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Arizona Health Care Cost Containment System

Independent Evaluation for Safety Net Care Pool for Phoenix Children's Hospital

Final Report

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I. Executive Summary

Public Consulting Group (PCG) has contracted with the Arizona Health Care Cost Containment System (AHCCCS) to provide an independent evaluation of the use made by Phoenix Children's Hospital (PCH) of funds available through the state's Safety Net Care Pool (SNCP) program. PCG's evaluation of PCH's use of SNCP payments consisted of a review of the hospital's costs prior to ACA implementation as well as a comparison to costs incurred during the first quarter of the post-implementation period. These costs were analyzed in detail to determine the extent to which post-implementation uncompensated costs are attributable to Medicaid shortfall or uninsured, in order to understand the potential impact of ACA reform on PCH.

Uninsured care historically has not been a major driver in PCH's uncompensated care costs, nor does it appear that ACA reform has exerted any significant influence on the relative levels of Medicaid versus uninsured patients seen by the hospital. Like most children's hospitals, PCH serves a population with a high rate of Medicaid coverage and a low proportion of uninsured patients in comparison to safety net hospitals. Before and after implementation of the ACA reforms, the uninsured have constituted a marginal group within the hospital's overall payor mix, with no significant changes in the proportion of "self-pay" clients over the past five years.

Analysis revealed an 83% growth in overall uncompensated care costs between FFY 2011 and FFY 2012, with a corresponding decrease in the supplemental payments available to PCH. This increase in costs is due to a number of causal factors introduced in that year, demonstrating the compounding effect of major changes in PCH volumes, higher patient acuity, and significant rate reductions implemented by AHCCCS. While the growth in payment amounts in FFY 2011 continued to keep pace with the growth in costs—in which PCH reported an 18% growth in Medicaid payments in alignment with a 19% growth in costs—this trend did not continue into FFY 2012. Overall Medicaid reimbursement actually decreased in that year, with a negative 2% change in payments, despite a 24% growth in costs. Consequently, while the level of uninsured uncompensated care remained relatively stable between FFY 2011 and FFY 2012, the amount attributed to Medicaid shortfall essentially doubled, growing from $49.7 million to $102.2 million.

Although PCH's financial picture in 2014 remains incomplete, it is apparent that some of the factors driving the hospital's higher uncompensated care since 2011 have been mitigated, if not eliminated, in the new fiscal year. Certainly, Medicaid shortfall trends at the hospital have not returned to their pre-2012 profile, and the financial dynamics which originally created the need for SNCP financing remain largely in place. However, it appears that the effort to contain Medicaid costs is increasingly effective, and that the care delivery system has become more closely aligned with the payment system and new reimbursement rates established by AHCCCS. An overall comparison with the 2012 baseline year reveals several encouraging trends at PCH on both the inpatient and outpatient side of uncompensated care.

PCH Medicaid Shortfall Trends	FFY 2010	FFY 2011	FFY 2012	FFY 2013*	CY 2014**
Medicaid Costs	$172,822,670	$204,927,400	$253,666,200	$279,631,564	$279,475,647
Medicaid Payments	$131,920,104	$155,153,467	$151,467,370	$144,443,969	$194,462,862
Medicaid Shortfall	$40,902,566	$49,773,933	$102,198,830	$135,187,595	$85,012,785
Cost Coverage	76.3%	75.7%	59.7%	51.7%	69.6%

* Partial projection provided by AHCCCS based on PCH's 2013 utilization and 2011-12 Medicare Cost Reports.
** Projection based on PCH's CY 2014 Q1 claims and encounter data.

AHCCCS efforts to contain Medicaid costs in the state have undoubtedly heightened the shortfall. Despite service delivery changes at PCH that have helped reimbursement levels to keep better pace with rising costs, it appears that even if overall payment levels more closely approximated their pre-2011 levels, the hospital's heightened service volume would still potentially produce a gap between Medicaid costs and payments which are too large to be filled with traditional supplemental payment programs.

This impact is most evident in the agency's recent policy shifts regarding outlier payments, where increased outlier thresholds, combined with outlier rate reductions, appears to be the single most important cost driver of uncompensated care at PCH. Given the hospital's business model and reliance on outliers to support its specialized efforts to provide care for high acuity conditions, the state's elevation of outlier thresholds has had a much deeper impact on payments than at hospitals serving populations with lower acuity.

