October 29, 2013

Mariaelena Ugarte
AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, Arizona 85034

Re: Proposed Hospital Assessment Rule R9-22-730

Dear Ms. Ugarte,

In order to support coverage pursuant to the voter-approved Proposition 204 and newly eligible persons under the expansion of Medicaid, the Arizona Health Care Cost Containment System (AHCCCS) Administration proposes a hospital assessment rule (R9-22-730) to establish an assessment based on certain hospital discharges beginning January 1, 2014. AHCCCS proposes establishing 13 separate hospital classifications with variable assessment rates or complete exclusion from the assessment. I am submitting the following comments and the request detailed below in the hope that AHCCCS will continue to refine its assessment model as specific examples of inequity or less-than-desirable public policy are brought to your attention.

On that point, I want to commend the AHCCCS Administration for the public, transparent and thoughtful process that has been used to develop the assessment model and consider industry recommendations. Throughout that process, Banner Health has expressed its support for an assessment model that included all or nearly all providers in the interest of fairness and broad-based support for the AHCCCS program. While AHCCCS adopted some recommendations, it failed to adopt others. Consequently, the proposed model unfairly excludes from the assessment a number of hospitals that benefit from the restoration and expansion of AHCCCS coverage while including some hospitals in the assessment that will not benefit from the restoration and expansion.

The specific example of this treatment I want to bring to your attention, and which I hope AHCCCS will address in the final assessment design and rule, relates to the exclusion of one **- and only one -** hospital because of its high percentage of Medicare discharges. This exclusion, noted in R9-22-730, Subsection H, Paragraph 7, of the Proposed Hospital Assessment Rule, applies to acute care hospitals *"located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare"*. Based on the assessment modeling provided, AHCCCS believes this exclusion applies only to Mayo Clinic Hospital in Phoenix. This language is identical to the language used for the City of Phoenix Access to Care provider assessment to exclude this same hospital from that assessment but the difference between that single-city, limited-duration, supplemental-funding provider assessment and this statewide assessment to replace state funding for the AHCCCS program can be measured in miles and I think it is fair to say an exclusion intended for one is not necessarily appropriate for the other. Specifically, the requirements for a qualifying hospital to be located in a city of one million and for 15 percent of its inpatient days ("on average", whatever that may mean) be attributed to out-of-state patients

seem at best anachronistic when considering: (a) the long-term nature of the statewide assessment; and (b) the intended use of the resulting funds to support the wholesale restoration and expansion of a portion of the AHCCCS program.

The logic of using the Medicare burden on any hospital as a criterion for disparate treatment and a separate classification or exclusion is compelling. As AHCCCS is aware, most hospitals provide care to Medicare patients at a loss and make up that loss with volume from commercial patients. If the Medicare portion of a hospital's patients rises above a certain level, there aren't enough commercial patients to offset those losses. Given that fact, layering on another significant expense in the form of this assessment – which equates to roughly a 3% surcharge - on each and every discharge, including Medicare, at such a hospital further weakens that hospital's ability to continue providing services to the seniors in that marketplace.

After a review of 2011 Medicare discharges at acute care hospitals statewide (see attached table 1), we believe the exclusion as drafted unjustly favors a single high-volume Medicare provider, Mayo Clinic Hospital, over other hospitals that serve significantly higher volumes of elderly patients. Banner has consistently supported a broad-based, "all-in" model, especially for hospitals that benefit under the coverage restoration and expansion. The other proposed exclusion criteria, particularly the requirement for a specified percentage of non-Arizona discharges, arbitrarily and capriciously exempts one high-volume Medicare provider, the Mayo Clinic Hospital, without any reasonable basis in policy or fact. If AHCCCS chooses to include this exclusion as part of the final model, I believe this exclusion should, like all others, treat similar hospitals equitably.

Over the initial six-months of the proposed assessment, Banner Boswell Medical Center in Sun City and Banner Del E. Webb Medical Center in Sun City West, all included in the assessment, lose a combined $(1,087,217) because of their high Medicare volumes. Once the assessment is scaled up for a full year and to the projected $256 million funding need, that annual loss grows to nearly $4 million based on the current design. As shown in the table below, each of these medical centers treat significantly more Medicare patients than the 50% of discharges threshold that is defined in the exclusion (and significantly more Medicare cases than does Mayo Clinic Hospital).

