October 1, 2019

The Honorable Karen Fann
Arizona State Senate
1700 W. Washington
Phoenix, AZ 85007

The Honorable Russell Bowers
Arizona House of Representatives
1700 W. Washington
Phoenix, AZ 85007

Richard Stavneak, Director
Joint Legislative Budget Committee
1716 W. Adams
Phoenix, AZ 85007

Matthew Gress, Director
Governor's Office of Strategic Planning and Budgeting
1700 W. Washington
Phoenix, AZ 85007

Dear President Fann, Speaker Bowers, Mr. Stavneak, and Mr. Gress:

Pursuant to A.R.S. § 36-2903.08, please find the enclosed AHCCCS Report on Uncompensated Care and Hospital Profitability.

Please feel free to contact Shelli Silver, Deputy Director, at shelli.silver@azahcccs.gov or (602) 417-4647 if you have any questions about this report.

Sincerely,

Jami Snyder
Director

cc: Christina Corieri, Governor's Office, Senior Policy Advisor

Report on Uncompensated Hospital Costs and Hospital Profitability

October 2019

Director, Jami Snyder

EXECUTIVE SUMMARY

From Hospital Fiscal Year (HFY) 2011 to HFY 2013, hospital uncompensated care grew from $500 million to almost $900 million. This increase was followed by a sharp decline from HFY 2013 to HFY 2015. By HFY 2015, uncompensated care fell below its HFY 2011 levels and has continued at this lower rate. These fluctuations were due in part to state budgetary changes implemented during this time period. Of particular importance was the imposition of a freeze on childless adult enrollment effective July 2011, and its restoration and Medicaid expansion in January 2014.

Despite those earlier, large increases in uncompensated care, total net operating profit remained relatively stable, fluctuating between $554 million and $765 million from HFY 2011 to HFY 2016. This was achieved with the help of the AHCCCS Safety Net Care Pool program, a temporary program designed to help mitigate the increase in uncompensated care associated with the enrollment freeze. In HFY 2018, net operating profit increased to $1.1 billion, the highest level observed since AHCCCS began writing these reports.

Operating profitability continues to vary considerably by hospital type. Both net operating margin and total margins for rehabilitation, short-term specialty, and psychiatric hospitals exceeded 10% in HFY 2018 while net operating margins for long term acute care hospitals were 3.2% in HFY 2018. While that was the lowest among hospital types in HFY 2018, it represents the first net operating profit for long term hospitals since AHCCCS began reporting this data (HFY 2012 first year of data reported). In HFY 2018, net operating and total margins for critical access hospitals and general acute care hospitals were between 3.3% and 6.8%.

It is important to note that there are a number of factors that influence hospital profitability and uncompensated care, including long-term and short-term business decisions made by hospitals, occupancy rates (which average approximately 65% statewide), the economy, federal and state policies, and changes in the healthcare industry as a whole.

BACKGROUND

A. R. S.§ 36-2903.08 mandates that AHCCCS provide a report on hospital finances, specifically:

> AHCCCS uncompensated care; hospital assessment; reports
> A. On or before October 1, 2014, and annually thereafter, the Arizona health care cost containment system administration shall report to the speaker of the house of representatives, the president of the senate and the directors of the joint legislative budget committee and governor's office of strategic planning and budgeting on the change in uncompensated hospital costs experienced by Arizona hospitals and hospital profitability during the previous fiscal year.

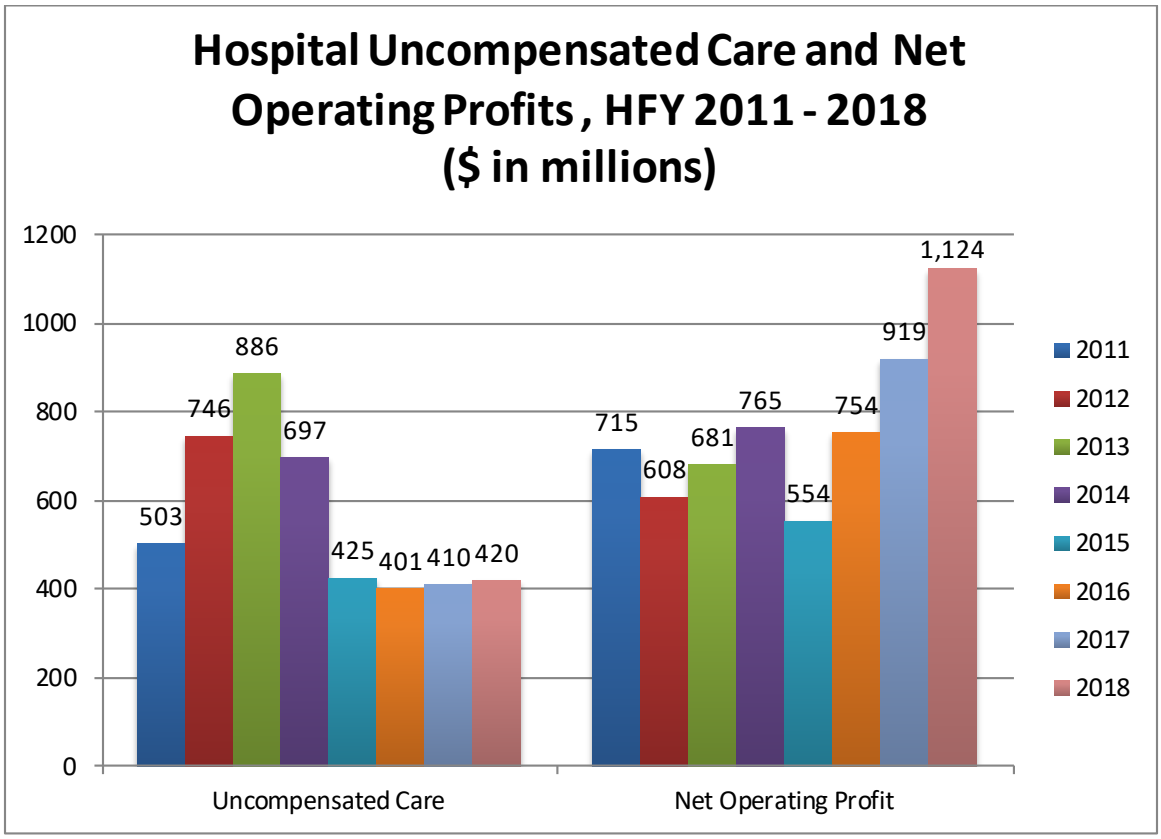
Hospital-reported data shows that total uncompensated care was relatively flat from Hospital Fiscal Year (HFY) 2017 to HFY 2018 and total net hospital profitability grew by 22.4% to $1.1 billion. During that time frame, average operating profitability, as well as average total income margin, also increased. The table below displays summary figures for Arizona hospitals going back to HFY 2011.

Hospital Profitability and Uncompensated Care, HFY 2011-2018
($ in Millions)

	2011[1]	2012	2013	2014	2015	2016	2017	2018	2017-2018 Change
Total Uncompensated Care	$503.3	$745.7	$885.9	$697.4	$425.3	$401.5	$410.1	$419.7	$9.6
Average Uncompensated Care Costs	$5.8	$8.0	$8.9	$7.0	$4.1	$3.8	$3.9	$4.3	$0.3
Uncompensated Care Costs as a % of Total Expenses	3.8%	5.8%	6.7%	4.7%	2.9%	2.6%	2.5%	2.5%	0.0%
Total Net Operating Profitability	$714.6	$607.6	$681.1	$765.2	$554.0	$753.6	$919.0	$1,124.4	$205.4
Average Operating Profitability	$8.1	$6.8	$6.9	$7.7	$5.4	$7.0	$8.8	$11.5	$2.6
Average Operating Margin	5.1%	4.5%	4.9%	4.9%	3.6%	4.6%	5.3%	6.3%	1.0%
Hospitals with a Positive Operating Margin	79.5%	73.3%	64.6%	64.0%	63.1%	59.8%	71.2%	73.5%	2.3%
Average Total Income Margin	5.1%	5.1%	6.0%	5.5%	3.9%	5.3%	6.8%	7.0%	0.2%
Average Occupancy Rate	62.0%	60.0%	59.0%	59.6%	60.8%	60.0%	60.2%	65.5%	5.3%

[1] 2011 figures taken from the 2013 Hospital Uncompensated Costs and Hospital Profitability Report. These numbers were not audited by AHCCCS.