It is not clear, however, that the most appropriate means for addressing the shortfall would be to increase those rates. The high cost of care at the hospital is not merely a function of higher patient acuity, but must also be placed within the wider context of PCH's ambitious organizational growth and its aspirations to be a national leader in high quality pediatric care, equipped with cutting-edge medical technology, attracting top physician talent, and producing highly-respected research. On the one hand, available quality measures indicate that PCH has achieved many of these institutional goals, delivering both high-quality and high-value care when compared to peer children's hospitals nationwide. On the other hand, the relative efficiency of the hospital's service delivery should not obscure the overall high expense of the types of care delivered at PCH. The unique services that PCH provides to the state of Arizona are beneficial but costly. Recognizing that the AHCCCS cuts in recent years have followed in the wake of a decade of an unprecedented growth in costs and revenue at PCH, it seems appropriate to consider whether their disproportionately negative impacts on the hospital are, perhaps, also the result of a business model and the development of service lines not previously oriented to the strict demands of cost containment.

Considering the high levels of Medicaid shortfall that will continue to occur under the current operational conditions at PCH, it is PCG's view that SNCP payments remain necessary to offset the costs of the hospital's heavy burden of uncompensated care. The analyses above suggest that the hospital's Medicaid shortfall is the unique consequence of a convergence between the state's cost containment efforts and PCH's high quality, high cost delivery system. While SNCP does not represent a permanent solution to assuring adequate Medicaid cost coverage to the hospital, it continues to serve as an essential mechanism for transitioning PCH to the post-ACA health care environment.

II. Project Overview

Public Consulting Group (PCG) has contracted with the Arizona Health Care Cost Containment System (AHCCCS) to provide an independent evaluation of the use made by Phoenix Children's Hospital (PCH) of funds available through the state's Safety Net Care Pool (SNCP) program. Although authorization for the SNCP program in the state's Section 1115 demonstration waiver was originally set to expire with the implementation of the Affordable Care Act (ACA), an amendment to this waiver in 2013 permitted PCH to extend its authorization to draw SNCP funds, on condition that the state provide for a study of the hospital's uncompensated care costs during the post-implementation period, as well as an evaluation of the continuing necessity of the SNCP as a financing mechanism to cover these costs.

PCG's evaluation of PCH's use of SNCP payments consisted of a review of the hospital's costs prior to ACA implementation as well as a comparison to costs incurred during the first quarter of the post-implementation period. These costs were analyzed in detail to determine the extent to which post-implementation uncompensated costs are attributable to Medicaid shortfall or uninsured, in order to understand the potential impact of ACA reform on PCH. In light of these findings, PCG has been tasked with assessing the necessity of SNCP funds as a financing mechanism for the hospital's current uncompensated care costs, as well as examining alternative payment reforms within the state designed to reduce or eliminate PCH's Medicaid shortfall. In accordance with these objectives, PCG's evaluation consists of the following three components:

1) **SNCP Payment Comparative Analysis**: an examination of changes in PCH's SNCP payments from the pre- to post-extension period, which began January 1, 2014. PCG received detailed data from AHCCCS on the SNCP payments required to cover Medicaid and uninsured shortfall in the pre-extension period, while PCH provided encounter and payment data from the first quarter of the 2014 post-extension period. After discussion with AHCCCS, PCG determined that 2012 would serve as an appropriate baseline year, representative of the hospital's costs prior to ACA implementation. In order to establish comparable cost and payment levels, PCG also performed an annual projection of total costs and payments for 2014, based on hospital data available from the first quarter of the calendar year.

2) **Uncompensated Care Cost Analysis**: a comparison of SNCP payments attributable to uninsured children and children who are Medicaid beneficiaries. In light of the objective of federal reform to reduce the ranks of the uninsured, an important element of this analysis is to determine whether the ratio of uninsured costs to Medicaid shortfall have changed significantly in the post-implementation period, as well as whether the ACA has reduced uncompensated care for the hospital overall. PCG's goal was to examine whether ACA reform has affected this proportionality, given PCH's extremely unique patient population. In order to understand these dynamics, PCG investigated not only whether significant fluctuations can be seen in PCH's payer mix between the two review periods,

but also whether the cost drivers in shortfall have changed substantially since the beginning of 2014.

3) **Contributing Factors to the Necessity of SNCP**: an explanation of the causal factors that result in high levels of uncompensated care for the hospital, including a determination of whether SNCP continues to be required as a financial remedy for covering these costs. Because PCH is a highly specialized hospital provider serving a high acuity children's population, the dynamics of uncompensated care for the hospital differ sharply from other safety net hospitals in Arizona and the region. Consequently, it was necessary for PCG to account for the hospital's special niche within the system of care, and to determine the specific relationship among its costs, patient population, and delivery system. As a part of this analysis, PCG also reviewed payment rate reform initiatives currently being implemented by AHCCCS to evaluate their potential effect on PCH's Medicaid shortfall.

