

## Background and Introduction

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. The counties in the USA had responsibility for indigent health care long before the state 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 County system which provide indigent care in a variety of settings and allow patients wider choices.

The years have also seen enormous increases in both health care 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, and 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 Organization, 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 President of the National Association of Public Hospitals and Health Systems, who 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. Major changes are already underway or authorized by the Florida Legislature, such as how managed care and DRGs 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.

We need to keep at least one cliché in mind. Economists are not correct about everything they say, but they are certainly right in concluding that *there is no such thing as a free lunch*. All apparently free lunches are in fact actually paid for by someone else.

In health care, this means that when a provider of care, especially a hospital, is faced with a prospective patient who is uninsured, or poorly insured and whose care is therefore likely to be all or in part *uncompensated*, the provider is in effect faced with a decision...it can (a) care for the patient, and find the necessary money elsewhere, or (b) refuse to care for the person.

In the United States (and in Florida) we have collectively determined that Option (b) is unacceptable. So since the middle of 1700s, we have...as a nation... been seeking solutions that deal with Option (a).

In terms of responsibility, we have determined that local government units...typically counties... are ultimately responsible for meeting the health care needs of their citizens/residents. This county responsibility can be traced through English common law to the Elizabethan period.

So, with significant leadership from our cities and counties, but lots of support from states and the federal government, our nation's communities...mostly at the county level, have devised and developed a wide range of solutions to this complex set of issues. The fact that we have hit upon many solutions, implemented in many ways is classically American, and something in which we should be taking great joy.

I. Extant solutions (big picture)

The solutions have included federal, state and local initiatives, including such things as the Medicare program, the Medicaid program, tax advantages for not-for profit entities, and many other policy interventions. Generally the solutions can be viewed in two major categories... those that involve the provision of some level of direct, patient-specific compensation by paying the bills incurred by specific patients, such as Medicare and Medicaid; and those that have provided resources (or relief from obligations) that have the effect of creating alternative means for hospitals to absorb the costs of care that are not directly paid or reimbursed. These latter include tax free status, local tax appropriations, charitable fundraising and a wide range of other initiatives.

The result is a wide-ranging, highly pluralistic set of interventions and combinations of interventions that are adapted in numerous ways to meet the perceived needs of widely diverse community circumstances. This is why no two hospitals, their patients, their medical staffs or their communities are the same. There simply is no single solution that optimizes all circumstances across all communities. Our nation's counties and cities have found the set of solutions that seem best to meet their unique needs and situations. States should be very cautious about dictating uniformity to local communities, just as the federal government should be very cautious about dictating uniformity to the states.

We must recognize that all hospitals are supported in various ways by taxpayers and revenues that derive from taxation. This is appropriate because all hospitals have some level of public function. It is well documented that taking care of individual patients, whether they are the victims of a natural

disaster or have some contagious disease, provides a public health benefit to the entire community, not just the patients involved. Support from taxpayers comes in many forms, including the noted direct payments. It is not realistic for our Commission to limit its consideration to one very specific type of tax support (locally assessed property taxes through taxing districts).

II. The diversity of Florida's solutions

Florida and our state's communities have embraced many of the national solutions and added numerous creative variations that fit the needs of our widely diverse communities.

These include traditional county-owned hospitals, hospitals previously owned by counties that have been sold or otherwise transferred to private entities, private entities that are highly charitable, those that are less so, and the tax districts that are primary focus of this Commission, all complimented by local charitable activities and organizations, including some foundations that are closely affiliated with hospitals for the purpose of channeling community support to the hospitals which are attempting to meet the community's obligations to care for its members.

But we need to keep in mind that together, Florida's hospitals deliver billions of dollars' worth of uncompensated care. This care is needed by the patients who are receiving it. The needs are not going away. Our current set of solutions to this problem is complex and pluralistic, based on the reality of widely diverse hospitals with widely diverse revenue sources and subtle cost shifting among those revenue sources. In the absence of genuinely universal insurance coverage, that solution, however cumbersome, may be the best option available.

**Commission Process**

On March 23, 2011, Governor Rick Scott issued Executive Order Number 11-63 ([hyperlink](#)) appointing a commission to review whether government-run hospitals are in the best interest of taxpayers. The Florida Commission on Review of Taxpayer Funded Hospital Districts was chaired by Dominic Calabro of Florida TaxWatch in Tallahassee. Other members of the Commission included:

- Brad Dinkins, Helping Hands Foundation, Ocala
- R. Paul Duncan, University of Florida, College of Health Related Professions, Gainesville
- The Honorable Matt Hudson, Florida House of Representatives, Naples
- Jacob C. Jackson, Southeast Regional Counsel for the Department of Children and Families, North Lauderdale
- Marshall Kelley, Health Management Associates, Tallahassee
- J. Scott McLeneghen, City National Bank of Florida, West Palm Beach
- Randall McElheney, CoastalMed, Inc., Panama City
- The Honorable Joe Negron, Florida Senate, Palm City

The Commission held twelve public meetings between May 23 and December 20, 2011 at the Agency for Health Care Administration (AHCA) in Tallahassee. The Commission created a webpage ([hyperlink](#)) and posted all materials considered at each meeting. Telephone call-in numbers were provided and audio

recordings of the meetings were later posted on the website. Staff maintained an email list and copied interested parties on meeting reminders and similar emails.

More than 18 individuals and organizations made presentations to the Commission. These presentations are described in meeting minutes which are posted on the website. Copies of handouts or PowerPoints presented at each meeting are also posted on the Commission webpage. These postings are organized by meeting date.

Presenters included representatives of special hospital districts, public and private hospitals and health care systems, state government officials and interested taxpayers. Dr. Keon-Hyung Lee of the Askew School of Public Administration and Policy at Florida State University presented an analysis of financial information that had been compiled for the Commission by staff.

Prior to the first Commission meeting in May, staff sent a letter to the hospital districts asking nine questions about their history, governance, programs and oversight. A sample of the outgoing letter, the specific responses from the districts, and a staff summary of the information organized by geographic market area are all posted on the web.

The final version of this report will include many active links to the Commission website. The Commission considered a large amount of detailed and diverse information throughout the busy meeting schedule and in the preparation of this report. While the document may be printed, online viewing allows direct links to extensive supporting documentation.

Executive Order Number 11-63 specified the following tasks for the Commission:

1. 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.
2. 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.
3. 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.
4. 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.

5. 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.
6. 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.

### **History of Special Taxing Districts in Florida**

Florida's first special district was created in 1845 by a special act of the Legislature, providing authority to five commissioners to drain the "Alachua Savannah." Special assessments were made on landowners to pay for the project. Early special districts were created to finance large engineering projects or to manage transportation and growth needs. Florida currently has special districts for a diverse group of activities, including aviation authorities and the control of beach erosion; the construction and maintenance of roads, bridges and drainage infrastructure; hospitals, health care, fire control, mosquito control and control of water hyacinths.