From HFY 2011 to 2013, total uncompensated care grew from approximately $500 million to almost $900 million and then started a sharp decline, falling to just over $400 million and remaining steady in HFYs 2015-2018. Meanwhile, total net operating profits doubled in HFYs 2015-2018, increasing from $554 million in HFY 2015 to $1.1 billion in HFY 2018, at an average annual increase of 27%.



Among other factors, these figures incorporate the impact of a number of different AHCCCS budgetary changes which have occurred since 2011:

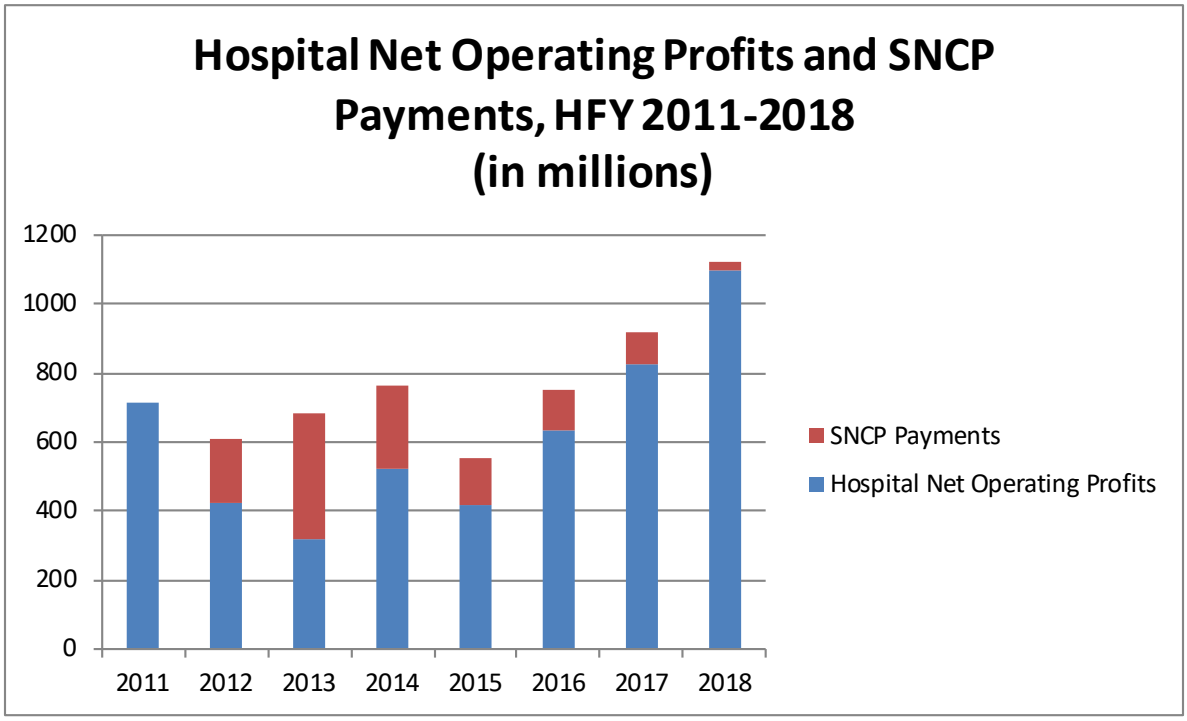
- The sustained 5 percent hospital payment rate decrease, effective April 1, 2011.
- The sustained 5 percent hospital payment rate decrease, effective October 1, 2011.
- The establishment of a 25-day inpatient day limit, effective October 1, 2011 - this policy ended on September 30, 2014, but the funding reduction continued.
- The imposition of a freeze on the spend-down program population effective May 1, 2011, and the subsequent elimination of the program effective October 1, 2011.
- The imposition of a freeze on childless adult enrollment, effective July 8, 2011 and its restoration on January 1, 2014.

- The implementation and expansion of several short-term funding mechanisms, such as the Safety Net Care Pool (SNCP) program designed to help mitigate the increase in uncompensated care associated with the enrollment freeze.
- The expansion of AHCCCS to adults from 106-138% of the federal poverty level beginning January 1, 2014.
- The implementation of a hospital assessment beginning on January 1, 2014. The hospital assessment is expected to collect $331.3 million in SFY 2020.
- The January 1, 2016, AHCCCS increase to the All Patient Refined Diagnosis Related Groups (APR-DRG) for high-acuity pediatric cases, increasing inpatient reimbursement by a projected $20 million annually for those cases. A second increase for an additional projected $20 million annually was made on January 1, 2017.
- The implementation of Differential Adjusted Payments (DAPs), effective October 1, 2016, increasing rates for acute care hospital providers who met established quality performance criteria. The DAP criteria was expanded to include all hospitals on October 1, 2017. Effective October 1, 2018, the Legislature provided new funding for an additional DAP increase of 2.5%.
- The modification of the methodology for calculating indirect Graduate Medical Education (GME) costs resulting in an approximate $100 million annual increase in indirect GME payments, beginning with the 2016 GME payment. GME payments have continued to steadily increase post-2016.
- The rebase of the APR-DRG reimbursement system, including a third increase to the policy adjustor for high-acuity pediatric cases and the addition of two new policy adjustors, for a net projected increase of $35 million annually for inpatient reimbursement effective January 1, 2018.

It is important to note the role that SNCP played over the years. In Federal Fiscal Year (FFY) 2012, SNCP payments were made to four hospitals. The program was then expanded for FFY 2013 to include nine additional hospitals through a City of Phoenix assessment. By the third year of the program, 17 hospitals had received SNCP payments. Total SNCP payments increased from approximately $185 million for FFY 2012 to $510 million for FFY 2013, a $325 million increase. With the exception of payments to Phoenix Children's Hospital (PCH), SNCP payments ended on December 31, 2013. Consequently, SNCP payments fell to $240 million in FFY 2014, $135 million in FFY 2015, $117 million in FFY 2016, $95 million in FFY 2017, and $23 million in FFY 2018. The Centers for Medicare and Medicaid Services (CMS) ended funding for the program after December 31, 2017.

Due to the differences between hospital and federal fiscal years, as described in more detail in the next section, the reporting of SNCP payments on hospitals' Uniform Accounting Reports (UARs) does not always match the FFY in which the payments were made. Additionally, the nine hospitals that received a payment where the state match was provided by the City of Phoenix assessment reduced their net operating revenues by the amount they contributed for the assessment. After adjusting the net operating revenues for net SNCP payments, hospitals report net operating profit falling from $715 million in HFY 2011 to $321 million in HFY 2013

and then increasing to $1.1 billion by HFY 2018. A comparison is displayed in the following chart.



DEFINITIONS, DATA SOURCES, AND LIMITATIONS

Under the authority of Arizona Revised Statutes § 36-125.04, Arizona Administrative Code (A.A.C.), Title 9, Chapter 11 specifies requirements for hospital financial reporting to the State of Arizona. With the exception of Indian Health Services hospitals and tribally owned or operated hospitals, Arizona hospitals are required to submit annual audited financial statements, the UAR, and hospital charge master rates and changes to the Arizona Department of Health Services (ADHS). AHCCCS used hospital-reported information in the UAR for the analysis conducted for this report. The data was reviewed by AHCCCS, and AHCCCS attempted to follow up with hospitals when hospital-submitted data was incomplete or appeared to contain errors. Any revisions made to the UAR data were reported to ADHS. AHCCCS chose to exclude one hospital from this report since it is not registered for Medicaid or Medicare. Additionally, four hospitals were excluded in HFY 2018 (Curahealth - Tucson, Hacienda Children's Hospital, Havasu Regional Medical Center, and Valley View Medical Center) since they did not submit their UAR by August 30, 2019, the cut-off date established by AHCCCS in order to complete this report timely. Four hospitals that submitted a UAR in 2017 subsequently closed (Abrazo Maryvale, Florence Hospital at Anthem, Gilbert Hospital, and Los Niños Hospital) and are therefore not included in the analysis of HFY 2018 UAR data.

The most recent complete year for which UAR data was available was HFY 2018. Reporting periods in each year vary by hospital based on each hospital's fiscal year date span; HFYs ended in June, July, August, September, or December. In a few cases, hospitals had less than twelve months of data due to the hospital changing its fiscal year. In cases where the hospital was open both prior to and after a fiscal year which contained greater than or less than 12 months' worth of data, AHCCCS annualized the data for a more accurate year-over-year comparison and to approximate a 12-month period for each hospital. For new hospitals and hospitals which closed, AHCCCS did not annualize the data.

