



May 12, 2015

Thomas J. Betlach, Director
AHCCCS
801 E. Jefferson St., MD 4100
Phoenix, AZ 85034

Re: *Provider Rate Reductions*

Dear Director Betlach:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our 71 hospital members, thank you for the opportunity to offer preliminary comments on the provider rate reductions authorized by Laws 2015, Ch. 14.

AzHHA is a statewide association of primarily hospitals and health systems. Our members provide a mix of short-term acute care, behavioral health, rehabilitation, long-term acute care and specialty medical services. They are located throughout the state, providing care to both rural and urban communities.

According to the AHCCCS website, the Administration is requesting information relating to the following factors, which will be used to assist the agency in developing rate changes:

- Medicaid population(s) served;
- Operating margins;
- Factors driving provider costs;
- Impacts of rate reductions.

Before addressing these specific factors, I would like to offer some general comments reflective of AzHHA's overall position on the budget cuts as proposed this past legislative session. First and foremost, our members continue to tell us that the trajectory the state is on—relying on provider rate cuts to “finance” the AHCCCS program and/or balance the state budget—is simply not sustainable over the long run. As you know, hospital, physician and other provider rates have been frozen and/or cut on a regular basis over the past seven years. For hospitals, the cumulative impact since 2008 of rate freezes, cuts and other reductions to AHCCCS reimbursement is \$911 million—a 38 percent reduction.¹ While AzHHA's Board of Directors was prepared to

¹ See the attached table for a breakout of these cuts.

reluctantly accept a 3 percent rate cut as proposed by Gov. Ducey, this was coupled with a position that the Legislature must find a way to start restoring funding in the near future. To continue to rely on hospitals and other providers to finance the Medicaid system and/or to pay for other state programs cannot continue, or at some point the provider network will begin to crumble.

Second, as the Administration looks to shift risk to providers through value-based purchasing, providers will justifiably expect some predictability around their actual risk exposure. Rate cuts enacted to simply balance the budget are not sound public policy around which to build a value-based system.

Having said this, we understand the AHCCCS Administration must function within their appropriated budget. With this in mind, we urge the Administration to build flexibility into the rate changes to allow rates to increase based on lower than expected utilization or other factors or data that become known down the road. And, it appears the Administration may be considering this—through a value-based incentive payment. We wholeheartedly support tying payment to value as a strategy for achieving the Triple Aim. However, before performance metrics and incentive payments are developed, data should be vetted and there should be some broader policy dialogue and consensus regarding the specific quality, health status or patient experience goals, the desired outcomes and appropriate interventions. This can be a very labor intensive and time consuming process. We are concerned that the time frame for enacting the FY 2016 rates may be too short to develop an optimum program. However, we look forward to having the dialogue with the Administration and other stakeholders.

Medicaid Populations Served

The payer mix at Arizona hospitals varies based primarily on location and services offered. Based on third quarter 2013 through second quarter 2014 inpatient encounter data, the AHCCCS payer mix at Arizona hospitals ranged from a high of 95.5 percent to a low of .04 percent. The mean was 23 percent. Seven hospitals or healthcare systems had AHCCCS caseloads of more than 40 percent. These included: two critical access hospitals; two behavioral health hospitals; two children's hospitals and one urban safety net hospital. Eighteen hospitals or healthcare systems had an AHCCCS payer mix greater or equal to 25 percent. In addition to the types of hospitals listed above, this group included larger urban facilities and sole community hospitals.

Based on the encounter data reported to the Department of Health Services, hospitals tend to have a higher AHCCCS payer mix for emergency department (ED) utilization. The range was 71.4 percent to 4.2 percent, with a mean of 33.9 percent. While not all hospitals provide ED services, of those that do, ten had AHCCCS caseloads exceeding

40 percent. Twenty-seven hospitals had an AHCCCS payer mix greater than 25 percent.

While Medicaid caseload is a significant factor in evaluating a healthcare providers' or group of providers' financial exposure, it should not be viewed in a vacuum. Other public payers, such as Medicare, also set reimbursement rates. The higher the public payer mix, the more difficult it is to cost shift Medicaid losses to other payers. For the quarter listed above, the public payer mix for Arizona hospital inpatient services ranged from 95.5 percent to 4.3 percent, with a mean of 71.4 percent. All hospitals, but one, had a public payer mix exceeding 40 percent. For ED services, the range was 92.1 percent to 51.4 percent, with a mean of 73.3 percent. Clearly, Arizona hospitals have a very substantial public payer mix. On the one hand, this makes them a valuable community asset. On the other, it makes them very vulnerable to rate cuts by government payers—more so than ambulatory care providers, who may have a larger commercial payer mix.

Operating Margins

The AHCCCS Administration reports annually on “Uncompensated Care and Hospital Profitability.” The most recent report filed in October 2014 includes information on Arizona hospital operating margins for 2012 and 2013. According to this report, the average operating margin for 2013 was 4.9 percent, with a range of 39.6 percent to negative 28.7 percent. Nearly one-quarter of hospitals had a negative operating margin in 2013.

