

REPORT HIGHLIGHTS PERFORMANCE AUDIT

Subject

The Maricopa County Special Health Care District (District) operates the Maricopa Integrated Health System (System), consisting of a teaching hospital, various health-care centers, and two health plans. Maricopa County originally operated the System, but transferred it to the District in 2005 after voters approved the District's creation.

Our Conclusion

This audit covers six areas as prescribed by law. It describes the District's: (1) revenue sources and how they are used; (2) fiscal condition and changes needed to ensure financial stability; (3) executive management salaries and how they compare nationally; (4) contract personnel and costs; (5) the amount of medical services provided to indigent individuals and policies governing those services; and (6) the amount of uncompensated care provided.



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District Revenues

In fiscal year 2008, the District had \$572 million in revenues. More than 80 percent of district revenues comes from two sources—patient service revenues and fixed monthly payments (capitation for each enrolled patient) paid by the Arizona Health Care Cost Containment System (AHCCCS). The largest category of revenue, net patient service, increased almost 28 percent (\$72.6 million) between fiscal years 2006 and 2008. The second largest category of revenue, capitation, increased by \$45 million (nearly 49 percent) since fiscal year 2006.



Source: Courtesy of Maricopa County Special Health Care District.

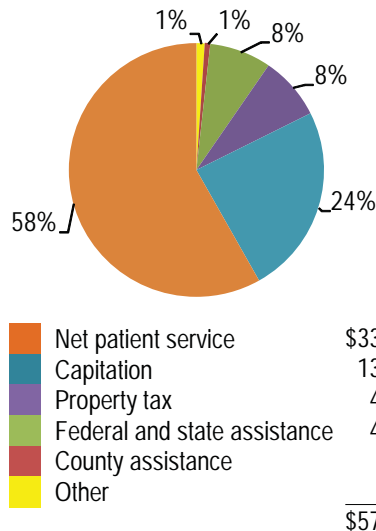
Ensuring Financial Stability

Immediately prior to its transfer to the District, the System was in poor financial condition. Since the District took over the System, audited financial statements show improved financial stability, with net assets almost doubling from \$71.9 million in 2005 to \$140.8 million at June 30, 2008. Improvements are a result of both increased revenues and improved operations.

An entity's financial condition can be measured by financial indicators, or ratios calculated from financial statements. The District's goal is to exceed the median values of the indicators held by hospitals with the minimum bond rating needed to issue investment-grade bonds. The District has shown improvement, but has not met all of its goals for the indicators it tracks, which can be categorized as profitability, liquidity, and debt ratios:

- Profitability ratios measure an entity's ability to make a profit. Although these ratios are improving, two of three indicators are still below the District's goals.
- Liquidity ratios measure an entity's ability to pay obligations as they become due. The most important of these ratios, days cash on hand, has shown improvement each of the past 3 years (fiscal years 2006 through 2008), but is still well below the District's goal.

Revenues by Source
 Fiscal Year 2008
 (In Millions)
 (Unaudited)



When Maricopa County voters approved the District in 2003, they also authorized the District to impose a secondary property tax. This tax began in fiscal year 2006 and generated revenues totaling \$40 million. In fiscal year 2008, the tax generated \$46 million in revenues because of increased county-assessed property values.

- Debt ratios measure an entity's ability to cover debt and issue more debt. These ratios exceed the District's goal, but this may reflect the fact that the District has not borrowed any money to build or construct buildings since its inception.

Although the District's financial stability has improved, it needs to further improve its financial situation because of its plan to spend several hundred million dollars on major capital expenditures.

This includes building a new hospital, improving its clinics, and integrating its business process and technology.

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. Although the District's financial management practices are generally in line with these recommended practices, the District should continue and enhance its current efforts.

Recommendations

To help ensure financial stability, the District should:

- Continue strategic and financial planning efforts.
- Evaluate the costs and terms of different financing options for upcoming capital projects.
- Enhance its process of analyzing which capital projects should be funded.
- Continue to monitor its financial and operational performance.

Executive Salaries

Compared to executives at similar healthcare facilities, the salaries for the District's top five executives are generally lower than those reported in national healthcare salary surveys.

The executives' total compensation packages include standard benefits that appear similar to Maricopa County's, such as medical and dental insurance, paid time off, and participation in the Arizona State Retirement System. However, because three executives' pay exceeded the maximum contribution allowed to state retirement, as of September 2008, the District also paid a total of \$190,000 into supplemental retirement plans for them.

The executives' other cash compensation appears to be significantly lower than the amounts reported by other hospitals in the salary surveys. For example, three of the five district executives received one-time merit pay in November 2008 ranging from \$8,600 to \$16,500 each. According to 2008 surveys by Mercer, SullivanCotter, and Watson Wyatt Data Services, some executives at healthcare facilities with similar net revenues to the District's received or were eligible to receive monetary awards ranging from \$62,300 to \$103,300. District executives also do not receive "perks" such as car allowances.