Various data points may provide a picture of hospital uncompensated care. Common definitions of uncompensated care include bad debt and charity care; other figures may specifically delineate the difference between Medicare and Medicaid payments and hospital "costs" (known as Medicare and Medicaid shortfall amounts). AHCCCS has defined uncompensated care costs to include bad debt and charity care data.

Bad debt consists of services for which the hospital anticipated but did not receive payments. Charity care, in contrast, consists of services which the hospital voluntarily provided free of charge or at a reduced charge due to the patient's inability to pay. Uncompensated care, charity care, and bad debt in this report are stated in terms of costs as opposed to charges. Costs are determined by multiplying the charges by the hospital specific cost-to-charge ratio computed by AHCCCS. The cost to charge ratio was calculated as follows:

$$\frac{\text{Total expenses exclusive of bad debt}}{\text{Gross patient revenue + other operating revenue}}$$

The cost-to-charge ratio averaged 21% in HFY 2017 and 20% in HFY 2018. That is, for every one dollar of hospital charges, hospital costs averaged approximately twenty cents.

As with uncompensated care, there are several ways to examine profit levels. Total net operating profit is the amount of remaining operating revenue after all operating expenses are paid. A hospital's operating expenses include items such as salaries, employee benefits, supplies, purchased services, and rentals. Total net profit includes total operating profit as well as revenues and expenses related to non-operating revenues and expenses. Non-operating revenues and expenses include items such as investments, endowments, donations, cafeteria and gift shop sales, and federal taxes paid by for-profit hospitals. Total net operating margin represents the percent of operating revenues left after operating expenses have been paid. Similarly, total income margin represents the total income available after operating and non-operating expenses are paid. AHCCCS has included both net operating margin and total income margin in this report.

SUMMARY OF FINDINGS

Statistics provided in this Summary of Findings are compiled based on individual and summary data provided by the hospitals included in Appendix C. Dollar figures are rounded and percentages are calculated from unrounded figures.

1. Uncompensated Care Costs

AHCCCS found a wide range of uncompensated care costs reported by hospitals, with such costs across all hospitals reaching slightly above $400 million in both HFY 2017 and HFY 2018. Uncompensated care costs for the two most recent reporting years are noted in Table 1 (in total dollars):

Table 1—Uncompensated Care Costs, All Hospitals

	2017	2018	Percentage Change
Total Uncompensated Care Costs	$410.1 Million	$419.7 Million	2.3%
Statewide Average Uncompensated Care Costs Per Hospital	$3.9 Million	$4.3 Million	8.6%
Lowest Uncompensated Care Costs *	$12,479	$7,771	
Highest Uncompensated Care Costs	$52.0 Million	$40.9 Million	

* Excludes hospitals which do not provide uncompensated care or reported negative uncompensated care.

2. Percentage of Uncompensated Care

Uncompensated care costs were also examined as a percentage of total expenses. Statewide average percentage uncompensated care costs remained flat during this period as shown in Table 2. At its peak, uncompensated care costs were 6.7% in HFY 2013.

Table 2—Percent of Uncompensated Care, All Hospitals

	2017	2018	Percentage Change
Average % of Uncompensated Care	2.5%	2.5%	0.3%
Lowest % of Uncompensated Care Costs	0.06%	0.01%	
Highest % of Uncompensated Care	18.7%	64.2%	

3. Operating Profitability

Operating profitability continues to range greatly, from significant losses to significant gains. In total, Arizona hospitals included in this analysis had operating profits increase by about $205 million and hospitals with a profit increased by 2.3 percentage points during this period.

Table 3—Operating Profitability, All Hospitals

	2017	2018	Percentage Change
Total Profitability	$919.0 Million	$1,124.4 Million	22.4%
Statewide Average Profitability	$8.7 Million	$11.5 Million	29.9%
Lowest Profitability/(Highest Loss)	($72.7) Million	($30.6) Million	
Highest Profitability	$126.4 Million	$133.7 Million	
Percent of Hospitals with a Profit	71.2%	73.5%	

4. Net Operating Margin

Net operating margin, defined as profit/loss as a percentage of total revenue, averaged 5.3% across all hospitals in HFY 2017 and 6.3% in HFY 2018 as shown in Table 4. For the purpose of this analysis, average net operating margin equals the statewide total profit(loss)/statewide total revenue. Overall, 71.2% of hospitals in HFY 2017 and 73.5% in HFY 2018 had a positive operating margin.

Table 4—Net Operating Margin, All Hospitals

	2017	2018	Percentage Change
Average Net Operating Margin	5.3%	6.3%	18.7%
Lowest Net Operating Margin*	(135.5)%	(239.4)%	
Highest Net Operating Margin	43.2%	39.3%	
Hospitals with Positive Margin	71.2%	73.5%	

*Excludes hospitals which have been open less than 3 years at the end of the reporting period.

5. Total Margin

As discussed earlier, total margin provides another way to evaluate the financial status of hospitals, as it includes non-operating revenues and expenses in addition to operating revenues and expenses. Average total margin is defined as statewide operating and non-operating profit/loss as a percentage of total operating and non-operating revenue. Average total margin was 6.8% across all hospitals in HFY 2017, increasing to 7.0% in HFY 2018, as shown in Table 5.

Table 5—Total Margin, All Hospitals

	2017	2018	Percentage Change
Average Total Margin	6.8%	7.0%	3.0%
Lowest Total Margin *	(135.5)%	(239.4)%	
Highest Total Margin	52.8%	41.9%	
Hospitals with Positive Margin	69.8%	73.5%	

*Excludes hospitals which have been open less than 3 years at the end of the reporting period.

6. Occupancy Rates

In addition to the items specifically requested in legislation, hospital occupancy rates may also be of interest in helping provide context to these figures. Table 6 shows a large increase from HFY 2017 to HFY 2018, with occupancy rates increasing from 60.2% to 65.5%. Approximately 2/3 of hospitals experienced an increase in occupancy rates during this time period.

Table 6—Occupancy Rates, All Hospitals

	2017	2018	Percentage Change
Average Occupancy Rate	60.2%	65.5%	8.9%
Lowest Occupancy Rate	2.1%	1.4%	
Highest Occupancy Rate	99.1%	105.5%	

7. Days in Accounts Receivable

Days in accounts receivable may also be of interest as an additional variable to provide context to the financial status of Arizona hospitals. Days in accounts receivable, or the average number of days that a hospital takes to collect payments, is one factor that is used to measure the liquidity of businesses. A high number of days in accounts receivable can indicate that a hospital is having trouble collecting payments and can have significant impacts on cash flow. As

shown in Table 7, average days in accounts receivable were 66 in HFY 2017 and 65 in HFY 2018. Moody's Investors Service reports an average accounts receivable of 47.5 days for not-for-profit hospitals in 2017.[2]

Table 7—Days in Accounts Receivable, All Hospitals

	2017	2018	Percentage Change
Average Days in Accounts Receivable	66	65	(1.5)%
Fewest Days *	17	28	
Most Days **	148	143	

* Excludes hospitals which reported negative days
** Excludes hospitals which have been open less than 3 years at the end of the reporting period.

DATA BY HOSPITAL TYPES

In order to provide more meaningful results, AHCCCS has stratified the data in a variety of ways. Below is a comparison of hospitals by peer group, urban and rural locations, for-profit and non-profit, Medicaid volume, and by hospital system.

Hospital Peer Types

Table 8 breaks out Arizona hospitals into six categories: critical access, long term acute care, rehabilitation, psychiatric, short term specialty, and general acute care. Hospitals were assigned these categories based on their classification in the ADHS Provider and Facility Database as of January 1, 2019. For purposes of this report, AHCCCS has categorized hospitals which do not fall into any of the other 5 categories as general acute care hospitals. Slightly more than half of the hospitals are classified as general acute care hospitals, but over 90% of the revenues are from general acute care hospitals.

