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TECHNICAL REPORT

Organization and Financing of Indigent Hospital Care in South Florida

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SUMMARY

Over 700,000 persons living in south Florida lack health insurance. When uninsured persons require hospitalization, access to non-emergency care may be difficult. All south Florida hospitals provide care to the uninsured. Federal regulation, specifically the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), requires all hospitals to provide emergency care regardless of the patient's ability to pay. Historically, tax-exempt hospitals provide care to the uninsured as a form of reciprocity for their tax exemption. In addition, social mores compel tax-exempt and tax-paying hospitals and community doctors to provide care to uninsured persons as well.

In Florida, local county government is responsible for providing health care services to uninsured, indigent persons. The state allows counties considerable leeway in how services are funded and provided. The three south Florida counties - Broward, Miami-Dade, and Palm Beach - have each established different local funding mechanisms and institutions to provide hospital care to the county's indigent.

The RAND Corporation was commissioned by the South Florida Hospital and Healthcare Association (SFHHA) to compare and contrast the health care systems in the three south Florida counties. The SFHHA was interested in understanding how local tax revenues were used to fund each county's system, identifying the impact each system has on patients' geographic access to hospital care and, to the extent possible, assessing which system is most efficient. In making this request, the SFHHA was motivated by several issues. First, the three counties offered a natural experiment through which to study different approaches to financing and providing health care for the uninsured. Second, the Office of the Florida State Attorney General, while investigating the impact of the sale of two Palm Beach County tax-exempt hospitals to a for-profit chain, authored a report addressing local public funding of care for the indigent in these three south Florida counties. Commonly known as the deGroot report, named for the author John deGroot, the report motivated discussion among hospital managers and others about local policy regarding hospital care for the indigent. Third, SFHHA executive staff were familiar

with a report that RAND had recently published looking at the impact the centralized approach taken by Miami-Dade County had on access to care for the uninsured.¹ That study, they felt, provided a useful framework to examine the systems across the three counties and would provide useful insights for informing local policies concerning the uninsured. Fourth, the SFHHA's board participated in the nationwide "Cover the Uninsured Week" sponsored by 23 national funders and led by The Robert Wood Johnson Foundation. The board felt that a report on south Florida's county systems for providing local tax funding for indigent care would serve as a baseline for that effort. Finally, to maximize the limited resources available in south Florida, the SFHHA believed it important to know how local funds were currently spent on care for the indigent.

In their request for this report, the SFHHA posed five questions. To answer these questions, RAND conducted a variety of analyses using information obtained through interviews with hospital managers and administrators, public records, and hospital finance and hospital discharge data collected and maintained by the State of Florida Agency for Health Care Administration (AHCA). The AHCA data, while they provide the basis of this report, also provide challenges to this analysis. First, the two types of data - finance and discharge data - do not use the same definitions for payment sources and institutional funding mechanisms. For example, hospitals record on their financial reports to AHCA the number of self-pay patients served and the charges associated with self-pay and charity-care patients and bad debt. Thus, from the financial records there is no specific count of charity-care patients.² The hospital discharge data, on the other hand, identifies patients by payer category. Patients who cannot pay for their care are categorized as self-pay, charity, or underinsured. In Palm Beach County, persons enrolled in the medical assistance plan are categorized as "other government." Persons whose care is subsidized by local tax revenues in

¹ See *Hospital Care for the Uninsured in Miami-Dade County* (Jackson et al., 2002).

² This is further complicated by there being two types of charity-care patients allowed under state law - those who are uninsured and have incomes below 150 percent of the federal poverty level, and those whose medical care services exceed 25 percent of their annual income, and that income cannot be more than four times the federal poverty limit for a family of four.

Broward and Miami-Dade County are not identified separately. Second, while Broward and Miami-Dade County tax-supported hospitals report unrestricted local tax revenues, it is unclear if these funds are used solely for hospital services or include funds for outpatient services. Third, the patient-level discharge data collected by AHCA represents only inpatient discharges and does not reflect utilization in outpatient or non-hospital settings that may be supported by local tax revenues. Before we address the answers to the specific questions from SFHHA, we provide a summary of our findings.

The three south Florida counties differ in how they use local tax revenues to provide indigent care and along many other dimensions as well. Broward has established two independent taxing districts, North and South Broward Hospital Districts. Each levies their own ad valorem property tax millage,³ and each operates a network of hospitals and other health care facilities and services. Nearly half of all the hospitals in the county are local-tax supported. The North Broward Hospital District is managed as a quasi-governmental agency, distinct from county government with an independent board of commissioners. South Broward Hospital District does business as the non-profit, tax-exempt Memorial Healthcare System, which manages the South Broward Hospital District facilities and programs. For both the North and South Broward Hospital Districts, the Florida governor appoints district commissioners without any required local input. The two districts levy and direct the spending of local tax revenues, own hospitals and clinics, and employ some physicians and contract with others.