	Mayo Clinic Hospital	Banner Boswell	Banner Del E. Webb
Medicare % of Discharges (2011)	54.5%	80.3%	64.3%
Medicare Cases (2011)	6,933	17,944	12,730
Gain/(Loss) from Proposed Assessment	$749,090	$(826,674)	$(260,543)

As the largest insurer in the state, and a publicly-funded program, it is important that AHCCCS treat all providers fairly to avoid creating distortions in the marketplace. The current design has the unfortunate result of providing an exclusion for one hospital in one city of the state that barely meets the Medicare volume threshold, resulting in a significant gain on the assessment for that hospital, and forcing at least three others with much higher percentages of Medicare volumes to pay the highest assessment rates, resulting in significant losses.

Consequently, I am requesting that AHCCCS modify the exclusion in question to: (a) make it better suited for a statewide assessment design, and (b) avoid the disparate and inequitable treatment of other high-volume Medicare hospitals. Specifically, I ask that AHCCCS: (a) expand the location requirement to include hospitals in unincorporated areas; (b) eliminate the out-of-state requirement; (c) maintain the minimum qualifying threshold of 50 percent Medicare volume; and (d) require an additional minimum qualifying threshold of 5,000 Medicare cases, in recognition of the burden borne by other high-volume Medicare hospitals. With assistance from HMA, we've concluded this can be achieved while still leveraging the necessary amount for the state share of coverage and meeting the necessary "B" test and Inpatient Hold Harmless Calculations (see attached table 2). With these changes, Banner believes the assessment model would not only be more equitable but also avoids a single-hospital exclusion that may be a concern for CMS.

Before I close, I want to express my appreciation for AHCCCS' willingness to establish a separate classification for high-volume pediatric hospitals. This rate adjustment establishes parity and fairness with the two children's hospitals that are excluded as a defined class under the assessment model and helps to ensure that all pediatric facilities can continue their commitment to the prevention, diagnosis and treatment of complex childhood diseases, injuries and medical conditions. The change we are requesting for Medicare hospitals is similar in logic, i.e., similar treatment for similar hospitals, and I thank you for your consideration of our input and for addressing both issues in the final rule.

Banner Health remains steadfast in its support of the Governor's Medicaid Restoration Plan and is committed to working with AHCCCS to ensure its success. I understand that AHCCCS will revisit the assessment model each year to account for enrollment changes and new data on provider payments. It is our hope that AHCCCS, with industry input, will continue to work toward a model that treats all facilities in the marketplace equally and moves us closer to an all-in assessment design.

Thank you for your time and consideration. I look forward to your response.

Sincerely,

Peter S. Fine, FACHE
President & CEO
Banner Health

cc: Tom Betlach
Beth Lazare
Monica Coury
Shelli Silver
JeanEllen Schulik
Scott Smith

Table 1.
2012 Arizona Acute Facilities Medicare Patients as a percent of Total Inpatient Discharges
Source: ADHS Inpatient Discharge Database