In HFY 2017 and HFY 2018, the average by hospital peer type for hospital uncompensated care as a percentage of total expenses ranged from 0.5% to 3.7% in HFY 2017 and from 0.5% to 5.0% in HFY 2018. Only one type of hospital experienced uncompensated care rates above 3.0% in both years (critical access hospitals) and two types experienced rates less than 1.0% in both years (short term specialty and rehabilitation). Both critical access and long term acute care hospitals experienced increases in uncompensated care from HFY 2017 to HFY 2018 (from 3.7% to 3.9% for critical access and 2.8% to 5.0% for long term acute care). The change in uncompensated care for long term acute care hospitals was primarily driven by one hospital

[2] https://www.beckershospitalreview.com/finance/45-financial-benchmarks-for-hospital-executives-062619.html

which had an increase of almost $2.8 million in bad debts from HFY 2017 to HFY 2018. For all other hospital peer groups uncompensated care remained steady from HFY 2017 to HFY 2018.

There continues to be a variance in net operating profit (as well as total profit) between the different peer groups, but that variance has decreased between HFY 2017 and 2018. In HFY 2017, net operating profit ranged from -13.3% (long term acute care) to 18.6% (rehabilitation). In HFY 2018, the range in net operating profit narrowed to 3.2% (long term acute care) to 14.7% (rehabilitation).

The number of long term acute care hospitals has declined from ten at the beginning of 2015 to six at the end of 2018. Some of the changes in net operating profitability, according to representatives of Arizona long term acute care hospitals, are due to changes in the way CMS began reimbursing long term acute care hospitals beginning in fiscal year 2016. As a condition of reimbursement, CMS now requires patients admitted to a long term care hospital to have spent at least three days in the intensive care unit, in the coronary care unit, or on a ventilator. The changes are dramatic enough that Standard & Poor's predicted in 2016 that a "material portion" of long term acute care hospitals nationwide would close over the next few years.[3]

The long term care acute hospital group collectively reported negative net operating profit in each year from HFY 2012 to HFY 2017. During the years HFY 2015 – 2017, no more than 33% of the individual hospitals in this group reported a positive operating margin in any year. HFY 2018, however, marked the first year in which the long term acute care hospital group reported a positive net operating profit since AHCCCS has been issuing this report. Furthermore, four of the five long term acute care hospitals included in the report had a positive net operating margin in HFY 2018.

While Arizona has lost long term care hospitals in recent years, the number of psychiatric hospitals and rehabilitation hospitals has grown. Since 2014, six psychiatric hospitals have opened, namely Palo Verde Behavioral Health, Oasis Behavioral Health, Quail Run Behavioral Health, Copper Springs Hospital, Cornerstone Behavioral Health El Dorado, and Tucson Medical Center Geropsychiatric Center. These new hospitals increase the number of behavioral health hospitals from ten to sixteen. Meanwhile, the number of rehabilitation hospitals has increased from seven to eleven with the addition of Honor Health Rehabilitation Hospital, Cobalt Rehabilitation Hospital, Dignity Health East Valley Rehabilitation Hospital, and Rehabilitation Hospital of Northern Arizona.

[3] https://www.fiercehealthcare.com/finance/s-p-long-term-care-hospitals-hit-hard-by-medicare-payment-changes

Table 8-- Uncompensated Care and Profitability by Hospital Peer Group

	Critical Access	Long Term	Rehabilitation	Psychiatric	Short Term Specialty	General Acute Care
Number of Hospitals which Submitted a UAR (HFY 2018	11	5	11	16	6	49
2017 Uniform Accounting Report						
Occupancy Rate	29.0%	53.9%	67.7%	75.6%	37.8%	59.5%
Total Gains, Revenues, and Other Support	$ 270,442,746	$ 80,285,945	$ 210,856,778	$ 311,501,812	$ 367,586,887	$ 16,152,355,801
Total Expenses	$ 260,828,881	$ 91,001,050	$ 171,610,653	$ 270,794,029	$ 304,735,696	$ 15,375,087,046
Net Operating Profit(Loss)	$ 9,613,865	$ (10,715,105)	$ 39,246,125	$ 40,707,783	$ 62,851,191	$ 777,268,756
Net Operating Margin	3.6%	-13.3%	18.6%	13.1%	17.1%	4.8%
Total Income Margin	4.2%	-14.0%	16.5%	12.4%	16.8%	6.5%
Days in Accounts Receivable	76	72	51	50	55	67
Cost to Charge Ratio	32.1%	29.0%	48.0%	36.4%	19.7%	20.9%
Cost of Bad Debts	$ 8,435,337	$ 2,552,493	$ 788,632	$ 3,166,846	$ 1,088,823	$ 193,702,523
Charity Cost	$ 1,274,373	$ -	$ 412,083	$ 1,039,817	$ 492,497	$ 195,894,932
Uncompensated Care Cost	$ 9,709,710	$ 2,552,493	$ 1,200,715	$ 4,206,663	$ 1,581,320	$ 389,597,455
Uncompensated Care Cost as a % of Total Expenses	3.7%	2.8%	0.7%	1.6%	0.5%	2.5%
2018 Uniform Accounting Report						
Occupancy Rate	31.6%	62.5%	66.8%	82.3%	36.4%	65.1%
Total Gains, Revenues, and Other Support	$ 332,150,150	$ 84,466,950	$ 224,939,798	$ 354,770,814	$ 363,206,025	$ 16,571,480,973
Total Expenses	$ 321,158,688	$ 81,788,150	$ 191,842,294	$ 310,690,432	$ 311,449,083	$ 15,589,638,494
Net Operating Profit(Loss)	$ 10,991,462	$ 2,678,800	$ 33,097,503	$ 44,080,382	$ 51,756,942	$ 981,842,478
Net Operating Margin	3.3%	3.2%	14.7%	12.4%	14.3%	5.9%
Total Income Margin	3.7%	2.2%	10.8%	11.7%	13.8%	6.8%
Days in Accounts Receivable	68	64	48	61	49	65
Cost to Charge Ratio	27.0%	26.1%	49.9%	35.7%	18.7%	19.9%
Cost of Bad Debts	$ 10,306,142	$ 4,071,551	$ 884,711	$ 3,862,324	$ 820,879	$ 179,019,945
Charity Cost	$ 2,314,302	$ -	$ 495,878	$ 1,111,643	$ 730,281	$ 202,979,668
Uncompensated Care Cost	$ 12,620,444	$ 4,071,551	$ 1,380,589	$ 4,973,967	$ 1,551,160	$ 381,999,613
Uncompensated Care Cost as a % of Total Expenses	3.9%	5.0%	0.7%	1.6%	0.5%	2.5%
CHANGE: 2017 to 2018						
Average Occupancy Percentage Points	2.6%	8.6%	-0.9%	6.7%	-1.3%	5.6%
Total Gains, Revenues, and Other Support	$ 61,707,404	$ 4,181,005	$ 14,083,020	$ 43,269,002	$ (4,380,862)	$ 419,125,171
Total Expenses	$ 60,329,807	$ (9,212,900)	$ 20,231,641	$ 39,896,403	$ 6,713,388	$ 214,551,449
Net Operating Profit(Loss)	$ 1,377,597	$ 13,393,905	$ (6,148,622)	$ 3,372,599	$ (11,094,250)	$ 204,573,723
Net Operating Margin	-0.2%	16.5%	-3.9%	-0.6%	-2.8%	1.1%
Total Margin	-0.4%	16.3%	-5.7%	-0.7%	-3.0%	0.3%
Average Days in Accounts Receivable	-8	-8	-3	11	-6	-2
Cost to Charge Ratio	-5.2%	-3.0%	1.9%	-0.6%	-1.0%	-1.0%
Cost of Bad Debts	$ 1,870,805	$ 1,519,058	$ 96,079	$ 695,478	$ (267,944)	$ (14,682,578)
Charity Cost	$ 1,039,929	$ -	$ 83,795	$ 71,825	$ 237,783	$ 7,084,736
Uncompensated Care Cost	$ 2,910,734	$ 1,519,058	$ 179,874	$ 767,304	$ (30,160)	$ (7,597,842)
Uncompensated Care Cost as % of Total Expenses	0.2%	2.2%	0.0%	0.0%	0.0%	-0.1%

Urban and Rural Hospitals

In addition to categorizing hospitals by peer group, this report displays the differences in uncompensated care and profitability for rural and urban hospitals in Table 9. For purposes of this report, AHCCCS has defined "urban hospital" as one which is physically located in Maricopa County or Pima County, consistent with A.A.C. R9-22-718. Rural hospitals include those located in any other Arizona county. During 2018, approximately 71% of hospitals were located in urban areas, and about 84% of total gains, revenues, and other support went to urban hospitals. From HFY 2017 to HFY 2018, uncompensated care declined slightly from 2.4% to 2.3% for urban hospitals but increased from 2.8% to 3.0% for rural hospitals.

