

- MEETING MINUTES-

Florida Commission on Review of Taxpayer Funded Hospital Districts

Meeting Date: July 20, 2011

Time: 10:00a.m. – 4:00 p.m.

Location: Agency for Health Care Administration, Conference Room B

Members Present: Dominic Calabro, Chair, Brad Dinkins, R. Paul Duncan, Jacob C. Jackson (via phone), Marshall Kelley, J. Scott McCleneghen (via phone), Randall McElheney, Representative Matt Hudson, and Jeff Gregg, Executive Director.

AHCA Administrators and Staff Present: Kaylyn Boles, Beth Eastman, Marsha Webb, Rydell Samuel, Ester Kim, Bill McCort, and Cruz Conrad

Interested Parties Present: Paul Belcher, Florida Hospital Association; Jennifer Hinson, Ausley & McMullen; Crystal Stickle, Safety Net Hospital Alliance of Florida; Sonya Sowards, Florida Tax Watch; Glenn Burhans, Greenberg Traurig; Blaine Cherry, Florida Tax Watch; John Benz, Memorial Healthcare System; Casey Perkins, Executive Office of the Governor; Eric Prutsman, Prutsman and Associates, PA; Jim Zingale, Safety Net Hospital Alliance of Florida; Tom Joos, Executive Office of the Governor; Christine Sexton, Florida Tribune; Bill Woeltjen, Sarasota Memorial Hospital; Warren Jones, Tallahassee Memorial Hospital; Dee Schaeffer, Halifax Health; Tony Carvalho, Safety Net Hospital Alliance of Florida; R.H. Hahn, Coventry Healthcare; Steve Purves, Munroe Regional Medical Center; Richard Mutarelli, Munroe Regional Medical Center; Melanie Pfister, Johnson & Blanton; Layne Smith, Mayo Clinic; Travis Blanton, Johnson & Blanton; James Call, Florida Public Radio; Amanda Prater, Florida House of Representatives; Eddie Metzger, Pittman Law Group; David Coburn, Capital Analytics; Lori Hundley, Parrish Medical and David Fifer, Akerman Senterfitt

Welcome and Introductions: Dominic Calabro, Chair, called the meeting to order and welcomed the Florida Commissioner's Review of Taxpayer Funded Hospital Districts (Commission members) and interested parties. The Chair requested the Commission members and interested parties to introduce themselves.

Review and Approval of June 20th Meeting Minutes: Chairman Calabro called for a review and approval of the minutes from the June 20th Commission meeting. Representative Hudson made a motion to approve the minutes and it was seconded by Mr. McElheney. The motion passed.

Impact of Medicaid Reform: Representative Hudson provided an overview of House Bills 7107 and 7109. As Healthcare Appropriations Chair of the House he realized that there was no way to do a budget, in the House, without addressing the Medicaid issue. Currently .28 cents of every tax dollar goes to one program and that is Medicaid. This impact on the State budget is tremendous as well as its impact on the healthcare delivery system in Florida is significant. Improving this is a challenge.

Why did they do it is the big question. The .28 cents on the dollar is based on cost, utilization and enrollment trends, and this is expected to increase to .33 or .34 cents within the next

several years. He noted that there was probably no one in the room on Medicaid, but that 1 in 6 Floridians are, therefore this impact statewide is very significant. While most people aren't on Medicaid, this increase has to come from somewhere; therefore, it will affect us all. There are a few problems with Medicaid. There is currently a pilot project, started by Governor Bush, going on in five different counties across the State (Baker, Clay, Nassau, Duval and Broward). There was a lot learned from this pilot project. The fee-for-service model is a very difficult model to manage. There are 80,000 providers with about 1.3 trillion lines of actual billables that were coming through and it is very difficult to weed out any fraud issues that may come along. There is also an issue with reaching the underserved communities. This was started 2 years ago. They looked at what was working and what wasn't working. They looked at bits and pieces of programs all over to see what worked. In order to alleviate the problems they thought it was best to get out of the fee-for-service model and get into a managed care model. Representative Hudson noted that there are critics of both models. The State of Georgia played a big role as a model for how best to make the change.

Overall, the new managed care model would help improve cost and utilization, provide better care in rural areas (access to specialty doctors/services), and the new system will be easier for AHCA to manage and would ultimately help eliminate fraud. The new plan would also bring long term care into the scope. AHCA is required to submit the plan to the Federal government in August 2011 and they are unsure about how long this will take for approval. The anticipated timeline for implementation would begin in July 2012 with the procurement of long term care plans, then January 2013 with the procurement of managed medical assistance plan. In October 2013 the enrollment in long term care plans would begin and October 2014 the enrollment in managed medical assistance plans would begin.

