hospital. This unit is listed as a skilled nursing facility according to the 1977 Resident Facilities and Classification Directory which accepts MediCal/MediCare patients. However, the complainant claims that the director of social services stated that MediCal does not pay enough to cover expenses. For a variety of reasons, the complainant wishes to place her mother in the Coronado Unit. If the hospital provides the necessary level of care and refuses admission soley on the grounds of the patient's MediCal status, this appears to be a direct violation of its community service obligation. The patient presently desires admission in the extended care unit.

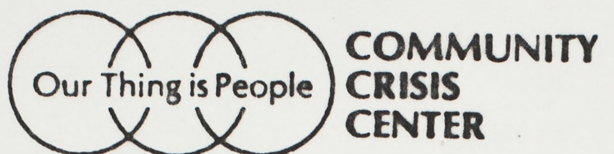
Please inform us of any actions taken on these complaints. The questions and policies raised by these cases are serious, and produce real barriers to full access to medical care under the Hill-Burton program. As two of the complainants have live issues, a timely resolution is necessary.

Yours,

Claire Lipschultz
Claire Lipschultz,
Co-Director

CL:hhe
Encls:
cc: Ann Grogin
Office of Civil Rights

Attachment "A"
page 2 of 3



COMMUNITY
CRISIS
CENTER

MEDICAL ★ COUNSELING ★
CRISIS INTERVENTION AND SOCIAL SERVICES

2754 IMPERIAL AVENUE • SAN DIEGO, CALIFORNIA 92102 • PHONE 239-0325

February 9, 1978

Calprig
300 E. Street
San Diego, California 92102

ATTENTION: Claire

Dear Claire:

On January 26, 1978 at 2:00pm Candida Casas age 23 a Spanish female came to the Crisis Center Clinic for treatment of burns which she had obtained on 1/23/78 while crossing the border.

The Physical findings was as follows- Second & Third degree burns on the inner aspect of both legs, pubic area, both arms, buttacks, back area and abdomen. On some of the above areas the skin was partially removed. Some blisters were noted on side of right leg and areas weeping. The wounds had been treated with Gentian Violet by the patient. Appeared very nervous, shaky and in pain.

Clothing removed by cutting, areas where clothing was stuck. It was removed with Aqueaus Zephrin solution. A disposable gowen was placed on the patient. Meanwhile the Emergency Room at Paradise Valley Hospital was contacted. The patient was sent to the Emergency Room with a letter. Copy enclosed. At 3:30pm the Crisis Center was notified that the patient was been cared for and was being admitted. Rx had been given for pain and an intravenous has been started.

On 1/28/78 about 9:00am I was notified that the patient in question was sent by ambulance to the hospital in Mexico, because no physician could be obtained to take care of her. Calprig was notified on 1/30/78 at 4:10pm regarding this incident.

On 2/2/78 at 11:00am the Medical Coordinator was contactd regarding this incident by Calprig and was requested to send a report to their office.

Sincerely,

Maudester E. George R.N.

Maudester E. George R.N.
Medical Coordinator

MEG:cad

Enclosure:

Attachment "A"
page 3 of 3

STATE OF CALIFORNIA EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
Facilities Development Section
107 South Broadway, Room 6015
Los Angeles, California 90012
(213) 620-4954

March 10, 1978

COPY

Administrator
Paradise Valley Hospital
2400 East Fourth Street
National City, California 92050

Dear Administrator:

COMPLAINTS/ALLEGATIONS/FOLLOW-UP

Please review the attached letter and provide this Department with a written explanation or response within 20 days from the date of receipt of this letter in accordance with the requirements of Title 22, Chapter 3, Section 91157 or 91175.

If further coordination or correspondence between the hospital and the complainant is necessary, a copy of such correspondence should be forwarded to this Department.

Your assistance and/or resolution of this matter is required. If you have any questions or need assistance, please contact our office.

