

### **Hospital Taxing Districts (Draft—Notes—M. Kelley)**

Most of the comments below are in bullet or short paragraph form. This is not meant to be a flowing narrative. These are draft notes and tentative alternatives or recommendations. I expect to change them each time we have meetings or when I review further material. This is just some initial, not final, feedback. Since we are working under the sunshine restrictions, I cannot discuss with other members. So, you can send to other members as appropriate, and I would like to receive other feedback in addition to the comments from Mr. Dinkins)

As the health care delivery system is rapidly changing, it poses a challenge to the publicly funded safety-net systems. Without initial and on-going public support, we would not have had the safety-net hospitals and the development of the tertiary services that many provide—as Dr. Duncan indicated, “we would not be having this discussion.” The counties in the USA had responsibility for indigent health care long before the state government and federal government got involved, so it is easy to see why we have many different variations of safety-net hospitals and taxing methods that evolved at the local level. As other providers later developed competing models and the need for primary and outpatient care became even more apparent, some of these systems have evolved to broader community models, such as the Health Care District of Palm Beach County and the Hillsborough system which provide indigent care in a variety of settings and allow patients wider choices.

The years have also seen enormous increases in both healthcare costs and the number of uninsured as more and more workers are without insurance because they and their employers are not able to afford it. It is not a simple matter of more taxes paying for the same health care need. It has been more taxes paying for increased costs and more and more people unable to afford healthcare. Having said that, there are ways to reform the system and develop a more level playing field.

Payment reform will change the way hospitals operate in the future. Managed care, capitated payments, DRGs, bundled payments have all become more prominent since the Medicaid program began with many hospitals paid on the cost-based reimbursement system. Now, potential payment for new models such as an Accountable Care Organizations, more comprehensive managed care, or payment through a DRG system, will be more likely than the continued per diem, cost-based, system in Medicaid. At the same time, if more individuals are financed through health reform, the likelihood of continued Low Income Pool and Disproportionate Share (DSH) payments at the same level will be challenged. LIP will expire in three years, and DSH will be reduced by 50%.

One of the documents provided to the Commission members was from the National Association of Public Hospitals and Health Systems, the President said in his message after discussing the accomplishments: "At the same time, safety net providers must also prepare for reforms of the delivery system itself, through enhanced coordination of health services across the full spectrum of care, as well as the expansion of primary care services and medical homes for the newly insured."<sup>1</sup>

Thus far, as a commission, we have seen many excellent systems and alternatives. Some of these I will point out in my notes below.

Major changes are already underway or authorized by the Florida Legislature and I will discuss these, such as how managed care and DRG's could change the current reimbursement system. In other cases we have seen what works in an individual community, and how each community may see their situation in the future differently as they have seen it differently in the past in the past. I favor the idea that we should respect each community's differences, and recognize the diversity of the state..

**A. Determine, based on objective data, whether costs in government-operated hospitals are higher or lower in comparison to similar non-government-operated hospitals offering similar services, and whether, assuming there is a such cost difference, it results in higher or lower Medicaid, Low Income Pool or other reimbursement, compared to other hospitals that provide care to the poor, and whether spending would be reduced or increased if the hospitals were operated at the same levels of efficiency.**

We have had confusion with some terms such as "government operated," and we use many terms such as exempt, non-exempt hospitals, taxing district hospitals, cost-based reimbursement, etc. "I am as guilty as anyone, but maybe we need a short glossary.

While we had been presented the data by FSU on the comparable costs, I would like to see the Tables we are going to include in the report. I recommend that we include some user friendly tables from Dr. Lee and report that Dr. Lee found xxxx. Then, we should include Dr. Zingale's report and say: Dr. Zingale presented data on the outliers that indicated xxxxx.

Do we have a clear statement on what the cause of the cost differences are?

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<sup>1</sup> America's Public Hospitals and Health Systems, 2009, P X

Want a user-friendlier table with qualifications and notes, such as the number of small rural hospitals, etc., as Jeff discussed. We should emphasize the heavy burden of indigent care these systems have had to contend with. We need a clear statement on whether there is any real cause/effect of the differences in cost because of Medicaid funding, or taxing district funding—we have made no connection here.

Whatever the cost difference the point that I have tried to make is that the second half of the Commission's charge in "A" has already been set in motion—that is that Medicaid reimbursement will change to a DRG system and the LIP will go no more than three years under the current initiatives we see at this point.

There are also opportunities for the Legislature to direct or study alternatives that will result in more LIP funds used to fund primary care and other services needed by the indigent population while it lasts.

