SNHA Safety Net Hospital Alliance of Florida

May 22, 2015

Office of Governor Rick Scott
State of Florida
The Capitol
400 S. Monroe St.
Tallahassee, FL 32399-0001

Dear Governor Scott:

It is with pleasure that I write in response to your May 8, 2015, correspondence. We were gratified to read of your focus on alternatives to "assist the institutions who most need funding assistance."

We thank you for your support of Florida's Low Income Pool (LIP) Program and efforts to renew the LIP waiver. The supplemental funding that LIP adds to Florida's Medicaid hospital reimbursement rates is critical to safety net hospitals providing care to large volumes of Medicaid patients. We stand in support of the Florida LIP redesign model submitted to US Department of Health & Human Services.

The Safety Net Hospital Alliance of Florida's (SNHAF) 14 members represent Florida's top teaching, public, children's, and regional perinatal intensive care center hospitals. SNHAF members shoulder a disproportionate share of Florida's hospital care responsibilities while providing highly specialized medical care and innovation. While SNHAF members account for only 10% of the state's hospitals they provide 100% of all pediatric level one trauma care, over 88% of all level one trauma care, 72% of graduate medical education programs, 41% of all charity care, 40% of all Medicaid days, and 25% of all hospital admissions. In fact, we provide almost 2½ times more charity care days than all of the for-profit hospitals in the state combined.

The SNHAF has been assisting state and national policy makers construct effective Medicaid policy more than three decades. We look forward to working with the *Commission on Healthcare and Hospital Financing* and discussing ideas for hospital profit sharing. We recommend that the Commission establish goals and objectives, as well as a common set of terms and definitions to ensure profit sharing scenarios offer comparative values. Unfortunately, the Florida Hospital Uniform Reporting System (FHURS) and the hospital profile data requested by the Commission are both inadequate and will not effectively support the Commission's analysis of hospital operating margins, thus hindering deliberations on revenue sharing scenarios.

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First, the Commission should use "operating margin" and not "total margin" as the basis for hospital-to-hospital profitability comparison. Operating margins reveal the true financial status of a hospital and a realistic picture of the day-to-day finances required for patient care and hospital operations. On the other hand, total margin data comparison is meaningless when applied for this purpose because total margins include other categories of finances such as capital outlay and reserve investments that can significantly vary from year to year and are subject to financial markets. Accordingly, the Commission should immediately remove or modify the total margins interactive margin tool on their website.

Second, the Commission should examine all operating cost data, including data on costs unique to mission-driven hospital systems that support Florida's communities. For example, the Commission should examine how hospital systems reinvest in their community's by: operating clinics serving low-income residents in underserved areas; providing for a continuum of care through home health care and skilled nursing care; and by offering physician specialty diagnostic and treatment services no longer available in the traditional physician office setting. These healthcare delivery centers, both inside and outside of the hospital setting, play an essential role in hospital system-wide operations and should be considered when conducting a comprehensive margin analyses.

Failure to define and incorporate these vital services in your cost analysis will result in an incomplete evaluation of hospital operating margins. For these reasons, and in order for the Commission to reach the desired goals as set forth in the Executive Order, the Commission should request a tailored hospital operating margin template be designed, with input from the hospital industry, for a sound foundation for decision-making.

Lastly and of critical importance, once a consensus is reached on a tailored uniform hospital operating margin template, the existing federal LIP funds must be deleted from the ledger's base. In order for the Commission to address options to offset the loss of federal LIP funds, the ledger must not account for the federal LIP funding currently in the Medicaid system.

Most Safety Net Alliance hospitals caring for the state's highest percentage of sick and vulnerable citizens would immediately fall into the red if they lost their LIP supplemental rate enhancements. In fact, the expiration of the LIP program would not only strip away the positive margins of most of our members, it would result in an overall operating deficit of over half-a-billion dollars or an average deficit worse than negative six percent.

On behalf of the hundreds of thousands of pediatric and adult patients, medical residents, and employees of SNHAF hospitals', we look forward to working with you and the Commission.

Regards,

Anthony P. Carvalho

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