Report of the Commission on Review of Taxpayer Funded Hospital Districts

December 30, 2011

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On March 23, 2011, Governor Rick Scott issued Executive Order Number 11-63, appointing a commission to "assess and make recommendations on the role of hospital districts, whether it is in the public's best interest to have government entities operating hospitals, and what is the most effective model for enhancing health care access for the poor." A copy of the Executive Order is included as Attachment 1 of this report. The Florida Commission on Review of Taxpayer Funded Hospital Districts was chaired by Dominic Calabro of Florida TaxWatch in Tallahassee. Taxwatch published a report on Florida's special hospital taxing districts in February 2009. A copy of the report is included as Attachment 2 of this report. Other members of the Commission included:

- Brad Dinkins, Bradford Development, Ocala
- R. Paul Duncan, Ph.D., University of Florida, College of Public Health and Health 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
- Randall McElheney, CoastalMed, Inc., Panama City
- J. Scott McLeneghen, City National Bank of Florida, West Palm Beach
- The Honorable Joe Negron, Florida Senate, Palm City

The Commission held 14 public meetings between May 23 and December 29, 2011 at the Agency for Health Care Administration (AHCA) in Tallahassee. The Commission created a webpage 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 20 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. In November, staff followed up with a public records request for executive and physician salaries. A sample of the outgoing letters, 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 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.

A Citizens' Commission

The Commission on Review of Taxpayer Funded Hospital Districts was described by Chairman Calabro as a "citizens' commission". He noted that most of the members were not directly tied to the hospital industry, and that it is important to have a commission made up of accomplished individuals from outside the industry who study the issues and make recommendations about the future of the districts and the hospitals they operate.

Chairman Calabro pointed to the findings submitted in draft text by Commissioner Brad Dinkins as the basis for several of the recommendations that are included in this report. These findings include the following points:

- Special hospital districts have governance models that are varied and inconsistent. District boards have a diverse array of member appointment processes.
- Some districts have taxation authority without elected board representation.
- Some public and private hospitals are receiving local tax revenue while making good and sometimes substantial profits or net income.
- Many private and some public hospitals provide quality health care without local tax support.
- The dollar value of the benefits received by special hospital districts or district hospitals as a result of their tax exemptions has not been clearly determined, nor has the dollar value of the community services they provide been precisely quantified.
- Over the years, some hospital districts have not re-evaluated the funding they have received from taxpayers, despite the creation of state indigent care programs, including the Public Medical Assistance Trust Fund, the Disproportionate Share Program, the Low Income Pool and the Health Care Responsibility Act.
- Unless they have already reached the limits of their taxation authority, all Florida counties have statutory authority to fund indigent care through a sales tax referendum.
- Unless all of the proceeds in the sale of a public hospital must be used to satisfy debt or other obligations such as under-funded pensions, public hospitals that sell their assets can use the proceeds from such sales to provide long term benefits to improve access to care for the poor.

Reflecting its makeup as a citizens' commission, this report makes no attempt to be an academic study. It is intended to be a plain spoken review of the information received and reviewed by commissioners in their public meetings. Much of the information was technical and complicated. Some of the information was controversial and the commissioners heard different views of the same situations.

The report includes recommendations in six specific areas that were included in the Governor's Executive Order. These specific areas are:

- Quality of Care
- Cost of Care
- Access to Care for the Poor
- Oversight and Accountability
- Physician Employment
- Changes of Ownership and Governance

After reviewing all of the information presented to the Commission, this report begins with a set of general recommendations:

- The Governor and other appointing authorities should appoint qualified individuals to district and hospital boards who do not have conflicts of interest.
- Board members should include health care stakeholders and members of the local community who have financial expertise and experience operating successful, larger enterprises.
- To ensure appropriate checks and balances, the membership of district and hospital boards should be separate and distinct.
- To ensure appropriate checks and balances, hospital boards should not include members who are part of the hospital's administrative staff.
- To ensure appropriate checks and balances, hospital boards should not include members who are also part of the hospital's management team.
- Special hospital districts should become indigent health care districts, funding indigent health care based on local priorities and not limited to hospitals owned or operated by the districts. As a part of the transition to indigent health care districts, hospital districts that own hospitals should de-couple them from the districts.
- When considering changes to taxation rates, millage rates should be adjustable with a maximum allowable rate, but with the flexibility to lower the rate if circumstances change.
- Boards of directors of hospital districts should be subject to appropriate oversight.

Summary of Commission Recommendations

General Recommendations

- The Governor and other appointing authorities should appoint qualified individuals to district and hospital boards who do not have conflicts of interest.
- Board members should include health care stakeholders and members of the local community who have financial expertise and experience operating successful, larger enterprises.
- To ensure appropriate checks and balances, the membership of district and hospital boards should be separate and distinct.
- To ensure appropriate checks and balances, hospital boards should not include members who are also part of the hospital's management team.
- Special hospital districts should become indigent health care districts, funding indigent health care based on local priorities and not limited to hospitals owned or operated by the districts. As a part of the transition to indigent health care districts, hospital districts that own hospitals should de-couple them from the districts.
- When considering changes to taxation rates, millage rates should be adjustable with a maximum allowable rate, but with the flexibility to lower the rate if circumstances change
- Boards of directors of hospital districts should be subject to appropriate oversight.

1. Quality of Care

a. Using the available outcome data, the Commission could not establish that there is a pattern of higher or lower quality of care in Florida hospitals based on ownership.

b. The Governor and Legislature should support the Agency for Health Care Administration in its effort to continue to refine and publish data on outcomes and quality by hospital and health care facility.

2. Cost of Care

a. The Agency should complete the legislatively mandated study on the use of diagnosis-related groups (DRGs) for Medicaid hospital reimbursement in a managed care environment in order to determine whether such a system will reduce inequities in the current Medicaid hospital reimbursement system.

b. After the completion of the DRG study, the Legislature should authorize the development of a DRG-based system that can be used as a basis for the negotiation of hospital payments under the future managed care environment.

c. The Legislature should provide incentives for the use of LIP funds for primary and specialist care to the indigent population through models that offer more community and hospital choices.

3. Access to Care for the Poor

a. Special hospital districts should not limit themselves to providing tax funds to hospitals. Indigent care funding models that are based on a "money follows the patient" system provide a

more equitable distribution of funds for indigent care and allow local communities to establish funding programs that reflect unique local needs.

b. The Legislature should consider the development of a mechanism in which public and non-public hospitals could seek relief from their Public Medical Assistance Trust Fund assessment to provide cost-effective services to a broad population, incentivize economic development, and provide a higher quality of healthcare delivery services.

4. Oversight and Accountability

a. Amend Chapter 189, Florida Statutes, to ensure that all hospital taxing districts contain a provision for a sunset review of the districts' authority to levy taxes every eight to twelve years. Re-approval of the districts' taxing authority should be voted on by local referendum in a general election. The sunset review should consider any impacts to the hospital's ability to obtain financing and access to the bond market.

b. Due to the structural diversity and unique circumstances of special hospital districts, both local bills and general laws are the most effective way to enact reforms such as the transition from a hospital district to an indigent care district.

c. In order to increase their accountability and transparency, special hospital districts should develop thorough and consistent mechanisms for annual reporting on their activities to both local taxpayers, stakeholders and to the state government. Such reporting should include a listing of each hospital's tax exemption benefits and the corresponding dollar value of each benefit, which should include ad valorem and tangible property taxes, local and state sales taxes, state corporate and federal income taxes.

5. Physician Employment

Using the available data, the Commission could not establish that there are inappropriate payments to physicians in Florida hospitals based on ownership type.

6. Changes of Ownership and Governance

With any change of ownership or governance, the Commission recommends that hospital district boards, county commissions and other oversight authorities should:

a. Ensure an open, competitive public procurement process or negotiation.

b. Ensure a fair and independent asset valuation process.

c. Establish guidelines to ensure an ongoing community benefit from any proceeds generated by the sale of a hospital.

d. Without inhibiting the functioning of a free market, maintain independent oversight of a process with review by an appropriate authority.

e. Require the maintenance and/or expansion of community health programs, with an emphasis on primary care and emergency room diversion.