As a whole, rural hospitals averaged higher net operating margins and total margins than urban hospitals; in HFY 2018, rural hospitals had a net operating margin of 9.1% compared to 5.8% for urban hospitals. In HFY 2018, total income margins were 10.5% for rural hospitals and 6.3% for urban hospitals.

Critical access hospital (CAH) is a federal designation given to certain rural hospitals which have no more than 25 acute care inpatient beds, are located more than a 35-mile drive from another hospital, offer emergency services 24/7, and have an annual average length of stay of 96 hours or fewer for acute care patients. Profit levels for CAH's were considerably lower than the average for all rural hospitals, at 3.3% net operating margin and 3.7% total margin for HFY 2018.

For Profit and Non-Profit Hospitals

Table 9 also stratifies hospitals by their tax status: for-profit and non-profit. Arizona non-profit hospitals are exempt from federal income taxes, sales taxes on most supplies and equipment, and some property taxes. Non-profit hospitals are required to provide charity care and community benefit[4]. Being a non-profit hospital does not mean that a hospital cannot make a profit. In fact, the most profitable hospitals in HFY 2018 were the non-profit hospitals, as a group.

Mayo Clinic had the largest net operating profit of $126 million in HFY 2017 and $134 million in HFY 2018. As a whole, non-profit hospitals had a net operating profit of approximately $711 million in HFY 2017 and $945 million ($234 million above HFY 2017) in HFY 2018. Of that $234 million gain, $148 million was attributable to HonorHealth John C. Lincoln, Banner University Medical Center Tucson, and HonorHealth Scottsdale Shea. In comparison, for-profit hospitals' net operating profit was approximately $208 million and $180 million in HFYs 2017 and 2018, respectively.

[4] Community benefits include patient financial assistance, unreimbursed Medicaid costs and other means-tested public programs, community health improvement services, health professions education, research, subsidized health services, and cash and in-kind support to community groups and organizations.

These dollar figures, however, must be viewed in the context of hospital size and business model. While non-profit hospitals constitute approximately half of all hospitals in Arizona, they received approximately 83% of total gains, revenues, and other support (in part because they are typically much larger than the types of hospitals that are more often for-profit). For-profit hospitals are more likely to be rehabilitation, psychiatric, short term specialty, or long term acute care hospitals, whereas the majority of non-profit hospitals are acute care hospitals, which tend to be larger than other hospital types.

Medicaid Volume

Table 9 also compares hospital uncompensated care and profitability by Medicaid volume: hospitals with Medicaid volume less than 25%, from 25-50%, and greater than 50%.[5]

The percentage of uncompensated care in both years was lowest at hospitals with Medicaid volume less than 25%, with uncompensated care at 1.8% in HFY 2017 and HFY 2018. Hospitals with Medicaid volume above 50% had the largest amounts of uncompensated care: 6.1% in HFY 2017 and 4.6% in HFY 2018. As explained earlier, uncompensated care in this report is defined as the sum of charity care and the provision of bad debts, so the uncompensated care would not include any shortfall associated with Medicaid payments and the cost of services.

In addition to uncompensated care costs, there continues to be a strong correlation between Medicaid volume and net operating margin. In both years, hospitals with Medicaid volume less than 25% had the highest net operating margins (8.2% in HFY 2017 and 9.2% in HFY 2018). Hospitals with Medicaid volume greater than 50% collectively had the lowest net operating margins (2.4% in HFY 2017 and 3.7% in HFY 2018). All three of the hospital groups experienced an increase in net operating margins in HFY 2018.

[5] To calculate Medicaid volume, AHCCCS divided inpatient days recorded in the AHCCCS payment system by total inpatient days as recorded on the hospital's most recent Medicare Cost Report.

Table 9 -- Uncompensated Care and Profitability by Various Hospital Type

	Urban	Rural	For-Profit	Non-Profit	Medicaid Volume > 50%	Medicaid Volume 25%-50%	Medicaid Volume < 25%
Number of Hospitals which Submitted a UAR (HFY 2018)	70	28	49	49	15	38	45
2017 Uniform Accounting Report							
Occupancy Rate	62.4%	47.9%	54.0%	63.5%	64.0%	64.1%	53.1%
Total Gains, Revenues, and Other Support	$ 14,505,154,140	$ 2,860,858,553	$ 3,360,427,844	$ 14,032,602,125	$ 1,663,983,863	$ 9,404,435,880	$ 6,324,610,226
Total Expenses	$ 13,842,318,928	$ 2,606,190,407	$ 3,152,224,745	$ 13,321,832,608	$ 1,624,401,193	$ 9,041,197,279	$ 5,808,458,882
Net Operating Profit(Loss)	$ 662,835,213	$ 254,668,145	$ 208,203,099	$ 710,769,516	$ 39,582,670	$ 363,238,601	$ 516,151,345
Net Operating Margin	4.6%	8.9%	6.2%	5.1%	2.4%	3.9%	8.2%
Total Income Margin	5.9%	11.0%	5.7%	7.0%	12.5%	4.4%	8.6%
Days in Accounts Receivable	69	56	64	67	56	61	77
Cost to Charge Ratio	21.2%	22.0%	16.9%	22.7%	29.1%	21.0%	20.2%
Cost of Bad Debts	$ 160,994,537	$ 47,047,893	$ 40,630,269	$ 167,371,694	$ 32,930,248	$ 112,664,771	$ 66,376,521
Charity Cost	$ 174,916,548	$ 26,527,445	$ 3,287,263	$ 210,544,911	$ 65,378,235	$ 112,666,685	$ 37,675,258
Uncompensated Care Cost	$ 335,911,085	$ 73,575,337	$ 43,917,532	$ 377,916,605	$ 98,308,483	$ 225,331,456	$ 104,051,779
Uncompensated Care Cost as a % of Total Expenses	2.4%	2.8%	1.4%	2.8%	6.1%	2.5%	1.8%
2018 Uniform Accounting Report							
Occupancy Rate	68.1%	50.6%	64.8%	65.8%	72.4%	67.2%	60.7%
Total Gains, Revenues, and Other Support	$ 15,150,582,797	$ 2,780,431,912	$ 3,110,147,601	$ 14,820,867,107	$ 1,766,138,096	$ 9,305,688,902	$ 6,859,187,711
Total Expenses	$ 14,278,262,979	$ 2,528,304,162	$ 2,930,464,528	$ 13,876,102,614	$ 1,700,661,519	$ 8,878,577,538	$ 6,227,328,085
Net Operating Profit(Loss)	$ 872,319,818	$ 252,127,749	$ 179,683,074	$ 944,764,494	$ 65,476,577	$ 427,111,364	$ 631,859,626
Net Operating Margin	5.8%	9.1%	5.8%	6.4%	3.7%	4.6%	9.2%
Total Income Margin	6.3%	10.5%	4.7%	7.4%	8.5%	4.8%	9.5%
Days in Accounts Receivable	67	54	65	64	73	56	75
Cost to Charge Ratio	20.1%	22.2%	15.3%	21.9%	28.3%	19.9%	19.5%
Cost of Bad Debts	$ 151,724,409	$ 47,037,108	$ 36,374,800	$ 159,823,751	$ 14,952,975	$ 115,249,057	$ 65,551,292
Charity Cost	$ 181,679,173	$ 28,481,430	$ 5,118,133	$ 218,917,961	$ 63,056,170	$ 113,151,096	$ 47,358,242
Uncompensated Care Cost	$ 333,403,581	$ 75,518,538	$ 41,492,933	$ 378,741,712	$ 78,009,146	$ 228,400,153	$ 112,909,534
Uncompensated Care Cost as a % of Total Expenses	2.3%	3.0%	1.4%	2.7%	4.6%	2.6%	1.8%
CHANGE: 2017 to 2018							
Average Occupancy Percentage Points	5.7%	2.6%	10.9%	2.4%	8.4%	3.1%	7.6%
Total Gains, Revenues, and Other Support	$ 645,428,657	$ (80,426,641)	$ (250,280,243)	$ 788,264,982	$ 102,154,233	$ (98,746,978)	$ 534,577,485
Total Expenses	$ 435,944,051	$ (77,886,245)	$ (221,760,218)	$ 554,270,005	$ 76,260,326	$ (162,619,741)	$ 418,869,203
Net Operating Profit(Loss)	$ 209,484,605	$ (2,540,396)	$ (28,520,025)	$ 233,994,977	$ 25,893,907	$ 63,872,763	$ 115,708,282
Net Operating Margin	1.2%	0.2%	-0.4%	1.3%	1.3%	0.7%	1.1%
Total Margin	0.4%	-0.5%	-0.9%	0.4%	-4.1%	0.4%	0.9%
Average Days in Accounts Receivable	(2)	(2)	1	(3)	17	(5)	(2)
Cost to Charge Ratio	-1.1%	0.2%	-1.6%	-0.8%	-0.7%	-1.1%	-0.8%
Cost of Bad Debts	$ (9,270,128)	$ (10,784)	$ (4,255,469)	$ (7,547,943)	$ (17,977,273)	$ 2,584,286	$ (825,229)
Charity Cost	$ 6,762,624	$ 1,953,985	$ 1,830,871	$ 8,373,050	$ (2,322,065)	$ 484,411	$ 9,682,984
Uncompensated Care Cost	$ (2,507,503)	$ 1,943,201	$ (2,424,598)	$ 825,107	$ (20,299,337)	$ 3,068,697	$ 8,857,755
Uncompensated Care Cost as % of Total Expenses	-0.1%	0.2%	0.0%	-0.1%	-1.5%	0.1%	0.0%

