FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
HEALTH AFFAIRS TASK FORCE

Tuesday, June 3, 2014
11:00 am **approximate start time*
Florida International University
Modesto A. Maidique Campus
MARC International Pavilion

Task Force Membership:

Jose J. Armas, *Chair;* Michael M. Adler, *Vice Chair*; Sukrit Agrawal; Cesar L. Alvarez; Jorge L. Arrizurieta; Robert T. Barlick, Jr.; Claudia Puig

AGENDA

1.	**Call to Order and Chair's Remarks**	**Jose J. Armas**
2.	**Approval of Minutes**	**Jose J. Armas**
3.	**Academic Health Center (AHC) Reports**	
3.1	Hodgkins Beckley Consulting LLC/Stephen L. Beckley and Associates Inc. College Health Program Report	**Douglas Wartzok**
3.2	Health-related collaborative research in the College of Engineering and Computing	**Amir Mirmiran**
4.	**Information Items**	
4.1	School of Integrated Science and Humanity Update	**Suzanna Rose**
4.2	Herbert Wertheim College of Medicine Update	**John A. Rock**
4.3	Nicole Wertheim College of Nursing and Health Sciences Update	**Ora Strickland**
4.4	Robert Stempel College of Public Health and Social Work Update	**Michele Ciccazzo**
5.	**New Business** *(If Any)*	**Jose J. Armas**
6.	**Concluding Remarks and Adjournment**	**Jose J. Armas**

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THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
Health Affairs Task Force

June 3, 2014

Subject: Approval of Minutes of Meeting held March 27, 2014

Proposed Task Force Action:

Approval of Minutes of the Health Affairs Task Force meeting held on Thursday, March 27, 2014 at the Florida International University Engineering Center, room 2300.

Background Information:

Task Force members will review and approve the Minutes of the Health Affairs meeting held on Thursday, March 27, 2014 at the Florida International University Engineering Center, room 2300.

Supporting Documentation: Health Affairs Task Force Meeting Minutes: March 27, 2014

Facilitator/Presenter: Task Force Chair Jose J. Armas

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FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
HEALTH AFFAIRS TASK FORCE
MINUTES
MARCH 27, 2014

1. Call to Order and Chair's Remarks

The Florida International University Board of Trustees' Health Affairs Task Force meeting was called to order by Task Force Chair Jose J. Armas at 10:19 am on Thursday, March 27, 2014, at the Engineering Center, room 2300.

The following attendance was recorded:

Present
Jose J. Armas, *Chair*
Michael M. Adler, *Vice Chair*
Sukrit Agrawal
Cesar L. Alvarez
Jorge L. Arrizurieta
Robert T. Barlick, Jr.
Claudia Puig

Trustees C. Delano Gray and Liane M. Sippin and University President Mark B. Rosenberg were also in attendance.

Health Affairs Task Force Chair Jose J. Armas welcomed all Trustees, faculty and staff to the meeting. He noted that at the next regularly scheduled meeting, the Task Force will discuss how the Herbert Wertheim College of Medicine is collaborating with the Colleges and Schools in the Academic Health Sciences and the Miami-Dade Department of Health on initiatives such as FIU Health and the Ambulatory Care Center and will review further details on the financial sources of funding for all departments involved in the Academic Health Center.

2. Approval of Minutes

Task Force Chair Armas asked that the members approve the Minutes of the meeting held on September 16, 2013. A motion was made and passed to approve the Minutes of the Health Affairs Task Force Meeting held on Monday, September 16, 2013.

3. Academic Health Center (AHC) Reports

3.1 Overview of Nurse Practioner Programs

Nicole Wertheim College of Nursing and Health Sciences Dean Ora L. Strickland noted that the College's Master of Science in Nursing programs focus on family adult gerontology, child health, family health and psychiatric-mental health. She added that today's nurse practitioners are educated to perform more procedures and enjoy more autonomy of practice than ever before. She stated that serving as primary care providers for a multitude of patient groups in a variety of health care settings, the nurse practitioner will have a critical role as access to health care becomes a reality for millions nationwide.

Dean Strickland provided an overview of the requirements for the Nurse Practitioner programs, noting that enrollment is limited and admission is competitive. She stated that the College's Simulation Teaching and Research (STAR) Center allows students to participate in real-world health care experiences on campus, adding that this helps to ensure a seamless transition to the work force. She indictated that faculty shortages limit student capacity at a time when the need for nurses continues to rise, further noting that this is occurring at nursing schools across the country. She discussed some of the factors that contribute to the shortage, such as an aging faculty, increasing job competition from clinical sites and that master's and doctoral programs in nursing are not producing a large enough pool of potential nurse educators to meet the demand.

3.2 Overview of the Collaborative Efforts of the Robert Stempel College of Public Health and Social Work within the AHC

Robert Stempel College of Public Health and Social Work (RSCPHSW) Dean Michele Ciccazzo provided an overview of the collaborative and overarching research efforts that extend to other University health-related disciplines. She noted that the Integrated Biostatistics Center supports the University's research mission by providing infrastructure support for research investigators and graduate students. She added that the Virtual Center for Community Health provides a setting for communication and collaboration across the AHC colleges and programs bringing interdisciplinary expertise and resources together to address community health needs in South Florida. She stated that the Center for Health Economics and Strategic Solutions assists local health providers in the design and implementation of health strategies.

Dean Ciccazzo discussed collaborative internships, noting that RSCPHSW students have completed internships with the Green Family Foundation NeighborhoodHELP™, which sends interdisciplinary teams of FIU students into communities of need to track and monitor the health of families throughout those students' education. She also indicated that RSCPHSW students have completed internships with the Global Water for Sustainability Program (GLOWS), a consortium led by FIU and financed by the United States Agency for International Development (USAID) to implement water supply, sanitation and hygiene services, improve water management practices, and build local capacity.

3.3 Update on Student Health Services

Provost and Executive Vice President Douglas Wartzok discussed how the Affordable Care Act will impact student health services at the University. He noted that the University's student health fee is independent of the Affordable Care Act. He indicated that the student health fee is not an

insurance policy and only covers some clinical and mental health services rendered on campus with FIU Student Health Services and/or Counseling and Psychological Services Center during the semester for which the student health fee is paid. He added that the State of Florida did not expand Medicaid to cover all adults below a certain income level and as such a large percentage of the University's uninsured student population will continue to remain uninsured. He presented the options available to University students for health coverage such as the FIU sponsored plan.

Provost Wartzok noted that a significant concern for access to medical services for FIU students is the large number of uninsured and underinsured students. He presented an overview of the College Health Program Report that was prepared for FIU by Hodgkins Beckley Consulting LLC/Stephen L. Beckley and Associates Inc. (HBC). He noted that the purpose of the report is to provide an overarching analysis for all available strategic and advantageous options for students that also takes full advantage of the University's resources. He noted that HBC recommends conducting a request for proposals (RFP), stating that continued study of actions can be considered to compare to all of the proposals that are garnered through the RFP process.

Trustee Robert T. Barlick, Jr noted that it would be advantageous to the Task Force Members to receive a copy of HBC's College Health Program Report. Provost Wartzok indicated that Trustees can expect to receive the Report with the recommendations at the Task Force's next regularly scheduled meeting. Task Force Chair Armas requested that the University's administration conduct a comprehensive review of the Report's recommendations, adding that the analysis should include a benchmark Health Fee comparison for peer institutions with relationships with academic medical centers.

Herbert Wertheim College of Medicine, Senior Vice President of Medical Affairs and Founding Dean John A. Rock requested that moving forward standing reports be included in the Task Force agendas for information only. There were no objections.

4. New Business

No new business was raised.

5. Concluding Remarks and Adjournment

With no other business, Task Force Chair Jose J. Armas adjourned the meeting of the Florida International University Board of Trustees Health Affairs Task Force on Thursday, March 27, 2014 at 11:28 a.m.

Trustee Requests	***Follow-up***	***Completion Date***
1. *Task Force Chair Armas requested that the University's administration report on how the Herbert Wertheim College of Medicine is collaborating with the Colleges and Schools in the Academic Health Sciences and the Miami-Dade Department of Health on initiatives such as FIU Health and the Ambulatory Care Center.*	*Dean and Senior VP John Rock*	*September 2014*

2. *Task Force Chair Armas requested that the University's administration report on the financial sources of funding for all departments involved in the Academic Health Center.*	*Senior VP Kenneth Jessell (E&G and Auxiliary) VP Andres Gil (Research)*	*September 2014*
3. *Task Force Chair Armas requested that the University's administration conduct a comprehensive review of HBC's College Health Program Report recommendations, adding that the analysis should include a benchmark Health Fee comparison for peer institutions with relationships with academic medical centers.*	*Provost and Executive VP Douglas Wartzok*	*June 2014*

MB 4.14.14

Agenda Item 3

THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
Health Affairs Task Force
June 3, 2014

Subject: Academic Health Center (AHC) Reports

Proposed Action:
None. Discussion Items.

Background Information:
Provost and Executive Vice President Douglas Wartzok will provide an overview of the College Health Program Report as prepared for FIU by Hodgkins Beckley Consulting, LLC/Stephen L. Beckley and Associates, Inc. and lead the discussion on the University's analysis and recommendations.

College of Engineering and Computing Dean Amir Mirmiran will facilitate a presentation of health-related collaborative efforts by faculty in the School of Computing and Information Sciences and the Departments of Electrical and Computer Engineering and Biomedical Engineering.

Supporting Documentation: College Health Program Report as prepared for FIU by Hodgkins Beckley Consulting, LLC/ Stephen L. Beckley and Associates, Inc.

Facilitator/Presenter: Douglas Wartzok

Amir Mirmiran

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Florida International University

Consulting Services for the
College Health Program

Volume One: Report Sections I-VIII

February 28, 2014

HBC | SLBA | HODGKINS BECKLEY CONSULTING LLC
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A. Use of Abbreviations and Definition of Key Terms

ACA: The Patient Protection and Affordable Care Act.
ACHA: American College Health Association.
AHC: Academic Health Center(s) (refer also to the Association of American Medical Colleges).
AUCCCD: Association for University and College Counseling Center Directors.
FIU Health: Faculty Group Practice at FIU.
HCN: FIU HealthCare Network, responsible for the management of FIU Health practice locations.
HBC: Hodgkins Beckley Consulting, LLC.
HIPAA: Health Insurance Portability and Accountability Act of 1996.
HHS: The United States Department of Health and Human Services or its subsidiary agencies.
RFP: A request for proposals process operated under the standard requirements of FIU's Purchasing Services Department.
SHIP(s): Student Health Insurance Program(s) for domestic and international students.
College Health Programs(s): As defined by the Lookout Mountain Group:

> A college health program describes the constellation of services, strategies, policies, and facilities an institution of higher education assembles to advance the health of its students and the academic community. On many campuses, college health programs move well beyond health care and refer to a variety of services, possibly including student health services, disability services, counseling services, crisis intervention and public safety services, health promotion and wellness services, alcohol, tobacco and other drug programming, student health insurance/benefit programs, sexual assault advocacy services, sports medicine services for intercollegiate athletes, and intramural recreation sports and fitness programs.

FIU Student Health Program: Florida International University's Student Health Program provided at its Modesto Maidique and Biscayne Bay Campuses. The principle components are Student Health Services (**SHS**) including primary care and ancillary services (e.g., pharmacy and laboratory), complimentary health services, public health and health promotion services, and Counseling and Psychological Services (**CAPS**). The health fee also provides funding for the Disability Resource Center and the Victim Empowerment Program.

B. Objectives for the Consultation

FIU's leadership expressed an overarching objective for the consultation to provide analysis for all available strategic options, with no presumption or preference for any specific direction. While the intention is to take full advantage of all of FIU's resources, FIU's leadership stipulated that any recommendations for change must not be disadvantageous for students. The following are the specific objectives for HBC's consultation.

1) Conduct an administrative review of SHS, with the following deliverables:

<u>Operational Review</u>

- Assessment of current scope and delivery of services, capacity, patient utilization, and access of services.

- Review of service mix, resources, confidentiality, patient- and work-flow, and administrative and support department processes.
- Review of data capture, reporting, and management decision-making tools.
- Assess and identify opportunities for integration with academic medical center.

Staffing Assessment

- Evaluation of provider and support staff productivity, staffing mix, staff efficiency, and costs.
- Identify process, system, and structural inefficiencies and strengths; and opportunities for improvement and for integration with academic medical center.

Financial Analysis

- Evaluation of financial performance and costs for components of service, including primary care, specialty care, ancillary services, and administrative and clinical support services.
- Review of funding model, including health fee support, general fund allocations, fee-for-service, and insurance reimbursement.
- Assessment of student health insurance program (SHIP) and future options/strategies.

2) External Environmental Assessment
   - Identify Florida regulatory environment concerns, including permissibility for self-funding, secondary payor status for health and counseling center funding, limitations for outsourcing/partnering, and other variables that could affect major strategic options.
   - Evaluate the availability of care and services; the organizational capability; and the perspectives, philosophy, and strategic goals of the FIU academic medical center and other area health care providers and health care organizations that may partner with the FIU student health program.
   - Identify the trends for major employer health plans in the Miami area.

3) Internal Environmental Assessment
   - Consider the impact on college health program components for expected major changes for FIU in the next five to 10 years. This includes current insurance status and demographics for the student population.
   - Garner the perspectives of leaders for other major student service departments and other FIU entities that routinely interface with the health center.
   - Conduct focus groups with student leaders.
   - Interview institutional leadership, specifically key leaders in student affairs, College of Medicine, and leadership for HCN.

4) Benchmark Study
   - Benchmark the mission/scope of services, funding, and integration components for peer institutions with relationships with academic medical centers.

- Interview representatives for each peer institution to identify integration challenges and benefits.

5) Seminar
   - Review the recent history, current situation, and trends for college health program components.
   - Discuss major trends for employer-sponsored health plans, the impact of the insurance mandate and availability of coverage under insurance exchanges, and likely organization and funding alternatives for college health programs.

On July 8, 2013, the scope of services was expanded to include HBC providing an implementation timeline for the strategic option(s) adopted by FIU.

C. Limitations

1. Some data analyses and conclusions are limited by the data maintained by the FIU Student Health Program and made available to HBC. In particular, the SHS does not maintain expenditure data by function or department, so the non-resale expenses (and, thus, total expenses) for Health Promotion, Pharmacy, and Laboratory are unknown. This is also true for University administrative and compliance functions such as immunization requirement compliance, medical withdrawal and disciplinary committees, etc. For BBC, the reports for patient visits provided to HBC had significant discrepancies. For Counseling, no information was provided as to the expectation for allocation of time and expenditures for non-clinical and other activities (i.e., outreach, training program) to assess the cost effectiveness of clinical services,

2. HBC conducted a limited administrative programmatic review that did not include physician or psychologist clinical assessments. This review also excluded health promotion, public health, disability services, and sports medicine for intercollegiate sports.

3. HBC does not provide legal advice to its clients. Legal issues must be reviewed by the client's legal counsel.

4. HBC's consultation is not intended to support program marketing claims about the quality of services delivered by health care providers relative to the technical delivery of medical or mental health care services. The scope of such evaluations may generally be found within the parameters of accreditation services performed by organizations such as The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), or the International Association of Counseling Services (IACS).

D. Major External Environmental Finding

1. **Long-Term Funding and Operational Structure**: As discussed in Section VI-E, Future of College Health Programs at Academic Health Centers, long-term funding for the student health (excluding public health and health promotion) and counseling components will likely shift from tuition/fee funding and/or institutional allocations to insurance/health plan capita-

tion. Many college health services will be outsourced or develop community partnerships (commonly referred to as management services only agreements) to facilitate reduced costs and insurance billing. This will be particularly true for colleges and universities located in states where Medicaid funds are not available to fund student health insurance/benefit programs, and where the student population includes a substantial number of Pell-eligible undergraduate and low-income graduate students. Ultimately, college health programs may evolve to providing students with a minimum of three choices for insurance and pre-funding of care, as suggested in the discussion of the Triple Option concept explained in Section VI, subpoint A-3, Long-Term Consideration for the ACA and College Health Programs.

2. **Short-Term Impact of the ACA**: As discussed in Section VI-A, the short-term impact of the ACA is significant for college health programs. Among insured students, there is a dramatic increase in the number of students covered by high deductible health plans ($1,000 or more). For one of HBC's clients, the increase among undergraduate students with high deductible health plans went from less than five percent in 2009 to more than 29 percent in 2013. This trend is resulting in major challenges for access to specialty care services, high cost prescription drugs (e.g., psychotropic medications), and high cost diagnostic services, particularly for students whose families have unfunded medical savings accounts and limited financial resources. Respondents to the Benchmark Study (refer to Section VIII) did not identify the trend for high deductible health plans as a major concern, but this is probably due to focusing on direct impacts to the operation of their student health services rather than a comprehensive assessment of the ACA for students and institutional concerns.

   A second important impact of the ACA is that students and parents are increasingly questioning the equity of health fees that duplicate the 100 percent, ACA mandated, preventive care benefits (regardless of deductible), particularly for women's annual health exams. The third major impact of the ACA is that it has effectively ended the debate about whether four-year degree-granting colleges should provide SHIPs with comprehensive coverage (fully comply with the insurance standards endorsed by ACHA) or whether SHIPs should provide nominal coverage and be low cost programs that students and parents are encouraged to rely on as a course of last resort. With the removal of pre-existing condition exclusions for SHIBP renewals for the 2014-15 plan year, it is likely that many student health insurance carriers (in some cases all carriers) will decline to renew voluntary programs for US citizens if there is not a substantial subsidy from a large group of international students or other defined student groups who are mandated to have health insurance, or there are other favorable risk factors. Many public colleges and universities will be faced with the immediate question of whether their institutions will discontinue offering a health insurance plan to domestic students, or if they will they move to adopt a requirement for health insurance as a condition of enrollment. Adopting an insurance requirement is somewhat easier in states that are choosing to expand Medicaid eligibility under the ACA. For many middle- and upper-income families, the trend for increased deductibles and reduced employer contributions for health coverage makes SHIPs an important cost savings alternative to paying for dependent coverage.

   For FIU, it is unlikely that its large number of uninsured students will decrease before the 2016 ACA individual mandate penalty reaches $695 or two percent of family income, whichever is

greater. Even then, the hardship exemptions are numerous, including a provision that the mandate is not applicable to childless young adults if the state did not expand Medicaid eligibility (refer to Section IX, Attachment A-1).

3. **FIU Peer Institutions**: Of the 141 accredited colleges of medicine in the United States (refer to the membership directory of the Association of American Medical Colleges), 34 public universities have a college of medicine co-located at a main campus. HBC estimates that more than 27 of these institutions have student health services report primarily to student affairs divisions. Common disadvantages for student health services operated by academic health centers (AHC), in both public and private universities, include:

    - differing missions for student affairs divisions and AHCs, including student involvement in program operation;
    - operation of student health services being a low priority for the AHC;
    - charges for services or supplies that greatly exceed fair market value;
    - lack of collaboration with counseling services, disability services, sexual assault prevention services, and other key student affairs departments; and
    - limited interest in providing comprehensive health education and wellness programs.

    Conversely, the advantages for an AHC operating student health services often include:

    - increased operational and clinical resources;
    - improved opportunity for recruitment of clinical staff in some environments;
    - better ability to obtain funding for new or renovated facilities;
    - ability to provide insurance participating provider status;
    - favorable access to billing services and electronic health records systems; and
    - student, parent, and other stakeholder perceptions of increased quality and scope of services.

4. **Benchmark Study**: The benchmark study for FIU is included in Section VIII (refer also to Section IX, Attachments B-1 and B-2). The public universities mutually selected with FIU were chosen, with the exception of Arizona State University (which is recognized as an important aspirant institution for FIU), because they are known to have a substantial level of integration or collaboration with their respective colleges of medicine and/or owned/affiliated hospitals and medical centers for the operation of their student health services.

    Arizona State University (FIU aspirant institution without an AHC, but with an increasing affiliation with Mayo Clinic)
    University of Florida
    University of Iowa
    Michigan State University
    Texas Tech University
    University of Washington

The funding and scope of services differences among the benchmark universities is significant. The total annual per-student expenditure for college health program services, including disability services and sexual assault prevention/victim's assistance, ranges from $185 at Texas Tech University to $509 at the University of Florida. The SHS budget for the University of Florida is $18 million with a per-student expenditure of $361, compared to $5.5 million for FIU, with an annual per-student expenditure of $118 (note that peer institution comparisons are based on total student enrollment rather than student enrollment eligible to use student health services, and that budget figures for FIU are for 2012-13).

With the exceptions of the University of Florida and Michigan State University, HBC generally does not find college health field best practices among these universities that FIU should consider emulating. The responses to inquiries regarding AHC integration did not reveal key approaches or outcomes that could be instructive for FIU. With regard to strategic options available to FIU for its college health program, the comparison to the University of Florida is still relevant and important with respect to the secondary payor funding system and their decision to require health insurance as a condition of enrollment for incoming students (following a previous implementation at Florida State University).

As referenced in Section III-J, Costs, as the campus residential complex is expanded in the future, FIU might consider providing community health and counseling services in or near new residence halls (as is being done with Engagement Centers at Michigan State University). This model might be consistent with FIU's student population's connection to community and with the institutional goal of full "Pantherization" of FIU students. To some extent it is already in place with BBC location. Such decentralization would address current issues or concerns with adequacy of space for the SHS at HCN's clinic location, especially if the on-campus student population is expanded in the future.

E. Major Internal Environmental and Administrative Review Findings

1. **Utilization of SHS:** Twenty percent of students received medical services from the SHS during 2012-13, and 23 percent received all services (including wellness visits). Public universities average about 50 percent of students utilizing medical services in any one fiscal year, with health centers that charge for services generally having lower utilization than those that do not charge for services. Many health centers on residential campuses serve 60 to 70 percent of their student populations in a fiscal year. For universities with mostly local students, a nominal campus residential population, and low numbers of uninsured students, at least one third of students would be expected to have provider visits at student health services. Given the high number of uninsured students, no out-of-pocket costs for medical services, and low cost for pharmacy and ancillary services, a 20 percent utilization rate at FIU is low. Some stakeholders suggested that there may be cultural factors that contribute to lack of utilization of the SHS. Given the low level of utilization, and the apparent high level of services that include ability-to-pay allowances available near the Modesto Maidique Campus, HBC was compelled to include a strategic option (refer to Section II-F, Eligibility and Access) for discontinuing to provide primary care and ancillary services at the SHS.

The undergraduate utilization of services at both the MMC and BBC locations was similarly low. Though a relatively small population, the one group of students using the health services at expected rates was graduate students at BBC (394 out of 855 students, or 46 percent). Although this group comprised 12 percent of the BBC enrollment, it represented 25 percent of the BBC visits (see Table III-1.2 in Section III-G, Utilization).

2. **SHS Cost of Services:** The estimated cost per office visit for the MMC location was $207, and the cost per visit at BBC was $417. In well-operated student health services, the cost per office visit ranges from $120 to $140. These costs often include extended hours for urgent care office visits and 24/7 telephone access (contracted or outsourced), office-based CLIA-waived lab tests, and some immunizations. For MMC, the leading contributor to the high cost of medical visits is high administrative/support staffing levels, with provider productivity and staffing mix having a secondary impact. For BBC, both low productivity and high staffing levels are responsible for the high costs.

   The Pharmacy had an operating loss of over $230,000 in 2012-13. This does not include any indirect or support costs (billing, IT, accounting, etc.) or expenditures related to inventory increases. In the absence of an opportunity to lease current retail space to an outside pharmacy, the SHS Pharmacy should be maintained only if it can break even or have very minimal losses, assuming the current pharmacy space would not be better utilized for other purposes. Students would fill their prescriptions at community pharmacies in the absence of the SHS Pharmacy. Alternately, the SHS could dispense a limited formulary of prepackaged medications (e.g., antibiotics) from the medical clinic.

3. **Utilization and Cost of CAPS:** The utilization of counseling services is low compared to universities with student enrollment similar to FIU. The staffing for CAPS, however, is comparatively high. Based on 1,859 reported clients and FIU total enrollment of 44,000 students, 4.2% of the student body utilized CAPS direct services. The recent AUCCCD survey reported that for universities with over 35,000 students, an average of 7.05% of the student population received counseling services. CAPS utilization rate is 63 percent of the AUCCCD mean.

   Based on the reported total of 12,956 service hours, the cost per hour was about $152 in 2012-13. It is difficult to evaluate whether this is a high or low number since there are no data on expectations for allocation of hours for outreach, training, and other activities that are not direct client care.

4. **Rationale for Health Fee Funding**

   Given the low levels of utilization of SHS and CAPS, it is difficult to justify charging a health fee to all students, especially since there are no research data to suggest that students do not have adequate access to health care services through community resources. If Medicaid eligibility is expanded in Florida for childless adults (international students would be excluded due to a five-year waiting period), the rationale for health fee funding would be further diminished, given the income status for a large percentage of FIU students.

There have been long-standing claims in the college health field that health care for college students is a specialty field. There is some legitimacy to this contention, as there are undoubtedly unique needs for cultural competency in serving international students, meeting the needs of a culturally diverse domestic student population, supporting the LBGT community; and with working with campus safety, disability services, campus housing, and other Student Affairs Division stakeholders. Working with student leaders/interested students to assure they have meaningful ownership of the program is also a relatively unique aspect of college health. HBC suggests, however, that there are numerous health care providers with equally challenging needs for cultural competency. Moreover, there is a widespread trend for outsourcing of college health services, particularly among private colleges and universities with fewer than 10,000 students, where the capabilities and resources of private health care organizations are combined with student affairs resources to provide optimal college health programs. There is no reason to believe that these same outcomes cannot be achieved at major public universities. The self-assessments in the Benchmark Study provided in Section VIII also indicate that the AHC integration has been highly successful at the University of Florida and Texas Tech University, in that both reported no current major challenges and that no significant changes are needed or planned.