Introduction and Background

While hospitals associated with Florida's current special hospital districts can trace their origins at least as far back as 1916, the state's first special hospital districts (in Jackson and Madison Counties) were created in the 1930s. Most were established in the middle decades of the last century when the state's hospital infrastructure was undeveloped but the population was beginning to grow very quickly. The health care system was much simpler than the diverse, complex system we have today. Some communities felt the need to fund hospitals and other health care infrastructure, and they were willing to be taxed to do so. Other communities created hospital districts without taxing authority and others chose not to create special districts. The Florida map on page 11 shows at a glance the diversity of approaches to special hospital districts.

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.

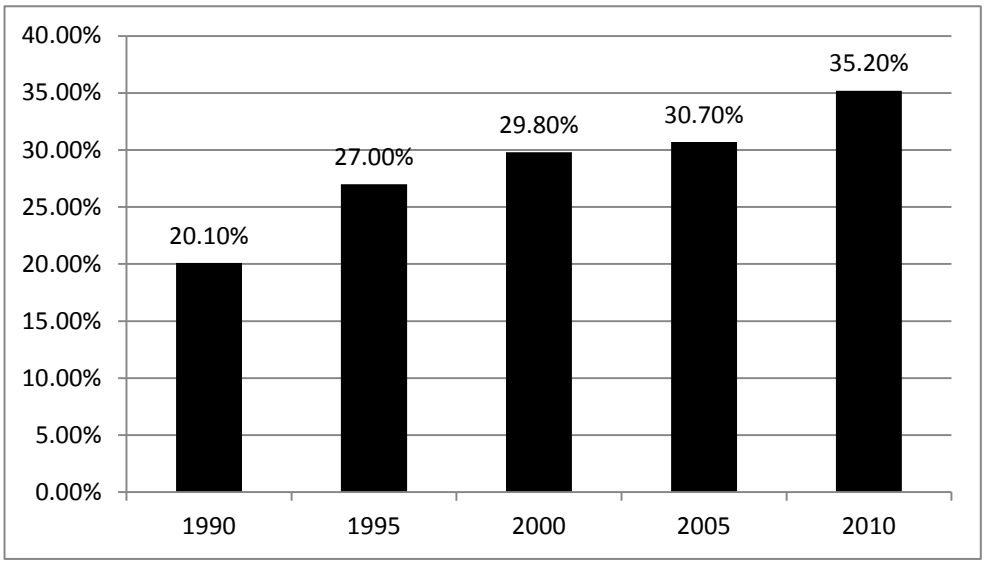
In the early 1980s, the need to change Medicare hospital reimbursement was clear. The inclusion of capital costs in patient bills had led to the overdevelopment of inpatient hospital beds. Inpatient reimbursement was switched to a system of prospective reimbursement based on the patient's diagnosis. 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. Figure 1 on the following page shows the increasing amount of the state's acute care hospital business that is devoted to outpatient care. Outpatient services require less capital investment than inpatient beds, particularly since hospitals have been free to renovate existing space or add new outpatient services without regulatory review since 1987. This is an example of a fundamental way that hospitals are changing and why it is a good idea to reconsider some of the funding mechanisms that have been in place since the time when hospitals delivered only simple, basic inpatient care.

Another way to see basic changes in Florida's hospital industry is to note the steady decrease in major capital projects or complex tertiary care programs that are subject to regulatory review. Declining numbers of certificate of need applications for hospital projects are partially due to de-regulation. However, compared to the 1980s, when new hospital beds and facilities were expanding very rapidly, applications for new hospitals and complex, tertiary care programs have dropped to very low levels. This is documented in Figure 2 on the following page.

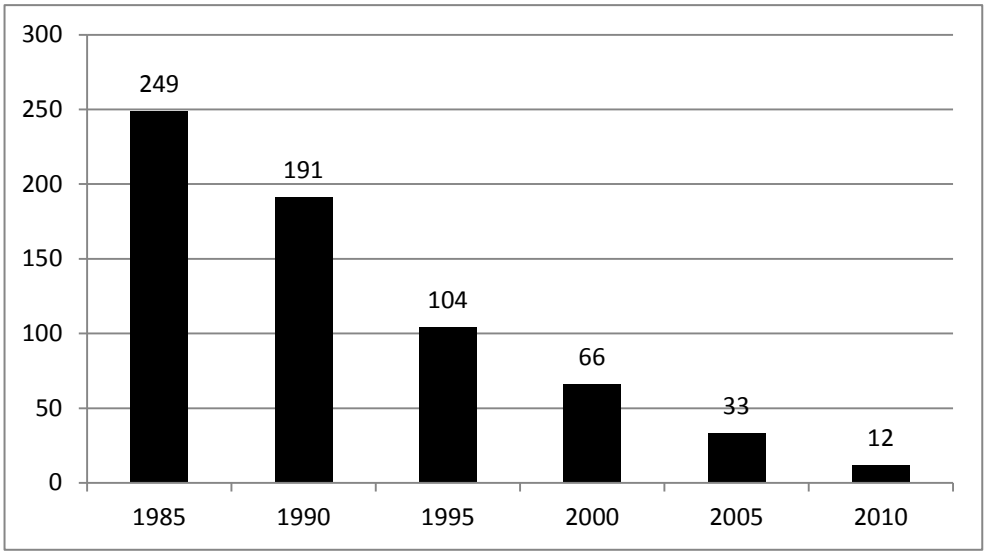
Many hospitals are now continuously re-aligning their services and renovating their facilities. As we look ahead to continued clinical and technological innovation and greater use of telemedicine and electronic health records, we see other reasons to re-evaluate the need for taxation and funding that is limited to hospital care.

Figure 1: Percentage of Total Charges for Florida Acute Care Hospitals Attributable to Outpatient Services, 1990-2010



Source: Agency for Health Care Administration, Florida Hospital Uniform Reporting System

Figure 2: Number of Certificate of Need Reviews for Hospital Projects, 1985-2010



Source: Agency for Health Care Administration, Certificate of Need Program

Compared to the time when many special hospital districts were being established, we now have a relatively mature, diverse, and very competitive hospital industry. The state's population growth has slowed and access to capital has become less predictable. The Commission heard numerous

presentations describing problem situations involving taxations levels, district oversight or changes in hospital ownership. While each set of local circumstances was unique, many of the issues faced by local taxing districts are similar, providing yet another set of reasons to evaluate the ongoing appropriateness of special hospital districts in Florida.

Diversity of Special Hospital Districts and Hospitals

A consistent message delivered to the Commission by many speakers was an emphasis on the diversity of special hospital districts, the hospitals they operate, and the hospitals that compete with district hospitals. A number of presenters remarked that, "When you've seen one, you've seen one," inferring that no two hospital districts are alike. While their differences posed a challenge to the Commission in developing comparative analyses, the taxing districts and the hospitals they support share enough common elements that valid comparative conclusions can be made.

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 of the Legislature, 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 municipality.

An ***independent special district*** does not have any dependent characteristics. Independent districts are created by counties, municipalities, the Governor and the Cabinet, and general law authority. The classification system applies to all districts, not just hospital districts. It 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 authority to levy property taxes (millage) or receive tax money.

In compiling this report, the Commission considered information from special districts that are inactive and also considered information from the Public Health Trust of Miami-Dade County, which is not a special hospital district but a part of county government. The Commission included Jackson Memorial Hospital in its analysis because it is the largest public hospital in the state and the governance of the

Public Health Trust has similarities to special districts. Three of the Panhandle districts included in the Commission's initial survey are now inactive.