Miami-Dade County has two tax-supported hospitals governed by the Public Health Trust (PHT), which is appointed by and accountable to the Miami-Dade County Board of County Commissioners. General revenues from property taxes, as well as a special sales surtax dedicated to funding Jackson Memorial Hospital, support these two hospitals. PHT board members are nominated through a committee process that seeks to identify appropriate candidates and are approved by the board of county commissioners. The mayor of Miami-Dade County can also appoint several county commissioners to the PHT board.

³ The millage rate is a unit of taxation expressed as mills per dollar value. A mill is equivalent to one-tenth of a cent applied to the property value.

In contrast, the Health Care District (HCD) of Palm Beach County does not operate any hospitals, but rather has created a health care assistance program funded by local ad valorem property taxes for eligible low-income county residents. The assistance program is operated similarly to an insurance plan and has an explicit benefit package that includes hospital and doctor reimbursement for covered services. The Florida governor appoints half of the board of the HCD; the other half is appointed by the Palm Beach County Commission. The HCD is also distinct in its autonomy, having no direct management responsibility for the hospitals and doctors receiving reimbursement under its program.

The three counties' sociodemographic characteristics also vary. Miami-Dade County has the youngest and poorest population. It also has the highest percentage of persons without insurance. The majority of the population lives around the urban area of the City of Miami in the northeast of the county, although there is growth in the south county area. The majority of hospitals are located in the urban core. Palm Beach County, on the other hand, has an older population and higher per-capita income. Much of the population hugs the shore, and lies east of Interstate 95. The majority of hospitals are located in this area, but some have followed the population growth to the west. Broward County is situated in the middle, both geographically as well as sociodemographically. Much of the population lives east of Interstate 75 and Sawgrass Expressway (869), although there is new growth west of that interstate. Hospitals are spread throughout the county, including the west.

The interactions between the population and hospital sectors vary across the three counties. We looked at geographic access to hospital care for patients under 65 years of age by type of insurance - commercial, Medicaid, and uninsured. In Broward County, we found few differences in geographic access to care, although uninsured persons tended to travel more than those with private insurance or Medicaid. These few differences could be due to the wide dispersion of private and local publicly funded hospitals in the county. Miami-Dade County showed the greatest differences in geographic access to care, with uninsured persons generally traveling further than those with private insurance or Medicaid. The greater travel seen generally within Miami-Dade County is most likely due to the concentration of hospital

facilities in the northeast part of the county. The differences between uninsured and insured persons' travel patterns are probably due to the concentration of local publicly funded hospital services in just two facilities. We found that persons in Palm Beach County tend not to travel very far for their hospital care. We interpret this as reflecting good geographic access to care, regardless of type of health insurance. This is perhaps the result of a number of factors, including the proximate locations of population concentrations and hospitals. The lack of differences in travel patterns between those with private insurance and those with the county insurance could also be due to the assistance program that reimburses all hospitals in the county for the care they provide to enrolled, otherwise uninsured individuals. Persons enrolled in the assistance program can go to any hospital in the county; thus, the program provides the most choice of hospital providers.

Accountability for local public funding varied among the three counties. Only Palm Beach County, with its managed care assistance program, has clear benefit guidelines for its local publicly funded program. There is a clear link between persons in the program and the amount and types of services reimbursed with local public funds. Anecdotal information for the other two counties suggests there are few limitations in the services provided for uninsured patients. However, there is no specific link between individual persons and the care reimbursed through local public funding in Broward or Miami-Dade Counties. Institutions and programs are funded, not reimbursed for services provided to specific individuals. Because of data limitations we could not explore the extent to which quality of care and patient satisfaction influenced where patients went for hospital care, nor did we have the ability to examine the services available and offered to patients.