Thank you,

Hector J. Diaz, A.I.A.
Construction Adviser

Attachment

HJD:dbs

ATTACHMENT "B"
PAGE 1 of 2

Facilities Development Section
107 South Broadway, Room 6015
Los Angeles, California 90012
(213) 620-4954

March 10, 1978

PARADISE VALLEY HOSPITAL
2400 EAST FOURTH STREET
NATIONAL CITY, CALIFORNIA 92050

LIST OF DEFICIENCIES:

1. There are no posted notices as distributed by the Department of Health. In addition, notices of obligation were not posted at the nearest social services office.

2. The hospital staff did not volunteer Hill-Burton information.

3. The hospital staff had little knowledge of the Hill-Burton program.

4. A list of doctors with staff privileges at the hospital were not gisen when requested by a member of the public.

5. The hospital staff did not know which doctors treated medicare patients.

HJD:dbs

Attachment "B"
page 2 of 2

RECEIVED

MAR 31 1978

FACILITIES CONSTRUCTION
SECTION - LOS ANGELES

Paradise Valley Hospital

March 21, 1978

STATE DEPARTMENT
OF HEALTH
RECEIVED

MAR 23 1978

FACILITIES CONSTRUCTION
SECTION - LOS ANGELES

Mr. Hector J. Diaz, A.I.A.
Construction Adviser
Facilities Development Section
Department of Health
107 South Broadway, Room 6015
Los Angeles, California 90012

Dear Mr. Diaz:

This letter is in response to your letter of March 10 regarding Candida Casas (copy of letter from Community Crisis Center to Calpirg). The letter and the attached complaint alleges that the patient "in her very serious condition was transported to Mexico."

Upon reviewing the records, the following are the facts:

1. The patient had sustained the burns four days prior to being seen at Paradise Valley Hospital.

2. The patient was an illegal alien.

3. Arrangements were attempted to transfer the patient to the University Hospital Burn Center. Our social worker had worked out the details; however, when the physicians consulted together over the telephone, the patient was refused because of her illegal alien status.

4. The back-up surgeon at Paradise Valley Hospital for the day declined the patient for admission. Subsequently a GP physician was persuaded to accept the patient.

5. In the meantime the husband of the patient made arrangements with a Tijuana hospital to accept the patient. The Mexican Red Cross ambulance agreed to meet the private ambulance provided for her by Paradise Valley Hospital at the Mexican border.

6. The patient was given care in the emergency department and was not in a serious condition to preclude her being transferred by ambulance.

Attachment "C"
page 1 of 3

Naturally Paradise Valley Hospital was unable to collect for the care given to this patient. The bill in this case, including the ambulance charge, is being credited against Hill-Burton Charity.

Incidentally, our physicians do more than their fair share of charity work for the community. A significant portion of our emergency department patients are charity cases, and the physicians who are on back-up rotation provide care for these patients. Paradise Valley Hospital provides more charity each year than is required by the Hill-Burton obligation.

If there are any further questions regarding this case, please let me know.

Yours very sincerely,

Henry P. Friesen
President
PARADISE VALLEY HOSPITAL

HPF*lf

Attachment "G"
page 2 of 3

Paradise Valley Hospital

April 7, 1978

Mr. Hector J. Diaz, A.I.A.
Construction Adviser
Facilities Development Section
Department of Health
107 South Broadway, Room 6015
Los Angeles, California 90012

Dear Mr. Diaz:

This letter is in response to your letter of March 10 which listed five deficiencies regarding the Hill-Burton obligations of Paradise Valley Hospital. Attached were general allegations from the Calpirg organization that were not specifically related to Paradise Valley Hospital.

In response, let me say that the Calpirg organization has never been in touch with my office with regard to the deficiencies that they allege. The notices are posted prominently and have been ever since they were received from the Department of Health. It is not clear to us as to what the nearest social services office or welfare office relates to.

Our hospital employees in the Outpatient Admitting and the Emergency Department are not authorized to extend charity whether regular or Hill-Burton charity. The decision is made by the patients business manager or his designee.

At the same time, Paradise Valley extends more than the required amount of Hill-Burton charity each year, and our physicians do more than their share of charity work. Any insinuations to the contrary are obviously incorrect.

If any further information regarding these "deficiencies" is required, please let me know.

