A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Special Audit

Maricopa County Special Health Care District

March • 2009
REPORT NO. 09-03

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

The **Auditor General** is appointed by the Joint Legislative Audit Committee, a bipartisan committee composed of five senators and five representatives. Her mission is to provide independent and impartial information and specific recommendations to improve the operations of state and local government entities. To this end, she provides financial audits and accounting services to the State and political subdivisions, investigates possible misuse of public monies, and conducts performance audits of school districts, state agencies, and the programs they administer.

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

March 11, 2009

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Betsey Bayless, Chief Executive Officer
Maricopa Integrated Health System

Transmitted herewith is a report of the Auditor General, A Special Audit of the Maricopa County Special Health Care District. This report is in response to Laws 2008, Chapter 288, §22 and was conducted under the authority vested in the Auditor General by Arizona Revised Statutes §41-1279.03. I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, the Maricopa County Special Health Care District agrees with the findings and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on March 12, 2009.

Sincerely,

Debbie Davenport
Auditor General

cc: Maricopa County Special Health Care District Board of Directors
Bill Bruno, Chairman
Susan Gerard, Vice Chairman
Elbert Bicknell, Director
Alice Lara, Director
Greg Patterson, Director

Attachment

SUMMARY

The Office of the Auditor General has conducted a special audit of the Maricopa County Special Health Care District (District), pursuant to Laws 2008, Chapter 288, §22. This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §41-1279.03.

In November 2003, Maricopa County voters approved the creation of a tax-levying healthcare district; subsequently, voters approved a special healthcare district governing board in the November 2004 election. On January 1, 2005, Maricopa County, which was operating the healthcare system, transferred the system's fiscal and operational responsibilities to the new Maricopa County Special Health Care District. The District consists of the District's Board of Directors and an integrated health system, which includes a teaching hospital, several other healthcare facilities, and two health plans. In fiscal year 2008, the District had a total of over 400,000 inpatient admissions and outpatient visits.

As directed by the Legislature, this audit focuses on providing information in the following areas of district operations:

- The sources and uses of district funds, including amounts generated through the District's taxing authority (Chapter 1, pages 11 through 19).

- The District's financial condition and changes required to ensure financial stability (Chapter 2, pages 21 through 31).

- Management salaries (Chapter 3, pages 33 through 38).

- Contract personnel and associated costs (Chapter 4, pages 39 through 48).

- The amount of medical assistance provided to indigent individuals and policies that have changed to restrict services to this population (Chapter 5, pages 49 through 53).

- The amount of uncompensated care costs the District had annually in relation to the amount provided before the District was formed and to the amounts other hospitals in Arizona had (Chapter 6, pages 55 through 63).

Where applicable, the audit also makes recommendations for improvement.

District revenues (see pages 11 through 19)

The District receives revenue from various sources, and while the District's revenue increased about 34 percent from fiscal years 2006 to 2008, the proportion of each revenue source remained relatively the same. In fiscal year 2008, more than 80 percent of the District's total revenue of about $572 million continued to be from two sources, patient service revenue and fixed monthly payments, known as capitation payments, that it receives from the Arizona Health Care Cost Containment System (AHCCCS), which administers the State's Medicaid program.

In fiscal year 2008, after patient revenues and capitation payments, the next largest sources of revenue were property taxes (8 percent) and federal and state assistance (8 percent). When voters approved the District's creation, they also gave the District authority to impose a secondary property tax. In fiscal year 2008, the District received over $46 million in property tax revenue—the maximum allowed without approval from voters for an override of the statutory levy limit. Most of the federal and state revenues are reimbursements for costs that the District has already incurred for specific patient populations, such as a federal program that reimburses teaching hospitals for a portion of the costs incurred for training residents.

Financial stability (see pages 21 through 31)

The District's financial stability has improved, but its plans for a new hospital highlight the need for it to take additional steps to ensure future stability. When the District inherited the health system from Maricopa County, the system was facing a financial crisis from large numbers of nonpaying patients, falling profitability, critically low cash levels, and obsolete infrastructure. Various financial indicators, such as total net assets almost doubling from June 2005 to June 2008, show that the District's financial condition has improved. In addition, auditors' analysis of nine financial indicators, such as "days cash on hand," shows that the District has improved in eight of the nine areas.[1] However, for four of the areas, the District is not yet meeting its goals. Further, other measures of financial stability point to ongoing concerns—the District reported that its financial condition is not yet strong enough to obtain an investment-grade bond rating and has older facilities, and the District's total expenses related to bad debt and charity care are also increasing, which means that more money is being spent on patients who cannot afford the full cost of their medical services.

1 "Days cash on hand" represents the number of days an entity could pay expenses if revenues were eliminated.

The District has taken preliminary steps to plan for a new hospital and has plans to improve its clinics—actions that, if carried out, may require the District to borrow substantially. Auditors identified several actions the District can take to help ensure future financial stability, in addition to the various initiatives the District already has underway. These actions include continuing strategic planning efforts and monitoring financial and operational performance, explaining financing options to its Board of Directors, and enhancing its process to analyze which projects should be funded.

Executive salaries (see pages 33 through 38)

When compared with similar healthcare facilities nationally, salaries for the District's top five executive management positions are generally lower than reported median salaries. For example, when compared to all types of hospitals and health systems with similar net revenues, the District's Chief Executive Officer's annual salary of $367,600 was lower than the reported median salaries by at least $232,500, and the Chief Medical Officer's annual salary of $315,100 was lower than the reported median salaries by at least $15,600.

The District's executives also receive other forms of compensation, including district contributions for benefits such as medical and dental insurance and the Arizona State Retirement System (ASRS), paid time off, and merit pay. In addition, three executives had district monies deposited into supplemental retirement accounts because their salaries exceeded the ASRS maximum salary amount of $230,000 for ASRS contributions.[1] However, they do not receive perks such as automobile allowances.

Contracting practices for healthcare personnel (see pages 39 through 48)

In fiscal year 2008, the District's two largest contracts were for doctors and temporary nurses. The District contracts with a private corporation that supplies all the doctors and allied healthcare providers for its hospital and healthcare facilities.[2] Although this structure is generally similar to the physician personnel structures at other teaching hospitals, it is also unique in that the District contracts with a private entity, while other teaching hospitals commonly contract with local university medical schools. The contract contains cost containment and quality control features such as quality performance contract incentives. However, this contract is a sole-source contract that the District inherited from Maricopa County in 2005, and the District has not re-evaluated the staffing model provided through the contract or determined whether a

1 As of December 2008, district counsel indicated that the District had no intention of making further contributions to this supplemental retirement savings plan for these three employees, at least through June 30, 2012.

2 According to district policy, allied healthcare professionals include professionals such as physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.

sole-source contract is still necessary. The District should re-examine whether this staffing model is still optimal.

The District also contracts for some nursing personnel, but unlike its physician positions, most of the District's nursing staff are district employees. The District will always need to supplement its nursing staff with contract nurses because of factors such as a nation-wide nursing shortage; however, to help control costs, the District has worked to increase its own nursing staff. For example, between fiscal year 2005 and October 2008, the average number of contracted nurses used each month has dropped from 109 to 35, whereas the monthly average number of district nurses has increased from 611 to 823 during this same period.

Medical services to indigents (see pages 49 through 53)

Since its inception, the District has had a program to serve indigent individuals who are not eligible for other healthcare programs, such as the State's Medicaid program administered by AHCCCS. The District's eligibility requirements and payment policies have changed over time, but the program has always offered both emergency and nonemergency services, such as outpatient surgeries and doctor's visits when a patient is ill. During fiscal year 2008, the program served approximately 39,540 individuals and had about $32 million in uncompensated medical services costs.[1] According to the District, uncompensated medical services costs, often referred to as charity care, are services provided to uninsured, low-income, and underinsured patients who are financially unable to satisfy their debt. However, under the District's program, now called Copa Care, all participants, based on income levels, are expected to pay some of the service costs. Although the program served more individuals in fiscal year 2008 than in fiscal year 2007, its uncompensated medical services costs decreased by about $7.5 million. According to the District, the reduction resulted from increased patient revenue and decreased operating costs.

Uncompensated care costs (see pages 55 through 63)

In fiscal year 2008, the District had approximately $87 million in uncompensated care costs—that is, costs incurred in providing care to people the District does not expect to receive payment from.[2] The federal government's Medicaid Disproportionate Share Hospital (DSH) Payments program reimburses states for a portion of these costs. The DSH program not only provides support for uncompensated care, but also helps hospitals deal with low Medicaid reimbursement rates that are frequently less than hospitals' costs. AHCCCS, the State's Medicaid agency, administers this

1 These uncompensated medical services costs are for the District's charity care program only, and do not represent the District's total uncompensated care costs, which were approximately $87 million in fiscal year 2008 (see Chapter 6, pages 55 through 63).

2 This report does not include uncompensated care costs for public hospitals in other states as requested in the legislation because auditors determined that states may have different methods for calculating uncompensated care costs, and thus it is not reasonable to compare these costs from state to state.

program, which involves determining which hospitals qualify based on established criteria, and then distributing to these hospitals the DSH monies the Legislature appropriates.

In fiscal year 2008, Arizona received nearly $94 million in federal DSH monies. AHCCCS distributed the monies as follows: approximately $4.2 million went to the District, approximately $17.3 million went to the private hospitals, and approximately $72 million was deposited in the State General Fund. In addition, AHCCCS distributed approximately $9 million from the State General Fund to the private hospitals, which is the required state match, and according to AHCCCS resulted in a net deposit to the State General Fund of approximately $63 million of federal DSH monies. The District believes it should receive a larger portion of the State's DSH funds because, as the State's primary safety net hospital, it has the largest amount of uncompensated care costs, which must be certified to draw down some of the federal DSH monies.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a special audit of the Maricopa County Special Health Care District (District), pursuant to Laws 2008, Chapter 288, §22. This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §41-1279.03.

As directed by the Legislature, this audit focuses on providing information in the following areas of district operations:

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- The District's financial condition and changes required to ensure financial stability (Chapter 2, pages 21 through 31).
- Management salaries (Chapter 3, pages 33 through 38).
- Contract personnel and associated costs (Chapter 4, pages 39 through 48).
- The amount of medical assistance provided to indigent individuals and policies that have changed to restrict services to this population (Chapter 5, pages 49 through 53).
- The amount of uncompensated care provided by the District annually in relation to the amount provided before the District was formed and to the amount reported by other hospitals in Arizona (Chapter 6, pages 55 through 63).

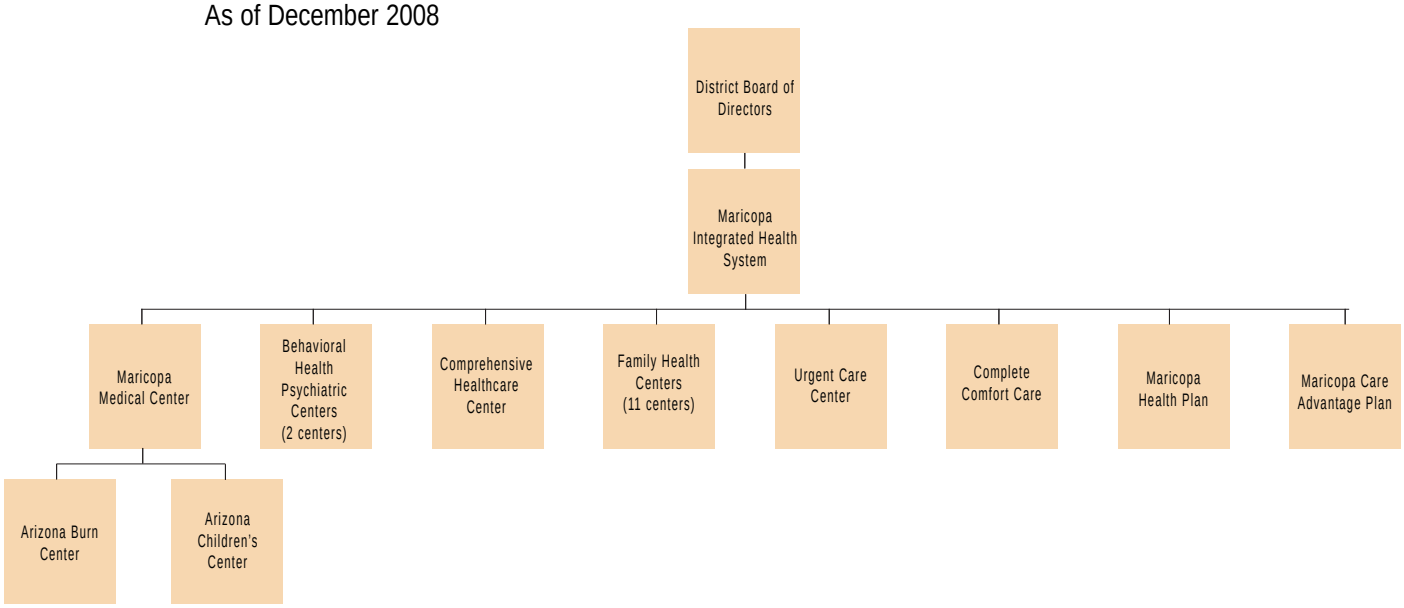
Where applicable, the audit also makes recommendations for improvement.

District history and system components

The Maricopa County Special Health Care District, as shown in Figure 1 (see page 2), consists of the District's Board of Directors and an integrated health system, that includes a hospital, several other healthcare facilities, and two health plans. In November 2003, Maricopa County voters approved the creation of a tax-levying healthcare district; subsequently, voters approved a special healthcare district

governing board in the November 2004 election. On January 1, 2005, Maricopa County, which was operating the healthcare system, transferred the fiscal and operational responsibilities for the system to the new District.

Figure 1: Organizational Chart
As of December 2008



Source: Auditor General staff analysis of district Web site facility description documents and health plan contract as of December 2008.

Maricopa County Special Health Care District Board of Directors (Board)—The Maricopa County Special Health Care District is governed by a five-member board of directors who are elected by Maricopa County voters and serve 4-year terms. The Board's responsibilities include appointing the District's Chief Executive Officer, monitoring the integrity of the District's financial statements, preparing budgets and capital plans, and reviewing and approving all plans related to the healthcare of uninsured and underinsured patients. It also reviews recommendations from the District's Medical Staff Executive Committee regarding appointment and reappointment of the District's medical, dental, and other healthcare staff.

Maricopa Integrated Health System (System)—The System consists of a hospital, several other healthcare facilities, and two health plans. According to district information, in fiscal year 2008, the System had over 21,000 inpatient admissions and over 380,000 outpatient visits. Many of these visits were made by patients who are eligible for the Arizona Health Care Cost Containment System (AHCCCS), which is the State's Medicaid program. In addition, in fiscal year 2008, over 39,500 patients eligible for the District's charity care program, now called Copa Care, accounted for 90,371, or over 22 percent, of total visits. The Copa Care program provides emergency and nonemergency healthcare to medically underserved individuals who do not qualify for other healthcare programs (see Chapter 5, pages 49 through 53, for additional information).

Specifically, the System operates under one hospital license for 717 beds and is composed of:

- **Maricopa Medical Center**—The Medical Center is a full-service teaching hospital with more than 440 beds. The District's hospital is an accredited teaching facility where the physicians who treat patients also teach the over 200 residents in training who are employed to work at the District's hospital and other centers, such as the Arizona Burn Center (see sub-bullet below).[1] The hospital includes an adult and pediatric emergency care center, a newborn intensive care unit, and the Arizona Children's Center (see sub-bullet below). In addition, the hospital provides healthcare to inmates from federal, state, county, and tribal correctional institutions. According to the District, in fiscal year 2008 it provided inpatient and outpatient care to 8,565 inmate patients.

    - **Arizona Burn Center**—The Burn Center, which is located within the Medical Center, is a facility with more than 40 beds that is designated as a regional burn center and provides inpatient and outpatient care for burns and skin diseases. According to district information, in fiscal year 2008, it provided care to 763 patients admitted to its facility and 6,462 patients on an outpatient basis.

    - **Arizona Children's Center**—The Children's Center, which is located within the Medical Center, operates the 24-hour Pediatric Emergency Department, a 12-bed Pediatric Intensive Care Unit that supplies inpatient services for infants, children, and adolescents, and a 40-bed Neonatal Intensive Care Unit that provides critical inpatient services for babies born in the hospital as well as babies transported from across the Southwest. According to the District, in fiscal year 2008, the Pediatric Emergency Department provided care to nearly 17,000 patients.

- **Behavioral health psychiatric centers**—The District operates two behavioral health psychiatric centers licensed for a total of 190 inpatient beds. According to district information, in fiscal year 2008, the District treated 2,520 patients admitted to its behavioral health psychiatric facilities. Inpatient services include chemical dependency treatment, psychological testing, group and family therapy, and medication education. According to district information, it also provided outpatient care to 2,575 patients at its Desert Vista Behavioral Health Center. Outpatient services include psychiatric evaluations, individual and family therapy, and prescription of medication, if necessary.

- **Comprehensive Healthcare Center**—The Healthcare Center provides primary care for children and adults, including specialty services such as cardio-pulmonary, dental, ear-nose-and-throat, internal medicine, dialysis, oncology, orthopedics, ophthalmology, pediatrics, pharmacy, radiology, vascular surgery, and women's health services.

[1] The Medical Center is accredited by the Accreditation Council for Graduate Medical Education, which is a private, nonprofit council that evaluates and accredits medical residency programs in the United States.

- Community-based family health centers—The District's 11 community-based family health centers provide primary care services for adults and children. In fiscal year 2008, the health centers provided services to over 152,000 patients. Some health centers also provide dental and pharmacy services. One of the centers specializes in human immunodeficiency virus (HIV) related medical care for adults.

- Urgent Care Center—The System opened an Urgent Care Center in 2007 to meet the needs of the residents who had relied on the former Phoenix Memorial Hospital for urgent care services. Located in the Emergency Department on the former Phoenix Memorial campus at 7th Avenue and Buckeye Road, the center, according to the District, served over 18,000 patients in fiscal year 2008.

- Complete Comfort Care—This program provides attendant care to elderly or disabled clients in their homes. Services are tailored to individual needs and can include cooking and cleaning, personal patient care, and companionship. According to the District, in fiscal year 2008, over 952,000 hours of care were provided to patients served through this program.

The System also contains two health plans:

- Maricopa Health Plan—The Maricopa Health Plan (Plan) is one of six health plans operating for Maricopa County residents that AHCCCS contracts with. The Plan was in operation for nearly 20 years before the District was formed. Prior to October 2005, Maricopa County operated the Plan. Starting in October 2005, the District contracted with Tucson-based University Physicians Health Plans, a division of University Physicians Healthcare, to manage the Plan. According to the District, as of December 2008 the Plan had over 50,000 members.[1] According to district information, the Plan offers its members complete healthcare services, including a choice of doctors, dentists, the Medical Center, the District's Family Health Centers, pharmacies, and emergency care in Maricopa County.