5. **Overview for SHS and CAPS**:

There are many components of student health program provided by FIU that are impressive; and the funding concept for the health fee including SHS, CAPS, the Victim Empowerment Program, and the Disability Resource Center are consistent with creating highly coordinated/integrated services. The co-location of SHS and CAPS, and their apparent excellent working relationship, is also noteworthy. The quality of the SHS and CAPS websites is impressive (the welcoming video for CAPS, although probably too long, reflects a commendable outreach effort).

Although the SHS has achieved accreditation, including a recent certification as a Medical Home, there are a number of areas of concern. It is HBC's general finding that the SHS has not had appropriate administrative oversight. There is a lack of financial, utilization, and staffing data and analysis to inform decisions or evaluate performance. Allocation of facility resources and renovations do not appear to be consistent with needs (e.g., poor clinical space, expansive administrative suite, pharmacy). Specific concerns are discussed in detail in Section III, Administration Review of Student Health Services and Section VII, Internal Environmental Assessment.

Though HBC's review of CAPS was more limited, there are similar concerns regarding CAPS, including staffing ratios and performance/productivity measures. Refer to Section IV, Administrative Review of Counseling and Psychological Services, for HBC's comments on utilization of services and staffing for CAPS.

Although HBC's consultation did not include clinical care assessments, whereby HBC's consultant physician and psychologist would provide clinical performance evaluations, the administrative review suggests that the concerns expressed by HCN for the operation of the SHS may have validity. Lack of meaningful administrative oversight often portends issues with quality of

care, even when health and counseling programs have achieved national accreditation.

F. Recommendations

There are three major factors that drive HBC's recommended strategic option: (1) there are major disadvantages associated with the current operation for SHS and CAPS, and the student health fee is difficult to rationalize given the low level of utilization; (2) there is a highly interested and capable community health care provider that has a sliding fee schedule based on patient's income; and (3) FIU's leadership has emphasized that any change must be assured of being in the best interests of both students and FIU.

Based on these three considerations, HBC recommends conducting the request for proposals (RFP) specified in Section II-B, Comprehensive Request for Proposals with Status Quo Option. As noted in the Summary Statement and Rationale for this strategic option, conducting an RFP process does not mean that a decision has been made to outsource either SHS or CAPS. During the RFP process, continued study of actions (refer to subpoint E, Permutations for Section II-A, Maintain Status Quo Program) can be considered to compare to all of the proposals that are garnered through the RFP process.

In the interim period while the RFP process is being conducted, SHS should discontinue the health fee subsidy for alternative therapies and prescription drugs. User fees should cover the costs of alternative therapies, and market rates (self-pay and insurance) should be used for the Pharmacy. Pharmacy staffing, pricing, and operations should be changed to eliminate or significantly reduce the current financial deficit. FIU should pursue contracting for a pharmacy vendor to operate in the current retail space on campus.

A significant concern for access to medical services for FIU students is the large number of uninsured and underinsured students. FIU should consider implementing an insurance requirement as a condition of enrollment with students having the option to waive out of the FIU sponsored plan if they have other coverage that meets FIU-defined criteria (Section II, Strategic Options, subsection G, Adopt Insurance Requirement).

A. Summary Statement and Rationale

Absent major risk management or legal compliance concerns, maintaining the *status quo* program can be a viable strategic option if (1) either major existing disadvantages or unique advantages cannot be identified or (2) there is significant risk that new unacceptable disadvantages will emerge as result of major change.

The rationale for maintaining the *status quo* program would be based on a conclusion that one or more of the following conditions exist:

- There is too much uncertainty for the long-term advantages associated with other strategic options.
- The ability to determine the best long-term approach will become clear over the next two to three years as the impacts of the ACA are determined, the stability and position of potential community partners is solidified, and the State of Florida's decision to expand Medicaid eligibility take other actions to provide health insurance for childless young adults is clarified.
- The revenue projection for a secondary payor system is not sufficient to warrant taking this action.
- A cooling-off period is called for given the level of distrust that has emerged among stakeholders, particularly concerns expressed by interested students/student leaders.
- The position of peer institutions does not yet suggest that there is a compelling case for any other strategic option.
- Conducting a comprehensive RFP process is the best strategic option, but time constraints preclude this action from being a viable strategic option for the 2014-15 academic year.

B. Proposed Actions

1. No major change would be adopted for the operational structure for the SHS or for the funding system for SHS primary care services.
2. The funding for alternative therapies (e.g., massage) would be on a fee-for-service basis with the expectation that user fees would cover the costs of these services and no longer be supported by the health fee. The Pharmacy would continue to be operated by the SHS only if charges are at market levels, if staffing and expense levels are such that the Pharmacy breaks even or operates at a minimal loss, and if the space is not better utilized for other functions. As with alternative therapies, the Pharmacy should not be substantially subsidized with health fee dollars. If the Pharmacy is closed, students would fill prescriptions at community pharmacies. Alternately, the SHS could operate a clinic dispensary where limited prepackaged drugs are dispensed by medical staff, and charges to students would cover drug costs.
3. Management reporting, accounting, staffing, scheduling/productivity, and other operational improvements would be implemented as discussed in Section III, Administrative Review of Student Health Services.
4. A comprehensive review and cost analysis of Laboratory operations should be conducted to de-

termine what tests should be performed in-house and which reference tests should be billed through SHS. Laboratory charges should be consistent with market rates (self-pay and insurance reimbursement rates), and there should be no or minimal health fee subsidy for laboratory services.

C. Expected Advantages

1. The ability to maintain a co-location and close collaboration between the SHS and CAPS, accreditation for the SHS, and student-focused care would be important factors associated with this strategic option.
2. There would be avoidance of possible disadvantages by maintaining the *status quo* program.

D. Expected Challenges or Possible Disadvantages

The opportunity to develop the most effective partnerships for operation of the Student Health Program may be diminished by waiting two to three years for the best possible approach to emerge.

E. Possible Permutations

1. Administratively merge the SHS and CAPS and create an Executive Director position.
2. Consider implementing a requirement for students to have health insurance as a condition of enrollment. This decision may be contingent upon the insurance status of students if Florida expands Medicaid eligibility under the ACA.
3. Implement the strategic option for secondary payor funding for primary care (see Section II, Strategic Options, subsection E, Secondary Payor Funding of Primary Care).
4. Facility changes can be made as discussed in Section III, Administrative Review of Student Health Services.
5. As referenced in Section III-J, Costs, with the expected expansion of the FIU campus and residential complex, FIU could create neighborhoods in/near new residence halls that include student health services, as is being done with Engagement Centers at Michigan State University. This model might be consistent with FIU's student population's connection to community and with the institutional goal of full "Pantherization" of FIU students. To some extent it is already in place with BBC location. Such decentralization would address current issues or concerns with adequacy of space for the SHS at the current medical school practice site, especially if the on-campus student population is expanded in the future. Please refer to Section II-B, subsection E-2 for more discussion of this option.

A. Summary Statement and Rationale

A comprehensive request for proposals (RFP) process could assure that all possible service options are explored and that the best interests of FIU and its students are carefully defined. Any preference for FIU-owned or affiliated health care providers could be quantified for the objective criteria scoring.

The primary rationale for this strategic option would be: (1) the best option for FIU and students cannot be credibly determined without a comprehensive RFP process, including consideration of vendors that specialize in providing not-for-profit services to economically disadvantaged community members; (2) appropriate long-term services and expectations between FIU and the contracted vendor(s) is best assured through detailed deliverables, performance objectives, and non-performance penalties (this is the approach that may best avoid the problems experienced by some peer institutions and assertions for conflicting organizational missions); (3) the comprehensive RFP process does not commit FIU to abandoning the *status quo* program (a declared option would be to reject all proposals).

B. Proposed Action

1. A comprehensive RFP process, with multiple funding and service delivery options (e.g., SHS only, SHS and CAPS, service availability both on- and off-campuses, or maintain internal operations for health promotion and wellness programs) would be conducted under the auspices of FIU's Procurement Department. Release of the RFP would occur in fall semester with an effective date of service for summer 2015.
2. Except as specifically defined in objective criteria scoring, no potential vendor would have preferential treatment under the RFP process.
3. Ability to assure long-term programmatic success, appropriate service, and minimum performance standards would be specified in the RFP process.
4. Ample time would be provided for prospective vendors to consider the RFP and submit proposals.
5. Prospective respondents would be encouraged to work collaboratively in submitting join venture proposals. For example, there may be options whereby HCN and other vendors could share capabilities and resources to provide a proposal that takes full advantage of the funding system options and scope/location of service options.
6. The RFP would specify the terms and conditions for annual contract renewals and the defined period (e.g., five years) for the contract, at which time a RFP process would again be conducted.
7. Consider implementing an insurance requirement as a condition of enrollment. This would address possible concerns by potential respondents to take on a new patient base with no ability to pay for more complex diagnostic and treatment procedures (high risk for uncompensated care). This decision may be contingent upon the insurance status of students if Florida expands Medicaid eligibility under the ACA.

C. Expected Advantages

1. The development of the RFP would allow stakeholders to carefully determine the desired approach to providing services, vendor capabilities, and assign weighted criteria values to various service options.
2. A comprehensive RFP process could reassure stakeholders that both the best interests of FIU and students are being appropriately considered.
3. Student leaders/interested students could be involved in the RFP process along with other key stakeholders.
4. All potential vendors would understand that FIU and its students are customers and that meeting their needs is key to receiving the award under the RFP and for subsequent renewals.
5. The best mix among service capability, perceived value, and cost of services is typically obtained through competitive bidding processes.
6. There could be scenarios whereby awards are made to more than one vendor, with collaboration expected among vendors.

D. Expected Challenges or Possible Disadvantages

1. Some stakeholders may be unable to envision any scenarios in which HCN is not the health care provider of choice for health care services needed for the FIU community.
2. A protracted RFP process could increase instability of the environment and result in polarization of the FIU community.
3. RFP processes are often costly and time consuming.

E. Possible Permutations

1. A request for information (RFI) process could be conducted to formally ascertain the interest, capabilities, and likely response of prospective vendors. This process could also better develop the alternative cost quotation options for an RFP process.
2. As reference in Section III-J, Costs, FIU could include in the RFP an option for creating FIU neighborhoods in new residence halls that include student health services, as is being done with Engagement Centers at Michigan State University (MSU). This model might be consistent with FIU's student population's connection to community and with the institutional goal of full "Pantherization" of FIU students. To some extent it is already in place with BBC location. Such decentralization would address current issues or concerns with adequacy of space for the SHS at the current medical school practice site, especially if the on-campus student population is expanded in the future. If this concept is adopted, new building plans could include such space.

   The student health services in the residence hall neighborhoods at MSU are each staffed by a nurse practitioner and registered nurse. The NP has 20-minute appointments which are 85 percent booked. The RN has appointments, sees walk-ins, and administers immunizations. The neighborhood health clinics are very popular with students. Evening hours to 8:00 are also popular since the clinics are located in students' living areas. These clinics utilize the health services' (and medical school) electronic health record and practice management systems. Appointments are booked centrally or may be made by the RN in the neighborhood.

The major disadvantage is cost. The neighborhoods only need to be staffed nine months of the year, and MSU finds it difficult to recruit staff for nine months (or who are willing to work until 8:00 PM). As with any remote location, if demand is not sufficient at the location and staffing is not flexible enough to avoid excess resources, this strategy can become very costly. FIU has an advantage over MSU, in this regard, in that FIU apparently does not have a problem recruiting part-time or partial-year providers. The option would be even more feasible with a larger, outsourced entity providing the services since they would have sufficient resources to flexibly staff the clinics as demand dictates. Management of this arrangement would require good metrics and financial oversight. This arrangement would also include the opportunity to include counseling (there seems to be sufficient staffing in CAPS to do this) and other student support services in the neighborhoods.

A. Summary Statement and Rationale

This strategic option is predicated on FIU determining that the business services offered by HCN should be utilized by Student Health Services (SHS), for both MMC and BBC locations. An incremental collaboration with HCN would be adopted in conjunction with a decision to adopt a secondary payor funding system as explained in Sections II-E. The initial contract period would extend through the 2015-16 academic year.

The rationale for this strategic option would be: (1) moving incrementally forward is the best way to determine if stakeholders can become comfortable with shifting the operation of the SHS from the Division of Student Affairs to HCN; and (2) FIU's position is that all delivery of health care services should ultimately be provided by HCN.

B. Proposed Action

1. HCN would provide insurance billing services for the SHS based on an always secondary payor funding system for primary care services proposed in Section II-E (possibly including insurance billing for CAPS).
2. Credentialing of SHS providers, obtaining participating provider status, HIPAA compliance, training for insurance coding, and other required business services would be provided by HCN.
3. The SHS could transition to the electronic health records system provided by FIU Health. This should include coordination with CAPS.
4. The cost for FIU Health's services should be assessed to determine if they are consistent with fair market value for the Miami area.
5. Periodic joint assessments for the operation of SHS and CAPS would occur with FIU Health and HCN. FIU Health would also be provided the opportunity to evaluate trends for the college health field, follow modifications for selected peer institutions, and work collaboratively with FIU student leaders.
6. Several actions and permutations listed in Section II-A, Maintain Status Quo Program, are also applicable to this strategic option.

C. Expected Advantages

1. HCN's business services capabilities can facilitate obtaining substantial savings that will allow for expanded services and/or health fee cost reductions.
2. This strategic option affords stakeholders an opportunity to develop relationships and move forward with potential long-term opportunities for improved services. Improved relationships are particularly important for the Division of Student Affairs leadership and stakeholders and interested students/student leaders.
3. The incremental change option gives time to consider the advantages for the SHS being co-located with CAPS.

D. Expected Challenges or Possible Disadvantages

Existing SHS staff may be resistant to this change knowing that it could ultimately lead to a major organizational transition. The success of this strategic option hinges on the commitment of existing

staff to act in the best interests of students and FIU.

E. Possible Permutations

1. Facility changes can be made as discussed in in Section III, Administrative Review of Student Health Services.
2. FIU could create neighborhoods in new residence halls that include student health services, as is being done with Engagement Centers at Michigan State University. This model might be consistent with FIU's student population's connection to community and with the institutional goal of full "Pantherization" of FIU students. To some extent it is already in place with the BBC location. Such decentralization would address current issues or concerns with adequacy of space for the SHS at the current medical school practice site, especially if the on-campus student population is expanded in the future.
3. Administratively merge the SHS and CAPS and create an Executive Director position.

A. Summary Statement and Rationale

HCN and FIU Health would be contracted to provide primary care services for students, receiving a negotiated portion of the health fee, with credit for adopting the secondary payor funding system specified in Section II-E for primary care services.

The primary rationale for this strategic option would be: (1) all health care services provided by FIU should be under the direction and control of HCN/FIU Health; (2) excess capacity at HCN's clinic can facilitate providing primary care services to students, resulting in both cost savings and improved services; and (3) co-branding of the facility with a student health designation and/or other accommodations can meet the needs of students to fulfill their interest in having student-centered health care services (e.g., cultural competency in care for international students, students with disabilities, and high profile populations such as the LGBTQ).

A key requirement for consideration of this strategic option is whether HCN/FIU Health is capable of working collaboratively with interested students, student leaders, and the Division of Student Affairs, or if FIU will simply direct that the transition of services be completed to HCN/FIU Health with the understanding that a period of unrest will be inherent to the change.

B. Proposed Action

1. Leadership and key personnel from FIU, including HNC and FIU Health, would conduct a site visit to the University of Florida to meet with UF's Student Health Advisory Committee (SHAC) members and key student affairs leaders to gain an understanding of the elements of the UF program that are key to programmatic success and student satisfaction.
2. The health fee would continue to provide funding for CAPS, the Victim Empowerment Program, the Disability Resource Center, and public health and health promotion services. These services would continue to be operated by the Division of Student Affairs.
3. HCN would be responsible for primary care services, including women's health, and all other services presently provided by the SHS that are not discontinued or retained for operation/delivery by the Division of Student Affairs. This includes providing clinical services on the Biscayne Bay campus.
4. The Pharmacy would be closed and students would get their prescriptions filled at local pharmacies. All primary care services would be provided at FIU Health's clinic(s) on the Modesto Maidique campus and at the current health center location on the Biscayne Bay campus. (HCN would have to provide the clinic at BBC). Services for athletic rehabilitation services, massage therapy, acupuncture, aromatherapy, dietician services, and HIV testing and counseling would either be discontinued or would continue to be provided by the Division of Student Affairs.
5. HCN would derive funding from (a) the current portion of the health fee funding primary care services and subsidizing the pharmacy and ancillary services; and (b) insurance revenue based on the health fee providing primary care services on an always secondary payor as specified in Section II-E. HCN would agree to not balance bill students for any services covered by the health fee.
6. The savings derived from the contract with HCN and secondary payor funding could be used to expand or improve services for CAPS or public health and health promotion services, could be

credited to students in the form of reduced health fees, and/or could be used to provide financial aid to low income students to support an institutional insurance requirement. HBC does not envision a rationale for use of the savings for providing access to physician specialty care services.

7. HCN would be responsible for immunization compliance and reporting.
8. HCN would work collaboratively with CAPS to provide close coordination of care.
9. Access for students would include both advanced scheduled appointments and same-day provider visits (appointments or walk-in) to meet student demand.
10. After hours, HCN would provide physician on-call services to student patients on the same basis as provided to other HCN patients.
11. Monthly and annual reporting of primary care service utilization by FIU students and the amount of insurance reimbursements will be provided to the Division of Student Affairs.
12. For the 2014-15 plan year, HCN would agree to capitation funding arrangements for providing primary care services to students covered by the SHIPs at a level that is based on a negotiated percentage of Medicare allowed charges. These funding arrangements would be based on direct payments from FIU to avoid insurance company retention expense charges.
13. The current accreditation for the SHS would not be maintained. A dedicated survey of student patients would be conducted at the beginning of the spring 2015 semester, and on a biannual basis thereafter.
14. HCN would agree to provide physician consultation for the Division of Student Affairs (including 24/7 emergency/urgent consultations), participate in student orientations and other promotion of student health care access, processing of medical leaves of absence, and other specified duties.

C. Expected Advantages

1. The position of HCN/FIU Health would be enhanced as the designed health care provider for the FIU community.
2. Cost savings will result from a significant reduction in administrative costs, and quality of care may be improved.
3. Students may perceive improved quality of care and will experience a more satisfying care experience given the highly attractive clinic facility.
4. The existing space required for primary care, pharmacy, and ancillary services can be used to expand CAPS, public health and health promotion, or may be used for other purposes.

D. Expected Challenges or Possible Disadvantage

1. Many students will articulate a desire for a medical care home that is devoted to meeting their desires and perceived unique needs. Careful consideration of a communication plan and collaboration with student leaders and interested students would be required to address this concern. Ongoing student involvement in the governance and management of the program would be a key point of consideration. A key component would also be that the overall program has an identity and culture that students relate to as their own.
2. Without the implementation of an insurance requirement, FIU Health could risk increased exposure to uncompensated care by expanding the number of uninsured patients.

E. Permutations

1. FIU would adopt an insurance requirement as a condition of enrollment. Students would have the option to waive the FIU plan if they have alternative coverage that meets FIU defined requirements. This permutation may be contingent upon the insurance status of students if Florida expands Medicaid eligibility under the ACA.
2. The FIU neighborhood concept discussed in other strategic options could be implemented.

A. Summary Statement and Rationale

This strategic option is predicated on a determination that it is legally permissible for student health fees at public universities to take an always secondary payor position in coordination of benefits with students' personal health insurance. This concept is explained in detail in the HBC's publication, "Considering Insurance Billing for a College Health and Counseling Services," included in Section IX, Attachment C.

The rationale for this strategic option would be predicated on a determination that: (1) there is an opportunity to reduce the cost for pre-funding of primary and preventive health care services, even though a limited study from July-August, 2013, suggests that between 30 and 43 percent of SHS users are uninsured, and it is likely that a large number of students will increasingly be covered by high deductible health plans; (2) FIU finds it acceptable that the economic value of the health fee will be variable, depending upon the insurance status of the student (the economic value of the fee is already variable, dependent upon whether a student has a need for services and decides to use the SHS or CAPS); (3) appropriate safeguards can be implemented to assure that students can obtain services without submitting charges to personal health insurance if there are valid confidentiality of care concerns; and (4) interim or annual renewal negotiations with the SHIP will not be adversely affected by the adoption of secondary payor funding. Concerns regarding uninsured and underinsured students and economic value of the health fee would be mitigated with the adoption of an insurance requirement (see Permutations).

The worst case scenario for cost reduction would be less than 15 percent savings for primary care and prevention services and the best case scenario is more than 40 percent savings. Incomplete insurance information for FIU students precludes more precise projections. It is noteworthy that almost all colleges that have long-standing experience with secondary payor status (particularly colleges and universities located in Massachusetts and Minnesota) have an institutional requirement for health insurance as a condition of enrollment.

B. Proposed Actions

The common required actions for adopting a secondary payor funding system for a college health program are discussed in detail in the HBC position paper referenced above. The following are specific action items for FIU:

1. HCN would be retained to provide insurance billing, participating provider contracts, insurance coding, provider credentialing and training, electronic health records system, and other key administrative functions. Understanding the opportunity to deliver and bill preventive care services under the ACA (refer to Section IX, Attachment D) is also a key component for this action.
2. A fee-for-service charge master would be developed for all primary care, preventive care, and ancillary services that would be provided to students. This fee schedule would already be in existence for HCN if it operates the SHS.
3. The services that would require submission to students' primary insurance would be determined. The University of Florida, for example, only submits medical office visit charges.
4. An intern or annual renewal negotiation for the SHIPs must include disclosure of the change to

the student health fee funding arrangement. A special fee schedule or self-funded capitation should be negotiated.

5. A plan document should be developed for the health fee funding arrangements, including exact provisions under which the health fee funds would reimburse charges on a primary care basis and any remaining balances would not be required to be submitted to the students' personal health insurance. These provisions would be published on the SHS website and in a prominent notice in SHS exam rooms.

C. Expected Advantages

1. Typically, under a best case scenario, more than 40 percent of the costs for providing primary care services could be funded by students' personal health insurance rather than health fee funds (not including costs for HCN administration).
2. Students and parents often better understand the concept that the health service participates with their insurance and remaining balances are funded by the college or university versus funding that is derived from tuition and fees.

D. Expected Challenges or Possible Disadvantages

1. There are ethical challenges associated with secondary payor funding systems when there is not an institutional requirement for health insurance. All students are paying the same health fee, but receiving significantly differing value from the fee. Some universities with secondary payor funding have addressed this concern by specifying that uninsured students or students with high deductible health plans will pay a minimum copayment for provider visits (e.g. $25) and 50 percent of the cost of ancillary services such as lab and radiology.
2. At the worst case cost reduction level of less than 15 percent of primary care and prevention services, the cost associated with insurance billing would not make the secondary payor status worthwhile.
3. Some students may not fully understand the exemptions for having to submit charges to their personal health insurance coverage. This may result in barriers to access to care and/or loss of confidentiality for services.

E. Permutations

1. Implement a requirement that students have health insurance as a condition of enrollment. This permutation may be contingent upon the insurance status of students if Florida expands Medicaid eligibility under the ACA.
2. A secondary payor funding system could also be adopted for counseling and psychiatry services. Many colleges and universities do not take this approach due to concerns (often unfounded) that confidentiality of care will be compromised for these services. Notable exceptions for universities that are billing for counseling and psychiatry services and taking a secondary position in coordination of benefits are Boynton Health Service at the University of Minnesota and University Health Services at the University of Massachusetts at Amherst.

A. Summary Statement and Rationale

The rationale for charging all students a major cost component of the health fee for primary care services is difficult to justify when only one in five students have provider visits at the SHS in a year. Significant cultural factors and availability of care through community resources may be contributing to the low level of utilization.

Discontinuing providing primary care services would allow for reduction of the health fee and/or expansion or improvement in public health, health promotion, CAPS, or other health-related services.

B. Proposed Actions

1. Discontinue providing primary care services and related ancillary services at an on-campus SHS and create referral service for students to use HCN or other community-based health care services.
2. Consider providing nominal first-aid services, immunization compliance, and other required services through administrative resources.
3. Evaluate developing a research-based health promotion program.
4. Contract with HCN/FIU Health to provide physician consultation services to Division of Student Affairs.
5. At a future date, reconsider operation of on-campus health services based on student surveys, further evolution of health care reform, and increase in the residential student population. Follow developments for telemedicine, integrated primary care and behavioral health, and other trends to provide optimal services at a future date.

C. Expected Advantages

1. Discontinuing primary care services creates an opportunity to significantly expand health promotion services or other college health program components to provide services to a much greater portion of the FIU student population.
2. This option demonstrates the ability of FIU to make decisions that are centered on a commitment to excellence and concern for the most effective use of tuition/fee resources.
3. Any confusion about the dual health care systems being operated by FIU would be eliminated by this option.

D. Expected Challenges or Possible Disadvantages

1. This strategic option would reflect a major change from the operation of student services at Florida universities. This action may require approval from the Trustees and/or Florida Board of Governors.
2. Collaborative consideration of this option with students would be essential for short-term acceptance.
3. Uninsured and underinsured students may have diminished access (perceived and/or real) to primary care and preventive services.

E. Permutations

1. A health care referral coordinator/case manager position could be created to help direct students to community care resources.
2. A requirement that students have insurance as a condition of enrollment would mitigate access concerns. Health fee savings could be used to provide financial assistance for students to obtain FIU sponsored health coverage.

A. Summary Statement and Rationale

It is likely that insurance requirements in Florida will become more common with the adoption of a requirement in 2014 for entering students at the University of Florida (refer to Section IX, Attachment E), following the model adopted by Florida State University. It is noteworthy that the uninsured populations at FSU and UF (prior to the insurance requirement) were probably lower than at FIU and other campuses that have a larger percentage of Pell eligible students. Consideration of institutional requirements for health insurance is greatly facilitated by state actions to expand Medicaid eligibility under the ACA, since the concern for adding a cost to the most vulnerable students, relative to economic status, is largely eliminated.