HOSPITAL SYSTEMS

Finally, AHCCCS has presented hospital profitability and uncompensated care by hospital systems. Table 10 lists all seven hospital systems that include at least 3 hospitals. A full listing of the hospitals in each system can be found in Appendix B. Seven hospital systems are included in Table 10, and total revenue, gains, and other support and expenses have been included, as well as other variables provided in previous tables. Hospitals are included as part of a hospital system if they were in that system as of June 30, 2019, regardless of whether they were in that hospital system in both 2017 and 2018.

Hospital system operating profits ranged from approximately $399 million (Banner Health) to $(27) million (Dignity Health) in HFY 2017 and $363 million (Banner Health) to $(1) million (Steward Health Care) in HFY 2018. Net operating margin ranged from 21.6% (HealthSouth) to (1.3)% (Dignity Health) in HY 2017 and 19.3% (Encompass Health) to (0.3)% (Steward Health Care) in HFY 2018.

Uncompensated care ranged widely between health systems, from a high of 3.0% to a low of 0.6% in HFY 2017 and a high of 3.0% to a low of 0.7% in HFY 2018. In both years, Dignity Health had the largest uncompensated care while Encompass Health had the lowest.

Banner Health, the state's largest health system, includes 17 hospitals and had annual hospital patient revenues of approximately $5.2 billion in HFY 2018. The next largest health systems had annual net patient revenues of approximately $2.2 billion (Dignity Health) and $1.8 billion (HonorHealth) in HFY 2018. Uncompensated care was 2.7% for Banner Health, 3.0% for Dignity Health, and 2.0% for HonorHealth in HFY 2018. The Encompass Health system consists of rehabilitation hospitals; consistent with its peer group, the system had a low level of uncompensated care of 0.7% in HFY 2018.

Table 10 -- Uncompensated Care and Profitability by Hospital System

	Abrazo Health Care	Banner Health Systems	Community Health Systems	Dignity Health	Encompass Health (Formerly HealthSouth)	HonorHealth	Steward Health Care
Number of Hospitals which Submitted a UAR (HFY 2018)	8	17	3	7	6	6	4
2017 Uniform Accounting Report							
Occupancy Rate	45.3%	65.9%	49.5%	74.6%	65.9%	55.2%	56.8%
Total Revenue, Gains, and Other Support	$ 1,212,846,659	$ 5,077,920,872	$ 556,224,577	$ 2,065,032,189	$ 133,131,853	$ 1,620,696,538	$ 364,552,000
Total Expenses	$ 1,173,503,827	$ 4,678,750,824	$ 491,965,111	$ 2,091,793,942	$ 104,353,681	$ 1,632,637,976	$ 359,061,000
Net Operating Profit(Loss)	$ 39,342,832	$ 399,170,048	$ 64,259,466	$ (26,761,753)	$ 28,778,172	$ (11,941,438)	$ 5,491,000
Net Operating Margin	3.2%	7.9%	11.6%	-1.3%	21.6%	-0.7%	1.5%
Total Income Margin	2.5%	7.9%	11.6%	-0.1%	18.3%	-0.7%	1.5%
Days in Accounts Receivable	79	54	53	75	48	56	59
Cost to Charge Ratio	15.2%	19.3%	11.4%	21.5%	51.0%	18.1%	18.0%
Cost of Bad Debts	$ 10,946,221	$ 48,300,451	$ 2,656,361	$ 31,584,714	$ 402,373	$ 16,914,860	$ 5,427,198
Charity Cost	$ 2,379,531	$ 68,826,232	$ 88,171	$ 30,782,656	$ 243,027	$ 17,554,839	$ 47,987
Uncompensated Care Cost	$ 13,325,751	$ 117,126,683	$ 2,744,532	$ 62,367,370	$ 645,400	$ 34,469,700	$ 5,475,185
Uncompensated Care Cost as a % of Total Expenses	1.1%	2.5%	0.6%	3.0%	0.6%	2.1%	1.5%
2018 Uniform Accounting Report							
Occupancy Rate	69.4%	68.0%	47.5%	76.0%	66.2%	59.9%	65.1%
Total Revenue, Gains, and Other Support	$ 1,170,942,955	$ 5,175,902,349	$ 573,946,827	$ 2,179,067,590	$ 135,711,175	$ 1,827,878,337	$ 429,391,628
Total Expenses	$ 1,149,971,451	$ 4,813,230,841	$ 490,486,591	$ 2,113,539,405	$ 109,528,429	$ 1,688,911,793	$ 430,866,977
Net Operating Profit(Loss)	$ 20,971,504	$ 362,671,508	$ 83,460,236	$ 65,528,185	$ 26,182,746	$ 138,966,544	$ (1,475,349)
Net Operating Margin	1.8%	7.0%	14.5%	3.0%	19.3%	7.6%	-0.3%
Total Income Margin	0.4%	7.0%	14.5%	4.0%	12.9%	7.6%	-0.3%
Days in Accounts Receivable	75	51	64	58	46	54	48
Cost to Charge Ratio	12.5%	18.9%	10.5%	20.7%	52.5%	16.7%	18.2%
Cost of Bad Debts	$ 11,273,992	$ 48,699,440	$ 4,005,280	$ 36,165,788	$ 547,965	$ 13,165,198	$ 5,702,600
Charity Cost	$ 3,340,640	$ 78,876,579	$ 229,944	$ 27,525,786	$ 200,841	$ 20,229,542	$ 10,619
Uncompensated Care Cost	$ 14,614,632	$ 127,576,019	$ 4,235,224	$ 63,691,574	$ 748,805	$ 33,394,741	$ 5,713,219
Uncompensated Care Cost as a % of Total Expenses	1.3%	2.7%	0.9%	3.0%	0.7%	2.0%	1.3%
CHANGE: 2017 to 2018							
Average Occupancy Percentage Points	24.2%	2.1%	-2.0%	1.4%	0.2%	4.7%	8.3%
Total Revenue, Gains, and Other Support	$ (41,903,704)	$ 97,981,477	$ 17,722,250	$ 114,035,401	$ 2,579,322	$ 207,181,799	$ 64,839,628
Total Expenses	$ (23,532,376)	$ 134,480,017	$ (1,478,520)	$ 21,745,463	$ 5,174,748	$ 56,273,817	$ 71,805,977
Total Net Operating Profit(Loss)	$ (18,371,328)	$ (36,498,540)	$ 19,200,770	$ 92,289,938	$ (2,595,426)	$ 150,907,981	$ (6,966,349)
Net Operating Margin	-1.5%	-0.9%	3.0%	4.3%	-2.3%	8.3%	-1.8%
Total Margin	-2.1%	-0.8%	3.0%	4.1%	-5.5%	8.3%	-1.8%
Average Days in Accounts Receivable	(4)	(3)	11	(17)	(2)	(2)	(11)
Cost to Charge Ratio	-2.7%	-0.5%	-0.9%	-0.8%	1.5%	-1.4%	0.3%
Cost of Bad Debts	$ 327,772	$ 398,989	$ 1,348,919	$ 4,581,075	$ 145,592	$ (3,749,662)	$ 275,402
Charity Cost	$ 961,109	$ 10,050,347	$ 141,773	$ (3,256,871)	$ (42,186)	$ 2,674,703	$ (37,368)
Uncompensated Care Cost	$ 1,288,881	$ 10,449,336	$ 1,490,692	$ 1,324,204	$ 103,406	$ (1,074,959)	$ 238,034
Uncompensated Care Cost as % of Total Expenses	0.1%	0.1%	0.0	0.0%	0.1%	-0.1%	-0.2%

HEALTHCARE INDUSTRY TRENDS

As mentioned in prior reports, there are a number of changes occurring across the health care delivery system that are impacting hospital finances, including a large number of mergers and acquisitions, vertical integration, the diversification of revenue sources, outpatient migration, the expansion of services closer to home (e.g. freestanding emergency departments and micro-hospitals), and value based purchasing initiatives.