In 1989, the Legislature passed the Uniform Special District Accountability Act (Chapter 189, Florida Statutes) which governs activities of the special districts in the state. The Special District Information Program ([hyperlink](#)) is the state's central location for the collection, dissemination, classification and maintenance of information about Florida's special districts.

Specifically, the private and public sectors use special districts to manage, own, operate, construct, maintain and finance basic capital infrastructure, facilities and services. Every parcel of land in Florida is covered by at least one special district.

### **The Definition and Organization of Special Districts**

Special districts are units of special-purpose government. They have authority to do only the things set out for them to accomplish in their creation document. Special districts are created by general law, special act, local ordinance or by rule of the Governor and Cabinet. These districts are classified as independent or dependent.

A ***dependent special district*** has at least one of the following characteristics:

- Its governing body members are identical to the governing body members of a single county or single municipality

- Its governing body members are appointed by the governing body of a single county or single municipality
- During unexpired terms, its governing body members are subject to removal at will by the governing body of a single county or single municipality
- The district's budget can be vetoed by the governing body of a single county or single municipality

An ***independent special district*** does not have any dependent characteristics. The classification system exists primarily for state and local financial reporting purposes.

Currently, the Department of Economic Opportunity's Special District Information Program lists approximately 1,615 active special districts and 30 active special hospital districts. Of these 30, six are dependent and 24 are independent. Sixteen of the hospital districts currently have millage or receive tax money.

### **History of Special Hospital Districts in Florida**

Florida's earliest special hospital district was created in 1916 and the most recent was established in 1990. The bulk of the hospital districts were established after World War II by special act of the Legislature and they have been periodically updated depending on local circumstances. Common topics in the creation of special hospital districts have included:

- creating a board appointed by the governor, a local government entity or the local electorate,
- granting authority to build and operate hospitals,
- allowing ad valorem revenue to be used for operating and maintaining hospitals,
- granting the power to assert eminent domain and
- providing that the facilities maintained by the districts be established for the benefit of the indigent.

In 1982, the Legislature enacted a law that enabled any county, district or municipality to enter into contracts or leases with non-profit corporations to operate their hospitals. This was later amended to include for-profit corporations.

- Of the 34 special hospital districts listed in the table below, 26 (76.48 percent) are classified as independent (I) and eight (23.52 percent) are classified as dependent (D).
- 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 12 (35.29 percent) do not have the authority to tax.
- Fifteen (44.12 percent) special hospital districts levy a millage rate on district residents 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.

**Table 1: Basic Structure and Taxing Authority of Florida Special Hospital Districts (Grouped Geographically)**

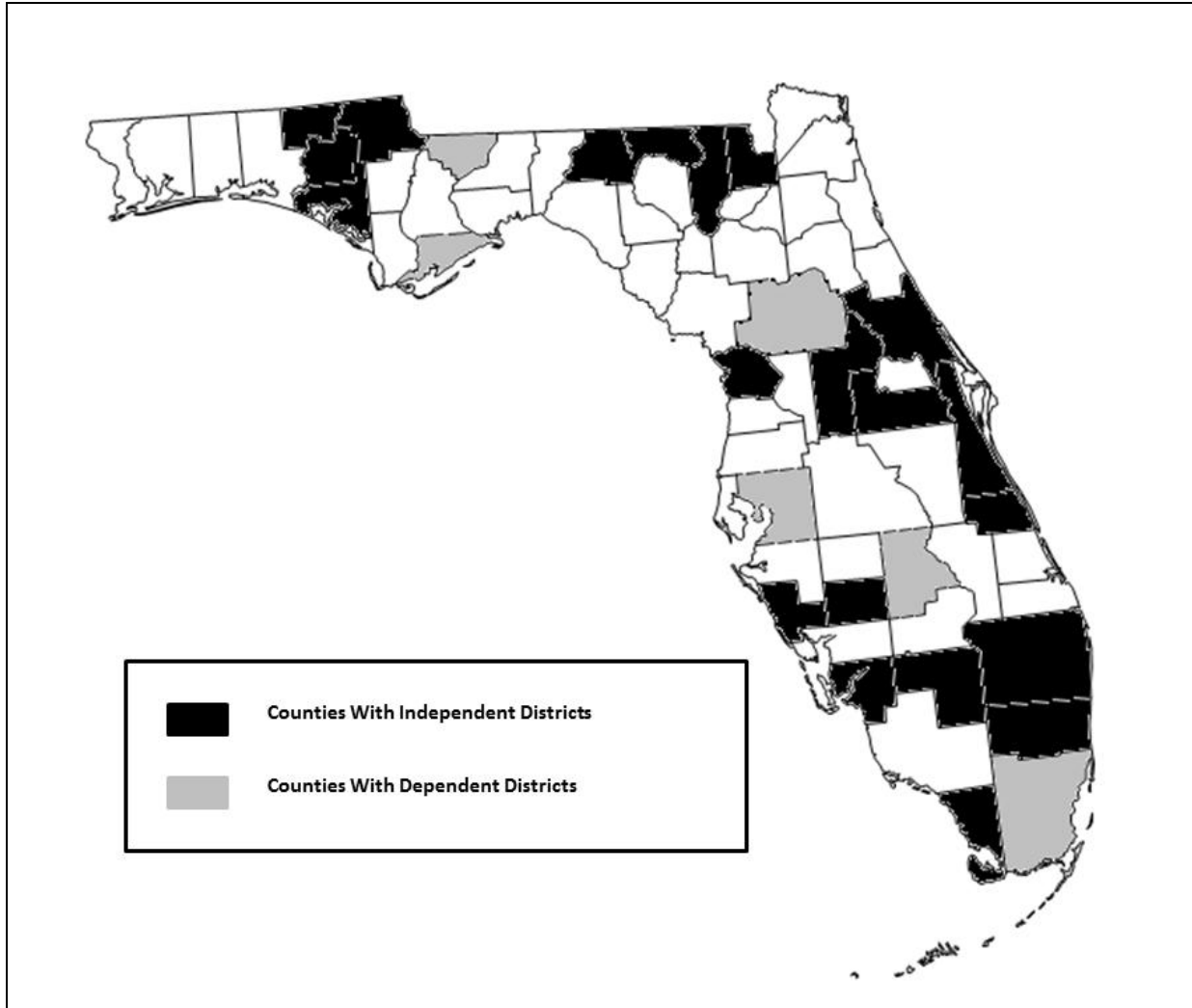
District Name	Type of District <sup>2</sup>	Board of Directors	Taxing Authority	Tax Levied	Millage Rate
<b>Panama City – Tallahassee</b>					
Bay County Hospital Taxing District	I	9 members, combination appointed and confirmed by County Commissioners and Bay Medical Trustees/Staff.	No		
Hospital District for the City of Carrabelle	D	NA	No		
Campbellton-Graceville Hospital	I	5 members, appointed by the Governor	Yes	Yes	1.5460
Jackson County Hospital District	I	9 members, appointed by the Governor	Yes	No	
Franklin County Hospital District	D	NA	No		
Holmes County Hospital District	I	5 members, appointed by the Governor	Yes	No	
NW Florida Community Hospital District	D	NA	No		
Gadsden County Hospital District	D	Appointed by the County Commissioners	No	Yes, but not millage	Part of a half-cent sales tax
Madison County Hospital District	I	7 members, appointed by the Governor	No		
<b>Lake City – Gainesville – Ocala – Leesburg – Brooksville</b>					
Lake Shore Hospital Authority	I	7 members, appointed by the Governor	Yes	Yes	0.962
Hamilton County Hospital District	I	5 members, appointed by the Governor	No		
Marion County Hospital District	D	7 members, appointed by the County Commissioners	Yes	No	
Citrus County Hospital District	I	5 members, appointed by the Governor	Yes	Yes	0.25
South Lake County Hospital District	I	11 members, appointed by the Governor	Yes	Yes	0.8666
North Lake County Hospital District	I	6 members, voted on in a general election	Yes	Yes	1.00
<b>Jacksonville - Daytona</b>					
Baker County Hospital Authority	I	5 members, appointed by the Governor	Yes	Yes	1.0571
Halifax Hospital Medical Center Taxing District	I	7 members, appointed by the Governor	Yes	Yes	2.00
Southeast Volusia Hospital District	I	Appointed by the Governor	Yes	Yes	3.25