III. Evaluation Methodology and Approach

PCG's approach began with an examination of the data provided by AHCCCS for the baseline year of 2012. This data included detailed ancillary and per diem uncompensated cost summaries pulled directly from PCH's Medicaid cost report (MCR), supplemental payment data, and payment tracking information. PCG initially examined the sources of the uncompensated costs, observing the large disparity between Medicaid shortfall and uninsured costs. This disparity, along with the need for support shown in the supplemental payment data and PCG's knowledge of the possible impacts and focus areas of ACA reform, helped PCG narrow the scope of the direction in which to take the evaluation.

Although the initial data provided a foundation for the analysis, PCG requested more detailed claim specific data on the baseline year of 2012. The additional data served two purposes, to provide supporting claim data subject to reconciliation with the initial data, and to provide PCG with a better understanding of important variables that pertain to each claim. These variables included inpatient/outpatient status, claim/encounter status, Medicaid payments, outlier payments, and charge to payment ratios. AHCCCS was able to provide the additional data, which PCG then used in order to analyze how these variables correlate with each other and what seasonal trends in the business cycle PCH is presented with during a calendar year.

With the data request fulfilled by AHCCCS, PCG's focus turned to 2014 and the post-ACA era. To analyze any possible effects of healthcare reform, additional data from the first quarter of 2014 was needed. PCH was able to supply a data set as well as their own analysis on the trends they had observed in the past three years. With the new data, PCG was able to develop a projection for the entire year of 2014 and a comparative analysis between this projection and the baseline year 2012. In addition, the analyses provided by PCH supported further the trends that PCG was already seeing in the data.

Once the data requests from both entities were fulfilled, PCG proceeded with the work plan centered on the analyses of the data. The work plan included the analysis of the different cost categories and the payments that pertained to them, calculations of PCH's costs for SNCP services, a comparative analysis of Medicaid payments to calculated costs, and an analysis of possible payment reforms. These analyses were designed to, in the end, evaluate the necessity of SNCP in this final report.

PCG's SNCP examination was focused on the findings of two main analyses. The first of which was a comparative analysis of the 2012 total costs and payments versus the 2014 projection of the same statistics. This provided the breakdown of the costs from each year into per diem and ancillary costs, both from inpatient and outpatient procedures, as well as the same breakdown of payments. These calculations were then used to calculate total shortfall projections and draw conclusions on what specific cost categories are responsible for big changes in the 2014 data. The second major focus in this examination was an analysis of the costs of PCH's uncompensated care. This analysis compared the Medicaid shortfall to the uninsured

costs that the hospital absorbs. The purpose of this analysis was to show the large disparity in the two and how PCH is largely excluded from the new benefits of ACA reform that focus on insuring more of the uninsured adult population. This is a clear indication of the large deficit that remains and the support that is still needed despite ACA reform.

PCG's final objective in this report was to analyze the payment reform that will be initiated in October of this year. This initiative will transform the Medicaid payment methodology from the current system that pays on a per diem rate to a fee for service system that pays based on the APR-DRG classification of service system. The purpose of this analysis was to quantify the impact this will have on PCH's total payments. A reexamination of a previous impact study by Navigant is an element of this analysis.

IV. Analysis of Key Review Areas

A. SNCP Payment Comparative Analysis

AHCCCS originally received federal approval to establish the SNCP program in April 2012 to fund unreimbursed costs incurred by hospitals caring for AHCCCS recipients and the uninsured through December 31, 2013. SNCP provided $150 million in total funds to participating hospitals in FY 2012 and $362 million in FY 2013. After implementation of the ACA in January 2014, PCH became the only hospital within the AHCCCS system that continued to qualify for SNCP funds via a waiver amendment request by AHCCCS. Although SNCP funding was discontinued for other Arizona hospitals due to the expected reduction of uncompensated care in the wake of federal reform, the pool has remained in place as a transitional funding mechanism for PCH on account of the hospital's special role within the health care safety net and the expected negligible impact of the state's Medicaid expansion on PCH.

The justification for the continuation of SNCP is due primarily to PCH's unique patient population, which is characterized by a heavy reliance on Medicaid as well as a complex mix of high acuity cases. As a children's hospital, PCH serves a low proportion of uninsured patients, while its Medicaid population is significantly higher than typical community hospitals, with approximately 54% of its patients covered by AHCCCS, compared to the statewide average of 23%. Because of its specialized role within the safety net, PCH also features a highly complex mix of cases in its patient population, exhibited by a case mix index (CMI) that not only exceeds other Arizona hospitals, but also ranks in the top quartile among all children's hospitals nationwide. PCH is fully staffed and trained to receive children at the highest level of acuity and complexity, which has resulted in a significant increase in its average level of acuity in its cases in recent years, with costs that well exceed Medicaid rates. These high levels of acuity are evident in PCH's patient day data, exhibiting an average length of stay of 6.3 days compared to the statewide average of 3.9. These longer lengths of stay are largely attributable to the severity of the cases seen at the hospital and contribute substantially to its uncompensated care costs.