- Maricopa Care Advantage—This health plan (Plan) which began January 1, 2008, provides access to similar services as the Maricopa Health Plan. However, this Plan is for a targeted special needs patient population of Medicare-eligible patients who have greater needs because of their severe or chronic health conditions. According to the District, this Plan had over 700 members as of December 2008. University Physicians Healthcare and the District partnered in a 50/50 joint venture to start the Maricopa Care Advantage Plan in order to secure a Medicare Advantage Special Needs Program contract with the Centers for Medicare and Medicaid Services. The District and University Physicians Healthcare shared in startup costs. Maricopa Care Advantage is overseen by a Board of Directors consisting of two members from the District and two members from University Physicians Healthcare. It is managed by the same

[1] University Physicians Healthcare is a nonprofit corporation supporting the faculty doctors at the University of Arizona College of Medicine. University Physicians Health Plans is a division of University Physicians Healthcare.

company that manages the District's other health plan, University Physicians Health Plans, a division of University Physicians Healthcare.

Accreditation

The District is accredited by a national healthcare accreditation organization. In December 2008, the District received full accreditation from the Joint Commission, a not-for-profit organization that evaluates and accredits healthcare programs in the United States. This followed an earlier, September 2007 decision by the Joint Commission to give the District a conditional accreditation, which means the organization is not in substantial compliance with the Joint Commission's standards and it must remedy the identified problem areas. The Joint Commission identified 17 such areas during its 2007 accreditation review. According to a district official it found that the District had remedied all 17 areas in the December 2008 review. For example, the Joint Commission found that the District needed to ensure it has a complete and accurate medical record for all patients served. The District has addressed this by providing training and auditing records for accuracy.

Organization and staffing

The District has a five-member executive management team consisting of Chief Executive, Financial, Operating, and Medical Officers, and a Senior Vice President and Chief External Affairs Officer.[1,2] These positions are involved in directing, controlling, evaluating, and developing organizational operations and resources to ensure quality healthcare. District staff is composed of both permanent and contracted employees. The District reported that it had an average of 3,630 permanent district employees per month in fiscal year 2008, including more than 800 nurses.

Although most staff are permanent employees, the District contracts for all of its physicians and allied healthcare providers, along with some of its nurses. The District contracts with a private corporation, Medical Professional Associates of Arizona (MedPro), for all of its physician and allied healthcare provider services.[3] MedPro was created in 1994 by physicians already employed by the Maricopa County Hospital (for more information about MedPro, see Chapter 4, pages 39 through 48). Although MedPro staff are subject to district board approval, MedPro is responsible for providing the District's physicians (medical doctors and doctors of osteopathy), and many other credentialed healthcare professionals. As of January 2009, according to

The District contracts for all of its physicians with a private corporation, MedPro.

1 The District's Chief Medical Officer retired in February 2008 and as of December 2008, this position remained vacant.

2 Prior to December 2008, this position's title was Vice-President Internal Development.

3 According to district policy, allied healthcare professionals include professionals such as physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.

MedPro, the District was contracting with them for the services of 205 physicians and 75 other healthcare providers. In addition, although the District has decreased the number of temporary nurses it contracts out for by hiring more nurses permanently (see Chapter 4, pages 39 through 48) from July through October 2008, the District contracted for an average of 35 nurses per month.

Assets and revenue

In 3 years, district assets have increased by more than $140 million.

The District's assets have increased since it began operation on January 1, 2005. As illustrated in Table 1 (see page 7), its assets have grown from $116.4 million at the end of fiscal year 2005 to $262.6 million at the end of fiscal year 2008. As shown in Table 2 (see page 8), in fiscal year 2005, some of the District's assets consisted of Maricopa County contributions. Specifically, Maricopa County contributed $6.3 million in cash and $62.8 million in other assets to the District in fiscal year 2005. Of the $62.8 million in other assets, $32.8 million was capital assets, appraised at fair market value on January 1, 2005, including property and equipment. However, according to a district official, Maricopa County did not contribute the main hospital, the Comprehensive Health Center, and one of the behavioral health psychiatric centers to the District. The District pays Maricopa County an annual amount of $12 for leasing the main hospital and the behavioral health center, and $1.4 million for leasing the Comprehensive Health Center, because Maricopa County has a long-term debt obligation on this property.

Further, as shown in Table 2 (see page 8), the District receives revenue from various sources and its revenue has also increased over time. In fiscal year 2008, the District had operating revenue of more than $500 million. Sources of operating revenue result from providing services through its normal operations and primarily consist of patient revenue. The District also receives nonoperating revenue. Nonoperating revenue is money derived from other sources, such as property taxes, grants, or investments. For example, in fiscal year 2008, the District received over $46 million from the property tax levy that was established when the District was formed, and more than $7 million in state and federal grants.

Audit scope and objectives

As set forth in Laws 2008, Chapter 288, §22, audit work focused on six areas within the District, and this report includes six chapters and recommendations as appropriate, covering the areas in legislation. Specifically:

- The Auditor General shall conduct a financial and performance audit of the Maricopa Special Health Care District, which includes the Maricopa Integrated

Table 1: Statement of Net Assets
As of June 30, 2005, 2006, 2007, and 2008
(Unaudited)

	2005	2006	2007	2008
Assets				
Current assets:				
Cash and cash equivalents	$ 7,972,267	$ 52,830,802	$ 4,305,003	$ 1,081,903
Short-term investments			60,258,608	69,991,227
Patient accounts receivable, net of allowances[1]	61,035,690	50,339,440	44,448,598	52,376,462
AHCCCS medical education receivable			2,893,945	28,466,815
Health plans receivable		6,135,431	15,964,742	21,623,212
Other receivables	4,666,291	11,489,302	11,629,058	8,564,740
Supplies	6,168,973	4,882,944	4,961,198	5,498,031
Prepaid expenses	851,387	1,389,050	1,726,713	1,799,127
Estimated amounts due from third-party payors	440,000	1,138,020		
Due from related parties	134,726	297,909	2,343,670	1,387,309
Total current assets	81,269,334	128,502,898	148,531,535	190,788,826
Long-term investments		14,564,020	2,070,750	
Capital assets:				
Land	4,090,000	4,090,000	4,090,000	4,090,000
Depreciable capital assets, net of accumulated depreciation	30,676,580	40,352,728	56,999,346	67,141,497
Total capital assets, net of accumulated depreciation	34,766,580	44,442,728	61,089,346	71,231,497
Other assets	373,912	4,330,997	1,584,815	612,874
Total assets	$116,409,826	$191,840,643	$213,276,446	$262,633,197
Liabilities and net assets				
Current liabilities:				
Accounts payable	$ 13,248,550	$ 21,935,749	$ 25,420,987	$ 24,059,017
Accrued payroll and employee benefits	12,058,797	12,036,622	14,766,906	17,915,732
Medical claims payable		17,350,990	20,167,480	20,569,645
Overpayments due to third-party payors	8,591,358	6,140,854	5,366,057	7,761,404
Other current liabilities	1,683,813	8,743,487	12,780,031	16,581,914
Current maturities of long-term debt and capital leases	1,133,098	2,460,318	3,734,453	10,326,879
Total current liabilities	36,715,616	68,668,020	82,235,914	97,214,591
Long-term debt	7,821,144	30,726,575	33,390,390	24,642,537
Total liabilities	44,536,760	99,394,595	115,626,304	121,857,128
Net assets:				
Invested in capital assets, net of related debt	27,733,755	63,477,195	41,898,763	49,655,337
Restricted for grants		290,665	712,178	459,687
Unrestricted	44,139,311	28,678,188	55,039,201	90,661,045
Total net assets	71,873,066	92,446,048	97,650,142	140,776,069
Total liabilities and net assets	$116,409,826	$191,840,643	$213,276,446	$262,633,197

1 Patient accounts receivable balances were reported net of allowances for uncollectible accounts totaling $38,643,601 for 2005, $40,688,387 for 2006, $33,843,156 for 2007, and $40,999,432 for 2008.

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for the 6-month period ended June 30, 2005, and for fiscal years 2006 through 2008.

Table 2: Statement of Revenues, Expenses, and Changes in Net Assets
Fiscal Years 2005 through 2008[1]
(Unaudited)

	2005 (6 months)	2006	2007	2008
Operating revenues:				
Gross patient charges	$417,135,447	$916,214,931	$1,110,290,697	$1,316,074,738
Less:				
Internal transactions		108,519,701	130,451,738	145,604,380
Contractual adjustments	223,729,268	463,030,829	531,822,429	657,394,894
Charity care program			122,915,022	127,832,108
Bad debts	38,643,601	84,620,871	41,975,974	52,692,740
Net patient service revenue	154,762,578	260,043,530	283,125,534	332,550,616
Capitation		92,781,362	126,222,832	137,852,101
Other	5,539,544	19,880,749	25,383,389	40,925,469
Total operating revenues	160,302,122	372,705,641	434,731,755	511,328,186
Operating expenses:				
Salaries and wages	69,618,101	145,476,202	165,654,356	194,842,815
Employee benefits	19,453,107	38,352,094	48,563,229	57,830,631
Purchased services	34,366,198	84,176,981	104,232,496	89,520,955
Medical claims		53,029,187	80,039,020	85,581,930
Supplies and other expenses	34,436,663	75,682,521	78,439,045	90,102,741
Depreciation	3,483,495	7,790,123	7,954,860	9,287,490
Total operating expenses	161,357,564	404,507,108	484,883,006	527,166,562
Operating loss	(1,055,442)	(31,801,467)	(50,151,251)	(15,838,376)
Nonoperating revenues (expenses):				
Property taxes		40,000,000	43,000,000	46,310,880
Noncapital grants	2,747,004	5,234,777	6,518,509	7,293,209
Noncapital subsidies from Maricopa County	1,773,948	3,547,900	3,547,896	3,547,896
Other nonoperating revenues	1,618,771	4,078,089	1,806,582	1,151,966
Investment income	256,013	1,717,452	2,988,257	2,890,090
Interest on debt	(580,211)	(2,203,769)	(2,505,899)	(2,229,738)
Total nonoperating revenues	5,815,525	52,374,449	55,355,345	58,964,303
Income before contributions	4,760,083	20,572,982	5,204,094	43,125,927
Contributions from Maricopa County[2]:				
Cash contributions	6,336,001			
Other assets[3]	62,838,753			
Increase in net assets	73,934,837	20,572,982	5,204,094	43,125,927
Net assets, beginning of year	(2,061,771)	71,873,066	92,446,048	97,650,142
Net assets, end of year	$ 71,873,066	$ 92,446,048	$ 97,650,142	$ 140,776,069

1 The District began operations on January 1, 2005, and therefore, fiscal year 2005 amounts represent activity for only 6 months.

2 Maricopa County transferred the assets of its Maricopa Integrated Health System to the newly created Special Health Care District on January 1, 2005.

3 Consists of patient and other accounts receivable, supplies, prepaid expenses, and property and equipment.

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for the 6-month period ended June 30, 2005, and for fiscal years 2006 through 2008.

Health System, pursuant to section §41-1278, Arizona Revised Statutes, and provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before March 15, 2009. The audit shall:

1. Identify and examine the current financial, administrative, and operational issues of the District and identify changes required to ensure financial stability (see Chapter 2, pages 21 through 31).

2. Identify the amount of funds generated through the taxing authority of the District and how such funds are used (see Chapter 1, pages 11 through 19).

3. Examine the personnel structure, specifically management salaries, contract personnel, and associated costs, and evaluate whether this structure is consistent with and necessary for the execution of the statutorily designated duties of the District (see Chapter 3 for executive management salaries, pages 33 through 38, and Chapter 4 for contract personnel, pages 39 through 48).

4. Identify all sources of state and federal funding received by the District and how these funds are used (see Chapter 1, pages 11 through 19).

5. Examine and identify the amount of medical assistance furnished to indigent individuals who are uninsured and ineligible for Medicaid and other health service programs and identify policies that have changed to restrict services to this population (see Chapter 5, pages 49 through 53).

6. Examine the amount of uncompensated care provided on an annual basis by the District and measure this amount in relation to the amount of uncompensated care provided by facilities of the District before the formation of the District, to the amount of uncompensated care provided by facilities of the District before the implementation of Proposition 204, and to the amount of uncompensated care reported by other private hospitals in Arizona and public hospitals in other states (see Chapter 6, pages 55 through 63).

7. Recommend programmatic, administrative, financial, and operational changes to ensure financial stability, improved accessibility, and effective healthcare delivery (see recommendations, Chapter 2, page 31, and Chapter 4, page 48).

The Auditor General and staff express appreciation to the District's Board of Directors, Chief Executive Officer, and staff for their cooperation and assistance throughout the audit.

CHAPTER 1

District Revenues

Legislative Item

The audit shall identify the amount of funds generated through the taxing authority of the District and how such funds are used; and identify all sources of state and federal funding received by the District and how these funds are used.

The Maricopa County Special Health Care District (District) receives revenues from various sources, including patient service revenue, the District's property tax, and federal assistance. From fiscal years 2006 to 2008, district revenues increased by about 34 percent, but during that time, the percentage of revenue from each source remained relatively consistent. Each year, more than 80 percent of district revenues primarily came from two sources—patient service revenue and fixed monthly payments (known as capitation)—received from the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency.[1] Although a district official indicated that all of the District's revenues can be used for its operation, most of the federal and state revenues are reimbursements for costs the District has already incurred for specific patient populations.

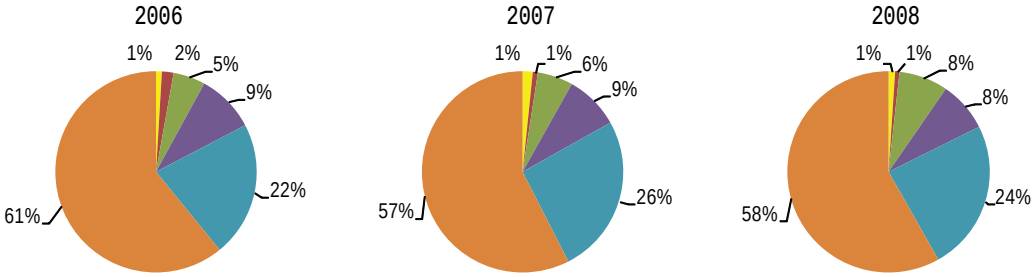
Figure 2 (see page 12) provides an overview of the revenues by source. The sections that follow explain the five largest sources in further detail, including the amount the District has received each year, the reasons for changes in the amounts over time, and estimates of the amounts available for fiscal year 2009, if available. The Office of the Auditor General is making no recommendations about the matters discussed in this chapter.

Net patient service revenue

Net patient service revenue is total gross patient charges less various transactions that reduce the amount of patient revenue received (see descriptions, page 13). As shown in Table 3 (see page 12), it has increased from $260 million in fiscal year 2006 to $332.6 million in fiscal year 2008, an increase of about $72.6 million, or almost 28 percent, during that time period. According to a district official and budget documents, the increase resulted from a higher service volume in clinic and urgent care visits and outpatient services, and a slight rate increase on the AHCCCS and Medicare accounts. The District expects net patient service revenue to increase by more than 6 percent in fiscal year 2009.

1 Patient service revenue is received from patients, and patients' insurers such as Medicare, Workers' Compensation, and private insurance companies.

Figure 2: Revenues by Source[1] Fiscal Years 2006 through 2008[2] (In Millions) (Unaudited)



	2006	2007	2008
Net patient service	$260	$283	$333
Capitation	93	126	138
Property tax	40	43	46
Federal and state assistance	22	28	45
County assistance	8	4	4
Other[3]	4	8	6
	$427	$492	$572

1 Each revenue source is described on pages 11 through 19.

2 Maricopa County transferred the Maricopa Integrated Health Care System's (system) fiscal and operational responsibilities to the District on January 1, 2005, and therefore, fiscal year 2005 amounts represent activity for only 6 months. Therefore, fiscal year 2005 amounts are not presented here because the data is not comparable to the 12-month data presented.

3 Amount consists of investment income, food sales, rental income, insurance proceeds for damaged property, and other miscellaneous sources.

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for fiscal years 2006 through 2008.

Table 3: Schedule of Net Patient Service Revenue Fiscal Years 2005 through 2008[1] (Unaudited)

	2005 (6 months)	2006	2007	2008
Gross patient charges	$417,135,447	$916,214,931	$1,110,290,697	$1,316,074,738
Less:				
Internal transactions		108,519,701	130,451,738	145,604,380
Contractual adjustments	223,729,268	463,030,829	531,822,429	657,394,894
Charity care program			122,915,022	127,832,108
Bad debts	38,643,601	84,620,871	41,975,974	52,692,740
Net patient service revenue	$154,762,578	$260,043,530	$ 283,125,534	$ 332,550,616

1 Maricopa County transferred the system's fiscal and operational responsibilities to the District on January 1, 2005, and therefore, fiscal year 2005 amounts represent activity for only 6 months.

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for the 6-month period ended June 30, 2005, and for fiscal years 2006 through 2008.

Specifically, net patient service revenue is derived from the following components:

- Gross patient charges—These charges represent the amount charged to patients who received inpatient, outpatient, behavioral health, and other medical services from the District's hospital and health clinics.

- Internal transactions—These transactions are revenue amounts that must be subtracted so that they are not counted twice. For example, the District operates one of AHCCCS' health plans and receives a monthly capitated amount as revenue for every person enrolled. When an individual covered by this health plan receives services from the District's hospital, the revenue is also recorded for the hospital, but it is then later subtracted to eliminate an internal transaction since both the hospital and the health plan are part of the District. For fiscal years 2006 through 2008, the amount of these transactions was about 11 to 12 percent of the total gross patient charges.

- Contractual adjustments—These adjustments are discounts granted to healthcare insurance organizations and government agencies based on agreed-upon contract rates that are below the gross patient charges.[1] For fiscal years 2006 through 2008, the amount of these adjustments was about 48 to 51 percent of the total gross patient charges.

- Charity care program—This program, now called Copa Care, was created to serve uninsured or underinsured patients who are ineligible for other programs such as the State's Medicaid program, administered by AHCCCS. Programs like these are often called charity care programs because services are offered for free or at a discounted rate. The District has established discounted fees for the Copa Care program based on patients' family size and income (see Chapter 5, pages 49 through 53, for additional information). The discounts granted to this patient population are deducted from gross patient charges. For fiscal years 2007 and 2008, these discounts amounted to about 10 to 11 percent of the total gross patient charges. Although the District had a charity care program in fiscal years 2005 and 2006, all of the discounts under the program at that time were written off as bad debt (see next bullet).

- Bad debts—These deductions consist of medical services the District provided and expected to receive payments for but did not. This happens when patients are unable or unwilling to pay their bills. Also, patients' insurance carriers dispute their bills for many reasons such as service coverage, billing timeliness, and patient eligibility. According to a district official, the District has an unwritten bad debt policy that writes off certain accounts after they are 120 or 150 days past due; however, the District continues to seek collection of the debts.[2] The total bad debt amount was over 9 percent of the total gross patient charges in fiscal

1 Healthcare organizations and government agencies include AHCCCS, Medicare, private insurance companies, law enforcement agencies, and workers' compensation.

