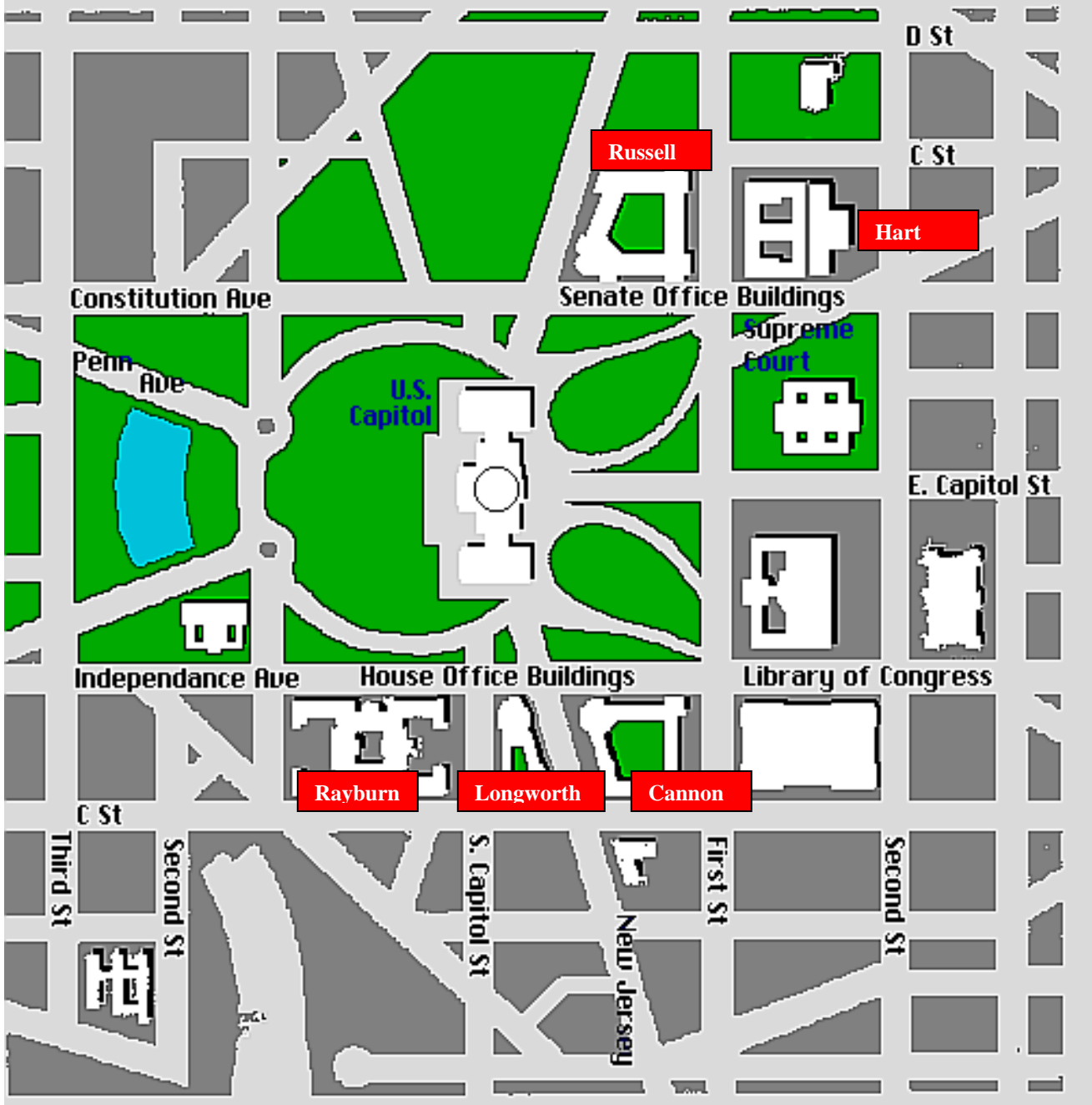


Table of Contents

Map of Capitol Hill.....	i
Schedule of Activities.....	ii
List of Participants.....	iii
Congressional Visits Schedule.....	iv - v
Congressional Visit Teams.....	vi - vii
Arizona Congressional Delegation Profiles	viii - x
U.S. Congress Committee Assignments.....	xi
AzHHA's 2009 Federal Advocacy Agenda.....	1-3
AzHHA Positions on Federal Issues.....	4-28
AHA's <i>Health for Life</i>	29-32
AHA's 2009 Federal Issue Papers	33-75

AzHHA Headquarters
Hotel Palomar
2121 P Street, NW
Washington, D.C. 20037
Telephone: (202) 448-1800
Fax: (202)-448-1839

MAP OF CAPITOL HILL



Schedule of Activities

**Unless otherwise noted, all activities will take place at the Hilton Washington (1919 Connecticut Avenue NW)*

SATURDAY, APRIL 25, 2009

3:00 p.m. – 5:00 p.m. Registration

SUNDAY, APRIL 26, 2009

8:00 a.m. – 5:00 p.m. Registration

11:30 a.m. – 1:30 p.m. PAC Appreciation Luncheon *(by invitation only)*
– The Hilton Washington (1919 Connecticut Avenue NW)

2:30 p.m. – 4:00 p.m. American College of Healthcare Executives

2:30 p.m. – 4:00 p.m. Trustee Educational Session I

5:00 p.m. – 6:00 p.m. Annual Meeting Opening Ceremony and Investiture of Chairman, AHA Board of Trustees

6:00 p.m. – 7:30 p.m. Reception Honoring Chairman, AHA Board of Trustees

MONDAY, APRIL 27, 2009

7:00 a.m. – 4:00 p.m. Registration

7:00 a.m. – 8:15 a.m. Section for Metropolitan Hospitals Breakfast Meeting

7:30 a.m. – 8:15 a.m. Section for Small or Rural Hospitals Breakfast Meeting

8:30 a.m. – 10:30 a.m. Federal Forum Opening Plenary

10:45 a.m. – 12:15 p.m. AHA Executive Briefings

10:45 a.m. – 12:15 p.m. Trustee Educational Session II

12:30 p.m. – 2:15 p.m. Government Relations Officers Network Lunch *(by invitation only)*

12:30 p.m. – 2:15 p.m. AHA Recognition Luncheon

2:30 p.m. – 4:00 p.m. Federal Forum Plenary

4:30 p.m. – 6:30 p.m. Ben Franklin Club Reception *(by invitation only)*

TUESDAY, APRIL 28, 2009

7:00 a.m. – 12:00 noon Registration

7:00 a.m. – 8:15 a.m. American College of Healthcare Executives Breakfast Meeting

7:30 a.m. – 8:15 a.m. Trustee Leadership Breakfast

8:30 a.m. – 10:30 p.m. Federal Forum Closing Plenary

10:45 a.m. – 12:15 p.m. Executive Briefings

10:45 a.m. – 12:15 p.m. Executive Briefings for Health System Leaders *(by invitation only)*

10:45 a.m. – 12:15 p.m. Trustee Educational Session III

12:45 p.m. – 1:45 p.m. AzHHA Caucus with Lunch – Hirshhorn Room –
Hotel Palomar (2121 P St. NW)

2:15 p.m. – 5:00 p.m. AzHHA State Delegation Visits – Capitol Hill

5:30 p.m. – 6:30 p.m. AzHHA Debriefing – Hirshhorn Room – Hotel Palomar (2121 P St. NW)

WEDNESDAY, APRIL 29, 2009

9:00 a.m. – 11:30 a.m. AzHHA State Delegation Visits – Capitol Hill

12:00 noon – 1:00 p.m. AzHHA Debriefing – Cafeteria in the Longworth Building



Arizona Hospital and Healthcare Association

List of Participants

Arizona Hospital and Healthcare Association

John Rivers, President/CEO

Laurie Liles, Senior Vice President, Public Affairs

Banner Health

Tom Dickson, CEO (Banner Thunderbird Medical Center)

Carondelet Health Network

Letty Ramirez, Chief Marketing and Communications Officer

Bill Pike, Director of Public Policy and Community Affairs

Catholic Healthcare West

David Covert, President and CEO (Chandler Regional Medical Center)

Linda Hunt, President (St. Joseph's Hospital and Medical Center)

Suzanne Pfister, Vice President of External Communications
(St. Joseph's Hospital and Medical Center)

Copper Queen Community Hospital

Jim Dickson, Administrator/CEO

Northern Arizona Healthcare

Jim Puffenberger, President and CEO

Bill Bradel, President (Flagstaff Medical Center)

Alan Everett, Board Member (Verde Valley Medical Center)