Mergers and Acquisitions

Nationwide, the number of hospital and healthcare systems has experienced a significant number of transactions, with 115 in 2017 and 90 in 2018.[6] The actual impact of these changes will depend upon the extent to which hospitals adapt their business models to these new health care delivery reforms. With the acquisition of 18 IASIS hospitals in 2017, four of which are located in Arizona, Steward Health Care became the largest privately-owned for-profit hospital operator in the U.S. In the six years prior, the John C. Lincoln Health Network merged with Scottsdale Healthcare and became HonorHealth, Banner Health acquired four hospitals, and Abrazo Healthcare grew from six to eight hospitals after creating a partnership with the Carondelet Health Network Hospitals.

Vertical Integration and Diversification of Resources

In addition to merging and acquiring other hospitals, hospitals continue to vertically integrate with the intention of lowering costs and/or spreading risks across different sectors. One such example is Banner Health. In March 2018, Banner Health announced the opening of its first medical spa. In addition to its 17 Arizona hospitals, Banner operates a physician medical group, urgent care centers, hospice, home health agencies, a health plan, and retail clinics in grocery stores.

Outpatient Migration

The shift from inpatient to outpatient care continues steadily as healthcare advances and payers are trying to cut costs. In the past decade, surgeries such as total joint replacement, spine fusions, and even some cardiovascular procedures have migrated to the outpatient setting. As this trend continues, we are likely to see only the most complex procedures and

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[6] KaufmanHall "2018 M&A in Review: A new Healthcare Landscape Takes Shape," 2019. https://mnareview.kaufmanhall.com/the-year-in-numbers?_ga=2.106166667.961128460.1568135132-839504734.1568135132 (accessed September 10, 2019).

KaufmanHall "2017 in Review: The Year M&A Shook the Healthcare Landscape," 2018. https://www.kaufmanhall.com/sites/default/files/2017-in-Review_The-Year-that-Shook-Healthcare.pdf (accessed August 20, 2018).

those for high-risk patients performed in an inpatient setting.[7] While some of these procedures have moved from inpatient to outpatient hospital setting, others have moved to ambulatory surgical centers, free-standing facilities that operate exclusively for the purpose of furnishing outpatient surgical services, further impacting hospitals' bottom lines. Between 2000 and 2017, the number of ambulatory surgical centers (healthcare facilities focused on providing same-day surgeries) nationwide increased by 86% from 3,028 to 5,634.[8]

Micro-Hospitals and Freestanding Emergency Departments

Despite healthcare industry consolidation, access points in some areas have increased. Dignity Health opened three "micro-hospitals" (St. Joseph Westgate, Arizona General Hospital – Laveen, and Arizona General Hospital – Mesa) in recent years, and Abrazo is planning on opening at least two micro-hospitals in the upcoming year. Although AHCCCS has been unable to find an official definition of a "micro-hospital," it is often described as a small inpatient hospital which operates 24/7, has an emergency department, and is usually around 15,000 to 50,000 square feet.[9] [10] [11] Unlike full scale hospitals, micro-hospitals have a limited number of inpatient beds. They offer a small number of services, such as surgical suites, a labor and delivery room, or primary care services on-site.

A number of hospital systems have built freestanding emergency departments (FrEDs) in recent years. FrEDs are facilities which are structurally separate and distinct from a hospital and are staffed 24/7 by emergency medicine physicians and nurses and do not offer any inpatient services. Although the services among FrEDs may vary, in addition to emergency and urgent care, most facilities offer x-rays, clinical laboratory services, CT scans, ultrasounds, and pharmaceuticals. While FrEDs initially emerged in the 1970s to fill a void in rural and underserved areas, FrEDs have recently proliferated in suburban areas. From 2008 to 2016 the

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[7] Dentler, Joan. "Outpatient Migration: 6 trends and development." May 21, 2018. https://www.beckershospitalreview.com/hospital-management-administration/outpatient-migration-6-trends-and-developments.html (accessed August 21, 2018).

[8] Avanza Healthcare Strategies. "Outpatient Statistical Snapshot." 2018 https://avanzastrategies.com/outpatient-statistical-snapshot/ (accessed September 10, 2019).

[9] Saulsberry, Kalyn. "To Grow Your Hospital, Think Micro." Advisory Board. May 20, 2016. https://www.advisory.com/research/financial-leadership-council/at-the-margins/2016/05/micro-hospitals

[10] Budryk, Zack. "'Micro-hospitals Offer Alternative to Urgent Care Model.'" FierceHealthcare. June 28, 2016. http://www.fiercehealthcare.com/healthcare/micro-hospitals-offer-alternative-to-urgent-care-model

[11] Andrews, Michelle. "Sometimes Tiny is Just the Right Size: 'Microhospitals Filling Some ER Needs." Kaiser Health News. July 19, 2016. http://khn.org/news/sometimes-tiny-is-just-the-right-size-microhospitals-filling-some-er-needs/

number of FrEDs in the U.S. grew from 220 to 566, a 157% increase.[12][13] In Arizona, at least 20 such facilities have opened since 2010.

Reimbursement

Since its rate reductions in FFY 2011-2012, AHCCCS has provided minimal base rate increases for hospitals. Base rates for most inpatient and outpatient services were reduced by approximately 10%, effective October 1, 2011. As of October 1, 2018, inpatient base rates are 6.4% lower and outpatient base rates are 8.7% lower than prior to the reductions being implemented. In addition to base reimbursement rates, some providers receive time-limited rate increases via DAP initiatives for meeting certain performance or quality criteria. AHCCCS also modified the methodology for calculating indirect GME costs, resulting in an approximate $100 million annual increase for GME hospitals.

Additional increases have been made which are not fully reflected in the data. Effective January 1, 2018, AHCCCS rebased the APR-DRG reimbursement system for a net projected annual increase of $35 million for inpatient reimbursement. In FFY 2020, the potential for differential adjusted payments increases by up to 4.0% for most hospitals and up to 8.5% for most CAHs.

Medicare also continues to make reductions in payments. As part of the Affordable Care Act (ACA), Congress enacted a number of market basket reductions beginning in 2010, lowering what Medicare will pay for services. Beginning April 1, 2013, Medicare imposed a 2% reimbursement reduction due to the Sequestration. Since October 2012, Medicare also began reducing payments for hospitals with excessive readmissions. The Arizona Hospital and Healthcare Association estimates that these and other recent Medicare cuts reduced payments to Arizona hospitals by approximately $450 million in 2016, and the cuts will grow in future years.

In recent years, additional Medicare cuts have been made, in many cases with the intention of trying to create efficiencies in the industry. In December 2017, CMS reduced payments to 340B hospitals by 28% (the 340B program allows certain organizations to register and receive reduced-price outpatient drugs). A U.S. District Court ruled in December 2018 and May 2019 that the reductions are unlawful and has required CMS to end the cuts prospectively. At this time, it is unclear if CMS will appeal this decision or consider implementing smaller cuts.