District Name	Type of District <sup>2</sup>	Board of Directors	Taxing Authority	Tax Levied	Millage Rate
West Volusia Hospital Authority	I	5 members, voted on in a general election	Yes	Yes	2.0818
<b>Tampa – Lakeland – Bradenton – Sebring</b>					
Hillsborough County Hospital Authority	D	15 members, appointed by the County Commissioners	No		
Highlands County Hospital District	D	5 members, appointed by the County Commissioners	No		
<b>Greater Orlando and Brevard</b>					
Cape Canaveral Hospital District	I	12 members, appointed by the Governor	Yes	No	
North Brevard County Hospital District	I	9 members, combination appointed and confirmed by City Council and County Commissioners	Yes	No	
West Orange Healthcare District	I	16, appointed by the Governor	No		
<b>Sarasota – Ft. Myers – Naples</b>					
DeSoto County Hospital District	I	5 members, appointed by the Governor	Yes	No	
Hendry County Hospital Authority	I	5 members, voted on in a general election	Yes	Yes	2.9
Lee Memorial Health System	I	10 members, voted on in a general election	No		
Sarasota County Public Hospital District	I	9 members, voted on in a general election	Yes	Yes	1.08
<b>West Palm Beach – Stuart – Ft. Pierce – Vero Beach</b>					
Indian River County Hospital District	I	7 members, voted on in a general election	Yes	Yes	0.9386
Health Care District of Palm Beach County	I	7 members, combination appointed by Governor, County Commissioners and the current Director of the Health Department	Yes	Yes	1.1451
<b>Broward</b>					
Broward Health	I	7 members, appointed by the Governor	Yes	Yes	1.875
South Broward Hospital District	I	7 members, appointed by the Governor	Yes	Yes	0.9963
<b>Miami-Dade and Monroe</b>					
Miami-Dade County Public Health Trust	D <sup>2</sup>	County Commissioners replaced the board with a Financial Recovery Board	No	Yes, but not millage	One half-cent sales surtax
Lower Florida Keys Hospital District	I	9 members, appointed by the Governor	Yes	No	

<sup>1</sup> A dependent special district (D) has at least one of the following characteristics: its governing body members are identical to the governing body members of a single county or single municipality; its governing body members are appointed by the governing body of a single county or single municipality; during unexpired terms, its governing body members are subject to removal at will by the governing body or a single county or single municipality; or the district's budget can be vetoed by the governing body of a single county or single municipality. An independent special district (I) does not have any D characteristics.

<sup>2</sup>The Miami-Dade County Public Health Trust is a part of county government and not a special district. It was included in the Commission’s analysis because of the large size of Jackson Memorial Hospital and its important role in the state’s health care system.

**Figure 1: Map of Florida Counties with One or More Special Hospital Taxing Districts**



1. 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.

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 (hyperlink). These measures of quality are on a par with the CMS Core Measures (hyperlink) referenced in the executive order.

**Table 2: Hospital Outcome Measures Considered by the Commission**

<b>AHRQ Inpatient Quality Indicators – Mortality Procedures</b>	
1.	Abdominal Aortic Aneurysm Repair Mortality
2.	Coronary Artery Bypass Graft Mortality
3.	Craniotomy Mortality (Surgical Opening of the Skull)
4.	Esophageal Resection Mortality (Surgical Removal of the Throat)
5.	Hip Replacement Mortality
6.	Pancreatic Resection Mortality (Surgical Removal of the Pancreas)
<b>AHRQ Inpatient Quality Indicators – Mortality Conditions</b>	
7.	Acute Myocardial Infarction (Heart Attack)
8.	Acute Myocardial Infarction (Heart Attack), Without Transfer Cases
9.	Acute Stroke Mortality
10.	Congestive Heart Failure Mortality
11.	Gastrointestinal Hemorrhage Mortality
12.	Hip Fracture Mortality
13.	Pneumonia Mortality
<b>AHRQ Patient Safety Indicators – Complication and Infection</b>	
14.	Decubitus Ulcer (Bed Sore)
15.	Iatrogenic Pneumothorax (Collapsed Lung Caused by a Medical Procedure)
16.	Infections Due to Medical Care
17.	Postoperative Hip Fracture
18.	Postoperative Pulmonary Embolism (Blockage in a Blood Vessel in the Lung) or Deep Vein Thrombosis (Blood Clot in a Deep Vein)
19.	Postoperative Sepsis (Whole Body Inflammation)

As discussed at the November 7th Commission 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.

**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.

If we could clearly define the groups of interests (but note from below that we cannot) it would be possible to construct a descriptive table noting the average score on the available indicators for each set of hospitals. That would not take into account the variation within the groups. Nor would it provide us with an understanding of the source or cause of any observed differences. I think our report should

indicate that answering this question superficially (as I describe briefly in the first sentence of this bullet item) has great potential for being misleading. Answering it as thoroughly and rigorously as current methods and data might allow would be a very significant undertaking...the kind of thing that might be pursued by a team of researchers with substantial funding from a major foundation or government agency.

