

Commissioners:

This is my attempt at a practical, plain English review of the issues that have been presented to you. It includes decision points for you to consider that can become Commission recommendations. My goal is to assist you to make practical recommendations that are useful and can be accomplished.

What Is the Problem You Are Trying to Solve?

Special districts were created throughout the middle decades of the last century when the state's health care infrastructure was very lean but the population was beginning to grow very quickly. The health care system was much simpler. We didn't have the diversity of facilities and practitioners that we have now. The for-profit hospital corporations did not exist. Some communities felt the need to fund hospitals and other health care infrastructure, and they were willing to be taxed to do so.

In the 1960s, the Medicare and Medicaid programs were enacted at the national level. By the 1970s, Medicare was funding an explosion of hospital development across the country because hospitals could allocate a portion of their capital costs to individual patient bills. This was called "cost plus" reimbursement. For-profit hospital corporations were created. Many new hospitals were built and existing hospitals expanded. Hospital spending began to grow at previously unseen rates. The federal government established a requirement for state certificate of need programs in part to control the explosive growth.

In the early 1980s, the need to change Medicare hospital reimbursement was clear. The inclusion of capital costs in patient bills had led to the overdevelopment of inpatient hospital beds. Inpatient reimbursement was switched to a system of prospective reimbursement based on the patient's diagnosis. This is still the reimbursement system today and it is generally referred to as DRGs (diagnosis related groups). A long process of trying to redirect patients away from more expensive inpatient care to greater use of outpatient services began. This stimulated the diverse array of outpatient health care providers that we have today. Many hospitals also own and operate diverse outpatient services.

In Florida, continuing rapid population growth fueled an ongoing expansion of the state's hospital industry, despite the Medicare reimbursement changes. For-profit hospitals increased and expanded until we became, and have remained, one of the states with the largest percentage of for-profit hospitals. Specialty hospitals for inpatient rehab, mental health and long term acute care developed. Over the same time period, many public hospitals changed their governance to private not-for-profit.

Hospital expansion slowed by the mid-1990s and this is generally attributed to an effort to expand managed care in that time period. In the 2000s, Florida hospitals began to show signs of a slow-down in development of inpatient facilities. Increased regulatory flexibility allowed existing hospitals to grow, replace themselves or renovate extensively. In the current time, with slowed population growth and a continuing interest in using the least intensive services appropriate to the patient's needs, the development of new general, acute care hospitals has slowed. It isn't at a standstill but, compared to the 1970s and 80s it is limited to certain local markets and situations.

This leaves us in the present with a relatively mature, diverse, and very competitive hospital industry. Population growth has slowed and access to capital has decreased. As far as our special taxing districts and publicly funded hospitals are concerned, there are a variety of situations that, while unique in many respects, have occurred in close proximity and led to an interest in evaluating the ongoing appropriateness of special hospital taxing districts in Florida. Please consider the following situations:

- Major financial and administrative problems at Jackson Memorial Hospital in Miami, which is the state's largest public hospital, have been extensively covered in the press. While not affiliated with a special hospital taxing district, Jackson is affiliated with a unit of county government that has similarities to a special district.
- A controversial effort to change the ownership structure of the four hospitals in the BrowardHealth system (north Broward) that was abandoned, perhaps temporarily.
- An uncertain situation at the North Lake County Hospital District which has led to the filing of a local bill in the 2012 legislative session. You heard about this at your first meeting and again when Representative Larry Metz made his presentation at your last meeting.
- A controversy involving local funding and the potential of a change of ownership at Munroe Regional Medical Center, which is associated with the Marion County Hospital Taxing District. This situation has been resolved at the local level for the present.
- An unusual circumstance involving the presence of two boards of directors associated with the Citrus County Hospital Board and Citrus Memorial Hospital is currently being litigated. The litigation is probably why you haven't heard from them.
- The Southeast Volusia Hospital District attempted to change the ownership of its Bert Fish Medical Center but it was invalidated by the court system due in part to Sunshine Law violations. You heard from their representatives at one of your earlier meetings.
- The West Orange Healthcare District considered and delayed a change of ownership for its Health Central Hospital, in part to wait for your recommendations (according to press reports.)