(Jeff: I am not sure that the Commission has a table or knowledge of how much of the multi-billion dollar hospital inpatient, outpatient and special hospital funding line items are funded through these local taxes to match the federal dollars and how little general revenue there is in these line items. Dr. Zingale presented this on 11/21—include chart on the 876 million and the matching funds they draw down)

The Legislature has addressed this issue to some extent with actions on a DRG study, the move to managed care, the necessity to include essential providers, and the LIP.

Following are sections from CS/HB 7107 and 7109 that are relevant to these issues:

CS/HB 7109, Engrossed 3, lines 689-702—(g) The agency shall develop a plan to convert inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis-related groups (DRG) and assigns payment weight based on the average resources used to treat Medicaid patients in that DRG.

AHCA must submit the Medicaid DRG plan to the Governor and legislature by **January 1, 2013**

CS/HB 7107, establishes timeframes for the Medicaid program to move to manage care for the vast majority of its recipients, only a few exceptions. This is to be completed for the **LTC recipients beginning July 1, 2012 and completed by October 1, 2013 and for Medical services by October 1, 2014—Implementation begins January 1, 2013.**

In a managed care scenario, the health plans and the hospitals would negotiate a rate—they are not tied to the Medicaid rate, but the Medicaid rate is normally used in the negotiations as a reference or starting point. Sometimes, it ends up being the negotiated rate. If the state moved to DRGs, the questions occur as to how this may effect the health plans/hospital negotiation and establishment of a rate, as well as how local contributions may be affected. CS/HB 7107, Engrossed 3, lines 1424—1434:

“(6) PROVIDER PAYMENT. -Managed care plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. For rates, methods, and terms of payment negotiated after the contract between the agency and the plan is executed, plans shall pay hospitals, at a minimum, the rate the agency would have paid on the first day of the contract between the provider and the plan. Such payments to hospitals may not exceed 120 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.”

In order to ensure the participation of the essential Medicaid hospitals in the managed care program, CS/HB 7107, Engrossed, lines 1283-1363. To paraphrase, health plans must contract with “essential providers” as defined by the Agency and the bill as “offer services that are not available from any other provider within a reasonable access standard, etc.” For our purposes statutory teaching hospitals, hospitals that are trauma centers, hospitals located at least 25 miles from any other hospital are listed. Then HB 7107 prescribes a method of payment if negotiations are not successful.”

7107 talking points: “Plans and providers must negotiate rates, but payments to hospitals may not exceed 120% of the Medicaid rate. This will ensure adequate compensation for entities that must contract with the plans.”

What rate does the agency see as the rate for the 120% above and what rate will the agency use to pass on in the managed care capitation reimbursement—how does this work?

It will be essential that managed care companies selected by AHCA in the competitive procurement process for the new managed care programs receive a fair portion in the capitation payment for the cells that represent the hospital component for each individual. Providing a system where managed care companies and hospitals receive fair compensation is a major challenge that will need continued monitoring and development by the Agency and Legislature. It has been a somewhat contentious battle between hospitals and managed companies surrounding the rate issues. AHCA should not grant hospital rate increases without coordination of the managed care rate for the new program to be a success.

Nevertheless, this system is already on a path for radical change as I have discussed above.

We could recommend that the extent possible that the Legislature provide incentives for the use of LIP funds for providing primary and specialists care to the indigent population through models that offer more community and hospital choices—perhaps AHCA could provide us with a better idea of our options here.

I am against any broad requirement to sell public hospitals and eliminate the taxing authority. I think the way to establish a level playing field is in payment reform, more consumer choice, and different incentives in some of our programs like the LIP. I also think these should be local decisions. Any broad requirement to change the current local situation could have complications we cannot think of at the present time with all of the other changes happening at the same time.

**B. Determine if there are better or worse outcomes on national measures of quality, such as the CMS Core Measures, in-government hospitals compared to non-governmental operated hospitals.**

As discussed in the November 7 meeting, it is difficult to reach a clear comparison of quality measures for a wide variety of reasons. This commission did examine data on quality measures. There is currently an emphasis on gathering data on quality and refining the measures on the part of CMS. AHCA, over the past decade, has also attempted to gather data on quality and has placed this information on its web site for consumers and researchers. The commission report could highlight the developments and limitations in this area, but also encourage the Governor and Legislature to support the resources required for AHCA to continue to develop and improve the hospital quality database. This information is best presented by hospital, rather than by groups of hospitals, at least from the consumer's point of view.

Accept staff recommendation in Jeff's paper. Also add a recommendation for the Governor and Legislature support for AHCA to continue to refine and publish data on outcomes and quality by hospital and health care facility. Improve healthcare consumer information should be adopted as a major goal.