Sierra Vista Regional Health Center

Margaret Hepburn, CEO

Lanny A. Kope, EdD, Chairman, Board of Directors

Bruce Dockter, Chairman, Government Relations Committee

Marie Wurth, Vice President, Human Resource and Public Relations

TMC Healthcare

Judy Rich, Executive Vice President, Hospital Administrator

University Medical Center

Greg Pivrotto, President and CEO

Matt Miller, Board Member

Bruce Nordstrom, Board Member



Congressional Visits Schedule

Tuesday, April 28, 2009

12:45 p.m.	<p style="text-align: center;"><u>Caucus/Lunch at Hotel Palomar</u> Hirshhorn Room (202) 448-1800</p>
2:15 p.m.	<p><u>Rep. Trent Franks</u> <i>Bobby Cornett, Healthcare Legislative Assistant</i> 2435 Rayburn House Office Building (202) 225-4576</p>
2:30 p.m.	<p><u>Carrie Solomon</u> <i>Healthcare Legislative Assistant for Rep. Harry E. Mitchell</i> 1410 Longworth House Office Building (202) 225-2190</p>
3:00 p.m.	<p><u>Rachel Dresen</u> <i>Healthcare Legislative Assistant for Rep. Jeff Flake</i> 240 Cannon House Office Building (202) 225-2635</p>
3:30 p.m.	<p><u>Talal Mir</u> <i>Healthcare Legislative Assistant for Sen. John McCain</i> 241 Russell Senate Office Building (202) 224-2235</p>
4:00 p.m.	<p><u>Rep. John Shadegg</u> <i>Paul Edattel, Healthcare Legislative Assistant</i> 436 Cannon House Office Building (202) 225-3361</p>
5:30 p.m.	<p style="text-align: center;"><u>AzHHA Debriefing</u> Hirshhorn Room, Hotel Palomar (202) 448-1800</p>
7:00 p.m.	<p style="text-align: center;"><i>DINNER ON OWN</i></p>

Congressional Visits Schedule

Wednesday, April 29, 2009

9:15 a.m.	<u>Sen. Jon Kyl</u> <i>Jennifer Romans, Healthcare Legislative Assistant</i> 730 Hart Building (202) 224-4521
10:00 a.m.	<u>Rep. Ann Kirkpatrick</u> <i>Betsy Quilligan, Healthcare Legislative Assistant</i> 1123 Longworth Building (202) 225-2315
10:30 a.m.	<u>Rep. Raúl Grijalva</u> <i>Gloria Montaña, Healthcare Legislative Assistant</i> 1440 Longworth Building (202) 225-2435
11:00 a.m.	<u>Rep. Gabrielle Giffords</u> <i>Caryn Schenewerk, Healthcare Legislative Assistant</i> 1728 Longworth Office Building (202) 225-2542
11:30 a.m.	<u>Karen Foster-Wright</u> <i>Healthcare Legislative Assistant for Rep. Ed Pastor</i> 2465 Rayburn House Building (202) 225-4065
12:00 noon	<u>AzHHA Debriefing</u> Cafeteria/Longworth Office Building
	<i>LUNCH ON OWN</i>

Congressional Visit Teams*

Tuesday, April 28, 2009

12:45 p.m.

[Caucus with Lunch at Hotel Palomar](#)
Hirshhorn Room
(202) 448-1800

Rep. Trent Franks

2:15 p.m.

Bobby Cornett, Healthcare Legislative Assistant
 2435 Rayburn House Office Building
 (202) 225-4576

Tom Dickson, Team Leader
 Bill Bradel Margaret Hepburn
 David Covert Lanny Kope
 Bruce Dockter Jim Puffenberger
 Alan Everett Marie Wurth

Carrie Solomon

2:30 p.m.

Healthcare Legislative Assistant for Rep. Harry Mitchell
 1410 Longworth House Office Building
 (202) 225-2190

Linda Hunt, Team Leader
 Jim Dickson Greg Pivirotto
 Matt Miller Letty Ramirez
 Bruce Nordstrom Judy Rich
 Bill Pike

Rachel Dresen

3:00 p.m.

Healthcare Legislative Assistant for Rep. Jeff Flake
 240 Cannon House Office Building
 (202) 225-2635

David Covert, Team Leader
 Tom Dickson
 Suzanne Pfister

Talal Mir

3:30 p.m.

Healthcare Legislative Assistant for Sen. John McCain
 241 Russell Senate Office Building
 (202) 224-2235

Greg Pivirotto, Team Leader
 Bill Bradel Matt Miller
 Jim Dickson Bruce Nordstrom
 Bruce Dockter Jim Puffenberger
 Alan Everett Judy Rich
 Margaret Hepburn Marie Wurth
 Lanny Kope

Rep. John Shadegg

4:00 p.m.

Paul Edattel, Healthcare Legislative Assistant
 436 Cannon House Office Building
 (202) 225-3361

Linda Hunt, Team Leader
 Suzanne Pfister
 Bill Pike
 Letty Ramirez

5:30 p.m.

[AzHHA Debriefing](#)
Hirshhorn Room, Hotel Palomar
(202) 448-1800
DINNER ON OWN

*Teams shown are suggestions only. Final teams will be determined during the AzHHA caucus on Tuesday, April 28.

Congressional Visit Teams*

Wednesday, April 29, 2009

Sen. Jon Kyl		9:15 a.m.
<i>Jennifer Romans, Healthcare Legislative Assistant</i> 730 Hart Building (202) 224-4521	Judy Rich, Team Leader David Covert Jim Dickson Bruce Dockter Alan Everett Margaret Hepburn Linda Hunt	Lanny Kope Matt Miller Bruce Nordstrom Marie Wurth Suzanne Pfister Greg Pivrotto
Rep. Ann Kirkpatrick		10:00 a.m.
<i>Betsy Quilligan, Healthcare Legislative Assistant</i> 1123 Longworth Office Building (202) 225-2315	Jim Puffenberger, Team Leader Bill Bradel Tom Dickson	
Rep. Raúl Grijalva		10:30 a.m.
<i>Gloria Montaña, Healthcare Legislative Assistant</i> 1440 Longworth Office Building (202) 225-2435	Greg Pivrotto, Team Leader Matt Miller Bruce Nordstrom Bill Pike Letty Ramirez	
Rep. Gabrielle Giffords		11:00a.m.
<i>Caryn Schenewerk, Healthcare Legislative Assistant</i> 1728 Longworth Office Building (202) 225-2542	Jim Dickson, Team Leader Bill Bradel Bruce Dockter Margaret Hepburn Lanny Kope	Jim Puffenberger Judy Rich Marie Wurth
Karen Foster-Wright		11:30 a.m.
<i>Healthcare Legislative Assistant for Rep. Ed Pastor</i> 2465 Rayburn House Building (202) 225-4065	Linda Hunt, Team Leader David Covert Tom Dickson Suzanne Pfister Bill Pike Letty Ramirez	
12:00 noon	<u>AzHHA Debriefing</u> Cafeteria/Longworth Office Building	
	LUNCH ON OWN	

*Teams shown are suggestions only. Final teams will be determined during the AzHHA caucus on Tuesday, April 28.

Arizona Congressional Delegation Profiles

SENATE

Sen. Jon Kyl (R)

- Elected to U.S. Senate in 1994
- Served four terms in U.S House

Support for AzHHA Positions

- Signed Smith-Baucus letter opposing Medicaid cuts in 2006
- Signed Santorum-Conrad letter opposing Medicare IPPS cuts in 2006
- Signed Thomas-Conrad letter opposing CMS transfer policy in 2005
- Led effort to secure section 1011 funds for undocumented immigrants hospital care in 2003

Committee Assignments/Leadership Post

- Senate Minority Whip
- Finance*
- Judiciary

Sen. John McCain (R)

- Elected to U.S. Senate in 1986
- Served two terms in U.S. House

Support for AzHHA Positions

- Voted for S. 338, Bipartisan Commission on Medicaid Act of 2005

Committee Assignments

- Armed Services
- Indian Affairs*

HOUSE

Rep. Ann Kirkpatrick (D), 1st District

- Elected to U.S. House in 2009
- Served in Arizona House of Representatives

Committee Assignments

- Small Business
- Veterans Affairs*

Rep. Trent Franks (R), 2nd District

- Elected to U.S. House in 2002
- Served in Arizona House of Representatives

Support for AzHHA Positions

- Signed English-Pomeroy letter opposing Medicare IPPS cuts in 2006

Committee Assignments

- Armed Services
- Judiciary

Rep. John Shadegg (R), 3rd District

- Elected to U.S. House in 1994

Healthcare Legislation

- Sponsored Patients Health Care Reform Act and Health Care Choice Act, focusing on free-market approaches to allow individuals to choose health insurance plan that meets their needs

Committee Assignments

- Energy and Commerce*

Rep. Ed Pastor (D), 4th District

- Elected to U.S. House in 1991, upon Rep. Morris K. Udall's (D) retirement
- Served as Maricopa County Supervisor

Support for AzHHA Positions

- Sponsored H.R. 2794, America's Partnership for Nursing Education, at AzHHA's request
- Signed Tubbs-Jones/Porter letter urging IRS to improve form 990 schedule H
- Signed Lewis-Weller letter opposing CMS' proposed Medicare cuts in 2007
- Signed Neal-English letter opposing Medicare and Medicaid cuts in 2007
- Voted for H.R. 985, Bipartisan Commission on Medicaid Act of 2005
- Signed 2008 letter to CMS urging withdrawal of capital IME cut

Committee Assignments

- Appropriations*

Rep. Harry Mitchell (D), 5th District

- Elected to U.S. House in 2006
- Served in Arizona Senate

Support for AzHHA Positions

- Signed Tubbs-Jones/Porter letter urging IRS to improve form 990 schedule H
- Signed Lewis-Weller letter opposing CMS' proposed Medicare cuts in 2007
- Signed Waxman-Walsh letter opposing CMS' proposed Medicaid rule in 2007
- Signed Neal-English letter opposing Medicare and Medicaid cuts in 2007
- Co-sponsored H.R. 1459, Protecting Rehabilitative Services Act of 2007
- Signed 2008 letter to CMS urging withdrawal of capital IME cut
- Signed Neal-Tiberi letter to President Obama urging withdrawal of capital IME cut in 2009