2 According to a district official, self-pay, Maricopa County Correctional Health, private insurer, lien, law enforcement, and AHCCCS pending accounts are written off after 120 days past due. AHCCCS grievance, private managed care, Medicare Special Needs, and Workers' Compensation accounts are written off after 150 days past due.

year 2006. It decreased to 4 percent in fiscal years 2007 and 2008, when the Copa Care program was implemented. However, for fiscal year 2009, a district official indicated that the bad debt amount will increase by more than $7 million because the District increased its gross patient charges.

Capitation

Capitation revenue is a fixed monthly advance payment that the District receives for providing a full range of healthcare services, such as inpatient and outpatient services, to AHCCCS and Medicare special needs members.[1] This revenue is restricted to paying for medical costs incurred by AHCCCS and Medicare special needs members and any allowable administrative costs. As shown in the textbox, capitation revenue was $137.9 million in fiscal year 2008, an increase of approximately $45 million, or nearly 49 percent, since fiscal year 2006. According to a district official, the increase is attributable to the fact that the District began the AHCCCS health plan operation in October 2005 and therefore received capitation revenue for only 9 months in fiscal year 2006. Since then the AHCCCS health plan has had nearly an 18 percent rate increase. In addition, during the second half of fiscal year 2008, the District began a new health plan for Medicare special needs patients (see Introduction and Background, pages 1 through 10, for additional information) and received almost $1.3 million in capitation revenue for this plan. According to district budget documents, the District expects increases in both AHCCCS and Medicare capitation for fiscal year 2009.

Capitation
Fiscal Years 2006 through 2008
(Unaudited)

2006	2007	2008
$92,781,362	$126,222,832	$137,852,101

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for fiscal years 2006 through 2008.

Property tax

When Maricopa County voters approved the creation of the Special Health Care District in the November 2003 election, the approval included authority to impose a secondary property tax. Statute stipulated that for the first year the tax was authorized and levied, it must not exceed an amount equal to $40 million, the maximum tax levy limit for the base year.[2] Each subsequent year, the District's levy amount can be adjusted from its prior year's levy amount based on a percentage equal to the rate of change in the County's levy limit between the current and prior years. The Maricopa County Assessor calculates the rate of change and the District's allowable levy limit for each fiscal year. If the District wants to increase its property tax revenue beyond the levy limit, voters must approve a tax levy limit override to increase the maximum

1 Under the Medicare Prescription Drug Improvement and Modernization Act of 2003, Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. Special needs plans were allowed to target enrollment to one or more types of special needs individuals identified by Congress as: (1) institutionalized; (2) dually eligible; and/or (3) individuals with severe or disabling chronic conditions.

2 A.R.S. §48-5565.

allowable levy. For fiscal years 2006 through 2008, the District received the maximum amount of its property tax revenue.[1]

The District's property tax revenue can be used to pay for any operating costs, including maintaining and operating the District's facilities, payments for professional and other services, and debt service, including principal and interest on any bonds issued. As shown in the textbox, property tax revenue was $46.3 million in fiscal year 2008, an increase of over $6.3 million, or nearly 16 percent, since fiscal year 2006. Although tax rates have declined since 2006, the District's property tax revenue has increased because of higher assessed property values in Maricopa County. The District's levy amount for fiscal year 2009 is approximately $49.9 million, a 7.8 percent increase from fiscal year 2008, which was the maximum allowable levy limit calculated by the County Assessor.

Property Tax
Fiscal Years 2006 through 2008
(Unaudited)

2006	2007	2008
$40,000,000	$43,000,000	$46,310,880

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for fiscal years 2006 through 2008.

Federal and state assistance

As shown in Table 4 (see page 16), federal and state assistance revenues have increased from $22.3 million in fiscal year 2006 to $45 million in fiscal year 2008, an increase of about $22.7 million or about 102 percent, during that time period.[2] Most of these revenues are reimbursements provided to cover the costs of services for various state or federal programs described below. Specifically:

- Graduate Medical Education (GME)—This federal program, which requires a state match, recognizes that teaching hospitals incur significant costs, such as residents' salaries, employee benefits, and training costs, in addition to the costs associated with patient care. AHCCCS is responsible for allocating the federal and state matching monies annually among the Arizona hospitals according to statutory and administrative code requirements.[3]

  The District's GME revenue has increased by approximately $13.2 million, or 144 percent, since fiscal year 2006. According to a district official, its payment has significantly increased because AHCCCS allocated monies to compensate for its uncompensated indirect program costs incurred for training the residents in fiscal year 2008.[4] Prior to fiscal year 2008, the District received allocations only for uncompensated direct program costs for training the residents. According to

1 Maricopa County transferred the system's fiscal and operational responsibilities to the District on January 1, 2005. The District's first property tax was levied in August 2005 in accordance with Arizona Revised Statutes §§42-17151 and 48-5563.

2 In Table 4 (see page 16), the sum of the "other" category represents less than 1 percent of the District's total revenues. Thus, auditors do not describe it in this chapter.

3 Arizona Administrative Code, Title 9, Chapter 22, Article 7.

4 The GME program recognizes that a hospital may experience a marginal increase in its operating costs. Therefore, the federal government has established a formula for calculating an indirect cost amount that is based on a hospital's residents-to-beds ratio and a congressionally approved rate.

Table 4: Schedule of Federal and State Assistance
Fiscal Years 2005 through 2008[1]
(Unaudited)

	2005 (6 months)	2006	2007	2008
Graduate medical education		$ 9,177,507	$10,528,218	$22,394,965
Medicaid disproportionate share hospital payments	$2,101,144	4,202,300	4,202,300	4,202,300
Federally qualified health centers		1,290,675	3,625,649	7,364,685
Ryan White grants	1,471,282	2,980,845	3,178,687	3,524,278
Arizona primary care program	1,035,401	1,804,010	2,473,706	2,668,146
Trauma and emergency services	896,833	2,377,933	3,000,441	3,630,129
Other[2]	237,996	449,922	1,403,316	1,262,192
Total federal and state assistance	$5,742,656	$22,283,192	$28,412,317	$45,046,695

1 Maricopa County transferred the system's fiscal and operational responsibilities to the District on January 1, 2005, and therefore, fiscal year 2005 amounts represent activity for only 6 months.

2 Consists of tobacco use prevention, hospital preparedness-bioterrorism, health academy, transportation-related injury prevention, newborn intensive care, and other program revenues.

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for the 6-month period ended June 30, 2005, and for fiscal years 2006 through 2008.

a district official, in fiscal year 2009, the District expects to receive approximately the same GME amount as in fiscal year 2008.

- Medicaid Disproportionate Share Hospital (DSH) Payments—Under this program, the federal government reimburses states for a portion of the medical services costs that their hospitals incur when providing care to people they do not expect to receive payment from. Such costs are known as uncompensated care costs (see Chapter 6, pages 55 through 63, for additional information). AHCCCS is responsible for allocating these monies annually to the State and qualifying Arizona hospitals. The District has received approximately $4.2 million in DSH monies each fiscal year since its inception. In January 2009, the Legislature eliminated the District's share of DSH monies for fiscal year 2009.[1]

- Federally Qualified Health Centers (FQHC)—This federal program, which requires state matching monies, provides the District with additional payments when AHCCCS members obtain services at district community centers that have been certified as federally qualified healthcare center look-alikes.[2] According to the District, it pursued the FQHC designation as an important step in allowing the District to expand services throughout the community and was awarded this designation in 2006. AHCCCS is required to reimburse the District

1 Laws 2009, 1st S.S., Ch. 4, §7.

2 A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service (PHS) Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC Look-Alike is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

quarterly for the difference between the FQHC rate and the AHCCCS rate for the Medicaid patients who visited the District's community health centers. The District began receiving the FQHC reimbursements from AHCCCS in March 2006.

The District's share of FQHC revenue has increased by $6.1 million, or nearly 471 percent, since fiscal year 2006. According to district budget documents and AHCCCS staff, the increase resulted from about a 20 percent in increase in clinic visits and a nearly 43 percent FQHC rate increase since March 2006. The District received a significant rate increase in October 2007 because AHCCCS adjusts the FQHC rate every third federal fiscal year. For fiscal year 2009, AHCCCS expects to reimburse the District approximately $7 million.

- Ryan White Grants—The Ryan White Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (HIV/AIDS) grants are for programs that provide HIV-related health services. These federal grant monies are to be used for those who do not have sufficient healthcare coverage or financial resources for coping with HIV. The District annually applies for these federal grants, which must be used to provide outpatient services including primary care, dental, mental health, and substance abuse services for HIV patients. The annual contract award amount is based on the amount budgeted at the federal level for these grants.

  The District's Ryan White grants have increased by over $500,000, or approximately 18 percent, since fiscal year 2006. According to the District, the primary reason for the increase is that more federal funding was available in fiscal years 2007 and 2008. According to district budget documents, for fiscal year 2009, the District expects the Ryan White grants to increase by nearly 1 percent.

- Arizona Primary Care Program—This program offers comprehensive primary care and preventive dental services to uninsured residents of Arizona whose family income is below 200 percent of the federal poverty guidelines and who are not eligible for Medicare or AHCCCS. This program is funded by the State General Fund and tobacco tax monies. Using a competitive bidding process, the Arizona Department of Health Services awarded a contract to the District that began in July 2005 with options to renew each year for a maximum of 4 years. The annual contract award amount is based on the amount budgeted at the state level for this program. The District submits expenditure and other data monthly to the Arizona Department of Health Services for reimbursement.

  The District's revenue for this program has increased by almost $900,000, or nearly 48 percent, since fiscal year 2006. According to a district official, the primary reason for the increase is that the State budgeted more funding for this program in fiscal years 2007 and 2008. For fiscal year 2009, the Department of Health Services renewed its contract with the District for $2.8 million, almost a 5 percent increase from fiscal year 2008.

- **Trauma and Emergency Services**—These revenues, which come from a portion of Indian gaming revenues, help to cover a portion of the unrecovered trauma and emergency services costs incurred by qualified trauma centers in the State.[1] The District's hospital is one of seven trauma centers in Arizona. According to administrative code requirements, AHCCCS is responsible for allocating these monies biannually among the State's trauma centers based on the reported number of trauma cases and the related unrecovered trauma and emergency costs.[2]

  The District's share of the trauma and emergency services payment has increased by about $1.3 million, or nearly 53 percent, since fiscal year 2006. According to district budget documents, the increase is attributable to better reporting of eligible expenses to AHCCCS. The District expects its fiscal year 2009 revenue from this source to remain nearly the same as fiscal year 2008.

County assistance

As shown in Table 5, the District has received assistance from Maricopa County since fiscal year 2005. These revenues subsidize the District's psychiatric residency teaching program and stabilize the District's financial position during the transition period.

Table 5: Schedule of Maricopa County Assistance
Fiscal Years 2005 through 2008[1]
(Unaudited)

	2005 (6 months)	2006	2007	2008
Psychiatric residency teaching program	$1,773,948	$3,547,900	$3,547,896	$3,547,896
Assistance package	1,618,771	4,446,768	767,976	817,126
Total county assistance	$3,392,719	$7,994,668	$4,315,872	$4,365,022

1 Maricopa County transferred the system's fiscal and operational responsibilities to the District on January 1, 2005, and therefore, fiscal year 2005 amounts represent activity for only 6 months.

Source: Auditor General staff analysis of the District's audited financial statements and general ledgers for the 6-month period ended June 30, 2005, and for fiscal years 2006 through 2008.

1 During the November 2002 election, voters approved Proposition 202, which allowed casinos to increase the numbers of slot machines and gaming tables, such as blackjack, in exchange for the State's receiving 1 to 8 percent of their revenue. A portion of that revenue is used to fund the trauma and emergency services program.

2 Arizona Administrative Code, Title 9, Chapter 22, Article 21.

Specifically, these revenues subsidize the following:

- **Psychiatric Residency Teaching Program—**The 1989 Arizona Supreme Court ruling in the *Arnold v. Sarn* case granted class action status to indigent seriously mentally ill people and ruled that both the State and Maricopa County had failed to provide adequate services and funding to this population in Maricopa County.[1] According to Maricopa County, in 1993 the court monitor assigned to assess compliance with the ruling determined that Maricopa County should continue to provide at least the same level of service to class members through the psychiatric residency teaching program as it provided in fiscal year 1993. As a result, since the District's inception, Maricopa County has provided approximately $3.5 million each fiscal year for the District's psychiatric residency teaching program. For fiscal year 2009, according to Maricopa County budget documents, the County budgeted the same amount for the program.

- **Assistance Package—**In June 2005, the District accepted the assistance package offered by Maricopa County's Board of Supervisors. According to this package, it serves as a means to stabilize the District's financial position. It includes:

  - Two waivers, one for approximately $1.6 million in election costs for the first election that created the District, and one for $1.1 million in rental payments for the Comprehensive Health Care Center.

  - $2.6 million in cash assistance to pay for consulting services.

  - Two loans—one for a $15 million line of credit and one for $443,000 in election costs for the second election that created the District's Board of Directors. These 10-year loans are interest-free for the first 5 years.

  The District recognized the election, consulting services, and rental assistance as revenues in fiscal years 2005 and 2006. The waiver of interest expense is being reported as revenue over the 5-year, interest-free period and will expire in fiscal year 2011.

1 *Arnold v. Sarn*, 160 Ariz. 593, 775 P.2d 521 (1989).

CHAPTER 2

Financial stability

Legislative Item

The audit shall identify and examine the District's current financial, administrative, and operational issues and identify changes required to ensure financial stability.

The Maricopa County Special Health Care District's (District) financial stability has generally improved, but the District's plans for a new hospital highlight the need for it to take additional steps to ensure future stability. When the District inherited the Maricopa Integrated Health System (System) from Maricopa County (County), the System's financial condition was weak. Various financial indicators show that the District's financial condition has since improved, though there are still reasons for concern. The District has taken preliminary steps to plan for a new hospital and improve its clinics—actions that, if carried out, may require the District to borrow substantially. Taking steps such as developing strategies for modifying projects and limiting risks, as well as continuing various financial stability initiatives already underway, will help the District as it prepares to address its future needs.

District has shown signs of improved financial stability

Since the District took over the System's operation from the County, the District has shown signs of improved financial stability. Reports from the County indicate that the System was facing a financial crisis before transitioning to the District in January 2005. Since then, the District's audited financial statements and related financial indicators have shown signs of improvement, such as total net assets almost doubling from June 2005 to June 2008. However, other measures of financial stability point to ongoing concerns—the District reported that its financial condition is not yet strong enough to obtain an investment-grade bond rating, has significant bad debt and charity care expenses, and has older facilities.

System in poor financial condition when transferred to District—Right before its transition from the County to the District, the System was in poor financial condition. According to a citizens' task force established in 2003 by the County's Board of Supervisors and a 2004 financial condition report by the County's Internal Audit Department, the System was facing a financial crisis. Reasons for this crisis

included large numbers of nonpaying patients, falling profitability, critically low cash levels, and obsolete infrastructure and capital investment needs at the main hospital and clinics. In addition, the County subsidized the System's hospital since 1994, including amounts ranging from $15.3 million to $66.2 million each year in fiscal years 2000 through 2004.

District financial reports show improvement—The District's audited financial statements show improved financial stability since it took over the System's operations on January 1, 2005. The District's total net assets (assets minus liabilities) have almost doubled, from $71.9 million at June 30, 2005, to $140.8 million at June 30, 2008 (see Introduction & Background, Table 1, page 7). Much of this increase occurred during fiscal year 2008 when the District's net assets increased by over $43.1 million, which represents approximately 7.5 percent of its total revenues of $572 million (see Chapter 1, Figure 2, page 12). Further, the District's cash and short-term investments, which can quickly be converted to cash, increased from about $8 million after the District's first 6 months of operation to about $71 million at the end of fiscal year 2008 (see Introduction & Background, Table 1, page 7). Much of this cash increase—nearly $44.9 million—occurred during fiscal year 2006 (see Introduction & Background, Table 1, page 7).

In all, the District improved its financial condition because of increased revenues and improved operations. For example, the District has increased patient service revenue (see Chapter 1, Table 3, page 12), which the District reports resulted from higher patient service volume and a slight rate increase on the Arizona Health Care Cost Containment System (AHCCCS) and Medicare accounts. The District's other revenues, such as federal and state assistance revenue, have also increased, such as an additional $12 million in reimbursements that the District reports is for indirect costs incurred for its graduate medical education program in fiscal year 2008 (see Chapter 1, Table 4, page 16). In addition, in fiscal year 2008, the District reduced operating expenses by replacing contract nurses with full-time employees (see Chapter 4, Table 12, page 47). However, progress was not steady throughout the 3-year period. Between fiscal years 2006 and 2007, some of the financial results worsened because eligibility was expanded for the District's charity care program, which serves indigent individuals and therefore has large amounts of uncompensated medical services costs (see Chapter 5, pages 49 through 53).

Financial indicators are ratios calculated using financial statement amounts. These indicators show an entity's financial condition and are used to establish its credit rating.

District financial indicators show signs of improvement—Auditors' evaluation of the District's financial indicators (see textbox) also shows that the District's financial condition has improved since fiscal year 2006, but there is still room for improvement.[1] The District tracks nine financial indicators, eight of which are cited by literature as being among the most important indicators of a hospital's financial stability.[2] The nine indicators can be categorized into three groups: profitability, liquidity, and debt ratios.

1 Fiscal year 2005 had only a 6-month operation period, and its financial indicators are not comparable to fiscal years 2006 through 2008. Therefore, they are not presented in Tables 6 through 8.

2 Berger, 2005; HFMA, 2007; Kaufman, 2006; Nowicki, 2004

Using the District's audited financial statements, auditors calculated the indicators for fiscal years 2006 through 2008 and compared them to the District's goals, which are median values of hospitals with a BBB bond rating by Standard & Poor's (S&P).[1] A BBB rating is the minimum rating the District would need for issuing investment-grade bonds to finance capital projects. Attaining these BBB goals would help fulfill the District's initial long-range financial goal to become a "creditworthy" organization by September 2011.

As shown in Tables 6 through 8 (see pages 23 through 25), the District improved on eight of the nine indicators by fiscal year 2008, though for four of the indicators, the results do not yet meet the District's goals. In addition, as discussed above, the District's financial results worsened in fiscal year 2007 because its charity care program was expanded.

- **Profitability ratios**—As shown in Table 6, the District showed improvement from fiscal year 2006 to 2008 in all three profitability ratios it tracks. Profitability ratios (see textbox) measure an entity's ability to make a profit, or excess of revenues over expenses. Literature indicates that the operating margin ratio is one of the most essential metrics.[2] The District's operating margin, while improving, remains below the District's goal, indicating a need for continued improvement.

