



September XX, 2011

Dear Chairman Calabro,

We appreciate the public invitation from Mr. Jeff Gregg, Executive Director of the Florida Commission on Review of Taxpayer Funded Hospital Districts (Commission) to provide written documentation of any concerns, problems or flaws with the financial and outcome data provided to members of the Commission. On behalf of the members of the Safety Net Hospital Association of Florida (SNHAF) some of which are subject to the review of the Commission, please find a list and explanation of our current concerns at this time. A number of hospital s identified significant issues with the way the data was reported, both because of inaccuracy in the data and methodologies for reporting the data that left inaccurate impressions.

The issues fall into the following categories:

**1) Provide tax trend information through 2012**

For most public hospitals, both the tax rate and the absolute value of tax collections have been declining substantially in recent years. The data matrix provides Hospital local tax revenue for 2010. Currently the tax decisions of local taxing districts are available through 2012 and provide a more accurate real time measure of hospitals’ access to these revenues.

For example, the following table provides a trend of property tax for Halifax Health through 2012, reflecting real time data for 2012 of \$12.5 million (36.3% lower than the information published in the data matrix for 2010).

	<b><u>Fiscal Year Ended September 30</u></b>					
	<b><u>2007</u></b>	<b><u>2008</u></b>	<b><u>2009</u></b>	<b><u>2010</u></b>	<b><u>2011</u></b>	<b><u>2012</u></b>
<b>Taxable Value Billions</b>	\$19.1	\$20.3	\$18.5	\$15.3	\$13.4	\$12.5
<b>Millage Rate</b>	2.76	2.50	2.25	2.00	2.00	1.75
<b>Property Taxes Levied millions</b>	\$52.7	\$50.7	\$41.6	\$34.4	\$26.8	\$21.9
<b>% decline from prior year</b>		3.8%	17.9%	17.3%	22.1%	18.3%
<b>% decline from 2010 to 2012</b>						33.6%

**Requested Action** – We request that the data matrix include a recent history of tax rates and revenues from 2007 through the 2012 budget year. We believe these trend data will provide a more accurate real time look at hospitals’ use of local taxes. Given the charge of the Commission, we are certain that the most recent data would be the most relevant and important to Commissioners and the public.

**2) Provide gross and net Low Income Pool (LIP) and Disproportionate Share Data (DSH)**

The current data matrix publishes only gross LIP and DSH distributions, which include IGT (Inter-Governmental Transfers) revenues that are contributed by local governments and returned to the contributing governments by the LIP formula. We believe the use of gross distributions instead of net distributions produces misleading results and is in conflict with the way the LIP Council, ACHA and the Legislature describe these distributions. For example, the LIP distribution in the Data Matrix for Sarasota Memorial Hospital is \$23,090,112 for FY 2011-12. This total includes the IGTs that Sarasota Memorial sent to the State to enable the State to draw down the Federal share of the \$1.0b in LIP funding.

The IGTs benefit the entire Florida Medicaid program and 70 hospitals through out Florida, not just Sarasota Memorial. For FY 2011-12, the amount that Sarasota Memorial actually benefitted from LIP is only \$1,808,791. We believe using the gross LIP distribution amounts in the report will distort the true underlying relationship and confuse the Commissioners and the public.

**Requested Action** - We request that commission staff amend the data matrix to include both the gross and net LIP and DSH distributions, and that an explanation be provided in the body of the report that clarifies the relationship between gross and net distributions in the LIP and DSH programs.

**3) Explain hospital variation in cost by adjusting costs for variation in case mix**

During the hearings, both Commissioner Kelly and Commissioner Duncan have indicated that the data on cost per adjusted admission in the data matrix needs to be adjusted to reflect the wide variations in case mix between hospitals. For example, the financial matrix provides the cost per adjusted admission for each hospital, which varies from a low of \$2,547 to a high of \$17,390. The data matrix also provides a Case Mix Index for each hospital, which is constructed using national data to control for the variation in each hospital’s procedure mix. The Case Mix Index ranges from a low of .7250 to a high of 2.1460. Hospitals that provide tertiary and specialty services tend to have a patient mix weighted to the expensive procedures and consequently have a relative high case mix index compared to community hospitals. The largest portion of the variation in hospital cost is explained by adjusting Average Cost Per Adjusted Admission data as reported in the data matrix for hospital variation in case mix. Failure to make this adjustment significantly distorts the underlying variation in hospital costs.