The fundamental differences in governing structure, taxing authority and taxing activity in the special districts are summarized in the following:

- 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-one (61.76 percent) of special hospital districts have taxing authority while thirteen (38.24 percent) do not have the authority to tax.
- Fifteen (44.12 percent) special hospital districts levy a millage rate between .25 and 3.25 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.

The following table provides a more detailed view of the governing structure, taxing authority and taxing activity in the special hospital districts.

Table 1: Basic Structure and Taxing Authority of Florida Special Hospital Districts

District Name	Type of District[1]	Board of Directors	Taxing Authority	Tax Levied	Millage Rate
Panama City – Tallahassee					
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		

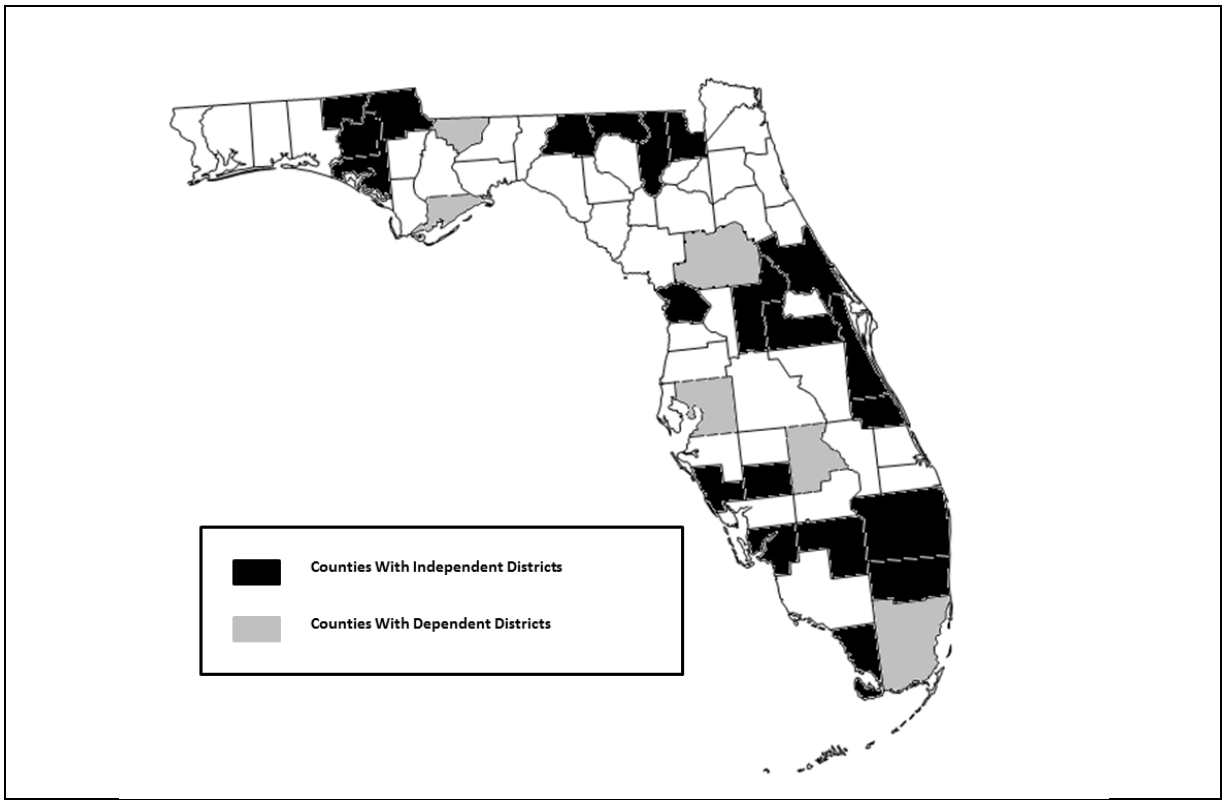
District Name	Type of District[1]	Board of Directors	Taxing Authority	Tax Levied	Millage Rate
Lake City – Gainesville – Ocala – Leesburg – Brooksville					
Lake Shore Hospital Authority	I	7 members, appointed by the Governor	Yes	Yes	0.962
Hamilton County Hospital District	I	5 members, appointed by the Governor	No		
Marion County Hospital District	D	7 members, appointed by the County Commissioners	No	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
Jacksonville - Daytona					
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
West Volusia Hospital Authority	I	5 members, voted on in a general election	Yes	Yes	2.0818
Tampa – Lakeland – Bradenton – Sebring					
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		
Greater Orlando and Brevard					
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		
Sarasota – Ft. Myers – Naples					
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

District Name	Type of District[1]	Board of Directors	Taxing Authority	Tax Levied	Millage Rate
West Palm Beach – Stuart – Ft. Pierce – Vero Beach					
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
Broward					
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	0.75
Miami-Dade and Monroe					
Miami-Dade County Public Health Trust	D[2]	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	

[1] 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.

[3] 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



Quality of Care

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 to commissioners are either inpatient quality indicators or patient safety indicators as defined by the federal Agency for Health Care Research and Quality (AHRQ). These measures of quality are on a par with the CMS Core Measures referenced in the executive order. The following table summarizes the specific measures:

Table 2: Hospital Outcome Measures Considered by the Commission

AHRQ Inpatient Quality Indicators – Mortality Procedures
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)
AHRQ Inpatient Quality Indicators – Mortality Conditions
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
AHRQ Patient Safety Indicators – Complication and Infection
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)

A key problem in attempting to conduct a comparative analysis of hospitals is that they are very diverse and their business models are complex. For example, one third of the state's publicly owned hospitals are small rural facilities. It is extremely difficult to compare rural hospitals to larger hospitals because rural hospitals often have too few patients to produce comparable data. It is also difficult to compare larger hospitals because they offer a different array of services.

This Commission considered the available data on quality measures. AHCA, over the past decade, has gathered data on hospital quality and has placed this information on its web site for consumers and researchers. Additionally, there is currently an initiative on the part of the federal Centers for Medicare and Medicaid Services (CMS) to collect data on quality, and CMS has placed this information on its website for consumers and researchers.

As noted in draft text submitted by Commissioner Paul Duncan, an experienced health services researcher, making conclusive statements about the quality of care in different hospitals without a thorough and rigorous analysis of available data has great potential for being misleading. This level of research would be a very significant undertaking, beyond the scope of the Commission and more appropriately conducted by a team of academic researchers.

Quality of Care Recommendations

1a. Using the available outcome data, the Commission could not establish that there is a pattern of higher or lower quality of care in Florida hospitals based on ownership type.

1b. The Governor and Legislature should support the Agency for Health Care Administration in its effort to continue to refine and publish data on outcomes and quality by hospital and health care facility.

Cost of Care

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 20th meeting. This information is available in detail on the Commission website.

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 is 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 process involved in reviewing data 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 and Percent Of Total Patient Charges)
20. Medicaid (Dollars and Percent Of Total Patient Charges)
21. Charity (Dollars and 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 Reimbursement Rate
30. Medicaid Outpatient Reimbursement Rate
31. Low Income Pool (LIP) Dollars
32. Disproportionate Share (DSH) Dollars

In order to provide the Commission with a credible analysis of cost differences between public and private hospitals, Dr. Keon-Hyung Lee of the Askew School of Public Administration and Policy at Florida State University was engaged to interpret the data on financial, facility, demographic and outcome information that was provided by Commission staff. Dr. Lee had authored a number of studies over an academic career that included comparisons between public and private hospitals in South Korea, and for-profit and non-profit hospitals in Florida.

Dr. Lee presented an initial analysis on patient expenses at the October 21st meeting. This analysis showed patient expenses in public hospitals being 15 to 18 percent higher after adjusting for factors such as patient volume, case mix, average length of stay, number of emergency department visits, number of uncompensated discharges, other operating expenses, and the level of indigent care provided. Other factors such as statutory teaching or rural status were also controlled for, in addition to whether or not a hospital includes a trauma center, is a Baker Act receiving facility, or offers obstetrical services. This initial analysis was also extended to evaluate Medicaid inpatient reimbursement rates and Low-Income Pool and Disproportionate Share (LIP/DSH) funding, after controlling for all of the same factors. Dr. Lee found that public hospitals were reimbursed between 28 and 33 percent higher on Medicaid inpatient reimbursement rates, and between 213 and 250 percent higher in LIP/DSH funds.

