Banner Health

Banner Health
1441 North 12th Street
Phoenix, AZ 85006
602-747-4277
www.BannerHealth.com

August 4, 2009

Anthony D. Rodgers, Director
Arizona Health Care Cost Containment System
801 East Jefferson
Phoenix, AZ 85034

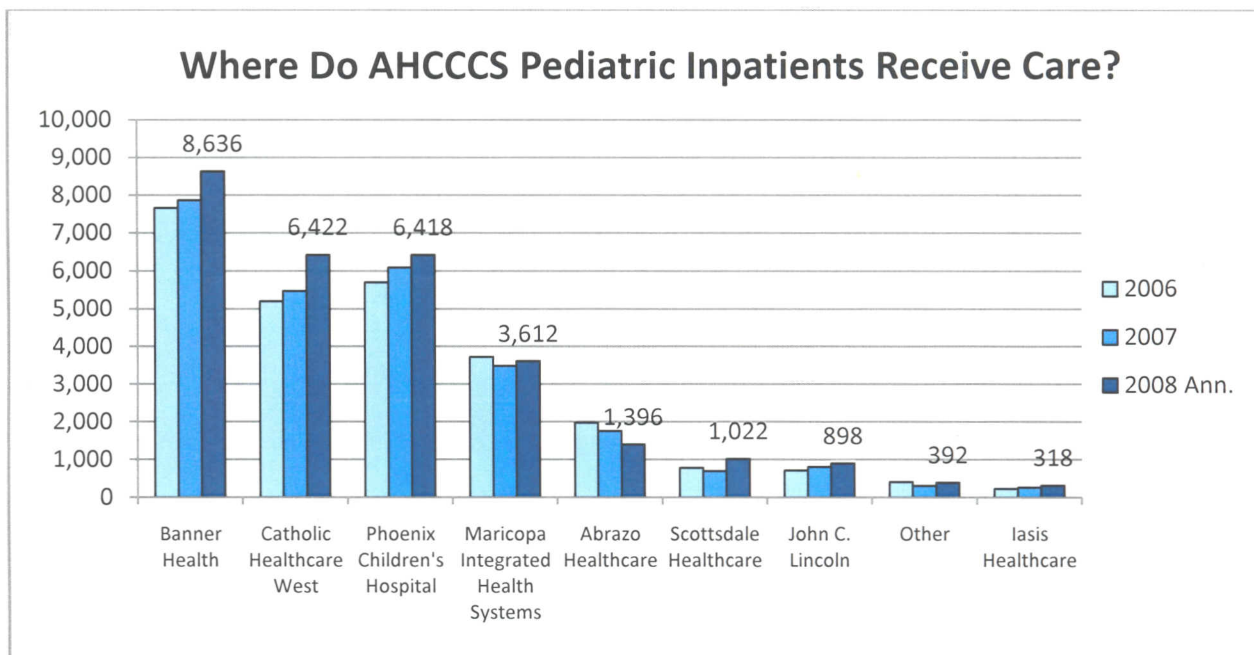
Dear Director Rodgers,

The Arizona Health Care Cost Containment System (AHCCCS) Administration established a fee schedule in 2004 to reimburse hospitals for outpatient medical care. The outpatient fee schedule provides rate adjustments for several peer groups including a 113 percent adjustment for a freestanding children's hospital that has at least 110 pediatric beds (A.A.C. R9-22-712.35). This special rate adjustment applies to a single hospital, establishing an unlevel playing field for pediatric providers as there are many hospitals across the state that serve a large number of children who are covered by AHCCCS.

While some peer group adjustments have merit, such as rate adjustments for public hospitals and small rural hospitals, there is no justification for a special rate adjustment for a freestanding children's hospital. In fact, there are several reasons the Administration should pay all hospitals the same rate for outpatient pediatric care.