As noted in the AHCCCS report, it is ‘important to understand the role that [the Safety Net Care Pool] SNCP played’ in 2012 and 2013. In 2012, the SNCP provided \$185 million in funding for three hospitals. This amount grew to \$510 million for 12 hospitals in 2013. With the elimination of SNCP for all hospitals except Phoenix Children’s Hospital, margins began to decrease in 2014. While publicly reported financial data for 2014 will not be available for several weeks, AzHHA’s monthly financial survey of hospitals shows a statewide margin of 2.2 percent in 2014. This is based on survey data collected from 79 percent of hospitals based on inpatient cases. For the 12 months ending February 2015, the statewide margin dipped to 1.9 percent. Over a quarter of hospitals continue to report a negative operating margin.

Uncompensated care has clearly decreased as a result of the restoration of Prop. 204 and further expansion of insurance coverage under the *Affordable Care Act*. However, underpayment by AHCCCS and other government payers—which make up a significant portion of hospital payers—continues to put downward pressure on hospital margins. Hospitals tell us that these underpayments are a key factor that threatens to destabilize their financial security. Reflecting this concern, it is noteworthy that eight Arizona hospitals filed for bankruptcy in 2013 and 2014, and

eleven either merged or entered into agreements to merge with other organizations. Moving forward, the legislative proposal to sweep additional federal disproportionate share hospital (DSH) funds into the state general fund will have a further destabilizing impact on safety net hospitals.

Factors Driving Costs

Based on 2013 Medicare Cost Reports, salary and benefits account for approximately 47 percent of Arizona hospital costs. For several hospitals this amount exceeds 60, even 70 percent. A significant portion of salary expenditures comes from nursing staff, which comprise the backbone of the hospital workforce. This is not an area where hospitals can simply cut back and reduce “production” as other industries can. Hospitals must meet strict acuity staffing requirements under state licensure requirements and patient safety requirements under Medicare Conditions of Participation. If staff is reduced, it generally means a loss of service to the community—especially if the cuts are in clinical areas. On the other hand, if the workforce continues to constrict as is anticipated, labor costs will undoubtedly increase—a cost that is not being recognized in the AHCCCS rates.

Moreover, a patient who enters a hospital with an emergency medical condition must be screened, treated and stabilized under Federal EMTALA requirements. Under state and federal law, the patient may only be discharged once it is ‘safe’ to do so. While hospitals have developed sophisticated and efficient staffing models, safe patient care is of paramount importance. And, it is a significant cost for an enterprise that must be open to all 24 hours a day, seven days a week—in comparison to ambulatory care centers.

Complicated federal and state regulatory and payer requirements also drive up the cost of care. Hospitals must invest significant resources in back office operations to comply with coding, billing, licensure, and myriad other legal and payer requirements. The transition to electronic health records has cost hospitals millions of dollars more than was funded through Meaningful Use incentive payments. And not least of all, hospitals must continue to invest in medical technology, replace surgical and diagnostic equipment, and purchase pharmaceuticals and other patient supplies—the cost of which continues to go up despite what AHCCCS reimburses hospitals.

Impact of Rate Reductions

Cuts to AHCCCS reimbursement will impact hospitals and patients they serve differently, depending on the hospital’s payer mix, the services they deliver, and whether the hospital is a sole community provider. I am confident that individual hospitals can and will communicate specific impacts themselves. Having said this, the following are options that hospitals will likely consider:

- Hospitals with a diverse payer mix will attempt to shift additional losses to commercial insurers and businesses—a “hidden healthcare tax.”
- Hospitals with high Medicaid utilization or a high concentration of Medicaid, Medicare, and self-pay patients will certainly not be able to shift all these unpaid costs to other payers. They will absorb the losses by reducing services and ultimately staff, further exacerbating Arizona’s slow economic recovery. The community’s access to certain services may suffer.
- Sole community hospitals, many of which also cannot shift unpaid AHCCCS costs to other payers, will evaluate high-cost services such as obstetrics and pediatrics, and whether they can continue to offer these services at a loss. If these services are discontinued at a sole community hospital, all patients lose access to these services, not just AHCCCS members.
- All hospitals will have fewer resources to invest in innovative practices that are improving quality and driving down the long-term cost of care.

In closing, I would like to thank the AHCCCS Administration for the opportunity to provide preliminary comments on pending rate cuts. We believe Arizona’s hospitals and the caregivers they employ provide high quality, cost-effective healthcare. Our members are always striving to improve—to create better health and more value for the communities they serve. However, this is becoming an increasingly difficult endeavor given the state budget trajectory and penchant for cutting rates again and again. This situation creates a lack of predictability, which undermines the strategic planning and investments that are necessary to transition to the second cost curve.

We urge the Administration to build as much flexibility into the rate structure as possible in order to restore funding if changes to utilization or other factors make this possible. We look forward to collaborating in the future on ways we can drive additional efficiencies through prevention or other mechanisms so as to place less pressure on provider rates during budget crises and economic downturns. Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me at 602-445-4300.

Sincerely,



Debbie Johnston
Senior Vice President, Policy Development