Dr. Lee was asked by the Commission to present a follow-up analysis at the meeting on November 7th. For his follow-up analysis, Dr. Lee incorporated the comments of Commission members, led by Commissioner Paul Duncan and his department at the University of Florida, and the Safety Net Hospital Alliance of Florida by controlling for additional factors such as relative wage levels, number of beds, percentage of specialty beds, the level of Medicare patients, and the level of Medicaid patients. The Commission also asked that the new analysis substitute total operating expenses for patient expenses, and that Jackson Memorial be taken out of the analysis. The follow-up analysis showed total operating expenses in public hospitals being 11 to 12 percent higher after adjusting for all of the factors mentioned. This follow-up analysis was similarly extended to evaluate Medicaid inpatient reimbursement rates and LIP/DSH funding as well. Dr. Lee found that public hospitals were reimbursed between 22 and 24 percent higher on Medicaid inpatient reimbursement rates, and between 229 and 293 percent higher in LIP/DSH funds.

Based on the data provided to the Commission, Dr. Lee was able to show that a group of 21 public hospitals, defined strictly by ownership type, had higher costs, higher Medicaid reimbursement rates, and higher LIP/DSH funding compared to non-public hospitals. Dr. Lee did not offer any theories for his findings. The magnitude of these differences and their causes can be more fully understood with further study and analysis, as is often the case with statistical research. All of the materials presented by Dr. Lee are included on the Commission website.

Dr. Lee's work was interpreted for the Commission by Dr. Duncan and extensive comments were also provided by Dr. Jim Zingale, representing the Safety Net Hospital Alliance of Florida.

Dr. Duncan commended Dr. Lee's work as an improvement over simplistic comparisons because it was effective in statistically controlling for 68 percent of the variations in hospital circumstances for cost per adjusted admission and 59 percent of cost per adjusted patient day, in addition to effectively controlling for between 63 and 73 percent of the variations in Medicaid inpatient reimbursement rates and LIP/DSH funding levels. On behalf of the Safety Net Hospital Alliance of Florida, Dr. Jim Zingale presented a response to Dr. Lee's analyses at the meeting on November 21st. This response included an analysis showing that the average cost per adjusted admission at public hospitals decreases from $8,048 to $6,874 (a 14.6 percent reduction) if Jackson Memorial and Campbellton-Graceville are removed from the calculation. Dr. Zingale did not attempt to show the effect on average cost per adjusted admission at private for-profit and non-profit hospitals if outliers were removed from these respective sub-samples. Further, this analysis did not control for additional factors that might impact average costs.

As noted in the draft report text submitted by Commissioner Marshall Kelley, a former Florida Medicaid Director, the Florida Legislature has acknowledged the importance of addressing the issue of hospital reimbursement rates by requiring Medicaid to complete a study on transitioning hospitals to a DRG reimbursement system within a managed care environment. The Legislature also directed AHCA to address the issue of including essential providers in managed care and the future of the low income pool (LIP). Based on 2011 legislation, AHCA must submit a plan to the Governor and the Legislature by January 1, 2013 for a Medicaid payment system that categorizes each hospital patient into a diagnosis-

related group (DRG) and assigns payment weight based on the average resources used to treat Medicaid patients in that DRG.

However, it is unlikely that Florida will be able to transition to a DRG reimbursement system for hospitals before 2015 because AHCA must first move its data systems from the ICD-9 to the ICD-10 medical coding systems. By way of background, the Health Insurance Portability and Accountability Act (HIPAA) mandated that all providers and payers begin using the International Classification of Disease-10th revision (ICD-10) by October 1, 2013. The ICD-10 are federally required changes to the entire U.S. health care industry and represent a significant modification to diagnosis coding that all health care providers and payers must adopt. Until the DRG system can be implemented, an interim reimbursement methodology should be considered.

The Legislature has also established timeframes for the Medicaid program to move to managed care for the vast majority of its recipients. This is to be completed for the individuals receiving Medicaid long term care services beginning July 1, 2012 and completed by October 1, 2013; and for individuals receiving acute care medical services by October 1, 2014 — implementation begins January 1, 2013.

In a managed care environment, health plans and hospitals will negotiate a reimbursement 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 moves to DRGs, questions will 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.

Health plans will be required to contract with “essential providers” that offer services that are not available from any other provider within a reasonable access standard. Statutory teaching hospitals, hospitals that are trauma centers, hospitals located at least 25 miles from any other hospital will be included in this group.

It will be essential that managed care companies selected by AHCA in the competitive procurement process for the new managed care programs receive a reasonable allocation 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 the Legislature. It has been a somewhat contentious battle between hospitals and managed care companies surrounding the rate issues. Hospital rate increases should not be implemented without coordination of the managed care rate for the new program to be a success.

Recommendations on the Cost of Care

2a. The Agency should complete the legislatively mandated study on the use of diagnosis-related groups (DRGs) for Medicaid hospital reimbursement in a managed care environment in order to determine whether such a system will reduce inequities in the current Medicaid hospital reimbursement system.

2b. After the completion of the DRG study, the Legislature should authorize the development of a DRG-based system that can be used as a basis for the negotiation of hospital payments under the future managed care environment.

2c. The Legislature should provide incentives for the use of LIP funds for primary and specialist care to the indigent population through models that offer more community and hospital choices.

Access to Care for the Poor

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 about access to care for the poor submitted by the state's special districts in response to a Commission inquiry is itemized in Attachment 3 of this report. There is no one method or model, but there are trends or examples of community-based models as opposed to hospital only models. Many of these approaches can be grouped under the general title of "acute care diversion." Similar to the idea of nursing home diversion in the Medicaid program that attempts to direct patients to less costly nursing home alternatives whenever possible, acute care diversion seeks to avoid expensive hospital inpatient care or emergency room care by diverting patients to less expensive alternatives such as primary care clinics or urgent care centers. For example, commissioners heard about a transition center operated cooperatively and collaboratively by Tallahassee Memorial Hospital and Capital Health Plan that provides focused, transitional care for socially and medically needy patients at risk for hospital readmission. The program offers short-term primary care services and support for individuals recently discharged from inpatient care who lack an established primary care medical home.

Commissioners heard a presentation by Dr. Ron Wiewora, Executive Director of the Health Care District of Palm Beach County, who described his district's approach to funding indigent care through a "money follows the patient model." While the Palm Beach district owns and operates a small rural hospital, it also operates managed care and health coverage programs that provide reimbursement to for-profit and not-for-profit hospitals in the county for eligible low income residents. The Palm Beach district was originally created to fund the county's trauma system. Currently, it also operates a school health, pharmacy and other programs that reflect local priorities. A copy of Dr. Wiewora's presentation is available on the Commission website.

Other districts and some county governments operate programs that are based on the "money follows the patient" concept. Hillsborough County operates such a program, as does the Lakeshore Hospital Authority in rural Columbia County.

Under Lakeshore's program, Columbia County residents may apply for medical care services under the indigent health care program for individuals or families whose income does not exceed 175 percent of the federal poverty level. Hospital Authority staff meet with individual applicants to determine their

eligibility for the program. If qualified, the Authority issues an indigent care ID card for individuals or families to use at primary care clinics or pharmacies that are under contract with the Authority.

Hospital Districts in Other States

Commission staff researched special hospital districts in other states and provided the information to commissioners. While it appears that just over half of states have organizations that are roughly equivalent to Florida's special hospital districts, their variety in terms of taxation, funding and governance limited the Commission's ability to draw any conclusions about their programs.

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.