**C. Determine if models exist in Florida and other states where local taxing authorities have created innovative programs and access for poor without operating hospitals and instead have created programs where the funds follow the patient to the hospital or outpatient service closest to their community.**

**Hillsborough County Health Care Plan** uses 600 primary care physicians, 12 clinics and five hospitals. “Case managers within the Department of Health and Social Services (HHS) determine eligibility, assign new members to a medical home, and facilitate access to other services.”

### **Palm Beach County**

Palm Beach Palm County Health Care District provides coordinated care through the Personal Health Plan/Healthy Palm Beaches, Maternity Care Program, and Vita Health. These are operated like an insurance plan and provide a comprehensive network of contracted providers; membership is determined through an eligibility process, and Utilization and quality is managed through nurse reviewers.

All 13 hospitals in Palm Beach County participate in the network; over 1200 physicians located throughout the county. Public Health Department Clinics and FQHCs participate as primary care providers—slides 4,5,6 presentation

Use community physicians

Lee Memorial—clinics

Community partnering slides pp11-12

South Broward—as described in Jeff’s paper

Campbellton Graceville as described in Jeff’s paper

### **D. Gather data and the various methods of providing access to the poor from each hospital district in Florida to determine the most cost-effective method of providing outpatient and inpatient hospital services to the broadest population possible and recommend the best models to the Governor and Legislature.**

Most of the information on this is provided in C above and in the presentations we have heard. There is no one method or model, but we have seen trends or example of a more wider range community-based models as opposed to more hospital only models. There is a continuum here and we have not determined cost-effectiveness of each.

After listening to the Keith Arnold presentation on the Public Medical Assistance Trust Fund, I recommend that our report include this as an example of what may be possible and that it should be studied to see if there is a way to use PMATF funds to incentivize more cost-effective services to a broad population, in this case a regional children’s hospital.

**E. Determine, if the existing governing-body model of the various government-operated hospitals optimizes the best governance practices, ensures proper oversight with accountability for the actions of board members, has had any violations of charter or governance rules by board members, has complied with the government-in-the-sunshine laws, and has consistently acted in the best interest of the primary shareholder-the taxpayer.**

No obvious changes to Chapter 189—If they did not have work in sunshine, or did not have to report financially or be audited etc., I might want to mandate these things, but the current law covers those major areas and I am very cautious about mandating more.

September 20 minutes “Lee Memorial has a 10 member board elected through a countywide non-partisan election. Sunshine and public record laws govern the board. All board meetings are publically noticed and open to the public.” In addition useful website—requires all documents and contracts. —A good example we had of best practice.

Totally agree with Jeff’s description and recommend local bills for any changes. While Lake County, Munroe, Volusia are all in central Florida, their solutions are not necessarily representative of the large urban areas in Florida, and I would be careful about mandating something statewide that does affect local control of the taxing districts. I am also supportive of Representative Hudson’s stance on the importance of local control and decision making. Agree with the Chairman’s desire to change mileage language to “up to.”

**F. Determine if taxpayer-funded hospital districts are using employment models for physicians wherein the physicians are being paid outside the norm for similar non-employed, non—tax-subsidized physicians in the geographic area, and whether other forms of compensation, such as medical directorships are being used, and subsidized by taxpayers, for the purpose of competing with private physicians, and not-for-profit and other community hospitals which enjoy no such tax subsidy.**

Is this about Hospitalists?

Lee Memorial use of FSU Family Practice Residency Program, Hospitalists

Hillsborough County Health Care Plan uses 600 primary care physicians, 12 clinics and five hospitals. “Case managers within the Department of Health and Social Services (HHS) determine eligibility, assign new members to a medical home, and facilitate access to other services.”

Palm Beach and other models based upon consumer access to a broad network is best outcome.

**G. Determine the best mechanism for transition of government-operated hospitals to more appropriate governance models based on the experience of the many public and government-operated hospitals that have implemented such conversions. Determine, if appropriate to convert government operated hospitals to different governance models, what the process should be for such conversion, provided that any such process should optimize the return for the taxpayers on the value of the assets and should be transparent to the public.**

I agree with the November 7<sup>th</sup> meeting recommendations by David Ross of Tenet as captured in Jeff's document.

Open public bid process

Fair and independent asset valuation process

Ensure on-going community benefit with any proceeds (should we say health care related or not—see 5?)

Independent oversight

Requiring the maintenance and/or expansion community health programs

The part that I am not clear on at this point is the possibility to have some negotiations held in private, recorded and later released to the public?