2. *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.*

Commission staff provided financial, facility, demographic and outcome information about the state's general, acute care hospitals for review by the Commissioners at the July 20<sup>th</sup> meeting. These measures are the latest information that has been fully processed and vetted by the regular AHCA data systems. This is important because the information does not always correct when it is initially submitted to the Agency. 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. The lengthy data review process of information submitted by hospitals prevented the consideration of new information. The specific financial, facility and Medicaid information that was supplied to Commissioners included:

1. Hospital Name
2. District
3. County
4. Ownership Type
5. Number Of Acute Care Beds
6. Number Of Specialty Beds
7. Whether Or Not OB Services Offered
8. Trauma Center (Level 1 Or 2)
9. Whether Or Not The Hospital Is Baker Act Receiving Facility
10. Case Mix
11. Number Of Discharges
12. Acute Care Bed Occupancy Level
13. Average Length Of Stay (Acute Care Beds)
14. Number Of Emergency Department Visits
15. Total Population By County
16. 65 And Older Population By County
17. Percent Under Poverty Level By County
18. Uncompensated - Uninsured Discharges (Dollars And Percent)
19. Bad Debt (Dollars & Percent Of Total Patient Charges)
20. Medicaid (Dollars & Percent Of Total Patient Charges)

21. Charity (Dollars & Percent Of Total Patient Charges)
22. Net Operating Revenue (Dollars And Percent)
23. Unrestricted Local Tax Revenue (Non-Operating)
24. Cost Per Adjusted Admission
25. Standardized Cost Per Adjusted Admission
26. Operating Margin (Dollars And Percent)
27. Total Margin (Dollars And Percent)
28. Debt To Equity Ratio
29. Medicaid Inpatient Rate
30. Medicaid Outpatient Rate
31. Low Income Pool (LIP) Dollars
32. Disproportionate Share (DSH) Dollars

Neither the current health services research literature nationally nor specific analyses of the rich Florida data held by AHCA allows for a definitive answer to the numerous questions that are imbedded in this part of the order.

First, there is no universally accepted definition of the term “costs” as used here. When legislators use this term they are thinking about the expenditure of state dollars, as in how much money the Medicaid program spends on various kinds of care. If that amount is reduced, the state’s “costs” can be seen as going down. But they are not being eliminated...the costs are simply being passed to some other source of payments. When provider use the term, they typically are referring to the sum of the prices they have to pay for such items as labor, utilities, debt, insurance, etc., ... what many of us think as the normal costs of doing a particular business or set of activities within a particular location and context. In health care, these costs are only paid by some patients (those that are well insured). All of the costs associated the care of patients for whom the provider is not paid, or is paid some amount less than the appropriate allocation of the core costs, must be included as part of the cost basis for any subsequent fiscal/budget cycle. When economists use the term costs, they are frequently referring to overall costs at a national level, often measured as the percent of our gross domestic product devoted to health care. When patients use the term, they mean their out-of-pocket costs.

As recently as September of this year Michael Porter and Robert Kaplan, both distinguished professors at Harvard declared that much of the health care cost escalation problem derives from the fact that we “have an almost complete lack of understanding of how much it costs to deliver patient care.”

Third, there is no realistic single category that captures the concepts of government operated hospitals, government hospitals, tax district hospitals, tax district owned hospitals, taxpayer-supported hospitals or the other terms casually employed in both the executive order and the Commission’s deliberations.

The degree to which Florida’s tax districts are actually operative and their relationships with hospitals vary dramatically. There are county-owned hospitals that seem to be similar in some ways to tax-district hospitals; there are private not-for-profit hospitals that have evolved from tax district and/or county ownership; there are tax districts that own hospitals and those that do not. Unless and until we can

devise a clear and consensually acceptable definition of exactly which hospitals are being referred to in this part of the order, it is not possible to answer the question objectively

While Dr. Lee's work is to be applauded, and represents an improvement over simplistic comparisons by attempting to statistically control for some of these variations in hospital circumstances, it remains plagued by questions about which hospitals belong in which groups, and by the specific data used to compare the undefined concept of "costs". Furthermore, the field of cost comparisons (given clear definitions of which hospitals are being compared and agreement on the relevant information) has actually moved beyond multiple regression methods to an even more esoteric and technical approach known as Stochastic Frontier Analysis. I can provide references to recent publications on this method, but almost all of the applications so far have compared for-profit to not-for-profit hospitals, rather than government to private hospitals. (And incidentally, the emerging consensus from the stochastic frontier approach seems to be that the not-for-profit hospitals are on average the more efficient group). Dr. Zingale's second presentation, did not include the statistical controls employed by Dr. Lee, but instead focused on what happens to the estimates when greater care is taken to be sure the comparisons are truly "apples to apples". It was informative and should be noted in this section of the report.

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.** (Staff suggestion: Live internet links instead of a printed 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. (Staff suggestion: Live internet links or a combination of links and tables provided by Lee and Zingale)

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

***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 second half of the Commission's charge in "A" has already been set in motion. 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 by requiring Medicaid to complete 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 managed 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 affect 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.”

“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.

### **Indigent Care**

- 3. 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.*

The information submitted by the state’s special districts is summarized in the table below.

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 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.

The presentation to the committee make it clear that Florida’s tax districts and their hospitals have been remarkably creative in the development many alternative approaches to the delivery of care to poor people. The system operating in Palm Beach County that emphasizes a kind of insurance or payment function seems to be working well in that setting. The system in South Broward, where the district owns the hospitals and allocates funds to support the institutions seems to work well in that setting. As an individual Commissioner, I have not yet been provided with a strong basis for concluding that either of these approaches is fundamentally superior to the other.

The single most important finding from the Commission’s work and the survey data collected by staff is that there is no single best model that should be applied state-wide.