While supplemental payments such as the Disproportionate Share Hospital (DSH) and the Graduate Medical Education (GME) programs continue to provide a substantial level of support to the hospital, the SNCP program has come to play a far more dominant role in covering the hospital's uncompensated care costs since its inception, especially as these costs have grown steadily after the state's economic downturn in 2009. State budget pressures have also led to a series of Medicaid rate reductions since 2009, leading safety net hospitals across Arizona to rely more heavily on supplemental payment programs to maintain Medicaid cost coverage. PCH has participated in these traditional supplemental payment programs as well, forming partnerships with legislatively approved political subdivisions, such as the University of Arizona College of Medicine, Phoenix, to gain access to federal matching dollars.

With the advent of the SNCP program in 2012, PCH began to rely primarily on SNCP payments to cover its uncompensated care costs, decreasing its share of the state's DSH allotment in order to increase the availability of these funds for other hospitals in the state. PCH's financials from FFY 2012 illustrate this shift in the sources of PCH's uncompensated care payments, with the hospital receiving a total of $8.6 million from the DSH and GME programs compared to $92 million from the SNCP program.

This fiscal year also introduced a series of financial trends that significantly increased the level of uncompensated care at PCH. Although PCH's delivery system has been responsive to the new budgetary environment, and appears to have mitigated these financial trends to some extent in 2014, they nevertheless continue to be seen in the hospital's current volume of uncompensated care. The dramatic growth in uncompensated care costs in FFY 2012 is evident in the table below, which provides a wider context of the costs and payments reported in the years before and after FFY 2012.

PCH Uncompensated Care Trends	FFY 2010	FFY 2011	FFY 2012	FFY 2013*
PCH Uncompensated Care Costs	$50,689,144	$60,794,180	$111,376,771	$145,249,268
Supplemental Payments**	$21,660,352	$22,448,865	$9,753,514	$14,040,776
SNCP Payments	$0	$0	$92,000,000	$121,189,584

* Costs projected based on FFY 2011-12 Cost Reports.
** Figures include DSH, GME, and Proposition 202 payments.

This table reveals an 83% growth in overall uncompensated care costs between FFY 2011 and FFY 2012. This precipitous increase in costs is due to a number of causal factors introduced in that year, demonstrating the combined effect of major changes in PCH operations as well as significant rate reductions implemented by AHCCCS. On the one hand, these costs were driven by PCH's own organizational expansion. The hospital opened a new tower facility in late summer of 2011, substantially increasing its own overall bed capacity, while simultaneously assuming responsibility for the pediatric unit at St. Joseph's Hospital and Medical Center.

The impact of the additional service volume is evident in the comparison of PCH's annual operating costs from 2009 to 2013, with the transitional year of 2011 already showing the financial effects of the hospital's expansion, and the full impact on costs visible in 2012.

PCH Net Operating Costs: 2009-2013	
CY 2009	$412,918,000
CY 2010	$414,576,000
CY 2011	$505,047,000
CY 2012	$579,020,000
CY 2013	$589,570,000

The effect of PCH's expansion on the Medicaid program also can be witnessed in the rapid growth of Medicaid costs during the period. The hospital's Medicaid costs grew 19% in FFY 2011, and 24% in FFY 2012, reflecting an overall increase in Medicaid costs of nearly 47% between FFY 2010 and FFY 2012.

PCH Medicaid Shortfall Growth Trends	FFY 2011	FFY 2012	FFY 2013	CY 2014*
Growth of Medicaid Costs	18.6%	23.8%	10.2%	-0.1%
Growth of Medicaid Payments	17.6%	-2.4%	-4.6%	34.6%
Growth of Medicaid Shortfall	21.7%	105.3%	32.3%	-37.1%

* Projection based on PCH's CY 2014 Q1 claims and encounter data.

The expected growth in uncompensated care from this expansion was exacerbated by a series of 5% rate reductions implemented by the State over several quarters in FFY 2011-2012, and compounded even further by an increase in outlier cost thresholds in FFY 2012. Although the growth in payment amounts in FFY 2011 continued to keep pace with the growth in costs—in which PCH reported an 18% growth in Medicaid payments in alignment with a 19% growth in costs—this trend did not continue into FFY 2012. Overall Medicaid reimbursement actually decreased in that year, with a -2% change in payments, despite a 24% growth in costs. Consequently, while the level of uninsured uncompensated care remained relatively stable between FFY 2011 and FFY 2012, the amount attributed to Medicaid shortfall essentially doubled, growing from $49.7 to $102.2 million.