A student body with adequate and appropriate health insurance is inextricably linked to campus safety and public health by improving access to long-term counseling services, prescription medications, and access to high cost diagnostic procedures. It is usually a key factor in the viability of funding student health services with fee-for-service charges and insurance reimbursements, and it is often a critical component when contracting/outsourcing student health services. Lastly, the cost advantages for student health insurance/benefit programs over either employer-based coverage or individual market insurance exchange options makes the requirement for health insurance a reasonable and appropriate policy option in meeting the ACA individual mandate.

B. Proposed Actions

1. Consider both restrictive waiver and loose waiver enrollment systems for US citizens or permanent residents. A highly restrictive waiver should be considered for international students. US citizens or permanent residents should be allowed to have high deductible health plans with self-attestation for adequate financial resources and/or fully-funded health savings accounts.
2. Develop comprehensive plan benefits with copayment benefit design (refer to example program from University of New Hampshire provided in Section IX, Attachment F). Gold or platinum level coverage should be provided.
3. Evaluate both fully insured and partial self-funding options through a RFP process. Conduct a feasibility study for partial self-funding prior to the RFP process (refer to Section IX, Attachment G).
4. Through the RFP process, evaluate both self-administration for the enrollment/waiver process and use of third party vendors.
5. Develop a program communication campaign, complete with social media and streaming video components (refer to www.northeastern.edu/NUSHP).
6. Implementation can be all at once or FIU could consider phased implementation for entering students, following approaches taken by FSU and UF.
7. Collaborate with other Florida public universities to consider a Florida Board of Governor's policy for requiring health insurance at all campuses (e.g., following system-wide policies in Montana, Idaho, Minnesota, California, Massachusetts, and North Carolina). The adverse financial results for consortium purchasing in both California and North Carolina from 2010 to present suggest caution for either purposeful or inadvertent cost projections.

C. Expected Advantages

1. FIU's large uninsured student population would be resolved ahead of the ACA mandates that become meaningful in 2016 (refer to Section IX, and Attachment A-1), and there would be substantial cost advantages for many students.
2. Campus safety and public health for the FIU campus are significantly enhanced.
3. The ability to move to a triple option funding system for FIU's college health program is increased. Refer to the discussion of the Triple Option concept included in Section VI, subpoint A-3, Long-Term Considerations for the ACA and College Health Programs).

D. Expected Challenges or Possible Disadvantages

1. The highly polarized political environment for the adoption and implementation of the ACA can make discussion of college or university insurance requirements challenging.
2. The need for an institutional requirement may be transitory as meaningful financial penalties for the ACA's individual mandate take effect in 2016.
3. The ethics associated with a phased-in adoption can be troubling if existing students are allowed to take advantage of the cost decrease for insurance (or even the program's existence) based on costs that are being imposed on entering students.

E. Permutation

There is a large spectrum of choices for loose versus restrictive waiver insurance requirements, including differing standards for insurance that could be imposed for domestic versus international students, campus residents, students involved in club or intramural sports, and other variables.

Any risk management or compliance concerns were communicated via privileged and confidential communication to Florida International University's legal counsel.

A. Overview

Analysis for Student Health Services (SHS) includes both MMC and BBC. At MMC, the SHS is collocated with Counseling and Psychological Services (CAPS) in two adjoined buildings, in a central campus location. SHS is accredited by AAAHC as a Medical Home. Also located at the SHS at MMC is a pharmacy, whose service includes the option for patients to have prescriptions delivered to campus locations. Prescription delivery is received favorably by, and is usually very popular with, patients in universities/colleges that offer this service.

During spring and fall semesters, SHS hours are 8:00 AM to 6:30 PM, Monday through Thursday and 8:00 AM to 5:00 PM on Fridays and term breaks. During the summer semester, SHS hours are 8:00 AM to 5:00 PM on all weekdays except on Tuesdays, when SHS is open until 6:30 PM. Having hours until 6:30 PM appropriately supports student demand which is typically highest in the afternoons. It also maximizes the ability to accommodate student demand for same-day appointments.

The SHS contracts with Nurse Response© for provision of 24/7 telephone consultations with registered nurses. The SHS service hours, delivery options, and scope of services reflect a patient-centered focus for SHS.

B. Mission and Operations

The mission and vision statements for Student Health Services are typical for a college health service and are easily found on the SHS website.

> SHS provides affordable and accessible student-focused medical care and promotes healthy lifestyles through education, mentorship, and research activities thus facilitating the academic success of our students. We proactively assess our diverse population, and work with university and community partners to address the changing needs of our students, in a holistic, innovative and supportive environment where optimal health can be realized.
>
> To be the premier university student health resource for the university by providing professional, innovative, state of the art, and accessible health care and wellness services to the FIU student body. We are committed to the belief that optimal health is essential for each individual to attain his/her highest potential.

SHS utilizes PyraMed practice management and electronic health records systems. In spite of shortcomings of the system reported by UHS staff for producing management reports, the staff at SHS was able to provide detailed appointment data in Excel format after the specific data fields were requested by HBC. HBC was able to use the data fields to produce reports and summaries that would be useful for utilization analysis. There appears to be little, if any, regular production or use of management reports for utilization, financial, or other critical management decision-

making purposes. While HBC was provided with volumes of data and reports, many reports were inaccurate, inconsistent, and minimally useful. In some cases the data were so divergent from one report to another that it was difficult for HBC to have confidence in any of the data. For example, for BBC, the annual report stated there were 6,632 encounters, but the encounter data field dump provided to HBC showed 4,890 encounters. Of the 4,890 encounters, the report indicated that 4,121 of them were appointments, yet the appointment data dump totaled only 2,956 arrived appointments.

There appears also to be no attempt to assess the financial performance of key functional areas such as pharmacy and laboratory services. Without regular management decision-making and performance reports, it is impossible to assess the value of services provided to students, to be good stewards of student funds, or to make appropriate programmatic decisions.

C. Services

SHS services include primary care services provided by physicians, nurse practitioners, and advanced practice nurses; CLIA-waived laboratory testing; immunizations; pharmacy services; complimentary alternative therapies; and health promotion programs. In addition, the SHS contracts with a reference lab for more complex testing and bills students for the reference lab services. The scope of services is generally consistent with other student health services serving a similar number of student patients. Health centers with utilization rates similar to FIU's are unlikely to have on-site radiology services due to costs. The main divergence for FIU is the scope of alternative therapies provided at SHS. These therapies are less common, but can be found at health centers of varying sizes, and are almost always supported by charging students fees for these services (not subsidized with health fees).

D. Communication

The main SHS website is easy to navigate, and it incorporates some information applicable to both MMC and BBC. For example, provider profiles include providers from both locations, and one may assume that covered services and charge policies apply to both locations as well. There are other areas/links that obviously apply only to MMC. For example, the *Directions* tab shows only the MMC location and not BBC.

As noted in Section VII, Internal Environmental Assessment, there are appropriate links to CAPS on the SHS website. HBC appreciates that encouraging student involvement can result in activities and promotions that may inadvertently not reflect well on the sponsoring organization. Relative to the health promotion social media and videos that are provided by peer institutions, the YouTube videos developed under the Healthy Panther program, and featured prominently on the home page for SHS, are of poor quality and do not reflect well on the SHS.

HBC was unable to find the location of the BBC clinic from the FIU main or BBC website. A search on BBC Home page for the student health service yields no results, and the link for health services in the Student Life pages goes to the SHS main website. Given that some information on the SHS website applies only to MMC, it is unclear to the consumer whether the hours are the same on BBC as on MMC and whether the scope of services at each campus are the same.

Communications to students for 2013-14 indicate that health fees cover office visits and a menu of other services at SHS. In recent communications with the SHS, however, some level of rollout for charging for services was planned to begin last fall but due to delays full implementation has not yet begun. Implementation is dependent on securing a billing specialist and is currently under recruitment. There has not yet been any communication of this change and how students will be affected on the website or in any other format.

E. Funding

A health fee is assessed to all registered students, excluding online and off-site students. The fee for 2013-14 is $94 per semester, and supports SHS, CAPS, the Victim Empowerment Program, and the Disabilities Resource Center. The heath fee covers most office visits to the SHS, health education and promotion services, and all counseling services at CAPS; and substantially subsidizes prescriptions and alternative therapies. The SHS charges fees-for-services for laboratory tests, prescription drugs, OTC medications/items, immunizations, and various medical procedures. The SHS website indicates that nominal fees are assessed for services not covered by the health fee. The SHS currently bills only the SHIP for services not covered by the health fee but intends to begin a soft rollout of billing for all services beginning November 1, 2013, with full implementation in spring 2014. This involves collecting insurance information from students and entering relevant information into the practice management system to collect data and to assess and develop processes for collecting complete information for billing. Students will not be billed for office visits until spring term.

An agreement of understanding was made in November of 2012 for HCN to provide billing services for the SHS. Billing for services was originally planned to begin prior to fall 2013. Delays in implementation occurred due to technical work that needed to be done to allow data interfaces between SHS's PyraMed and HCN's Origins practice management systems; and to resolve issues related to the charge master, hiring a coder for SHS, communication, priorities, and collaboration. The intention was to use HCN charge master for insurance billing, use the current SHS fee schedule for cash patients, and not charge for visits for uninsured students. HCN would be responsible for credentialing, contracting with insurance companies, billing, and collections. HCN would receive 15 percent of receipts in compensation for billing services. Certain contracts, such as interdepartmental charges and SHIP would be excluded from the HCN arrangement. The contract between the SHS and HCN appears to HBC to be clear and appropriate, except for the wording related to waiving of copayments and coinsurance. HBC assumes that the intention is for the implementation of a secondary payor system, consistent with state legal requirements, and that the wording can be easily changed to meet regulatory requirements. The contract appears to respect the independent department status of the SHS and is clear about the delegation of responsibilities.

International students, visiting scholars, medical school students, and graduate assistants are required to have health insurance and are automatically enrolled in the FIU Student Health Insurance Plan (SHIP) unless proof of comparable coverage is provided. FIU covers 75 percent of the cost of the SHIP for graduate assistants and 100 percent of the cost for visiting scholars. There is no insur-

ance requirement for all other FIU students, and a significant number of FIU students are uninsured.

As shown in subsection H, Utilization of Services, the penetration rate for medical services is about 20 percent of the eligible student population. In addition to funding primary care office services, all students who pay the health fee are also subsidizing Pharmacy losses and alternative therapies.

Revenue Potential for Billing Model:

If FIU established an insurance requirement as a condition of enrollment and implemented health fees secondary to students' personal health insurance, HBC estimates that FIU would realize about $1.1 to $1.4 million in new revenues from office visits. This is based on current visit utilization of 18,200 office visits and the assumptions in the table below. It is assumed that revenues from immunizations and CLIA-waived laboratory tests would remain the same and that reference lab tests would be billed by reference labs and/or capitated for SHIP enrollees. Only CLIA-waived tests would be done in the health center. Additional savings would be realized with the closure of the Pharmacy.

CPT Code	Distribution	Count	Medicare Miami	Medicare Extension	Medicare + 15% Extension	Medicare + 20% Extension
99201	1%	171	$ 47.77	$ 8,000	$ 9,000	$ 10,000
99202	19%	3,020	$ 81.02	245,000	282,000	294,000
99203	5%	727	$ 119.81	87,000	100,000	104,000
99204	0%	6	$ 182.88	1,000	1,000	1,000
99211	0%	55	$ 21.78	1,000	1,000	1,000
99212	6%	960	$ 47.77	46,000	53,000	55,000
99213	41%	6,297	$ 79.15	498,000	573,000	598,000
99214	27%	4,151	$ 115.84	481,000	553,000	577,000
99215	0%	49	$ 138.59	7,000	8,000	8,000
99385	0%	17	$ 141.96	2,000	2,000	2,000
99395	0%	42	$ 126.14	5,000	6,000	6,000
	100%	15,500		$ 1,381,000	$ 1,588,000	$ 1,656,000
99385	12%	325	$ 141.96	$ 46,000	$ 53,000	$ 55,000
99386	0%	12	$ 163.93	2,000	2,000	2,000
99395	28%	748	$ 126.14	94,000	108,000	113,000
99396	0%	12	$ 135.31	2,000	2,000	2,000
99401	57%	1,529	$ 38.93	60,000	69,000	72,000
99402	3%	71	$ 66.94	5,000	6,000	6,000
99404	0%	12	$ 118.72	1,000	1,000	1,000
	100%	2,700		$ 210,000	$ 241,000	$ 251,000
		18,200		$ 1,591,000	$ 1,829,000	$ 1,907,000
		Covered at 100%		**$ 210,000**	**$ 241,000**	**$ 251,000**
		19% Grad Students		**$ 262,000**	**$ 302,000**	**$ 315,000**
		GTF		$ 105,000	$ 121,000	$ 126,000
		HDHP		-	-	-
		Copayment Plan		71,000	84,000	89,000
				$ 176,000	**$ 205,000**	**$ 215,000**

CPT Code	Distribution	Count	Medicare Miami	Medicare Extension	Medicare + 15% Extension	Medicare + 20% Extension
		81% Undergrad		**$ 1,119,000**	**$ 1,286,000**	**$ 1,341,000**
		SHIP		$ 448,000	$ 514,000	$ 536,000
		HDHP		-	-	-
		Copayment Plan		282,000	337,000	356,000
				$ 730,000	**$ 851,000**	**$ 892,000**
		Total		**$ 1,116,000**	**$ 1,297,000**	**$ 1,358,000**
		Average/Visit		$ 61.32	$ 71.26	$ 74.62

Assumptions:	w/ Plan	Pay
Grads with SHIP	40%	100%
Grads with HDHP	27%	0%
Grads with Copay Plan	33%	$ 20.00
	100%	
Assumptions:	w/ Plan	Pay
Undergrads with SHIP	40%	100%
Undergrads with HDHP	27%	0%
Undergrads with Copay Plan	33%	$ 20.00
	100%	

F. Eligibility and Access

All students are eligible for services at SHS. Online and off-site students who have not paid the health fee can pay this fee on their initial visits to SHS or can be seen on a fee-for-service basis. There are no current financial barriers to accessing primary care services, so low utilization is likely related to demand rather than financial disincentives or lack of capacity.

G. Utilization

Table III-1 shows utilization by month and division for BBC and MMC.

Table III-1
MMC 2012/2013
Active Appointments by Month and Division

	MMC				BBC		
Month	**Gen Med**	**Wellness**	**Women's**	**Total**	**Gen Med**	**Wellness**	**Total**
Jan	936	98	437	1,471	243	37	280
Feb	1,031	134	439	1,604	296	33	329
Mar	901	101	391	1,393	240	14	254

Table III-1 MMC 2012/2013 Active Appointments by Month and Division							
	MMC				BBC		
Month	Gen Med	Wellness	Women's	Total	Gen Med	Wellness	Total
Apr	1,026	244	466	1,736	289	16	305
May	566	85	263	914	169	12	181
Jun	577	90	253	920	144	14	158
Jul	596	23	279	898	199		199
Aug	785	50	310	1,145	232		232
Sep	834	104	402	1,340	269		269
Oct	976	127	515	1,618	297		297
Nov	778	145	411	1,334	283	12	295
Dec	426	112	273	811	151	6	157
Total	**9,432**	**1,313**	**4,439**	**15,184**	**2,812**	**144**	**2,956**

Based on published enrollment for fall 2012, the penetration rate (percent of student population using SHS) for students utilizing primary care provider services is about 20 percent for MMC and 22 percent for BBC. Enrollment excludes 5,763 non-classified/non-degree students. This is less than half the penetration rate of residential public universities where health fees cover office visits; below residential public universities that charge community rates for office visits and collect co-payments, coinsurance, and deductibles from students; and also below universities with a mostly local, off-campus student population. FIU graduate and professional students utilize the SHS at higher rates than undergraduates. The utilization of graduate and professional students on BBC, however, is closer to rates at public, residential universities.

Table III-1.1 Medical Appointments 2012/13				
MMC				
	SHC Patients	# Enrolled	% Enrolled	% of Patients
Undergraduate Students	5,357	29,921	17.9%	72.6%
Graduate & Professional	2,018	7,559	26.7%	27.4%
Total	7,375	37,480	19.7%	100.0%
BBC				
	SHC Patients	# Enrolled	% Enrolled	% of Patients
Undergraduate Students	1,180	6,296	18.7%	75.0%
Graduate & Professional	394	855	46.1%	25.0%
Total	1,574	7,151	22.0%	100.0%

The penetration rate for all services (ancillary, immunizations, wellness, and alternative therapies) for each campus is about 23.5%. This, too, is low in comparison to peer universities. In the most recently released Sunbelt Survey, the average reported penetration rate was 51 percent. This survey includes small and large, public and private, residential, and urban institutions with varying methods for, and institutional levels of, funding. Both in this survey and in HBC's experience, the highest utilization rates are in health centers where there are no out-of-pocket charges for students (health fees or general fund allocations cover office visits). Conversely, the lowest rates are in health centers where there are significant fee-for-service charges with balances billed to students (and lower institutional subsidies required).

Table III-1.2
All SHS Services 2012/13

MMC				
	SHC Patients	**# Enrolled**	**% Enrolled**	**% of Patients**
Undergraduates	6,507	29,921	21.7%	74.0%
Graduate & Professional	2,291	7,559	30.3%	26.0%
Total	8,798	37,480	23.5%	100.0%
BBC				
	SHC Patients	**Enrolled**	**% Enrolled**	**% of Patients**
Undergraduate Students	1,282	6,296	20.4%	75.5%
Graduate & Professional	416	855	48.7%	24.5%
Total	1,698	7,151	23.7%	100.0%

	MMC	BBC
Appointments	13,820	2,812
Number of Patients	7,414	1,595
Visits per Patient	1.9	1.8

In addition to looking at what percent of the student population uses health services, HBC also looks at the average number of medical visits for those students who actually do use the health center. If there is significant variance from college health means, this metric may suggest concern for appropriateness of medical care (e.g., too many unnecessary return visits or, conversely, insufficient follow-up). For the FIU students who do receive provider services at the SHS, the number of provider visits per patient was 1.9 at MMC and 1.8 at BBC. The ACHA median provider visits per patient is 1.8 to 2.0. Visits per patient at SHS are consistent with college health medians.

H. Staffing

The first staffing metric is a comparison to ACHA means of the ratio of FIU's provider and registered nurse staffing levels to the student population. Since the average ACHA penetration rate is approximately 50 percent and the average number of visits per student patient is 1.8 to 2.0, an av-

erage ACHA university of 37,480 students (MMC enrollment) would have 33,700 to 37,500 visits. ACHA average staffing, then, is relative to meeting this average visit demand. SHS, however, had only 15,200 visits for which staffing was needed to meet demand (MMC). In order to compare FIU staffing to ACHA staffing, HBC needs to adjust the ACHA comparison population to one that is most similar to FIU utilization. Based on the number of students receiving services and the number of visits, SHS operates in an environment most similar to a university of 18,000 students for MMC and 3,500 students for BBC. In other words, an average ACHA university with a population of 18,000 students would be expected to have 16,000 to 18,000 visits, and average total staffing would follow. Tables III-12 in Section III-M shows MMC and BBC staffing by position type. For MMC, there are 6.79 FTE providers and 5.05 registered nurses; there are 2.52 providers and 2.77 RNs at BBC. Comparing MMC provider and RN staffing per 10,000 students to ACHA means, MMC's staffing is 45 percent lower for providers and 46 percent lower for RNs for a university with 37,480 students. However, since MMC is most comparable to a university of 18,000 students, the more relevant ratio indicates that MMC providers are 14 percent greater and RNs are 12 percent greater than ACHA means. For BBC, staffing for providers and RNs is 7 percent and 55 percent higher than ACHA means, respectively, based on 7,151 students. Adjusting for the more comparable population of 3,500, BBC is 118 percent higher for providers and 216 percent higher for RNs than ACHA. These figures are illustrated in the tables below.

Table III-2.1
MMC Clinical Staff per 10,000 Students

	ACHA	Population @ 37,480	Difference	Population @ 18,000	Difference
Providers	3.3	1.81	-45%	3.77	14%
RN	2.5	1.35	-46%	2.81	12%

Table III-2.2
BBC Clinical Staff per 10,000 Students

	ACHA	Population @ 7,151	Difference	Population @ 3,500	Difference
Providers	3.3	3.52	7%	7.2	118%
RN	2.5	3.87	55%	7.9	216%

The following tables (Tables III-3) compare MMC and BBC clinical support staffing levels to median support staffing reported by the Medical Group Management Association (MGMA) for Family Practice practices. The first column shows the support categories defined by MGMA. The second column is the MGMA median per FTE provider for Family Practice practices for each of the staffing categories. Note that the aggregated group totals for each of the MGMA staffing categories do not equal the sum of the categories. This is because not every practice reports all of the position categories (e.g., not every practice has radiology or licensed practical nurses). In comparing FIU staffing to MGMA, HBC removed FIU staffing for programs/services that are not usually part of a community medical practice; and HBC removed some of the support staff that support these programs. The programs/services that were removed from comparison are the Pharmacy, health

promotion, alternative therapies, nutrition, and specialty RN clinics. The allocation of staffing is shown in Table III-15.1 in Section III-M. No adjustments are made for immunization compliance functions (or insurance compliance administration, if applicable), since this is more than offset by not having insurance billing and payment processing, contracting, and patient accounts functions to be staffed, or other administrative overhead functions that are provided centrally by the University (e.g., payroll, accounts payable, etc.).

The total provider FTE of 6.79 was reduced by .58 FTE, for allocation of administrative time for Schwartz and Sheehan, to arrive at 6.21 clinical FTEs for MMC. HBC compared this clinical FTE level with MGMA staffing levels. For example, for 6.21 FTE providers, the MGMA median number of business operations staff would be 5.7. MMC has 16.2 FTE business operations staff for its 6.23 clinical FTE providers. In comparison to MGMA, adjusted for programs unique to college health, MMC is significantly overstaffed in administrative positions and understaffed in front office and direct clinical support staff. With regard to clinical support staff, MMC is overstaffed for registered nurses and understaffed for lower cost medical assistants. Overall, MMC is overstaffed by five to seven FTEs. This assumes that 6.21 FTE clinical providers is an appropriate number to meet MMC's patient demand. Data for visits and productivity suggest that demand could be met with fewer than 6.0 FTE providers, in which case the clinical support staff would be accordingly lower.

Similarly, BBC is high in administrative staffing compared to MGMA medians, with total clinical support staffing being somewhat lower, though more heavily utilizing RN coverage rather than medical assistant/LPN coverage. Of more significance for BBC, however, is that the low productivity rates (less than 50 percent of ACHA median) strongly suggest that demand could be met with fewer than 2.0 FTE providers, in which case support staff would be expected to be much lower.

Table III-3.1
MMC Clinical Support Staffing Compared to MGMA

	MGMA Median per FTE Provider	Number @ 6.21 Clinical FTE	MMC Actual	Difference
General Administrative	0.17	1.1	10.1	9.0
Patient Accounting	0.51	3.2	3.5	(0.1)
General Accounting	0.07	0.4		
Information Technology	0.07	0.4	2.5	2.1
Housekeeping, Maintenance, Security	0.06	0.4	-	(0.4)
Total Business Operations Staff	**0.91**	**5.7**	**16.1**	**10.4**
Medical Receptionists	0.64	4.0	2.9	(1.9)
Medical Secretaries	0.13	0.8		
Medical Records	0.22	1.4	2.9	1.6
Other Administrative Support	0.11	0.7		(0.7)
Total Front Office Support Staff	**1.20**	**7.5**	**5.8**	**(1.6)**
Registered Nurses	0.29	1.8	4.1	2.2
Medical Assistants	0.24	1.5	2.9	(3.3)
Licensed Practical Nurses	0.76	4.7		

Table III-3.1 MMC Clinical Support Staffing Compared to MGMA				
	MGMA Median per FTE Provider	Number @ 6.21 Clinical FTE	MMC Actual	Difference
Total Clinical Support Staff	**1.38**	**8.6**	**7.0**	**(1.6)**
Clinical Laboratory	0.31	1.9	2.0	0.1
Radiology and Imaging	0.18	1.1	-	(1.1)
Other Medical Support Staff	0.18	1.1	-	(1.1)
Total MGMA Support Staff	**3.96**	**24.6**	**30.9**	**6.3**
RN Specialty Clinic			1.0	
Pharmacy			3.6	
Health Promotion & Massage			6.7	
Dietician			0.4	
Allocated to Non-Medical Clinic			3.6	
	Total Non-Providers		46.2	
	Providers		6.2	
	Total		**52.4**	

Table III-3.2 BBC Clinical Support Staffing Compared to MGMA				
	MGMA Median per FTE Pro-vider	Number @ 2.52 Clinical FTE	BBC Actual	Difference
General Administrative	0.17	0.4	4.22	3.8
Patient Accounting	0.51	1.3	1.43	0.0
General Accounting	0.07	0.2		
Information Technology	0.07	0.2		(0.2)
Housekeeping, Maintenance, Security	0.06	0.2		(0.2)
Total Business Operations Staff	**0.91**	**2.3**	**5.65**	**3.4**
Medical Receptionists	0.64	1.6	1.00	(0.6)
Medical Secretaries	0.13	0.3		(0.3)
Medical Records	0.22	0.6	1.00	0.4
Other Administrative Support	0.11	0.3		(0.3)
Total Front Office Support Staff	**1.20**	**3.0**	**2.00**	**(1.0)**
Registered Nurses	0.29	0.7	1.77	1.0
Medical Assistants	0.24	0.6	-	(2.5)
Licensed Practical Nurses	0.76	1.9		
Total Clinical Support Staff	**1.38**	**3.5**	**1.77**	**(1.7)**
Clinical Laboratory	0.31	0.8		(0.8)
Radiology and Imaging	0.18	0.5	-	(0.5)
Other Medical Support Staff	0.18	0.5	1.85	1.4
Total MGMA Support Staff	**3.96**	**10.0**	**11.27**	**1.3**
RN Specialty Clinic			1.00	

Health Promotion & Massage		3.63
Allocated to Non-PC		
	Total Non-Clinicians	16.40
	Providers	2.52
	Total	18.42

I. Productivity

Tables III-4, below, show the annual visits and FTEs per provider. The annual visits per paid FTE are compared to median annual visits reported by the American College Health Association (ACHA) and the Medical Group Management Association (MGMA). For ACHA, FIU physicians are compared to medians for primary care physicians, except for Dr. N whose visits are compared with the ACHA median visits for gynecologists (2,479) and Dr. O whose visits are compared to medians for psychiatrists (1,380). Note that the total ACHA median total provider annual visits is 2,356. For comparisons to MGMA, MGMA data for family practice providers paid at 100 percent salary is shown, as is comparative data for all family practice providers (regardless of compensation model). Since several of FIU's providers exclusively provide women's health services, the table also includes MGMA data for OB/GYN nurse practitioners.