Committee Assignments

- Science and Technology
- Transportation and Infrastructure
- Veterans Affairs*

Rep. Jeff Flake (R), 6th District

- Elected to U.S. House in 2000

Positions on Healthcare Issues

- Sponsored legislation to limit Medicare to low-income seniors and modernize Medicare, focusing on market-based reforms
- Strongly supports reform of congressional practice of earmarking line-item spending projects in major appropriations bills

Committee Assignments

- Foreign Affairs
- Resources
- Oversight and Government Reform

Rep. Raul Grijalva (D), 7th District

- Elected to U.S. House in 2002
- Served as Pima County Supervisor

Support for AzHHA Positions

- Signed Waxman-Walsh letter opposing CMS' proposed Medicaid rule in 2007
- Signed Tubbs-Jones/Porter letter urging IRS to improve form 990 schedule H
- Signed Lewis-Weller letter opposing CMS' proposed Medicare cuts in 2007
- Co-sponsored H.R. 1459, Protecting Rehabilitative Services Act of 2007
- Signed English-Pomeroy letter opposing Medicare IPPS cuts in 2006
- Voted for H.R. 985, Bipartisan Medicaid Commission Act of 2005
- Voted for H.R. 3373, Preserving Patient Access to Inpatient Rehabilitation Hospitals of 2005
- Signed 2008 letter to CMS urging withdrawal of capital IME cut
- Signed Neal-Tiberi letter to President Obama urging withdrawal of capital IME cut

Committee Assignments

- Education and Labor
- Resources

Rep. Gabrielle Giffords (D), 8th District

- Elected to U.S. House in 2006
- Served in Arizona Senate

Support for AzHHA Positions

- Signed Neal-English letter opposing Medicare and Medicaid cuts in 2008
- Signed Tubbs-Jones/Porter letter urging IRS to improve form 990 schedule H
- Signed Lewis-Weller letter opposing CMS' proposed Medicare cuts in 2007
- Signed Neal-English letter opposing Medicare and Medicaid cuts in 2007
- Signed Waxman-Walsh letter opposing CMS' proposed Medicaid rule in 2007
- Signed 2008 letter to CMS urging withdrawal of capital IME cut
- Signed Neal-Tiberi letter to President Obama urging withdrawal of capital IME cut in 2009

Committee Assignments

- Armed Forces
- Foreign Affairs
- Science and Technology

U.S. Congress Committee Assignments

SENATE

Sen. Jon Kyl (R) Assistant Minority Leader

*Finance
Judiciary

Sen. John McCain (R)

Armed Services, Ranking Member
*Indian Affairs
Energy and Natural Resources
*Health, Education, Labor and Pensions
Homeland Security and Government Affairs

HOUSE

Rep. Ann Kirkpatrick (D), 1st District

Small Business
*Veterans Affairs

Rep. Harry Mitchell (D), 5th District

Science and Technology
Transportation and Infrastructure
*Veterans Affairs

Rep. Trent Franks (R), 2nd District

Armed Services
Judiciary

Rep. Jeff Flake (R), 6th District

Foreign Affairs
Resources
Oversight and Government Reform

***Rep. John Shadegg (R), 3rd District**

Energy and Commerce

Rep. Raul Grijalva (D), 7th District

Education and Labor
Natural Resources

Rep. Ed Pastor (D), 4th District

*Appropriations

Rep. Gabrielle Giffords (D), 8th District

Armed Services
Foreign Affairs
Science and Technology

* Committees with Healthcare Jurisdiction

AzHHA'S Positions on Federal Issues



Arizona Hospital and Healthcare Association

THERE TO CARE: INVESTING IN A HEALTHY ARIZONA

Arizona Hospital and Healthcare Association 2009 Federal Advocacy Agenda

Arizona's Hospitals Face Turbulent Economic Times

- Arizona's hospital community has been a leading economic catalyst throughout this decade, contributing \$11.5 billion to Arizona's gross state product and employing 73,300 people.
- Recent reports reveal the economic downturn and state budget cuts have significantly eroded hospitals' financial performance:
 - Hospitals' operating margins and total income margins declined 54 percent and 91 percent respectively in the quarter ending September 30, 2008, compared to the same quarter in 2007.
 - 47 percent of the reporting hospitals lost money during the third quarter of 2008.
- Hospitals are employing various strategies to weather the storm, including shifting costs to commercial payors; implementing hiring freezes; postponing capital construction and renovation projects; and delaying the purchase of clinical equipment and information technology improvements.

The 2010 Budget: Protecting Hospitals on the Road to Healthcare Reform

- The Arizona Hospital and Healthcare Association (AzHHA) applauds President Obama and the Congress for making healthcare reform a centerpiece of the FY 2010 budget. The budget creates a \$630 billion 10-year reserve fund to finance healthcare reform, half of which would come from increased taxes and the other half from budget savings.
- AzHHA urges Congress and the president to thoughtfully consider negative consequences of proposed budget-saving options. These include bundling payments for hospital and post-acute services, value-based purchasing plans that cut payments up front, and arbitrary policies that assume many hospital readmissions within 30 days are not appropriate.
- AzHHA supports the American Hospital Association's proposed national framework for change, *Health for Life: Better Health. Better Health Care*. *Health for Life* identifies five essential elements of reform necessary to achieve better health and better healthcare:

- A focus on wellness—As health status improves, costs of health insurance and healthcare can be better controlled.
- The most efficient, affordable care—Consumers will not be satisfied until the cost of insurance and the cost of healthcare are affordable.
- The highest quality care—Healthcare professionals, hospitals, patients and others must work together to make sure the right care is given at the right time in the right setting.
- The best information—Good information is the gateway to good care.
- Health coverage for all paid for by all—Individuals, businesses, insurers and governments must all play a role in expanding coverage and paying for it. Health coverage for all is a shared responsibility.

American Recovery and Reinvestment Act: The Case for Protecting Provider Payments

- AzHHA applauds Congress for passing the American Recovery and Reinvestment Act (ARRA), which will pump \$4 billion into Arizona's economy over the next two years.
- The ARRA will infuse an estimated \$1.9 billion in additional federal matching funds for Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) over two years.
- The ARRA's maintenance of effort (MOE) provision required states that wish to qualify for the increased Federal Medical Assistance Percentage (FMAP) not to reduce Medicaid eligibility. States may, however, slash provider payments.
- Arizona hospitals face \$209 million in total proposed AHCCCS payment cuts in FY 2010, on top of \$200 million in cuts hospitals have absorbed since 2007.
- AHCCCS currently pays hospitals 76.6 percent of their costs. If proposed cuts are enacted, AHCCCS cost coverage will dip to 70.7 percent.
- AzHHA urges Congress to amend the ARRA's MOE provision to incentivize states not to reduce provider payments.

Supporting the Rural Healthcare Safety Net

- AzHHA supports efforts to protect small rural hospitals, including Critical Access Hospitals (CAHs), such as ensuring CAHs are appropriately reimbursed under Medicare Advantage; restoring cost-based reimbursement for lab services provided by a CAH regardless of where the specimen is collected; and allowing flexibility for bed size.
- AzHHA supports changes to the CAH geographical restrictions that would allow a tribal or Indian Health Service hospital and a community hospital operating within 35 miles of one another and that otherwise meet CAH eligibility requirements to qualify for CAH status.
- AzHHA supports the **Rural Hospital Assistance Act of 2009 (H.R. 362/S. 318)**, which would improve Medicare payments to rural hospitals that are too large to be CAHs, but too small to be financially viable under the Medicare prospective payment system.

Recovery Audit Contractors

- AzHHA supports fair efforts to identify improper Medicare payments, but is concerned about audits conducted under the Recovery Audit Contractor (RAC) program. We believe the proposed expansion does not represent the best approach and strongly support congressional efforts to place a moratorium on the program while the Centers for Medicare and Medicaid Services and the Government Accountability Office evaluate and report on RAC performance in the three pilot states.

Caring for Foreign National Patients: Reauthorize Section 1011

- Section 1011 of the Medicare Modernization Act of 2003, which authorized funds to offset a portion of the costs hospitals incur treating undocumented immigrants, expired September 30, 2008. Hospitals may continue to file claims until the remaining funds are exhausted, but eventually those funds will be depleted.
- Hospitals' legal obligation to treat these patients continues despite the fact that section 1011 was allowed to expire.
- AzHHA strongly supports reauthorization of the section 1011 funds for care hospitals provide to undocumented immigrants.

Specialty Hospitals

- AzHHA supports federal legislation banning Medicare payment to new physician-owned special surgical hospitals, eliminating the “whole hospital” exception to the Stark laws, or imposing a moratorium on Medicare participation in such facilities.

Support Free & Fair Union Elections

- AzHHA strongly opposes the **H.R. 1409/S. 560 Employee Free Choice Act** and urges Congress to preserve the current election system that ensures ballots are cast in private, free from interference or influence from either side.