Although PCH's financial picture in 2014 remains incomplete, it is apparent that some of the factors driving the hospital's higher uncompensated care since 2011 have been mitigated, if not eliminated, in the new fiscal year. Certainly, Medicaid shortfall trends at the hospital have not returned to their pre-2012 profile, and the financial dynamics which originally created the need for SNCP financing remain largely in place. However, it appears that the effort to contain Medicaid costs is increasingly effective, and that the care delivery system has become more closely aligned with the payment system and new reimbursement rates established by AHCCCS. An overall comparison with the 2012 baseline year reveals several encouraging trends at PCH on both the inpatient and outpatient side of uncompensated care.

PCH Medicaid Shortfall Trends	FFY 2010	FFY 2011	FFY 2012	FFY 2013*	CY 2014**
Medicaid Costs	$172,822,670	$204,927,400	$253,666,200	$279,631,564	$279,475,647
Medicaid Payments	$131,920,104	$155,153,467	$151,467,370	$144,443,969	$194,462,862
Medicaid Shortfall	$40,902,566	$49,773,933	$102,198,830	$135,187,595	$85,012,785
Cost Coverage	76.3%	75.7%	59.7%	51.7%	69.6%

* Partial projection provided by AHCCCS based on PCH's 2013 utilization and 2011-12 Medicare Cost Reports.
** Projection based on PCH's CY 2014 Q1 claims and encounter data.

The table above illustrates the fact that the hospital's costs in 2014 have remained approximately at FFY 2013 levels, reversing the trend of rapid cost growth that occurred in FFY 2011-12. While some of these lowered costs are attributable to the fact that PCH's lease on Banner Good Samaritan's Neonatal Intensive Care Unit (NICU) was terminated in March 2013, resulting in the loss of 100 NICU beds, changes in inpatient care delivery at the hospital have also exerted a significant influence on cost. PCH appears to have adjusted its care delivery to conform more closely to the financial incentives available in AHCCCS reduced reimbursement structure. The cost coverage provided through AHCCCS' payment rates is projected to verge around 70% in CY 2014, a sharp increase over the low of 52% in the previous year.

The table below offers a more detailed comparison of the different elements driving high rates of uncompensated care in 2012 versus 2014:

Uncompensated Care Cost Comparison	**CY2012 Baseline**		**CY2014 Projection**	
Hospital Costs	Medicaid	Uninsured	Medicaid	Uninsured
IP Days	53,938	991	46,020	920
Per Diem	$2,188	$2,188	$2,338	$2,338
Per Diem Costs	$118,026,806	$2,168,500	$107,578,543	$2,151,571
IP Ancillary and OP Costs	$145,478,922	$9,821,837	$171,897,104	$10,704,309
Total Costs	**$263,505,728**	**$11,990,338**	**$279,475,647**	**$12,855,880**
Hospital Payments				
Total IP and OP Payments	**$152,316,955**	**$2,913,735**	**$194,462,862**	**$4,278,183**
Hospital Medicaid Shortfall				
IP and OP Service Shortfall	***$111,188,773***	***$9,076,603***	***$85,012,785***	***$8,577,697***
PFS Costs				
Professional Fee Charges	$66,973,481	$2,448,826	$76,674,992	$2,913,650
Cost-to-Charge Ratio	33.5%	33.5%	31.5%	31.5%
Cost of Medical Group Services	**$22,436,116**	**$820,357**	**$24,152,622**	**$917,800**
PFS Payments				
Payments for Services	**$20,539,418**	**$235,498**	**$21,542,209**	**$280,049**
PFS Shortfall				
Professional Fee Services Shortfall	***$1,896,698***	***$584,859***	***$2,610,413***	***$637,751***
Total Shortfall				
Total Shortfall	***$113,085,472***	***$8,417,066***	***$87,623,198***	***$9,215,448***

When uncompensated care is analyzed into individual cost components, several significant developments from 2012 to 2014 become visible. The two most important trends that manifest themselves are: 1) fewer inpatient days and declining average lengths of stay (ALOS), and 2) increasing costs attributable to inpatient ancillary services and outpatient services. It is PCG's view that these trends reflect, on the one hand,

considerable efforts by PCH to improve the efficiency of its high quality care, and on the other hand, strategic shifts away from forms of service delivery that yield lower reimbursement rates to services that provide greater cost coverage.