Table III-4.1
MMC 2012/13
Active/Arrived Appointments

MMC 2012/13					% ACHA	% MGMA		
PC Physicians	**Appts**	**Total FTE**	**Clinical FTE**	**Annual**	**PC Dr. (2,767)**	**% Sal FP (3,168)**	**All FP (4,185)**	
A	1,444	0.60	0.60	2,407	87%	76%	58%	
B	1,126	0.34	0.34	3,312	120%	105%	79%	
C	1,168	0.86	0.43	2,716	98%	86%	65%	
D	192	0.23	0.08	2,400	87%	76%	57%	
	3,930	2.03	1.45	2,710	98%	86%	65%	
APRN					**NP (2,100)**	**All NP (2,429)**	**FP NP (2,992)**	**OB GYN (2,005)**
E	160	0.06	0.06	2,667	127%	110%	89%	
F	683	0.31	0.31	2,203	105%	91%	74%	
G	825	0.30	0.30	2,750	131%	113%	92%	
H	2,177	1.00	1.00	2,177	104%	90%	73%	
I	395	0.12	0.12	3,292	157%	136%	110%	
J	464	0.40	0.40	1,160	55%	48%	39%	58%
K	1,023	0.49	0.49	2,088	99%	86%	70%	
L	1,982	0.97	0.97	2,043	97%	84%	68%	102%
M	1,899	1.00	1.00	1,899	90%	78%	63%	95%
	9,608	4.65	4.65	2,066	98%	85%	69%	
Specialty Physicians								
N	69	0.02	0.02	3,450	139%			

O	213	0.09	0.09	2,367	171%			
					All (2,356)			
Total Providers	**13,820**	**6.79**	**6.21**	**2,225**	**94%**			

Table III-4.2
BBC 2012/13
Active/Arrived Appointments

BBC 2012/13					**% ACHA**	**% MGMA**		
Physician	**Appts**	**Total FTE**	**Clinical FTE**	**Annual**	**PC Dr. (2,767)**	**% Sal FP (3,168)**	**All FP (4,185)**	
O	23	0.01	0.01	2,300				
P	805	0.31	0.31	2,597	94%	82%	62%	
APRN	**Appts**	**Total FTE**	**Clinical FTE**	**Annual**	**NP (2,100)**	**All NP (2,429)**	**FP NP (2,992)**	**OB/GYN (2,005)**
Q	842	1.00	1.00	842	40%	35%	28%	42%
R	950	1.00	1.00	950	45%	39%	32%	47%
S	191	0.21	0.21	910	43%	37%	30%	45%
Total	**2,811**	**2.53**	**2.53**	**1,111**	**47%**			

BBC's APRN annualized visits are significantly below ACHA median levels and physician annualized visits are about at ACHA median levels. MMC's providers' annualized visits per FTE averages about ACHA median level. The ACHA median, however, is a low goal to which to aspire. One reason ACHA annual per provider visits is low is that the majority of student health centers have excess capacity during breaks and summer and do not optimize nine- and ten-month appointments. Many student health centers also have inefficient facilities, and few of them have compensation systems that have productivity-based components. The excess staffing during the low demand periods of term breaks and summer bring down the annual averages. An ACHA survey from 2006 indicated that colleges and universities that operate only nine months per year have about a 30 percent higher annualized visit rate than those that are open for twelve months. The FIU use of significant number of part-time providers should result in FIU having higher annual averages than ACHA overall medians.

Table III-5 illustrates an alternative way of looking at annualized visits per provider for MMC. HBC estimated MMC FTEs based on MMC providers' clinical dates worked and hours of the day booked for 2012-13 and calculated FTE based on these schedules. HBC assumed an average number of work days for a full-time equivalent provider to be 215 based on the average number of days off in the chart below.

Work Year:	
Hours	2,080
Hours/Day	8
Days	260
Holidays	(12)

Open Clinic Days	248
Vacation	(20)
CME	(5)
Sick	(8)
Work Days	215

Table III-5 shows active appointments (excluding no-show, cancelled, and bumped appointments) for MMC by provider. The first data column reflects the total number of appointments, the second column shows the number of clinical days worked, and the third column is the average number of appointments/visits per clinic days worked. The fourth data column is the average clinical FTE worked only on days that providers saw patients in the clinics. For example, Dr. A worked 183 days in 2012-13; on some of those days she worked four hours (.5 FTE), some she worked six hours (.75 FTE), and some she worked seven hours (.88 FTE), depending on the month of the year. Over the 183 days, she averaged an estimated .70 FTE. The final FTE for Dr. A, then, is consistent with paid FTEs in Table III-4 (183/215 X .7 = .60 FTE). The *Average Visits per Day per FTE* column shows the average for 1.0 FTE based on the actual FTE rate. The final column is the annual number of appointments/visits for 1.0 FTE assuming a 215-day work year. The average visits per day per 1.0 FTE for days worked is 12.9 per physician, 10.2 per APRN, and 11.1 per provider overall. The actual visits per day per provider can be found in Table III-14 in Section III-M.

In total, there were 13,820 medical visits/appointments at MMC, averaging a total of 56 visits per day over the 248 clinic days of the year.

Table III-5
Active/Arrived Appointments MMC 2012/13

	Total	Days Worked	Average per Day per Provider	Average FTE On Days Worked	Average Visits per Day per 1.0 FTE	Annual Total Visits (215 days)
Physicians						
A	1,444	183	7.9	0.70	11.3	2,424
B	1,126	124	9.1	0.61	14.9	3,201
N	69	11	6.3	0.38	16.5	3,549
O	213	36	5.9	0.50	11.8	2,544
C	1,168	120	9.7	0.80	12.2	2,616
D	192	30	6.4	0.60	10.7	2,293
Total	**4,212**	**504**				
Weighted Avg/ Avg			**8.4**	**0.67**	**12.9**	**2,771**
APRN						
E	160	30	5.3	0.50	10.7	2,293
F	683	67	10.2	1.00	10.2	2,192
G	825	85	9.7	0.80	12.1	2,608
H	2,177	215	10.1	1.00	10.1	2,177
I	395	33	12.0	0.80	15.0	3,217

Table III-5 Active/Arrived Appointments MMC 2012/13						
	Total	**Days Worked**	**Average per Day per Provider**	**Average FTE On Days Worked**	**Average Visits per Day per 1.0 FTE**	**Annual Total Visits (215 days)**
J	464	80	5.8	1.00	5.8	1,247
K	1,023	119	8.6	0.90	9.6	2,054
L	1,982	207	9.6	1.00	9.6	2,059
M	1,899	208	9.1	1.00	9.1	1,963
Total	**9,608**	**1,044**				
Weighted Avg/ Avg			**9.2**	**0.95**	**10.2**	**2,201**
Total Providers	**13,820**	**1,548**	**8.9**	**0.79**	**11.1**	**2,387**

Providers	**# Appts**	**Total FTE**	**Clinical FTE**	**Average Per clinical FTE**	**Total Average Visits/Day**
Physicians	4,212	2.14	1.56	2,700	17.0
APRN	9,608	4.65	4.65	2,066	38.7
All Medical Providers	13,820	6.79	6.21	2,225	55.7

The MMC data suggest that the significant use of part-time providers with flexible staffing somewhat reduces the excess capacity during summer months and term breaks compared to average student health centers, but the average number of visits per day during the academic year is low in comparison. In addition, there appears to be little expansion of capacity on the busiest days of the year. Excluding Dr. C, who frequently saw in excess of 20 visits in a day in 2012-13, no other provider had more than 17 visits in a day. This creates ample opportunity for FIU to make improvements, because it is often more difficult for health centers to effectively vary staffing hours to meet demand than to fix components of provider productivity and scheduling. Table III-9 in Section III-M shows appointments by month by provider. These data are summarized in the Tables III-6 and III-7 below.

Table III-6 shows data from the three highest utilization months in 2012-13. APRNs averaged 11.8 patients per FTE and physicians averaged 15.4 patients per day per FTE for these three busiest months. There was significant variation among providers. Generally, HBC would expect providers to average between 15 (usually NP/APRN) and 18 (physicians) patients per day during the months of peak demand; and average higher than this if only days worked are counted.

Table III-6
Active/Arrived Appointments MMC 2012/13
Average per Day per Provider for Days Worked
Feb, Apr, Oct Only

Provider	Total	# Days	Average Per Day	FTE	Per 1.0 FTE
A	496	51	9.7	0.8	12.2
B	320	29	11.0	0.6	17.2
C	385	33	11.7	0.7	16.7
Average					15.4
E	54	9	6.0	0.4	15.0
F	270	25	10.8	1.0	10.8
G	234	25	9.4	1.0	9.4
H	709	61	11.6	1.0	11.6
I	85	7	12.1	1.0	12.1
J	142	22	6.5	0.5	12.9
K	398	40	10.0	1.0	10.0
L	675	62	10.9	0.8	13.6
M	582	56	10.4	1.0	10.4
Average					11.8

Table III-7 shows the average number of provider visits per day by month and illustrates the number of FTE providers that would be needed each month to meet demand if providers averaged 15 patients per day and 18 patients per day (excluding any FTE allowances/adjustments for paid time off).

Table III-7
Active/Arrived Appointments MMC 2012/13

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
All Medical Providers	**1,373**	**1,467**	**1,275**	**1,475**	**820**	**825**	**875**	**1,095**	**1,236**	**1,491**	**1,189**	**699**	**13,820**
Total Clinic Days	21	20	21	22	22	20	21	22	19	23	19	18	248
Average per Day	65	73	61	67	37	41	42	50	65	65	63	39	56
FTEs @15/Day	4.4	4.9	4.0	4.5	2.5	2.8	2.8	3.3	4.3	4.3	4.2	2.6	3.7
FTEs @18/Day	3.6	4.1	3.4	3.7	2.1	2.3	2.3	2.8	3.6	3.6	3.5	2.2	3.1

Table III-8 suggests that one possible contributor to the productivity level is the high rate of cancelled appointments for the Women's Clinic. HBC did not have data on how many of the slots that held cancelled appointments were able to be refilled. HBC sampled the dates and times of the cancelled appointments and compared them to filled slots and concluded that a significant number of slots likely remain unfilled when appointments are cancelled. In addition, most appointment slots for both Women's Clinic and Primary Care are 30 minutes in duration. While two appointments are often booked into 30-minute slots for some providers, this double-booking is infrequent for

other providers. No-shows and late cancellations can have a significant impact on productivity with this scheduling system.

Table III-8 MMC 2012/2013 Visits by Appointment Status					
Status	**Active**	**Bumped**	**Cancelled**	**No Show**	**Total**
General Medical	9,432	28	971	571	11,002
	86%	0%	9%	5%	
Wellness	1,313		85	93	1,491
	88%	0%	6%	6%	
Women's Clinic	4,439	11	1,196	333	5,979
	74%	0%	20%	6%	
Grand Total	**15,184**	**39**	**2,252**	**997**	**18,472**
	82%	0%	12%	5%	100%

J. Costs

As illustrated in Section III-H, Staffing, the overall administrative staffing level is high and influences the amount of administrative overhead expense allocation to the pharmacy and laboratory services discussed in this Section.

Pharmacy

The Pharmacy had a loss of over $230,000 in 2012-13, for income less direct expenses. This does not include any indirect or support costs (billing, IT, accounting, etc.) or expenditures related to inventory increases. Allocated overhead is estimated at $66,900 (see allocated in Table III-15), bringing the total operating loss to over $297,000. The increase in inventory for 2012-13 was $44,650.

Pharmacy:	
Income	$365,964
Expenses	
Cost of Goods	$297,400
Salaries & Fringes	$ 243,818
Estimated Supplies	$ 25,000
Total Direct Expenses	$566,218
Net	($230,336)
Allocated Overhead Expenses	$66,900
Net Income/(Loss)	($297,236)

Analysis of the level of Pharmacy charges to market rates was beyond the scope of the HBC consultation. HBC did not evaluate whether the charges for Pharmacy were set below market rates as implied in SHS communications that indicate nominal fees are charged for services for which fees are assessed. In addition, the reports of the top drugs dispensed (by drug) that were provided to HBC

had data that were inconsistent with other reports and appeared unreliable. Therefore, HBC could not assess whether the health fee subsidy of the Pharmacy operation is intentional or if it could be reduced or eliminated with funding and operational changes. Most university health services that continue to run their own pharmacies generally find that the pharmacies either break even or require some subsidies to remain operational. There is an increasing trend for health centers to close their pharmacies or contract them out. Most do not use health fees to subsidize pharmacy operations to the extent of FIU, especially when there is low student utilization and availability of community resources.

Laboratory

Based on the limited data provided to HBC, the laboratory operation netted between $4,000 and $26,000 per year before any indirect expense allocations, depending on which reported revenue figures are valid. The allocated salary and fringe expenses are $77,000 (see Table III-15 in Section III-M), though not all of these allocated expenses would be saved should MMC discontinue providing laboratory services.

HBC compared the fees for a sample of most frequently ordered laboratory tests, both in-house and contracted, to Medicare reimbursement rates for Florida (see Table III-9 in Section III-M). Some of the FIU rates were higher and some lower than Medicare, with overall rates for FIU being somewhat lower than Medicare. It appeared that the FIU laboratory profiles represented favorable rates in comparison to Medicare. These rates suggest that SHS is charging a fair, market rate for laboratory services and likely a more favorable rate for test panels. This is a positive finding in that SHS has avoided a common problem in many college health services, which is overcharging for laboratory services with resultant unfair charges to students and the SHIP. If an insurance reimbursement model is adopted at FIU, there may not be a significant drop in revenues as a result of the SHS having to accept insurance reimbursement rates that are lower than current charges. It should be noted, however, that HBC conducted only a small sample of higher volume laboratory tests, and the rate comparison may not be representative of the total costs. Generally, in-house moderately complex to complex clinical laboratories lose a significant amount of money because of low insurance reimbursement rates. SHS Laboratory operations, revenues, and expenses should be evaluated further to determine the performance of the Laboratory and the possible impact of insurance reimbursement on future revenues. If an insurance reimbursement model is adopted, the reference laboratory should bill students and their insurance plans for services provided (except for capitated SHIP services). Direct billing to the SHS by the reference lab would be continued in those cases where doing so would be to the students' financial advantage (e.g., lower cost for uninsured students).

Office Visits

The following table summarizes revenues and expenses for MMC per year end ledgers. HBC made assumptions/estimates for Wellness, compliance, and ancillary overhead expenses in order to arrive at a cost for office visits. Allocation of salaries and fringes are found in Table III-15 in Section III-M.

MMC 2012/13 Year End Ledgers		
Revenues	**Revenues by Unit**	**Collections per Summary**
General Medical	$ 229,875	
Women's Clinic	24,673	
Laboratory	347,547	
Pharmacy	365,964	
Faculty/Staff	7,878	
Other	5,410	
Fee-for-Service Revenue	$ 981,347	$ 920,866
Health Fees	3,845,445	3,845,445
Total Revenues	$ 4,826,792	$ 4,766,311
Total Operating Expenses		$ 4,401,310
Total Non-Operating Expenses		190,600
Laboratory		(257,222)
Pharmacy Cost of Goods		(297,400)
Pharmacy Increase in Inventory		(44,656)
Pharmacy Salaries & Fringes		(243,818)
Pharmacy Supplies (estimated)		(25,000)
Immunizations		(147,082)
Other		(5,410)
Cost for Medical & Wellness		$ 3,571,322
Wellness Salaries and Estimated Expenses		(330,000)
Estimated Compliance/Admin Functions		(150,000)
Overhead Allocations, Lab, Pharm, & Wellness		(224,600)
Cost for Medical PC Services		$ 2,866,722
Arrived Appointments		13,820
Estimated Cost per Arrived Appointment		$ 207

The following shows expenses for BBC for 2012-13.

BBC

2012/13 Year End Ledgers	
Revenues	$ 124,056
Expenses:	
Operations Account	$ 128,266
Health Services Admin Account	1,354,947
Total Expenses	$1,483,213

	Total	Med Clinic	Health Promotion
Salaries & Benefits	$ 1,168,578	964,474	204,104
Other Expenses	314,635	267,440	47,195
Total	**$ 1,483,213**	**1,231,914**	**251,299**

Arrived Appointments	2,956
Cost per Appointment	$417

The office visit costs at both the MMC and BBC are high. In well-operated student health services, the cost per office visit ranges from $120 to $140. These costs often include extended hours for urgent care office visits and 24/7 telephone access (contracted or outsourced), office-based CLIA-waived lab tests, and some immunizations. Note this is the total cost independent of source of funding (insurance reimbursements, institutional funding, and student payments). It is clear from previous analysis that low productivity and high support staffing levels are the major contributors to the high cost of care.

While it is an insignificant contributor to overall cost for medical visits, a FIU administrative overhead assessment of approximately 5.5% of expenditures is included in expenses. Although this percent is lower than the usual FIU charge of seven percent on auxiliary departments, it should be noted that assessing these surcharges on the cost of goods (e.g., prescription drugs) and/or on pass-through expenses (reference laboratory charges) can be problematic when assessing financial performance of certain operations. The margins on prescription drug sales and laboratory reimbursements are usually so low that such a charge can be the difference between the unit breaking even and losing money. In addition, such an assessment does not accurately reflect administrative costs associated with the activity/cost center. For example, if a new drug or immunization is introduced that replaces older technology, costs ten times more, and the cost is passed on to the patient/insurance, the administrative overhead cost to the University doesn't also increase tenfold.

K. Facility

The current clinical space in the SHS facility is poorly designed for efficient patient flow. As with all student health services, demand for SHS services varies significantly during the year and by time

of day. During the busiest hours of the day, during the busiest month of the year (April), there was an average of six to seven patients per hour, with a maximum of eleven patients seen in an hour in the General Medical clinic. For the Women's clinic, there was an average of about four patients an hour, with a maximum of six patients per hour.

Attempting to assess the facility needs based on the current patient flow is problematic in that SHS providers schedule two patients per hour rather than the typical four patients per hour for family practice providers. It is also unusual for student health services to have half-hour appointment slots for almost all services. The number of rooms is a function of the number of providers which, in turn, is a function of provider productivity and scheduling. In a typical family practice medical practice, there would be three exam rooms per provider, plus one consultation room per provider, plus one minor surgery room for a practice of three to four physicians. The following table illustrates the relationship of number of patients per hour, number of providers, and number of exam rooms.

Patients per Hour	# Providers Needed			Rooms Needed @2 Rooms per Provider		Rooms Needed @ 3 Rooms per Provider
	@2 Patients per Hour	@3 Patients per Hour	@4 Patients per Hour	@2 Patients per Hour	@3 Patients per Hour	@4 Patients per Hour
11	5.5	3.7	2.8	11	7.3	8.3
10	5.0	3.3	2.5	10	6.7	7.5
7	3.5	2.3	1.8	7	4.7	5.3
6	3.0	2.0	1.5	6	4.0	4.5

For the average number of patients per hour for the month of April, there would need to be 11 exam rooms to meet a demand of eleven patients an hour, if there were 5.5 providers seeing two patients per hour. If the demand was met by providers seeing three patients per hour, only seven to eight exam rooms would be needed. Providers would need more than two exam rooms per provider in order to see four patients per hour. The table does illustrate, however, that the current FIU Health practice facility, which has ten exam rooms, may not be of sufficient size to meet student demand at peak times of the year unless changes were made to practice scheduling. In addition to the medical clinical care, best practices would also dictate that there be counselors and/or case managers imbedded in the medical clinic. If staffing, productivity, and scheduling changes were made, the current faculty practice facility may be able to accommodate office visits but may require expansion into the adjoining retail space. There may not be sufficient space for other clinical activities such as immunization/flu clinics or for administrative and business activities. The space is more consistent with a multi-site clinical operation with remote central business, administrative, and IT offices and support, and it is unlikely to be able to accommodate both clinical and administrative/support functions.

With growth in the FIU student population, especially residential students, expected in the future, the current faculty practice site would not be sufficient to meet increased clinical demand. This being said, FIU might consider locating a second MMC student health clinic into a new residence hall

or adjacent to new residence halls when built. These residence hall-based neighborhood health clinics are currently being used at Michigan State University. This model might be consistent with FIU's student population's connection to community. To some extent it is already in place with BBC location. The disadvantage of this type of arrangement is that if demand is not sufficient in any one location and staffing is not flexible enough to avoid excess resources, this strategy can become very costly. This is already the case at FIU's BBC location, where there is apparently excess capacity and a high cost per visit.

Since HBC is recommending closing the health center pharmacy and leasing campus space to a retail pharmacy, the FIU Health clinic facility would not have to accommodate a pharmacy. Some health education/promotion activities would have to be moved to other areas within Student Affairs. This administrative model for health promotion does exist at several universities, and there is recent movement at many universities to remove health promotion from health centers. The reasons cited are to gain better integration with residence life and other departments, to eliminate duplicate services, and to preserve budget allocations that are often squeezed in the medical/clinical environment.

If a *status quo* strategic option variation is adopted by FIU, a multi-clinic student health program could be implemented, whereby the current health center facility could contain all administrative and support functions; and clinical services could be provided at the current location, at the FIU Health clinical site, and in new residence halls.

L. Summary

The current scope and hours of services is typical for a student health program, and the program is student-focused. Many part-time providers are employed that, in theory, would allow for optimal balance of resources with demand and keep costs low. However, actual costs are high due to low productivity levels that are likely a function of scheduling policies, low clinical support staffing, and inefficient facility layout for MMC. For BBC, level of staffing for the number of visits rendered and the productivity of APRNs are significant factors in high costs. In addition, for both locations, administrative support levels are high, contributing to excess costs. There is a lack of meaningful management, financial, or utilization data and analysis of program performance.

Twenty percent of students received medical services from the SHS during the year, and 23 percent receive some type of service (medical and wellness visits). For universities with mostly local students, a nominal campus residential population, and low numbers of uninsured students, at least one third of students would be expected to have provider visits at student health services. Some stakeholders suggested that there may be cultural factors that contribute to lack of utilization of the SHS. Currently health fees, charged to almost all students, support or subsidize these services, including alternative therapies and prescription drugs.

The Pharmacy is operating at a significant loss. If the University has the option to rent out current retail space to a community pharmacy, this would be the optimal choice for providing on-campus pharmacy services. Alternately, if the SHS Pharmacy could be operated at break-even while charging market rate prices (self-pay and insurance), consideration could be given to maintaining SHS

control. This alternative would not have the advantage of freeing up space in the SHS facility for other services or for bringing in rental income for the retail space.