Comparison of the District's Executive Salaries To Those of Selected Facilities Nationally with Similar Net Revenues¹

Position	District Annual Salary	Watson Wyatt Data Services Median Annual Salary	SullivanCotter Median Annual Salary	Watson Wyatt Data Services Median Annual Salary	Mercer Median Annual Salary
Chief Executive Officer	\$367,600	\$600,100	\$601,900	\$612,500	\$605,400
Chief Operating Officer	330,000	331,700	386,700	379,800	329,500
Chief Medical Officer	315,100	330,700	332,700	338,700	336,000
Chief Financial Officer	305,000	328,700	343,000	344,100	307,900
Vice-President Internal Development	172,400	205,300	193,500	205,300	152,800

¹ 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.

Contracting for Healthcare Personnel

The 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 MedPro contract totals \$45 million for 205 physicians and 75 allied healthcare professionals. The Broadlane contract for temporary nurse services totals \$11 million.

Quality of care—The District uses a closed physician staffing model. This means that only physicians who work for MedPro may work for the District. To help ensure quality of care, the District requires that physicians are:

- Currently licensed.
- Evaluated after 1 year and re-evaluated every 2 years thereafter.
- Participating in quality control programs similar to those found at most healthcare institutions.

Performance incentives/penalties—The MedPro contract also provides incentives for meeting performance goals and penalties if performance falls below the targets. These incentives apply to both cost containment and quality-of-care measures.

Recommendation

The District should assess whether its closed physician staffing model is optimal and whether the sole source is still needed, and take appropriate action based on the assessment.

For example, the District and MedPro jointly staff a team to review cost-savings measures, and they share any identified cost savings. According to the District, this team identified an estimated \$500,000 cost savings between April and November 2008.

Contract not bid—Maricopa County developed the MedPro contract as a sole-source procurement in 2001 when it operated the System. This contract was transferred to the District in 2005, and it signed another 3-year contract in 2008. Because the District has not evaluated the closed staffing model and its sole-source procurement with MedPro, the District should assess whether it still considers this model to be optimal and whether sole source is still necessary.

Contract nurses used on limited basis—Because of a nation-wide shortage of nurses and increasing patient volume, many healthcare institutions and the District need to use some contracted nurses even though they are more expensive. However, the District has made a concentrated effort to control costs by hiring more district nurses and significantly reducing its use of contract nurses from an average of 111 per month in fiscal year 2007 to 35 per month from July to October 2008.

Medical Services to Indigents

The District has always had a charity care program to serve people who are not eligible for other healthcare assistance programs. In fiscal year 2008, the District's program, now called CopaCare:

- Served 39,540 individuals.
- Had about \$32 million in uncompensated medical services costs.²

Changes in eligibility and payment policies—When the District took over the System in 2005, eligibility was restricted to people who did not qualify for other healthcare programs and it was capped at an income level of 200 percent of the federal poverty guidelines. Further, fees were discounted based on household size and income categories, and patients seeking nonemergency medical services were not provided services unless they could pay the fees in full.

In July 2006, the District expanded eligibility for the program, and it was no longer capped at a specific income amount. However, to qualify, participants still had to be ineligible for other healthcare programs. The District also developed a new fee schedule. Participants no longer had to pay the fees in full before receiving nonemergency services, but were expected to provide a payment or deposit.

In July 2008, because of concerns about rising program costs, the District raised some of the fees it charges to higher-income participants. In fact, some fees may now be higher than the amounts that privately insured individuals' insurance companies pay for the same services. Eligibility requirements were not changed.

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

² 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 page 4).

Uncompensated Care Costs

Congress established the Disproportionate Share Hospital (DSH) Payments program in 1981 to reimburse states for a portion of their hospitals' uncompensated care costs. These costs occur when hospitals provide services but do not receive payment for them. The DSH payments not only help with uncompensated care costs, but also with Medicaid reimbursement rates that are often less than hospitals' costs.

AHCCCS, the State's Medicaid agency, administers the DSH program, which includes distributing DSH monies according to legislative appropriations. Participating hospitals apply through AHCCCS to receive payment. Eligibility primarily requires that a hospital serve a higher proportion of Medicaid or low-income patients than other hospitals. In fiscal year 2008, 37 private hospitals in Arizona were eligible for DSH monies as well as Arizona's 2 governmentally operated hospitals: the Arizona State Hospital (ASH), and the District's hospital, called the Maricopa Medical Center.

In fiscal year 2008, the State received nearly \$94 million in federal DSH reimbursements. Specifically, ASH had approximately \$28 million in uncompensated care costs, which enabled the State to receive approximately \$19 million in federal DSH reimbursements, which were deposited into the State General Fund because ASH receives a State General Fund appropriation. The District had approximately \$87 million in uncompensated care costs, which enabled the State to receive

approximately \$57.5 million in federal DSH reimbursements. The Legislature appropriated \$4.2 million to the District, with the remaining \$53.3 million being deposited into the State General Fund. Finally, for the uncompensated care costs for private hospitals that the State claims, Arizona is required to provide a state match. Although the private hospitals had a total of approximately \$531.5 million in uncompensated care costs, 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 million in federal DSH reimbursements. AHCCCS then proportionately distributed the combined federal and state amount among the eligible qualifying private hospitals.

The District believes that it should receive a larger share of the DSH payment because it incurs the majority of the State's uncompensated care costs, and it must certify its costs for the State to receive some of the federal DSH monies. 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.

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A copy of the full report can be obtained by calling
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Contact person for this report:
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¹ Laws 2009, 1st S.S., Ch. 4, §7.