Representative Hudson also noted that the new managed care model is not related to National Health Care Reform, which could potentially add another 1.5 million participants to Medicaid increasing the amount to .40 cents on the dollar. This will be a huge problem for the state budget.

Chairman Calabro asked what would happen if Florida does not get the Federal Medicaid waiver and when do we need to know that. Can we act presumptuous that we will get the waiver, etc? Representative Hudson stated that he would not presume anything that the Federal government would do. Historically there has been a strained relationship with them. There have been a lot of letters sent in from advocacy groups encouraging them to not approve it, so it will be interesting to see what happens. Chairman Calabro also asked have there been similar waivers in other states and what has been approved or denied. Representative Hudson stated that all parts of the plan have been approved in some shape or format in another state. Not collectively all together but in pieces.

Mr. Kelly asked about discussing the provisions dealing with hospitals, specifically intergovernmental transfers, essential providers and the DRG study. He also noted that he agrees with this and has looked at a lot of states and many are all managed care. Representative Hudson directed the members to look at the handout of HB 7107, page four, for information on intergovernmental transfers (IGT). He noted that IGTs are a challenge and are very confusing. He explained that a local community, taxing district, or a county can effectively raise money to give to the state, which is then sent to the Feds and matched with Medicaid matching dollars. The money then comes back to the local community with part of the match of the additional dollars and gets spread out to hospitals around the state of Florida to handle some of the low income population that they may not be compensated for. He then explained that for the essential providers they tried to lump everybody and not leave anyone out.

Representative Hudson noted that they tried to include everyone and not leave anyone out. They also included the medically needy in the managed care plan. There are approximately 75,000 medically needy people at any given time in the state of Florida. This population is very unique as they aren't typically Medicaid eligible, because of income status, or they are in a situation where they cannot get regular insurance or they are simply a medically complex individual. He noted that hospitals will be reimbursed for these cases and that even though it doesn't seem like a lot of people, they are an expensive group of people.

Mr. Jackson asked for elaboration on the two instances of where the low income pool (LIP) has been changed as it relates to managed care. Representative Hudson asked if he would email Director Gregg and he will provide a more detailed and accurate response.

Chairman Calabro responded with another question about changes to the low income pool and do we look at what works and doesn't work with the low income pool today. Representative Hudson responded that the low income pool has a lot of challenges. The council that looks at how the money is split up is a perpetual battle between the for-profit and not-for-profit industry to make sure that everyone is getting their slice of the pie. The council comes up with a recommendation and without any hesitation the Legislature passes it and does what they want to. He stated that systemically it is broken in terms of how it is divvied up.

Dr. Duncan commented that the approval of the previous waiver created the low income pool with a short list of very specific objectives about where the money could come from, how it would be matched and how it had to be distributed. He mentioned that you couldn't have a program that said here's the money you put it on the table, you match it, you send it back, here's the money, put it on the table, and so on. He stated this could not be done. The Federal government required that it be distributed more widely than that and had specific expectations about how that would happen. His research indicates that this has happened. He stated that no one knows how the modifications in the new language will impact this.

Mr. Jackson commented that one of his questions about the low income pool is the issue about whether or not the money follows the patient. With the new changes to the low income pool and methodology, for example, if we have some private hospitals who are given low income pool money are we able to measure if that money matches the number of patients as well as with the public hospitals that need to be audited. What is the methodology of making sure the money is truly following the patient and to make sure they are being matched together? Chairman Calabro commented that it is a critical part and as we look at the hospital districts there is a growing concern that the money follows the patient. Representative Hudson commented that it is in part a philosophical question about whether or not various types of organizations are getting various types of money and then there is another question that is more data driven. On the philosophical question, assuming that they are receiving money, are they expending it in ways that align with the intentions of the Legislature. At the level of the first round was to follow the CMS terms/conditions. We should explore this question and how to follow that money. At the second level, for those that are receiving LIP money, are they delivering new care in exchange for that.