M. Additional Tables

Table III-9
Active/Arrived Appointments MMC 2012/13
By Provider by Month

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MD													
A	150	146	140	151	100	123	33	87	89	199	141	85	1,444
B	117	100	82	82	52	53	67	116	145	138	96	78	1,126
N*	2	7	5	6	6	7	9		6	8	7	6	69
O**	15	20	16	20	20	17	14	6	27	22	19	17	213
C	94	130	86	115	38	61	80	84	117	140	167	56	1,168
D							54	98	40				192
	378	**403**	**329**	**374**	**216**	**261**	**257**	**391**	**424**	**507**	**430**	**242**	**4,212**
APRN													
E	9	18	16	14	15	12		16	12	22	21	5	160
F	94	132	143	138			176						683
G	97	68	50	68	41	71	47	105	79	98	58	43	825
H	184	213	182	224	135	111	132	193	196	272	216	119	2,177
I	28							80	129	85	60	13	395
J	35	47	54	32	47	33	37	24	17	63	43	32	464
K	157	201	169	197	159	130						10	1,023
L*	207	194	170	223	88	100	138	136	197	258	158	113	1,982
M*	184	191	162	205	119	107	88	150	182	186	203	122	1,899
	995	**1,064**	**946**	**1,101**	**604**	**564**	**618**	**704**	**812**	**984**	**759**	**457**	**9,608**
All Medical Providers	**1,373**	**1,467**	**1,275**	**1,475**	**820**	**825**	**875**	**1,095**	**1,236**	**1,491**	**1,189**	**699**	**13,820**

Table III - 10
Appointments/Encounters

		MMC		BBC	
		#	%	#	%
Freshman	Undergrad	998	5.3%	146	3.7%
Sophomore	Undergrad	2,064	10.9%	229	5.8%
Junior	Undergrad	2,663	14.1%	709	17.9%
Senior	Undergrad	6,994	37.0%	1,830	46.1%
	Total Encounters	12,719	67.2%	2,914	73.4%
	# Individuals	5,357	72.3%	1,180	74.0%
	Average/Patient	2.4	0.0%	2.5	

Table III - 10 Appointments/Encounters					
		MMC		BBC	
Prof Year 1	Professional	92	0.5%	1	0.0%
Prof Year 2	Professional	327	1.7%		0.0%
Prof Year 3	Professional	500	2.6%	10	0.3%
Prof Year 4	Professional	108	0.6%		0.0%
	Total Encounters	1,027	5.4%	11	0.3%
	# Individuals	340	4.6%	7	0.4%
	Average/Patient	3.0		1.6	
Z6	Grad Student	1,907	10.1%	655	16.5%
Z7	Grad Student	3,189	16.9%	360	9.1%
	Total Encounters	5,096	26.9%	1,015	25.6%
	# Individuals	1,678	22.6%	387	24.3%
	Average/Patient	3.0		2.6	
Other/Blank	Other	72	0.4%	29	0.7%
Total Encounters		18,914	100.0%	3,969	100.0%
Active Appointments		13,820		2,812	
		7,414		1,595	
		1.9		1.8	

Table III-11 Sample Laboratory Charge Comparison to Medicare					
Code	Quantity	Medicare		FIU	
36415	1707	$ 3.00	$ 5,121	$ 7.50	$ 12,803
87880	635	$ 16.49	$ 10,471	$ 15.00	$ 9,525
87491,87591	354	$ 48.24	$ 17,077	$ 40.00	$ 14,160
80053,80061, 82977,83540, 85025	335	$ 62.44	$ 20,917	$ 40.00	$ 13,400
84443	331	$ 23.10	$ 7,646	$ 20.00	$ 6,620
86592	326	$ 18.13	$ 5,910	$ 10.00	$ 3,260
81003	288	$ 3.09	$ 890	$ 10.00	$ 2,880
84439	266	$ 12.40	$ 3,298	$ 13.00	$ 3,458
86308	242	$ 7.11	$ 1,721	$ 10.00	$ 2,420
86706	212	$ 14.76	$ 3,129	$ 16.00	$ 3,392
83036	203	$ 13.34	$ 2,708	$ 18.00	$ 3,654
85025	110	$ 10.69	$ 1,176	$ 12.00	$ 1,320

Table III-11 Sample Laboratory Charge Comparison to Medicare					
Code	**Quantity**	**Medicare**		**FIU**	
87086	99	$ 11.10	$ 1,099	$ 22.00	$ 2,178
81001	55	$ 4.35	$ 239	$ 10.00	$ 550
			$ 81,403		$ 79,620
					97.8%

Table III-12.1 MMC Staffing	
Positions	**FTE**
Physician	1.92
APRN	4.66
Physician (Admin)	0.23
Director	1.00
IT	3.54
Accounting/Billing	3.97
Administration	11.64
Medical Assistants	2.90
Medical Records	2.92
Other Clinical Support	1.89
RN	5.05
Dietician	0.43
Health Promotion	6.42
Massage	0.27
Laboratory	2.00
Pharmacy	3.55
Total	**52.39**

Table III-12.2 BBC Staffing*	
Accounting and Billing	1.43
Business - Other Support Staff	4.22
APRN	2.21
Other Clinical Support	3.85
Physicians	0.31
RN	2.77
Health Educators	0.09
Massage Therapist	0.14

Health Promotion/Wellness	3.40
Total	**18.42**
*Excludes dietician (listed in MMC)	

Table III-13
MMC
Allocation of FTEs for Comparison to MGMA

	Medical Clinic	Other	Total
Medical Director	0.43		0.43
Physician Admin	0.15		0.15
Director	0.50	0.50	1.00
Administration	9.00	1.64	10.64
Accounting/Billing	3.47	0.50	3.97
Medical Records	2.92		2.92
IT	2.54	1.00	3.54
RN	4.05	1.00	5.05
Medical Assistants	2.90		2.90
Medical Records	2.92		2.92
Other Clinical Support	2.89		2.89
Laboratory	2.00		2.00
	33.77	4.64	38.41

Table III-14
MMC
Average Visits for Clinic Days Worked

Provider	Sep	Oct	Nov	Feb	Apr	Jan	Mar	Dec	May	Jun	Jul	Aug
A	5.9	11.1	10.1	9.1	8.9	10.0	9.3	7.7	5.9	7.7	3.3	4.6
B	11.2	12.5	10.7	11.1	9.1	10.6	8.2	8.7	5.8	6.6	5.6	8.3
C	14.6	15.6	13.9	11.8	8.8	7.8	7.8	9.3	4.2	5.1	6.2	21.0
D	8.0										4.9	7.0
E	4.0	5.5	5.3	6.0	7.0	4.5	5.3	5.0	5.0	4.0		8.0
F				11.0	10.6	10.4	11.0				8.8	
G	13.2	10.9	11.6	9.7	7.6	12.1	10.0	7.2	10.3	7.9	6.7	10.5
H	11.5	13.0	11.4	11.2	10.7	10.8	9.6	9.2	7.1	8.5	7.3	10.2
I	14.3	12.1	12.0			14.0		13.0				8.9
J	5.7	7.9	6.1	6.7	4.6	7.0	6.8	6.4	5.9	4.7	4.1	4.0
K				10.6	9.4	7.9	8.9	5.0	8.0	6.9		
L	10.9	11.2	10.5	11.4	10.1	11.5	8.9	8.7	6.3	7.1	7.7	8.5
O	9.0	7.3	4.8	6.7	6.7	5.0	5.3	8.5	5.0	4.3	4.7	6.0

Table III-14
MMC
Average Visits for Clinic Days Worked

Provider	Sep	Oct	Nov	Feb	Apr	Jan	Mar	Dec	May	Jun	Jul	Aug
M	10.1	9.8	10.7	11.2	10.3	12.3	9.5	8.1	6.3	7.1	5.9	7.9
Average/ Provider	**9.9**	**10.6**	**9.7**	**9.7**	**8.6**	**9.5**	**8.4**	**8.1**	**6.3**	**6.4**	**5.9**	**8.7**

Table III-15.1
MMC
Staffing Expense Allocation

	FTE		Med Clinics	Lab	Health Promotion	Pharmacy	Total
Physician	1.91	345,455	345,455				345,455
APRN	4.65	48,659	448,659				448,659
Physician (Admin)	0.23	56,664	56,664				56,664
Director	1.00	135,055	67,528	13,506	33,764	20,258	135,055
IT	3.54	140,048	98,034	14,005	14,005	14,005	140,048
Accounting/Billing	3.97	191,026	162,372	9,551	9,551	9,551	191,026
Administration	11.64	462,720	393,312	23,136	23,136	23,136	462,720
Medical Assistants	2.90	96,552	96,552				96,552
Medical Records	2.92	113,323	96,325	6,998			113,323
Other Clinical Support	1.89	68,523	68,523				68,523
RN	5.05	361,861	361,861				361,861
Dietician	0.43	18,546			18,546		18,546
Health Promotion	6.42	261,640			261,640		261,640
Massage	0.27	23,211			23,211		23,211
Laboratory	2.00	81,337		81,337			81,337
Pharmacy	3.55	243,818				243,818	243,818
Total	**52.37**	**3,048,438**	**2,195,284**	**58,533**	**83,853**	**310,768**	**3,048,438**
Direct			1,377,714	81,337	303,397	243,818	2,006,266
Allocated			817,570	77,196	80,456	66,950	1,042,172
			2,195,284	158,533	383,853	310,768	3,048,438

Table III-15.2
BBC
Staffing Expense Allocation

Category	FTE	Salary & Benefits	Med Clinics	Health Promotion	Total
Business - Accounting and Billing	1.43	66,714	60,042	6,671	
Business - Other Support Staff	4.22	254,099	228,689	25,410	
APRN	2.21	197,425	197,425		
Other Clinical Support	3.85	146,950	146,950		
Physicians	0.31	134,690	134,690		
RN	2.77	196,678	196,678		
Health Educators	0.09	7,624		7,624	
Massage Therapist	0.14	11,960		11,960	
Health Promotion/Wellness	3.40	152,439		152,439	
Total	**18.42**	**1,168,578**	**964,474**	**204,104**	**1,168,578**

A. Overview

FIU Counseling and Psychological Services (CAPS) provides assessment/screening, individual and couples therapy, group psychotherapy, holistic health coaching, biofeedback, and psychiatric consultations. CAPS services also include psycho-educational testing, a victim empowerment program, outreach, and workshops. The psychiatrists are shared with the SHS (utilization is reported in the SHS Section of this report). CAPS has an American Psychological Association (APA) accredited training program and is accredited by the International Association of Counseling Services (IACS).

All students are eligible to use CAPS, but the medical school has its own counseling center for its students, and medical students utilize that program rather than CAPS.

B. Utilization and Staffing

The 2012-13 Annual Report states that 12,956 hours were spent providing direct services to 1,839 students and that 3,792 individual sessions were provided. The staffing ratio for CAPS was computed based on 27 FTE clinicians for 48,000 students, or 1,778 students per FTE. This ratio was compared to those of schools of much smaller size. The Annual Report also appears to compare its 3,792 sessions with the average number of sessions for smaller schools and concludes that this shows that CAPS has above average performance. The text is below:

> This student to staff ratio is 1,778. Other universities that have a similar ratio (1,741) provided an average of 3,028 individual therapy sessions to students. CAPS provided 3,792. This above average performance speaks volumes to the concise execution of staff resource available to the center. CAPS' student to staff ratio is comparable to other universities that have a student population of 7,500-10,000, and yet services are being rendered to a much larger student body.

The conclusion confuses staffing ratios with productivity. At the AUCCCD reported ratio of 1,741 students per FTE, a school of 10,000 would have 5.7 FTEs, and the average individual sessions per FTE would be 531 (3,028/5.7). At this productivity level, CAPS would need only 7.1 FTEs for 3,792 sessions, not 27. If the data referred to in the CAPS Annual Report were accurate, the CAPS productivity rate would be 140 (3,792/27) individual sessions per FTE.

CAPS comparative individual sessions, however, were actually higher than 3,792. Since intakes, walk-in consultations, and crisis interventions are also individual sessions and are usually counted as such in the AUCCCD and IACS surveys, for the purpose of analysis and comparison to AUCCCD benchmarks, HBC used the total of reported intakes and individual session, walk-in consultations, and crisis interventions (**7,373** hours) as the number of individual sessions for CAPS. The Annual Report lists specific services, summarized in the chart below.

Services per Annual Report		
	Sessions/Hours	Hours
Intakes & Individual	5,624	5,624
Couples	42	42

Services per Annual Report		
	Sessions/Hours	Hours
Group	2,928	2,928
Victim's Advocacy	140	140
Holistic Coaching	10	10
Testing	1,074	1,074
Walk-In Consultation	1,476	1,641
Crisis Intervention	45	108
Total	**11,339**	**11,567**

CAPS provided HBC with the number of appointments and number of clients with frequency of appointment (the first and second columns in the table below). The total number of sessions (column three) was computed based on the data provided. Given the information above, one has to assume that the figures in the table below include groups, testing, and other services not generally considered individual sessions. If accurate, this leaves almost half of all sessions being utilized by only 173 individuals.

Report Provided to HBC 2012/13		
# Appointments	**# Clients**	**# Total Sessions**
1	600	600
2	253	506
3	163	489
4	130	520
5	113	565
6	86	516
7	57	399
8	59	472
9	49	441
10	45	450
11	34	374
12	21	252
13	34	442
14	31	434
15	11	165
16+	173	6,331
Total Sessions	**1,859**	**12,956**

The penetration rate for CAPS is low. Based on 1,859 clients and total enrollment of 44,000 students, 4.2% of the student body utilized CAPS direct services. Based on 40,000 students who paid the health fees, 4.6% of students utilized the services. For universities with over 35,000 students, students receiving counseling services averaged 7.05% of the student population. FIU CAPS utilization rate is 63 percent of the AUCCCD mean. Based on the number of students using counseling services, CAPS looks more like a counseling service in a school having an enrollment of 25,000 to 30,000 students (1,760 clients for a school of 25,000; 1,818 clients for a school of 30,000).

Like the SHS, CAPS appears to report only staffing headcount and not FTEs in its annual report. The Annual Report states there are 27 clinicians, and it goes on to state there are 11 full-time and four part-time psychologists, two part-time psychiatrists, and four licensed social workers, plus 12 trainees/interns. For purposes of analysis, HBC will assume 17 FTE paid professional staff and 11 FTE trainees. The 7,373 CAPS individual sessions is in the range of what would be expected for schools with enrollments between 20,000 and 30,000 students. Based on both number of students seen and total sessions provided, the ratio of FIU's students to providers should be based on a total population base of 25,000, not 48,000. The table below compares the ratio of students to staff with AUCCCD ratios reported by various enrollment categories.

	FTE	**Student to Staff Ratios**			
	FIU	FIU Ratio @ 25,000 Students	AUCCCD, 4-Yr Public		
			+35,000	25 - 30,000	20 - 25,000
Paid Professional	17	1,471	2,772	2,391	2,534
Paid Professional + Trainees	28	893	2,039	2,056	2,219

Another way to look at the staffing (and productivity) is illustrated below. For example, 7,373 individual sessions and 1,800 clients are average for a school of 25,000, and the average students to paid professional staff is 2,400 for schools of this size. This translates to 10.4 FTE average paid professional staff and 708 individual sessions per FTE paid professional staff. At 17 paid professional staff FTEs, FIU is 63 percent higher in staffing and 39 percent lower in productivity. The differences are greater for total paid professional and trainees.

	Comparison University	FIU	
	#	#	% of Comp
FIU Individual Sessions	7,373	7,373	
Enrollment	25,000	44,000	
Students/Paid Professional Staff	2,400	2,588	
FTE Paid Professional	10.4	17.0	163%
Sessions/FTE Provider	708	434	61%
Students/Paid Professional + Trainees	2,100	1,571	

	Comparison University	FIU	
	#	#	% of Comp
FTE Paid Professional + Trainees	11.9	28.0	235%
Sessions/FTE Provider + Trainees	619	263	43%

C. Productivity

AUCCCD survey reports that 24 hours per week is the average number of individual counseling sessions for a counselor who primarily does clinical work. The rest of the counselor's time is allocated to groups, outreach, workshops, campus consultations, etc. This amount is lower for counseling directors and for other individuals who have other major administrative roles, such as training director. Assuming 2.0 FTEs of the 17 full-time FTE counselors are removed for administrative roles and that trainees are worth only half of a full-time professional in terms of productivity, there would be 20.5 FTEs available to provide the 7,373 individual sessions, averaging 360 hours per year or 11 hours per week based on 33 weeks or 9 hours per week based on a 40-week year. Even if only the 15 FTE full-time staff figures were used for the calculation, the hours per year per FTE comes to 492 or 15 per week based on 33 weeks and 12.3 per week based on 40 weeks. The individual session productivity is very low compared to AUCCCD averages.

Whether these figures are problematic or not depends on what the goals, expectations, and priorities are for the counseling program at FIU. If CAPS' primary mission is to support a training program and do testing, workshops, and outreach, then the low individual session numbers may not be a concern.

D. Cost of Services

Simply dividing the expenditures by the reported number of service hours (12,056) yields a cost per hour of $152. It is difficult to evaluate whether this is a high or low number since there are no data on expectation for allocation of hours for outreach and other activities that are not direct client care. It is high for a counseling center and suggests that either more time is spent on other activities and/or that productivity is low.

E. Summary

The utilization of counseling services is low compared to universities of FIU's size but the staffing level is comparatively high. CAPS has data and management issues similar to the SHS, and it was not possible to accurately assess productivity or cost of services. Any assessment for the appropriateness of the quantity of direct services would be dependent upon the mission and priorities of the program (i.e., direct client care versus training program, outreach, and other campus activities).

A. Overview for Voluntary and Hard Waiver Student Health Insurance Programs

The 2013-14 brochure for the voluntary student health insurance program (V-SHIP) for FIU domestic students is provided in Section IX, Attachment H. HBC received a report from FIU dated July 31, 2013, showing that enrollment in this program for 2012-13 averaged 25 students for annual, 13 students for fall, 32 students for spring, and nine students for summer coverage periods.

The 2013-14 brochure for the hard-waiver student health insurance program (HW-SHIP) for FIU international students, visiting scholars, medical school students, and graduate assistants is provided in Section IX, Attachment I. These students are automatically enrolled in the program unless proof of comparable coverage is furnished. HBC received a report from FIU dated August 10, 2013, showing December 2012 enrollment included 1,961 students, 8 spouses, and 16 child(ren).

New ACA compliance requirements will specify removal of the pre-existing condition exclusion and the lifetime maximum for all enrollees, and providing preventive dental care services for children for the 2014-15 plan year. There will also be major cost impacts as market regulations issued in February of this year (CMS 9972-F) preclude age-based premiums for fully insured student health insurance programs for the 2014-15 plan year. The V-SHIP may not be viable if the adverse selection costs cannot be sufficiently subsidized by the separate HW-SHIP.

While there are significant cost advantages for student health insurance programs over insurance exchange programs (assuming the student is not eligible for premium subsidies) and dependent coverage for many employer-sponsored plans, it is likely that the V-SHIP cannot be sustained on a system-wide basis. Conversely, as the compliance penalties increase and students become subject to the insurance exchange mandate if Florida adopts Medicaid, the V-SHIP may regain viability in 2016 and beyond. This is, of course, highly speculative. In the near-term, FIU should anticipate that it may not be possible to maintain a SHIP on a voluntary basis for domestic students.

B. Mission and Management Parameter

There are no mission or management parameter statements for either the V-SHIP or the HW-SHIP. There is no reference to standards endorsed for student health insurance/benefit programs by the American College Health Association (refer to Section IX, Attachment J) or acknowledgment of applicable federal or state statutes and regulations.

The Florida Board of Governors has reportedly adopted a new health insurance policy for international students (refer to Section IX, Attachment K), and full mandates for the ACA will be applicable for the 2014-15 plan year, as noted above in subsection A.

C. Eligibility and Cost of Coverage

There are standard eligibility provisions for both programs. Eligibility for the V-SHIP requires enrollment for a minimum of three credit hours or enrollment in a practical training program, with actively attending class for 31 days. Dependents of eligible students, including domestic partners, are also eligible.

For the HW-SHIP, all international students, visiting scholars, medical school students, and gradu-

ate student assistants are automatically enrolled unless proof of comparable coverage is furnished. Students enrolled in the Basic coverage are eligible to purchase the Optional Major Medical program. This program also requires actively attending classes for 31 days and provides eligibility for dependents, including domestic partners, of eligible students.

There will be no reason to continue to offer an optional Major Medical Program since full compliance for the ACA attaches to both programs for the 2015-16 plan year.

Both programs have a 12-month extension of benefits provision for total disability or pregnancy, after termination of coverage. Both this provision and dependent eligibility could be reconsidered for the 2014-15 plan year, given the eligibility provisions under the ACA. The only exception for discontinuation for eligibility for dependent coverage might be for dependents of international students.

The following table shows the premium rates for both the voluntary and hard waiver programs.

V-SHIP	2013-2014 Annual Rate	PPACA Fees/Taxes	2013-2014 Total Annual Rate	2013-2014 Monthly Rate
Student, Under age 24	$1595	$61	$1656	$138
Student, Age 24 to 29	$2020	$68	$2088	$174
Student, Age 30 and Older	$2967	$81	$3048	$254
Spouse	$5174	$108	$5280	$440
All Children	$3644	$88	$3732	$311

HW-SHIP	2013-2014 Annual Rate
Student	$2,017
Spouse	$5,225
Each Child	$3,804
All Children	$4,580

There are two major concerns for the separate programs and cost structures for the programs endorsed by FIU. First, it is likely that the international students are heavily subsidizing the cost of coverage for graduate students. While there may not be much of a concern for this subsidization because it does not affect US citizens/permanent residents, the indirect subsidization of a significant expense for FIU's graduate programs raises, at minimum, ethical concerns.

Age rating requires compliance with the Age Discrimination Act of 1975 (ADA). The ADA does not have specific mandates for student health insurance/benefit program management or benefit levels. Although there is no case law or OCR rulings relative to the Age Discrimination Act, the United States Department of Education's Office for Civil Rights (OCR) has confirmed that age-rated student health insurance/benefit programs do not violate the ADA if such policies (1) do not exclude access to the program based on age; and (2) the age-rating practice falls within the normal operations exception for the ADA. More specifically, there must be a sound actuarial standard as

the basis for the age rating.

If FIU's program was to transition to self-funding and an age rating system maintained, an actuarial certification for the rating scheme should be obtained. Generally, a rating system with only three age bands would raise concerns for actuarial validity.

D. Scope of Coverage

As noted above in subpoint A, the scope of coverage for both the V-SHIP and HW-SHIP meets or exceeds all of the requirements specified for fully insured student health insurance plans under the ACA for the 2013-14 plan year. For both the V-SHIP and the HW-SHIP, with the exception of exclusion 22 pertaining to skydiving, bungee jumping, or flight in any kind of aircraft, the exclusions are all common for employer-sponsored group health insurance programs. It is important that the program does not include exclusions for self-inflicted injury or attempted suicide.

Both programs feature the national network of participating hospitals, physicians, behavioral health counselors, and other health care providers (including pharmacies) provided under standard products of United Healthcare. There is also world-wide coverage and unlimited medical evacuation and repatriation coverage provided through Frontier MEDEX.

E. Regulatory Environment

As explained in Section I, Executive Summary, subpoint D-2, Short-Term Impact of the ACA, there are widespread and substantial effects on college health programs under health care reform. The regulations issued under the ACA concluded that student health insurance is a form individual insurance rather than group insurance; and the regulations assured the continued viability for student health insurance/benefit programs through the following:

1. The application of the guaranteed issue and guaranteed renewability provisions did not apply to student health insurance programs, thus allowing colleges and universities to limit eligibility to their students and permitting coverage to be terminated when student status is discontinued.
2. The surcharges for young adults to subsidize coverage for older applicants in the insurance exchanges (commonly estimated to be at least 20 percent of premium) do not apply to student health insurance/benefit programs. The cost of the coverage can be based solely on the expected paid claims for a specific student population.
3. The existence of student health and counseling services was recognized. The regulations specifically authorized student health insurance/benefit plans the ability of student health centers to require that preventive care services be provided at on-campus facilities when the student is in the area of the college or university he or she attends. It is noteworthy that this exception was not granted to employers operating on-site employee health clinics. For employer plans, preventive care services must be covered at any in-network participating provider.
4. Regulations have been issued assuring that colleges and universities, where permissible under state statutes and regulations, can operate self-funded student health benefit plans. These programs are not subject to the market rules, disallowing age rating and surcharges for smokers, which apply to fully insured programs. Self-funded plans can also fully retain

surplus funds whereas fully insured plans must return any surplus funds to the insured students, subject to the minimum medical loss ratio requirements that are applicable to all fully insured individual health insurance plans.

It is important to note that existing federal and state statutes continue to apply to fully insured and self-funded student health insurance/benefit programs. For example, a self-funded program that chooses to adopt an age rating system would still have to operate the age rating scheme in a manner that is permitted under the ADA.

In regard to self-funding, HBC is not aware of any public or private university operating a self-funded student health benefits plan in the State of Florida. FIU chose not to request an evaluation of the permissibility of self-funding via its legal counsel.

In regard to general liability, it is HBC's expectation that state and federal regulatory agencies will have increased scrutiny of the operation of college health programs, particularly student health/insurance benefit programs, given the results of the 2010 investigation by the New York State Attorney General, and recent fraud cases and lawsuits regarding the malfeasant operation of these programs by colleges and universities.

F. Vendor Selection

Request for proposals (RFP) documents were not provided by FIU to HBC for this programmatic review. Accordingly, a review of RFP processes was not included in this consultation.

While not unusual, there is no use of direct contracting with health care providers to create special access or cost reductions for either the V-SHIP or HW-SHIP. There has been no effort to explore direct contracting with HCN or other local area health care providers.

G. Program Communication and Marketing

As is the case for most student health insurance/benefit programs, there are nominal expenditures and resources committed to program marketing. The success of a program usually hinges on the strength of the institution's insurance requirement. It is HBC's expectation that many colleges and universities will find that advanced practice operated student health benefit plans (e.g., self-funding and use of direct provider contracting) create a significant student recruitment and campus safety asset. Refer to the international and domestic student streaming videos recently developed by Northeastern University for examples (www.northeastern.edu/nushp).

A. Impact of Health Care Reform on College Health Programs

1. Three Immediate Consequences for the ACA

The passage of the Patient Protection and Affordable Care Act (ACA) is beginning to have substantial impact on college health programs. Many observers are, however, surprised to find that informal surveying of college health professionals at four-year degree granting institutions shows only nominal reduction in the large number of uninsured students resulting from the expansion of eligibility to age 26 for dependent coverage under parental health insurance. The Lookout Mountain Group's estimates (refer to page three and Appendix A of their 2009 report, provided in Section IX, Attachment L) that four million uninsured college students appear to largely remain uninsured. Uninsured students are primarily enrolled at the approximately two-thirds of public institutions that do not require health insurance as a condition of enrollment. The large uninsured college student population was not caused by students aging out of dependent coverage on parental health insurance. Rather, it was caused by almost all job growth occurring among small employers over the past three decades. Small employers are least likely to provide health insurance or subsidized coverage for children, and both large and small employers that do provide health insurance have substantially shifted the premium cost to employees. Internal Revenue Service regulations issued late in 2012 confirm that employers do not have to provide coverage for the spouse of employees under the ACA and that there is no mandate that coverage for children be affordable.

The main impacts of the ACA on college health programs are three-fold.

a) College health professionals have seen a substantial increase since 2010 in the number of students who are covered by high deductible health plans (HDHPs). This experience is borne out by the employer surveying data provided by the Kaiser Health Foundation showing that one in five workers is covered by a high deductible health plan in 2013, up from eight percent in 2009.