Arizona Hospital and Healthcare Association

Arizona Hospitals Face Turbulent Economic Times

Arizona's hospitals—like the patients they serve—are facing unprecedented financial pressures as they strive to fulfill their missions in the midst of the current economic downturn. Two recent Arizona Hospital and Healthcare Association (AZHHA) surveys revealed that, in the third quarter of 2008, Arizona hospitals' financial performance declined due to a convergence of economic and financial events. The reports debunk the traditional view that Arizona's hospital community is recession-proof and signal uncertain times ahead. The surveys found:

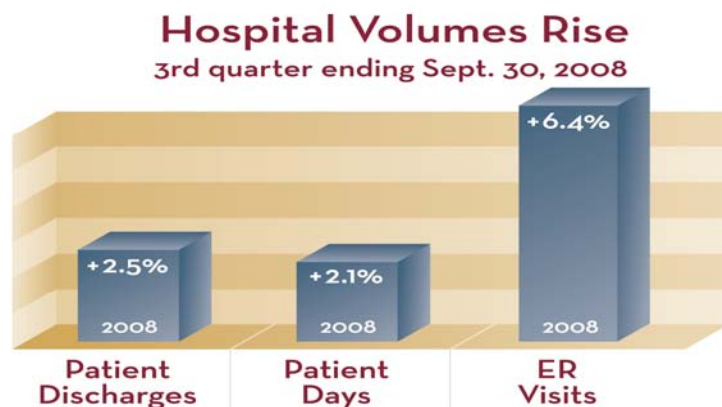
- **Hospitals' operating margins and total income margins declined 54 percent and 91 percent respectively in the quarter ending September 30, 2008 compared to the same quarter of 2007.**
- **Nearly half of the responding hospitals lost money during the third quarter of 2008.**

Arizona's hospitals also reported an increase in overall patient volume coupled with a troubling change in payer mix. Visits to emergency departments jumped 6.4 percent in the third quarter of 2008. **However, an alarming 61 percent of responding hospitals reported a decline in elective medical procedures, which are typically covered by private health insurance plans.**

The cost of uncompensated care—charity care hospitals provide to qualifying patients who have no health insurance combined with bad debt hospitals write off when uninsured patients do not pay their hospital bills—jumped 8.3 percent from the third quarter of 2007 to the same quarter of 2008.

And enrollment in the state's

Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS)—which pays Arizona's hospitals just 76.6 percent of their costs—spiked 7 percent in 2008. Growth in hospital uncompensated care and the AHCCCS population typically climb



with Arizona's unemployment rate, which rose from 4.5 percent in February 2008 to 7.4 percent in February 2009 (Arizona Department of Economic Security).

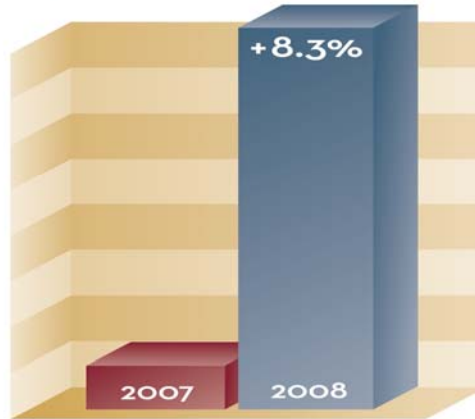
Even as uncompensated care and AHCCCS caseloads increase, hospitals are seeing their investment portfolios shrink and their access to the capital markets diminish. And philanthropic giving to hospitals' charitable foundations—which support hospitals' capital construction and renovation projects—has dropped precipitously since the recession began.

To weather the economic storm, Arizona's hospitals have been compelled to employ a variety of strategies that reverberate across Arizona's economy. Chief among these tactics is attempting to negotiate higher rates paid by commercial health plans. **Fifty-nine percent of hospitals surveyed reported costs to commercial health response to the economic downturn and a legislatively freeze on AHCCCS hospital payment rates that took on October 1, 2008.**

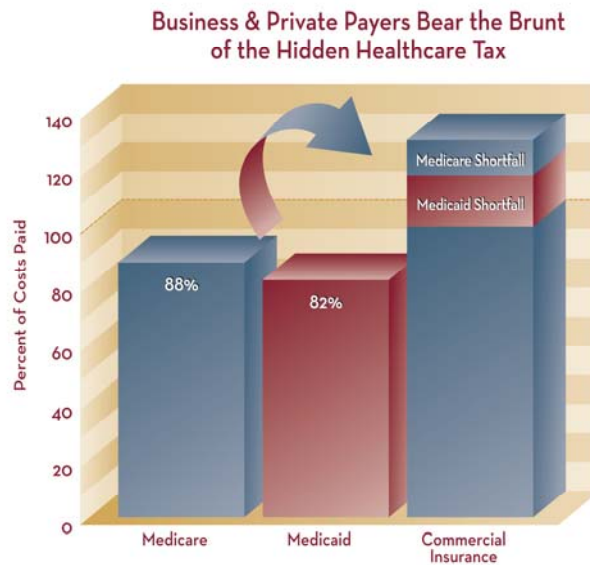
Arizona business groups are increasingly concerned that inadequate payment from healthcare programs like AHCCCS and Medicare, along with economic pressures, is forcing hospitals to charge higher rates to private health plans in what amounts to a "hidden healthcare tax" on businesses and other healthcare consumers. The Arizona Chamber Foundation recently released a study conducted by The Lewin

Uncompensated Care is on the Rise

3rd quarter ending Sept. 30, 2008



Cost of Uncompensated Care



Sources: Intellimed, Uniform Accounting Reports, American Hospital Association, Milliman USA

shifting plans in enacted effect

growing

public

Group, which found that **Arizona employers and the state's 3.5 million privately insured consumers pay 40 percent above cost** for hospital services primarily because AHCCCS and Medicare underpay hospitals for those same services. The Lewin report found that **in 2007 private insurance payments for Arizona hospital services exceeded costs by \$1.3 billion in order to offset underpayment from AHCCCS and Medicare as well as uncompensated care provided to patients without insurance.**

The economic downturn is also taking its toll on hospital jobs. Arizona's hospital community has been a powerful economic catalyst throughout this decade, contributing \$11.5 billion to the state's gross product and employing 73,300 workers. In an alarming development, **45 percent of hospitals responding to AzHHA's surveys reported they have implemented hiring freezes.** Historically, Arizona's hospitals have been a leading source of jobs for the state, employing both highly skilled employees and unskilled workers. Since 1990, Arizona's healthcare industry employment has grown more than twice as fast as national employment. From 1990 to 2005, hospital jobs in Arizona increased 46 percent. Nationally, those jobs increased 24 percent during the same period.

Arizona's hard-hit construction industry is also feeling hospitals' pinch as hospitals delay capital projects. **Seventy-four percent of hospitals responding to AzHHA's surveys reported they are postponing planned construction and renovation projects. Seventy-one percent estimate their capital projects will be delayed more than a year.**

In the following issue papers, AzHHA outlines critical challenges facing Arizona's hospitals and proposes solutions that will enable our congressional delegation to preserve the hospital community's vital role in Arizona's economy. AzHHA appreciates our lawmakers' commitment to quality healthcare for all Arizonans and we stand ready to serve as a resource as Congress works to resolve the challenges hospitals face.



Arizona Hospital and Healthcare Association

The 2010 Budget: Protecting Hospitals on the Road to Healthcare Reform

The Arizona Hospital and Healthcare Association (AzHHA) applauds President Obama and the Congress for making healthcare reform a centerpiece of the FY 2010 budget. AzHHA remains steadfast in our commitment to healthcare reform, the primary goal of which must be coverage for all Americans. True reform will require a bipartisan approach that allows members of Congress to fully debate all options. For this reason, AzHHA joins the American Hospital Association (AHA) in supporting the Senate budget resolution's rejection of reconciliation instructions for healthcare reform. As the conferees begin to reconcile differences between the House and Senate versions of the budget resolution, AzHHA urges Arizona's congressional delegation to support a budget blueprint that allows Congress to thoughtfully debate all options for reforming our nation's healthcare system.

As Congress turns to healthcare reform, AzHHA recommends consideration of AHA's proposed national framework for change, *Health for Life. Better Health. Better Health Care* (See attachment). *Health for Life* identifies five essential elements for reform necessary to achieve better health and better healthcare:

- A focus on wellness—As health status improves, costs of health insurance and healthcare can be better controlled.
- The most efficient, affordable care—Consumers will not be satisfied until the cost of insurance and the cost of healthcare are affordable.
- The highest quality care—Healthcare professionals, hospitals, patients and others must work together to make sure the right care is given at the right time in the right setting.
- The best information—Good information is the gateway to good care.
- Health coverage for all paid for by all—Individuals, businesses, insurers and governments must all play a role in expanding coverage and paying for it. Health coverage for all is a shared responsibility.

Paved with Good Intentions: The Dangers of Financing Reform through Medicare Savings

In his 2010 budget outline, President Obama calls for reducing the deficit, enacting healthcare reform and restructuring entitlement programs. We note with concern, however, that the president's budget lacks specific details regarding the shape entitlement and healthcare reform will take. The plan raises several key issues for hospitals.

The administration's \$3.6 trillion fiscal blueprint creates a \$640 billion 10-year reserve fund to finance healthcare reform, half of which would come from increased taxes and other half from cuts in Medicare. The budget outline calls for \$170 billion in cuts to Medicare Advantage plans and approximately \$38 billion in reductions in Medicare payments to hospitals. The proposal contains few details on the Medicare hospital payment cuts, but specifically envisions:

- Savings of \$17.84 billion over 10 years achieved by bundling payments for hospital care and post-acute services;
- Savings of \$8.43 billion over 10 years derived by paying hospitals with certain readmission rates less for patients who are readmitted within 30 days of discharge; and
- Savings of \$12.09 billion over 10 years as a result of linking a portion of inpatient hospital payment to performance on specific quality measures.