Chairman Calabro then asked if there was a way that we can ask that the Legislature to adopt considerations to ensure, encourage or incentivize health outcomes in some consideration of feasible costs in allocating funds for LIP and other types of programs, so that we recognize those that do their job with tougher patient caseloads at a reasonable cost. Representative Hudson responded that recommendations to the Legislature can be made for anything;

however, this is so demographically challenging to compare some of these patients. It would be hard to come up with a metric system to compare based on demographics and it would be a challenge to distribute LIP money based on outcomes. He noted that if there was a metric created to incentivize good outcomes, what would it be, based on a level playing field.

Mr. Jackson stated that one of the basic questions that we want to look at whether or not entities are receiving LIP funding and the decreases that is happening on a continual basis. This may be of concern to the taxpayer regarding a pattern over time. There doesn't seem to be an identifiable methodology about how money is being distributed. Is there a methodology to track this? Dr. Duncan replied that there is not a state of the art methodology for pursuing that kind of question. He then explained that part of it is contradictory, on one hand we are trying to achieve efficiency by aggregating 80,000 providers in the state to a smaller number or average. He went on to explain that patients want to see data based on the individual level, not an average of all patients. Representative Hudson commented that most of this is connected to the IGT.

Mr. Kelly asked if there was a definition of what is meant by "money follows a person". He noted that he had heard several meanings and would like clarification. He stated that we need this as it is part of the mission of the Commission. Dr. Duncan agreed and that it had not been clearly defined as it relates to the taxing districts. Representative Hudson stated that being able to track money by person will be very challenging. Mr. Jackson stated that it may be better to say "money following the population." He gave the example of an increase in LIP funding; however, the funding for the population to be served by that has decreased within that system. Representative Hudson agrees and that a metric could probably be created in that regard to some degree; however, he is still unsure how this can be tied to the outcome data.

Chairman Calabro asked if AHCA could determine where some of the Medicaid reductions are occurring.

Review of Commission Survey Material Submitted by Hospital Districts: Director Gregg provided a summary of the responses received from the hospital districts in response to the letter sent in May. The letter contained nine questions. There were several districts that haven't submitted responses yet, but they are expected soon. The summary sheet will be updated to reflect the new information as it becomes available. Director Gregg also presented a matrix of hospitals, which includes hospital name, county, ownership (For Profit, Not for Profit or Government), number of acute care/specialty beds, and the hospital district it is part of (if any). This list is to assist the Commission in determining the publicly funded hospitals and provide a framework for the hospitals that need to be examined further. Director Gregg stated that staff will review the responses more thoroughly and contact facilities/districts to fill in the missing information.

Director Gregg noted that there has been a communication challenge with Tampa General Hospital. There have been three letters received from them and they don't think this applies to them. He will continue to pursue obtaining more information from them. He later noted that a response has not been received from Jackson Memorial; however, he has spoken with them and expects a response in August. This information should be available by the next meeting. Director Gregg also noted that they are not a special taxing district; they are a unit of county government (Miami Dade County Public Health Trust). Representative Hudson stated that initially Jackson Memorial wasn't on the list and he inquired about that, because although they are not technically a taxing district per se, they do spend a lot of taxpayer money and they have a unique role in Southwest Florida as it relates to access. He noted that it was important to put them on the radar screen.

Dr. Duncan stated that the Commission, at some point, needs to come up with a more manageable list. He noted that there are facilities that may need to be included, that weren't originally and some excluded that are currently on the list. He stated that coming up with the list will be hard to do, but it will make it easier to make recommendations. Chairman Calabro agreed. He noted that the Commission needs to figure out how to break down the tasks as outlined in the Executive Order into workable components. He went on to note that as part of this the Commission needs to know who is in and who is out. There was discussion about how to define tax dollars, whether by a taxing district or public trust. Mr. McElheney suggested that we look at the intent of the language. Mr. Kelly suggested that if you look at tax dollars, all hospitals receive tax dollars (Medicaid, Medicare, etc.). Mr. McElheney noted that it is not fee-for-service, but appropriations. Mr. Kelly suggested that in order to avoid issues with defining tax dollars you can create multiple tables with and without the facilities in question (i.e., Jackson Memorial). This will also help alleviate issues with those larger facilities skewing the data. Chairman Calabro agreed and noted that the facilities may fall under taxpayer supported even though they aren't in a taxing district. He stated that knowing this in advance will help as they move forward.

Public Comment: The Commission members received comment from Mr. Steve Purves, President and CEO, Munroe Regional Medical Center. Mr. Purves first thanked the Commission for the opportunity to speak. He then explained that he was at the meeting because his facility had been mentioned several times at Commission meetings and he would like to provide some detailed information about Munroe Regional Medical Center. The hospital has been around for about 113 years and was the fourth hospital established in the state. It was created as a mission to serve the needs of the community, which is still the mission today.