Due to unfunded or under-funded Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs), many students covered by these plans are reluctant to obtain high cost prescription drugs, diagnostic imaging and scans, long-term mental health care counseling, emergency room treatment, and other perceived discretionary high cost services. From a national perspective, the good news is that HDHPs are having a favorable impact on the cost trend for health insurance for both employers and employees. The bad news is that there is great uncertainty as to the impact on long-term health, either positive or negative, by lower utilization of health care services. For college health professionals, there are concerns for access to care for students and for how to communicate the importance of the insurance decision, in particular, waiving enrollment in a SHIP that provides extensive, traditional first dollar benefits rather than maintaining enrollment in a HDHP. Most colleges and universities are unprepared to deal with this situation and are only beginning to become aware of the impact on budgets (e.g., significantly increasing expenditures for intercollegiate athletes for care that was previously funded by students' health insurance).

b) The adoption of 100 percent coverage (i.e., benefits are provided without deductibles, copayments, or coinsurance) for a broad spectrum of medical and mental health care services (refer to Section IX, Attachment D) is creating questions and communication challenges for explaining the rationale for designated mandatory health fees and for why health and counseling services do not participate with students' personal health insurance. As explained in HBC's recent paper on insurance billing for college health programs (refer to Section IX, Attachment C), there are complex regulatory environmental questions and revenue/return on investment projection challenges associated with insurance billing.

c) The ACA has effectively ended the debate about whether four-year degree-granting colleges should provide SHIPs with comprehensive coverage (fully complying with the insurance standards endorsed by the American College Health Association, refer to Section IV, Attachment J) or whether SHIPs should provide nominal coverage and be low cost programs that students and parents are encouraged to rely on as a course of last resort.

With the removal of pre-existing condition exclusions for SHIBP renewals for the 2014-15 plan year, it is likely that many student health insurance carriers (in some cases all carriers) will decline to renew voluntary programs for US citizens unless there is either a substantial subsidy from a very large number of international students who are mandated to have health insurance or other favorable risk factors. Many public colleges and universities will be faced with the immediate question of whether their institutions will not offer a health insurance plan to domestic students or whether they will move to adopt a requirement for health insurance as a condition of enrollment. Adopting an insurance requirement is somewhat easier in states that are choosing to expand Medicaid eligibility under the ACA, and the trend for increased deductibles and reduced employer contributions for dependent coverage makes SHIPs an important cost savings feature for many middle- and upper-income families.

Fortunately, final market rules (CMS-9972-F) were adopted in late February affirming that fully insured student health insurance programs were not subject to the guaranteed issue and guaranteed renewability provisions (i.e., eligibility for SHIPs could be limited to currently enrolled students) and that the cost of the coverage could be based on the expected paid claims for a specific group of covered students. The end result is that SHIPS that continue to exist will have a substantial cost advantage over individual coverage available through the insurance exchanges, in large part because young adults will not be expected to subsidize coverage for older insured persons.

Fully insured student health insurance program benefit design changes are likely to be required for compliance with the State of Florida's Essential Health Benefits Benchmark Plan (refer to Section IX, Attachment M). It does not appear, however, that the benefit design changes required will have significant cost impact on the program.

2. ACA Individual Insurance Mandate, Cost Subsidies, and Medicaid Eligibility Expansion

The cost subsidies for low income individuals will not have significant impact for many students, because (1) they will still be dependents on a parents'/guardians' tax returns and the family income calculation will preclude subsidies, and/or (2) students will have access to employer-sponsored health plans. In states where Medicaid expansion is not adopted, there will be no insurance exchange cost subsidization for individuals with income at less than 133 percent of the federal poverty level.

In states that do adopt expansion of eligibility for Medicaid, it is possible that administrative rules or specific legislation may be adopted to allow Medicaid funds to be used to pay for the cost of SHIPs. The American College Health Association (ACHA) recently published a position paper on this subject (refer to Section IX, Attachment N).

Even though the cost penalties increase significantly in 2016 to 2.5% of income or $695, whichever is higher, it is likely that FIU will continue to have a very large uninsured student population because of the numerous ACA hardship exemptions. One of the most important is point 12 from the Hardship Exemptions from the Healthcare.gov website (refer to Section IX, Attachment, A-1):

> You were determined ineligible for Medicaid because state didn't expand eligibility for Medicaid under the Affordable Care Act.

The ACA's individual insurance mandate will not apply to a large number of FIU students because there is an exemption under the ACA if a person would have otherwise qualified for Medicaid had the state acted to expand eligibility.

3. Long-Term Considerations for the ACA

The long-term impact of the ACA will be highly variable among four-year degree granting institutions at both public and private colleges and universities. This is due to the exceptional diversity that presently exists for the mission and funding for college health programs. It is arguable that no other student service area (e.g., housing, dining services, career services, recreation centers, or other common service areas) has such variability in mission and funding.

It is not uncommon to find four-fold differences in funding and widely different methods of operation and scope of mission for health services and counseling centers among every major cohort of peer institutions (e.g., athletic conferences, institutional research classifications, or US regions). This is certainly the case in Florida as the health fees (calculated at 15 credit hours) average $132.30 per semester for the 2013-14 academic year, with the highest reported semester health fee being at the University of Florida at $211.65 and the lowest semester fee for a residential campus at New College of Florida at $72.15. These data are obtained from the Florida Board of Governor's website at:
http://www.flbog.edu/about/_doc/budget/tuition/Local-Fee-History-thru-2013-14.xls.

Ultimately, the ACA's incentive for moving to Accountable Care Organizations and Patient Centered Medical Homes will shift large components of in-network care, including primary care services and mental health care services, to outcomes-based reimbursement rather than the current fee-for-service reimbursement system. The intention is to move to evidence-based health care, fully integrating specialty providers and health care delivery facilities, and to compensate providers for optimal health outcomes rather than the volume of services and procedures provided. This will have profound ramifications for the operation of college health programs. For example, it is difficult to imagine that integration of mental health care services into the primary care clinic will not become an expectation for college health programs.

It is also likely that the public health promotion model for college health programs will be expanded or largely replaced by individualized biometric-based health coaching. HBC has clients that are considering both incentives and penalties for student health benefit plan participants who demonstrate favorable health behaviors and avoid unhealthy behaviors. For example, a student could receive financial benefits (e.g., reduced cost of coverage for their junior and senior year) for not having alcohol and drug infractions during their freshmen and sophomore years.

The ACA, combined with pressures to control tuition and fee costs, are likely to compel a shift for primary care and counseling services funding from tuition and fees/fee-for-service charges to capitation funding from student health insurance benefit programs and supplemental health care programs as shown below for a Triple Option system. It is also possible that many public colleges and universities, particularly those with highly transitory student populations and limited residential campuses, will discontinue providing primary care and counseling services. Because the ACA includes an insurance requirement, these institutions may decide that there is no compelling rationale for them to provide health care services beyond those that are otherwise available in local communities.

In regard to funding systems for college health programs, HBC anticipates that a Triple Option (a term we have coined) system will emerge at many colleges and universities for funding college health programs. This new system will replace the designated health fees, institutional funding, and/or fee-for-service charges and insurance reimbursements for funding on-campus health and counseling services. Under the Triple Option program students and parents will be advised that they have three choices for a health care delivery system.

Option One: Students could enroll in the college's **Comprehensive College Health Program**, which includes a self-funded student health benefits plan and funding for on-campus health and counseling services.

Option Two: Students who have **Gold or Platinum** level coverage (either insurance exchange or employer-sponsored coverage) would have no institutional costs for access to on-campus health or counseling services.

Option Three: Students who choose to enroll in Young Adult Plan (YAP), Bronze, or Silver level of coverage, or have Medicaid or other governmental insurance coverage (e.g., a graduate student who is eligible for premium assistance on the insurance exchange) would be automatically enrolled in a **Supplemental Health Care Plan** that covers on-campus care and limited

community care services that are not likely to be covered by a high deductible health plan (e.g., long-term counseling).

Shown in the following in the following illustration is modeling HBC recently completed for a public university with 21,000 students.

In this illustration, the cost is projected for maintaining the separate health fee and having a separate insurance program costs for Undergraduate (UG) and International (INT) and university-employed Graduate Assistants/Researchers (GA) and Graduate (GRAD) students as Strategic Option Two. Under the Triple Option, the funding for on-campus health and counseling services shifts from designated health fees/institutional support and fee-for-services charges to capitations from the Comprehensive College Health Program and the Supplemental Care Program. For this illustration, the approximately 1,500 students anticipated to have gold or platinum level coverage are primarily students from the local area who are covered by Taft-Hartley Union plans. These students are presently making nominal use of health and counseling services because they have high level insurance coverage and existing health care provider relationships in the community.

There are numerous permutations for the Triple Option concept. The health and counseling service could become a participating provider with insurance plans if there is sufficient number of students with Gold or Platinum coverage. Students could also be allowed to waive a substantial portion of the Supplemental Care Plan if they can demonstrate they have adequate financial resources to pay for expenses not covered by insurance (e.g., a fully funded medical savings account).

A key point for the legal permissibility of the Triple Option program is based on the continued ability of colleges and universities to operate on-campus health and counseling services without having to provide preventive care benefits mandated by the ACA or meet other essential bene-

fit requirements and minimum coverage levels for these programs (i.e., health and counseling services are not a form of health insurance). In March of 2012, HHS noted the following in its regulations for fully insured student health insurance plans.

> This final rule also retains the clarification that student administrative health fees are not cost-sharing under Section 2713 of the PHS Act. Student administrative health fees are those that are charged to all students enrolled at a college or university, regardless of whether a student enrolls in student health coverage or utilizes any services offered by the clinic, which gives all students access to a student health clinic's services and supports a number of services and activities that foster a healthier campus community.

As long as the Supplemental Care Program is automatically charged to all students, HBC's legal counsel believes it meets the stipulations required for being a student administrative health fee. The ability to waive the fee based on personal health insurance does not diminish its compliance with the intention or requirements of the regulations under the ACA relating to college health programs. It is noteworthy that many colleges and universities have provisions for waiving health fees and they have not changed these arrangements as a result of the passage of the ACA (e.g., the University of Pennsylvania). FIU is advised to consult with its own legal counsel on this interpretation. Another modification could be that colleges and universities will not allow students to waive enrollment in the Comprehensive College Health Program if they have a Young Adult Plan, which provides even lesser benefit levels than bronze coverage.

There are independent, multiple advantages for the long-term transition of college health programs to the Triple Option concept.

- Moving to capitation funding and away from fee-for-service/insurance reimbursement is consistent with the future envisioned for health care delivery, specifically under the promotion of Accountable Care Organizations and Patient Centered Medical Homes. This funding arrangement for college health programs looks similar to the way large employers operate and fund work-site health clinics, employee assistance programs, and behavioral health counseling.

- The Triple Option funding arrangement allows for significant increases in base-line funding for on-campus services, which allows for reduction or elimination of most fee-for-service charges at health and counseling services. The trend for the college health field to move away from pre-paid funding over the past thirty years is due almost entirely from pressure to constrain tuition and fee costs rather than the cost effectiveness of fee-for-service charges or the need to create financial disincentives for excess use of services.

- The Triple Option assures all students have access to essential health care services and promotes campus safety, especially by providing long-term counseling services. It is the appropriate and best response to the trend for high deductible health plans among employers and the high likelihood that most consumers will choose Silver or Bronze

levels of coverage under the insurance exchanges. Access to long-term counseling is particularly important as the Supplemental Care Plan and the Comprehensive College Health Program facilitate the ability to enter into direct contracts with community mental health care providers, many of whom may not otherwise participate with other commercial health insurance plans or have closed practices to new patients.

- Future funding increases for on-campus health and counseling services will be less likely to be subject to limits for fee charges. Accordingly, the long-term funding for on-campus health and counseling services is better secured by being derived from capitations under the Triple Option concept.

- The importance of the choice of insurance is clarified and enhanced under the Triple Option. Students and parents are less likely to optimistically assume that on-campus health and counseling services will meet almost all health care needs, when the fee is no longer a required cost that is not linked to an insurance choice. The value, both for higher benefit levels and more cost effective coverage, for the student health insurance component of the Comprehensive College Health Program option may be more carefully considered and appreciated by parents and students under the Triple Option concept.

- Confidentiality of care is greatly increased as charges that would otherwise be submitted to parents' insurance, even to help satisfy a high deductible, will be covered by the Comprehensive College Health Program or the Supplemental Care Plan. Under the Supplemental Care Plan, the student would be in a much better position to decide whether the nominal copayments for community services (e.g., long-term counseling) should be submitted to parental health insurance.

- Shifting the cost of the operation of health and counseling services from tuition/fee funding to capitations under the Triple Option reduces reported cost of attendance. Presently, student health insurance costs that are automatically included in fees are not included in the total cost of attendance because the fee is not completely mandatory (i.e., they can be waived), even when there is requirement for health insurance as a condition of enrollment.

There are, of course, substantive disadvantages for the Triple Option program, most of which will be variable based on the circumstances of a specific college or university. There are two requirements, which some observers may rightfully view as disadvantages, which are essential for consideration of a Triple Option program.

First, the regulatory expectations and operational need for advanced program management increase when a Triple Option program is adopted. Capability for self-funding both the Comprehensive College Health Program and Supplemental Care Plan; ability to enter into direct contracts with health care providers; assuring the cost effectiveness, productivity, and quality of care for on-campus services; and other major best practices, fiduciary responsibility, and ac-

countability concerns are increased. In summary, all of the resources and expertise requirements for management of an employer-sponsored benefits and wellness program will be required of college health administrators to achieve success with the Triple Option program.

Another important requirement is to commit sufficient resources and expertise to developing and implementing communication of the new approach for providing services for students. Although the full implementation of the ACA over the next two years creates a widespread expectation for change for almost all facets of health care delivery and insurance, effectively communicating the Triple Option program will require much greater resources and varied communications than has been historically required for college health programs.

B. State of Florida Regulatory Environment

1. Permissibility for Always Secondary Payor Funding System

   Several other universities in Florida have structured funding for their on-campus health services based on a requirement that charges first be submitted to students' personal health insurance. The health fee then funds the remaining balance for eligible expenses. This funding arrangement is commonly referred to as an always secondary payor system.

   The State of Florida did not adopt the National Association of Insurance Commissioner's model statue for coordination of benefits between health insurance plans. More specifically, the Florida Office of Insurance Regulation has informally opined that colleges and universities may take always secondary payor positions for their health fee/institutional allocation funding in coordination of benefits with students' personal health insurance. These regulatory conditions also exist in Minnesota and Massachusetts. At least one university has also affirmed that, contingent on appropriate program structuring and controls, the always secondary payor system for its health fee funding would be permissible under common insurance provider contracts, Florida's False Claim Law, and anti-kickback statutes, such as the Federal Stark Law and Florida's Patient Self-Referral Act. HBC has provided referral to FIU for another public university that has completed this legal research.

   As specified in the strategic options for FIU, Section II-E, Secondary Payor Funding for Primary Care, there are important implementation requirements to assure legal and ethical program operations. For example, most states require that charges submitted by the health or counseling services to the college- or university-endorsed SHIP are within the range of fair market value for charges submitted to other insurance companies. While the SHIP can have the lowest fee schedule, it should not be at level that is below Medicare participating provider allowed charges or reflect a high fee schedule that would put the insurance vendor in a position of possible rebating. Other important considerations are also specified, such as having a formal plan document and fully disclosing the conditions under which the SHS or CAPS would agree to waive submission of charges to students' personal health insurance.

2. Permissibility for Self-Funding of SHIPs

   The recognition of self-funding for student health benefit plans in regulations issued by HHS

(refer to Section IX, Attachment P) increases the likelihood that states will adopt specific enabling legislation to allow for self-funding of student health benefit plans. These have already been adopted in New York, Montana, Massachusetts, and Idaho. Self-funding of student health benefit plans is occurring without enabling legislation in New Hampshire, Illinois, Minnesota, Iowa, California, Wisconsin, Ohio, New Jersey, Connecticut, and numerous other states (refer to HBC's Primer for Self-Funding a Student Health Benefit Plan).

It is HBC's understanding that the Florida Office of Insurance Regulation has informally opined that self-funding of student health benefit plans is permissible under the authorities granted public universities related to public health and delivery of related services. HBC expects that the HHS certification process (refer to Section IX, Attachment P) specified for self-funded student health benefit plans for the 2015-16 plan year will require that these programs comply with all essential health benefit and consumer protection requirements that would otherwise be applicable to fully insured student health insurance programs. Thus, the advantages for operating a self-funded student health benefits plan are likely to include:

- ability to fully capture surplus funds rather than have favorable claims experience be required to be commingled with a student health insurance carrier's national book of student insurance business and be subject to the minimum medical loss ratio and premium rebate provisions for individual health insurance coverage under the ACA;
- reduced costs for coverage that are common for self-funded student health plans compared to fully insured student health insurance (e.g., lower risk charges, elimination of most of the tax costs, and reduction of profit components);
- ability to have flexibility in having an age rating system and/or other cost structures; and
- ability to provide benefits at any level with an actuarial value of 60 percent or greater versus the requirement for fully insured student health insurance plans to have benefit levels within + or – 2.0% of the actuarial values for the metal levels of coverage in the insurance exchanges.

Self-funding of student health benefit plans creates a heighted responsibility to operate the programs solely in the best interests of students. These legal and ethical requirements are explained in the HBC publication provided referenced above.

C. Outsourcing/Partner Opportunities

There are numerous opportunities for outsourcing or partnering with health care providers to provide various components of the Student Health Program.

1. FIU Health

   FIU Health has a clinic location on the Modesto Maidique Campus. The clinic is a modern facility with attractive décor, excellent patient flow, fully HIPAA compliant, and is a participating provider with the following insurance plans:

   AvMed (Commercial)

AvMed (Medicare)
Blue Cross Blue Shield – Florida Blue (Commercial)
Blue Cross Blue Shield – Florida Blue (Medicare)
Blue Cross Blue Shield - Health Options (Commercial)
Blue Cross Blue Shield - Health Options (Medicare)
Cigna (Commercial)
Coventry (Commercial)
Medicaid
Medica (Medicare)
Medicare
Psychcare (Medicaid)
University of Miami Behavioral Health (Commercial)
University of Miami Behavioral Health (Medicare)
University of Miami Behavioral Health (Medicaid)
UnitedHealthcare (Commercial)
UnitedHealthcare – Neighborhood Health Partnership (Commercial)

The marketing materials for FIU Health, including a streaming video at its website (refer to http://www.youtube.com/watch?v=DR2Nd5SXAdo&feature=player_embedded) are predicated on the assumption that FI Health will serve the entire FIU community, including students.

Leadership for FIU Health asserts that there is presently excess capacity that would facilitate providing care to FIU students who have paid the health fee. FIU Health stresses that there could be cost savings and/or expansion of services, increased quality of care, and improved integration of care.

FIU Health, through the HCN, also has the capability to provide management services only (MSO) support for community physician practices. Under Business Services, the following are listed on the FIU Health Network for MSO capabilities:

- Payor Contracting
- Billing and Collections
- Business / Market Development
- Clinical Credentialing

During the course of HBC's consultation, plans were being considered for having the HCN provide insurance billing services for primary care services for Student Health Services (SHS), facilitating the health fee taking an always secondary payor position in coordination of benefits with private health insurance (refer to Section IX, Attachment C). There has been no discussion of billing for services provided by Counseling and Psychological Services (CAPS) and having the health fee funding also take a secondary payor position.

HBC provided HCN's leadership with the insurance study referenced in Section VIII, subpoint

A, conducted by SHS from July and August. The study showed that, based on 400 patient health histories (237 female and 163 male), 30 percent of students indicated they were uninsured and 13 percent did not identify a health insurance plan providing coverage. In HBC's experience, self-reported insurance status data generally over-state the level of health insurance coverage for students. FIU Health was not concerned that providing care for a large uninsured student population could result in uncompensated care for services not covered by the health fee.

FIU Health suggested it could work with one or more of its affiliate hospitals to also provide a direct contract fee schedule for both physician and facility contracts to create favorable cost contracts for a SHIP provided by FIU. This could significantly reduce the cost for the SHIP, especially if it is done in conjunction with developing a not-for-profit self-funded student health benefits plan. This could be done for the international plan and a domestic student program if an insurance requirement is adopted and/or Medicaid is expanded by the State of Florida and Medicaid funds are available to pay for the cost of SHIPs (refer to Section IX, Attachment N, for the American College Health Association's advocacy position paper on this subject).

2. Hospitals/Multi-Specialty Physician Practices

There is a national trend for hospitals to operate college health services, particularly at private colleges and universities with fewer than 10,000 students. Generally, there is a common threshold whereby the costs for obtaining electronic health records systems, engaging in insurance billing, and complying with HIPAA compels consideration of outsourcing or partnering with community health care providers. There is often partial outsourcing already in existence at small college health services as employed providers often consist of nurse practitioners or physician assistants but the medical director is a contracted community physician.

There are six hospitals with emergency departments near the Modesto Maidique Campus. It is likely that several of these hospitals would be interested in responding to a request for proposals (RFP) for operation of FIU's SHS and CAPS, particularly given their existing operation of urgent care clinics and/or family practice physician offices. Given the large number of uninsured students at FIU, many hospitals would be likely to defer responding to an RFP until Florida expands Medicaid eligibility and/or FIU adopts an institutional requirement for health insurance as a condition of enrollment.

3. Urgent Care Clinics

There are three urgent care clinics located near the FIU campus and Minute Clinics are also located at CVS Pharmacies.

Baptist Urgent Care Center, Tamiami
14660 S.W. 8th Street, Suite 100
Hours: 7 days/ week 11am- 11pm

Baptist Urgent Care Center, Westchester
8840 Bird Road, Suite 100
Hours: Mon-Fri 6pm-11pm; Sat and Sun 1pm-11pm

Doctors After Hours
11479 S.W. 40th Street
Hours: Mon, Tues, Thurs, Fri 9am-8pm; Wed 9am-6pm; Sat & Sun 1pm- 6pm

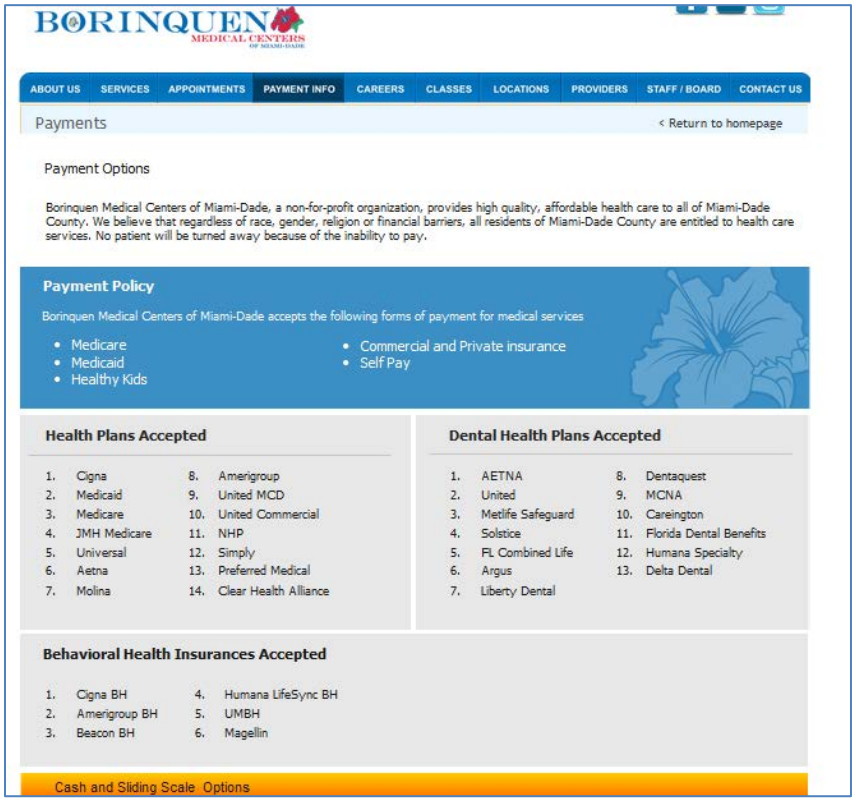
While there are relatively few college health centers that are operated solely on an urgent care model (e.g., University of Northern Colorado's Student Health Center), walk-in care is often preferred by students. It also common to create direct contracts with urgent care clinics to obtain reduced fee schedules for students and direct reporting of visits and health record transmission.

4. Federal Qualified Health Centers (FQHC)

Given the large percentage of current SHS users who are uninsured, it is possible that a FQHC could be induced to take over operation of the SHS and/or CAPS if rent-free space could be provided. Given the close proximity of the Borinquen Health Center (refer to location on 8th Street), this could be an ideal arrangement for providing services to FIU students, particularly if there could be flexibility to limit operations on the FIU campus when there are relatively few students present. A campus location for a FQHC could also be configured to maintain all of the focus and features desired by students (refer to Section VII, Internal Environmental Assessment, subpoint C,).

The following website screen shots suggest that almost all of the services provided by FIU's SHS and CAPS (including pharmacy) could be provided by Borinquen Health Center.