Arizona hospitals serve as the state's healthcare safety net and already face significant economic pressures. Accordingly, AzHHA urges Congress and the administration to proceed with caution when considering additional cuts to Medicare and Medicaid, both of which already pay hospitals significantly below the costs they incur serving elderly and low-income patients. In fact, a new Arizona Chamber Foundation study conducted by The Lewin Group revealed that Medicare pays Arizona hospitals just 89 percent of their costs. Payment for Arizona's Medicaid program, the Arizona Health Care Cost Containment System has dropped to 76.6 percent of cost as state lawmakers have enacted payment rate freezes and reductions to address state budget deficits. Arizona hospitals simply cannot sustain additional payment cuts.

AzHHA believes it is appropriate to thoughtfully explore the use of bundled payments for post-acute services and incentives for improving quality of care through value-based purchasing. However, because we believe that overall savings can be achieved by improved care leading to fewer medical visits, we join the AHA in expressing concern about the budget outline's design for value-based purchasing that cuts payments up front.

Additionally, AzHHA opposes arbitrary payment policies that assume many hospital readmissions are inappropriate. Determining preventable readmissions is a complex undertaking. It is critical that the decision to readmit a patient be made by the patient's physician and other clinical caregivers in the patient's best interest.

AzHHA supports efforts to make healthcare more affordable by focusing on wellness and prevention, better coordinating care and utilizing comparative effectiveness research to determine the most effective treatment. And we are committed to utilizing health information technology, creating alternative liability systems and reducing administrative costs.

Ensuring Access to Physician Care

With 219 physicians per 100,000 population, Arizona continues to rank well below the national average of 293 per 100,000. The 2010 budget and the healthcare reform debate

present an opportunity to address several current barriers Arizonans face regarding access to physician services.

First, Congress must include the physician fee schedule “fix” in the 2010 Medicare baseline budget. AzHHA applauds the House for addressing flaws in the current physician payment system in its budget resolution, and we urge Arizona’s congressional delegation to support a final budget plan that includes the physician payment fix.

In addition, we urge all members of Arizona’s congressional delegation to support teaching hospitals by calling on the Centers for Medicare and Medicaid Services (CMS) to withdraw a provision in the 2010 Inpatient Prospective Payment System (IPPS) rule that would eliminate the Indirect Medical Education (IME) adjustment to the capital PPS. This cut was scheduled to take place over two years; however, Congress canceled the first year of the cut in the American Recovery and Reinvestment Act passed earlier this year. AzHHA joins the AHA in asking Congress to urge CMS to withdraw the provision entirely in this year’s IPPS rule.

To further protect teaching hospitals and help shore up Arizona’s physician workforce, we strongly urge Arizona’s congressional delegation to support increasing the number of physician residency slots authorized under Medicare.

Finally, we applaud the president for recognizing the need to address physician self-referral to facilities in which the physician has an ownership interest. In addition to raising significant concerns about conflict of interest, these specialty hospitals attract badly needed physician specialists away from full-service community hospitals. AzHHA looks forward to working with Congress and the administration on legislation to resolve that issue.



Arizona Hospital and Healthcare Association

The American Recovery and Reinvestment Act: The Case for Protecting Provider Payments

The Arizona Hospital and Healthcare Association (AzHHA) applauds Congress for passing the American Recovery and Reinvestment Act (ARRA) of 2009 to stimulate the nation's economy and assist states struggling to balance their budgets during the current recession.

Importantly, this vital federal stimulus legislation authorized \$87 billion for a temporary increase in the federal medical assistance percentage (FMAP) designed to “protect and maintain state Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates.” *ARRA §5000*. Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) is eligible to receive an expected \$1.7 billion in additional FMAP funds over 27 months as the federal share of AHCCCS costs increases to 75 percent from 66 percent.

Maintenance of Effort Provision Must Apply to Provider Payments

A centerpiece of the federal stimulus package is a maintenance of effort (MOE) provision that requires states to maintain Medicaid eligibility criteria in place on July 1, 2008 in order to qualify for the FMAP increase. While AzHHA strongly supports an MOE requirement for eligibility, we are deeply concerned that Congress opted not to apply the provision to provider payments. To understand our concern, the members of our congressional delegation need look no further than the Arizona Legislature's current debate over how to balance the state's FY 2010 budget.

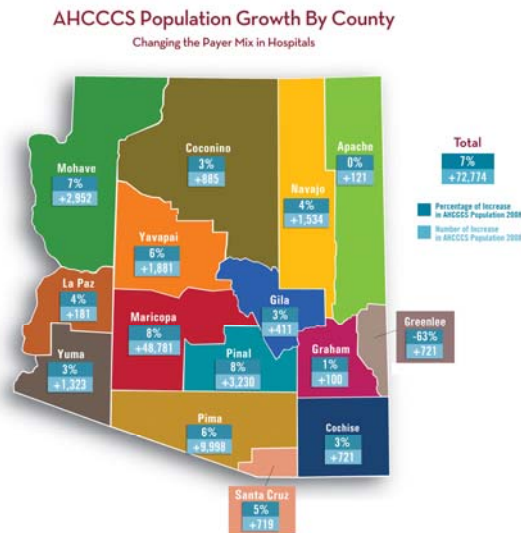
Arizona faces a budget deficit of nearly \$3 billion in FY 2010. As Governor Brewer and state lawmakers search for solutions, their choices are limited. Both the federal stimulus legislation and Arizona's Voter Protection Act prohibit state policymakers from reducing AHCCCS eligibility, which—other than for KidsCare and long-term care services—was established by a voter-passed initiative in 2000. Reductions in the AHCCCS benefit package must be carefully considered to ensure they do not unintentionally make AHCCCS care more expensive.

With these limited options at their disposal, lawmakers are targeting payments to AHCCCS providers—particularly hospitals—for budget cuts. For FY 2010, state lawmakers are considering cutting AHCCCS hospital payments by nearly \$209 million. These cuts are in addition to \$200 million in payment reductions Arizona hospitals have sustained since 2007.

AzHHA is urging Governor Brewer and state lawmakers to use a portion of the \$775 million additional FMAP funds available in FY 2010 to avoid these cuts. However, without a

meaningful MOE provision in the ARRA, the Legislature is free to use the FMAP monies to fund other state spending priorities while significantly reducing AHCCCS hospital payments.

State lawmakers' proposal to cut \$209 million from AHCCCS hospital payments threatens Arizona's healthcare safety net and would damage our state's overall economy. Previous recessions have demonstrated that safety net programs like Medicaid are countercyclical: as people lose their jobs and their health insurance, demand for Medicaid services increases. Arizona's recent experience underscores the point. As the state's unemployment rate has risen—reaching 7.4 percent in February—AHCCCS has seen a corresponding jump in enrollment. More than 1.1 million Arizonans are now enrolled in AHCCCS. From March 1, 2008 to March 1, 2009, AHCCCS enrollment increased 8 percent with the addition of 85,370 new enrollees. Hospitals cannot sustain payment cuts of this magnitude even as they are being asked to serve increasing numbers of AHCCCS patients.



New Study Reveals Hospital Payment Cuts Are Driving up Arizona's Hidden Healthcare Tax

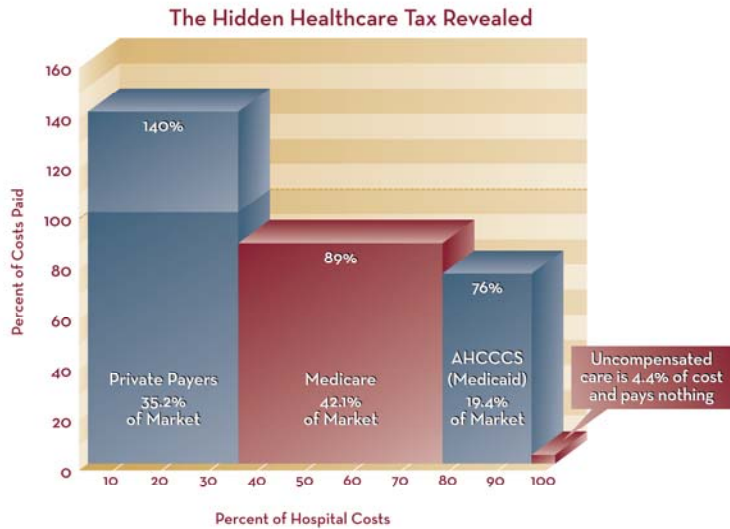
Cuts in AHCCCS hospital payments—already insufficient to cover the costs of caring for AHCCCS patients—force hospitals to shift costs to commercial health insurance plans, resulting in a “**hidden healthcare tax**” on businesses and families who pay higher health insurance premiums.

A new Arizona Chamber Foundation study conducted by The Lewin Group reveals that AHCCCS payments fall significantly below hospitals' costs. When payment reductions the Legislature enacted in FY 2007, FY 2008 and FY 2009 are taken into consideration, AHCCCS payments cover only **76.6 percent** of hospitals' total costs. If the FY 2010 proposed cuts are enacted, AHCCCS payments will cover only 70.7 percent of hospitals' total costs.