Several of these situations include issues or problems associated with a change of ownership or governance, which is one of the areas of emphasis in the executive order.

In light of these and other circumstances that we may not know about, I would say that the basic underlying questions for the Commission report are:

1. If special hospital taxing districts were developed in a time when there was a great need to expand hospital infrastructure, what is the priority need now?
2. Do hospitals associated with special districts have an unfair advantage in a diverse, competitive, mature health care marketplace?
3. What is the best role for special hospital taxing districts as we move into the future?

Comparing Special Taxing Districts and Hospitals

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

Hospitals have become extremely diverse. It is hard to compare them. Smart people have been working on meaningful ways to compare hospitals for at least the past two decades. There is uncertainty about what the public really wants to know and what we non-practitioners can use to make better health care decisions. There is also great difficulty in translating information about our most complicated type of health care provider in a way that the public can understand.

There are numerous public and private rating systems intended for use by patients and families, but their methods are different and there is no consensus about the best approach. There are many very detailed clinical outcome data systems that have been developed by and for physicians, but they are not only limited to clinical specialties, they sometimes focus primarily on specific procedures. There are no simple outcome measures that attempt to summarize and report on the operations of an entire hospital. There are many outcome systems that view hospital operations in different ways.

The clinical outcome measures that staff provided are either inpatient quality indicators or patient safety indicators as defined by the federal Agency for Health Care Research and Quality. These measures of quality are on a par with the CMS Core Measures referenced in the executive order.

DECISION POINT: The staff recommendation is for the Commission to report that, based on the available outcome data, there is no pattern of higher or lower quality based on ownership type.

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 such a 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.

The financial, facility, demographic and outcome information about the state's general, acute care hospitals that staff provided to you earlier this year was the latest information that had been fully processed and vetted by the regular AHCA data systems. This is important because the information does not always arrive at the Agency in a usable state. Medical records coding uncertainties, details of financial classification, IT-related issues and other types of detailed issues must be worked out. It can take the Agency months to certify and publish a set of data from hospitals. This is what precluded us from asking for any new data.

Dr. Keon-Hyung Lee used the data that was provided to the Commission to complete his financial analysis. Dr. Lee brought an academic approach to the subject and his analytical methods are sophisticated. His list of public hospitals strictly defines the government operated hospitals by ownership type. That is the cleanest way to define them, but seven of the 21 facilities are small, statutory rural hospitals (five of which are located in the Panhandle) and they are included in a group

that also includes the largest general hospital in the state (Jackson Memorial), as well as the ninth (Sarasota Memorial), eleventh (Memorial of South Broward) and twelfth (Broward General) largest general acute care hospitals in Florida. The remaining public hospitals fall in the mid range between these two extremes. This is another area where the diversity makes it difficult to draw conclusions.

Dr. Lee reported higher costs in public hospitals, but he did not attempt to extend his analysis to the impact on Medicaid rates nor did he attempt connect financial performance with clinical outcome measures. The immediate challenge for the Commission is to decide how to incorporate Dr. Lee's study into the report.

DECISION POINT: Provide guidance to staff on the interpretation of Dr. Lee's report and suggest ways to use the report to answer the specific question in the executive order.

Indigent Care

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

We have enough information from the responses to the Commission survey, and some of the presentations that you have heard, to fully answer this question. Below are three examples of what has been reported.