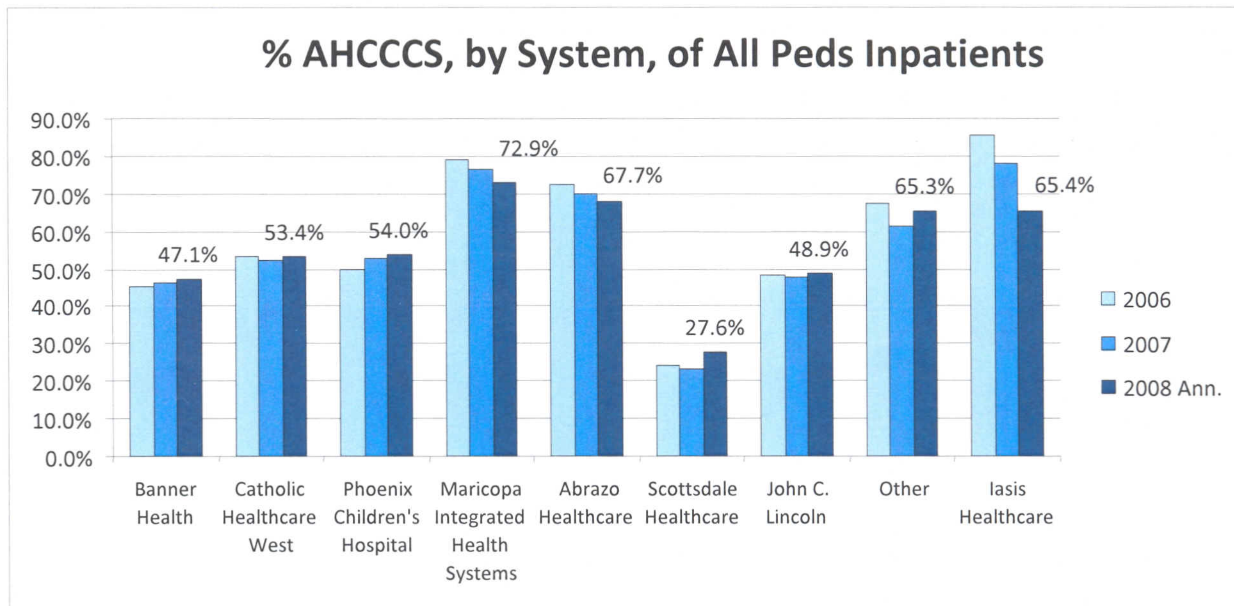
Many hospitals are committed to preventing, diagnosing and treating complex childhood diseases, injuries and medical conditions. According to 2008 inpatient discharge data that is reported to the Arizona Department of Health Services (ADHS), the vast majority of children who are covered by AHCCCS and receive inpatient services at Maricopa County facilities are treated by full service acute care hospitals that serve patients of all ages.

**FIGURE 1: AHCCCS Pediatric Inpatient Caseload**



For many of these hospitals, nearly half or more of their total inpatient pediatric volume is covered by AHCCCS. This is significant given the fact that AHCCCS reimbursement accounts for only 76 percent of hospitals' costs, on average.

**FIGURE 2: AHCCCS Pediatric Inpatient Mix**




With respect to outpatient data, hospitals only report data relating to emergency department visits. As you can see in Figures 3 and 4, the majority of AHCCCS-covered children visit emergency departments at non-freestanding children's hospitals. More so, nearly half or more of the total emergency department volume at these hospitals is covered by AHCCCS.