Short summaries of information gathered about special hospital districts in other states are included in Attachment 4 of this report.

Recommendations on Access to Care for the Poor

3a. Special hospital districts should no longer limit themselves to providing tax funds to hospitals. Indigent care funding models that are based on a "money follows the patient" system provide a more equitable distribution of funds for indigent care and allow local communities to establish funding programs that reflect unique local needs.

3b. The Legislature should consider the development of a mechanism in which public and non-public hospitals could seek relief from their Public Medical Assistance Trust Fund assessment to provide cost-effective services to a broad population, incentivize economic development, and provide a higher quality of healthcare delivery services.

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. The Commission did not consider regulatory sanctions to be a valid basis for the comparison of hospitals.

At the August 16th 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. A copy of the presentation is included on the Commission website.

However, commissioners also heard from a variety of presenters and other interested persons who described shortcomings in the oversight of special districts. One common theme in the comments from people was a lack of effective communication when dealing with special districts. Special hospital districts should develop transparent, thorough and consistent mechanisms for reporting on their activities to both local taxpayers, stakeholders and to the state government.

Mrs. Marilyn Bainter, a board member of the North Lake County Hospital District, presented to the Commission at its first meeting in May, describing unique problems with oversight in that special district. Representative Larry Metz later presented a proposed local bill with a plan to reform that district. Local bills (which are included in the category of special acts) can be tailored to the specific needs of each local situation. Representative Metz described a unique situation involving a merger of two former special districts and a funding system with local hospitals that likely has no parallel among other districts. This again underscores the diversity of special hospital districts and suggests that local bills are the most effective way to reform many special districts. At an earlier meeting, Representative Matt Hudson, a Commission member, had advocated the use of local bills to address local hospital district issues.

Senator Joe Negron, a Commission member, provided draft text to other commissioners recommending amendments to Chapter 189, Florida Statutes, to ensure that all hospital taxing districts contain a sunset provision every eight years to review the districts' authority to levy taxes. Re-approval of the districts' taxing authority should be voted on by local referendum in a general election.

Oversight and Accountability Recommendations

4a. Amend Chapter 189, Florida Statutes, to ensure that all hospital taxing districts contain a provision for a sunset review of the districts' authority to levy taxes every eight to twelve years. Re-approval of the districts' taxing authority should be voted on by local referendum in a general election. The sunset review should consider any impacts to the hospital's ability to obtain financing and access to the bond market.

4b. Due to the structural diversity and unique circumstances of special hospital districts, both local bills and general laws are the most effective way to enact reforms such as the transition from a hospital district to an indigent care district.

4c. In order to increase their accountability and transparency, special hospital districts should develop thorough and consistent mechanisms for annual reporting on their activities to both local taxpayers, stakeholders and to the state government. Such reporting should include a listing of each hospital's tax exemption benefits and the corresponding dollar value of each benefit, which should include ad valorem and tangible property taxes, local and state sales taxes, state corporate and federal income taxes.

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.*

Florida is a large and diverse state with widely varying health care markets. South Florida is known for being one of the most expensive health care markets in the country, but the state also has many small cities and rural areas that cannot be readily compared to south Florida or other metropolitan markets. In rural areas, physician employment can be a very important factor in the preservation of access to hospital services. Physician recruitment and retention is one of the greatest challenges that confront rural hospitals. Maintaining a medical staff that can admit patients or treat them in emergency departments is the key to access in rural communities.

Taxpayer funded hospitals in urban markets include some of the state's largest general acute care hospitals. These facilities have diverse needs for physicians to fill various roles, including medical directorships of specialized programs, hospitalists who specialize in inpatient care and various specialists who are paid to be available to patients in emergency departments. Increasing employment of physicians by hospitals is a documented trend in the health care literature.

When staff surveyed the hospital districts about physician employment, they generally wrote about the use of the Medicare-related resource based relative value scale, private market-based salary systems or consultants, and compliance with applicable state and federal anti-kickback laws. This information is included in Attachment 5. The diversity of urban and rural markets served by Florida's taxpayer funded hospitals makes it difficult to generalize about their use of employed physicians.

Physician Employment Recommendations

Using the available data, the Commission could not establish that there are inappropriate payments to physicians in Florida hospitals based on ownership type.

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 4th Commission meeting described a very problematic attempt to change the ownership of the hospital. 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 7th meeting, Dave Ross, Chief Financial Officer of Tenet Healthcare's Florida region, made recommendations concerning changes of ownership at tax district hospitals. As a representative of a private, for-profit hospital corporation that sometimes considers the acquisition of public hospitals, his recommendations included:

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

It is also worthwhile to repeat the Commission's earlier recommendation regarding oversight and accountability because it applies to changes of ownership or governance:

- Special hospital districts should develop transparent, thorough and consistent mechanisms for reporting on their activities to both local taxpayers, stakeholders and to the state government.

Recommendations on Changes of Ownership and Governance

With any change of ownership or governance, the Commission recommends that hospital district boards, county commissions and other oversight authorities should:

6a. Ensure an open, competitive public procurement process or negotiation.

6b. Ensure a fair and independent asset valuation process

6c. Establish guidelines to ensure an ongoing community benefit from any proceeds generated by the sale of a hospital

6d. Without inhibiting the functioning of a free market, maintain independent oversight of a process with review by an appropriate authority.

6e. Require the maintenance and/or expansion of community health programs, with an emphasis on primary care and emergency room diversion.

Attachment 1 - Executive Order 11-63

STATE OF FLORIDA

OFFICE OF THE GOVERNOR

EXECUTIVE ORDER NUMBER 11-63

(Creation of Commission on Review of Taxpayer Funded Hospital Districts)

WHEREAS, according to the *Official List of Special Districts* maintained by the Florida Department of Community Affairs, there are 27 active independent health-care, health-facility, and hospital districts and 36 active dependent health care, health facility and hospital districts in the State of Florida; and

WHEREAS, of the active health-care, health-facility, and hospital districts in Florida, 24 are independent hospital districts and six are dependent hospital districts; and

WHEREAS, many health care, health facility and hospital districts, some originating as early as the 1930s, have been granted the authority to levy taxes for the purpose of making health care services available to low-income and under-served populations, as well as to provide direct health care services to populations served within the district service areas; and

WHEREAS, some health-care, health-facility, and hospital districts fulfill their mission by levying taxes and acquiring services from community-based providers, while other health care, health facility and hospital districts levy taxes and utilize these revenues for the purpose of subsidizing government-operated hospitals; and

WHEREAS, many tax-supported and non-tax supported government-operated hospitals operate competitively with non-government-operated hospitals while utilizing the benefit of taxes, enhanced Medicaid reimbursement and subsidies for losses, and in some counties, have acquired the assets of competing entities; and

WHEREAS, upon reviewing the distribution of public dollars provided for covering the cost of uncompensated care, I find that there is little correlation between the amount of uncompensated admissions and uncompensated Emergency Room visits in the aggregate by hospital systems grouped by affiliation, and the amount of dollars provided by the Medicaid Low Income Pool program for those services provided to the poor; and

WHEREAS, there is significant variation in Medicaid rates paid to hospitals for nearly identical services within markets, with such rate differences being driven primarily by variations in cost at the facility level irrespective of demonstrable justification for the difference in outcomes, with some hospitals demonstrating significantly higher cost notwithstanding a lower severity of illness of patients than comparison hospitals; and

WHEREAS, it is the intent of this administration to develop a more rational approach to compensating hospitals with a higher degree of predictability and fairness, and which does not incentivize inefficiency, higher cost, or irrational business practices; and

WHEREAS, the purpose of utilizing tax revenue to provide local health care services may be achieved without the taxing authority acting in the dual-capacity of operating hospitals while also using the tax revenue to subsidize such assets, and in fact, many special taxing authorities throughout Florida provide access to trauma, physician, and hospital services without the taxing authority operating any hospitals whatsoever; and

WHEREAS, many taxing authorities in Florida and in other states have divested hospital assets to independent entities through sale or lease, and such hospitals have thrived as private entities while continuing to serve the poor at consistent levels and returning millions of dollars to the taxpayers through tax contributions, principal on the value of the hospitals, and reduced taxes; and

WHEREAS, as a result of the foregoing, it is appropriate and necessary to review the contribution made to access for the poor by hospitals that receive no direct local tax subsidy, and the opportunity to ensure the taxpayer's resources are optimized in the community,

NOW, THEREFORE, I, RICK SCOTT, Governor of the State of Florida, by the powers vested in me by the Constitution and laws of the State of Florida, do hereby issue the following Executive Order, effective immediately:

Section 1.