1. The Health Care District of Palm Beach County provides the largest example of a special district that has taxing authority but doesn't limit the funding to its own hospital. When Dr. Ron Wiewora presented to the Commission, he described different local programs that use the district's funding to reimburse care for specific groups of low income residents. He also illustrated how local priorities can influence special districts by describing the priorities for funding the local trauma system, pharmacy services and school health programs.
2. The South Broward Hospital District reported allocating all of its tax revenues to outpatient primary care instead of inpatient hospital operations. This is intended to provide indigent care to the broadest possible group, but also to avoid the need for an expensive hospital stay by providing less costly outpatient care.
3. Campbellton Graceville Hospital reported the direct employment of primary care physicians in their very rural Panhandle community. While increased employment of physicians by hospitals is generally reported in the health care literature, this is of particular importance for rural hospitals and the communities they serve. One of the greatest challenges for small hospitals that are attempting to preserve access to care for rural residents is the need to attract and retain admitting physicians.

Commission staff has information about other states with organizations that can be compared to Florida's special districts. We haven't completed the research, but we have the basic information we need.

Staff does not request additional input on this subject but would be glad to take further direction from Commissioners.

Oversight and Accountability

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.

You previously received information that documented a small number of complaints about special hospital district board members that have been considered by the Florida Commission on Ethics. Only one of the four cases that had been considered since the late 90s resulted in any sanctions. None of those situations appeared to be comparable to the more recent situation that involved the invalidated change of ownership at Bert Fish Medical Center. Similarly, staff also forwarded information taken from AHCA regulatory activities about sanctions imposed on Florida hospitals. A very small percentage of the sanctions related to hospital governance, which prevents us from drawing any general conclusions, particularly in terms of any differences between public and non-public hospitals.

You heard from Jack Gaskins of the Department of Community Affairs (now the Department of Economic Opportunity) who indicated that the oversight of special districts is very similar to the oversight of local government. Mr. Gaskins' presentation described what appears to be a complex and detailed system of oversight of special districts, including hospital districts.

The Uniform Special District Accountability Act of 1989 (Chapter 189, Florida Statutes), along with other laws, provides for minimum standards of accountability and conduct, such as requirements to:

- File financial audits and information with state and local agencies
- Comply with sunshine laws, public notice and public meeting laws
- Comply with ethics laws
- Develop a regular public meeting schedule (quarterly, semiannually, or annually) and publish in the newspaper.

Special districts must prepare an annual budget, in accordance with generally accepted accounting principles, adopt it by resolution, and starting October 1, post the final budget on the special district's official web site. Special districts may not expend or contract for expenditures unless pursuant to their adopted budget.

Special districts with revenues or combined expenditures and expenses that exceed \$100,000 must file an annual audit with the Auditor General within 45 days, or 9 months after the fiscal year end,

whichever comes first. All special districts must report their revenues, expenditures, and long-term liabilities to the Department of Financial Services no later than nine months after the fiscal year end (June 30). There are additional detailed requirements to state government agencies that are detailed in the presentation that Mr. Gaskins made to the Commission at your August 16th meeting. The entire presentation is posted on the Commission website.

Mr. Gaskins also described the different ways that special districts have been created:

- The Florida Legislature creates independent special districts by special act.
- Counties and municipalities create dependent special districts by ordinance.

He further detailed the requirements for repeals, mergers or other reforms of special districts:

- A county or municipal ordinance is needed to repeal or merge a special district created by a county or municipal ordinance
- A special act of the legislature is needed to repeal or merge a special district that was created by special act.
- If an independent special district was approved by referendum, then a referendum is required to dissolve or merge the district.
- If an independent district has ad valorem authority, the same procedure required to grant that authority is required to dissolve or merge the district.
- The dissolved special district's property and debt are transferred to the county or municipality in which the special district was located.

The Commission has heard from a variety of presenters and interested parties who have complained about a lack of oversight. However, the details presented in the above bullets suggest that a legislative proposal to require additional oversight of special hospital districts could be seen as redundant. It is difficult to resolve the apparent extent of oversight in existing law with the complaints that have been presented to the Commission.

The reform approach exemplified by Representative Larry Metz's local bill regarding the North Lake Hospital District provides an alternative to a general bill that attempts to amend Chapter 189. Local bills (which are included in the category of special acts) can be tailored to the specific needs of each local situation.