**FIGURE 3: AHCCCS Pediatric Emergency Department Visits**

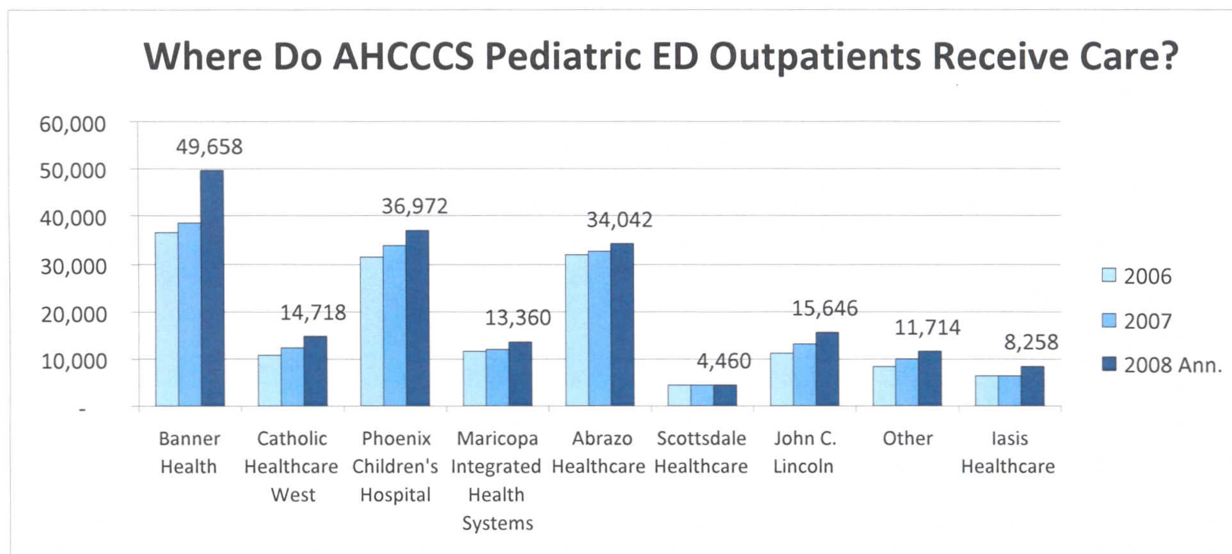
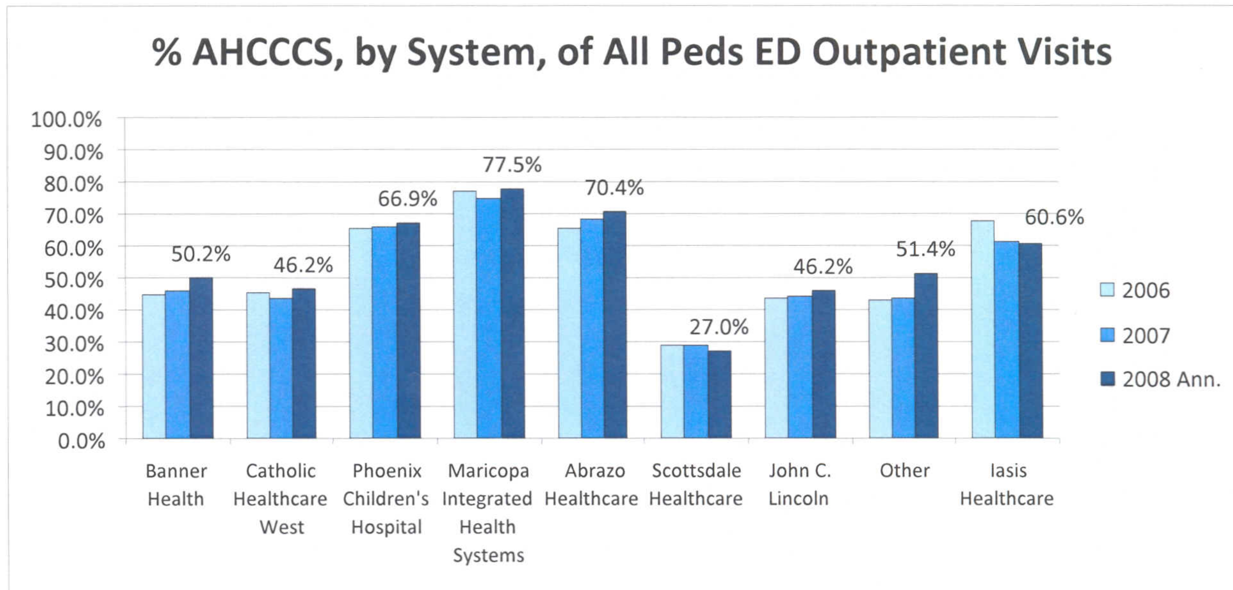


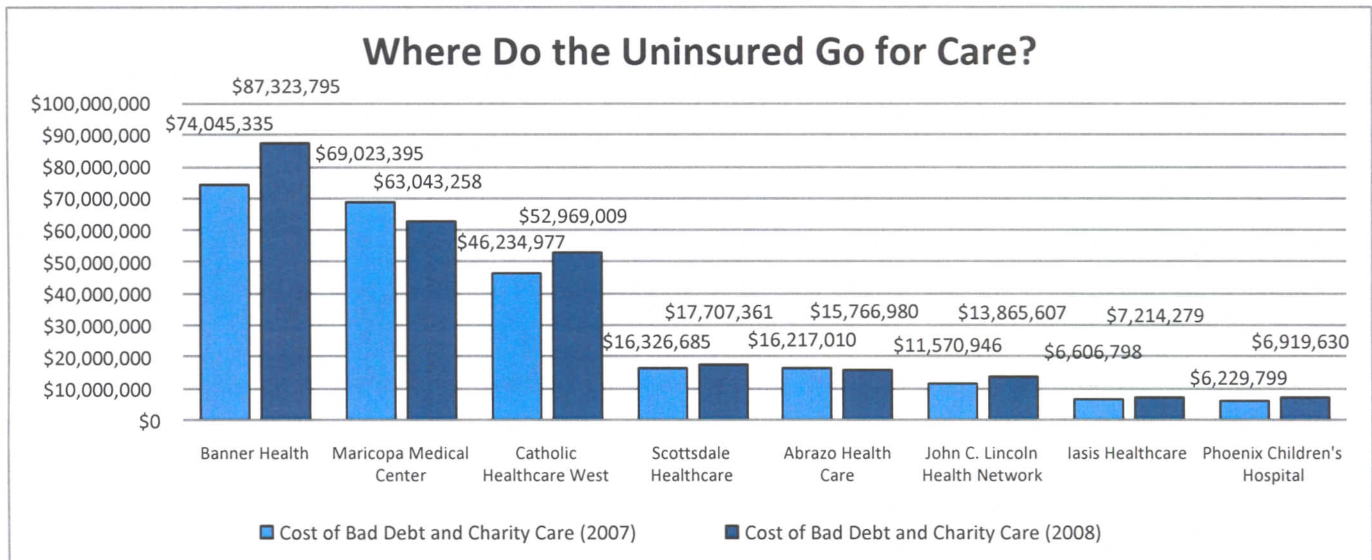
**FIGURE 4: AHCCCS As A Percent Of Pediatric Emergency Department Visits**