Profitability Ratios

Operating margin is the percentage of operating revenues that represents operating profit.

Excess margin is similar to the operating margin except it includes nonoperating revenues, such as the property tax monies and grants, and overall profit.

Earnings Before Interest, Depreciation, and Amortization (EBIDA) is the same ratio as excess margin except it excludes expenses from interest, depreciation, and amortization.

Table 6: Profitability Ratios Compared to District Goals[1]
Fiscal Years 2006 through 2008
(Unaudited)

Ratio[2]	2006	2007	2008	September 2011 District Goal
Operating margin	(8.5)%	(11.5)%	(3.1)%	2.1%
Excess margin	4.8%	1.1%	7.5%	4.5%
EBIDA margin	7.2%	3.2%	9.5%	11.1%

1 District goals are median values of hospitals with a BBB bond rating, which is the minimum rating needed to issue investment-grade bonds.

2 Lower negative or higher positive numbers are desirable.

Source: Auditor General staff analysis of the District's audited financial statements for fiscal years 2006 through 2008 and the District's September 2008 *Financial Indicators—Consolidated* report.

1 A bond rating is a grade given to an organization that helps investors understand the relative risk involved with purchasing bonds for that organization. S&P, a major bond-rating entity, provides the following investment-grade bond ratings: AAA, AA, A, and BBB. The District does not yet have a bond rating.

2 Berger, 2005; HFMA, 2007

Liquidity Ratios

Days cash on hand represents the number of days an entity could pay expenses if revenues were eliminated.

Days in net patient accounts receivable measures the average number of days that patient accounts are due before they are collected.

Cushion ratio compares the relationship between available cash and total debt service (payments made on principal and interest amounts).

Unrestricted cash to long-term debt represents the availability of an organization's liquidity to pay off existing long-term debt. This is the only ratio not identified by literature as being one of the most important ratios.

- **Liquidity ratios**—As illustrated in Table 7, three of the four liquidity ratios that the District tracks improved from fiscal year 2006 to 2008. Liquidity ratios (see textbox) measure an entity's ability to pay its obligations as they come due. Literature says that the *days cash on hand* indicator is the most important indicator of credit position in the not-for-profit healthcare market and that higher cash balances tend to correlate with higher credit ratings.[1] In addition, literature states that most hospital analysts believe that the *days in net patient accounts receivable* metric is critical to proper financial management functioning.[2] The days of cash on hand, while slightly improved, remains well below the District's goal. The improvement in days in net patient accounts receivable has been greater, with the District's 2008 figure relatively close to its goal. Of the four liquidity indicators, only the cushion ratio failed to improve; however, the District continues to exceed its goal for this ratio.

Table 7: Liquidity Ratios Compared to District Goals[1]
Fiscal Years 2006 through 2008
(Unaudited)

Ratio	2006	2007	2008	September 2011 District Goal
Days cash on hand[2]	48.6	49.4	50.1	124.4
Days in net patient accounts receivable[3]	70.7	57.3	57.5	52.3
Cushion ratio[2]	13.3	12.0	12.7	8.4
Unrestricted cash to long-term debt ratio[2]	171.9%	193.4%	288.4%	81.9%

1 District goals are median values of hospitals with a BBB bond rating, which is the minimum rating needed to issue investment-grade bonds.

2 Higher numbers are desirable.

3 Lower numbers are desirable.

Source: Auditor General staff analysis of the District's audited financial statements for fiscal years 2006 through 2008 and the District's September 2008 *Financial Indicators—Consolidated* report.

1 Berger, 2005; HFMA, 2007; Kaufman, 2006

2 Berger, 2005

- **Debt ratios**—As shown in Table 8, from fiscal years 2006 to 2008, the District improved in both debt ratios it tracks. Debt ratios (see textbox) measure an entity's ability to cover debt and take on additional debt. In both cases, the District's fiscal year 2008 ratios are better than its goals, but this may reflect the fact that the District has not borrowed any money to construct or purchase buildings since its inception. If the District follows through on its plans for a new hospital and changes to its network of clinics, this situation may change considerably.

Debt Ratios

Debt service coverage measures the hospital's ability to repay its long-term debt and represents overall profit adjusted for depreciation and interest, divided by debt payments.

Long-term debt to capitalization indicates the level of long-term debt that the entity is carrying compared to its net assets that are not dedicated for a specific use.

Table 8: Debt Ratios Compared to District Goals[1]
Fiscal Years 2006 through 2008
(Unaudited)

Ratio	2006	2007	2008	September 2011 District Goal
Debt service coverage[2]	7.7	2.9	9.7	3.1
Long-term debt to capitalization[3]	51.7%	37.8%	21.4%	42.8%

1 District goals are median values of hospitals with a BBB bond rating, which is the minimum rating needed to issue investment-grade bonds.

2 Higher numbers are desirable.

3 Lower numbers are desirable.

Source: Auditor General staff analysis of the District's audited financial statements for fiscal years 2006 through 2008 and the District's September 2008 *Financial Indicators—Consolidated* report.

Other stability measures suggest continued reason for concern—Despite the District's improvement, concerns remain. A report by the Healthcare Financial Management Association (HFMA) lists financial warning signs of financially distressed hospitals, and the District has a few of these signs.[1] For example, the average age of its facilities is greater than 10 years (see page 26 for more information). In addition, the District's total expenses related to bad debt and its charity care program (see Chapter 1, Table 3, page 12) are increasing, which means that more money is being spent on patients who cannot afford the full cost of their medical services.

District officials also reported that the District's financial condition is not yet strong enough to obtain investment-grade bonds. As previously indicated, the District has not met four of its nine ratio goals, which provide guidance on performance needed to obtain an investment grade bond rating. Along this line, another HFMA

1 HFMA, 2006a

report has a method to determine a hospital's ability to borrow money.[1] A hospital with a high ability to borrow money is described as being able to fund its own capital needs or considered as an excellent credit risk to the capital markets. A hospital with a limited ability to borrow money is described as being under significant financial strain and having access to capital from only a limited number of sources and at a higher cost than hospitals with stronger financial performance. Using the HFMA's method, auditors determined that the District is somewhere in between or has a moderate ability to borrow money because it still has room for financial improvement.

District's plans for capital projects highlight need for continued improvement

Although the District has improved its financial stability, plans for new capital projects highlight the need to make even more improvements. The District is planning for three major capital projects: constructing a new main hospital, improving its clinics, and improving and integrating its business process and technology. These projects, particularly the new hospital, could add hundreds of millions of dollars to the District's financial obligations. Such projects may require the District to borrow substantial sums of money—something the District has not done yet.

District plans to build new main hospital and improve clinics—District officials reported that a new main hospital and improved clinics are needed based on consultant reports, changes to building codes since the facilities were constructed, and the District's impact on the community. Specifically:

- Facilities in poor condition—According to two 2006 consultant reports, the main hospital and many of the clinics are in poor but serviceable condition. One of the consultants, Health Management Associates, stated that the District should construct new facilities so that its main campus and its neighborhood clinic system can remain viable.[2] In addition, this report stated that the facilities on the main campus and the clinic sites, most of which were constructed between 1970 and 1996, suffer from underfunded and poorly executed maintenance. For example, this report listed the facilities' functional and physical concerns, such as a lack of storage space, and roof and plumbing/HVAC piping systems leaks in many facilities reviewed. These leaks caused mold growth, which reportedly led to about $1.8 million in annual abatement costs. The other consultant, 3D/International, reported that the hospital's major systems, such as plumbing, cooling, and electrical, were nearing the end of their useful lives and have high replacement costs.[3] The District reported that it had spent approximately $22 million from January 1, 2005, to the end of fiscal year 2008, to repair and maintain its facilities.

1 HFMA, 2006b

2 Health Management Associates, 2006

3 3/D International, 2006

- **Renovations may reduce hospital capacity**—Building codes and standards have changed since the facilities were built, and the District believes this adds to the need for a new main hospital. Although not required to follow newer building codes and standards unless required by the Arizona Department of Health Services (DHS), district officials are concerned that the main hospital, built in 1970, has an outdated design. For example, it has four-bed patient rooms instead of the new construction minimum standard of one-bed rooms. Similarly, the adult intensive care units have six to nine beds, some of which are not aligned with current standards, such as space at each bedside for visitors and a window in each patient bed area. An official from the DHS reported that it would require the District to come into compliance with building codes for new construction if the hospital undergoes substantial renovations. District officials estimate that converting four-bed patient rooms into single-bed rooms and complying with other requirements in the codes would reduce the bed size in the main hospital by at least one-third, from more than 440 licensed beds to 300. According to the District, renovations would cost about the same as new construction costs and also result in lost revenues while floors were shut down for renovations. As noted previously, several of the hospital's major systems are nearing the end of their useful lives and a major problem in one of these systems could trigger the need for renovations. The District thinks that renovations would have a severe negative impact on the community and its operations if areas were shut down and if the bed size were reduced.

- **Importance to the community**—Further, district officials reported that if they do not build a new hospital and system failures in their current hospital are large enough, the District will need to permanently close its doors, which would result in many patients being displaced to other hospitals and some patients not receiving healthcare. The District is a significant provider of uncompensated care in the State (see Chapter 6, pages 55 through 63); provides important behavioral health services; offers inpatient and outpatient care to federal, state, county, and tribal inmate populations; and has the region's only burn center. In addition, officials stated that a new hospital would result in increases in operational and efficiency savings.

The District has taken preliminary steps to plan for a new main hospital and improve its clinics. District officials met with architects in 2007 to start preliminary planning for a new main hospital and expect to resume planning activity during fiscal year 2010. The District estimates that the new hospital would take 4 to 5 years to build at an estimated cost of between $400 million and $600 million. The District also plans to reconfigure its clinics. Specifically, a district official stated that the District is analyzing if it has the right number of clinics, if they are in the right locations, and if they are offering the right services. The District's strategic plan includes developing a facility financing plan by June 2009, reconfiguring its clinics by 2012, and constructing a new main hospital by 2014.

District has started project to improve and integrate its business process and technology—Another major project, referred to as the ARK project, was initiated to improve and integrate the District's business process and technology, and includes making medical records available in an electronic format. District officials reported that this project will provide a new, enterprise-wide system to replace and enhance clinical and financial systems to better support the healthcare delivery process. Anticipated benefits include enhanced patient safety, quality of care, regulatory compliance, operational efficiencies, and employee satisfaction. For example, electronic records can help eliminate unavailable, misplaced, or overlooked information, which may lead to decisions based on a clinician's memory, and instead provide automated alerts and searchable information, which may lead to more consistent care. According to the District, the ARK project will also help AHCCCS with its efforts to implement a state-wide online electronic health records system. District officials stated that implementation of the ARK project in their existing hospital will be transferrable to a new hospital and will not result in any lost effort.

The ARK project is divided into three phases, which would take place through 2017 at an estimated cost of $83 million. In August 2008, the Maricopa County Special Health Care District Board of Directors (Board) approved the first phase, which is designed to provide a full electronic medical record system by 2013 at an estimated cost of $32.8 million. The District has not borrowed any money to implement this project and plans to pay for all phases with cash.

Improving financial stability involves maintaining current initiatives and adding new ones

The District should continue and expand its efforts to improve its financial condition. These efforts are important both because the District still has room for improvement and faces additional challenges if it carries out plans to build a new hospital and improve its existing clinics. Literature provides a framework for hospital financial management that includes strategic and financial planning, deciding how to pay for projects, analyzing and selecting potential projects, and monitoring progress.[1] Although the District's financial management practices are generally in line with these recommended practices, the District should continue and enhance its current efforts. Specifically, four areas need continued attention: overall strategic planning, identifying ways to pay for capital projects, enhancing its process to analyze which capital projects should be funded, and monitoring financial and operational performance.

- Strategic and financial planning—The District should continue its strategic and financial planning efforts. The District developed an organization-wide strategic plan that was approved by the Board in August 2008. The plan includes

1 HFMA, 2005a; Kaufman, 2006

reconfiguring its clinics by 2012 and building a new hospital by 2014. Financial planning includes such things as identifying ways for building cash and debt capacity, and analyzing creditworthiness. For example, in line with recommended practices, the District analyzes the profitability of its service lines, and officials reported that this practice has helped them negotiate payer agreements and conduct further analyses resulting in efforts to maximize reimbursements. It also has begun to assess its creditworthiness, which according to literature is critical to the success of future strategic and financial planning, by comparing its monthly progress on nine financial indicators as discussed above. The District should continue its strategic and financial planning efforts, which include analyzing its profitability and creditworthiness.

The District plans to build a new main hospital by 2014.

- **Paying for capital projects**—The District should continue its efforts to identify and plan for ways to pay for its capital projects. Capital projects are typically long-term projects requiring large sums of money to develop, improve, or maintain assets that generate income. Literature indicates that no healthcare organization can fund its long-term growth strategy solely from reserves and operating cash flow.[1] The District believes its long-term growth requires a new hospital and improvements to its clinics, and as of December 2008, the District was still considering how it will pay for these capital projects. According to Arizona Revised Statutes §48-5541.01, the District may borrow and invest monies, create debt, assume debt, and refinance debt. The District is also evaluating other options such as lease-to-own arrangements, and the District expects to present a financing plan to its Board by June 2009. To help the Board decide how to pay for capital projects, the District should ensure that this financing plan includes an explanation of the costs and terms of different financing options and how these options will support the District's competitive position and financial performance. This is especially important because the District may have challenges obtaining debt under reasonable terms and paying it off.

The District should explain the costs and terms of different financing options to its Board of Directors.

- **Analyzing and selecting capital projects**—Once the District knows how much money it has available and can borrow for capital projects, it should enhance its process to analyze which projects should be funded. According to literature, some key elements of this process include creating a solid business plan (see textbox) for each capital investment project and projecting cash flows in a net present value (NPV) analysis. Among other things, an NPV analysis determines a project's dollar value and estimates future cash flow amounts. Although district managers have used business plans and projected cash flows for some projects, they can take additional steps to improve. Specifically:

A **business plan** describes a capital project and specifies why it is needed and how it will be implemented. The plan should include other elements, such as a strategy to modify or terminate the project.

  - **Add strategies to modify projects and limit risks**—The District made business plans for its project to create electronic medical records and other capital projects. However, the District's business plans lacked a

[1] Kaufman, 2006; Nowicki, 2004

strategy to modify projects and limit risks if warning signs arose. The District needs to add such strategies to its business plans, including plans that will be made for building a new hospital, improving its clinics, and all other capital investment projects.

- **Include projected cash flows for capital projects over a threshold amount**—As of December 2008, the District had projected future cash flows, including revenues and expenses, for a few capital projects. In addition, the District's strategic plan includes steps that will likely require more capital projects. Even if these projects do not generate revenue, cash flows can be projected by estimating how the projects will save money. For example, the District's Finance Department projected three types of cost savings for a project involving leased laundering equipment. Literature suggests that organizations determine a threshold, such as $500,000, that dictates when it will conduct more detailed financial analyses.[1] The threshold is applied to capital investment projects that are strategically driven and not to routine replacement items such as roofing repairs. The District should determine a threshold amount and project cash flows for all potential strategically driven capital projects over that amount.

- **Conduct NPV analyses**—As of November 2008, the District's capital allocation committee had not yet conducted an NPV analysis to help select which capital projects to pursue. To help prioritize its capital projects and strategic initiatives, this committee should use the projected cash flows to conduct NPV analyses.

The District has various mechanisms to monitor financial and operational performance.

- **Monitoring performance**—The District should continue its efforts to monitor its financial and operational performance. In addition to tracking the nine financial indicators mentioned above, the District uses daily, weekly, and monthly reporting mechanisms to monitor its financial condition. For example, one of the District's monthly reports shows whether the cost of salaries, supplies, and other operating expenses in eight operating areas varied from budgeted amounts. According to a district official, senior management reviews this report and meets each month to discuss variances from budgeted amounts to hold each other accountable for the results and to discuss ways in which the operating areas can help each other. In addition, the District prepares monthly reports with graphs of numerous operational indicators such as a count of the number of patient visits, patients' lengths of stay, and the number of employees per patient for presentation to the Board. For example, the District's operational indicators showed that in fiscal years 2007 and 2008, the number of inpatients remained relatively stable and the number of outpatients increased.

[1] Kaufman, 2006

Recommendations:

2.1. To help ensure financial stability, the District should continue and expand its efforts to improve its financial condition by:

a. continuing its strategic and financial planning efforts, which include analyzing its profitability and creditworthiness;

b. ensuring its financing plan due to the Board in June 2009 includes an explanation of the costs and terms of different financing options and how these options will support the District's competitive position and financial performance;

c. enhancing its process to analyze which capital projects should be funded by adding strategies to its business plans to modify projects and limit risks if warning signs arise, by determining a threshold amount and projecting cash flows for all potential strategically driven capital projects over that amount, and by ensuring the capital allocation committee uses the projected cash flows to conduct net present value analyses; and

d. continuing its efforts to monitor its financial and operational performance.

CHAPTER 3

Executive salaries

Legislative Item

This audit shall examine the personnel structure, specifically management salaries, contract personnel, and associated costs and evaluate whether this structure is consistent with and necessary for the execution of the statutorily designated duties of the District.

When compared to salaries in national healthcare surveys, the Maricopa County Special Health Care District's (District) executive management salaries generally are lower. These executives also receive benefits such as healthcare and retirement benefits, but their total compensation packages do not include perks, such as automobile allowances. Their salaries, as of December 2008, were also lower than salaries paid to the contractors who held these positions just prior to and after the District's inception in January 2005. The Office of the Auditor General is making no recommendations in this area.

District executives' salaries generally lower than counterparts' nationally

In comparison with similar healthcare facilities as measured by net revenues and type of facility, the District's executive salaries are generally lower than those reported by national healthcare salary surveys.[1] The District considers its executive management to comprise five positions (see textbox). These positions are involved in directing, controlling, evaluating, and developing organizational operations and resources to ensure effective, quality healthcare.

District Executive Management Positions

- Chief Executive Officer
- Chief Operating Officer
- Chief Medical Officer
- Chief Financial Officer
- Vice-President Internal Development[1]

1 In December 2008, the District changed the responsibilities and title of this position to the Senior Vice-President and Chief External Affairs Officer.

When compared nationally to all types of hospitals and health systems or to other teaching hospitals with similar net revenues, the District's five executive salaries are generally lower than reported median salaries. As shown in Table 9 (see page 34), in a national comparison with all types of hospitals and health systems with net revenues that are similar to the District's, the District's salaries for all five positions are

1 To perform their analyses, auditors used 2008 healthcare salary surveys from Mercer, SullivanCotter, and Watson Wyatt Data Services. See Bibliography, pages c-i through c-iv, for additional details. Information from the surveys is used pursuant to licenses with the survey companies. This information is or may be proprietary and is intended and may only be used for the purposes of this report.