The Arizona Chamber Foundation study also shows that Arizona's 3.5 million privately insured consumers pay **40 percent** above cost for hospital services in order to cover losses incurred from AHCCCS, Medicare and uninsured patients. Private insurer payments exceeded costs by **\$1.3 billion** for hospital care in 2007 in order to cover underpayments from

public payors and uncompensated care. **The total cost to Arizona employers and their employees for AHCCCS underpayment to hospitals in 2007 was \$407 million.**

A typical annual family policy of \$11,617 cost an additional **\$1,017** in 2007 due to the hidden healthcare tax from Medicare, AHCCCS and uncompensated care. **Of that additional \$1,017, \$324 was due to AHCCCS underpayment. An average annual single premium cost an additional \$396, of which \$126 resulted from AHCCCS underpayment.**



Source: Analysis of Hospital Cost Shift in Arizona, Prepared for The Arizona Chamber Foundation, The Lewin Group, March 2009

If all proposed FY 2010 hospital cuts are enacted, the hidden healthcare tax resulting from AHCCCS underpayment will increase from \$407 million to \$663 million. The total hidden healthcare tax due to government underpayment and uncompensated care would rise from \$1.3 billion to \$1.63 billion and the hidden healthcare tax to each privately insured person will increase by 16 percent from \$398 to \$462 by 2010.

Cuts to AHCCCS hospital payments drive up the hidden healthcare tax on businesses and individuals at a time when investment portfolios are plummeting, credit is scarce and businesses and families are struggling to cover basic expenses.

For this reason, AzHHA strongly urges Congress to amend ARRA's MOE provision to apply to Medicaid provider payments as well as eligibility.



Arizona Hospital and Healthcare Association

Supporting the Rural Healthcare Safety Net

As Congress considers changes to Medicare payment policies, the Arizona Hospital and Healthcare Association (AzHHA) urges careful consideration of the unique challenges facing Arizona's small rural hospitals. More than 1.6 million people living in rural Arizona depend on their community hospitals for necessary healthcare services. In order to continue to meet their communities' divergent needs, rural hospitals must receive adequate compensation. Recent changes in Medicare policy have left these safety net hospitals vulnerable. In order to protect small rural hospitals, AzHHA urges Congress to:

- Ensure critical access hospitals (CAHs) and the rural health centers (RHCs) they operate are appropriately reimbursed;
- Allow CAHs to use an alternative bed limit methodology that is sensitive to seasonal fluctuations; and
- Ease the CAH geographical distance requirements for a community hospital that does not meet the distance threshold due to proximity to an Indian Health Services or tribal hospital that is already licensed as a CAH.

Ensuring CAHs Receive Appropriate Reimbursement

There are currently 14 CAHs located in remote communities throughout rural Arizona. These hospitals, which are capped at 25 beds, are paid 101 percent of allowable costs for services provided to Medicare beneficiaries. Congress has long recognized that this reimbursement structure is essential for maintaining the financial viability of these hospitals. Unfortunately, recent regulatory and legislative actions have resulted in CAHs receiving less than cost for many services.

For example, the Medicare Modernization Act of 2003 (MMA) created structural and economic incentives for Medicare Advantage (MA) managed care plans to enter the rural marketplace. However, no provisions were included to ensure that CAHs would receive cost-based reimbursement as they do under traditional Medicare. Because private fee-for-service MA plans—which are not required to negotiate contracts with providers—have saturated the rural marketplace, most CAHs receive less than 101 percent of their costs from these MA plans.

Also in 2003, the Centers for Medicare and Medicaid Services (CMS) began requiring Medicare beneficiaries to be physically present in a CAH when a lab specimen is drawn in order for the hospital to receive cost-based reimbursement. Because lab services are limited in small rural communities and Medicare beneficiaries are not always able to travel far distances, many CAHs had been collecting specimens from outpatients off-campus (e.g., at clinics,

skilled nursing facilities, etc.). Under the 2005 regulation, CAHs have not received cost-based reimbursement for these needed services.

AzHHA urges Arizona’s congressional delegation to support legislation to require MA organizations to pay for CAH and Rural Health Center services at a rate of at least 101 percent of allowable costs and restore cost-based reimbursement for referral lab services provided by CAHs.

Retain CAH Bed Limit with Flexibility

A CAH may operate no more than 25 beds at any time under current law. This cap makes it extremely difficult for CAHs to respond to seasonal fluctuations. Without any flexibility in this bed limit, CAHs are often forced to transfer patients to hospitals many miles away. This imposes a tremendous burden on patients and families, and increases the overall cost of healthcare. The situation is further exacerbated when tertiary hospitals are over capacity and unable to accept transfers from small rural hospitals.

We urge Arizona’s congressional delegation to support S. 307/H.R. 668, the Critical Access Hospital Flexibility Act of 2009, which would permit CAHs to meet the statutory CAH bed threshold with a 20-bed average daily census.

Grant CAH Status to Hospitals Serving Diverse Populations

Arizona is home to many Indian Health Service (IHS) and tribal hospitals, several of which have been designated as CAHs in rural communities. These hospitals serve a specific patient population within their communities, i.e., American Indians. Other members of the community receive healthcare services at community hospitals. Because CAH distance criteria do not distinguish between the patient populations served at IHS/tribal hospitals and community hospitals, such hospitals—if located in the same community—will not qualify for CAH status.

AzHHA urges Arizona’s congressional delegation to support efforts to ease the CAH distance criteria in order to permit both an IHS/tribal hospital and a community hospital located within 35 miles (15 mile in mountainous terrain) of each other to qualify for CAH status if they otherwise meet CAH eligibility criteria.



Arizona Hospital and Healthcare Association

Recovery Audit Contractors: Establish a Fairer Medicare Payment Compliance Process

The Medicare Modernization Act of 2003 established the Recovery Audit Contractor (RAC) program as a demonstration program in California, New York and Florida to identify improper Medicare payments. Before the demonstration program was completed and fully evaluated, the Tax Relief and Healthcare Act of 2006 authorized the Centers for Medicare and Medicaid Services (CMS) to expand the program to all 50 states by 2010. The experience of healthcare providers in demonstration states raised serious concerns with the program, prompting CMS to revise the RAC Scope of Work (SOW). Despite these revisions, Arizona hospitals remain deeply concerned about the program, which is scheduled to expand to Arizona in March 2009.

To resolve these concerns, AzHHA urges Congress to develop appropriate RAC payment incentives, refocus RAC audits and make operational improvements to the overall program.

Arizona hospitals strive for billing accuracy and are committed to fair efforts to reduce improper Medicare payments. Nonetheless, we have grave concerns about the RAC program. Most significantly, the program will add to the complexity and administrative burden of complying with an already complicated Medicare billing, payment and audit process, including compliance with existing Medicare Integrity Program requirements. Additional compliance costs will have the unfortunate effect of redirecting valuable hospital resources away from patient care—a tenuous prospect given the current economic climate.

Hospitals are further concerned about the method by which RACs are paid. Under the RAC program, contractors are paid a contingency fee for identifying potential improper payments. This contingency fee or “bounty payment” has led to overly aggressive and erroneous determinations. During the demonstration program, the California RAC denied nearly all claims for the admission of patients with joint replacement procedures to inpatient rehabilitation facilities. As a result, CMS was forced to hire an independent contractor to evaluate the denials, which in the end overturned 40 percent of the RAC determinations.

With these concerns in mind, Arizona hospitals recommend Congress consider several improvements to the RAC program:

Focus on Automatic Reviews; Eliminate Medical Necessity Reviews

- CMS should eliminate medical necessity determinations from the RAC program’s purview. Medical necessity reviews are too complex and patient-

specific for contractors who employ staff without the appropriate clinical expertise.

- Automatic reviews, on the other hand, use software analysis to identify errors in large batches of Medicare claims. This objective form of auditing is appropriate for RACs because it relies on their technical expertise and does not require individual auditors to offer subjective medical opinions about care provided years prior to the audit. Medical necessity audits should remain in the purview of Medicare Administrative Contractors, Fiscal Intermediaries and Quality Improvement Organizations, rather than with the RAC.

Develop Appropriate RAC Payment Incentives

- Considering the financial incentive for a RAC to deny an inpatient admission based on medical necessity, penalties should be assessed on RAC contractors with a high reversal rate for appealed medical necessity denials. For example, RACs with an overturn rate of 25 percent or greater per year should be subject to a monetary penalty.
- Bonuses for individual RAC auditors should be prohibited. Such bonuses provide an inappropriate incentive for denials that place the burden of proof on providers able to appeal RAC denials.

Operational Improvements

- The RAC audit look-back period should be reduced from three years to 12 months, as local and national coverage policies change from year to year.
- Timely billing guidelines should be adjusted to allow re-billing of RAC-denied claims. A process for re-billing denials at the alternative level of care or code determined by a RAC (e.g., inpatient to outpatient) should be established.
- Considering the high volume of medical necessity reviews conducted by RACs, each contractor should be required to engage physicians other than the single medical director currently required by the SOW. Such physicians are necessary to conduct reviews, provide clinical guidance to other personnel conducting audits, and respond to provider inquiries on denied claims.
- A portion of recouped funds should be invested in provider education consistent with associated CMS contractors and a centralized, secure, Web-based reporting system for CMS, CMS contractors, and providers. Such collaborative efforts will improve overall Medicare payments, thus reducing the need for targeted audits.