We understand that freestanding children's hospitals argue that they cannot cost shift to adult populations like other hospitals. The cost shifting phenomenon has been well documented and was quantified earlier this year by the Lewin Group on behalf of the Arizona Chamber Foundation (see attachment). The Lewin study revealed that private insurers paid 40 percent above hospital costs, enabling hospitals to cover payment shortfalls from Medicaid, Medicare and uncompensated care. All hospitals are forced to cost shift to the commercial market, regardless of whether the coverage is for a child or adult. It is the commercial market that pays for government underpayments and since freestanding children's hospitals also treat commercially covered patients, they engage in cost shifting like every other hospital.

Another cost of our current system of financing healthcare is the provision of charity care to patients who are unable to pay for their medical care. Here too, it does not appear that a freestanding children's hospital is disadvantaged by their charity care burden as shown in Figure 5.

**FIGURE 5: Uncompensated Care Costs**




Source: 2007 & 2008 Arizona Hospital Uniform Accounting Reports extracted from http://www.azdhs.gov/plan/crr/cr/hospitals.htm

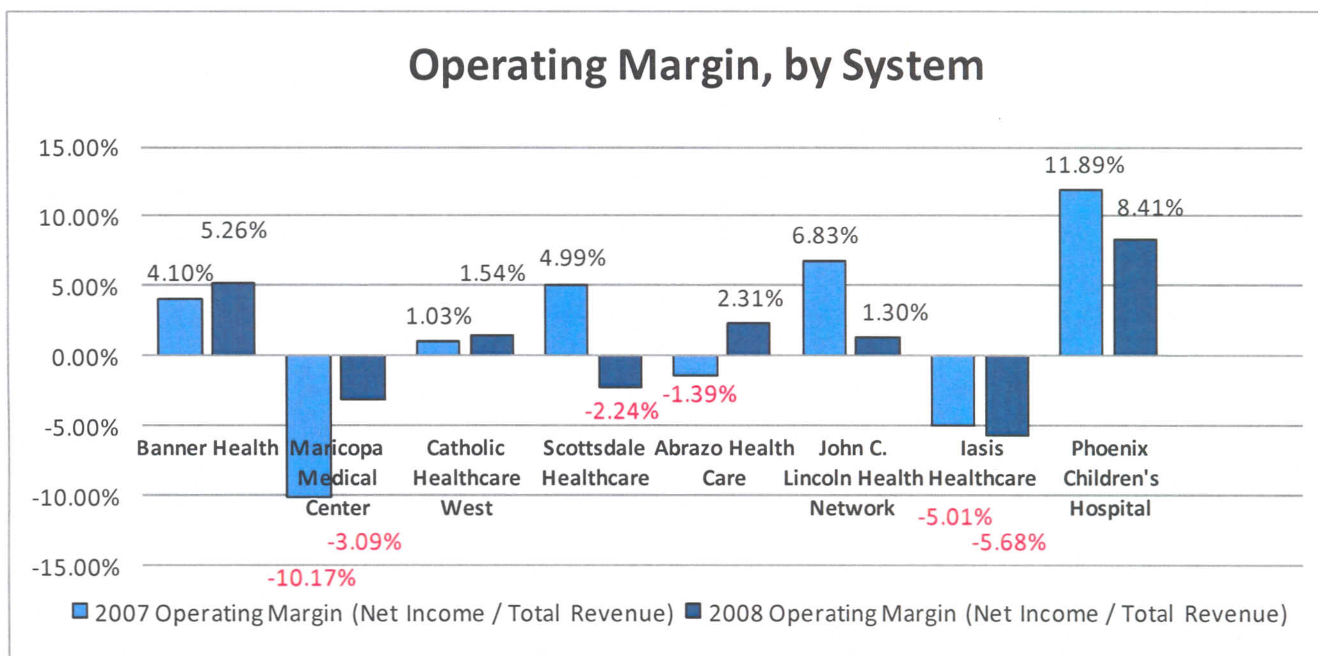
It would also be helpful to point out that full-service hospitals care for patients of all ages, including our most vulnerable populations such as seniors who are covered by Medicare and adults who need behavioral or mental health services. Because we treat all patients, our commercial patient population (to whom we shift costs) makes up a smaller percent of our total patient population, as compared to a freestanding children's hospital. The following table, using only a subset of Arizona acute care facilities, illustrates this point.