Table 9: Salary Comparison Tables
As of December 2008
(Unaudited)

A: Comparison of the District's Executives' Salaries to Those of Selected National Hospitals and Health Systems with Similar Net Revenues

District		Watson Wyatt Data Services[1,2]		SullivanCotter[2]	
Position	Annual Salary	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting
Chief Executive Officer	$367,600	$600,100	32	$601,900	56
Chief Operating Officer	330,000	331,700	42	386,700	39
Chief Medical Officer[3]	315,100	330,700	34	332,700	40
Chief Financial Officer	305,000	328,700	65	343,000	64
Vice-President Internal Development[4]	172,400	205,300	24	193,500	23

B: Comparison of the District's Executives' Salaries to Those of Selected National Teaching Hospitals with Similar Net Revenues

District		Watson Wyatt Data Services[1,2]		Mercer[1,2]	
Position	Annual Salary	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting
Chief Executive Officer	$367,600	$612,500	16	$605,400	38
Chief Operating Officer	330,000	379,800	20	329,500	55
Chief Medical Officer[3]	315,100	338,700	18	336,000	42
Chief Financial Officer	305,000	344,100	36	307,900	71
Vice-President Internal Development[4]	172,400	205,300	11	152,800	18

1 Salary survey data includes the District's data that because of survey firm client confidentiality policies, could not be removed. See Appendix A, pages a-i through a-v, for further details.

2 Watson Wyatt Data Services and SullivanCotter data was based on hospitals and health systems with net revenues of $400 million to $900 million whereas Mercer data was based on hospitals with net revenues of $400 million or more. See Appendix A, pages a-i through a-v, for further details.

3 In February 2008, the District's Chief Medical Officer retired at an annual salary of $315,100. Subsequent to his retirement until October 2008, a contracted physician filled this position on an interim basis at an estimated annual salary of $229,100. As of December 2008, this position remained vacant.

4 In December 2008, the District changed the responsibilities and title for this position to the Senior Vice-President and Chief External Affairs Officer with an approximate annual salary of $209,700.

Source: Auditor General staff analysis of district-provided executive salary information and Mercer, SullivanCotter, and Watson Wyatt Data Services salary survey data.

lower than the median salaries reported. For example, the District's Chief Executive Officer's salary of $367,600 was lower than the reported median salaries by at least $232,500, and the Chief Medical Officer's salary of $315,100 was lower than the reported median salaries by at least $15,600. In a national comparison limited to teaching hospitals with similar net revenues, three of the five executives' salaries (the Chief Executive Officer, Chief Financial Officer, and Chief Medical Officer) were lower than reported median salaries (see Table 9, page 34). For further salary comparisons, such as by region, see Appendix A, pages a-i through a-v.

Total compensation packages include standard benefits but not perks

The five district executives' total compensation packages include benefits and other forms of compensation, but do not include perks, such as automobile allowances. Auditors' comparisons of other aspects of executives' compensation packages besides salary showed the following:

- **Benefits**—District executives, like all district employees, receive benefits that appear to be similar to Maricopa County's, including district contributions for medical and dental insurance, the Arizona State Retirement System (ASRS) (see textbox), and paid time off. Like other district employees, district executives pay a portion of their salaries for some benefits, such as healthcare and ASRS benefits.

  Paid time off for executives begins somewhat higher than for most other district employees. As of December 2008, district executives received 26 to 29 days personal and 7.5 days family/medical paid leave annually, while other district employees received 15 to 29 days personal and 5 to 7.5 days family/medical paid leave annually, depending on tenure. In addition to these paid leave accruals, the executives received an additional 5 to 10 personal and 5 to 92 family/medical days paid leave upon hire.[1] Personal leave may be used for vacation, illnesses, and medical appointments. Like other district employees, the five executives receive 10 paid holidays.

  For three of the District's five executives, the District has paid additional monies into a supplemental ASRS 401 (A) savings plan. All district employees, age 40 and older, are eligible to participate in a supplemental ASRS 401(A) plan that

Arizona State Retirement System (ASRS)

The ASRS provides pension, disability, survivor, and retiree health insurance benefits, and educational services for most public sector employers in Arizona, including state universities, community colleges, public school districts, local and county governments, and the State of Arizona.

Source: Auditor General staff analysis of information from the ASRS' Web site.

[1] The one district executive who received the 92 days family/medical paid leave at initial hire transferred in approximately 87 days paid sick leave from a previous position.

allows them to defer a maximum $46,000 pre-tax contribution annually from their salaries.[1,2] Although the amount deferred may comprise employer and, as of January 2009, employee contributions, according to district counsel, the combined total cannot exceed the annual maximum. In addition, district counsel explained that, because state law limits the amount of compensation that can be considered for benefits under the regular ASRS plan, in June 2008 the District's Chief Executive Officer approved the District's contributing to the ASRS 401(A) supplemental retirement savings plan for three executives.[3,4] These included the Chief Executive, Financial, and Operating Officers whose salaries were above the defined limit.[5] Further, a district official reported that, as of September 11, 2008, the District had contributed a total of more than $190,000 into their supplemental retirement plans, which an outside consultant determined would provide comparable benefits to ASRS if the employees' full compensation was considered under the ASRS. As of December 2008, district counsel indicated that the District had no intention of making further contributions to this supplemental retirement savings plan for these three employees, at least through June 30, 2012.

A district official reported that, as of September 2008, the District contributed more than $190,000 to three district executives' supplemental retirement plans.

The District's executives are also eligible for the District's tuition reimbursement program. Under this program, employees are eligible to receive up to $5,250 per year for tuition and book fees so that they may pursue their educational objectives for improving job performance or developing work-related skills, and/or enhancing professional growth opportunities within the District. In 2008, according to a district official, the Vice-President Internal Development received $2,448 under this program.[6]

- Other cash compensation—The District's other cash compensation for the five executives appears to be significantly lower than the amounts reported by some other hospitals in salary survey data. According to literature, other forms of cash compensation include incentives and bonuses.[7] The District has established a merit program that allows all district employees, including executives, to annually receive a one-time lump sum merit payment of, according to a district official, up to 5 percent of their salary based on performance criteria. Payment is based on the District's ability to pay, and the Chief Executive Officer's and

1 According to district counsel, the Internal Revenue Service increases the contribution amount annually based on increases in the cost of living, and the limit for fiscal year 2009 is $46,000.

2 Although the 401(A) plan is available to eligible participants in various state retirement plans including the ASRS, each government unit must individually adopt the plan.

3 A.R.S. §38-746.

4 District counsel explained that the District's Chief Executive Officer approved the contributions using contractual authority delegated by the Maricopa County Special Health Care District Board of Directors and the District's approved compensation plan.

5 The fiscal year 2009 ASRS compensation limit that can be considered for benefits is $230,000.

6 In December 2008, the District changed the responsibilities and title of this position to the Senior Vice-President and Chief External Affairs Officer.

7 Flannery, 2002

Human Resource Department's recommendations. According to a district official, the District's Board determines the Chief Executive Officer's merit payment amount. This district official also reported that, in November 2008, three of the District's five executives—the Chief Operating Officer, Chief Financial Officer, and Vice-President Internal Development—received merit payments totaling more than $35,000.[1] These merit payments ranged from approximately $8,600 to $16,500. By comparison, according to December 2008 healthcare salary survey data, 40 to 74 percent of Chief Operating Officers in hospitals or health systems with net revenues similar to the District's received or were eligible to receive median monetary awards ranging from $62,300 to $102,300.[2]

According to a district official, in November 2008, three district executives received merit payments totaling more than $35,000.

- **Perquisites**—The District does not offer perquisites, or "perks." According to literature, perks may include automobiles, club memberships, financial counseling, or supplemental life, medical, or disability insurance.[3] For example, according to January 2008 survey data, 49 to 61 percent of health system executives were eligible to receive car allowances with an average monthly amount ranging from $652 to $725.[4]

District executives' salaries less than those offered to contractors before and after District's inception

As of December 2008, the District's executives' salaries fell below those paid to the contractors who held these positions for Maricopa County just prior to and after the District's inception. In January 2005, the District took over the fiscal and operational responsibilities of the integrated health system from the County. When the District was first established, its executive positions were filled mostly by contractors. These contractor positions were eventually filled by district employees whose salaries are generally lower than those paid to contractors. For example, as shown in Table 10 (see page 38), the District's Chief Executive Officer is paid $367,600 annually, but the contracted Chief Executive Officers for the County and the District when it was first established were paid an estimated $549,100 and $571,000, respectively. Although contractors' salaries exceeded those paid to the District's executives, their compensation did not include health benefits, paid leave, or ASRS benefits.

1 In December 2008, the District changed the responsibilities and title of the Vice-President Internal Development to the Senior Vice-President and Chief External Affairs Officer.

2 Mercer, 2008; SullivanCotter, 2008; Watson Wyatt Data Services, 2008

3 Flannery, 2002

4 SullivanCotter, 2008

Table 10: Comparison of Annual Contracted County and District Executive Salaries to December 2008 District Salaries (Unaudited)

Position	Maricopa County Contract Position As of December 2004 (Estimated)[1]	District Contract Position As of January 2005 (Estimated)[1]	District (Actual)
Chief Executive Officer	$549,100	$571,000	$367,600
Chief Operating Officer	457,600	475,800	330,000
Chief Medical Officer[2]	216,100	216,100	315,100
Chief Financial Officer	561,600	457,600	305,000
Vice-President Internal Development[3]	N/A	N/A	172,400

1 Estimated annual salary was based on contractual hourly or daily pay rates.

2 The Chief Medical Officer was a county and district employee. In February 2008, the District's Chief Medical Officer retired at an annual salary of $315,100. Subsequent to his retirement until October 2008, a contracted physician filled this position on an interim basis at an estimated annual salary of $229,100. As of December 2008, this position remained vacant.

3 The District created and filled this position in November 2005. In December 2008, the District changed the responsibilities and title for this position to the Senior Vice-President and Chief External Affairs Officer with an approximate annual salary of $209,700.

Source: Auditor General staff analysis of a Maricopa County employment contract and district-provided salary information.

CHAPTER 4

Contracting practices for healthcare personnel

Legislative Item

Examine the personnel structure, specifically management salaries, contract personnel, and associated costs and evaluate whether this structure is consistent with and necessary for the execution of the statutorily designated duties of the District.

The Maricopa County Special Health Care District (District) contracts with two private entities, MedPro and Broadlane, to provide all physicians, allied healthcare professionals, and temporary nurses to the District's hospital and healthcare facilities.[1] The contract with MedPro for physicians and allied healthcare professionals contains both cost containment and quality control features such as quality performance contract incentives. However, this contract is also a sole-source contract that the District inherited from the County in 2005, and the District has not re-evaluated the staffing model provided through the contract or determined whether a sole-source contract is still necessary. The District should re-examine whether this staffing model is still optimal. With regard to the contract for temporary nurses, the District supplements its own nursing staff by contracting with Broadlane for temporary nurses. Because hiring more nurses costs less than contracting for them, the District has significantly reduced its use of temporary nurses since 2005 by successfully working to hire more district nurses.

District contracts for some personnel services

The District contracts for many kinds of services, ranging from laundry and cleaning supplies and food to consulting and patient care. In fiscal year 2008, the District paid a total of over $80 million to vendors. According to October 2008 information, the District contracted for a variety of products and services with over 600 individuals and entities. The scope of these contracts varied widely and included contracts for items and services such as pest control, laundry and cleaning supplies, food, consulting, and patient care. However, the two largest contract payments in fiscal year 2008 were for patient-care services at the hospital and other healthcare facilities, including a $45 million contract for physician and allied healthcare professional services, and payment of $11 million for temporary nurse services. Specifically:

In fiscal year 2008, over $56 million was paid to vendors to provide physicians, allied healthcare professionals, and temporary nurses.

[1] According to district policy, allied healthcare professionals include professionals such as physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.

- **Physician contract**—The District's hospital and other healthcare facilities are staffed by 205 physicians and 75 allied healthcare professionals employed through a large, sole-source contract with Medical Professional Associates of Arizona (MedPro), a multi-specialty professional corporation. MedPro was created in 1994 by physicians already employed by the Maricopa County hospital.[1] According to the District, the corporation was formed in response to the Maricopa County Board of Supervisors' request that each department within the county hospital separate from the hospital and create third-party groups for service contracting.[2] The County established the contract with MedPro as a sole-source provider in 2001.

  The MedPro contract was transferred from Maricopa County to the District when the District was established in 2005, and then in 2008 the District signed another 3-year contract with MedPro. According to the District's contract, it is effective for 3 years and may be extended one additional year upon mutual agreement.[3] MedPro provides the District all of its qualified physicians (medical doctors and doctors of osteopathy), and many other credentialed healthcare professionals such as dentists, podiatrists, physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. MedPro doctors are responsible for providing care to patients, teaching resident physicians, supervising in most levels of management, and serving on committees such as the patient safety and peer review committees. The allied healthcare professionals perform a variety of functions at the District, including providing medical care under guidance of a physician, providing anesthesia, and working in labor and delivery. According to the District, MedPro employees are full-time and do not practice privately, with the exception of temporary specialist positions, such as ophthalmologists, that the District uses on an as-needed basis.

- **Temporary nurses contract**—The District also has a contract to supply temporary nurses (also known as contract nurses) to supplement the District's own nursing staff. In 2004, the District began contracting with Broadlane Inc. (Broadlane), a contract negotiation and vendor management provider of healthcare staffing services. Broadlane subcontracts with qualified temporary nurse staffing agencies, which then provide the District with contracted registered nurses for its hospital and healthcare facilities and other staff, such as sitters, who specifically observe and verbally communicate patient status in the hospital. From July through October 2008, the District used an average of 35 contract nurses each month to supplement its own nursing staff, which averaged 823 per month. Like the District's nurses, these contract nurses assist

1 According to the District, the resulting organization was initially called the Maricopa Faculty Association, but with additional changes in 1999, the name was changed to MedPro.

2 The District does not know why the Maricopa County Board of Supervisors requested this change in 1994.

3 These provisions are in compliance with the District Procurement Code rather than the State Procurement Code because the District is not subject to state procurement regulations. The District should adopt and administer competitive procurement rules necessary to administer and operate its programs and any property, according to Arizona Revised Statutes §48-5541.01(M)(1).

in patient care by collaborating with the physicians, performing patient assessments, and administering medication.

MedPro contract contains quality-of-care and cost containment requirements

The District's contract with MedPro contains various requirements designed to encourage quality of care and cost containment, such as those related to hiring qualified practitioners, meeting national standards required for accreditation, and offering incentives for meeting specific performance goals.

Contract includes qualified practitioner requirements—The contract requires that all MedPro physicians and allied health professionals be licensed and/or credentialed in Arizona. Prior to accepting a MedPro doctor or allied health professional to be part of the District's medical staff, the District's medical staff bylaws require that the District perform three reviews of the applicant's professional information, such as whether he/she has professional training and experience and has had any past disciplinary action. These three reviews are conducted by different individuals or groups, including the Chair of the Department to whom the application and relevant information are submitted; a credentialing committee made up of physicians representing most departments, such as internal medicine or surgery; and a District Medical Executive Committee that includes all department chairs and the District's Chief Medical Officer. The Medical Executive Committee then submits a report and recommendation to the Maricopa County Special Health Care District Board of Directors (Board) for final approval.

In addition, the Joint Commission requires that every physician be periodically evaluated including a review of the physician's performance and competence.[1] The District requires these evaluations as part of staff reappointment after their first year and every two years thereafter. This includes review of the physician's performance in relation to department data for patient outcomes, such as infection rate. Further, according to district officials, beginning in January 2009, the District will respond to a recent Joint Commission requirement to increase the review of department data to more than once per year to determine if there are any physicians whose patient outcomes differ substantially from the normal ranges.

Contract requires national quality control programs—The District's contract with MedPro requires MedPro to participate in the quality control programs required by national entities such as the federal Centers for Medicare and Medicaid Services (CMS) and the Joint Commission. According to the District, these programs require organizations to measure the quality of certain processes that are commonly found at most healthcare facilities. Data is collected and reported to CMS on processes such as administering aspirin on arrival for heart

The contract with MedPro requires adherence to national quality control programs.

[1] The Joint Commission is a not-for-profit organization that evaluates and accredits healthcare programs in the United States.

attack patients and administering an initial antibiotic within 6 hours of hospital arrival for pneumonia patients. According to the most current national CMS data available, between April 2007 and March 2008, the District was below the national average for three of the four CMS measured areas.[1]

The District also collects data on the Joint Commission National Patient Safety Goals, which include processes such as implementing a program for reducing the number of patients' falls and communicating a complete list of patient medications to the next provider when a patient is transferred. Information on the Joint Commission's Web site showed that the District had not passed 5 of the 18 National Patient Safety Goals measured in September 2007. However, in December, Joint Commission surveyors reviewed all areas and found the District to be in full compliance.

Contract requires participation in District's Performance Improvement Program—The contract requires MedPro physicians to participate in performance improvement programs such as the District's long-standing, Joint Commission-required quality control program referred to as the District's Performance Improvement Program (PI Plan). The PI Plan's purpose is to act as a guide to quality healthcare services by measuring key processes and outcomes, and identifying opportunities for change that enhance the quality of care. Although the District has a general PI Plan, each department, such as the behavioral health psychiatric centers and the community-based family health centers, has individualized quality indicators that address areas' specific needs. For example, the department that oversees the District's community-based family health centers measures progress on specific goals such as decreasing the length of patient stay and the percentage of urgent care patients who leave without care. Performance on the indicators in the departments' PI Plans is presented to an executive committee, which provides accountability for quality improvement throughout the organization. For example, a report on quality indicator progress showed that in October 2008, the average length of a patient visit for the 11 family health centers was 79 minutes, which is less than the 120-minute goal.

Contract provides incentives for quality and cost containment—As shown in Table 11 (see page 44), the MedPro contract provides incentives to MedPro for meeting goals related to quality of care and cost containment, and for some incentives, the District is allowed to reduce MedPro payments if it does not meet the goals. According to literature, in the healthcare field, healthcare service costs may be contained when payment is tied to performance.[2] In addition, the National State Auditors Association's contracting best practices include tying payments to deliverables in the contract provisions.[3] Between April 2008 and

1 Some of the CMS measures are based on as few as 14 cases at the District, which may be too small a number to reliably tell how the hospital is performing. According to the District, the small number of cases is because the CMS quality data is collected for Medicare patients only and not for all patients.

2 Bokhour et al., 2006; Gaynor, Rebitzer, & Taylor, 2004; Torgerson, 2008

3 National State Auditors Association, 2003

January 2009, the District paid a total of over $1,086,562 in incentives to MedPro. According to district officials, the MedPro contract incentives/penalties were added in April 2008 as part of management's intention to improve quality of care. The contract includes incentives such as:

Between April 2008 and January 2009, the District paid MedPro about $1 million for quality and cost controls incentives included in the contract.