		Medicare Cases	% Medicare	Total Cases
Facility_Market	**Facility**	**2011**	**20112**	**20113**
Maricopa-Pinal	BBWMC	17,944	80.3%	22,352
Maricopa-Pinal	BHH	4,335	73.7%	5,879
Southern AZ	Benson	251	72.8%	345
Southern AZ	Oro Valley	3,394	69.2%	4,905
Maricopa-Pinal	BBMC	14,188	66.9%	21,220
Maricopa-Pinal	Wickenburg	368	67.8%	543
Northern AZ	White Mtn	226	56.5%	400
Maricopa-Pinal	BDWMC	12,730	64.3%	19,798
Maricopa-Pinal	AZ Heart	1,566	53.0%	2,952
Northern AZ	Yavapai	4,290	62.5%	6,867
Northern AZ	Havasu	3,837	59.3%	6,473
Northern AZ	Western Arizona	3,936	64.7%	6,088
Southern AZ	Heart & Vasc Institute	1,632	63.3%	2,577
Southern AZ	La Paz	442	56.5%	782
Northern AZ	Verde Valley	2,548	54.6%	4,663
Northern AZ	Kingman	4,471	52.4%	8,538
Northern AZ	Payson	1,246	53.4%	2,333
Northern AZ	Sage	262	59.8%	438
Maricopa-Pinal	Scotts-Thompson Pk	1,962	51.1%	3,837
Maricopa-Pinal	Mayo	6,933	54.5%	12,719
Southern AZ	Copper Queen	219	51.8%	423
Southern AZ	St Mary's	6,741	49.0%	13,757
Maricopa-Pinal	JCL-NM	7,975	49.5%	16,110
Southern AZ	N Cochise	304	55.4%	549
Maricopa-Pinal	AZ Ortho	362	38.1%	949
Maricopa-Pinal	AZ Spine & Joint	485	54.6%	888
Southern AZ	Northwest	8,961	47.3%	18,932
Maricopa-Pinal	St Luke's	2,635	46.2%	5,709
Maricopa-Pinal	Mtn Vista	4,411	45.2%	9,755
Maricopa-Pinal	Casa Grande	3,951	46.5%	8,499
Maricopa-Pinal	AZ Reg-AJ	614	43.9%	1,399
Maricopa-Pinal	Scotts-Osborn	7,551	45.2%	16,716
Maricopa-Pinal	OASIS	215	39.2%	549
Southern AZ	Yuma	7,094	44.8%	15,822
Northern AZ	Valley View	2,117	65.3%	3,243
Southern AZ	St. Joseph's (Tucson)	7,946	43.6%	18,228
Maricopa-Pinal	JCL-DV	4,923	40.5%	12,141

Southern AZ	UMC-South	2,118	31.7%	6,682
Northern AZ	Summit	1,187	30.5%	3,892
Maricopa-Pinal	West Valley	4,239	37.0%	11,459
Maricopa-Pinal	Paradise Valley	2,591	36.7%	7,054
Northern AZ	Little Colorado	423	31.9%	1,324
Northern AZ	Cobre Valley	736	42.3%	1,738
Maricopa-Pinal	Chandler	6,766	36.9%	18,327
Maricopa-Pinal	Scotts-Shea	8,117	36.9%	21,982
Maricopa-Pinal	Arrowhead	4,405	34.2%	12,881
Southern AZ	TMC	11,797	35.4%	33,345
Southern AZ	Sierra Vista	1,948	37.0%	5,268
Maricopa-Pinal	Mercy Gilbert	4,827	34.0%	14,193
Maricopa-Pinal	BTMC	11,522	34.7%	33,248
Maricopa-Pinal	AZ Surgical	537	37.7%	1,426
Maricopa-Pinal	BGSMC	13,436	33.5%	40,082
Northern AZ	Yavapai-East	1,459	34.1%	4,283
Southern AZ	UMC	8,280	31.3%	26,457
Southern AZ	Southeast AZ	70	29.3%	239
Maricopa-Pinal	BEMC	6,144	32.2%	19,105
Northern AZ	Flagstaff	3,950	29.2%	13,516
Maricopa-Pinal	BGMC	4,481	30.6%	14,620
Northern AZ	Mt Graham	621	28.2%	2,203
Maricopa-Pinal	Phx Baptist	2,904	29.2%	9,943
Maricopa-Pinal	BDMC	10,437	27.1%	38,500
Maricopa-Pinal	St Joseph's	8,702	26.2%	33,213
Maricopa-Pinal	AZ Reg	454	26.3%	1,725
Maricopa-Pinal	Maryvale	1,599	28.3%	5,648
Maricopa-Pinal	Gilbert	176	14.7%	1,199
Maricopa-Pinal	BIMC	645	23.5%	2,741
Northern AZ	Page	99	17.9%	553
Southern AZ	Holy Cross	270	17.3%	1,561
Maricopa-Pinal	Tempe St Luke's	715	19.5%	3,670
Maricopa-Pinal	Scotts-Greenbaum	68	27.8%	245
Maricopa-Pinal	Maricopa	2,431	13.9%	17,445
Maricopa-Pinal	CTCA	13	2.3%	554
Maricopa-Pinal	PCH	53	0.4%	13,318
Maricopa-Pinal	Florence	414	41.4%	1,000
Northern AZ	Hualapai Mtn	757	62.6%	1,209
Grand Total		281,699	40.1%	703,226

Table 2.