AzHHA urges Arizona's congressional delegation to support efforts to refocus RAC audits, develop appropriate payment incentives and make operational improvement to the RAC program.



Arizona Hospital and Healthcare Association

Caring for Foreign National Patients: Reauthorize Section 1011 Funds

The Arizona Hospital and Healthcare Association (AzHHA) remains grateful for the leadership of Senator Kyl and Arizona's congressional delegation in securing federal funds for care hospitals provide to undocumented immigrants through section 1011 of the Medicare Modernization Act of 2003. We appreciate our lawmakers' leadership in protecting these funds during earlier congressional discussions regarding funding offsets; however AzHHA is deeply concerned that Congress did not reauthorize section 1011 before it expired on September 30, 2008. We are committed to working with Arizona's congressional delegation, the American Hospital Association (AHA) and other state hospital associations to reauthorize section 1011 funds this year.

Arizona hospitals depend on the section 1011 funds to offset a portion of the costs they incur treating undocumented immigrants. The most recent report on section 1011 claims compiled by Trailblazer, which contracts with the Centers for Medicare and Medicaid Services (CMS) to pay section 1011 claims, reveals that Arizona hospitals continue to provide a significant amount of uncompensated care to undocumented immigrants. According to Trailblazer, for the quarter ending June 30, 2008, the value of submitted claims related to that quarter totaled \$51.4 million. Of that amount, Trailblazer paid Arizona hospitals nearly \$8.7 million, or 17 percent.

Section 1011 allocated approximately \$11.1 million for Arizona through September 30, 2009. For a variety of reasons—including implementation delays at the program's inception and the fact that section 1011 only pays for the first two days of a patient's hospital stay—approximately \$76 million remains available for Arizona providers. At the current rate of spending, AzHHA estimates the remaining funds will be exhausted by September 30, 2010.

Although section 1011 was allowed to expire, hospitals' legal obligation to care for all patients under the federal Emergency Medical Treatment and Labor Act—without regard to their citizenship status or ability to pay for services—continues. In the absence of federal immigration reform that includes healthcare coverage for immigrants, AzHHA believes Congress has an obligation to pay hospitals and other healthcare providers for the care they are legally required to provide to undocumented immigrants.

To ensure hospitals retain the ability to recover at least a portion of the costs of treating foreign national patients, AzHHA urges Congress to:

- **Reauthorize the section 1011;**
- **Appropriate to CMS an amount sufficient to support the administrative costs associated with processing section 1011 claims; and**
- **Seek solutions to assist hospitals with discharge and transition of undocumented and foreign national patients who need long-term and other types of post-acute care.**



Arizona Hospital and Healthcare Association

The “Boutique” Hospital Boom

Even as Arizona’s healthcare community works with policymakers to achieve healthcare reform, our state faces a looming public health crisis resulting from an insufficient number of physicians, particularly specialists who are willing to serve on the on-call rosters of hospital emergency departments.

The emergence of so-called “boutique” hospitals—hospitals that limit their scope of service to profitable specialties like orthopedic surgery and cardiac care—has exacerbated Arizona’s shortage of on-call specialty physicians, as orthopedic surgeons and other specialists have migrated to limited-service providers. These hospitals primarily serve a commercially insured and Medicare population, and tend not to treat Medicaid or uninsured patients. Focusing on scheduled elective procedures, boutique hospitals typically do not provide a full range of emergency services.

The Arizona Hospital and Healthcare Association (AzHHA) appreciates that, in his 2010 budget outline, President Obama acknowledged the need to address physician referral to facilities in which the physician has an ownership interest. AzHHA also applauds the U.S. House of Representatives for including a ban on self-referral in its version of the American Recovery and Reinvestment Act of 2009 and for acknowledging the cost savings that can be achieved through such a ban. **As Congress continues to debate key provisions of the 2010 budget and healthcare reform, AzHHA urges Arizona’s congressional delegation to resolve the critical issue of physician self-referral.**

Congressional Response: Moratorium on New Limited-Service Hospitals

Concerns about the impact these limited-service providers will have on community hospitals—and physicians’ ability to refer patients to facilities in which they have an ownership interest—led Congress to enact a moratorium on the growth of these providers as part of the Medicare Modernization Act (MMA) of 2003 and, in the Deficit Reduction Act of 2005, to extend the moratorium until August 8, 2006.

On January 12, 2005, the Medicare Payment Advisory Commission (MedPAC) adopted a recommendation to extend the MMA’s moratorium until January 1, 2007. The commission also voted in favor of changes to Medicare’s hospital inpatient payment system to curb financial incentives that Medicare creates for physician-owned specialty hospitals to specialize in more profitable services and select healthier patients. MedPAC also recommended that hospitals be allowed to offer incentives to physicians to encourage

physician and hospital cooperation to lower costs and improve care. According to the recommendation, these so-called “gainsharing” arrangements, which are currently prohibited under federal law, could foster improved hospital-physician relationships.

Now that the moratorium has expired, the policy issue facing Congress is the fact that current laws governing hospital-physician business relationships—and the consequential growth of limited-service hospitals—have resulted in a distortion of the healthcare marketplace that threatens the financial viability of community hospitals and raises serious implications for patient safety. In short, **current laws allow limited-service hospitals to enter into precisely the same business arrangements with physicians that are illegal for general acute care hospitals.** Taking advantage of the “whole hospital” exemption in the Stark laws governing physician self-referral, the typical business model for these facilities relies heavily upon financing from physician investors who comprise their medical staffs.

Implications for Arizona’s Patients and Community Hospitals

The delivery of healthcare in Arizona—and across the nation—is changing rapidly in response to myriad forces, not the least of which is innovation. An ongoing concern is the growing imbalance between those healthcare providers who share in the social and community obligation of providing care to all and those who do not.

The last decade has been marked by a dramatic proliferation of these providers across America, and there is strong evidence to suggest that potential investors continue to see Arizona as an attractive target marketplace. In its April 2003 report to Congress, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, the Government Accountability Office (GAO) reported that certain types of specialty hospitals have tripled since 1990. In this study and an earlier one, the GAO defined a specialty hospital as a facility in which the diagnoses of two-thirds of its Medicare patients fell into no more than two major diagnosis-related-groups (DRGs) (e.g., diseases of the circulatory system), or those in which at least two-thirds of its Medicare patients were classified into surgical DRGs. According to the GAO, hospitals that meet these criteria fall into five types of specialty hospitals: cardiac, orthopedic, surgical, women’s, and other.

In its October 2003 report, the GAO cited 100 specialty hospitals in 28 states and another 26 facilities under development. Nearly two-thirds of the hospitals operating or under development are concentrated in seven states: Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. Eighty-five percent of them are in rapidly growing urban areas, and nearly all (96 percent of those built since 1990) are in states—like Arizona—that do not have laws requiring developers to obtain a “certificate of need.”

In Arizona, with our explosive population growth, large uninsured population, and critical shortage of physicians, the specter of an unfettered proliferation of limited-service providers would be disastrous to community hospitals and the patients they serve.

Potential Threats to Patient Safety. The GAO found that more than 90 percent of the specialty hospitals that have opened since 1990 are for-profit and only 45 percent of them have emergency departments and treat Medicaid and uninsured patients. If they do provide emergency services, these services tend to be extremely limited. In Arizona, limited-service providers—even those that are licensed as acute care hospitals with emergency departments—generally refer emergency patients with conditions beyond their capability to nearby full-service hospitals. And given the fact that most limited-service providers focus on surgical services, there could be serious implications for patients who have an unanticipated event during surgery (e.g., cardiac arrest, pulmonary embolism), and who would need to be transported to a general hospital. Indeed, the death of a patient in a Texas specialty surgical hospital underscored these patient safety concerns.

In addition, given the current shortage of specialty physicians who are willing to remain on the call rosters of general hospitals, the potential for specialty hospitals to monopolize specialists further undermines hospitals' ability to meet critical community needs. A number of general hospitals in Arizona have experienced this phenomenon firsthand. Orthopedic surgeons, hand surgeons, neurosurgeons and other specialists are increasingly unwilling to take emergency call, citing lifestyle, payment and liability concerns. In recent years, when limited-service providers have opened, community hospitals in the same service area have seen specialists resign from their medical staffs en masse and affiliate with the limited-service provider, where surgeries are scheduled during business hours, patients have insurance and, because they have a relationship with their physician, are less likely to sue. This leaves community hospitals struggling to staff their emergency departments for certain specialties and provide inpatient care for patients who cannot afford care at the special hospital or who have complex medical needs that involve multiple specialties.

Stark Exception Distorts Marketplace and Creates Uneven Playing Field. Another concern centers on the ability of physicians to refer patients to specialty hospitals in which they have a financial interest. Supporters of specialty hospitals argue that in a free market, competition is healthy. But under the Stark laws, limited-service hospitals can do with impunity what community hospitals cannot do. Indeed, Stark carries grave penalties, including substantial civil money penalties and exclusion from federal programs. It also may be the basis for related claims under federal fraud and false claims laws, which can result in criminal penalties. As a result, the chief executive officer of a general acute care hospital can go to prison for entering into certain ventures with a physician that are perfectly legal for physicians to enter into with specialty hospitals.