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[12] Harish Nir, Jennifer L. Wiler, and Richard Zane. "How the Freestanding Emergency Department Boom Can Help Patients." NEJM Catalyst. February 18, 2016. http://catalyst.nejm.org/how-the-freestanding-emergency-department-boom-can-help-patients/

[13] MedPAC, "Chapter 8: Stand-Alone Emergency Departments," Report to the Congress: Medicare and the Health Care Delivery System, June 2017 . http://www.medpac.gov/docs/default-source/reports/jun17_ch8.pdf

As mentioned earlier in the report, Medicare began changing the way it reimbursed long term acute care hospitals from 2016 to 2017. This change was implemented to help address increased Medicare spending of $3.7 million to $5.5 million between 2004 and 2013,[14] but it is contributing to the closure of some long term acute care hospitals.

CONCLUSION

The HFY 2017 and HFY 2018 hospital uncompensated cost and profitability data, and the changes observed year-over-year, continue to provide useful information when evaluating hospital finances and the impact of the AHCCCS-related changes which began in 2011. Hospital uncompensated care as a percentage of total expenses remained flat at 2.5% in the most recent year data is available. Net operating profitability increased 22.4% in HFY 2018 to its largest historical level. Additionally, the percentage of hospitals with a positive operating margin increased by 4.6 percentage points from HFY 2017 to HFY 2018.

It is important to be aware that the most recent data included in this report is from HFY 2018. Since hospitals have different fiscal years, the most recently reported years ended between June 2018 and December 2018.

While the number of acute care hospitals in Arizona has remained relatively stable in recent years, growth has occurred in both psychiatric hospitals and rehabilitation hospitals but the number of long term acute care hospitals has declined. Since 2014, the number of long term acute care hospitals in Arizona has declined from ten to six, the number of behavioral health hospitals has increased from ten to sixteen, and the number of rehabilitation hospitals has increased from seven to eleven.

Finally, it should be noted that a number of changes in the health care industry may be particularly challenging financially for rural hospitals. Since 2010, at least 113 rural hospitals have closed nationally, two of which were located in Arizona[15]. Cochise Regional Hospital in Douglas closed in June 2015 and Florence Hospital at Anthem (located in Florence) closed in June 2018. Experts report varied reasons for these closures, including an often high number of Medicare and Medicaid recipients, the aging of the baby boomers, continued impacts from the recession, smaller economies of scale, and challenges in adapting to changing health care service delivery models (e.g., formation of accountable care organizations). Closures of rural

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[14] Wilson, Les. "Furtureproofing: How LTACHs Can Survive and Even Thrive after Medicare Reform." 2018. https://cantatahealth.com/futureproofing-how-ltachs-can-survive-and-even-thrive-after-medicare-reform/ (accessed August 27, 2018).

[15] Ellison, Ayla. "State-by-State Breakdown of 113 Rural Hospital Closures." 2019. https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-113-rural-hospital-closures-082619.html (accessed September 17, 2019)

hospitals may be particularly challenging to nearby patients, who often must travel a considerable distance to the next closest hospital. AHCCCS is continuing to monitor market conditions to ensure that AHCCCS members have adequate access to care.

Appendix A

Medicaid Volume <25%

Arizona Orthopedic Surgical Hospital
Arizona Spine & Joint Hospital
Banner Baywood Medical Center
Banner Boswell Medical Center
Banner Del E. Webb Medical Center
Banner Heart Hospital
Benson Hospital Corp
Chandler Regional Medical Center
Cobalt Rehabilitation Hospital
Copper Queen Community Hospital
The Core Institute
Cornerstone Hospital of Southeast Arizona
Curahealth Hospital Phoenix – Northwest
Curahealth Hospital Tucson
Dignity Health East Valley Rehabilitation Hospital
Encompass Health East Valley (formerly HealthSouth East Valley Rehabilitation Hospital)
Encompass Health Northwest Tucson (HealthSouth Rehab Hospital of Southern Arizona)
Encompass Health Scottsdale (formerly HealthSouth Scottsdale Rehabilitation Hospital)
Encompass Health Tucson (formerly HealthSouth Rehabilitation Institute of Tucson)
Encompass Health Valley of the Sun (formerly HealthSouth Valley of the Sun Rehabilitation)
Havasu Regional Medical Center
HonorHealth Deer Valley Medical Center
HonorHealth Rehabilitation Hospital
HonorHealth Scottsdale Osborn Medical Center
HonorHealth Scottsdale Shea Medical Center
HonorHealth Scottsdale Thompson Peak Medical Center
Kingman Regional Medical Center
La Paz Regional Hospital, Inc.
Los Niños Hospital
Mayo Clinic Arizona
Mercy Gilbert Medical Center
Mountain Valley Regional Rehabilitation Hospital
Northern Cochise Community Hospital
Northwest Medical Center
OASIS Hospital
Oro Valley Hospital
Promise Hospital of Phoenix
Rehabilitation Hospital of Northern Arizona
Santa Cruz Valley Regional Hospital
Scottsdale Liberty Hospital

Select Specialty Hospital – Phoenix
Select Specialty Hospital – Phoenix Downtown
St. Joseph's Hospital (Tucson)
Valley View Medical Center
Verde Valley Medical Center
Western Arizona Regional Medical Center
White Mountain Regional Medical Center
Wickenburg Community Hospital
Yavapai Regional Medical Center
Yuma Rehabilitation Hospital

Medicaid Volume = 25-50%

Abrazo Arrowhead Campus
Abrazo Central Campus
Abrazo Scottsdale Campus
Abrazo West Campus
Abrazo Heart Hospital
Arizona General Hospital
Banner Casa Grande Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Ironwood Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner - University Medical Center Phoenix
Banner - University Medical Center South
Banner - University Medical Center Tucson
Canyon Vista Medical Center
Cobre Valley Regional Medical Ctr
Flagstaff Medical Center
Haven Senior Horizons
Holy Cross Hospital
HonorHealth John C. Lincoln Medical Center
Mt. Graham Medical Center
Mountain Vista Medical Center
OASIS Behavioral Health
St. Joseph's Hospital and Medical Center
St. Joseph's Westgate Medical Center
St. Luke's Medical Center
St. Mary's Hospital

Summit Healthcare Association
Tempe St. Luke's Hospital
The Guidance Center
TMC Geropsychiatric Center at Handmaker
Tucson Medical Center
Valley Hospital
Windhaven Psychiatric Hospital
Yuma Regional Medical Center

Medicaid Volume> 50%

Aurora Behavioral Health System
Aurora Behavioral Healthcare-Tempe
Banner Behavioral Health Hospital
ChangePoint Psychiatric Hospital
Copper Springs Hospital
Cornerstone El Dorado
The Guidance Center
Hacienda Children's Hospital
Little Colorado Medical Center
Maricopa Medical Center
Page Hospital
Palo Verde Behavioral Health
Phoenix Children's Hospital
Quail Run Behavioral Health
Sonora Behavioral Health Hospital
St. Luke's Behavioral Hospital

Appendix B

Hospitals included in each hospital system are as follows:

Abrazo/Tenet
Abrazo Arizona Heart Hospital
Abrazo Arrowhead Campus
Abrazo Central Campus
Abrazo Scottsdale Campus
Abrazo West Campus
Holy Cross Hospital
St. Joseph's Hospital (Tucson)
St. Mary's Hospital

Banner Health
Banner Baywood Medical Center
Banner Behavioral Health Hospital
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Del E. Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner - University Medical Center Phoenix
Banner - University Medical Center South
Banner - University Medical Center Tucson
Page Hospital

Community Health Systems
Northwest Medical Center
Oro Valley Hospital
Western Arizona Regional Medical Center

Dignity Health
Arizona General Hospital
Chandler Regional Medical Center
Dignity Health East Valley Rehabilitation Hospital
Mercy Gilbert Medical Center
OASIS Hospital

St. Joseph's Hospital and Medical Center
St. Joseph's Westgate Medical Center

HealthSouth
Encompass East Valley Rehabilitation Hospital
Encompass Rehabilitation Hospital of Southern Arizona
Encompass Rehabilitation Institute of Tucson
Encompass Valley of the Sun Rehabilitation Hospital, LLC
Encompass Scottsdale Rehabilitation Hospital
Yuma Rehabilitation Hospital

HonorHealth
HonorHealth Deer Valley Medical Center
HonorHealth John C. Lincoln Medical Center
HonorHealth Rehabilitation Hospital
HonorHealth Scottsdale Osborn Medical Center
HonorHealth Scottsdale Shea Medical Center
HonorHealth Scottsdale Thompson Peak Medical Center

Steward Health Care
Mountain Vista Medical Center
St. Luke's Behavioral Hospital
St. Luke's Medical Center
Tempe St. Luke's Hospital