The Commission on Review of Taxpayer Funded Hospital Districts ("Commission") is hereby created to assess and make recommendations on the role of hospital districts, whether it is in the public's best interest to have government entities operating hospitals, and what is the most effective model for enhancing health-care access for the poor. The Commission will:

A. Determine, based on objective data, whether costs in government-operated hospitals are higher or lower in comparison to similar non-government-operated hospitals offering similar services, and whether, assuming there is 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.

B. 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.

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

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

E. Determine if the existing governing-body model of the various government-operated

hospitals optimizes the best governance practices, ensures proper oversight with accountability for the actions of board members, has had any violations of charter or governance rules by board members, has complied with the government-in-the-sunshine laws, and has consistently acted in the best interest of the primary shareholder – the taxpayer.

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

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

Section 2.

A. I hereby appoint Dominic Calabro as the Chair of the Commission.

B. The initial membership of the Commission shall be composed of the following:

i. Dominic Calabro;

ii. J. Scott McCleneghen;

iii. Jacob C. Jackson;

iv. Marshall Kelley;

v. Dwight Chennette;

vi. Brad Dinkins;

vii. Randall McElheney; and

viii. R. Paul Duncan.

C. At the discretion of, and by appointment of, the Senate President, a member of the Florida Senate may serve as an additional member of the Commission. This member shall serve at the pleasure of the Senate President.

D. At the discretion of, and by appointment of, the Speaker of the House of Representatives, a member of the Florida House of Representatives may serve as an additional member of the Commission. This member shall serve at the pleasure of the Speaker of the House.

E. With the exception of the members appointed by the Florida Legislature, who shall serve at the pleasure of the applicable presiding officer, each member shall serve at the pleasure of the Governor and the Governor may fill any vacancy that occurs.

Section 3.

The Commission shall meet upon the call of the Chair. The Commission shall act by a vote of the majority of its voting members present, either in person or via communication technology whereby every member may hear every other member. No member may grant a proxy for his or her vote to any other member or member designee, except with the prior approval of the Chair.

Section 4.

The Commission shall submit a report setting forth its findings and recommendations, including any recommendations for legislative action, to the Governor, the Speaker of the House of Representatives, and the President of the Senate on or before January 1, 2012.

Section 5.

Commission members shall receive no compensation, but shall be entitled to per diem and travel expenses while attending meetings of the Commission to the extent allowed by Section 112.061, Florida Statutes. Per diem and travel expenses shall be paid in accordance with Chapter 112, Florida Statutes, to the extent that funding is available.

Section 6.

The Chair may designate an Executive Director of the Commission, who shall be administratively housed at the Agency for Health Care Administration. The Agency for Health Care Administration shall provide further staff and administrative support to the Commission. All agencies within the authority of the Executive Office of the Governor are directed, and all other agencies and educational institutions are requested, to render full assistance and cooperation to the Commission to further the purposes of this Executive Order. To the extent information requested by the Commission is determined by a health-care, health-facility or hospital district to be confidential, the Commission shall request assistance from the appropriate state agency with authority to conduct a review of the information requested, and such information shall, if determined to be protected by statutes, be reviewed by the agency with such investigatory powers as may be necessary to review such information. The agency may provide information in the aggregate, to the extent necessary withholding identifying information, in order to be responsive to this Executive Order.

Section 7.

The Commission shall continue in existence only until its objectives are achieved, but not later than March 1, 2012, unless extended by further Executive Order.

IN TESTIMONY WHEREOF, I have hereunto set my hand and have caused the Great Seal of the State of Florida to be affixed at Tallahassee, this 23rd day of March, 2011.

GOVERNOR

ATTEST:

SECRETARY OF STATE

Attachment 2

BRIEFINGS

February 2009

106 N. Bronough St. ï P. O. Box 10209 ï Tallahassee, FL 32302 ï (850) 222-5052 ï FAX (850) 222-7476

This report was initially released electronically before being printed in hardcopy format

Florida's Fragmented Hospital Taxing District System in Need of Reexamination

Florida's hospital taxing districts, complete with the power to levy ad valorem (property) taxes, have been around for more than 80 years. These districts, originally created to address very important needs, have evolved over the years. Their traditional purposes of providing indigent care and ensuring access to hospital facilities are often no longer the main focus, as hospital districts expand their roles and compete with other non-tax supported hospitals.

Hospital districts have been subject to the same criticisms as other special districts in Florida: lack of accountability, mismanagement, escalating taxes, and expansion of purpose and power. Florida TaxWatch has been a proponent of a thorough review of all special districts[1]. Hospital taxing districts appear especially overdue for a comprehensive re-examination.

According to the *Official List of Special Districts* maintained by the Department of Community Affairs, there are 32 active hospital districts in Florida, including six dependent districts and 26 independent districts, of which 16 are independent hospital taxing districts – those with the ability to levy ad valorem taxes. These 16 independent hospital taxing districts are the focus of this report.

Independent special districts, in contrast to dependent special districts, have governing bodies that are not under the control of a county or municipal board. Their budgets are not approved by any county or city government. Also, independent districts' millage rates are not included in a county or city 10-mill cap[2]. While local governments create dependent districts, independent districts can generally only be created by legislative authorization. (There are, however, statutory provisions authorizing local governments to create special taxing districts for children's services, health and community development.) All independent hospital taxing districts in Florida were created by special acts of the Legislature.

The Evolution of Taxing Districts

Hospital districts were first created in the 1920s. While the very first districts were created to provide indigent care for county residents, many later legislative acts had the stated purpose of establishing hospitals for residents' benefit. There are far fewer hospital taxing districts now than there once were. Over time, many districts were dissolved when the hospitals were sold or

[1] Stan Bainter, *Who'sWatchingFlorida'sSpecialDistricts*, Florida TaxWatch, January 2007
[2] Counties and municipalities are constitutionally limited to 10 mills of property taxes. Dependent districts count towards that cap but independents do not.

transferred to the county and leased to managing corporations. Currently, there are 16 independent hospital taxing districts, serving just 12 Florida counties.

The first independent hospital taxing district created by a special act of the Legislature was the Halifax Hospital District (Volusia County) in 1925. The provisions of the act became common in future acts, including: creating a board appointed by the Governor; granting authority to build and operate hospitals; granting the power to assert eminent domain; issuing bonds payable from ad valorem taxes; allowing ad valorem revenue to be used for operating and maintaining hospitals; and providing that the facilities be established for the benefit of the indigent sick.

Many of the early special acts sought only to create county hospitals, not expressly create hospital districts. Beginning in the late 1970s, counties began to dissolve their districts and sell their hospitals or lease them to managing corporations. These transactions were not a problem for county hospitals created by local ordinance, but special districts needed legislative approval. In 1982, the Legislature enacted a law to allow any county, district, or municipality to enter into contracts or leases with non-profit corporations to operate their hospitals. The law was later amended to allow leases or contracts with for-profit corporations. This change allowed the districts to avoid the regulatory obligations of government entities such as competitive bidding and public records, and to enter into profit-making activities.

However, some districts chose to retain control in order to keep sovereign immunity, antitrust immunity, and the control of tax dollars. Beginning in the mid 1980s, these districts began getting the Legislature "to amend their charters to give them all the advantages of a private corporation without actually becoming one."[3]

These changes launched a new era that allowed district hospitals to begin actively competing with private hospitals.