In the first instance, it appears that PCH has responded to lower AHCCCS payment rates by discovering ways to do more with less. In light of the fact that discharges have continued to grow since 2009, the decreasing lengths of stay and total patient days suggests that the hospital is making great strides in delivering high value care and reducing excessive hospital stays. Notably, patient acuity has not declined; on the contrary, PCH's CMI has also risen steadily since 2009, indicating that the hospital's role as a specialized provider within the health care safety net has become more pronounced in the last five years. The high acuity of PCH's patient population may also be a reason that inpatient ancillary costs have not decreased, but rather have increased 10% since 2012, despite representing a lower proportion of total ancillary costs. The table below illustrates the steady annual increase in the hospital's CMI.

PCH Case Mix Index	2009	2010	2011	2012	2013
Acuity	1.45	1.41	1.58	1.68	1.69

Figures provided by PCH illustrate a 17% overall decrease in the cost per case between 2009 and 2013. When costs are adjusted by case mix, decline in costs is more dramatic, resulting in a 29% drop over five years.

In addition to these signs of growing efficiency at PCH, indicators also suggest that the hospital has begun to transition away from services that have been the most negatively affected by AHCCCS rate reductions, and toward services whose payment methods offer more favorable cost coverage. Prior to 2010, PCH's delivery system appears to have relied heavily on outlier payments from AHCCCS, which according to PCH estimates, consisted of over 60% of the hospital's inpatient payments. By the beginning of FFY 2013, however, rate reductions had whittled down that percentage to 23%, while decreasing inpatient cost coverage overall. As a highly specialized children's hospital provider, PCH is naturally more dependent than typical community hospitals on outlier payments to ensure cost coverage, but the hospital's 2014 figures indicate a shift in costs (and payments) from inpatient to outpatient services, which reimburse significantly better than the 55% cost coverage projected for PCH's inpatient ancillary services. The table below illustrates how the percentage of inpatient and outpatient costs are projected to shift in 2014.

Ancillary Cost Comparison	CY 2012		CY 2014	
Service Type	Cost	Cost Percentage	Cost	Cost Percentage
IP Ancillary Costs	$71,445,654	49.1%	$79,128,957	46.0%
Outpatient Costs	$74,033,268	50.9%	$92,768,148	54.0%
Total Costs	$145,478,922	100.0%	$171,897,104	100.0%

Compared to 2012, Medicaid costs have transitioned significantly from inpatient to outpatient services. This analysis also explains the relative improvement in payment rates in 2014 versus 2012-13, since outpatient services draw substantially better reimbursement, resulting in a consequent decrease in the hospital's Medicaid shortfall. Despite these positive trends, however, the level of uncompensated care costs remains elevated in 2014. If DSH and GME payments remain relatively stable, PCH will still have an estimated financial need for SNCP of over $85 million.

B. Uncompensated Care Cost Comparison

Because health care for children from low-income families is heavily subsidized by Medicaid and the Children's Health Insurance Program (CHIP), children's hospitals tend to be like safety net hospitals in their reliance on revenues from Medicaid. However, because these program also ensure a high rate of coverage for the child population, children's hospitals serve a low proportion of uninsured patients in comparison to safety net hospitals.

PCH is no exception to this general profile. Before and after implementation of the ACA reforms, the uninsured have constituted a marginal group within the hospital's overall payor mix, with no significant changes in the proportion of "self-pay" clients over the past five years. Like other children's hospitals and safety net providers, PCH also features the state's Medicaid agency as the dominant payor. Despite significant changes in Medicaid eligibility and enrollment over the past five years, PCH's Medicaid population has remained stable, increasing by less than two percentage points since 2010.

PCH Payor Mix	2010	2011	2012	2013	2014 YTD
AHCCCS	52.4%	53.3%	52.9%	54.8%	54.0%
Self-Pay (Uninsured)	1.1%	1.1%	1.5%	1.3%	1.7%

Although the percentage of uncompensated care costs attributable to the uninsured has shown greater variability than the payor mix listed above suggests, the changing proportion of uninsured costs within the pool of uncompensated care is a consequence of major fluctuations in the level of post-2010 Medicaid rather than a dynamic within the uninsured population itself. Predictably, uninsured costs have increased as a result of inflation and the expansion of PCH's care capacity. However, because these factors have similarly affected Medicaid costs, the apparent causal variable in the proportion of uninsured care is the Medicaid reimbursement rate more than anything else.