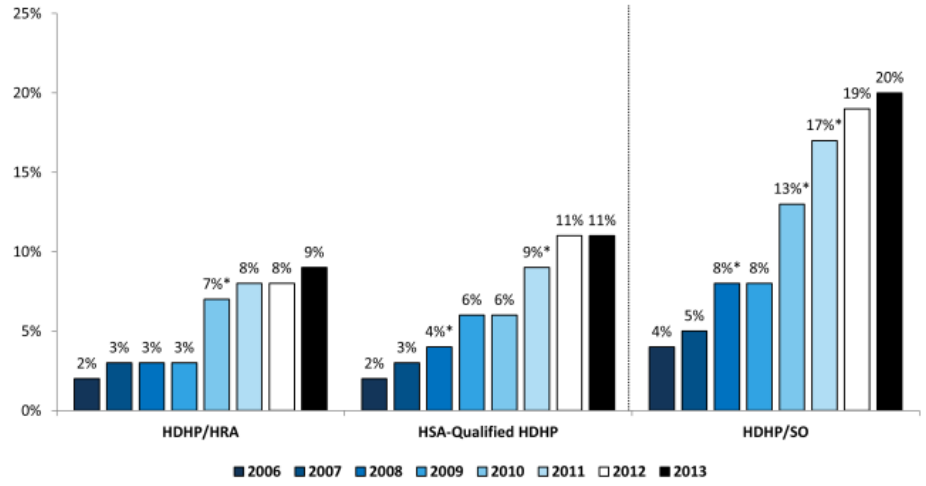

BORINQUEN
MEDICAL CENTERS
ABOUT US
SERVICES
APPOINTMENTS
PAYMENT INFO
CAREERS
CLASSES
LOCATIONS
PROVIDERS
STAFF / BOARD
CONTACT US
Services
< Return to homepage
Borinquen Medical Centers of Miami-Dade provide a comprehensive range of health and social services to our culturally diverse community in Miami-Dade County.
Primary Care
Specialty Care
Speciality Services Available
Internal Medicine
HIV
Pediatrics
Adolescent
OB/GYN, Including Delivery
Family Planning
Healthy Start
Nutritionist
Dental Health
Behavioral Health
Psychiatry
Susbtance Abuse
Case Management
Prevention Education
Podiatry
Optometry / Opticals
Speech Language and Communication Disorders Treatments - performed by Apex, SpeechCare Systems.
Laboratory
X-Ray
Pharmacy
Medicaid Eligibility
Additional Primary Care
Health Connect in our Schools


BORINQUEN
MEDICAL CENTERS
ABOUT US
SERVICES
APPOINTMENTS
PAYMENT INFO
CAREERS
CLASSES
LOCATIONS
PROVIDERS
STAFF / BOARD
CONTACT US
Payments
< Return to homepage
Payment Options
Borinquen Medical Centers of Miami-Dade, a non-for-profit organization, provides high quality, affordable health care to all of Miami-Dade County. We believe that regardless of race, gender, religion or financial barriers, all residents of Miami-Dade County are entitled to health care services. No patient will be turned away because of the inability to pay.
Payment Policy
Borinquen Medical Centers of Miami-Dade accepts the following forms of payment for medical services
Medicare
Medicaid
Healthy Kids
Commercial and Private insurance
Self Pay
Health Plans Accepted
1. Cigna
2. Medicaid
3. Medicare
4. JMH Medicare
5. Universal
6. Aetna
7. Molina
8. Amerigroup
9. United MCD
10. United Commercial
11. NHP
12. Simply
13. Preferred Medical
14. Clear Health Alliance
Dental Health Plans Accepted
1. AETNA
2. United
3. Metlife Safeguard
4. Solstice
5. FL Combined Life
6. Argus
7. Liberty Dental
8. Dentaquest
9. MCNA
10. Careington
11. Florida Dental Benefits
12. Humana Specialty
13. Delta Dental
Behavioral Health Insurances Accepted
1. Cigna BH
2. Amerigroup BH
3. Beacon BH
4. Humana LifeSync BH
5. UMBH
6. Magellin
Cash and Sliding Scale Options

D. Trends for Employer-Sponsored Health Plans

Following the passage of the ACA in 2010, employers aggressively moved to increase the availability of high deductible health plans. The following bar chart from the Kaiser Family Foundation's 2013 survey shows that one in five workers is now covered by a high deductible health plan (HDHP) with a savings option (SO).

Exhibit 8.5
Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2013



* Estimate is statistically different from estimate for the previous year shown (p<.05).
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2013.

The trend for adoption of high deductible health plans is expected to continue, and the consequences for access to care are uncertain. Many health care economists and other observers are confident that the adoption of HDHPs is the single largest factor in the favorable trend for health care costs over the past four years (refer to Section IX, Attachment Q).

While employers are adopting HDHPs, many are also investing heavily in on-site employee health clinics. More than 40 percent of employers with more than 1,000 workers are reported to have such clinics. These clinics often feature integrated primary care and mental health care services and biometric-based health coaching and wellness programs (refer to Section IX, Attachments R-1, R-2, and R-3, and to OnSite Clinics.org). These trends suggest major changes for the long-term operation of college health programs as it is likely that the effectiveness of these approaches can be translated to the college health field.

The other significant change for employer-sponsored health plans since the passage of the ACA is to discontinue subsidizing dependent coverage and transition to unbundled cost contributions from employees for dependent coverage. Many employers are adopting per-dependent cost contributions rather than simply having single employee and family rate structures. This means that increas-

ing numbers of parents are seeing a specific health insurance cost for their college student. As shown in the video produced this summer by Northeastern University, this situation creates an opportunity for highly effective college health programs to become a student recruitment asset.

As noted above in Section A-3, the ACA is intended to ultimately shift funding from fee-for-service medicine to evidence-based and outcomes funding through Patient Centered Medical Homes and Accountable Care Organizations. This shift is already occurring among employer-sponsored plans that have sufficient size to provide on-site employee health clinics. As mentioned above, surveys suggest that more than 40 percent of employers with 1,000 or more employees now have on-site employee health clinics that are funded primarily from capitations from self-funded health plans (refer to Section IX, Attachment R-1). Unlike almost all previous efforts and cost containment and wellness programming, these on-site clinics are producing consistent and replicable cost savings for employers, both in regard to direct health care costs paid through self-funded health plans, reductions in employee absenteeism, and increased productivity. A key element of these programs is often the use of biometric-based health coaching (refer to Section IX, Attachment R-2) and integration of behavioral health and primary care services (refer to Section X, Attachment R-3). Section IX, Attachment R-4, includes media reports over the past three years for adoption of on-site clinics by large Florida employers.

E. Future of College Health Programs (CHPs) at AHCs

CHPs exist at the intersection of higher education and healthcare. It is difficult to envision two fields in society that are valued more by Americans or have higher expectations for change relative to cost of services. It is a particularly challenging time for CHP and student affairs leaders because success has been achieved over the past few decades by making incremental changes and relying on increased enrollment to provide increased baseline funding from tuition and fees and/or institutional allocations. Following the economic downturn that began in 2008, it has become clear that this strategy is no longer viable at many private and public colleges and universities. Many colleges and universities have reached a major turning point, and there is now a genuine focus on controlling costs of attendance and reconsidering methods of operation.

The implementation of the ACA contributes significantly to this background context for the operation of CHPs. Interestingly, highly effective CHPs, particularly student health insurance/benefit program components, can result increased access to care and substantial cost savings students and parents due to the employer-cost shifting discussed in subpoint C. This requires reconsidering the mission, scope of services, funding systems, and methods of operation for college health programs. Finding opportunities to improve fiscal effectiveness, increase productivity, reduce costs, improve campus safety, and increase monitoring capability are key drivers, especially for the objectives of student recruitment, retention, and the enhancement of the educational experience.

The operation of CHPs at campuses where an academic health center (AHC) is co-located with a health center on the university's main campus has been a major concern for the past three decades. An informal organization, Student Health Services at Academic Medical Centers (SHSAAMc), was formalized in 1999 (refer to Section IX, Attachment S, for an article in the *Journal of American College Health,* providing a history of SHSAAMc). One focus of early meetings was the likelihood that a major trend would emerge for student health services to shift from reporting to student affairs di-

visions to colleges of medicine and/or university-owned/affiliated hospitals. In Dr. Ted Grace's presentation, *In the Path of the Elephant*, at the 1999 meeting in San Francisco, there was a sense of inevitability of outsourcing through a shift in organizational reporting.

Of the 141 accredited colleges of medicine in the United States (refer to the membership directory of the Association of American Medical Colleges), 34 public universities have a college of medicine co-located at a main campus. HBC estimates that more than 27 of these institutions have student health services that report primarily to student affairs divisions. Prominent public universities where the student health service reports primarily to the college of medicine, university hospital, or other academic medical center department include:

Michigan State University
Texas Tech University
University of Florida
University of Iowa
University of Toledo
University of Washington

As noted in subpoint A, the ACA's requirement that all health insurance plans provide 100 percent coverage for preventive care services has increased challenges for many CHPs, particularly for primary care services to participate with insurance and not use health fees or institutional allocations to provide benefits that are otherwise mandated for insurance plans to provide under preventive care benefits specified by the ACA. Regardless of this mandate, the long-term funding of many CHPs is likely to shift primarily to insurance reimbursements because of the cost advantages for student health insurance/benefit programs and the ability to offer supplemental health benefit plans (e.g., refer to Section IX, Attachment T, for Ohio State University's Wilce Care program). The concept is discussed in the Triple Option system explained in Section VI, subpoint A-3, Long-Term Consideration for the ACA and College Health Programs.

In most instances, the ability to shift to insurance reimbursement hinges on having an effective institutional requirement for health insurance for both domestic and international students. If Florida ultimately expands Medicaid eligibility (or other governmental action occurs to provide subsidized health insurance for childless young adults), it may be viable to proceed with an insurance reimbursement system based solely on the ACA's mandate for health insurance, as financial penalties become substantial in 2016.

It is encouraging to many higher education stakeholders to see key tenants of the college health field being adopted for large employer-sponsored health plans. Conversely, an important question for the college health field is whether the current approach to public health and health promotion could be supplanted or replaced by individualized biometric-based student health coaching. As noted in Section VI, subpoint A-3, Long-Term Consideration for the ACA and College Health Programs, HBC already has clients interested in developing pilot studies for this approach to operating self-funded student health benefit plans.

A. Insurance Status for MMC Students

FIU did not have credible survey data for the insurance status of its students, either for the uninsured or under-insured (e.g., students covered by high deductible health plans with inadequate medical savings account or personal savings). FIU's last survey using the American College Health Association's National College Health Assessment (NCHA) had only a seven percent response rate, and 71.3% of the respondents were female. As a result, the credibility of the survey relative to insurance status of students is very low. If the NCHA survey results were accurate, more than 6,000 students would have been covered by FIU's student health insurance plans in the fall of 2011.

At HBC's request, SHS conducted a review of 400 student patient visits for July through August, 2013, examining the insurance status field in the medical record. As shown in the following table, 30 percent of the patients were uninsured.

	Uninsured Students	**Insured Students**	**Insurance Not Indicated**	**Total**	% Uninsured
Male	46	**93**	24	163	**28.2%**
Female	74	**134**	29	237	**32.2%**
>18	2	**8**	0	10	
18-21	46	**86**	26	158	**29.1%**
22-25	34	**72**	15	121	**28.1%**
26-30	25	**33**	7	65	**38.4%**
31-39	9	**20**	2	31	
40+	4	**8**	3	15	
Total	**120**	**227**	**53**	**400**	**30.0%**

Generally, HBC finds that students who do not know their insurance status are often uninsured. It is also common to see significantly higher uninsured males than females, so the limited insurance status assessment conducted by SHS probably understates the overall uninsured status for the FIU student population.

Not having credible insurance status data may be the single most important criticism of the existing student health program at FIU.

B. Relationship Overview: HCN, SHS, Students, and Other Stakeholders

At best, the relationships between HCN, the SHS, and student affairs stakeholders could be characterized as being strained. Generally, there is distrust and confusion for the initiatives for SHS to use HCN's resources to begin insurance billing. The rationale for moving to insurance billing was not made based on reliable insurance status information for students and credible net-income projections, and the possibility for having HCN provide services to students at MMC Family Group Practice location is viewed through different perspectives.

- Students perceive the SHS and CAPS as a sort of health care cooperative for which they should have a key voice in determining the mission, scope of services, and methods of operation, since almost all of the funding is derived from student health fees and fee-for-

service charges paid by student patients/clients.

- HCN seems to view student health fee funding as an insurance program that should be controlled by the health care providers and FIU. Students are prospective patients who would receive outstanding health care experiences from FIU Health in a highly attractive state-of-the-art facility. In the view of HCN, this should be an easy choice compared to the existing SHS facility and methods of operation. FIU Health envisions that it would have responsibility and control over all health care services, probably with the exception of wellness activities oriented toward students, and is best equipped to provide quality care; and that the focus of any programmatic change should be on the best way to expedite a transition for the student health program to FIU Health rather than consideration of all strategic options, including *status quo* or modifications for SHS and CAPS.

- Student Affairs leadership expressed frustration by the miscommunications and differing perspectives that evolved through the process of contracting for insurance billing with HCN. There are concerns for the numerous roles that SHS provides that are germane to academic and institutional functions (e.g., administering medical withdrawals and participation in threat assessment teams).

- SHS and CAPS operate from the perspective that college health is a sub-specialty, and its mission is centered on meeting the unique needs of FIU students, with emphasis on prevention and wellness (mission statements from the SHS and CAPS websites are included in Section IX, Attachment U). SHS believes its AAAHC accreditation and recent certification as one of only 15 college health centers to be certified as a Patient Centered Medical Home assures the excellence of their services.

- FIU's leadership is disappointed that HCN and SHS have not worked collaboratively. A clear expectation has been communicated via the consultations that the future of the student health program must be founded on the most advantageous approach for both students and FIU.

C. Assessment of Interested Students/Student Leaders

HBC met with students involved with Student Health Advocates for Peer Education (SHAPE), the Student Health Advisory Committee (SHAC), officers, senators, and representatives of the Student Government Association, and other interested students. These student leaders/interested students expressed a consensus for the following perspectives:

- The SHS and CAPS are important services. Student leaders have a high level of trust for their current operation, scope of services, and quality of care.
- A student-focused program is an important asset. Students want to receive health care or counseling services in a facility that is designated as an FIU student health program. Understanding the highly diverse student population and culturally competent care is essential component of this expectation. This includes providing effective services for international students, the LBGTQA community, and students of color.

- Students want to participate in FIU student community health and wellness initiatives.
- Access to health care services is not a major concern for the general student population. The ACA individual mandate penalty of $95 in 2014 would not be sufficient to cause students to obtain health insurance. There is a perception that the largely local student population has access to community health care resources, sometimes using highly informal community care systems that are culturally based.
- Students are open to other partnerships for operation of the SHS and CAPS, but it is imperative that they have an effective voice in how their health fee funds are expended and the service must meet the expectations noted above.

D. Assessment of HCN

HBC met with Dr. Fernando Valverde, Chief Executive Officer for FIU Academic Health Center Health Care Network; Mauricio Sirvent, Chief Financial Officer, FIU HealthCare Network; and Dr. Yolangel Hernandez Suarez, Chief Medical Officer of the FIU HealthCare Network. A tour of MMC Family Group Practice was also provided. The following are HBC's notations from these meetings and subsequent email exchanges.

- HBC appreciated the time that HCN's leadership devoted to our meetings and their demonstrated interest in providing services to the entire FIU community.
- The contract proposed by HCN to provide insurance billing for to SHS is within the sphere of HCN's declared Business Services capabilities for private-sector health care clinics, and HBC found the proposed contract for SHS to be straightforward with an appropriate cost.
- MMC Family Group Practice has excess capacity and could accommodate student visits. It is questionable whether there would be sufficient exam rooms and staffing to provide appropriate access if demand for services remains at present levels.
- HCN would consider additional branding of the facility to recognize the SHS location.
- As of HBC's last communication with leadership for HCN in October, no interest was expressed for trying to reset relationships, understand other stakeholder perspectives (e.g., concerns student affairs leadership might have in not seeing many peer universities having AHCs operate their student health services), or begin a dialogue with student leaders and other key stakeholders.
- Counseling is not integrated into the existing MMC Family Group Practice. Given this priority and space limitations, CAPS would probably need to stay in its present location.

E. Assessment of SHS and CAPS

The following comments are germane only to MMC locations for SHS and CAPS.

- It is clear that SHS and CAPS have devoted substantial time and resources to garnering the support of student consumers, particularly interested students and student government leaders. This is highly commendable and a key element for having the capability to obtain resources to meet organizational missions.

- Generally, the SHS website is well organized and the content is provided in graphically attractive format.
- The role of SHS in supporting the tobacco- and smoke-free campus initiative is a commendable health improvement action.
- It is commendable that SHS has achieved accreditation, including a recent certification as a Medical Home. Accreditation, however, does not guarantee clinical quality or fiscal efficiency.
- No research has been conducted for assessing the insurance status of students. The stated rationale was that FIU's leadership has not supported the concept of an insurance requirement. Given the inextricable link between access to health care services and the existence of insurance, a health care organization with a declared mission of advocacy and health care access would be concerned with both the insurance status of students, their usage of services (both SHS and elsewhere), and their perceptions for access to care. These statements are not intended to suggest that such studies would result in showing a compelling need for an insurance requirement for FIU. Rather, they provide important background context for considering the low level of utilization of SHS services by FIU students. Study of the student population may show that there is appropriate access to care via community health care organizations and/or there are cohorts of students with significant unmet healthcare needs.
- While HCN could have been more accommodating and understanding of the perspectives of student leaders and other stakeholders, it also appears that SHS has been resistant to the change for HCN to do its insurance billing. For example, SHS leadership reported to HBC that one reason for implementation delay was that HCN would not be providing staffing for insurance coding. While training is an appropriate service to be provided by HCN (and is addressed in the contract), initial coding is done in the clinic by the clinic personnel who render the services (i.e., by SHS personnel). In most practices, the electronic health record requires and/or informs the coding. The HCN contract did not include coding services, so it is unclear why there should be confusion and delay surrounding this function.
- There is a lack of accurate, consistent, reliable data (e.g., providing basic information such as FTE status for staff). There is no accounting for, or analysis of, performance or cost effectiveness by function or department (e.g., pharmacy, laboratory services, primary care, or women's services).
- The SHS indicates that it has a research mission, but there does not appear to be any substantive assessment for the health promotion or marketing programs. The National College Health Assessment survey was last conducted in 2011, and the sample demographics and responses did not produce reliable results. The CORE survey was last conducted in 2008.
- There were no data on the effectiveness of the Healthy Cash program to support use of the Pharmacy, or for the effectiveness and return on resource investment for other health promotion and marketing activities. Only anecdotal information could be provided to HBC in support of these activities.
- Although the design of the SHS facility is poor (e.g., patient flow, narrow hallway), the use of existing space and renovations that were underway during HBC's visit do not appear to be well conceived.

- HBC appreciates that encouraging student involvement can result in activities and promotions that may inadvertently not reflect well on the sponsoring organization. Relative to the health promotion social media and videos that are provided by peer institutions, the YouTube videos developed under the Healthy Panther program, and featured prominently on the home page for SHS, are of poor quality and do not reflect well on the SHS.
- While complimentary health services can be popular with students, they are rarely funded with health fees or institutional allocations. In an environment where there is a stated shortage of space and a concern for funding (the rationale for billing), it is difficult to understand the allocation of facility and financial resources for these activities.
- Overall, it appears that programmatic decisions are often made randomly rather than based on careful analysis of need or on strategic direction.

The benchmark study was revised by FIU and HBC to be an email survey of six mutually selected public universities, five of which were known to have significant operating relationships between their respective student health services and AHCs. Arizona State University was added to the survey because it is an aspirant university for FIU, and it is known to have secondary payor status for student health services funding. The survey was distributed via email from the FIU Provost's office on November 1, 2013 (refer to Section IX, Attachment B-1).

A. Mission, Scope of Services, Funding, and AHC Integration

On the surface, the missions for the health and counseling centers in the benchmark study are similar, as shown in the following table referencing mission statements on websites and/or annual reports.

Florida International University	Health Services SHS provides affordable and accessible student-focused medical care and promotes healthy lifestyles through education, mentorship, and research activities thus facilitating the academic success of our students. We proactively assess our diverse population, and work with university and community partners to address the changing needs of our students, in a holistic, innovative and supportive environment where optimal health can be realized. Vision: To be the premier university student health resource for the university by providing professional, innovative, state of the art, and accessible health care and wellness services to the FIU student body. We are committed to the belief that optimal health is essential for each individual to attain his/her highest potential.
	Counseling Center (refer welcome video at: https://www.youtube.com/watch?v=iS1xG6ko7gg&feature=player_embedded) Our mission is to provide assistance to help you have the most rewarding and successful university experience while at FIU.
Arizona State University	Health Services The mission of the ASU Health Services is to provide high quality health care that is accessible, affordable and compassionate in order to ensure the well-being and educational success of students at Arizona State University. Through our internal and external academic partners, the ASU Health Services faculty and staff are an integral part of the New American University. The ASU Health Services provides medical care to faculty and staff that supports the university mission.
	Counseling Center ASU Counseling Services work to support the academic mission of the university by providing mental health, consultation, and outreach services that facilitate the student learning experience and student success in persistence and graduation.
University of Florida	Health Services (refer to welcome video link at: http://shcc.ufl.edu/new-students/) The mission of the University of Florida Student Health Care Center (SHCC) is to help each student achieve maximum physical and emotional health so that each may participate fully in the educational and personal growth opportunities afforded by the university. The SHCC is committed to providing the highest quality primary health care. All activities and programs of the SHCC operate to assure a nonjudgmental environment and sensitivity to individuals with disabilities and those representing diverse cultural, racial, religious, gender or sexual orientation groups.
	Counseling Center The Mission of the Counseling and Wellness Center at the University of Florida is to facilitate the total development of students by reducing psychological problems

	and distress and by enhancing mental health, well-being, quality of life, and optimal functioning, through the delivery of high quality, culturally sensitive services to UF students and the larger campus community. Our primary focus is on providing brief, confidential counseling aimed at helping students succeed academically and interpersonally.
University of Iowa	Health Services The student health service mission is to provide quality healthcare, education and health promotion to enhance student learning and success. Vision: Maintain and enhance our role as health care experts and community resources. Anticipate and adapt to the evolving health needs of university of Iowa students. Foster an environment that contributes to the mutual satisfaction of students and staff. Explore and optimize space and technology. Values: • empathy, compassion and understanding for patients and each other • quality of care • teamwork • communication • work-life balance • flexibility
	Counseling Center (refer to welcome video link at: http://counseling.studentlife.uiowa.edu/about/introductory-video/) The mission of the University Counseling Service is to provide compassionate psychological services, outreach, and training that foster the mental health of students, nurture student success, and contribute to a safe, welcoming, and multi-culturally aware campus community.
Michigan State University	Health Services To support the mission of Michigan State University and the success of its students by enhancing personal health, removing barriers to academic achievement, and promoting a healthy learning environment.
	Counseling Center In keeping with the mission of the Division of Student Affairs, the Michigan State University Counseling Center seeks to create and sustain a campus environment that supports the holistic development of each student and contributes to their optimal academic success by facilitating and supporting identity development, community responsibility, health and wellness, multicultural awareness, social justice, and career development. In doing so, the Counseling Center seeks to support the University's overarching mission of being a "world-grant" institution by helping students become healthy, informed, aware and committed citizen-scholars. The MSU Counseling Center will be recognized as a global leader in college student mental health and well-being. We are committed to a diverse, confidential, dynamic, cutting-edge approach to each of our services in counseling, training, substance abuse prevention and services, sexual assault treatment and prevention, and comprehensive testing services. We will offer the highest quality of professional services to support MSU's status as an international leader in higher education.
Texas Tech University	Health Services There are differing mission statements at the SHS website (refer also to 2010 Strategic Plan at: http://www.ttuhsc.edu/studenthealth/stratplan.aspx). Student Health Services "promotes each student's learning experience" by providing

	health care and health education to insure academic success of students. Student Health Services provides comprehensive, cost effective, and compassionate medical care to students. This includes health education to promote healthy behaviors and avoidance of preventable disease.
	<u>Counseling center</u> The student counseling center (SCC) promotes student success. Vision: the student counseling center (SCC) aspires to American Psychological Association standards of excellence in practice for its provision of student psychological services and accreditation standards for clinical supervision of professionals-in-training. Values: • Respect for diversity and individuality; • The importance of balancing academic, personal, and social pursuits; • The integrity and responsibility of individual choice; • Self-knowledge and self-efficacy; and • Advocating for social justice and human dignity.
University of Washington	<u>Health Services</u> Our mission is to facilitate the academic success of UW students and the well-being of all of our patients through a commitment to high quality patient-centered health care. Vision: Hall Health Center will provide the best primary health care and health promotion services available. UW students will have their academic success supported by accessible health care. Through collaboration with UW entities, HHC will meet the ever-changing needs of UW students. Values: For our patients we strive to: • Provide high quality, patient-centered, cost-effective, and timely primary, specialty, and mental health care, and health promotion services in a safe and nurturing environment. • Respect and respond to the diversity of the people we serve. • Empower and equip our patients with reliable and accessible health information through open communication between patient and health care team, our e-care system, and the HHC website. For our employees we seek to provide: • A worker-friendly environment, which recognizes and rewards employees for their professional contributions and creates the opportunity and incentive to achieve full potential as contributing members of the practice team. • A setting that offers and promotes open communication, respect, honesty, teamwork, and integrity. • Flexibility and responsiveness to the changing conditions and priorities in the workplace and shared responsibility for processes and outcomes.
	<u>Counseling Center</u> (refer to welcome video link at: http://www.washington.edu/counseling/) The UW Counseling Center provides a safe environment to help students explore the challenges of life and learning through counseling, outreach, preventive pro-

	gramming, advocacy, and consultation. The Counseling Center strives to create a diverse, inclusive, and multicultural learning community. As both a service and training site, the staff is committed to excellence within the college mental health profession. We provide personal counseling, career counseling, and other services to currently-enrolled UW students. The Counseling Center also provides consultation to faculty, staff, and parents who have concerns about a student.

The following are HBC's major observations from reviewing the missions, scope of services, Funding, and AHC integration for these institutions.

- **Mission**: The true mission for these programs varies significantly. The University of Florida has the requisite funding to realize the missions for health, counseling, and wellness services. With the addition of an insurance requirement effective for the 2014-15 academic year, objectives for access becomes a much more meaningful objective. All of the other institutions do not require health insurance as a condition of enrollment and, undoubtedly, have substantial concerns for large uninsured and/or underinsured student populations.