Assessment Basis:	*Patient Discharges*

Assessment Rate Inputs	SFY 2014
Urban Acute Provider	139.00
Non-CAH Rural Acute Provider	139.00
Freestanding Children's Provider	0.00
CAH	139.00
LTAC Provider	30.50
Small Psychiatric Providers and AZ State Hospital	0.00
Large Psychiatric Provider	30.50
Freestanding Rehabilitation Provider	0.00
Pediatric-Intensive General Acute Hospitals	30.50
Psychiatric Sub-Provider	30.50
Short Term Specialty Hospital	0.00
Specialty Med-Hospitals Less than 20 beds	0.00
Large High Medicare Utilization Hospital[1]	0.00

Assessment Unit Threshold	29,000
Assessment Unit Rate Above Threshold	12.25

State Assessment Summary	SFY 2014
Total Assessments	75,418,724
State Share of Coverage Payments	75,339,400
Assessments Net of State Share	79,324

Hospital Net Gain/Loss Summary	SFY 2014
Total Projected Coverage Payments	183,736,472
Estimated Net Gain/Loss	108,317,748
Number of In-State Hospitals with Estimated Gain	89
Number of In-State Hospitals with Estimated Loss	3
Number of In-State Hospitals with $0 Gain or Loss	6
Number of In-State Hospitals Systems with Estimated Loss	0

B Test Calculation	SFY 2014
B1 Value	0.000003743
B2 Value	0.000003729
B1/B2 Value	1.0037941

Inpatient Hold Harmless Calculation	SFY 2014
Total Assessment Amount	75,418,724
Inpatient Net Patient Revenues	6,668,244,493
Ratio	1.13%

[1] Revised exclusion definition now includes Mayo, Banner Del Webb, and Banner Boswell.

From: Goda, Joan M. [mailto:Joan.Goda@carondelet.org]
Sent: Wednesday, September 04, 2013 7:43 AM
To: FFS Rates
Cc: Bojorquez, Joel
Subject: AHCCCS Draft Proposed Hospital Assessment Rule - CHN Comments

Carondelet Health Network appreciates the invitation to participate in the Statewide Hospital Assessment Workgroup and the opportunity for collaborative discussion and recommendations. We found the effort to be quite productive and educational. Upon review of the Draft Rule, we felt compelled to share our comment as a follow-up to previous discussions and recommendations for future consideration.

While we understand the need to develop the 2014 Assessment based on 2011 Discharges, there was lingering concern related to the excluded facilities that for 2014 will not pay into the Assessment, but based on the various models are predicted to benefit financially from the upcoming changes. Our recommendation is that consideration be made for a deeper cost/benefit analysis as part of the rate reconsideration planned for Q-1 2015. The thought is that a deeper evaluation of excluded facilities and/or negative financial impact by case for included facilities and/or systems should be incorporated into the planned rate reviews moving forward using FY 2012 data.

We appreciate the opportunity to share our suggestions for upcoming consideration and look forward to rejoining the Workgroup when it is time to reconvene. In the interim, we are happy to join any type of discussion relating to opportunities for future evaluation as needed. Thank you for your consideration.

Kindest Regards,

Joan Goda
Vice President, Managed Care - Network Services
Carondelet Health Network
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♥ **Carondelet. Be well.**

And

Joel Bojorquez | Sr. Director Hospital Finance
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♥ **Carondelet. Be Well.**

From: Jim Childers [mailto:jchilders@cvrmc.org]
Sent: Thursday, September 05, 2013 4:55 PM
To: AHCCCS Rules
Cc: njensen@cvrmc.org
Subject: Notice of Final Rule Making; R9-22-730

Mariaelena Ugarte,

We firmly believe the hospital assessment model as couched in this proposed rulemaking favorably benefits the Hospitals who have chosen a different patient care delivery model by not serving AHCCCS patients, thus avoiding the assessment to the detriment of the remaining hospitals. This could create an adverse selection which could hurt hospital's financially.

We would be please to elaborate on our comments at the appropriate time.