**TABLE 1: 2008 Payor Mix For Phoenix Area Hospital Systems (Including Adults And Pediatrics)**

| Hospital System | % HMO / PPO / Commercial | % Government Payors | % Self Pay / Charity | % Other |
|---|---|---|---|---|
| Abrazo Healthcare | 27.5% | 69.9% | 2.3% | 0.3% |
| Banner Health | 31.6% | 65.4% | 2.4% | 0.6% |
| Catholic Healthcare West | 35.9% | 58.2% | 4.3% | 1.6% |
| Iasis Healthcare | 23.0% | 72.6% | 3.6% | 0.8% |
| John C. Lincoln Health Network | 27.5% | 63.7% | 7.1% | 1.7% |
| Maricopa Medical Center | 8.9% | 72.5% | 12.1% | 6.5% |
| Phoenix Children's Hospital | 42.4% | 53.5% | 1.7% | 2.5% |
| Scottsdale Healthcare | 43.6% | 52.3% | 2.5% | 1.6% |

A review of hospital profit margins also undermines any argument that the ability of a freestanding children's hospital to cost shift is limited.

**FIGURE 6: Operating Margins**




Source: 2007 & 2008 Arizona Hospital Uniform Accounting Reports extracted from http://www.azdhs.gov/plan/crr/cr/hospitals.htm

Due to statutory licensing regulations, a freestanding children's hospital can receive higher reimbursement for outpatient care delivered at multiple outpatient treatment centers that are not physically located at the main inpatient hospital campus. Specifically, A.R.S. §36-422 (F) requires ADHS to issue a single group license to a hospital and up to **ten** of its designated satellite facilities that are located farther than one-half mile from the main hospital building (as long as those facilities comply with the Department's licensure requirements). Any hospital that qualifies for the freestanding children's hospital outpatient rate adjustment could operate up to ten outpatient treatment facilities under a single group hospital license and qualify for the special AHCCCS rate adjustment. While this is perhaps an unintended consequence of ADHS licensing statutes, the peer group adjustment provided in the AHCCCS outpatient fee schedule was probably not designed for outpatient care provided at satellite facilities located away from the freestanding children's hospital.

At a time when government resources are limited and healthcare costs are continuing to grow at a fast pace, AHCCCS payment methodologies should be based on efficiencies in the healthcare system. Instead of spending hundreds of millions of precious healthcare dollars on freestanding facilities and infrastructure, several hospitals around the state—Cardon Children's Medical Center (Banner Health), Diamond Children's Medical Center (University Medical Center), the Arizona Children's Center at Maricopa Medical Center, the Children's Health Center at St. Joseph's Hospital & Medical Center, and Tucson Medical Center for Children—have established children's hospitals within existing hospitals. The "hospital within a hospital" model reduces the need to duplicate expensive infrastructure that is unrelated to the delivery of care or clinical outcomes, yet this unnecessary infrastructure is required by state licensing standards. These hospitals provide the same high level care and quality to children as is delivered in a freestanding facility. More so, the additional costs are approximately 3 to 5 percent of total costs and in no way justify the current level of rate support for a freestanding children's hospital.

As AHCCCS begins to rebase the outpatient fee schedule, I strongly urge the AHCCCS Administration to establish a fee schedule that reimburses all pediatric providers equally. Over the last decade, the AHCCCS population has nearly doubled and now covers 1.25 million Arizonans, or roughly 19 percent of the state's population. At the same time, the number of people covered in the commercial market has declined, and AHCCCS reimbursement to hospitals has dropped from nearly 94 percent of cost to 76 percent of cost. AHCCCS has become one of the largest insurers, if not the largest, in the state. It is important that this public program treat all providers fairly and equally, especially considering its ability to create distortions in the marketplace.

Thank you for your time and consideration.

Sincerely,

Peter S. Fine, FACHE
President & CEO
Banner Health

Enclosure

cc: Shelli Silver
Eileen Klein
Beth Kohler Lazare