**Requested Action** – We understand that ACHA publishes a Standardized Cost Per Admission data set for each hospital that adjusts Cost per Adjusted Admission for case mix. We request that you include this critical measure in explaining cost variations in the data matrix. You can describe the importance of this adjustment in the body of the report.

**4) Explain hospital variation in cost by adjusting for county variations in cost of living**

A significant portion of the Cost per Adjusted Admission variation between hospitals can be explained by regional variations in cost of living. The Florida Legislature uses the Florida Price Level Index to adjust for cost of living in Public School Funding. This county cost of living ranges from a low of .8823 to a high of 1.0523. Cost of living directly influences many of the expenditure categories in every hospital.

**Requested Action** – The Standardized Cost Per Admissions variable published by ACHA not only controls for case mix but also controls for regional variation in price-level. We request that you include this measure in the data matrix. You can explain the importance of controlling cost for regional variation in cost of living in the body of the report.

**5) Explain hospital variation in hospital costs by adding additional columns to reflect unique specialty services provided by hospitals and by acknowledging that hospital costs can vary by the severity of illness within a standardized procedure group**

The data matrix currently identifies only a few of the critical life-saving programs and services offered by hospitals (OB services, Trauma Level 1 and 2 designation and Baker Act). The listing of these services beyond Acute Care Beds and Specialty beds begins to identify services that differentiate between hospital systems, but does not illuminate that many essential specialized hospitals services are provided by a only few hospitals. For example, a number of specialized hospitals such as statutory teaching hospitals, children’s hospitals, or hospitals with burn units have the expense of those programs and services embedded in their cost structure. By limiting the identification of specialty services to only a few life saving services, the Commission and the public are given only a narrow view of the diversity of hospital services and their potential impact on average cost.

In addition, while the Case Mix Index controls for the variation in each hospital procedure mix, it does not control for hospital variations in severity of patient illness within a procedure group. A significant portion of the cost per adjusted admission can be explained by this variation. Higher acuity services such as those found in trauma units, disproportionate specialty beds, burn units and emergency visits, can increase severity of illness, and thus cost within a procedure group. Variation in a hospitals average severity of illness contributes to hospital variations in Cost per Adjusted Admission.

**Requested Action** – We request that the data matrix be expanded to include other critical hospital designations: Burn Unit, Regional Perinatal Intensive Care Center (RPICC), Pediatric Trauma Center, Statutory Teaching Hospitals and those that include a children’s hospital under their main hospital license. We are also request that the body of the report include a comprehensive discussion on the impact of variations in severity of illness and the impact that expanded services have on Cost per Adjusted Admission.

**6) Debt-to-Equity Ratio is highly misleading in comparisons between public, not-for-profit and for-profit hospitals**

The Debt-to-Equity Ratio in the Data Matrix for many for-profit hospitals shows a ratio of zero or near zero. In comparisons with public and not-for-profits hospitals, this measure distorts the relative debt positions of for-profit hospitals since their corporate office records much of the debt of for-profit hospitals.

**Requested Action** - We request that the Debt-to-Equity Ratio be eliminated from the Data Matrix or that the body of the document include clarification that this measure cannot be used to fairly compare with different types of hospitals.

**7) Total Margin is highly misleading in comparisons between public, not-for-profit and for-profit hospitals**

The Data Matrix includes a Total Margin Percentage measure which uses Total Operating Revenue in the denominator instead of the Total Revenue, which we believe is a more accurate representation of Total Margin. Accounting differences between not-for-profit and for-profit hospitals in the handling of investment income and management fees distort comparisons between the hospital systems and make them highly misleading.

**Requested Action** - We request that the Total Margin Percentage be eliminated from the Data Matrix or that a detailed description of the accounting differences between hospital systems be included in the body of the document.

The information above represents the major, immediate issues that we have identified thus far with the published data on your website. We understand the importance of having accurate, reliable data as you proceed with the task of issuing policy recommendations. We will provide you with further information as we continue our review process of the data. Additionally, we believe that individual hospitals will also submit information regarding issues that are unique to their institutions. We will collect these changes and corrections and submit them to you and your staff in a separate communication.

Again, thank you for the opportunity to raise issues of concern with the Commission. We look forward to your response to our concerns and requests.

Sincerely,

Dr. James A. Zinale

cc. Jeff Gregg and each of the Commissioners