Thank you,
Jim

James R. Childers, CFO, FHFMA
Administration

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www.CVRMC.org

From: Tim Blanchard [mailto:TBlanchard@azkrmc.com]
Sent: Thursday, August 29, 2013 10:11 AM
To: FFS Rates
Subject: Comments on Proposed Hospital Assessment

In reviewing the proposed assessment it is noted that there is a reduced assessment rate for Hospital's with more than 29,000 discharges annually. Our understanding is that AHCCCS is attempting to meet certain ratios by providing relief to large hospitals with a large governmental/self pay burden. Our feeling is that if reductions are to be provided, it would be more appropriate and equitable to include all facilities across the state that take on a high government payer/self pay burden rather than just looking at numbers of discharges. The current proposed approach assists a small number of large providers, but ignores several medium sized or small providers that have a higher governmental/self pay burden than the large providers. This more equitable approach would provide relief to those really in need of relief.

Exclusions for facilities that do not accept or limit AHCCCS patients should be adjusted or phased out over time. This would give these facilities the opportunity to begin accepting AHCCCS patients to help offset the assessment burden.

Sincerely,

Tim Blanchard
Chief Financial Officer
Kingman Regional Medical Center
3269 Stockton Hill Rd.
Kingman, AZ 86401
928-681-8668

SCOTTSDALE
HEALTHCARE

September 4, 2013

Director Thomas J. Betlach
AHCCCS
801 East Jefferson
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to participate in the Statewide Hospital Assessment Workgroup over the last several months. Scottsdale Healthcare appreciated the opportunity to provide feedback on draft models and discuss concerns. Your staff, as always, was extremely responsive to answering questions and clarifying information.

As you know, we have been historically opposed to hospital provider assessments because of their redistributive nature and very complex CMS requirements. While the draft model proposed by AHCCCS does not negatively impact any hospital systems, it certainly meets the federal requirement to be redistributive in nature and produces a loss for our Scottsdale Healthcare Shea Medical Center.

The creation of a successful and sustainable provider assessment formula for Arizona will continue to require a significant amount of work by AHCCCS and stakeholders, especially in SFY15 and beyond when revenue needed for funding the nonfederal share of costs for Medicaid expansion will likely be more than triple than what is required from an assessment in SFY14. Scottsdale Healthcare respectfully requests your continued commitment to the same overarching principles and goals you utilized to develop the SFY14 assessment, what you articulated and documented for all stakeholders in January 2013 at the inception of this initiative. Preventing negative impacts to hospital systems is vital for the development of future assessment models, and we are very grateful for your continued effort in that regard.

Some peer hospitals were provided exemptions from the provider assessment for the primary reason of ensuring that no hospital systems would be negatively impacted. We understand and appreciate the legitimate rationale for such exemptions, and Scottsdale Healthcare would like to be provided the same exemption consideration in the future should our three hospitals pay more in an assessment model than they receive in expanded AHCCCS payments. This appears to be the best way to ensure that patients or third party payers continue to be protected from increased costs from to the assessment.

As a locally owned, nonprofit healthcare system with three hospitals in Scottsdale, our first priority is our patients and the community we serve. As we close an affiliation agreement on September 30, 2013 with John C. Lincoln Health Network to create a complementary and more resourceful network, it is an important to note each will remain separate legal entities (structured

under two unique Obligated Groups with unique stakeholders). Any impact to Scottsdale Healthcare should continue to focus on the three hospitals that comprise the Scottsdale Healthcare system today.

Thank you, again, for consistently maintaining your policy objectives and for continuing to include Scottsdale Healthcare in the development of future successfully assessment models.

Sincerely,

Todd LaPorte, C.P.A.
Executive Vice President and Chief Financial Officer

TMC
HEALTHCARE

August 27, 2013

Mariaelena Ugarte
AHCCCS Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, Arizona 85034

Dear Ms. Ugarte

This letter is in response to the Notice of Proposed Exempt Rulemaking, Title 9 Health Services, and Chapter 22 in which, the Arizona Health Care Cost Containment System (AHCCCS) Administration has established a hospital assessment schedule in order to fund the current Medicaid expansion. Under the draft rule, a separate assessment rate has been provided for short-term acute care hospitals with more than 80 pediatric beds as reported in the hospital's 2012 Uniform Accounting Report. We believe that a "pediatric intensive" hospital definition should include not only pediatric beds, but also beds designated for neonatal intensive care and pediatric intensive care.

At Tucson Medical Center, our pediatric program is called TMC for Children. TMC for Children is Southern Arizona's Children Miracle Network hospital with 38 inpatient pediatric med/surg beds, 12 pediatric intensive care beds and 42 neonatal intensive care beds (a total of 92 beds), backed by a full complement of pediatric-focused radiology, surgical and therapy inpatient and outpatient services.