Because the systems used in the counties to fund and provide hospital care to uninsured persons and the demographics of the population and geographic dispersion of hospital facilities are so different, we cannot make a definitive statement as to which system is "best." Each county's approach to local public funding of hospital services for the indigent has benefits and drawbacks. Because the Palm Beach County system is run as an insurance plan, all hospitals in the county interact to some degree with HCD. In Broward and

Miami-Dade Counties, non-tax-supported hospitals have no formal relationship with the agencies overseeing local public funds. While the majority of hospitals provide some level of charity care, all charity care provided by tax-exempt and tax-paying hospitals is uncompensated. Although the costs of hospital care within a county were similar across types of hospitals in Broward and Palm Beach, the average cost of hospital care was higher in the local-tax-supported and tax-exempt hospitals in Miami-Dade. Thus, if "best" is interpreted as cheapest, both Broward and Palm Beach Counties' local publicly funded services are provided in low-cost hospitals. Miami-Dade, on the other hand, has the majority of subsidized care for indigent persons being provided at a high cost, teaching hospital.

We now address the five questions from SFHHA and discuss the answers we determined through our analysis.

1. How are the governmental bodies that levy the taxes used for hospital and medical care services determining the amount of revenue needed?

Our review of public documents, interviews with representatives of the (HCD) of Palm Beach County, and our previous experience in Miami-Dade County suggest that there is no direct dynamic between anticipated annual levels of uncompensated care provided and budget levels. It appears that historical trends are used in budgeting future revenues and costs. Consequently, there is little flexibility to prepare for increases in the uninsured population due to economic conditions, such as occurred after the 9/11 tragedy.

In Broward and Palm Beach Counties, funding for health care for the uninsured is raised through ad valorem millage to property taxes. The public agencies in these two counties have the power to raise and lower the millage rate within certain state-set limits without referendum. Since the millage rate is applied to property values, constant millage rates result in increased funding as property values increase. The two local-tax-supported hospitals in Miami-Dade County are funded through the board of county commissioners from property tax and a half-penny sales tax approved by public referendum. The agency operating the public facilities, the PHT, cannot by itself raise or lower either funding level. To some extent, funding for indigent care competes with other county funding needs for property tax revenues, while the sales tax is dependent on a volatile economy.

In sum, budgets for publicly provided hospital care for uninsured persons are driven by historical trend. Within limits, the hospital districts in Broward and HCD in Palm Beach can increase their tax revenues as needed. Miami-Dade County's PHT is dependent on the board of county commissioners or the voters for additional funding.

2. Do the differences in the governmental structures used to assess, spend, and monitor such public health care resources result in different decisions being made about what services to fund and which people are eligible for local government subsidized care?

Eligibility for county-funded care is driven in large measure by the state's definition of charity care, which uses federal poverty level limits on income and Medicaid guidelines. Officially, local tax support is intended for care for those indigent not otherwise eligible for Medicaid or other government programs. Low-income residents of Palm Beach County can enroll in a county-sponsored program that provides primary and hospital care. In Broward and Miami-Dade Counties, tax-supported facilities determine eligibility for publicly subsidized care provided through their facilities, but frequently that occurs after services are provided. There still remain some persons who are uninsured and not eligible for locally funded subsidized care as defined by the county agencies, and their care is totally uncompensated.

The range of services provided to indigent patients in Miami-Dade and Broward is dependent on the services available where they are treated. Uninsured persons requiring specialty care available only at a specific local-tax-supported facility may be transferred from tax-exempt or tax-paying hospitals, and this care would be subsidized. However, hospitals and doctors report that such transfers are difficult; rather, private hospitals are encouraged to transfer such patients to the closest facility offering the specific service whether or not the closest hospital is public or private. In Palm Beach County, county-funded services are limited to the benefit package determined by the HCD and enrolled persons can access any hospital - tax exempt or tax paying - within the county. Here, too, transfers can occur between hospitals but without the same financial consequences

Recently, the (PHT) limited the discretion that the hospital executive has with respect to permitting out of county uninsured patients to be admitted

or transferred into the public system and receive locally subsidized care (Nieves, 2003b). These limitations were put in place after an out-of-country patient was admitted with the hospital president's approval and accrued over \$2 million in uncompensated charges.

In sum, Palm Beach County can limit the services provided in its assistance program through plan benefit design and has no restrictions on which hospital in the county can be used. The practice of defining an explicit benefit package is comparable to that of other third-party-payer insurance plans. Broward County has implicit service limits on what services are available at individual tax-supported hospitals. However, patients are transferred among facilities when specialty services are needed. Only hospitals owned by the hospital districts receive any local public revenues for the uncompensated care provided. Miami-Dade County has few limitations on services provided to uninsured patients generally, but new admission policies restrict admissions of uninsured foreign nationals. Only hospitals owned and operated by the (PHT) receive local funding to subsidize care provided to uninsured persons.

3. Does the ownership or tax status of a provider institution/organization influence its relationship with local government funders? With its patient population?