### Access to Care for the Poor

**Table 3: Innovative Access Programs within Hospital Districts**

District	Summary of Information Submitted by Florida Hospital Taxing Districts About Innovative Access Programs
Bay County Hospital Taxing District	A number of outreach programs and services that provide access to care to the broadest population possible. These programs include: Bay Medical Physician Group, St. Andrew Community Medical Center, lab services at the After Hours Care Clinic at the Bay County Health Department, basic labs and x-rays at the Community Health Center and Avicenna Clinic, Bay Cares, Pharmacy Indigent Program, Tobacco Cessation Program, Asthma Education Program, BayMed Plus Program.
Campbellton-Graceville Hospital	Provides emergency care to any patient requesting it without regard to the ability to pay. Increased access to Primary Care with the Physicians’ Office Building. A Rehabilitation Program offering inpatient and outpatient physical therapy. Made a building available to the Jackson Health Department to utilize for the WIC Program and the Prescription Assistance Program.
Jackson County Hospital District	As the District is in a federally designated Healthcare Profession Shortage Area, the District aggressively recruits physicians to expand services and add medical specialists. The District has several other programs to increase access, including: outpatient clinical testing services via a mobile unit, tuition-free health courses and disease-specific support groups, expanded outpatient clinical services, outpatient medication infusions, inpatient/outpatient therapy services, timely “urgent care” services, medical stabilization program, partnership with Big Bend Area Healthcare Network, Rural Health Training site and assistance for filling out Medicaid applications.
Holmes County Hospital District	Provides laboratory and radiology services to the Health Department as a discounted rate. Runs the Pink Program for low income members to pay for mammograms. Provides a medical office building for out-of-town specialists.
Gadsden County Hospital District	Provides funding to the “We Care” program and helps fund the County Health Department.
Madison County Hospital District	Operates a Rural Health Clinic that uses a sliding scale to determine patient charges.
Lake Shore Hospital Authority	The Hospital Authority has contracted with four primary care clinics and four pharmacies to provide primary health care and pharmaceuticals to indigent patients at a discounted rate.
Hamilton County Hospital	Funds services for the Hamilton County Public Health Department and Haven Hospice.

District	Summary of Information Submitted by Florida Hospital Taxing Districts About Innovative Access Programs
District	
Marion County Hospital District	Provided \$2.5 million of inpatient and outpatient care through the “We Care” program in 2010. Munroe Regional Health System operates the only Marion County hospital providing services in obstetrics, ophthalmology and oral/maxilla-facial surgery. Operates a freestanding emergency center and five LifeTime Centers. Provides funding to the local Federally Qualified Health Center. Provides care for pregnant women who have no access to obstetrical care.
South Lake County Hospital District	Supports the free clinic for the uninsured residents of south Lake County.
Baker County Hospital Authority	Constructed and financially supports the Dopson Medical Center to help offset the cost of treating Baker County residents that are uninsured or cannot afford medical treatment.
Halifax Hospital Medical Center Taxing District	Offers the area’s only Level II Trauma Center, Comprehensive Stroke Center, Neonatal and Pediatric Intensive Care Unit, Pediatric Emergency Department, Child and Adolescent Behavioral Services, Kidney Transplant, Radiosurgery, Gynecological Oncology and Neurological services. In addition, the District operates two outpatient clinics, one for adults and one for children. The District also has multiple programs in place, including: the Halifax Health Center for Family and Sports Medicine, an Endocrinology Clinic, surgical specialist referrals, pediatric sub-specialty program, Healthy Communities, Halifax Behavioral Services, Adult Psychiatric Services, psychiatric services to the Star Center Homeless Shelter, outpatient IV antibiotics, Chest Pain Center and community education classes/seminars/support groups.
Southeast Volusia Hospital District	Operates a Community Health Center. Participates with Health Communities and Healthy Kids to facilitate the provision of preventative care. The District has Medical Services Agreements with physician specialists for referral from the Community Health Center. The District has an agreement with a local pharmacy to provide medications to Charity Care patients. The District has funded studies to ensure patient access to quality care.
West Volusia Hospital Authority	The Authority has entered into contracts to provide indigent residents with primary care access at health centers or primary care clinics operated by local non-profit and religious organizations. The Authority has established an outpatient specialty care network accessible to indigent residents. Part of the sale agreement with Florida Hospital was provision that required Florida Hospital to maintain the availability of essential health care programs and services to indigent residents. Florida Hospital is reimbursed by the Authority at a negotiated rate.
Highlands County Hospital District	The District annually considers allocating income from the Hospital’s lease for health related services in the form of grants.
North Brevard County Hospital District	Operates Brevard County’s only hospital-based diabetes education program. It offers 16 community support groups and participates in health fairs, health-related seminars and health screenings. Constructed, opened, partially funds and services a community medical clinic. Opened a Children’s Center. Every few years, the District conducts/participates in a community needs assessment to define community outreach needs.
West Orange Healthcare District	The District provides 911 service and paramedic services for the Western third of Orange County. The District provides all diagnostic and radiology services at no cost to 9 faith-based clinics. Allows Midwives to deliver in OB suites to provide lower cost of delivery services. The District provides mammogram services to women. The District leases facilities to the Community Health Center at cost.
DeSoto County Hospital District	The District opened a federally qualified rural health clinic. Established a Care Payment program to allow patients to borrow money for services without interest for 24 months. The emergency room provides primary care to a large number of residents. The hospital does not turn away non-emergent patients. The District is developing a dual track system for “urgent care” within the ER to better serve patients.
Hendry County Hospital	The Authority operates two provider based CMS designated Rural Health Clinics. The Authority provides cardiology, ENT, wound care and surgical outpatient clinic services. The Authority provides free diabetes

District	Summary of Information Submitted by Florida Hospital Taxing Districts About Innovative Access Programs
Authority	education classes, smoking cessation classes a community health and wellness fair, free screenings at county festivals and a health awareness newsletter. The Authority is active in local community civic groups, the local Economic Development Council and State/National Hospital Associations.
Lee Memorial Health System	The Health System provides a number of outreach programs and services including Lee Physician Group, access to independent physicians, asthma management services, diabetes management education services, Dunbar clinic, Jennings Behavioral Health, Level II Trauma Center, OB.NICU service, outpatient oncology, outpatient infusion center and funds three beds per day at the Southwest Florida Addiction Services facility. The Health System has helped create and fund several community-based partnerships including: the Bob Janes Behavioral Triage Center, East Fort Myers and Dunbar United Way Houses, Lee Memorial Health System Parish Nursing, McGregor AIDS Clinic, The Salvation Army Medical Respite Unit and We Care.
Sarasota County Public Hospital District	The only hospital in the county that delivers babies, provides NICU care and provides the full array of inpatient/outpatient psychiatric services to patients of all ages. The Hospital District funds a specially equipped maternal-neonatal critical care ambulance. The Hospital District opened a freestanding ER and Outpatient Care Center. The Hospital District's innovative programs include: an annual subsidy to the Sarasota County Health Department for primary care, an annual subsidy to the Sarasota County School Nurse Program, and annual subsidy to the Community AIDS Network, a Charter Plan offering access to affordable health care to small businesses, the Breast Health Navigator, provides highly specialized outpatient preventative/disease management programs to low-income patients.
Indian River County Hospital District	The Hospital District pays the county's share of Medicaid. The Hospital District implemented and fund the Partner's in Women's Health Program, completed construction of the Human Services Building for the Visiting Nurse Association of the Treasure Coast, partnered with the Visiting Nurse Association for mobile health services and hospice house. Leases space to the Indian River County Health Department's Primary Care Clinic. The Hospital District funds various primary care, dental and mental health services.
Health Care District of Palm Beach County	Operates a small rural hospital and a skilled nursing facility. Operates a Trauma System for the county. The Health Care District initiated a health coverage program to provide a source of funding for indigent and medically needy residents not eligible for other programs. The Health Care District administers the School Health Program with the Palm Beach County Health Department and the School District. The Health Care District established the Maternity Care Program, Healthy Palm Beaches, Inc. and Vita Health.
	Provides Community Health Services, an outpatient clinic network that includes healthcare for the homeless.
South Broward Hospital District	The Hospital District provides services including: primary care, Hospital District Charity Policy, the uninsured/underinsured discount program, behavioral health services, disease management services, homeless health outreach program, school-based health services, ER diversion program, mobile mammography services, community health services and health intervention with a targeted service program.
Miami-Dade County Public Health Trust	The Jackson Health System provides inpatient and outpatient care to individuals regardless of their ability to pay. The Health System developed the Access Plus Program providing healthcare to the uninsured/underinsured. The Health System operates several programs geared towards low-income populations. The Health System is the largest comprehensive HIV/AIDS service provider in Miami-Dade County.
Lower Florida Keys Hospital District	Helps fund a primary care clinic providing care to the "working poor" and indigent. The District has funded the Rural Health Network in the past to assist in operating a dental clinic. Leases a skilled nursing facility to a private, not-for-profit operator.