A neonatal intensive care unit (NICU) is vital to any large pediatric program. With 42 NICU beds, TMC had 793 NICU admissions in 2012, which was 83% greater than the number of NICU admissions at the next busiest NICU in Southern Arizona. (See Attachment A) In addition, TMC had 27,848 pediatric ED visits in 2012, which was 59% more than the next busiest pediatric emergency department in the region as well as being a much more significant percentage of the total population seen (see Attachment A). In fact, 26.2% of all encounters at TMC during 2012 were pediatric patients.

TMC for Children inpatient and pediatric intensive care units are staffed by pediatric hospitalists from the University Of Arizona School of Medicine (the same group that provides coverage at University of Arizona Medical Center – Diamond Children's). TMC for Children includes a robust pediatric subspecialty service including cardiology, neurology, ENT, GI, pulmonary, etc. When constructing new surgical suites, TMC designated a specific track for pediatric patients that are separate and distinct from our adult track (the only dedicated pediatric surgical center in Southern Arizona). TMC for Children is Southern Arizona's Children's Miracle Network hospital and we have the only pediatric hospice in the region. TMC for Children is a member of the Children's Hospital Association and is the lead agency for Safe Kids Tucson. TMC's pediatric program goes far beyond a typical community hospital with a few general pediatric beds and a newborn nursery.

TMC understands that setting up separate rate assessment groups for free standing children's hospitals and for "pediatric intensive acute care hospitals" makes sense as all of the population that the assessment is funding is not a pediatric population. However, looking only at the pediatric inpatient beds of a hospital is not the best measure of whether a hospital is truly a pediatric intensive hospital. We believe that TMC's pediatric program meets the objective of a "pediatric intensive" hospital definition and respectfully request that AHCCCS include pediatric, pediatric intensive care and neonatal beds in calculating the total of 80 beds for a pediatric intensive care hospital. We appreciate your consideration. Please feel free to contact us with any questions.

Sincerely,

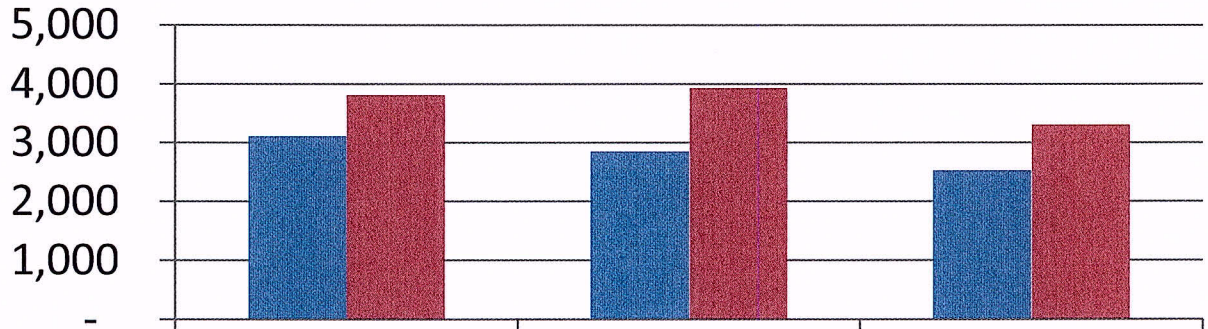
Judy Rich
President and Chief Executive Officer
TMC HealthCare