- Supply Chain Improvements Team—One incentive (see Table 11, page 44) provides up to $400,000 per year for collaboration between MedPro and the District through the Supply Chain Improvements Team (Team). According to literature, a collaborative approach between physicians and the hospital that includes discussion of equipment purchasing and treatments helps to ensure high service quality and cost control.[1] The Team consists of district administration and physician members meeting to discuss possible cost savings measures and determine vendors for the purchase of products and equipment for medical use. According to the District, although the Team existed prior to April 2008, the incentive was added to improve physician attendance. The Team met monthly between July and October 2008, and opportunities for physicians to participate should increase in the last quarter of contract year 2009. According to the contract, the District may pay MedPro physicians who participate in the collaborative meetings an hourly compensation of $125 that may not exceed $25,000 per year total for all physicians combined. In addition, MedPro receives 50 percent of any cost savings the team creates up to $375,000 per contract year. Between April and November 2008, the Team identified cost savings totaling an estimated $500,000, which may be paid at the end of the contract year.

- Emergency Department—This incentive (see Table 11, page 44) provides up to $900,000 per year to MedPro when the Adult Emergency Department complies with various requirements. For example, MedPro can receive up to $250,000 per year when a review of its Adult Emergency Department shows that 90 percent or more of the time it follows best practice processes on five of the seven CMS Core Measures for the treatment of maladies such as heart attack and pneumonia. The incentives are generally calculated monthly and paid the following month, unless specified otherwise in the contract. For example, MedPro was paid nearly $42,000 in incentives in October 2008 for its Adult Emergency Department's performance.

- Patient visits in federally qualified health centers—This area (see Table 11, page 44) includes both incentives and penalties, which means that the District may provide up to $1,134,732 per year to MedPro for meeting goals for the number of patient visits at the District's 13 federally qualified healthcare centers, and that the District may also withhold up to this same amount from MedPro payments if it does not meet the incentive baseline requirement. The contract includes a baseline number of appointments with patients in 2007; and the incentive is based on exceeding the baseline in increments of 5 percent, while the penalty will be triggered by not meeting the baseline in decrements of 5 percent. The

1 Torgerson, 2008; Vogenberg, Lichtig, Weinberg, & DeSantis, 2004; Williams, 2008

Table 11: MedPro Contract Services Quality Control Incentives
As of January 2009

Incentive	Maximum Annual Incentives Available for Achieved Goals	Maximum Penalties for Not Meeting Goals	Incentive Payments June 2008 through January 2009
On-time Surgery Starts When surgeons are in operating rooms ready to start at 7:30 a.m. 95 percent or more of the time, MedPro receives 100 percent of incentive. Percentage of incentive money decreases as percentage of on-time starts decreases.	$500,000		
Supply Chain Improvements When a MedPro/district supply chain management team meets twice a month to design and implement cost savings initiatives, up to $25,000 is paid. Also, when cost savings are realized, MedPro and the District share savings at 50 percent up to a total of $375,000.	400,000		
Medical Staff Development Plan To receive this incentive, MedPro and district representatives must strategically create a measurable plan for services, such as deciding how many physicians by specialty are required. This plan has been started, but has not yet been approved.	100,000		$ 100,000[1]
Emergency Department To receive this incentive, MedPro must meet several goals with monetary incentive values assigned to them. For example, up to $350,000 of the incentive is available when 95 percent of medical record charts are updated within 72 hours.	900,000		601,669
Family Health Clinic (FHC) and Comprehensive Healthcare Center (CHC) To receive this incentive, patient visit counts in the FHCs and the CHC must meet the contract incentive requirements for number of patients seen by staff. Each facility will have an incentive/penalty pool, and a facility may receive a 5 percent incentive or penalty based on the performance of the individual facility and another 5 percent only if the requirement is met for the aggregate of all FHCs. a. Each clinic (5 percent) b. Consolidated (5 percent)	 567,366 567,366	 $ 567,366 567,366	 265,513
Regulatory Compliance Eight Joint Commission standards selected in the contract must be met with 90 or 100 percent compliance to receive this incentive. For example, departments must use approved abbreviations or complete post-anesthesia assessment forms.	500,000		119,380
Totals	$3,534,732	$1,134,732	$1,086,562

1 These incentives were earned between April and December 2008 and were paid by January 2009.

Source: Auditor General staff analysis of the April 2008 MedPro contract and the District's January 2009 MedPro payment detail.

incentive further requires that the actual number of patient visits be verified daily by the clinic manager and the District's Medical Director. Two separate incentives are available: one incentive for when the individual centers meet the requirement; and a second incentive when all the centers combined meet their patient visit requirements. This incentive is reported monthly and paid quarterly, and as of January 2009, MedPro had received over $265,000 for this incentive.

According to the District, payments for some incentives have not yet occurred because they are not yet due or the minimum requirement has not been met.

District should re-evaluate its model for obtaining physician services

Although the District's model of obtaining physician personnel through a closed, medical staff model is typical, the unique aspect of the model is that the District contracts with a private organization, MedPro, rather than a local university medical school, like many teaching hospitals. Because other hospitals use different methods to staff their hospitals and healthcare facilities, and because the District has not re-evaluated the model since it inherited the contract in 2005, the District should analyze whether its physician contracting practice is still optimal.

District uses closed physician staffing model—The District's physician staffing model has some similar characteristics to the models commonly used by other teaching hospitals. District officials characterize their physician staffing model as a "closed medical staff" model, meaning that the District's physicians are limited to only those already employed by MedPro as opposed to opening the staff to physicians from the community. Information in literature indicates that many hospitals are staffed by physicians and teaching faculty through a closed medical staff model.[1] According to the District, it uses a closed medical staff model in order to ensure continuity of care and continuity of faculty to work with medical students. Further, the District describes its staffing model as somewhat similar to a Faculty Practice Plan, which, according to *The Managed Health Care Handbook*, is a medical group organized around a teaching program, primarily at a university.[2] In one respect, however, the District's model is unique: the contract is with a private corporation rather than a local university medical school.

District should consider whether physician staffing model and contract type is most effective—Because the District inherited the MedPro contract and its sole-source procurement from the County in 2005, the District should assess whether it still considers this model to be optimal and whether the sole source is still necessary. The current medical staff model has been used since

1 Cuellar & Gertler, 2005; Green & Bowie, 2005

2 Kongstvedt, 2001

1994 and was transferred from Maricopa County when the District was established in 2005. Information in literature shows that healthcare is always changing and that there is no consensus on the "right way" to configure healthcare services because each model has strengths and weaknesses.[1] According to the District, it has not weighed the costs and benefits of using this staffing model versus any other staffing model since the MedPro contract was transferred to the District in 2005.

The MedPro contract was inherited from the County and has not been re-evaluated by the District.

In addition, the District has not evaluated the choice to use a noncompetitive procurement—also known as a sole-source contract. According to a Maricopa County 2001 document prepared to justify its use of a sole-source contract, some of its reasons for seeking a sole-source contract with MedPro were that using a third party reduced administrative costs for overseeing physicians, it was unlikely that other providers would offer proposals, and the sole-source procurement eliminated the expenses of deliberating over the procurement decision. In contrast, other public contracts involve a periodic competitive bidding process that allows other vendors to compete, thus driving down prices. To ensure it considers contracting in ways that most efficiently and effectively fit its purpose and mission, the District should perform a cost/benefit analysis of its physician staffing model, including the continued need for a sole-source contract.

District uses contract nurses on limited basis

Although the District also contracts for some nursing personnel, most of the District's nursing staff, unlike its physician positions, are district employees. To help control costs, the District has worked to increase its own nursing staff. The District requires that staffing agencies, which provide contract nurses through the Broadlane contract, ensure the quality of their nurses by verifying credentials and providing an ongoing education program. In addition, the District helps ensure contract nurse quality through orientation and performance evaluations.

District limits use of contract nurses to control costs—According to the District, it has made a concentrated effort to control costs by limiting its use of contracted nursing personnel. Contracted nurses cost more per hour than district nurses. For example, according to district information, the District's average cost for employing a Registered Nurse (RN) is about $49 per hour (salary and benefits), whereas the average cost for a contracted RN can range from about $56 to $63 per hour. As shown in Table 12 (see page 47), between fiscal years 2005 and 2009, the average monthly number of district nurses had increased by about 200 nurses and its use of contracted nurses had declined to only about 4 percent. However, according to district officials and literature, because of factors such as increasing patient volume and a nation-wide nursing shortage, many hospitals, including the District's, will continue to need to use some contracted nurses.[2]

As of fiscal year 2009, only about 4 percent of the District's total nursing staff were contract nurses.

1 Burns, Morrisey, Alexander, & Johnson, 1998; Kongstvedt, 2001; Mallon, 2004

2 American Association of Colleges of Nursing, 2002; PriceWaterhouseCoopers, 2003; Reis, 2005; Stiehl, 2004

District takes steps to ensure contract nurse quality—The District requires the staffing agencies who provide the contracted nurses to ensure their qualifications, including verifying credentials and providing some continuing education. Further, the District provides an orientation and performance reviews to contracted nurses.

Table 12: Comparison of the Average Monthly Number of District Nurses to Contracted Nurses[1] Fiscal Years 2005 through 2009[2,3]

Fiscal Year	Average Monthly Number of Nurses: District	Contracted	Total	Percentage of Contracted Nurses
2005[2]	611	109	720	15.14%
2006	604	73	677	10.78
2007	614	111	725	15.31
2008	801	55	856	6.43
2009[3]	823	35	858	4.08

1 The average monthly number of nurses was calculated by adding the total nursing hours worked for the month and dividing by the hours available in a month based on an 8-hour workday. The average for the year was determined by adding these monthly totals and dividing by 12 to determine the FTE (full-time equivalent).

2 The District was established on January 1, 2005; therefore, fiscal year 2005 amounts are for the period January through June 2005.

3 Amounts for fiscal year 2009 include data through October 2008.

Source: Auditor General staff analysis of district fiscal year data compiled from payroll information for the period January 2005 through October 2008.

Contracted staffing agencies ensure contracted nurses are qualified by verifying credentials and providing continuing education. Specifically:

- Licensure and credential verification—To meet district contracting requirements, staffing agencies verify the qualifications of their nursing staff. However, according to the District, before a contract nurse may proceed to an assignment, information such as licenses and certifications must be on file with the District.

  In addition, the contractor, Broadlane, performs an initial business and clinical survey of all subcontracted staffing agencies, ensuring that the agencies are complying with state and federal regulations. Further, Broadlane pulls a sample of nurse files to check for current licensure, certifications, education, background checks, health checks, and other specific information. Lastly, Broadlane conducts additional surveys annually or at the District's request.

- Continued nursing education opportunities—The District's Broadlane contract requires staffing agencies to provide their own education programs and maintain records of any training a nurse completed while on assignment. In addition, according to the District, contracted nurses do not receive continuing education through the District. However, they may choose to attend presentations or lectures offered through the District if their attendance would not result in the District's incurring costs.

The District provides new contracted nurses with orientation and performance reviews. Specifically:

- Contract nurse orientation procedures—According to district information, a nurse contracted for a long-term assignment will receive the same 6-day, district-provided orientation that is provided to district nurses. Orientation includes information and instruction regarding risk management and incident reporting, an overview of current patient safety goals, and "skills station" testing where the District requires nurses to perform basic medical tasks in a trainer's presence to demonstrate competence in those areas. Additional unit-level orientation is conducted once the contract nurse arrives on the unit. Contract nurses who will be employed for only a few days receive a 1-day orientation.

- Regular performance reviews—According to district officials, to help ensure the performance level of contract nurses, the district unit that the contracted nurse is assigned to completes a performance evaluation form. For example, nurses with long-term assignments are evaluated at the request of their agency once an assignment is complete. Nurses with short-term assignments are evaluated monthly, or anytime they are moved to work on a new unit.

Recommendation:

4.1. Because the District inherited the MedPro contract and its sole-source procurement from the County in 2005, the District should assess whether it still considers this model to be optimal compared to other models and whether the sole source is still necessary, and take appropriate action based on the results of the assessment.

CHAPTER 5

Medical services to indigents

Legislative Item

The audit shall examine and identify the amount of medical assistance furnished to indigent individuals who are uninsured and ineligible for Medicaid and other health service programs and identify policies that have changed to restrict services to this population.

Since its inception, the Maricopa County Special Health Care District (District) has had a program to serve indigent individuals who are not eligible for other healthcare programs. The District's eligibility requirements and payment policies have changed over time, but the program has always offered both emergency and nonemergency services, such as outpatient surgeries and doctor's visits when a patient is ill. During fiscal year 2008, the program served approximately 39,540 individuals and had about $32 million in uncompensated medical services costs.[1] The number of individuals served has not been restricted as the enrollment has increased from fiscal year 2007, but the uncompensated costs associated with these patients declined by about $7.5 million because of decreases in more costly inpatient visits. The Office of the Auditor General is making no recommendations in this area.

Eligibility and program fees have changed over time

One of the District's primary statutory missions is to serve the medically underserved, and its program to do so—now called Copa Care—has changed over the past few years. According to district documents, the program has always provided people of all ages with both emergency and nonemergency medical services, such as hospital emergency services for severe or life-threatening injuries as well as doctor's visits when a patient is ill or pregnant. Further, the program has always been directed to people who are uninsured or underinsured and are ineligible for other healthcare service programs, such as the State's Medicaid program. However, eligibility requirements and payment policies have changed since the District was created.

Providing medical services to uninsured and underinsured people is a common practice among hospitals in the United States. For example, federal law requires that if a hospital determines that a patient has an emergency medical condition, the hospital must provide the treatment necessary to stabilize that person or arrange for

1 These uncompensated medical services costs are for the District's charity care program only, and do not represent the District's total uncompensated care costs which were approximately $87 million in fiscal year 2008 (see Chapter 6, pages 55 through 63).

an appropriate transfer to another healthcare facility, regardless of the patient's ability to pay or his/her citizenship status.[1] Also, according to the American Hospital Association, in October 2007, more than 86 percent of the over 5,700 hospitals registered in the United States reported that they provided charity care services.[2] The District defines charity care as services provided to uninsured, low-income, and underinsured patients who are financially unable to satisfy their debt.

The District's program has changed a few times, as follows:

- **January 1, 2005—Program already in place was retained.** When the District was first established, it used the charity care policy that was in effect at Maricopa County before the integrated health system was transferred to the District. This policy restricted program eligibility to people who did not qualify for other healthcare programs, such as the State's Medicaid program administered by the Arizona Health Care Cost Containment System (AHCCCS), and whose income was less than or equal to 200 percent of the federal poverty guidelines. This means that people whose income was more than 200 percent above the guidelines would not qualify for the District's charity care program. The federal poverty guidelines establish income levels, based on household size, at or below which a person is considered to be impoverished (see textbox for 2008 federal poverty guidelines).

  Under this charity care policy, eligible persons' medical fees were discounted based on income and household size categories. However, if a patient was seeking nonemergency services and was unable to pay his/her bill in full, he/she was not provided medical services during the visit.

- **July 1, 2006—Eligibility and services were expanded and a new fee schedule was adopted.** Starting in fiscal year 2007, the District established its own, less-restrictive eligibility policy for the program. Under this policy, although individuals still had to be determined ineligible for other healthcare programs such as Medicaid, eligibility was not capped at a specific income amount. Also, the policy expanded covered services. For example, pharmaceuticals for primary care and specialty care patients were not covered under the previous policy, but were added to the District's policy. In addition, using AHCCCS' fee schedule and the federal poverty guidelines, the District established its own fee schedule. For example, patients whose income was between 301 and 500 percent of the federal poverty guidelines were expected to pay 125 percent of the AHCCCS fees for outpatient services. Further, under this policy, although participants did not have to pay for their services in full before receiving treatment, depending on their income level, participants were expected to provide a payment or a deposit and were billed for any remaining amount.

2008 Federal Poverty Guidelines

Persons in Family or Household	Income ≤
1	$10,400
2	$14,000
3	$17,600
4	$21,200

Source: United States Department of Health and Human Services. (2008). *2008 Poverty guideline computations.* Retrieved January 23, 2008, from http://aspe.hhs.gov/poverty/08computations.shtml

1 42 U.S.C.A. §1395dd.

2 American Hospital Association, 2007

- **July 1, 2008—Fees increased for some participants.** The District changed the name of this program to Copa Care, and for fiscal year 2009, the program's eligibility requirements remain the same as described in the bullet above. In addition, the District continues to charge program participants for services, but the District increased fees for some program participants because of concerns about the program's rising costs raised by the Maricopa County Special Health Care District Board (Board).

  These concerns resulted in the District's seeking program fee information from other hospitals. According to district officials, it sent surveys to the 28 members of the National Association of Public Hospitals to learn about their financial assistance programs. The District received 11 surveys back, and according to district officials, it found that the District generally provided more generous discounts to individuals with higher income levels. Therefore, the District increased fees for patients whose income is greater than 200 percent of the federal poverty guidelines. For example, patients who needed outpatient services and whose income is 301 to 500 percent above the federal poverty guidelines had their fees increased from 125 percent to 175 percent of the AHCCCS fee schedule, and are required to provide a $300 deposit prior to receiving services. Further, the fees established for patients with higher income amounts can now be higher than the fee a privately insured individual's insurance company pays for the same service (see textbox).

Examples of Fees for Copa Care Participants with a Household Size of One Compared to Other Rates

Service: Hospital outpatient surgery to repair a rotator cuff

AHCCCS rates for this service:
- $1,912

Amount charged for a privately insured patient:
- $896-$2,211—If the patient is privately insured and the insurance carrier has a contracted price for this procedure.

Amount charged Copa Care patient:
- $25—If the patient's annual income is less than or equal to $10,400 or 100 percent of the federal poverty guidelines.
- $574 with a $50 deposit—If the patient's annual income is $10,504 to $15,600 or 101 to 150 percent over federal poverty guidelines.
- $3,345 with a $300 deposit—If the patient's annual income is $31,304 to $52,000 or 301 to 500 percent over the federal poverty guidelines.
- $4,779 with a $500 deposit—If the patient's annual income is $52,104 or more, or 501 percent or more over federal poverty guidelines.

Source: Auditor General staff analysis of the January 2008 Federal Poverty Guidelines, the District's July 1, 2008, Copa Care fee schedule, and other district rate information.

Program costs and population served

The District did not begin capturing uncompensated care cost and participant data for its charity care program, now called Copa Care, until it established its own charity care policy in fiscal year 2007. As shown in Table 13, during fiscal years 2007 and 2008, the program served 36,121 and 39,540 individuals, respectively. In fiscal year 2008, the District recorded more than 90,000 visits from these 39,540 individuals. Most of the visits were adult outpatient and emergency medical services. Other types of visits included inpatient and dental services. Although the program served more individuals in fiscal year 2008, its uncompensated medical services costs decreased. According to the District, the reduction resulted from increased patient revenue and decreased operating costs. For example, inpatient costs are much higher than outpatient costs, and during fiscal year 2008, there were fewer inpatient visits.