Hospital districts are not as diverse and complicated as the hospitals themselves, but there are important differences among them, as summarized below:

- Of the 34 special hospital districts, 26 (76.48 percent) are classified as independent and 8 (23.52 percent) are classified as dependent.
- In terms of governance --17 (50 percent) have boards appointed by the Governor, six (17.65 percent) have elected boards, five (14.71 percent) have boards appointed by the county commissioners, three (8.82 percent) have a boards appointed by a combination of government officials and three (8.82 percent) do not have boards.

- Twenty-two (64.71 percent) special hospital districts have taxing authority while twelve (35.29 percent) do not have the authority to tax.
- Fifteen (44.12 percent) special hospital districts levy a millage rate on residents of the special hospital district and two (5.88 percent) receive tax support from a sales or surtax. Seventeen (50 percent) special hospital districts do not receive a specific sales/surtax or millage revenue.

DECISION POINT: The staff recommendation is to support the use of local bills to address needed changes in special hospital taxing districts.

The scope and scale of the existing oversight provisions in Chapter 189 appear so detailed that the Commission might choose to make recommendations that attempt to improve the communication and involvement between special districts and local taxpayers. It is clear that there are some dissatisfied individuals in some locations, but it is less clear what the level of dissatisfaction may be at the community level. The explanation that Representative Hudson provided to Ms. Patchett of Volusia County regarding different ways to engage the local political process was an excellent example of this issue. Potential recommendations could require special districts to more actively inform the public about the district, its board, and important decisions of interest to taxpayers. District websites would also be the correct place to consolidate and display all of the various reports that must be submitted to different state and/or local government organizations

Another area of Commission recommendations could address issues such as:

- replacing specific tax levies with an adjustable range that specifies the maximum,
- encouraging the use of tax funds for indigent care rather than hospital operations,
- ensuring that district boards and the boards of hospitals controlled by districts are not identical, and
- recommending periodic sunset reviews of hospital district legislation.

If you agree with the staff recommendation that local bills should be the vehicle to address changes in special districts, general recommendations about the operation and oversight of special districts could be expressed in terms of recommendations for use by legislators in future local bills.

DECISION POINT: The staff recommendation is to have the Commission position its recommendations about improvements in oversight and accountability as guidelines for future local bills.

Physician Employment

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.

When staff surveyed the hospital districts early last summer, we asked them about physician reimbursement. The answers that we received were rarely specific. They generally spoke about the use of the resource based relative value scale, private market-based salary consultants and compliance with applicable state and federal anti-kickback laws. In an attempt to get more specific information, we have made a public records request on your behalf to get more information about physician reimbursement.

Regarding the employment of physicians, a shift away from the private practice model toward increased employment in hospitals, HMOs and other organizations is widely reported in health care publications. Florida's large size and diversity of health care markets again challenges our ability to make broad statements about physician employment. There are particular differences between rural and non-rural communities. Physician employment can be an important part of promoting and preserving access to basic hospital services in rural markets. Hospitals in more urban markets would tend to employ more specialized physicians for medical directorships and other specific purposes.

There is no decision point on this subject at present.

Changes of Ownership and Governance

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.

The presentation by representatives of Bert Fish Medical Center at your October 4th meeting described a very problematic attempt to change the ownership of the facility. The Commission has an important opportunity to assist special hospital taxing districts to avoid similar problems in the future by making recommendations about changes of ownership and governance.

At your November 7th meeting, Dave Ross of Tenet Healthcare made recommendations concerning changes of ownership at tax district hospitals. His recommendations included:

1. Ensuring an open, public bid process
2. Ensuring a fair and independent asset valuation process
3. Establishing guidelines to ensure on-going community benefit with any proceeds from the sale of a hospital
4. Maintaining independent oversight of process
5. Requiring the maintenance and/or expansion community health programs

DECISION POINT: The staff recommends that the above recommendations related to changes of ownership be adapted for use in the Commission report.