### Hospital Districts in Other States

According to the U.S. Census Bureau, as of March 2007, there were 692 hospital districts/authorities acting as units of local government in twenty-eight states. These states are: Alabama, Arizona, California, Colorado, Florida, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Utah, Virginia, Washington and

Wyoming. The U.S. Census website explains that a service district is not counted as a separate unit of government if it lacks autonomy.

- The Alabama legislature expanded and elaborated on the activities permitted to the governing bodies of public hospitals and renamed them health care authorities in 1982 under Act 82-418. As of 2007, the state had 38 Health Care Authorities or Hospital Districts, owned by a city or county, or jointly between the two. These special districts provide physician services and a few have long-term care facilities.
- There are 85 health care districts in California. Fifty-two of these districts operate a hospital or health facilities, 16 provide health related services and have either leased or sold hospital facilities and 17 provide community-based health related services. Thirty-one of health care district-based hospitals are classified as rural by the State of California. These “rural” institutions provide a significant portion of the medical care to minority populations and the uninsured in medically underserved regions of the state and are mainly funded by Medicare, Medi-Cal and district tax dollars. According to the U.S. Census Bureau, 56 of these health care districts are classified as separate units of local government.
- Many hospitals in Georgia are owned by a county hospital authority and act as a transfer account for funds between the state and the hospitals. According to the Directory of Registered Local Government Authorities, there were 96 registered hospital authorities in Georgia in 2011. Seventy-six of these are listed as independent special districts and 20 are dependent special districts. The U.S. Census Bureau lists 108 of these Healthcare Districts as separate units of local government.
- Idaho currently has 22 hospital districts, eleven are county based hospitals, eight of these cross county lines and are therefore district-based hospitals. Three operate without a hospital. The U.S. Census Bureau lists 13 of these hospital districts as separate units of local government. Idaho has a “catastrophic” program to fund hospitalization and medical care which is an incident-based program not an eligibility-based program. The counties make the determination on indigent care classification, dependent on the cost of medical bills regardless of the income of the patient. This is a non-matched program and when payments are made by the counties, it is at the unadjusted Medicaid rate.
- In Illinois, all hospital districts are governed by nine-member boards of trustees and may levy property taxes or issue bonds. There are currently 25 hospital districts. The districts are established by the circuit court on petition of the voters after a local referendum. The U.S. Census Bureau lists 19 of these hospital districts as separate units of local government.
- In 1968, the General Assembly of Kentucky created a public health taxing district in every county that had a health department but had not established a taxing district — with certain exclusions. The boards of the tax districts may, if the appropriations are not sufficient, request the fiscal court to impose a special ad valorem tax in an amount it deems sufficient. The fiscal court may levy the tax, not to exceed 10 cents per \$100. The U.S. Census Bureau lists seven hospital districts in the state of Kentucky.
- Louisiana authorizes parish hospital service districts in parishes having a population in excess of 110,000 but not more than 135,000. Only one parish met the population requirement at the time of the law’s enactment. This district is governed by nine commissioners appointed by the Governor, with senate confirmation. The district may fix and collect fees, may levy taxes and issue bonds with voter approval. The U.S. Census Bureau lists three hospital service districts, two in St. Tammany Parish and one in Rapides Parish. Parish police juries may divide parishes into one or more hospital service district or combine with other parishes to form a hospital service district to operate hospital facilities and voter approval is necessary for tax levies and bond issues. These are considered subordinate agencies by the U.S. Census Bureau.
- The U.S. Census Bureau lists two hospitals districts for the State of Maine. Indigent care for qualified patients is funded on a per person basis at any hospital by the state Free Care policy.