Table 13: Charity Care Patients, Revenues, and Costs
Fiscal Years 2007 and 2008
(Unaudited)

Fiscal Year	Patients Served	Patient Revenue	Uncompensated Medical Services Costs[1]
2007	36,121	$2,693,000	$39,466,000
2008	39,540	4,095,000	31,953,000

1 These costs represent the District's direct operating costs that are discounted for the patients in its charity care program, now called Copa Care. For fiscal year 2008, the District had a total of approximately $87 million in uncompensated care costs (see Chapter 6, pages 55 through 63).

Source: Auditor General staff analysis of the District's unaudited billing data for fiscal years 2007 and 2008 and notes to the fiscal year 2008 audited financial statements.

During fiscal year 2008, the program served participants of all ages, with the median age of patients being 30. Most patients were female (55 percent). Further, as illustrated in Table 14 (see page 53), 68 percent of patients were Hispanic and 62 percent of patients had an income that was 301 percent or more above the federal poverty guidelines.

Table 14: Charity Care Program Patient Demographics
Fiscal Year 2008
(Unaudited)

	Number of Patients	Percentage of Patients
Age of Patients		
0-10 years	5,186	13%
11-20 years	5,474	14
21-40 years	18,047	46
41-50 years	5,899	15
51-65 years	4,126	10
66 years and over	808	2
Ethnicity of Patients		
Unknown	796	2%
Other	1,460	4
African American	3,337	8
Caucasian	7,022	18
Hispanic	26,925	68
Income Level of Patients over Federal Poverty Guidelines		
Other[1]	376	1%
0-100%	8,102	21
101-150%	3,695	9
151-200%	1,342	3
201-300%	1,390	4
301% and over	24,635	62

1 Fees for these patients, who include the homeless, are not based on income level.

Source: Auditor General staff analysis of fiscal year 2008 charity care program demographic information from the District's STAR patient accounting system as of November 6, 2008.

CHAPTER 6

Uncompensated care costs

In fiscal year 2008, the Maricopa County Special Health Care District (District) had approximately $87 million in uncompensated care costs—that is, costs incurred in providing care to people the District does not expect to receive payment from. The federal government's Medicaid Disproportionate Share Hospital (DSH) Payments Program reimburses states for a portion of these costs. In Arizona, the Arizona Health Care Cost Containment System (AHCCCS) administers this program, which involves determining which hospitals qualify based on established criteria, and then distributing the DSH monies to these hospitals according to legislative appropriations. In fiscal year 2008, Arizona received nearly $94 million in federal DSH monies. AHCCCS distributed the monies as follows: approximately $4.2 million went to the District, approximately $17.3 million went to the private hospitals, and approximately $72 million was deposited in the State General Fund. In addition, AHCCCS distributed approximately $9 million from the State General Fund to the private hospitals, which is the required state match, and according to AHCCCS resulted in a net deposit to the State General Fund of approximately $63 million of federal DSH monies. The District believes it should receive more DSH money because, as the State's primary safety net hospital, it has the largest amount of uncompensated care costs and it must certify its costs for the State to receive a federal DSH payment. The Office of the Auditor General is making no recommendations in this area.

Legislative Item

The audit shall examine the amount of uncompensated care provided on an annual basis by the District and measure this amount in relation to the amount of uncompensated care provided by facilities of the District before the formation of the District, to the amount of uncompensated care provided by facilities of the District before the implementation of Proposition 204, and to the amount of uncompensated care reported by other private hospitals in Arizona and public hospitals in other states.

Federal government helps states cover uncompensated care costs

Congress established the DSH program in 1981. The federal Centers for Medicare and Medicaid Services (CMS) administers this program, which reimburses states for

a portion of their hospitals' uncompensated care costs. Hospitals incur uncompensated care costs when they provide medical care, but do not receive payment for the services provided. According to a report on Medicaid and the uninsured, the DSH program not only provides support for uncompensated care, but also helps hospitals deal with low Medicaid reimbursement rates that are frequently less than hospitals' costs.[1] The federal government shares in the cost of DSH expenditures based on a state's Federal Medical Assistance Percentage.[2] However, to control DSH payments to states, the federal government also establishes an annual limit or allotment for each state. Arizona began participating in the DSH program in 1992. In fiscal year 2008, Arizona's federal allotment for the DSH program was approximately $95 million. For fiscal year 2009, the federal DSH allotment for Arizona is approximately $102 million. The allotment represents the total federal amount that a state can drawn down from the federal government for that year.

AHCCCS administers Arizona's DSH program

AHCCCS, the State's Medicaid agency, administers the State's DSH program. Administering the DSH program involves working with CMS to establish a method for determining which Arizona hospitals can be considered DSH-eligible and how to calculate uncompensated care costs, as well as distributing the DSH monies according to legislative appropriations.

AHCCCS' method for calculating uncompensated care costs changed in fiscal year 2008. According to an AHCCCS official, although CMS had never communicated any concerns with its prior methods, because AHCCCS was updating the terms and conditions for its Medicaid program, CMS also required changes to Arizona's DSH program.[3] According to AHCCCS, the most significant changes to its DSH program were a change to a more reliable data source for determining a hospital's eligibility and calculating uncompensated care costs, and the requirement for governmentally operated hospitals to certify their uncompensated care costs.[4] Key aspects of AHCCCS' DSH calculation methods include:

- **Determining eligibility**—Starting in fiscal year 2008, Arizona hospitals interested in receiving a DSH payment must apply through AHCCCS. AHCCCS then uses data submitted by the hospital to determine if it is eligible. The data AHCCCS uses includes standardized information that hospitals report to CMS, such as total inpatient days, and AHCCCS data, such as state payments a hospital received for state programs such as the Department of Economic Security's

1 Hadley, Holahan, Coughlin, & Miller, 2008

2 Federal Medical Assistance Percentage (known as FMAP) is the percentage of federal matching dollars available to a state to provide Medicaid services. For Arizona, in fiscal year 2008 the federal match was 66.2 percent.

3 AHCCCS has a waiver granted by the federal government for its Medicaid program that allows it to not follow certain federal statutes and regulations. However, AHCCCS must run its program under Special Terms and Conditions required by the federal government. Included in these terms and conditions are the methods for the DSH program.

4 The new process established in 2008 uses some hospital data from a Medicare cost report, which AHCCCS considers more reliable than data from an accounting report submitted by hospitals to the Department of Health Services.

Comprehensive Medical and Dental Program. Using this information, AHCCCS applies CMS-approved eligibility criteria, which are primarily related to the proportion of Medicaid or low-income patients a hospital serves compared to its total patients. For example, to be eligible, hospitals must serve a higher proportion of Medicaid or low-income patients than other hospitals. Governmentally operated hospitals are required to submit data to AHCCCS for calculating uncompensated care costs, but do not have to go through the DSH eligibility calculation process. In fiscal year 2008, 37 private hospitals in Arizona were eligible for DSH monies. In addition, Arizona has two governmentally operated hospitals: the Arizona State Hospital (ASH), and the District's hospital, called the Maricopa Medical Center.[1]

- Calculating uncompensated care costs—AHCCCS then calculates the amount of DSH-uncompensated care costs for each hospital. This calculation is based on both uncompensated care costs for Medicaid patients, known as a Medicaid shortfall, and uncompensated care costs for uninsured patients. For private hospitals, AHCCCS determines the relative proportion of each hospital's uncompensated care costs and uses this in part to help determine how to distribute among the private hospitals the amount of DSH monies that the Legislature appropriates for private hospitals.

- Obtaining certification and required state match—If a hospital is a governmentally operated hospital, beginning in fiscal year 2008, it must certify the public expenditures it or the State is claiming for federal DSH reimbursement. This requirement does not apply to private hospitals because federal regulations allow only state and local governmental units to fund the nonfederal share of Medicaid expenditures. Public expenditures are state or local tax dollars that were used to satisfy the governmentally operated hospitals' cost of providing services to Medicaid and uninsured individuals. Therefore, the federal DSH monies are effectively a repayment of the federal share of the uncompensated care costs. In addition, the State is required to appropriate state monies as a required state match for the private hospitals.[2] AHCCCS then uses the certifications and state match to obtain federal DSH reimbursement for the State. Without these certifications and the state match for the private hospitals, Arizona would not be eligible to use the federal DSH allotment to the State.

  As illustrated in Table 15 (see page 58), in fiscal year 2008 the State received nearly $94 million in federal DSH reimbursements. Specifically, ASH certified that it had approximately $28 million in uncompensated care costs, which based on the federal share of these costs enabled the State to receive approximately $19 million in federal DSH reimbursements. The District certified that it had approximately $87 million in uncompensated care costs, which, based on the

1 The Arizona State Hospital provides court-ordered treatment to individuals suffering from a behavioral health illness that has severely impaired their functioning and their ability to be maintained in the community.

2 The required state match for the private hospitals is the difference between the FMAP and 100 percent. For fiscal year 2008 Arizona's state match was 33.8 percent.

Table 15: Arizona Hospitals' Uncompensated Care Costs Claimed and Related Federal DSH Reimbursements and Distributions
Fiscal Year 2008
(Unaudited)

Hospital	Arizona's Claimed Uncompensated Care Costs	Federal DSH Reimbursements	DSH Amount Distributed to Hospitals	Amount Deposited in (Appropriated from) State General Fund
Arizona State Hospital	$ 28,474,900	$18,850,384	$ 0	$18,850,384
Maricopa County Special Health Care District	86,920,707	57,541,508	4,202,300	53,339,208
Private Hospitals (37)[1]	26,147,700	17,309,777	26,147,700[2]	(8,837,923)
Total	$141,543,307	$93,701,669	$30,350,000	$63,361,669

1 In fiscal year 2008, AHCCCS determined that the 37 private hospitals that were eligible to receive a DSH payment had approximately $531.5 million in uncompensated care costs; however, based on the state match amount of approximately $9 million, which the Legislature appropriated from the State General Fund, Arizona was able to claim approximately $26 million in private hospital uncompensated care costs.

2 Of the approximately $26 million in DSH monies distributed to the private hospitals, approximately $9 million was the required state match, which the State General Fund provided.

Source: Auditor General staff analysis of AHCCCS and JLBC information for fiscal year 2008.

federal share of these costs enabled the State to receive approximately $57.5 million in federal DSH reimbursements. Finally, for the uncompensated care costs for private hospitals that the State claims, as mentioned previously, Arizona is required to provide a state match. Although the private hospitals had a total of approximately $531.5 million in uncompensated care costs in fiscal year 2008, based on the approximately $9 million the Legislature appropriated for the state match, the State claimed a total of approximately $26 million in uncompensated care costs for private hospitals. This enabled the State to receive approximately $17.3 million in federal DSH reimbursements.

- Distributing allotment and reconciling uncompensated care costs—Once the State receives the DSH allotment from CMS, AHCCCS distributes the monies according to legislative appropriations and the associated budget reconciliation bill. In fiscal year 2008 (see Table 15), all of the approximately $19 million in federal DSH reimbursements that the State received due to ASH's uncompensated care costs certification was deposited in the State General Fund because ASH receives a State General Fund appropriation. In that same fiscal year, of the approximately $57.5 million in federal DSH reimbursements that the State received due to the District's uncompensated care costs

certification, the Legislature appropriated $4.2 million to the District, with the remaining $53.3 million being deposited in the State General Fund. Finally, in fiscal year 2008, the Legislature appropriated approximately $9 million from the State General Fund and approximately $17 million in federal DSH monies for the private hospitals. AHCCCS then proportionately distributed the combined federal and state amount, approximately $26 million, among the eligible qualifying private hospitals. The legislative appropriations were the same for fiscal year 2009, but in January 2009, the Legislature eliminated the fiscal year 2009 DSH appropriation for the District and private hospitals.[1] However, according to AHCCCS' approved DSH methodology, it is required to make a minimum payment of $5,000 to all qualifying private hospitals to maintain the DSH program in Arizona. AHCCCS is working with CMS to determine the minimum required private DSH distribution and to allocate a minimum of $500,000 among the private hospitals.

In making distributions, AHCCCS must take into account that the federal DSH monies Arizona receives are a reimbursement for estimated expenditures. Because of timing differences in the state and the federal fiscal years as well as when the Medicare cost report data, which is used in part of the calculation, is finalized, the uncompensated care cost amounts AHCCCS calculates are an estimate. CMS requires that this estimate be reconciled when the data is finalized.

Arizona's uncompensated care costs and DSH payment distributions

Since Arizona began participating in the DSH program, it has distributed monies to three groups: (1) public or governmentally operated hospitals, (2) private hospitals, and (3) the State General Fund. As just discussed, in fiscal year 2008 various changes were made to the DSH program; therefore, Table 16 (see pages 60 and 61) presents uncompensated care costs and distributions related to the DSH program for fiscal years 2001 through 2007.[2]

As Table 16 shows (see pages 60 and 61), during fiscal years 2000 through 2007, AHCCCS' calculations of Arizona's total uncompensated care costs ranged from a low of approximately $266 million in fiscal year 2001 to a high of approximately $732 million in fiscal year 2007. The Maricopa County Medical Center's or the District's calculated uncompensated care costs have ranged from about $46 million in fiscal year 2001 to about $98 million in fiscal year 2007.

1 Laws 2009, 1st S.S., Ch. 4, §7.

2 Table 16 does not include uncompensated care costs for public hospitals in other states. Although the Legislature requested this information, auditors determined that states may have different methods for calculating uncompensated care costs and so it is not reasonable to compare these costs from state to state.

Table 16: Arizona Hospitals' Uncompensated Care Costs and Monies Received Related to DSH
Fiscal Years 2000 through 2007
(Unaudited)

Fiscal Year	Hospital	AHCCCS' Calculated Uncompensated Care Costs	Monies Received Related to DSH[1]	Percent of Costs Reimbursed by DSH Monies
Prior to Proposition 204 Implementation				
2000	Arizona State Hospital	$ 27,041,236[2]	$ 0[3]	0%
	Kino Community Hospital[4]	15,258,263	6,102,000	40
	Maricopa County Medical Center	91,817,163	13,140,300	14
	Private hospitals (26)	247,580,812	15,150,000[5]	6
	State General Fund	N/A[6]	46,607,700	
	Total	381,697,474	81,000,000	
2001	Arizona State Hospital	30,465,328[2]	0[3]	0
	Kino Community Hospital[4]	13,253,518	6,102,000	46
	Maricopa County Medical Center	45,895,542	13,140,300	29
	Private hospitals (28)	176,100,397	15,150,000[5]	9
	State General Fund	N/A[6]	49,442,700	
	Total	265,714,785	83,835,000	
After Proposition 204 Implementation				
2002	Arizona State Hospital	41,893,766[2]	0[3]	0
	Kino Community Hospital[4]	21,113,161	0	0
	Maricopa County Medical Center	53,657,062	0	0
	Private hospitals (33)	168,264,519	20,250,000[5]	12
	State General Fund	N/A[6]	65,391,855	
	Total	284,928,508	85,641,855	
2003	Arizona State Hospital	28,474,900[2]	0[3]	0
	Kino Community Hospital[4]	15,939,539	281,000	2
	Maricopa County Medical Center	71,593,438	5,109,800	7
	Private hospitals (38)	227,576,305	24,959,600[5]	11
	State General Fund	N/A[6]	51,857,989	
	Total	343,584,182	82,208,389	
2004	Arizona State Hospital	36,211,520[2]	0[3]	0
	Maricopa County Medical Center	67,568,856	4,202,300	6
	Private hospitals (38)	430,210,517	26,147,700[5]	6
	State General Fund	N/A[6]	65,019,400	
	Total	533,990,893	95,369,400	
2005	Arizona State Hospital	37,568,943[2]	0[3]	0%
	Maricopa County Special Health Care District	89,621,423	4,202,300[7]	5
	Private hospitals (37)	336,160,714	26,147,700[5]	8
	State General Fund	N/A[6]	65,019,400	
	Total	463,351,080	95,369,400	

(Continued)

Table 16: Arizona Hospitals' Uncompensated Care Costs and Monies Received Related to DSH
Fiscal Years 2000 through 2007
(Unaudited)
(Concluded)

Fiscal Year	Hospital	AHCCCS' Calculated Uncompensated Care Costs	Monies Received Related to DSH[1]	Percent of Costs Reimbursed by DSH Monies
After Proposition 204 Implementation				
2006	Arizona State Hospital	43,524,967[2]	0[3]	0
	Maricopa County Special Health Care District	83,750,394	4,202,300	5
	Private hospitals (37)	430,648,729	26,147,700[5]	6
	State General Fund	N/A[6]	62,319,777	
	Total	557,924,090	92,669,777	
2007	Arizona State Hospital	34,757,791[2]	0[3]	0
	Maricopa County Special Health Care District	97,865,664	4,202,300	4
	Private hospitals (38)	599,212,330	26,147,700[5]	4
	State General Fund	N/A[6]	65,019,400	
	Total	731,835,785	95,369,400	

1 The amounts listed in this column represent the net amount each entity received. Prior to fiscal year 2008, the Legislature appropriated State General Fund monies as a state match to both private and public hospitals and then used intergovernmental transfers to return a portion of the payments made to public hospitals to the State General Fund. The amounts listed for Kino Community Hospital and Maricopa County Medical Center/Maricopa County Special Health Care District came from audited financial statements. The amounts listed for the Arizona State Hospital and private hospitals are based on AHCCCS and JLBC information. Finally, the amounts listed for the State General Fund are calculated estimates based on the federal allotment amount CMS reported, as of January 2009, that the State had used, less any amounts received by the hospitals.

2 Federal regulations limit the amount of uncompensated care costs that an Institution for Mental Disease can claim under the DSH program. According to a CMS official, Arizona's limit is $28,474,900. So, even if ASH's uncompensated care costs are higher than that amount, it is only eligible to receive federal reimbursement for the $28 million amount.

3 According to JLBC information, the Arizona State Hospital does not receive any DSH payments because it receives a State General Fund appropriation.

4 Kino Community Hospital was a public hospital located in Pima County. However, after fiscal year 2003, it was no longer considered a county hospital because in fiscal year 2004, University Physicians Inc. assumed full fiscal and operating responsibilities for the Hospital.

5 The amount private hospitals receive includes the required state match, which the State General Fund provides (see footnote 2, page 57 for more information).

6 Only hospitals report uncompensated care costs.

7 On January 1, 2005, Maricopa County, which was operating the healthcare system, transferred the system's fiscal and operational responsibilities to the new Maricopa County Special Health Care District; therefore, Maricopa County received half of the $4.2 million allocated, and the District received the other half.

Source: Auditor General staff analysis of notes to county audited financial statements, and AHCCCS, CMS, and JLBC information for fiscal years 2000 through 2007.