Proportion of Uninsured Uncompensated Care	FFY 2010	FFY 2011	FFY 2012	FFY 2013	CY 2014
Hospital Medicaid Shortfall	$40,902,566	$49,773,933	$102,198,830	$135,187,595	$85,012,785
Pro Fee Medicaid Shortfall	$4,331,043	$5,505,444	$2,625,424	$2,573,005	$2,610,413
Total Medicaid Shortfall	*$45,233,609*	*$55,279,377*	*$104,824,254*	*$137,760,600*	*$87,623,198*
Hospital Uninsured Costs	$5,455,534	$5,514,803	$6,552,516	$7,488,668	$10,612,826
Pro Fee Uninsured Costs	$953,826	$729,951	$1,350,350	$1,916,698	$637,751
Total Uninsured Costs	*$6,409,360*	*$6,244,754*	*$7,902,866*	*$9,405,365*	*$11,250,577*
Uninsured Cost Percentage	**12.4%**	**10.2%**	**7.0%**	**6.4%**	**11.4%**

The table above demonstrates that uninsured care historically has not been a major driver in PCH's uncompensated care costs, nor does it appear that ACA reform has exerted any significant influence on the relative levels of Medicaid versus uninsured patient seen by the hospital. Given the 1-2% proportion of self-pay clients, one would expect that uninsured care would fall between 6-13% of the hospital's uncompensated care costs. The dip in this percentage which occurred in 2012-13 is easily explained by the low Medicaid cost coverage exhibited in those years. As PCH has responded to the new fiscal environment,

and Medicaid shortfall rates have come closer to pre-2012 levels, the proportion of uninsured costs also appears to have returned to its pre-2012 pattern.

Given the limited availability of 2014 financial and utilization data from the hospital, it is difficult to draw decisive conclusions regarding whether and how ACA reform has changed the underlying dynamics of PCH's payor mix, especially in isolation from the rest of the hospital "ecosystem" in the city of Phoenix and Maricopa County. On the one hand, there have been significant enrollment shifts in Medicaid and CHIP during the period under review, which could potentially affect the hospital. On January 31, 2014, the state's temporary KidsCare II program expired, requiring AHCCCS to transfer approximately 23,000 Arizona families to the Medicaid program, and to direct 14,000 additional families to the state's federally-operated health care exchange. Despite this shifting landscape in PCH's potential patient population, the payor mix data does not indicate any trend toward an increase in commercial payors for the hospital in 2014.

C. Causal Analysis of Medicaid Shortfall and Payment Reform Efforts

Although the cost analysis predicts that Medicaid shortfall will be significantly reduced in 2014, there will still be a large need for support from SNCP funds to help cover these uncompensated costs. It is clear that, as rising health care costs and the increasing acuity of PCH's patient population continue to drive upward the hospital's costs to Medicaid, current AHCCCS payment rates are insufficient to support the hospital's care delivery without further supplement. Despite service delivery changes at PCH that have helped reimbursement levels to keep better pace with rising costs, it appears that even if overall payment levels more closely approximated their pre-2011 levels, the hospital's heightened service volume would still potentially produce a gap between Medicaid costs and payments too large to be filled with traditional supplemental payment programs.

It is certainly true that AHCCCS rate cuts have contributed significantly to the level of uncompensated care at PCH. From the decline in GME and DSH payments, to inpatient and outpatient rate reductions, AHCCCS efforts to contain Medicaid costs in the state have undoubtedly heightened the shortfall. This impact is most evident in the agency's recent policy shifts regarding outlier payments, where increased outlier thresholds, combined with outlier rate reductions, appears to be the single most important cost driver of uncompensated care at PCH.

Given the hospital's business model and reliance on outliers to support its specialized efforts to provide care for high acuity conditions, the state's elevation of outlier thresholds has had a much deeper impact on payments than at hospitals serving populations with lower acuity. AHCCCS rates the severity of each case on a 1 to 4 scale, with 1 being minor to 4 being extreme. PCH has the highest percentage of AHCCCS level 3 and 4 patient days at 59.2% compared to a statewide average of 40.6%, indicating the severity of the cases it receives, and predictably generating more frequent outlier cases. This indicator is also clearly correlated with PCH's high ALOS and demonstrates why the outlier threshold and associated rate reductions together impact the hospital more profoundly than many other hospitals within the state.

It is tempting, perhaps, to conclude from this analysis simply that the state's outlier payments are inadequate to cover care delivery at PCH, and that the most appropriate means for addressing the shortfall would be to increase those rates. However, the high cost of care at the hospital is not merely a function of higher patient acuity, but must also be placed within the wider context of PCH's ambitious organizational growth and its aspirations to be a national leader in high quality pediatric care, equipped with cutting-edge medical technology, attracting top physician talent, and producing highly-respected research. On the one hand, available quality measures indicate that PCH has achieved many of these institutional goals, delivering both high-quality and high-value care when compared to peer children's hospitals nationwide. On the other hand, the relative efficiency of the hospital's service delivery should not obscure the overall high expense of the types of care delivered at PCH. The unique services that PCH provides to the state of Arizona are beneficial but costly.