Yours very sincerely,

Henry P. Friesen
President

HPF*lf

STATE DEPARTMENT
OF HEALTH
RECEIVED

APR 10 1978

FACILITIES CONSTRUCTION
SECTION - LOS ANGELES

Attachment "C"
page 3 of 3

2400 EAST FOURTH STREET · NATIONAL CITY · CALIFORNIA 92050 (714) 474-6311

car walked 01 26 78 3:30 AM XX PM 95-1816034 28 34 67

CASAS, CANDIDA 115 28th ST SD CA 92102 COLONIA EL RIO, Calle Fermina Rivera - 772, Tijuana

F W 23y 02 02 54 M MANUEL 7510784

THIRD PARTY PAYOR'S NAME

INSURED'S NAME AND RELATIONSHIP TO PATIENT: no insuraco no deposit

CLAIM CERTIFICATE IDENTIFICATION NO (HIC)

GROUP NAME NUMBER

MEDICAL NO.

WORKER'S COMPENSATION NO.

pt

XMMMMM unemployed

GUARANTOR'S EMPLOYER'S NAME AND ADDRESS

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT: I HEREBY CONSENT TO AND AUTHORIZE ALL TREATMENT THAT MAY BE CONSIDERED NECESSARY OR ADVISABLE BY THE PHYSICIAN. I UNDERSTAND THAT SEPARATE CHARGES WILL BE MADE FOR THE PHYSICIAN, FOR USE OF THE EMERGENCY ROOM, FOR X-RAY AND LABORATORY EXAMINATION, ETC. AND HEREBY AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SUCH CHARGES. I UNDERSTAND CHARGES ARE DUE AND PAYABLE AT TIME OF SERVICE. SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY OR AGENCY FOR COLLECTION THE UNDERSIGNED SHALL PAY REASONABLE ATTORNEY'S FEES AND COLLECTION EXPENSE BASED ON THE LEGAL RATE. **INSURANCE ASSIGNMENT:** I HEREBY CONSENT TO AND AUTHORIZE RELEASE OF INFORMATION AND INSURANCE ASSIGNMENT TO THE HOSPITAL / PHYSICIAN.

PATIENT'S AGENT OR REPRESENTATIVE: Manuel Casas

PATIENT'S SIGNATURE: X Casas Candida

DATE OF SIGNING: 1 26

ANIMAL CONTROL / POLICE / CORONER / CHAPLAIN / OTHER

Clark

TETANUS STATUS: YES / NO X

Rep's 2nd + 3rd Degree burns on legs, pelvis, back yesterday c hot ... 4 days ago

ALLERGIC TO: NKA

There are 2nd, 1st, & possibly 3rd deg burns extending from the mid-portion of the back at approx L-1, spreading laterally to encompass the buttocks. There is extensive burning of the anterior abd wall & the buttocks. There is extensive burning of the anterior abd wall & the inner aspects of both thighs as well involving the groin area. Genitilia are spared.

TREAT: 1. Meperidine, 75 mg; Phenergan, 25 mg IM. 2. Discuss with Dr. McDonald at Univ ~~& she is to be transferred directly to Burn Unit~~ there. ~~3. Tet tox, ½ cc; Hyperte,~~ [illegible] units.

VITAL SIGNS		
TIME		7
T	101	
P		
R		
BP	118/70	112/68

Meperidine 75 mg ... Phenergan 25 mg ... Harris RN

4:15 Hypertet 250 ... Tet toxoid ½ cc ... 4:30 1000 cc lactated Ringer's ...

1st degree burns, back, abdomen, & legs. 9481
2nd degree burns, back, abdomen, & legs. 9482
Tetanus inoculation. Y812

RAB Clark, MD

ADMITTED ROOM NO: NO X / YES

PHYSICIAN: [signature]

NURSE'S SIGNATURE: Terrie Llino

Hospitalization needed
Turned down - Border Patrol

DR. [illegible]

Attachment "D"

Paradise Valley Hospital — EMERGENCY SERVICE RECORD

ATTACHMENT E

2400 E. [illegible]th Street
National City, Ca 92050
Rec'd. 4-12-78 #

APPLICATION FOR HILL-BURTON ASSISTANCE

You may qualify for Hill-Burton assistance if you:

1. Are not eligible for any government programs

2. Are not covered by adequate insurance

3. Would suffer extreme hardship in making any payments on your bill

4. Would suffer economic catastrophy by making payment in full

If you believe you are eligible, please complete the following:

1. Are you a resident of California? ☐ YES ☐ NO

   If you are not a resident, do you intend to make California your home? ☐ YES ☐ NO

2. How many family members are there in your home?__________________

3. Is the wage earner in your family working? ☐ YES ☐ NO

   If so, what is the take home pay?_______________Weekly

   _______________Monthly

   _______________Other

4. Do you have any additional income in the family (such as spouse's income)? ☐ YES ☐ NO

   Source of income______________________________Aomunt_______________

5. Do you live in your own home or are you renting? ☐ IN HOME

   ☐ RENTING

6. Do you have a savings account? ☐ YES ☐ NO Balance_______________

7. Do you have a checking account? ☐ YES ☐ NO Balance_______________

8. Do you have your own car? ☐ YES ☐ NO Year________Make of Car____________

9. Do you have medical insurance to cover your services? ☐ YES ☐ NO

10. Are you able to pay for these services by obtaining a loan through a bank or finance company? ☐ YES ☐ NO

11. Can anyone in your family assist you financially? ☐ YES ☐ NO

12. Please state briefly why you believe you are eligible for Hill-Burton assistance.

OBLIGATION TO SERVE THE COMMUNITY

This facility has a HILL-BURTON obligation to make its services available to the general public and is prohibited by law from discrimination.

In case you need a physician to provide you with services at this facility, a list of staff physicians will be provided by our business office.

If you are a Medi-Cal, Medicare, or other federal program beneficiary and you are having difficulty obtaining services, contact our ____________ ____________________________ for assistance.

NUESTRA OBLIGACIÓN A LA COMUNIDAD

Es requerido según el programa federal de HILL-BURTON que esta facilidad ofresca sus servicios al público en general y por ley está obligada a ofrecer los servicios sin discriminar.

En caso que necesite usted un médico que le atienda en esta facilidad, pregunte en nuestra oficina de negocios por la lista de médicos con privilegios en esta facilidad.

Si usted recibe beneficios de Medi-Cal, Medicare o de otro programa federal y tiene dificultad en obtener nuestros servicios, favor de pedir ayuda en ____.

Should you believe this facility is in violation of the above obligations, please inform the __________ _____________. In addition, you may provide your name, address, telephone number and write or call:

Si usted cree que esta facilidad está en contra con las obligaciones indicadas aquí, informe a la ___ _____________. Debe de dar su nombre, dirección, teléfono y escribir o llamar a la agencia del estado:

STATE HILL-BURTON AGENCY

744 "P" Street, Room 422
Sacramento, CA 95814

Telephone No. (916) 445-2603
Toll Free No. (1-800-952-5270)

65327-088 1250 - OSP

PART-PAY or NO-CHARGE HEALTH SERVICES TO PERSONS WITH LOW INCOME

To qualify you must be near Medi-Cal income and property levels. Some services not covered by Medi-Cal or Medicare can be provided to eligible HILL-BURTON patients.

It is very important to have your eligibility determined prior to treatment or prior to release in case of emergency service.

For more information, please contact our ___
______________________________.

SERVICIOS A COSTO REDUCIDO O SIN COSTO PARA PERSONAS NECESITADAS

Para calificar tiene usted que estar cerca de los niveles de salario y propiedad establecidos por Medi-Cal. Ciertos servicios que no se pueden cubrir por Medi-Cal o Medicare se pueden ofrecer a costo reducido o sin costo.

Es muy importante establecer sus calificaciones con nuestra oficina de negocios antes de admisión como paciente o después de una emergencia.

Para más información, pase usted a nuestra ____
______________________________.

Should you believe this facility is in violation of the above obligations, please inform the __________ _____________. In addition, you may provide your name, address, telephone number and write or call:

Si usted cree que esta facilidad está en contra con las obligaciones indicadas aquí, informe a la ___ _____________. Debe de dar su nombre, dirección, teléfono y escribir o llamar a la agencia del estado:

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744 "P" Street, Room 422
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65327-888 750 - OSP