Hospital Districts Levy Nearly $600 Million in Property Taxes

Hospital taxing districts take in a significant amount of property taxes from their citizens and businesses, and that amount is rising rapidly. In 2007, ad valorem revenue for the state's

districts totaled $597 million, which is more than double (132% growth) from the $257 million collected ten years earlier. These collections have risen 75 percent in just the last five years, from $340 million in 2002. This compares to statewide population growth of 11.6% and inflation of 14.5% from 2002-2007.

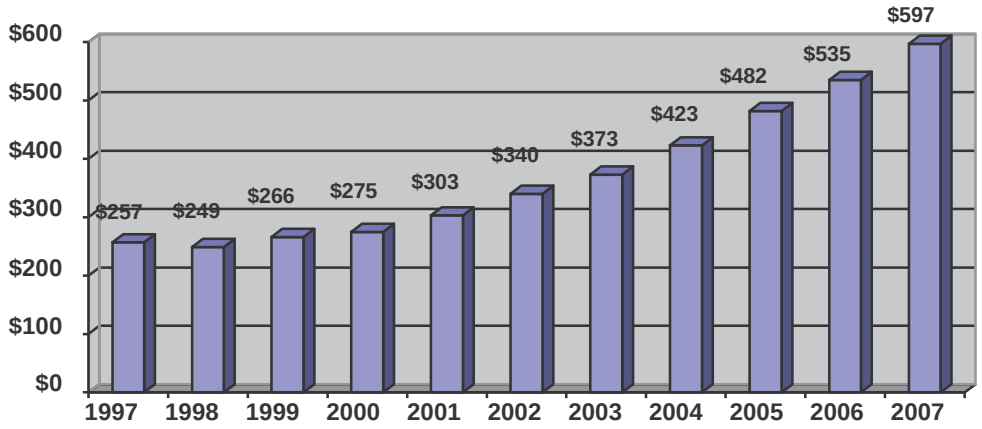
The ad valorem data come from the Annual Financial Reports districts are required to submit to the Florida Department of Financial Services. Not all districts are in full compliance. The data from two of the smaller districts that have sporadic reporting or levying of property taxes have been omitted from this analysis. Also, the analysis includes the Health Care District of Palm Beach County, which, while not technically a hospital district, levies property taxes to reimburse hospitals and doctors in the district for indigent care.

[3] *A Study of Hospital Districts*, Florida House of Representatives, Committee on Health Care, February 1996.

Seven, or half on the 14 districts considered in this analysis, had property tax revenue that more than doubled in the five years from 2002-2007. Of these, the two fastest growing districts were the Citrus County Hospital District (603%) and the Sarasota County Public Hospital District (500%). The largest collection in 2007 belonged to the North Broward Hospital District ($197 million) and the smallest was the Baker County Hospital District ($789,000).

Ten Year Growth in Hospital District Property Taxes

Statewide 1997-2007 $ in millions



Source: Florida TaxWatch and the Florida Department of Financial Services, February 2009.

Taxing Districts Are Just One Way Counties Fund Indigent Care

There are myriad ways that counties fund indigent care. Manatee County, for example, sold its public hospital and created a trust fund, and now uses interest earnings from the fund to pay indigent care costs.

A 2003 study by the Florida Office of the Attorney General examined three South Florida counties, each with very different ways of funding indigent care. [4] Broward County has two separate hospital districts funded by ad valorem taxes. Miami-Dade does not have a taxing district, but uses local government funding (sales and property taxes) to help fund its local nonprofit hospital, Jackson Memorial Hospital. The Health Care District of Palm Beach County uses ad valorem revenues to reimburse any and all local hospitals for indigent care, similar to an insurance plan.

Citing the wide disparity in the financial trends of the hospitals in these counties, the report suggests a legislative study is needed to determine which method of using tax dollars for indigent care is the most effective, both in terms of taxpayer cost and meeting the needs of the indigent.

[4] John deGroot, *Florida Hospital Financial Trends,* Florida Office of the Attorney General, January 2003.

There are Many Differences Among Hospital Districts

While there are different approaches that counties use to provide indigent care, there are also many differences among one of those approaches – the hospital taxing district.

The creation of hospital districts by one special act at a time, and the subsequent amendments of those individual establishing laws, have led to a hodgepodge of characteristics, powers and regulations. Most have boards that are appointed by the Governor, while some have elected boards; some have separate district and hospital boards. Districts have varying maximum millage rate caps. Some have management corporations and allow joint ventures. Other differences relate to residency requirements for indigent care, referendums for bonds, and authorized uses of ad valorem tax dollars.

Only five of the 16 independent hospital taxing districts have elected boards. The existence of appointed boards empowered with the ability to levy taxes raises questions of representation and accountability. Other concerns occur in districts that have the same board for both the district and the hospital, which could create potential conflicts of interest and may not be the best way to safeguard taxpayers.

Purposes of Hospital Districts Expanding

The traditional purposes of providing indigent care and ensuring access to hospital facilities are no longer the main focus of most hospital districts as they have expanded their roles and compete with other non-tax supported hospitals.

The 2003 Attorney General study found that between 1990 and 2001, the average daily uninsured population **declined** 38 percent for both the average non-profit and the average government-operated hospital. The uninsured population of the average for-profit hospital **increased** 7 percent. Over the

same period, government hospitals recorded a 111% increase in profits (the average Florida hospital's profits rose 156%).

The report raised the public policy question: "What impact do the above trends have on the various tax and funding advantages Florida's non-profit and tax-supported hospitals enjoy over the state's for-profit hospitals?"

It also noted that Broward's two hospital districts had **increased** tax revenue of 44% from 1995-2001, while the actual cost of charity care **declined** 28 percent. Also, the report noted that the two Broward districts reimbursed themselves for indigent care at much higher rates than Medicaid and Medicare, and questioned whether there was any incentive for the hospitals to qualify indigent patients for Medicaid.

Volusia County: Three Separate Hospital Taxing Districts

While only 12 counties have hospital taxing districts, some counties have more than one. Broward and Lake counties have two districts, while Volusia County has three. The existence of

three separate districts in one county, each with different laws governing them, raises some questions.

Volusia presents a microcosm of the differences in the state's hospital districts. The West Volusia Hospital Authority has an elected board, while Halifax Hospital Medical Center and the Southeast Volusia Hospital District have boards appointed by the Governor. And while the other two have separate district and hospital boards, Halifax does not. Indigent care funds "follow the patient" in West Volusia and Southeast Volusia – meaning they can reimburse providers that are not controlled by the district. Unless otherwise required by law or by agreement with the Volusia County Health Department, Halifax's ad valorem tax revenues can pay for indigent care only if provided at facilities in which the district owns or holds an ownership interest. Halifax's authorizing law also allows them to form nonprofit and for-profit corporations that can enter into joint ventures or other cooperative projects with third parties.

In the 1990s, two separate Volusia County task forces examined the county's fractured system and cited problems including excessive administrative and tax collection costs and duplication. Additionally, the districts were using tax dollars to pay for services that were eligible for Medicaid reimbursement and the districts were consistently collecting more tax dollars than they were spending on charity care. Volusia's cost for indigent care was the highest in the state.

A December 2007 article in the *Daytona Beach News-Journal* found that Volusia County property taxpayers paid $65 million for indigent health care in 2006 — about $30 million more than five years prior.[5] (Florida TaxWatch research finds that the total ad valorem revenue for the three districts climbed to $83 million in 2007.) The article says that although taxpayers pay for indigent care in some way in every county, their contributions vary significantly across the state. The per capita amount in Volusia County, the only Florida county with three separate hospital taxing authorities, was $131 in 2006, as much as 20 times more than other similarly sized counties.