PCH maintains 365 beds among its facilities and employs the vast majority of the pediatricians not only within the AHCCCS network, but also in the wider regional market. Yet this vital community infrastructure is also leveraged to support a broad array of low volume, high cost programs and services that inevitably drive costs upward for the PCH network as a whole. Even when the hospital's case mix is adjusted for acuity—as was done in a recent analysis of FFY 2011 hospital costs performed by Navigant—PCH's cost per inpatient case was among the highest in the state. With a case-mix adjusted cost per case of $11,114, the cost of care at PCH was 43% higher than the comparison hospital average of $7,785. Recognizing that the AHCCCS cuts in recent years have followed in the wake of a decade of an unprecedented growth in costs and revenue at PCH, it seems appropriate to consider whether their disproportionately negative impacts on the hospital are, perhaps, also the result of a business model and the development of service lines not previously oriented to the strict demands of cost containment.

Although high acuity is not the sole causal variable in PCH's elevated Medicaid shortfall relative to other hospitals in the state, AHCCCS has acknowledged the need for payment methods that more adequately reflect severity differences in the patient populations served by its hospital providers. At the beginning of FFY 2015, AHCCCS will transition from its tiered per diem reimbursement for inpatient services to a payment system based on APR-DRGs, adjusting payment according to provider case mix. According to the fiscal impact analysis conducted by Navigant in early 2014, this payment reform is projected to increase payments to PCH by $9.7 million in FFY 2015, which is the largest increase among network hospitals. While this amount represents only a portion of the total Medicaid shortfall likely to accrue in that year, its impact nevertheless would be significant.

Although PCH initially championed this reform, the hospital now contends that that APR-DRG reform will create a slight $600K decrease in payments, based on its own internal projections. Given the unavailability of the data sets used in either of these analyses, as well as PCG's limited access to the calculation methodologies and assumptions used to generate their conclusions, PCG is unable to discern the root of the disparities in projected outcome. There are significant differences between each analysis, however, both in data set and in the rate assumptions employed. In the original Navigant study, the projection was performed on AHCCCS utilization data from FFY 2011, while PCH relied on its own data from CY 2013. Perhaps

more importantly, the Navigant analysis assumed—in the absence of any knowledge of MCO contracted rates with specific hospitals—rates set at 100% of the AHCCCS fee-for-service rate. However, PCH based its analysis on its CY 2014 contracts, which it claims are lower than the AHCCCS rate. Given these discrepancies, PCG is unable to determine whether the implementation of these reforms will have a net positive or negative effect on the hospital.

This last point underscores additional concerns about the unintended consequences of addressing PCH's Medicaid shortfall through a direct rate increase. In addition to the indirect influence exerted by the AHCCCS rate structure on contract negotiations with Medicaid MCOs and other insurers, rate modifiers established to enhance payments for different types of hospitals could also lead to uneven effects within Arizona's Medicaid network and negative impacts on PCH. The state's Outpatient Peer Group Modifier, for example, ensures that PCH, as a freestanding children's hospital, is paid at higher rates for some outpatient emergency procedures than many other types of hospitals, in an effort to reflect its higher costs. However, given the significant differences between the cost of care at PCH and other area hospitals, there is a fear among officials at AHCCCS, at least, that attempting to address uncompensated care costs through rate increases rather than supplemental payments programs such as SNCP could have a cumulative effect of inadvertently pricing PCH out of the market and lowering its competitiveness against regional providers.

V. Findings and Conclusions

Considering the high levels of Medicaid shortfall that will continue to occur under the current operational conditions at PCH, it is PCG's view that SNCP payments remain necessary to offset the costs of the hospital's heavy burden of uncompensated care. The analyses above suggest that the hospital's Medicaid shortfall is the unique consequence of a convergence between the state's cost containment efforts and PCH's high quality, high cost delivery system. While SNCP does not represent a permanent solution to assuring adequate Medicaid cost coverage to the hospital, it continues to serve as an essential mechanism for transitioning PCH to the post-ACA health care environment.

It is important to note that the hospital's care delivery has been responsive to AHCCCS rate reforms. PCG's analysis indicates that SNCP funding has not adversely affected the hospital's capability or willingness to achieve greater efficiencies. Rather than insulating PCH from the budget pressures that tend to drive the development of value-based health, SNCP payments appear in fact to have facilitated the hospital's ongoing movement in this direction, allowing PCH the budgetary room to implement additional efficiencies, including value-based delivery system and payment reforms, without substantially disruptive effects on the hospital's level of quality. For this reason, extension of SNCP authorization appears justifiable.