- Hospital districts in Minnesota were made possible by a 1959 statute which was intended to enable cities and townships in remote areas to collectively fund a hospital through tax revenues. Thirteen hospitals out of 151 in the state are run by hospital districts. These hospitals have all signed an agreement with the State's Attorney General to follow specific guidelines for both discounted pricing for the uninsured and for fair billing/collection practices.
- Nebraska authorized hospital districts under two laws in 1959 and in 1971. The 1971 law established a hospital authority by the board of county commissioners after petition of voters and public hearing. The initial board of trustees is appointed by the county governing body with succeeding trustees elected. The hospital districts may fix rates, charge for services and may issue revenue bonds. The U.S. Census Bureau lists 22 hospital districts in the State of Nebraska.
- Special hospital districts in New Mexico are created by the county board of commissioners to provide, operate and maintain hospital facilities on petition and after local referendum. An elected board of trustees governs each district and districts may fix charges. After voter approval, districts may levy ad valorem taxes and issue general obligation bonds. The U.S. Census Bureau lists five hospital districts in the State of New Mexico.
- North Carolina provided for hospital authorities in a 1943 law. These hospital authorities may be created to provide and operate hospitals in any municipality or county by resolution of the municipal council or the board of county commissioners. A board of commissioners appointed by the mayor or the chairperson of the board of county commissioners governs each authority. The authorities may issue revenue bonds, fix and collect rates/fees and accept grants and city/county appropriations. Hospital Authorities may extend services to include additional cities and counties. The U.S. Census Bureau lists three hospital districts in North Carolina.
- All Ohio residents live in a health district — either a city health district or a general health district — that is primarily funded from tax levies of the municipalities in the district and from separate health district tax levies. The health district board appoints a health commissioner and hires other employees necessary to carry out its duties. The health district board has powers to condemn and sell real property, quarantine people and establish rules for the protection of the public health. The U.S. Census Bureau lists six hospital districts in the State of Ohio.
- Hospital districts were established in South Carolina by special acts to provide, operate and maintain hospitals with substantially uniform provisions for each district. Following implementation of 1975 home-rule legislation, statutory powers and functions of public service districts remained with the districts and authority to modify those powers remained with the state general assembly. However, subject to referendum, the governing body of any hospital district is authorized to transfer assets, properties and responsibilities to another entity and to dissolve the district. The 2010 Biennial Directory of Special Purpose Districts in South Carolina contains four hospital districts and three health care system/service districts. The U.S. Census lists nine hospital/health services districts in the State of South Carolina.
- Texas authorizes the legislature to provide for the creation, establishment, maintenance and operation of hospital districts and requires that the hospital districts assume the full responsibility of providing medical and hospital care for the needy inhabitants of the district. The hospital districts have the power to issue general obligation bonds, revenue bonds and impose property taxes annually at a rate not to exceed 75 cents per \$100 valuation of all taxable property in the district. The Texas Comptroller of Public Accounts lists 139 hospital districts that collected taxes in the State of Texas for 2010. The U.S. Census lists 119 hospital districts in the State of Texas. In addition, Texas also has hospital authorities which do not have taxing power but do have the power of eminent domain. Texas has health service districts that can issue revenue bonds and impose sales taxes in addition to any county sales and use tax. A health service district is created by one or more counties and one or more hospital districts by adopting concurrent

orders by contract to provide health care services to indigent residents of the district on a sliding-fee scale.

- Virginia allows hospital authorities to be established in a city or county (other than the one in which another authority has been established) after a governing body has motioned to establish one or upon a petition of 100 voters. There is no referendum provision to establish a hospital authority but a referendum provision is required for jurisdiction to participate in a health center commission. Hospital authorities and health center commissions in Virginia do not have taxing authority but may issue revenue bonds.
- In Washington, the legislature granted local communities the ability to create their own hospital districts in 1945. As of 2010, the state has 56 public hospital districts operating 43 hospitals—representing almost half of the acute care hospitals in the state. The U.S. Census lists 49 hospital districts in Washington.
- Wyoming has two different forms of districts, hospital districts and rural healthcare districts. Hospital districts can be established by the board of county commissioners on petition of landowners after a local referendum. The trustees of the hospital board are elected and can fix charges but need voter approval for levying ad valorem taxes (up to 6 mills) and to issue bonds. Rural health care districts are governed and empowered the same as a hospital district, except ad valorem taxes cannot exceed 4 mills. Rural health care districts are established by petition to the county commissioners after a public hearing and referendum. The U.S. Census lists 14 hospital districts in Wyoming.

## Oversight and Accountability

4. *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.*

Commissioners reviewed 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 1990s resulted in any sanctions. None of those situations was 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. Since the regulatory structure allows for a plan of correction when a deficiency is cited, there are very few sanctions that remain uncorrected. Regulatory sanctions do not provide any basis for the comparison of hospitals.

At the August 16<sup>th</sup> meeting, the Commission heard a presentation 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 16<sup>th</sup> 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.

There is no evidence of systemic problems in the oversight and management of Florida’s tax districts or their hospitals. If anything the evidence seems to suggest that the hospital tax districts are less frequently involved in issues of this nature than many other district entities.

Nevertheless, the development of careful, transparent, thorough and consistent mechanisms for reporting on their activities to both local stakeholders and to the state government would be valuable.

**Physician Employment**

5. *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.

**Physician Employment Models**

**Table 4: Physician Employment Models Reported by Florida Hospital Taxing Districts**

District	Information Submitted by Florida Hospital Taxing Districts About Physician Employment Models
Bay County Hospital Taxing District	The Hospital District has several types of arrangements with physicians. These are regulated by state and federal law and developed to ensure that salaries are commercially reasonable while protecting ER specialty call. The Hospital District also contracts with independent physicians for specific professional services including medical directorships and patient care services.
Campbellton-Graceville	Campbellton-Graceville Hospital employs two full-time physicians for \$260,000 annually. Physicians in the ER are paid \$65 per hour for any hours worked. The Hospital acknowledges that this compensation

District	Information Submitted by Florida Hospital Taxing Districts About Physician Employment Models
Hospital	is outside the average but that it must make allowances to recruit to the Hospital. Two ARNPs are employed by the hospital and are paid \$95,000 annually and are paid \$35 dollars per hour for ER work outside their regular schedule. A supervising physician is paid \$500 a month to provide oversight for ARNPs working in the hospital.
Jackson County Hospital District	Physician employment agreements include a base salary and incentives for quality outcomes and customer service ratings. Physician salaries are based on the national average for the medical specialty within the norm for similar physicians in similar geographical areas. There are no compensated medical directorships for inpatient services.
Holmes County Hospital District	The Hospital District does not employ any physicians although it does contract with the active members of the medical staff at a rate of \$90 an hour to provide coverage in the ER. The Hospital District provides professional liability insurance that covers the doctors while working in the ER. There are no paid medical directorships.
Lake Shore Hospital Authority	The Hospital Authority does not employ any physicians. The Hospital Authority budgets \$120,000 as an annual stipend to be paid to Hospital physicians for providing on-call medical services to indigent patients.
Marion County Hospital District	The Hospital District employs ten physicians and employment packages include base pay, standard fringe benefits and incentives for attainment of financial and quality metrics. The Hospital District has 15 Medical Directorships, these physicians are responsible for the preparation and submission of monthly payment logs documenting the activity and time spent—reimbursement is not made without documentation and a valid contract in force.
Halifax Hospital Medical Center Taxing District	The Medical Center states that physician employee models and pay rates are compliant with state and federal law. All physician compensation arrangements must meet Fair Market Valuation tests. Halifax does have medical directors where appropriate and compensation is based on actual time worked.
Southeast Volusia Hospital District	The Hospital District uses a Fair Market Value of Physicians Clinical Compensation and bonuses are paid when met by Worked Relative Value Unit calculations. A minimal amount of Medical Directorships are utilized in key clinical areas with a regulatory requirement or needed service line. Medical Directors operate under contracts set in advance and paid at the appropriate fair market value for services rendered.
North Brevard County Hospital District	The Hospital District employs physicians according to a Medicare formula called Workload Relative Value Unit and a percentage of the income is withheld pending achievement of predetermined quantifiable quality of care and patient satisfaction benchmarks. Medical Directors are paid a monthly stipend based on fair market value and are conditioned on achievement of key quality, safety and effectiveness benchmarks.
West Orange Healthcare District	The Healthcare District's employment model includes a base rate of pay and provides incentive provisions for improving patient satisfaction or cost effectiveness of the care provided. The Healthcare District utilizes medical directorships that are contracted and compensated based upon the number of hours worked multiplied by a negotiated fair market hourly rate.
DeSoto County Hospital District	The Hospital District employs four physicians, paid an undisclosed salary. Two of these physicians are entitled to a performance bonus for reaching certain goals—but these physicians have not received a bonus yet. The director of the Center for Family Health receives a \$2,000 per month supplement. The Hospital District contracts with five ER physicians, paid \$140 per hour and receive no benefits. One of these physicians receives a \$3,000 monthly stipend for serving as the director of the emergency department.
Hendry County Hospital Authority	The Hospital Authority awarded the Hospitalist service to an outside contractor effective July 15, 2011 and the physicians are no longer Hendry Regional Medical Center employees. The Hospital Authority pays a medical director fee for Cardio-Pulmonary services and for the Hendry Convenient Care Rural Health Clinic.
Lee Memorial Health System	The Health System employs both primary care and specialty physicians and utilizes three compensation models depending upon specialty and type of practice. These models are: a salary based model, a salary combined with the ability to earn a productivity bonus and a compensation model based upon