During fiscal years 2000 through 2007, the County/District received a DSH payment to help cover a portion of its costs in every year except 2002. This was the year that Proposition 204 was implemented. Proposition 204 was a ballot initiative, passed in November 2000, in which Arizona voters voted to use tobacco settlement monies to increase AHCCCS healthcare coverage from people living at 34 percent or less of the federal poverty level to 100 percent or less of the federal poverty level.[1] According to an AHCCCS official, the DSH monies were used to help offset the State's increased costs for providing healthcare services to more people as well as eligibility determination and indigent care costs formerly paid for by the counties.[2]

In fiscal year 2003, the Legislature appropriated to the County $5.1 million in DSH monies. Since fiscal year 2004, the Legislature has appropriated to the County or the District $4.2 million annually in DSH payments. Auditors were unable to obtain any conclusive information on how this amount was determined, but according to various interviews, this amount was roughly equal to the amount of state funding the Maricopa County Medical Center received under a state-only emergency services program that was eliminated in fiscal year 2002. According to the District, it was not involved in any discussions related to determining the $4.2 million amount.

District believes it should receive more DSH money

The District believes that it is entitled to receive a larger portion of the State's DSH payment. As the State's primary safety net hospital, the District believes it incurs the majority of the State's uncompensated care costs, which must be certified to draw down some of the federal DSH monies.[3] Thus, according to district officials, it should receive the full federal reimbursement for the amount it certifies, which is approximately $53.3 million more of the State's DSH payment. Also, the District feels that it has not been adequately involved in discussions about the DSH program. For example, according to district officials, it was not informed that CMS required AHCCCS to change the DSH methodology until the District was told that it needed to certify its uncompensated care costs. In addition, according to a letter to the Governor from the Maricopa County Special Health Care District Board of Directors (Board), for years the District has had concerns about the amount of DSH monies it receives. The District's Board initially refused to certify the costs. AHCCCS filed a lawsuit against the District to obtain the certification, but the lawsuit was dismissed when the District agreed to certify the fiscal year 2008 amount. However, because the

1 The tobacco settlement monies were the result of a lawsuit filed by the attorneys general of 46 states, including Arizona.

2 According to a 2003 AHCCCS memorandum that analyzed data from the eligibility enrollment report, by September 2003 AHCCCS enrollment had increased by 74 percent since Proposition 204 was implemented in 2002, and 33 percent of that growth was due to the proposition.

3 According to Weinick & Billings, Introduction: Tools for Monitoring the Health Care Safety Net, healthcare safety net was defined as follows, "Those providers that organize and deliver a significant amount of healthcare and other health-related services to uninsured, Medicaid, and other vulnerable patients" (as cited Institute of Medicine, 2000).

District still has concerns with the amount of DSH monies it receives, it has filed an appeal with AHCCCS. As of January 2009, this appeal, which will be heard by the Office of Administrative Hearings, has been delayed until April 2009 while the District works with AHCCCS and the Governor's Office to identify other potential sources of money to help cover a greater portion of the District's uncompensated care costs.

APPENDIX A

Salary survey analysis methodology and additional salary information

Chapter 3 (pages 33 through 38) and this appendix contain several tables showing comparisons of the Maricopa County Special Health Care District's (District) executive management salaries to median salaries for comparable positions reported in national salary surveys. This appendix also describes the methodology auditors used to produce the results in those tables. The Office of the Auditor General obtained salary surveys from three nationally recognized salary survey companies: Mercer, SullivanCotter, and Watson Wyatt Data Services.[1] All three companies provide documentation describing the source of the salary data, and this can be found in each survey or through the companies' Web sites.[2]

Auditors made the following decisions regarding the data:

- Aging of data—Because the data from each survey was effective between January and March 2008, auditors aged the data to December 2008, to coincide with the end of the year. Auditors aged the data from each survey based on SullivanCotter's analysis of budgeted salary increases for hospitals and health system executives for 2008 (3.5 and 4 percent, respectively). The data was aged in proportion to the number of months between the data effective date and December 2008.

- Choice of Chief Executive Officer (CEO) position—Although the SullivanCotter survey offered only one choice for the CEO position data, both Mercer and Watson Wyatt Data Services offered multiple choices. Mercer offered two choices—CEO of a standalone or system-owned hospital. Because Mercer considers a single hospital, not owned by a healthcare provider system, with multiple nonhospital facilities such as outpatient clinics and a health plan as a standalone hospital, and auditors considered that this definition most closely matched the District's profile, auditors chose the CEO of a standalone hospital

1 To perform their analyses, auditors used 2008 healthcare salary surveys from Mercer, SullivanCotter, and Watson Wyatt Data Services. See Bibliography, pages c-i through c-iv, for additional details.

2 Although SullivanCotter does not provide online access to its survey, both Mercer and Watson Wyatt Data Services provide Web site access at http://www.imercer.com/ and http://www.wwds.com/, respectively.

for their analysis. In the Watson Wyatt Data Services survey, there were four choices—CEO of a multi-unit organization, an independent or subsidiary hospital/facility, or a nonhospital facility. Auditors chose the multi-unit organization position for their analysis because Watson Wyatt Data Services defined it as the CEO of a healthcare organization with various hospitals and/or facilities such as healthcare clinics, and auditors considered this definition most similar to the District's profile—a full-service teaching hospital with several healthcare facilities, and two health plans.

- Choice of hospital types—For each analysis, auditors chose the healthcare organization type that appeared to most closely match the District's. As indicated in the Introduction and Background (see pages 1 through 10), the District's integrated health system consists of a full-service teaching hospital, several other healthcare facilities, and two health plans.

    - Mercer—This survey provided data for various hospital types, and auditors determined that the teaching facility group was the most comparable to the District because it included organizations that provide teaching programs for medical students. However, for some comparisons, the survey restricted the auditors' choice to the general hospital group.

    - SullivanCotter—This survey provided data for both hospitals and health systems. Auditors chose the health system data because the survey's description of a Single Hospital System (one acute care hospital and multiple healthcare-related entities, such as outpatient/ambulatory care) appeared to most closely reflect the District's profile.

    - Watson Wyatt Data Services—This survey provided a general hospital group and various specific hospital types. Auditors chose the general medical and surgical teaching hospitals group, which appeared to most closely reflect the District's profile. However, for comparisons where auditors used SullivanCotter's data or Mercer's general hospital group data, auditors used Watson Wyatt Data Services' general hospital group data so the data would be more comparable.

- Choice of regions—In addition to comparing executive management salaries nationally, auditors also compared salaries regionally. Because both Watson Wyatt Data Services and Mercer define the South Central region to include Arizona, Arkansas, Colorado, Louisiana, New Mexico, Oklahoma, Texas, and Utah, auditors included this region in their analysis. However, auditors could not perform a regional analysis using SullivanCotter's health system data because it lacked a regional breakdown of the data. At the District's request, auditors also included the West Coast region. Watson Wyatt Data Services defines the West Coast region to include Alaska, California, Hawaii, Nevada, Oregon, and Washington. Mercer includes these states in the West Coast region and adds Idaho and a small northwestern portion of Arizona.

- Choice of revenue increments—Working within each survey's confine, auditors chose revenue increment amounts that most closely matched the District's net revenues. Net revenues are gross revenues less items that reduce total revenue, such as bad debt (amounts that patients or insurers never paid). In fiscal year 2008, the District had $572 million in net revenues.

    - Mercer—The revenue increment amount available in this survey that most closely matched the District's was $400 million or more. This survey only provides the ability to select revenue amounts for certain analyses. For example, the survey restricted auditors from selecting revenue amounts when comparing all hospitals nationally.

    - SullivanCotter—This survey provides several revenue increments for any analyses conducted for health systems. Auditors chose the $400 to $900 million increment as most comparable to the District's.

    - Watson Wyatt Data Services—Although the Watson Wyatt Data Services data was available in many different revenue increments, auditors chose one similar to SullivanCotter's to provide the most comparable data.

- Inclusion of the District's data—The data used in the tables for two of the three surveys—Mercer and Watson Wyatt Data Services—includes the District's data within the reported amounts from all hospitals. Because of these companies' confidentiality policies, auditors were unable to obtain the survey data with the District's data removed.

- Unreported data—To maintain client confidentiality, the survey firms do not report data in a category where fewer than five participants respond. The dashes in each table represent where this has occurred.

- Use of median salaries—Although a variety of measures are available for each survey, auditors predominantly chose the median salary because it is the value that has an equal number of values above and below it, thereby eliminating the influence of any extremely high or low values. However, in one instance, auditors chose the 25th percentile because the comparable hospital grouping for that survey included hospitals with net revenues extending to more than $1.5 billion, which auditors felt would inflate the salary data and make it incomparable (see Table 17, pages a-iv through a-v).

In addition to the analyses presented in Chapter 3, pages 33 through 38, auditors performed the analyses on Table 17 (see pages a-iv through a-v) by comparing the District's executives' salaries to national healthcare facilities' and teaching hospitals' without consideration of net revenues, and hospitals' executives' salaries by region both with and without considering net revenues.

Table 17: Additional Salary Comparison Information
As of December 2008
(Unaudited)

A: Comparison of the District's Executives' Salaries to Those of Selected Hospitals and Health Systems Nationally Without Regard to Net Revenues

	District	Watson Wyatt Data Services[1]		SullivanCotter		Mercer[1]	
Position	Annual Salary	Median Annual Salary	Number of Organizations Reporting	25th Percentile Annual Salary[2]	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting
Chief Executive Officer	$367,600	$586,000	93	$540,400	192	$544,400	69
Chief Operating Officer	330,000	292,500	130	331,700	137	195,700	317
Chief Medical Officer[3]	315,100	298,800	112	302,400	130	285,900	116
Chief Financial Officer	305,000	274,000	204	295,500	200	179,800	460
Vice-President Internal Development[4]	172,400	150,900	72	157,800	69	145,200	36

B: Comparison of the District's Executives' Salaries to Those of Selected Teaching Hospitals Nationally Without Regard to Net Revenues

	District	Watson Wyatt Data Services[1]		Mercer[1]	
Position	Annual Salary	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting
Chief Executive Officer	$367,600	$615,800	43	$584,700	52
Chief Operating Officer	330,000	328,400	53	258,000	124
Chief Medical Officer[3]	315,100	323,300	51	307,900	74
Chief Financial Officer	305,000	322,300	79	242,900	142
Vice-President Internal Development[4]	172,400	199,000	28	144,300	25

C: Comparison of the District's Executives' Salaries to Those of Selected Hospitals Regionally Without Regard to Net Revenues

	District	Watson Wyatt Data Services[1]				Mercer[1]			
		South Central[5]		West Coast[6]		South Central[5]		West Coast[6]	
Position	Annual Salary	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting
Chief Executive Officer	$367,600	$486,200	18	—[7]	1	$620,900	11	—	2
Chief Operating Officer	330,000	265,500	18	$192,600	8	170,800	81	$188,900	50
Chief Medical Officer[3]	315,100	331,000	14	361,800	6	259,000	22	302,200	14
Chief Financial Officer	305,000	272,000	31	232,700	13	174,300	127	179,800	59
Vice-President Internal Development[4]	172,400	200,700	7	209,400	6	—	3	162,400	6

(Continued)

Table 17: Additional Salary Comparison Information
As of December 2008
(Unaudited)
(Concluded)

D: Comparison of the District's Executives' Salaries to Those of Selected Hospitals Regionally with Similar Net Revenues

District		Watson Wyatt Data Services[1,8]				Mercer[1,8]			
		South Central[5]		West Coast[6]		South Central[5]		West Coast[6]	
Position	Annual Salary	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting	Median Annual Salary	Number of Organizations Reporting
Chief Executive Officer	$367,600	$524,700	7	—[7]	0	$625,400	7	—	1
Chief Operating Officer	330,000	200,200	6	—	4	262,000	11	$294,500	9
Chief Medical Officer[3]	315,100	—	3	—	2	—	4	310,800	10
Chief Financial Officer	305,000	297,600	11	$256,700	5	235,300	12	338,700	11
Vice-President Internal Development[4]	172,400	—	2	—	4	—	1	189,100	5

1 Salary survey data includes the District's data that could not be removed because of survey firm client confidentiality policies. See page a-iii for further details.

2 The 25th percentile instead of the median annual salary was used to make a more appropriate comparison. See page a-iii for further details.

3 In February 2008, the District's Chief Medical Officer retired at an annual salary of $315,100. Subsequent to his retirement until October 2008, a contracted physician filled this position on an interim basis at an estimated annual salary of $229,100. As of December 2008, this position remained vacant.

4 In December 2008, the District changed the responsibilities and title for this position to the Senior Vice-President and Chief External Affairs Officer with an approximate annual salary of $209,700.

5 Watson Wyatt Data Services and Mercer both define the South Central region as including Arizona, Arkansas, Colorado, Louisiana, New Mexico, Oklahoma, Texas, and Utah.

6 Watson Wyatt Data Services defines the West Coast region as including Alaska, California, Hawaii, Nevada, Oregon, and Washington. Mercer includes these states in the West Coast region and adds Idaho and a small northwestern portion of Arizona.

7 The survey companies do not report data in a category when there are fewer than five organizations reporting.

8 Watson Wyatt Data Services data was based on hospitals with net revenues of $400 million to $900 million whereas Mercer data was based on hospitals with net revenues of $400 million or more. See above for further details.

Source: Auditor General staff analysis of district-provided executive salary information and Mercer, SullivanCotter, and Watson Wyatt Data Services salary survey data.

APPENDIX B

Methodology

As set forth in Laws 2008, Chapter 288, §22, audit work focused on six areas within the Maricopa County Special Health Care District (District). General methods used included interviews with the District's Board of Directors, management, and staff; reviews of district documents such as the Board of Directors' policy statements and meeting minutes; and an analysis of applicable state and federal laws.

In addition, auditors used the following specific methods:

- To identify and examine the financial, administrative, and operational issues of the District and identify changes required to ensure financial stability, auditors analyzed the District's financial documents and practices and compared them to information and practices in literature.[1] To select literature, auditors consulted with experts and reviewed various books, articles, audits, reports, and organizations' Web sites. To assess financial stability, auditors analyzed the District's audited financial statements and financial indicators, such as "days cash on hand," and compared them over time to the District's goals, which are based on median values reported by Standard & Poor's, a bond rating agency. To determine steps needed to ensure financial stability and to determine future financial needs, auditors interviewed district officials and reviewed literature, statutes, and district documents such as its strategic plan, internal reports, board meeting minutes, and policies. In addition, auditors reviewed consultant reports to identify previous findings and recommendations related to the District's financial stability and facilities.

- To identify the amount of funds generated through the District's taxing authority and how these monies were used, auditors obtained annual tax levy reports from the Maricopa County Assessor's Office and Finance Department Web sites and data from the District's audited financial statements, reviewed applicable statutes, and obtained and reviewed various voter documents related to establishing the District and its Board of Directors.

1 For these literature citations, see footnotes in Chapter 2 and Appendix C, the bibliography.

- To examine the District's management salaries, auditors reviewed literature and interviewed an expert and district personnel to identify leading national salary surveys and key executive positions. Auditors then purchased three national salary surveys to use to compare the District's executive salaries to national salary data.[1] (For a detailed explanation of survey analysis methodology, see Appendix A, pages a-i through a-iii). In addition, auditors interviewed district human resources personnel and legal counsel, and reviewed district information related to employee compensation and other benefits, including retirement plans and compensation literature, to identify the total compensation provided to the District's executive management positions. In addition, to compare the District's executive management salaries in 2008 to the salaries of comparable contracted positions at the District's inception in January 2005 and comparable positions for Maricopa County in 2004 prior to the District's inception, auditors obtained and analyzed various district and Maricopa County documents.

- To examine contract personnel and associated costs, auditors reviewed district information for payments made to vendors to identify key personnel contracts. Auditors' work in this area then focused on the District's two largest personnel contracts: MedPro for physicians and allied healthcare professionals, and Broadlane for temporary nursing staff. To evaluate whether the staffing structure used for its doctors, allied healthcare professionals, and nurses was consistent with and necessary for executing the District's statutory duties, auditors interviewed district management, obtained and reviewed various documents such as contracts, and reviewed literature related to physician staffing models and use of temporary nurses. Auditors also reviewed various documents, including the District's performance improvement plan and policies, to obtain information on the steps the District or its contractors take to ensure quality physicians are hired, quality patient care standards are followed, and costs are controlled.

- To identify all sources and uses of district funding, auditors analyzed and reconciled the District's detailed financial data to its audited financial statements for fiscal years 2005 through 2008. Auditors also obtained various district documents and other state and federal documents to develop descriptions of each revenue source. Finally, auditors used the District's 2008 and 2009 budget documents, an Arizona Department of Health Services contract, Arizona Healthcare Cost Containment System (AHCCCS) data, and state appropriation reports to explain the District's revenue changes over time.

- To examine the amount of medical services that indigent individuals who are uninsured have received from the District and to determine if policies have changed to restrict services to this population, auditors reviewed board meeting minutes to determine if the Board requested or voted on any policy changes. In addition, auditors obtained and reviewed Maricopa County's charity care policies in place before the District was established as well as the District's

[1] For national salary survey information see Footnote 1, page 33.

policy and other documents related to its Copa Care (charity care) program, including fee schedules. In addition, to gather information about the population that is served by the District's Copa Care program and any uncompensated medical care costs, auditors obtained and analyzed unaudited data from the District's billing and accounting systems.

- To examine the amount of uncompensated care provided by the District, auditors interviewed members of the District's Board of Directors and management, an AHCCCS official, a Joint Legislative Budget Committee (JLBC) analyst, and e-mail correspondence with an official from the federal Centers for Medicare and Medicaid Services (CMS). Auditors also obtained and analyzed AHCCCS and CMS data to determine the uncompensated care costs reported by and the amount of Medicaid Disproportionate Share Hospital (DSH) payments distributed to the District, qualified private hospitals, and the State in fiscal years 2000 through 2008. To obtain a historical perspective on how the DSH monies have been distributed, auditors also reviewed AHCCCS and JLBC documents, various legal documents, and federal and state laws.

- To develop information for the Introduction and Background, auditors reviewed voter documents relating to the District, Web site descriptions of each district component such as the hospital and burn center, contract information, district staffing documents, and information from the District's audited financial statements for fiscal years 2005 through 2008.

APPENDIX C

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AGENCY RESPONSE

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March 6, 2009

Ms. Debra K. Davenport
Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport:

As the Chief Executive Officer of the Maricopa Integrated Health System (MIHS), I respectfully submit the MIHS response to the Performance Audit of the Maricopa County Special Health Care District. I would like to commend the staff of the Auditor General's Office for the thoughtful and comprehensive examination of the District's operations.

The findings and recommendations in your report have been carefully reviewed by the staff of MIHS.

In response to recommendations stated in Chapter 2.1 (page 31), we agree to the finding and the audit recommendations will be implemented.

In response to recommendations stated in Chapter 4.1 (page 48), we agree to the finding and the audit recommendation will be implemented.

I would again like to thank you and your staff for the hard work and professionalism displayed throughout the audit. Your work on this audit will be of great value to MIHS and ultimately to the entire community.

Very truly yours,

Betsey Bayless
Chief Executive Officer
Maricopa Integrated Health System

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