  It is important to note that none of the benchmark institutions, in comparison to FIU, have comparable levels of low income students or students of color. All of the benchmark institutions also have a much larger percentages of students residing in university-owned or -affiliated campus housing. Income status and ethnicity are heavily correlated with insurance status and are usually predictors of high utilization of primary care services at student health services. High levels of fee-for-service charges, combined with the lack of an institutional requirement for health insurance, also affect usage of primary care services. Only the University of Florida has a level of student health service provider visits (1.44 visits per student) that is consistent with expected utilization. The utilization levels among the other benchmark institutions suggest either a limited mission relative to eligibility and/or cost factors that create a barrier for access to care. The concern for cost factors is undoubtedly linked to the amount of fee-for-service charges and the amount of pre-funding of care from designated health fees and/or institutional allocations. The University of Florida has the highest designated health fee at $14.11 per credit hour ($423.30 per academic year at 15 credit hours). The student health service at the University of Florida has both a high level of pre-funding and substantial third party payor revenue. This is because they charge the students' personal insurance for medical office visits and the health fee funds any remaining balance (i.e., secondary payor funding).

- **Integrated Care**: None of the benchmark universities have fully integrated health and counseling services. Two examples where there is effective integration at land grant institutions are Gannett Health Center at Cornell University and the CSU Health Network at Colorado State University. Many of the health service and counseling websites do not cross reference services, either in the statement of services or for urgent/emergency care situations. FIU's SHS website does list CAPS under the Services page as shown in this website screen shot in Section IX, Attachment V. Unfortunately, there are no references to CAPS on the SHS pages under After Hours Care or Emergency Information other than the Quick Links on the bottom of the pages. On the CAPS website, there are no references to SHS, except for a Student Health link, along with Victims Advocacy and Emer-

gency tabs, at the top of the page.

- **Integration with AHC**: The University of Florida and Texas Tech University have the highest levels of AHC integration, as their student health services are operated by the physician practices of their respective colleges of medicine. The Texas Tech website has the strongest communication of this operating structure, as Student Health Services is a subpage under the department of Family Medicine (UFL's SHS also operates as a department within Family Medicine). None of the AHCs are operating counseling services. All of the counseling services appear to be operated under student affairs divisions. As noted previously, Arizona State University does not have an AHC. Interestingly, they are developing an increasingly close relationship with the Phoenix location of the Mayo Clinic for health promotion and use of technology. The University of Iowa noted that providing telemedicine (they referred to this as e-visits) could be a major opportunity in the next five years.

B. Response to Four Specific Benchmark Inquiries

Each university's response to the five major benchmark questions is provided on pages two to five in Section IX, Attachment B-1. The following are HBC's general analysis of the responses.

1. **What do you see as the major short- and long-term impact of the Affordable Care Act on your student health program?**

   None of the respondents expressed major concerns for the immediate viability of their voluntary student health insurance programs following removal of pre-existing condition exclusions and other required ACA changes for the 2014-15 plan year. HBC anticipates that many voluntary student health insurance programs will not be renewed, and alternative insurance carriers will not be available, if the plans are not heavily subsidized by international students or institutional contributions for graduate student teaching assistants/researchers, or have other favorable environmental factors.

   Only Arizona State noted the expansion of Medicaid eligibility for childless adults as having a significant short-term impact on college health programs. This may be because the other health services already participate with Medicaid and do not see the potential reduction in uninsured students (many uninsured would be middle income students who would not qualify for Medicaid) as highly consequential. None of the respondents noted an increase in students with high deductible health plans as being a major short-term impact of the ACA. Generally, HBC views this as one of the three major short-term impacts of the ACA on college health programs (refer to Section VI, subpoint A, Impact of Health Care Reform on College Health Programs).

2. **What do you see as the major concerns or opportunities for the operation of your student health program over the next five years?**

   Stability of health fee funding, dealing with needed facility renovations, adequacy of third party reimbursement rates, financial viability of pharmacies, development of narrow accountable care organizations that may not include student health services, and servicing distance learners were listed as concerns. None of the respondents perceived a fundamental need for restructuring college health programs along the lines of the Triple Option program suggested in Section VI, subpoint A-3, Long-Term Considerations for the ACA and

College Health Programs).

3. **Insurance Status:**

   a) **Does your university require health insurance as a condition of enrollment? If so, to what groups of students does the requirement apply (e.g., all students, full-time, international, medical)?**
   b) **Does your university provide health insurance to graduate research and/or teaching assistants as part of the compensations package?**
   c) **Are any changes envisioned?**

All of the respondents have voluntary insurance for domestic students, except for the requirement that is being adopted by the University of Florida for incoming students for the fall of 2014. The University of Florida's policy adoption is included in Section IX, Attachment E. Ultimately, the expansion of Medicaid eligibility in numerous states will facilitate universities adopting health insurance requirements. Conversely, some colleges and universities will terminate their student health insurance plans, even though many students may ultimately pay significantly higher costs through the insurance exchanges or employer-sponsored health plans.

4. **AHC Integration:**

   a) **Please describe the extent, if any, of the relationship between your academic health center/university physicians and the operation of your health and counseling services?**
   b) **Are any changes being considered?**

As previously noted, none of the respondents have counseling integrated with primary care services, and none of the AHCs are providing individual counseling services. This is a significant shortcoming for the operation of these college health programs and will likely be addressed as result of ACA requirements and recognition of best practice trends.

Based on the responses provided, there are no substantive reported problems with the full ACH integration at the University of Florida and Texas Tech University. While separate electronic health records and practice management systems were noted as a concern by some respondents, problems associated with responsiveness to university stakeholders and student patients, availability of services, excessive charges, or other concerns were not noted.

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Agenda Item 4

THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
Health Affairs Task Force
June 3, 2014

Subject: Information Items

Proposed Committee Action:
None. Information/Discussion only.

Background Information:
The Information Items consist of Updates from the following areas:

- School of Integrated Science and Humanity
- Herbert Wertheim College of Medicine
- Nicole Wertheim College of Nursing and Health Sciences
- Robert Stempel College of Public Health and Social Work

Supporting Documentation: **Updates:**
School of Integrated Science and Humanity
Herbert Wertheim College of Medicine
Nicole Wertheim College of Nursing and Health Sciences
Robert Stempel College of Public Health and Social Work

Facilitator/Presenter: Suzanna Rose
John A. Rock
Ora Strickland
Michele Ciccazzo

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Florida International University
Board of Trustees
Health Affairs Task Force
June 2014

A. Unit Reports

I. SCHOOL OF INTEGRATED SCIENCE AND HUMANITY

The School of Integrated Science and Humanity (SISH) was established in 2009 by the College of Arts and Sciences to provide a multi-disciplinary home for the study of health-themed sciences such as biochemistry, biophysics, behavioral science, cognitive and neurosciences. The School incorporates academic departments as well as innovative research centers and institutes. Other SISH faculty members are active in health-themed research not directly related to the three centers and institutes listed below, with total AY 2013-14 expenditures of $1M. The *Health Behavior and Policy Initiative* conducts research on the immune mechanisms underlying HIV infections and the role of recreational drugs as cofactors in disease progression. Two *Parenting Programs* funded by the Children's Trust provide a home visiting program that supports a parent's role in promoting school readiness for children and a parenting intervention program to reduce obesity prevention in children. The following provides an update on the health-related initiatives of the School.

1. Center for Children and Families

The Center for Children and Families (CCF), under the directorship of Dr. William Pelham, is a multidisciplinary team of researchers and service providers committed to improving the lives of children suffering from mental health problems and providing support to their families. Its three main goals are: (1) to advance our understanding of the cause, course, and outcome of child and adolescent mental health disorders through field-leading research; (2) to develop, test, and deliver effective mental health treatments, proven to work through rigorous research; and (3) to train researchers and clinicians to further these goals, and to train other service providers, mental health

professionals, teachers and trainers on the knowledge and treatments we develop. Since the center's founding in 2010, the CCF has produced numerous articles, hosted conferences and training seminars on a wide range of topics, and trained graduate students in all aspects of research and practice. The CCF is the leading provider of evidence-based services for children with ADHD in Miami, already having served more than 1200 families. The center's Summer Treatment Program (STP) has been recognized as a model program by the American Psychological Association and Children and Adults with Attention Deficit Disorder and is listed on the National Registry of Evidence-Based Programs and Practices. The STP served 226 South Florida children in the summer of 2013. For AY 2013-14, the CCF produced over 100 peer-reviewed articles. Grant expenditures exceeded $4.1M.

Four sub-disciplines within Psychology have direct bearing on human health and mental health and are affiliated with the CCF.

- The Developmental Psychology group focuses on research related to intersensory perception, spatial cognition, language, and motor and social development from the prenatal period into adolescence. As of fall 2013, the group is training 32 Ph.D. graduate students.
- The Clinical Science program focuses on a broad range of diagnostic categories, including internalizing, externalizing, and developmental and learning problems. It is one of a small group of programs nationally that focus exclusively on children/adolescents. Training is aimed at preparing students (currently 25 Ph.D. students) for academic and research positions.
- The new Cognitive Neuroscience track that is also part of the CNI described below will accept its first cohort of doctoral students in Fall 2015.
- The Professional Counseling Psychology MS program is a two-year, self-sustaining program that attracts students who seek advanced training and licensure in mental health counseling. Currently there are two cohorts of students enrolled with 24 students and 27 students, respectively.

2. Biomolecular Sciences Institute (established May 2014)

The Biomolecular Sciences Institute (BSI), led by Dr. Yuk Ching Tse-Dinh, maps directly onto FIU's iREAL Commission recommendation – to innovate and integrate healthcare education, research and delivery – by focusing on state-of-the-art research and enhancing funding opportunities in the areas of *biomolecular and biomedical science related to human health*. The BSI is multidisciplinary in conception and fosters collaborative research in areas of strength in the departments of Biological Sciences (specifically Molecular Biology), Chemistry & Biochemistry, and Physics. Sixteen core faculty members consider the BSI their primary Institute in which to conduct research; an additional 14 Collaborators from the College of Engineering & Computing, the Robert Stempel College of Public Health and Social Work, and the Herbert Wertheim College of Medicine are affiliated with the BSI. The cross-department and cross-college faculty

interactions create the potential for more innovative approaches to problems than those addressed by individual faculty alone. BSI integrates both basic and applied research. The faculty who will become Core BSI faculty published a total of 35 articles in peer-reviewed journals in AY 2013-14, expended 1.3M$ in grant funds in AY 2013-14, and obtained 2 provisional patents.

The Biochemistry doctoral program was established in 2011 and is a multidisciplinary program involving faculty in Chemistry and Biochemistry, Biological Sciences, and Medicine. The program has attracted high quality graduate students and postdoctoral students to FIU (18 Biochemistry PhD graduate students in AY 2013-14).

3. Proposed Cognitive Neuroscience Institute

The proposed Cognitive Neuroscience Institute (CNI), to be led by Dr. Angela Laird, will be a multidisciplinary group of faculty focusing on mental processes in the healthy and diseased human brain across the lifespan. The study of the mind and brain relates to the neurobiological mechanisms underlying all aspects of human behavior, including cognition, emotion, perception, and action. The CNI will host faculty members in the College of Arts & Sciences, the College of Engineering & Computing, the College of Education, the Herbert Wertheim College of Medicine, and the Nicole Wertheim College of Nursing and Health Sciences. The CNI will be designed to encourage collaborative research and scholarship that transcends typical disciplinary boundaries. CNI research will range over multiple scales of inquiry, from molecular to cellular to physiological to systems neuroscience, and will seek to translate basic research into novel health and educational solutions for the public. Of particular interest is research in higher cognition that underlies complex human behavior, such as attention, language, memory, and cognitive control. In AY2013-14, faculty proposed to be affiliated with CNI published over 40 articles in peer-reviewed journals and had over $800K in grant expenditures.

An interdisciplinary Graduate Certificate program in Cognitive Neuroscience began in spring 2013. Ten students are enrolled in this program and one graduated in spring 2014. A new cognitive neuroscience doctoral track within psychology will begin in Fall 2015 and three new tenure-track cognitive neuroscience faculty have been hired to start the program. This new group will overlap to some extent with the Center for Children and Families above.

II. HERBERT WERTHEIM COLLEGE OF MEDICINE

1. Continued Development of the Doctor of Medicine Degree Program

- Achieved Full Accreditation status from the Liaison Committee on Medical Education in February 2013
- Enrolled fifth cohort in August 2013 (122 students); graduated second cohort in April 2014 (43 students); will achieve planned total enrollment of 440 students in August 2015 and maximum planned enrollment of 480 in August 2016
- Class of 2014 achieved excellent match results in the National Board of Medical Examiners National Resident Matching Program: 42 of 43 students matched (98%)
- Class of 2014 achieved 100% pass rate on the United States Medical Licensing Examinations Step 1, Step 2 CK, and Step 2 CS
- NeighborhoodHELP™ interdisciplinary student teams have conducted 1,175 household visits to date this year (through May 9, 2014), up from 918 during the previous full academic year; patient visits to mobile health vans total 1,005 by 418 patients to date this year (through May 9, 2014), up from 644 visits (170 patients) during the previous academic year; plans are underway to increase the number of mobile health vans from 1 to 4, allowing greater community impact in future years

2. Research Extramural Funding Awards (July 1, 2013 through May 7, 2014)

- $3.37 million funding authorized this year (27 awards of which 18 are new this year; additional $290k pending receipt from National Institutes of Health)
- $27.38 million in proposals submitted
- $1.70 million in total R&D expenditures (as of March 20, 2014); approximately $1.24 million in direct costs and $458K in indirect costs

3. Clinical Practice: FIU Health

- Approximately 9,300 patient visits (July 1, 2013 through April 30, 2014); 13,000 expected by the end of the fiscal year
- $3.9 million total revenues, of which approximately $2.7 million derives from clinical services
- $1.3 million increase in total revenues over previous year ($800K of clinical net revenues)

III. NICOLE WERTHEIM COLLEGE OF NURSING AND HEALTH SCIENCES

1. From Medic to Nurse: The New Veterans Bachelor of Science in Nursing Program

Recently, the Nicole Wertheim College of Nursing and Health Sciences (NWCNHS) was awarded a $1.3 million grant from the Health Resources and Services Administration (HRSA), Department of Health and Human Services to implement the Veteran's Bachelor of Science Degree in Nursing (VBSN) program. The VBSN program is a BSN accelerated program for Veteran students, who are former military corpsmen and medics. The curriculum consists of competency exams (which equate to credits awarded for military training, education, and experience) and a semester by semester fast track draft of course sequencing. The program is aimed at improving health outcomes and reducing health disparities of the increasingly diverse South Florida population by relieving the shortage of registered nurses by educating medics and corpsmen as registered nurses. After completing their program, these Veteran RNs will provide culturally/ linguistically competent care to Veterans as well as populations in diverse healthcare facilities and communities.

FIU VBSN students will benefit from mentorship from nursing faculty (especially Veteran faculty) and BSN graduates. VBSN students will also gain value from the FIU Service member Certified Registered Nurse Anesthetist (CRNA) project where experienced Veteran BSNs who are pursuing their MSN and CRNA will provide social support and mentorship to the VBSN students. The FIU CRNA program boasts one-third of its enrollment as veterans. VBSNs will benefit from the FIU Department of Veteran and Military Affairs, where program advisement and One Stop Application/Registration services are provided. VBSN students will also have access to FIU's Center of Psychological Services and Office of Student Affairs Veteran support services which includes mentoring, tutoring, and transition support. FIU also has an on-site Veterans Assistance service. Support with challenges related to school finances is provided through the various military tuition assistance programs, GI Bill benefits, Veteran benefits, and VA benefits, which are individualized and customized to each student's specific needs. Students enrolling in this accelerated BSN program will have significant financial need for scholarship support in order to improve recruitment and retention and to avoid working multiple jobs to support their families while in the program. The College is actively seeking scholarship support to assist these Veterans and their families.

2. Nicole Wertheim College of Nursing and Health Sciences is Selected to Receive Two Prestigious Nursing Scholarship Awards

The Nicole Wertheim College of Nursing and Health Sciences was recently selected to receive two prestigious scholarship awards – the Jonas Nurse Leader Doctoral Scholarships and the Helene Fuld Health Trust Scholarships. The Jonas Center for

Nursing and Veterans Healthcare awarded FIU a $40,000 gift over 2 years to be matched by NWCNHS, for scholarships of up to $20,000 for 5 doctoral nursing students. The *Jonas Nurse Leaders Scholar Program* was created in 2008 to support educational development of new nursing faculty and stimulate models for joint faculty appointments between schools of nursing and clinical affiliates. The grants, made through institutional awards, also prepare doctoral candidates to help students address the needs of future patients – from dealing with co-morbidities and chronic illnesses to providing culturally competent care. Schools of nursing can apply for Jonas Scholarships by invitation only. This year FIU was invited to apply for the first time and received 5 doctoral scholarships for PhD and DNP students. Two of the scholarships are Veteran scholarships and focus on the Jonas Center's vision and intent to help improve the healthcare of US Veterans returning from Iraq and Afghanistan by supporting doctoral level (PhD and DNP) education advancement of nurses who will be involved in all levels of Veterans' healthcare, from administration and policy to direct patient care.

The College also received $650,000 from the *Helene Fuld Health Trust Scholarship Fund* for student scholarships in its accelerated second degree baccalaureate programs. These programs include the Foreign Educated Physician BSN Program, and an accelerated second degree BSN program which will enroll its first students during the 2014-2015 academic year. Schools of nursing can apply for Helene Fuld Health Trust Scholarships by invitation only. The grant will be paid in installments over a period of three years. In Year 1, a $150,000 gift will be used for $75,000 in scholarships for '14-'15 and $75,000 will be used to establish the Helene Fuld Health Trust Accelerated Nursing Student Scholarship Endowment. In Year 2, a $250,000 gift will be used for $125,000 in scholarships for '15-'16 and $125,000 to add to the endowment; and, in Year 3, a $250,000 gift will be used for $125,000 in scholarships and $125,000 in '16-'17 to add to the endowment. The monies generated by the endowment will be used to continue the College's Helene Fuld Health Trust Scholarship Fund.

In addition to these prestigious scholarship awards, the College also had the following significant contributions for this academic year thus far:

- A planned gift for $4 million for graduate nursing scholarships.
- A gift of $130,000 for BSN nursing scholarships.
- A gift of $60,000 for scholarships to assist 100% of nursing faculty members to complete their doctoral degrees and support nursing student scholarships.
- A gift of $55,000 for the Bedside Leadership Project.
- Gifts of $37,745 plus $34,113 in stock to fund the William Gutierrez Physical Therapy Scholarship Endowment.
- A gift of $50,000 for Nursing Scholarships.

3. Nicole Wertheim College of Nursing and Health Sciences is Finalist for the Veterans Administration Nursing Academic Partnership Program

The Nicole Wertheim College of Nursing and Health Sciences and the Miami Veterans Administration Healthcare System were recently informed that their proposal to become VA nurse academic partners was among a select group of finalists for the program. The Miami-based partners are expected to be awarded over $8 million in support from the Department of Veterans Affairs if selected for the program. Four VA nurse academic partners will be selected from across the nation. The Department of Veterans Affairs Nursing Academic Partnerships (VANAP) program is designed to foster the development of closer relationships between VA facilities and schools of nursing (SON) with baccalaureate degree programs.

This program provides the financial and consultative resources to enable substantive change in VA/nursing school relationships and promote innovation in nursing education and practice. VA facilities and affiliated nursing schools committed to enhancing academic partnerships were invited to submit proposals to participate in this program. It is a requirement that sites develop and implement a post-baccalaureate nurse residency (PBNR) program for accreditation. The VANAP will leverage academic and clinical resources to increase student enrollment, enhance VA VANAP faculty competencies and professional scholarship, revise the school's academic curriculum to include Veteran specific health problems, develop interprofessional education, develop Veteran-centric practice and education initiatives and increase the recruitment and retention of VA nurses. Sites selected for VANAP will be required to develop and implement a Veteran-centric PBNR curriculum and program evaluation and successfully obtain CCNE accreditation. The majority of clinical training in this program will occur within the VA healthcare system. Other university finalists in addition to FIU included the University of Alabama, University of Michigan, University of Memphis, University of Missouri-St. Louis, University of San Francisco, and Texas Women's University.

IV. Robert Stempel College of Public Health and Social Work

Faculty in the College of Public Health & Social Work have been actively involved in developing and implementing collaborative research across many, if not most, of Florida International University's colleges and academic centers. Major collaborative research efforts, not including those of individual faculty participating in individual grant activities, are in the College's research centers and groups. The collaborative research activities presented in the report represent funded and unfunded initiatives. Where informative, dates for completion of activities, such as the submission of whitepapers and applications, are presented.

1. Integrated Biostatistics Center

The purpose of the Integrated Biostatistics Center (IBC) in the Robert Stempel College of Public Health & Social Work is to provide critical research support services to the University community. The IBC assists investigators to conceptualize, develop, and implement their research projects. In doing this, the IBC provides competent and timely support for developing research designs, research methodologies, and data management and data quality plans and solid biostatistics, statistics, and psychometrics expertise. Recently, basic operations of the IBC were funded by FIU for the remainder of 2013-2014 through 2014-2015.

In 2013, the IBC provided biostatistical and data management services to 94 projects from ten FIU colleges and centers. Seventy percent of IBC's collaborative projects was with faculty conducting in the College and Centers. A further 20% of work performed by the IBC was for doctoral students working on their dissertations and professional staff involved in research projects in the research centers. The remainder of effort in 2013 was provided to scientists outside FIU, including Baptist Hospital, Camillus House, the Behavioral Science Research Institute, and the Planning Center for Community Health. The IBC expects to increase its internal and external collaborative research efforts in 2014.

Consistent with IBC's plans to grow its collaborative research portfolio, the IBC has recently entered into an agreement to manage data for a collaborative U24 grant involving investigators at the University of Florida and Florida International University. The IBC will provide data management support to build a shared project database between UF and FIU. The IBC is also negotiating with U24 investigators to develop a budget for infrastructure support and joint database development through 2014-2015. Most recently, the IBC led the development and submission of an application to the Florida Department of Health to fund the FIU Tobacco Control Infrastructure Initiative (TCII). The purpose of TCII, if funded, will be to develop accessible and sustainable infrastructure to support tobacco control research in Florida. With youth and novel tobacco use methods (e.g. e-cigarettes, hookah) as the initial target, the grant would support a broad tobacco control research agenda. This agenda addresses three overarching issues: 1) the need in Florida for infrastructure to support tobacco control research; 2) an emerging epidemic of novel tobacco use methods in Florida in the absence of an adequate policy/regulatory framework; and 3) the availability of expertise in evidence-based research to foster policy development for novel tobacco use methods and other tobacco control issues. The application was a collaborative effort among faculty from the Colleges of Medicine, Arts and Sciences, and Public Health and Social Work.

2. Proposed Center for Health Economics and Strategic Solutions

The mission of the Center for Health Economics and Strategic Solutions (CHESS) is to assist government, business, and community-based organizations (CBOs) reach critical health policy and economic strategy goals and to contribute the University's expertise in health program design, implementation, and outcomes evaluation. In other metropolitan communities where schools of public health have established similar centers, these centers have become part of regional '*health ecosystems,'* where scientists are working with community organizations to design and implement new health strategies. Services CHESS will provide include, health services research, program and strategic design, resource center for successful health strategy models and tools, and data analysis, interpretation and graphic representation.
Faculty from the Colleges of Medicine, Arts and Sciences, Business, and Public Health and Social Work and the School of Integrated Science and Humanity met in early May to develop mission and vision statements for the Center. The vision of CHESS is to employ the synergies of industry, academics, and scientific inquiry to create a new data analytics paradigm to improve health and wellness of the citizens of Florida and the nation. The mission of the Center is to use multidisciplinary analytical methods to improve the delivery of cost-effective, strategic solutions to healthcare organization, management, quality, and payment options. While it was understood that the cornerstones of the Center will be health economics and health informatics, CHESS was committed to drawing from a wide scope of academic and professional disciplines to develop economically viable and sustainable solutions to health and healthcare problems. Participants recognize that developing viable and sustainable solutions begins by clearly identifying health and wellness as the products of social, political, and individual level factors and by recognizing that viable and sustainable solutions for improving health and wellness can only be achieved through a multifaceted approach. Solutions to increase health and wellness range from designing neighborhoods to encourage walking and other healthy activities to designing programs to increase the intake of healthy fruits and vegetables. The source of these innovative solutions will be the synergy that develops between experts in architecture, bioengineering, business, clinical medicine, computer science, data management, health economics, health informatics, law, policy analysis, psychology, urban planning, and other disciplines and the communities in which the solutions are to be implemented.

To propel the trajectory of CHESS forward, the faculty proposed to complete four projects before September 2014. Reports of the four projects, which will be new projects completed during the summer, will become the basis of a white paper to be delivered to the FIU and South Florida communities. The purpose of the white paper will be to demonstrate the potential of CHESS to further health and well-being.

3. Virtual Center for Community Health

The vision of the Virtual Center for Community Health (VCCH) was developed to promote community health through innovative research, training, and service. The aims of the VCCH at FIU are to bring the interdisciplinary expertise and resources available at FIU together in a concerted and comprehensive approach in partnership with community members and stakeholders to address the health needs of communities in South Florida. The Center's focus on community heath is consistent with the Academic Health Center's goals, and creates a unique opportunity for greater communication and collaboration across colleges by leveraging the strengths and expertize in place at FIU. Although housed in the College of Medicine, the Center involves faculty from all FIU colleges and non-FIU faculty interested in taking advantage of the unique opportunities provided by the Center. Initially, faculty involved in conceptualizing and developing the Center's vision and aims are in the College of Medicine and the College of Public Health & Social Work. The Center is co-led by Pedro J Greer, Jr. (CoM) and O. Dale Williams (Stempel). A Center data team consists of Wasim Maziak (Stempel) and Juan Acuna (CoM).

In April members of the Center met with scientists from RAND Corporation to discuss data collection and management needs. Possible research questions and areas were discussed. Members of the Virtual Center are anticipating the delivery of the results of the RAND visit.