Only tax-supported facilities in Miami-Dade and Broward Counties are allocated public funds to offset the costs of providing care to the uninsured. All other hospitals in these counties provide "charity" care as a community benefit. The AHCA data limitations, compounded by hospitals varying in their billing and accounting practices, make it difficult to distinguish charity care from uncompensated care or other non-paying patients. The trends in the amount of charity care show that tax-exempt and tax-paying hospitals generally provide low levels of care, while the tax-supported facilities provide more. Of course, the tax-supported hospitals are specifically established in part to provide services to uninsured persons with the support of local tax revenues. The levels of charity care in North Broward and Miami-Dade are the highest across the three counties. As a proportion of total costs, charity-care levels are declining in North Broward Hospital District facilities. All hospitals in Palm Beach County participate in the HCD's assistance program

that reimburses for care provided to enrolled residents. The county's plan reduces the amount of care that is defined as charity. However, care provided to uninsured patients who are not enrolled in the county program is not reimbursed or otherwise subsidized with tax revenue.

In sum, the HCD of Palm Beach County has contractual relationships with all the hospitals in the county and numerous physicians. Tax-exempt and tax-paying hospitals in Broward and Miami-Dade Counties have no formal relationships with the public agencies funding and providing care to the uninsured. Uncompensated care provided to uninsured persons by private hospitals generally gets categorized as charity care, per state definition, or as bad debt.

4. Do the differences in which people and services are funded in turn make a difference in patient utilization patterns?

We examined geographic access to care, assuming that once patients go to a hospital, the appropriate care was provided. Using patient travel pattern analysis to look at geographic access, it appears that the county-specific distribution of facilities and resident preferences drive geographic access. While statistically significant differences were found, the magnitude of these differences is small. Variation by insurance coverage was greater across counties than within counties. Earlier work (Jackson et al., 2002) found differences in patient travel patterns attributable to insurance type when smaller geographic areas were studied, such as the western and southern regions of Miami-Dade County.

The analysis also revealed that the percentage of admissions due to emergency conditions for uninsured patients was always greater than that for insured patients. Miami-Dade County's two local-tax-supported facilities have the highest percentages of emergency admissions across all insurance groups, with the uninsured having the highest percentage.

In sum, because the counties vary along numerous demographic dimensions, it is impossible to identify distinct effects of local-county-tax-supported structures for indigent care. However, when locally funded services are available to the uninsured across the county, as is the case in Broward and Palm Beach, there appears to be better geographic access to care and less patient traveling.

5. Are the differences in local governmental funding mechanisms resulting in differences in other accountability measures, e.g., cost per day or staffing ratios?

The hospital financial data reveal that all hospitals provide uncompensated care. Local-tax-supported hospitals provide the majority of uncompensated hospital care. Tax-exempt and tax-paying hospitals provide similar levels.

In general, the overall costs of patient care are correlated with the hospital Medicare case mix index; that is, hospitals that have more complex patient populations have higher costs. The average cost of hospital care is highest at the local-tax-supported hospitals in Miami-Dade. Costs are lower and fairly uniform across hospitals of all ownership types in Broward and Palm Beach Counties. The average cost per adjusted uncompensated admission is more variable than the average cost per adjusted admission overall, undoubtedly because of the smaller number of uncompensated admissions. Tax-paying hospitals generally have the lowest average costs per adjusted uncompensated admission. In Palm Beach County, tax-exempt hospitals have higher average uncompensated care costs than tax-paying hospitals. There does not appear to be a clear relationship between cost of care and funding mechanism. However, the data suggest that the cost of care provided is not fully reimbursed in any of the systems used in south Florida.

LIMITATIONS

There are several limitations to this study. The principal limitation concerns the data used. The hospital financial data are self-reported to the state, as is the hospital discharge data. While some data checking is done by the state, there can be variation in the interpretation and categorization of information reported by the individual hospitals that can affect this analysis. Moreover, the two data reporting systems - hospital financial and hospital discharge - have inconsistent reporting standards concerning the amount of charity care and uncompensated care provided and the number of charity-care and uncompensated-care patients. These data differences diminish our ability to compare and contrast analyses across hospitals and patients.

Data issues similarly affected the deGroot report (2003). His analysis examined typical hospital productivity measures such as staff-to-bed ratios.

Unfortunately, hospitals report only salaried staff and not contract staff in their annual reports to AHCA. Consequently, comparisons of staffing ratios across hospitals using the AHCA data can be misleading in that they may not include all the staff providing care.

A final limitation to this report is the non-participation of representatives from North and South Broward Hospital Districts. This greatly reduced our understanding of these two locally funded systems.