District	Information Submitted by Florida Hospital Taxing Districts About Physician Employment Models
	productivity only. Other forms of compensation utilized by the Health System include: sign-on incentives, reimbursement for moving expenses and reimbursement for continuing medical education. The Health System contracts with independent physicians for specific professional services including medical directorships, management services agreements and recruitment agreements.
Sarasota County Public Hospital District	The Hospital District through its subsidiary employs physicians and mid-level providers. These physicians are generally employed under fixed compensation agreements for the first two years and after that are compensated under the FPG pay model. The Hospital District compensates certain specialty physicians for an ER call. The Hospital District contracts with physicians to provide medical directors for hospital services as required by regulation, Medicare Conditions of Participation accreditation standards or community needs.
Indian River County Hospital District	The Hospital District does not employ any physicians directly. The Hospital District employs one full-time Executive Director and one part-time staff.
Health Care District of Palm Beach County	The Health Care District employs three physicians at Lakeside Medical Center set at fair market value for three and five years, with salaries increased three percent from year-to-year. Compensation models include standard employee benefits, limited continuing education expense reimbursement and vacation time. One agreement has a bonus potential. The Health Care District has medical directorships at Lakeside Medical Center as required by the CMS Conditions of Participation for the Clinical Laboratory and the Respiratory Care Services. Medical Directors are fully contracted and required to provide documented service logs.
North Broward Hospital District	The Hospital District states that physician contracts are compliant with State and Federal Stark & Anti-Kickback laws. The Hospital District primarily uses the Integrated Health System for Fair Market Value analysis. The Hospital District does utilize medical directorships to oversee medical programs as necessary.
South Broward Hospital District	The Hospital District states that its physician employment agreements are simple compensation arrangements and are not incentive base arrangements. The Hospital District does pay a medical directorship stipend for certain administrative functions in a physician’s specialty.
Miami-Dade County Public Health Trust	The Public Health Trust uses four models for contracting with physicians that all follow a fair market value pay structure. These agreements are: an Annual Operating Agreement, a Management Services Agreement/Asset Purchase Agreement, an On-Call Agreement and a Medical Directorship Agreement.
Lower Florida Keys Hospital District	The Hospital District does not employ or compensate any physicians directly. The Hospital District does provide \$500,000 annually to HMA for physician reimbursement for a primary care clinic.

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.

**Changes of Ownership and Governance**

6. 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 the October 4<sup>th</sup> 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 the November 7<sup>th</sup> 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

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.”

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?

The key principles here are not as obvious as this section of the executive order implies. Obviously, a community (or any owner, for that matter) should consider divesting a significant asset only if it determines a clear and compelling reason for doing so. And the simple presence of a willing buyer is by no means sufficient reason. In fact, this situation reveals one of the great contradictions of a market process: when a prospective buyer seeks to purchase an asset, the current owner should immediately

become less interested in selling...and vice versa. In the specific question at hand if a private entity seeks to purchase a publicly-owned asset, the private entity must have some strong basis for believing the asset has value both in the short term and as an investment that will provide additional value over time. If such a value to the potential purchaser is clear enough to foster interest, the same value must at least theoretically be available to the current owners.

If despite that basic logic, a community still determines that it should divest a community-owned asset, the process for doing so should ensure the transparency and openness necessary to protect the community's interests, both short term and long term, while recognizing that transactions of this nature may require some levels of confidentiality. But any regulatory constraints in this area should be titled in the direction of protecting the interests of the community, not those of prospective buyers. The most obvious dimension of this requirement is price...the community should receive full and fair value, not a kind of "fire sale" price. In the case of hospitals and other health care capacity it is also important that a transfer from public to private ownership include mechanisms to ensure in perpetuity an ongoing capacity and willingness to provide care for poor people...the fundamental reason the public health care entity exists in the first place.

Broward Health included a "preliminary" Risk Assessment from 2010 on the effects of converting a public hospital to a not-for-profit corporation. This included documents from hospitals in Florida that had been through a similar transition such as the Citrus County Hospital Board, the Indian River Hospital Board and Everglades Memorial Hospital with the Northwestern District/Palm Beach County Health Care District.

Broward Health's Risk Assessment focuses on the new Federal HealthCare Program and how its implementation might hamper the District's ability to function and be as profitable without a conversion. Specifically, Accountable Care Organizations were cited a reason to initiate the transition from a public hospital to a not-for-profit corporation. The intention of Accountable Care Organizations is to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. The Risk Assessment stated that it was not clear if there are restrictions that would allow the District to develop a public integrated system that would qualify as an Accountable Care Organization to take advantage of the Medicare Shared Savings Program. The Risk Assessment does note though, that there are inherent risks to providers associated with an Accountable Care Organization model which may not be sufficiently addressed or mitigated in a transition from public hospital to not-for-profit.

On September 10, 2010, the Commissioners of the North Broward Hospital District voted 6-1 in favor of a resolution to "initiate and facilitate the process of leasing the District's facilities to a non-profit entity." This vote resulted in a complaint to the State Attorney's Office alleging a violation of the Sunshine Law, specifically that commissioners had conversations about the resolution outside the publicly noticed meeting. On February 28, 2011, after an investigation by the State Attorney's Office, it was determined that there was no violation of the Sunshine law committed by the North Broward Hospital District.