The newspaper also found that:

- Of the three Volusia districts, the largest amount of property tax revenue goes to the state's original independent hospital taxing district – Halifax Health;
- Halifax has the state's second highest hospital district millage rate and it makes more money than any similarly sized public hospital in the state;
- Halifax's net assets increased by 80% from 2003 to 2005; and
- Halifax spent $2 million on a television ad campaign and spends 1.1% of its budget on marketing, twice the percentage of hospitals nationwide.

A subsequent article[6] noted taxpayer dissatisfaction with the district's spending of more than $350,000, without competitive bidding, to celebrate the groundbreaking for a 10-story patient tower.

[5] Anne Geggis, "Halifax hospital emergency? Higher tax rates have groups up in arms," *Daytona Beach News- Journal,* December 2, 2007.
[6] Anne Geggis, "Halifax Health party spending under scrutiny," *Daytona Beach News-Journal,* April 3, 2008.

The Expansion of Hospital Districts Raises Questions of Competition and the Proper Use of Tax Dollars

The Daytona Beach News Journal article points out that by using tax dollars to offset indigent care costs, hospitals like Halifax can put more money toward its quality of care. Added specialty services, such as the trauma center, the newborn intensive care unit and the pediatric intensive care unit, would not be possible without tax support.

The *News-Journal* quotes Halifax's Chief Marketing Officer: "The health care industry in Central Florida is very competitive, and many consumers can choose their health care provider. Our market research shows that people didn't know the breadth of service available here and didn't believe that a medical center of this caliber would exist in a market this size."

While creating a first class health facility with a wide range of services certainly benefits a district's residents, it raises questions about the true purpose of special districts, ad valorem taxation, and competition. Some districts have become major forces in their local health care markets.

As the report by the Florida House of Representatives Committee on Health Care stated; "Today many of these same publicly owned facilities co-exist with other private not-for-profit or for- profit hospital facilities. The question now is whether a governmental entity complete with the advantages of ad valorem taxing power, corporate flexibility, and antitrust protections should continue to participate in a competitive marketplace as a health care provider."[7]

Conclusion

Florida TaxWatch finds that hospital taxing districts can have a role in Florida's healthcare landscape and the funding of care for those who cannot afford it. However, it is apparent that a comprehensive review by healthcare experts, and follow-up by elected officials, is needed.

Florida TaxWatch has been a proponent of increased oversight for all special districts and has

recommended a sunset review process for them. Hospital taxing districts seem especially overdue for such a comprehensive re-examination.

First, while keeping in mind that different counties have diverse and unique needs, the funding of indigent care should be re-evaluated with an eye toward better coordination statewide and increased uniformity. All current models should be compared to determine which method of using tax dollars for indigent care is the most cost-effective – considering both taxpayer cost and the needs of the indigent.

Each hospital taxing district, and the laws governing the creation of new ones, should also be examined.

[7] *A Study of Hospital Districts*, Florida House of Representatives, Committee on Health Care, February 1996.

Florida TaxWatch finds that:

- Any board that can levy property taxes and set millage rates should be elected, not appointed;
- Hospital boards and tax district boards should be separate; and,
- Oversight of districts should be increased.

Other issues to be considered:

- Should indigent care dollars "follow the patient" – instead of only going to a single provider? Should all hospitals and providers in the district be eligible to share in reimbursement dollars? The Palm Beach County model, where rather than operating hospitals, the district simply reimburses all providers for indigent care, should be evaluated.
- Should tax districts have management corporations and joint ventures clauses?
- Should there be more than one hospital taxing district in a single county?

Florida's hospital taxing districts have been around for over 80 years and they have evolved significantly since their original conception. Their traditional purposes of providing indigent care and ensuring access to hospital facilities are often no longer the main focus, as they have expanded their roles and now compete with other non-tax supported hospitals. Districts have changed, and so have, presumably, the health care needs of Florida. It is time to see whether the laws governing these special hospital taxing districts need to change as well.

This *Briefing* was written by Kurt R. Wenner, Director of Tax Research. David A. Smith, Chairman; Dominic M. Calabro, President, Publisher, and Editor.

www.FloridaTaxWatch.org

Florida TaxWatch Research Institute, Inc.

About Florida TaxWatch

Florida TaxWatch is a nonpartisan, nonprofit research institute that over its 30-year history has become widely recognized as the watchdog of citizens' hard-earned tax dollars. Its purpose is to provide the citizens of Florida and public officials with high quality, independent research and education on government revenues, expenditures, taxation, public policies and programs. The three-pronged mission of Florida TaxWatch is to improve taxpayer value, government accountability, and citizen understanding and constructive participation in their government.

The Florida TaxWatch Board of Trustees is responsible for the general direction and oversight of the research institute and safeguarding the independence of the organization's work. In his capacity as chief executive officer, the president is responsible for formulating and coordinating policies, projects, publications, and selecting professional staff. As an independent research institute and taxpayer watchdog, Florida TaxWatch does not accept money from Florida state and local governments. The research findings and recommendations of Florida TaxWatch do not necessarily reflect the view of its members, staff, distinguished Board of Trustees, or Executive Committee, and are not influenced by the positions of the individuals or organizations who directly or indirectly support the research.

Attachment 3

Innovative Programs for Access to Care by the Poor - Reported by Hospital Districts

District	Summary of Information Submitted by Florida Hospital Taxing Districts About Innovative Access Programs
Bay County Hospital Taxing District	Outreach programs and services that provide access to care to the broadest population possible, including: 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 County Health Department for the WIC Program and the Prescription Assistance Program.
Jackson County Hospital District	As the district is in a federally designated health care professional 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, serving as a rural health training site and providing assistance with Medicaid enrollment.
Holmes County Hospital District	Provides laboratory and radiology services to the county health department at a discounted rate. Runs the Pink Program for low income residents 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 District	Funds services for the Hamilton County Public Health Department and Haven Hospice.
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-maxillofacial 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

District	Summary of Information Submitted by Florida Hospital Taxing Districts About Innovative Access Programs
	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 Healthy 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 a provision that required Florida Hospital DeLand (formerly Memorial Hospital – West Volusia) 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 a community needs assessment to define community outreach needs.
West Orange Healthcare District	The District provides a 911 service and paramedic services for the western third of Orange County. The District provides all diagnostic and radiology services at no cost to nine faith-based clinics. Allows midwives to deliver in OB suites to provide lower cost of delivery services. The District provides mammogram services to women and 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 Authority	The Authority operates two federally designated rural health clinics. The Authority provides cardiology, ENT, wound care and surgical outpatient clinic services. The Authority provides free diabetes 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 the Lee Physician Group, access to independent physicians, asthma management services, diabetes management education services, Dunbar Clinic, Jennings Behavioral Health, Level II trauma center, OB and NICU services, outpatient oncology, an 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: annual subsidies for the Sarasota County Health Department for primary care, the Sarasota County School Nurse Program and the Community AIDS Network; a Charter Plan offering access to affordable health care to small

District	Summary of Information Submitted by Florida Hospital Taxing Districts About Innovative Access Programs
	businesses, the Breast Health Navigator and 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 funded 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 a 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.
Broward Health	Provides community health services and an outpatient clinic network that includes healthcare for the homeless.
South Broward Hospital District	The Hospital District provides services including: primary care, the 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 health care 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.

Attachment 4

Information on Special Hospital Districts in Other States

- 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. 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. 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 health care 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, based 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. Parish police juries may divide parishes into one or more hospital service districts or combine with other parishes to form a hospital service district to operate hospital facilities. 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 enabled the creation of hospital authorities by boards of county commissioners after a petition of voters and a 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 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 2010. The U.S. Census lists 119 hospital districts in 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 hospitals 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 health care districts. Hospital districts can be established by a board of county commissioners on petition of land owners 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.

Attachment 5
Information on Physician Employment Models Reported by Hospital 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 Hospital	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 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 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.

District	Information Submitted by Florida Hospital Taxing Districts About Physician Employment Models
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 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 and 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 based 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.