They operate under the Marion County Hospital District, which was created in 1965 to help fund citizen care in the community. He noted that that was a long time ago and things have changed since that time. The District is governed by a seven member board of trustees. They have the fiduciary responsibility of the district and all aspects of the district are under the Munroe Regional Health System, Inc. (MRHS). They were created by the district to manage and operate cost cutting. This is because of law changes that allowed public hospitals to lease operations to private organizations. He then went on to explain that today the hospital is run under the MRHS board, which consists of the seven trustees and six non-trustee directors. The seven trustees are trustees of the district and the six non-trustee directors help round out the board of MRHS. They represent the community, bring expertise and broaden the capabilities of the board.

He noted that MRHS is not a management company and that they were created to carry out the mission of the hospital. The District itself does not have tax levying authority, which lies with the County Commission. The trustees can only make recommendations. Mr. Purves then discussed the comparison of the percentages of those providing indigent care in the community between MRMC and Ocala Regional Medical Center. He noted that it was misleading to look at only the percentage of charges, because charges vary between hospitals. He then noted that another aspect that the Commission is interested in is the amount of tax support that is funded and where that money is going, how it is being used and is it efficient.

He stated that between 2005 and 2009, ORMC has received \$3 million dollars from the county for indigent care. He noted that MRMC or the hospital district has not requested or received any levy or tax support for 30 years. MRMC has conducted several cost efficiency analyses and it was concluded that their issue is a revenue issue – not a cost issue. He stated that in their strategic plan it was very clear that from the trustees that they needed to find supplemental

sources of revenue. In conclusion he asked that when the Commission makes their recommendations that they won't rush to conclusions about cost efficiency, transparency and the operation of a public institution.

Chairman Calabro noted that Mr. Purves made a compelling argument about the difference between cost and charges and that costs are simply costs. He then asked why a for-profit hospital is receiving tax help when a not-for-profit hospital isn't. Mr. Purves stated that you would have to go back a long time and look at the landscape at the time. He explained that in the early 1990s there was a concern about indigent care and in order to convince the HCA hospital to participate in the plan the county put aside about \$2.4 million dollars to be distributed to a variety of sources. So, money was allocated to the hospital so that they would participate in the program. At that time, MRMC did not accept any money.

Chairman Calabro asked if the hospital district had ever levied a tax and Mr. Purves responded that it had not in over 30 years. The money that is received from the County comes from their general appropriations. Mr. Kelly stated that the Commission has been given distinct tasks in the Executive Order and that any recommendations from MRMC or any other hospital would be helpful in addressing each task.

Review of Issues Regarding Oversight of the Special Districts: Director Gregg stated that AHCA is not involved with the districts, only the hospitals. The Department of Community Affairs (DCA) oversees the Districts. Director Gregg spoke with lobbyist, Chris Lyon, who represents the Florida Association of Special Districts, who then referred him to Jack Gaskins at DCA. During his conversations with them he learned that the hospital districts make up a small portion of all special districts in Florida. Mr. Gaskins referred Director Gregg to a lot of information on the special districts. He learned that the accountability of the special districts is the same as that of elected officials. Commission members would like to have Mr. Lyon or Mr. Gaskins come to a meeting to discuss special districts in more detail and to answer any questions.

Meeting Summary and Adjourn:

Director Gregg provided the Commission members with the next steps. They are as follows:

1. Presentation by Phil Williams on Medicaid rate setting and related issues
2. Presentation by Palm Beach County
3. Presentation by Lee Memorial Hospital
4. Presentation by Jack Gaskins – general information about special districts
5. Update of spreadsheet from first meeting by AHCA Financial Analysts
6. Update of large matrix with new information as it becomes available
7. Continue to update/refine hospital list
8. Provide additional information on the single hospital license versus multiple hospital license (i.e. hospitals with premise hospitals all using same license number)
9. Provide additional information on the organizational structure of districts – trustees of the districts and those operating the hospitals
10. Provide more detailed information on the low income pool program – Representative Hudson and AHCA staff will provide more information

11. Provide additional information on the compliance mechanism if a consumer has a complaint about a hospital district
12. Provide additional information on the type of tax funding each district receives – LIP funds, appropriations, etc.
13. Provide additional information on the trend of the districts; millage rate increases, etc.

The meeting adjourned at 2:30 p.m. The next scheduled meeting is August 16, 2011.