Under the Ethics in Patient Referrals act of 1989 (commonly referred to as Stark I) and a subsequent law passed in 1993 (Stark II), Congress sought to limit physician self-referral by prohibiting federal reimbursement for many arrangements, including physician investments in hospital departments to which they refer. However, the Stark law contains several exceptions, notably, the “whole hospital” exception, which permits physicians to self-refer when they have ownership in the whole hospital, as opposed to a single department. The exception was intended to allow for ownership in general hospitals that provide a full array of healthcare services, where self-referral would produce little personal economic gain. But, as the GAO noted in its 2003 study, because specialty hospitals are typically much smaller in size than general hospitals—and closer in size to hospital departments—the whole hospital

exception to Stark could allow physician owners to influence their hospitals, and therefore their own, financial gain through practice patterns and referrals.

Financial Impact on Arizona Community Hospitals. Limited-service providers focus on the most profitable services in healthcare today—cardiac care, orthopedic surgery, obstetrics, etc.—and recruit the specialty physicians who provide this type of care as admitters and investors. This trend, combined with the fact that these hospitals typically do not provide emergency services, and are therefore not required to comply with the federal Emergency Medical Treatment and Labor Act’s mandate to treat all patients without regard to their ability to pay, positions them to siphon off the revenue community hospitals need to subsidize the uncompensated care they provide in their emergency departments.

Arizona’s community hospitals often provide services that are vital to a community but are financially risky. Trauma centers, burn centers and emergency department services provided to those without health insurance are often underwritten with revenue generated from other hospital departments. If this ability to cross-subsidize is eliminated, so will be the services provided to the community that result from that cross-subsidization.

Arizona’s healthcare market has long been a model of healthy competition. But even in a competitive environment, caring for sick people transcends the simple buyer/seller relationship. Some basic principles must endure: 1) patients must be able to trust that decisions about their care will be made based on what is in their best interest, not that of their provider; and 2) being a healthcare provider has always carried social and community obligations and must continue to do so.

The Arizona Hospital and Healthcare Association (AzHHA) strongly supports competition in the healthcare marketplace. But the current whole hospital exception to the Stark law threatens patient safety, distorts fair competition, and fosters conflicts of interest. Communities must rely on all healthcare providers to share in solutions for treating the poor and uninsured, and for ensuring access to essential services in the communities they serve. And patients must rely on policymakers to ensure that the incentives and business imperatives of a competitive market do not eclipse the public good.

Because these issues are so critical, it is vital that Congress act on them this year. **AzHHA urges Congress to enact legislation that would:**

- **Permanently ban Medicare payment to new physician-owned special surgical hospitals, with a grandfather provision for existing physician-owned hospitals;**
- **Eliminate the whole hospital exception to the Stark laws; or**
- **Reinstate the moratorium on Medicare payment to new physician-owned special surgical hospitals.**



Arizona Hospital and Healthcare Association

Free & Fair Union Elections

Enacted more than 70 years ago, the National Labor Relations Act (NLRA) guarantees employees the right to determine whether they wish to be represented by a particular union through a secret ballot election. Under this law, the National Labor Relations Board (NLRB) protects the interests of both employers and employees by ensuring that both sides have an opportunity to make their case, and that employees are able to express their decision privately—the same opportunity afforded voters in a political election.

The Arizona Hospital and Healthcare Association (AzHHA) strongly opposes **H.R. 1409/S. 560, the Employee Free Choice Act (EFCA) of 2009**, because the legislation seeks to overturn a bedrock principle of free and fair elections where ballots are cast in private, free from outside influences. These bills would make the most dramatic changes in the NLRA in 60 years and would be particularly disruptive to hospitals, where employees must work as a team to care for patients.

EFCA Dramatically Alters Labor Relations

Card-check recognition for unions. Currently, “card check” recognition occurs only when a union obtains signed authorization cards from a majority of employees in a proposed bargaining unit and the employer voluntarily agrees to recognize the union. In the vast majority of cases, employers decline voluntary recognition, which means that employees may express their preference regarding unionization in a secret ballot election administered by the NLRB. Under EFCA, however, a union would become the exclusive bargaining representative if it simply obtains signed authorization cards from a majority of employees in the proposed unit, even without employer agreement.

Mandatory arbitration for first contracts. EFCA would change current law by fast-tracking initial negotiations and effectively guaranteeing a first contract. Currently, employer and union must bargain in good faith over wages, hours and working conditions, but neither is required to make concessions or reach an agreement. If agreement is reached, employees vote on whether to ratify the contract. Under EFCA, if no agreement is reached within 90 days after bargaining starts, either party could request government mediation. If that does not produce an agreement within 30 days, the dispute would be referred to government arbitration, which would decide all disputed terms and impose a contract that binds the parties for two years.

Increased penalties on employers. EFCA would make three major changes to the NLRA’s enforcement provisions, all of which pertain to unfair labor practices committed by *employers* during a union organizing drive or during bargaining for an initial contract. It is important to note that the legislation proposes no changes to address unfair labor practices committed by *unions*.

- Mandatory injunction proceedings if there is reasonable cause to believe that the employer discharged, threatened or otherwise discriminated against employees.
- Mandatory triple back pay for employees discharged in violation of the NLRA.
- Civil penalties of up to \$20,000 per violation if an employer “willfully or repeatedly” commits certain unfair labor practices.

EFCA’s Particular Dangers for Hospitals

Strips hospital employees of their right to a secret ballot election. The NLRB and the courts have long recognized that secret ballot elections are the preferred and most reliable method to determine employee preferences regarding unions. This is because employees often sign union authorization cards for reasons other than actual support for the union, including peer pressure, a desire to stop union agents from bothering them, misunderstanding what they are signing, or because they are coerced or intimidated. Yet the unreliable card check process is a central feature of EFCA. If a bare majority of the employees in a proposed unit sign authorization cards, they will deprive the rest of the employees in the unit of their right to vote on unionization. The negative impact of card check unionization drives at hospitals will be acute. Hospital personnel work in close-knit teams throughout the hospital. Without a secret ballot to decide union representation, hospital employees may face increased pressures during union campaigns. Employee fears in the current economy likely will only exacerbate the problem.

Ability to unionize through card check will result in an almost constant state of campaigning. Many hospitals are large employers with large campuses, so it is not difficult for card signing to be conducted without management’s knowledge. Today, if a union obtains enough signed cards to seek an election, hospitals have an average of six weeks before the election to inform employees of the hospital’s views, including the benefits of remaining union-free. Under EFCA, union representation could be approved before a hospital even knows there is an organizing campaign. This deprives employees of the opportunity to receive valuable information that could inform their decision. Moreover, without a fixed election date and pre-election campaign period, hospitals will have to be prepared for continuous organizing, which detracts from their primary mission of caring for patients.

Binding arbitration provisions could deprive employees of the right to vote on contract terms. Workers could be deprived of their right to vote not only on whether to unionize, but also on whether to accept contract terms negotiated by their union. If management and union cannot agree on initial contract terms within four months, the terms would be

imposed by government arbitrators, and there would be no employee ratification vote on the contract.

Binding arbitration provisions could lock hospitals into rigid agreements that handcuff their ability to adapt to new patient care models. The mandatory fast-track negotiation period could hamstring the development of balanced contract provisions and result in initial contracts that bind hospitals to rigid requirements at odds with new healthcare quality and payment initiatives.

Accelerated timetable for contract negotiations is entirely unrealistic. Under EFCA, to avoid mediation and arbitration, negotiations for a first contract must be completed in the incredibly short time period of 90 days, a timeframe almost unheard of in collective bargaining negotiations, especially for first contracts. This problem is even more troubling for hospitals because, due to NLRB rules, they may face multiple organizing efforts and a proliferation of small bargaining units.

New provisions are one-sided. While unions are vigorously advocating to ease the method for gaining representation of workers, they believe these rules shouldn't apply when workers no longer want union representation. Under EFCA, a secret ballot election is still required when the issue is whether to vote a union out. Similarly, EFCA enhances penalties for employer unfair practices, but not for union misconduct.

Congress Must Preserve Secret Ballot to Protect Patient Safety

Too often during a union campaign, hospital employees report feeling intimidated by union organizers and fellow staff who pressure them to sign union cards. Even employees who indicate they would not vote to unionize in a private election are reluctant to speak out publicly against unionization at a caucus or open forum and may sign cards just so union organizers will leave them alone.

Unfortunately, employees who refuse to sign union “cards of interest” report being bullied, belittled, or singled out as “non-team players.” In a hospital setting, where patients depend on employees to work as a team, such behavior could have serious consequences for patient safety.

In the fast-paced world of the modern hospital, busy healthcare professionals may not have time to read the “fine print” on cards of interest that indicate that the signed card can or will be used to demonstrate to management that a majority of employees are interested in being represented by a union. Moreover, not all cards of interest contain this information, nor do they include the pros and cons of unionization. Consequently, employees could easily find themselves with a union and not realize that the cards they signed a month earlier resulted in this outcome. By contrast, a secret ballot election allows for full disclosure of information from both management and the union, and allows each employee to make an informed decision.

Arizona hospitals believe that the men and women who care for patients are entitled to choice. They also must be guaranteed confidentiality in their decision to unionize or not to unionize. The proposed legislation strips them of the protections afforded under current law and leaves them vulnerable to unwanted interference.

AzHHA urges Arizona’s congressional delegation to oppose H.R. 1409 and S. 560 and protect employees’ right to confidentiality in unionization elections.

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