Cc: Tom Betlach, AHCCCS Director

Attachment

ATTACHMENT A

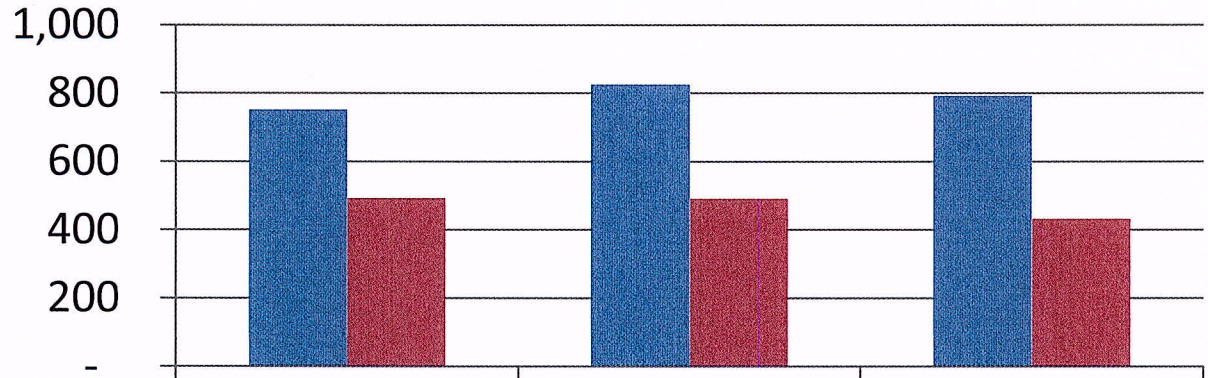
Pediatric Inpatient Admissions
TMC and UMC: 2010-2012



	2010	2011	2012
TMC	3,111	2,847	2,523
UMC	3,815	3,934	3,306

TMC UMC

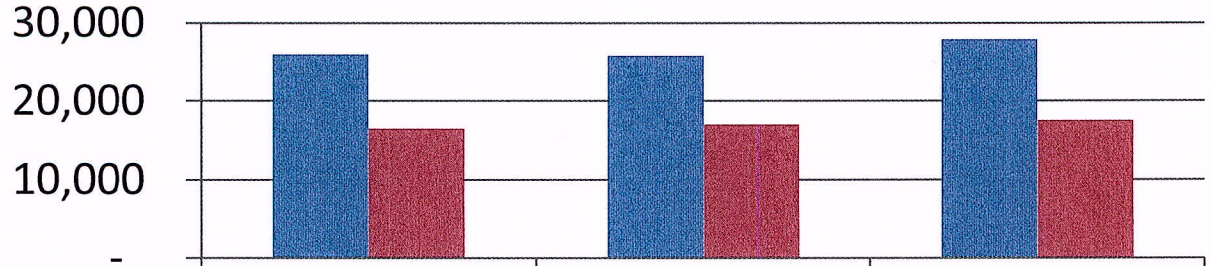
NICU Admissions
TMC and UMC: 2010-2012



	2010	2011	2012
TMC	752	826	793
UMC	493	492	433

TMC UMC

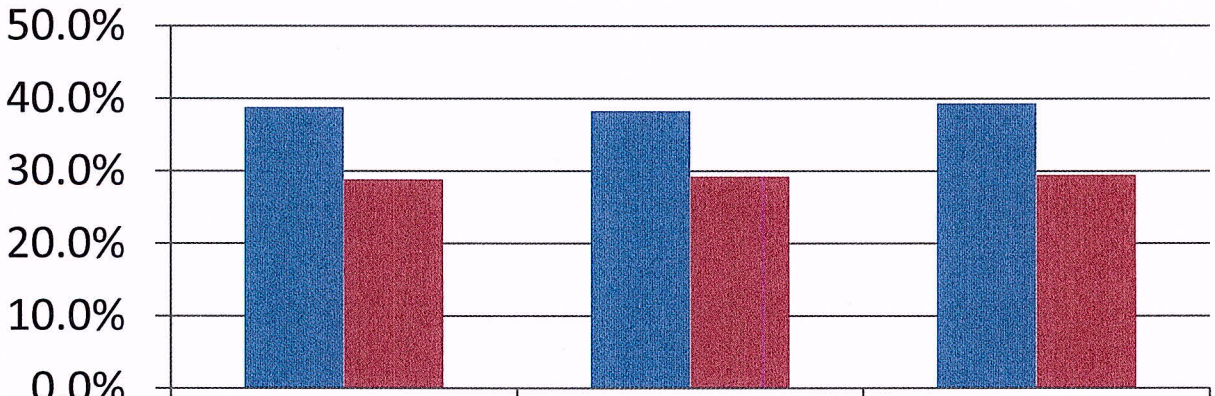
Pediatric Emergency Visits
TMC and UMC: 2010-2012



	2010	2011	2012
TMC	25,953	25,812	27,848
UMC	16,488	17,007	17,545

TMC UMC

% of Pediatric to Total Emergency Visits
2010-2012



	2010	2011	2012
TMC	38.8%	38.3%	39.3%
UMC	28.8%	29.2%	29.5%

TMC UMC