Holy Cross Hospital Community Meetings

Converting to Critical Access Hospital (CAH) Status

January, 2017

Our Mission…

To provide our community with high quality health care choices close to home, in an environment of continual improvement and service excellence.

Our Vision…

Taos Health System is a progressive organization committed to improving the health of our community.

Taos Health System/Holy Cross Hospital makes an impact!

Number of jobs (directly hired) = **~450**

Salary dollars pumped into the local economy = **$24,791,810**

Number of patients cared for (Fiscal Year 2016 numbers)…

Emergency Department = **15,208**

Babies Born = **214**

Inpatients admitted = **1,565**

Outpatients served = **45,573**

Surgical procedures = **2,650**

Things have improved!

Bottom-line:

2013 = an audited loss of **($5,701,450)**

2014 = an audited loss of **($7,237,662)**

2015 = an audited loss of **($1,524,735)**

2016 = an audited profit of **$1,125,525**

2017 (thru November) = an unaudited profit of **$108,822**

Days Cash-on-hand = **33** (November financial statements)

Accounts payable = **36** (November financial statements)

And are getting better!

The recently approved mill levy will provide ~**$5,000,000** for needed medical equipment and building maintenance/repair projects over the next four years!

But clouds are on the horizon for rural healthcare

- Rural hospitals across the country are struggling financially!
- **673** rural hospitals are vulnerable to closure based on financial stability, patient satisfaction, and quality indicator data (iVantage Health Analytics).
- More than 70 rural hospitals have closed since 2010 and many more may be headed down the same path (Beckers Hospital Review).

But clouds are on the horizon for rural healthcare

- In July 2016 – Medicaid cut our reimbursement by **5%** for inpatients and **3%** for outpatients
- New Mexico is struggling to fill a **$500,000,000+** shortfall and additional cuts to the Medicaid program may be part of the solution.
- Medicare currently pays **79% of our cost** to provide care!
- **Everything** we hear from the government and from our commercial payers **says that our revenues will continue to decline** and we all understand that our expenses will continue to grow.

The Critical Access Model (CAH)

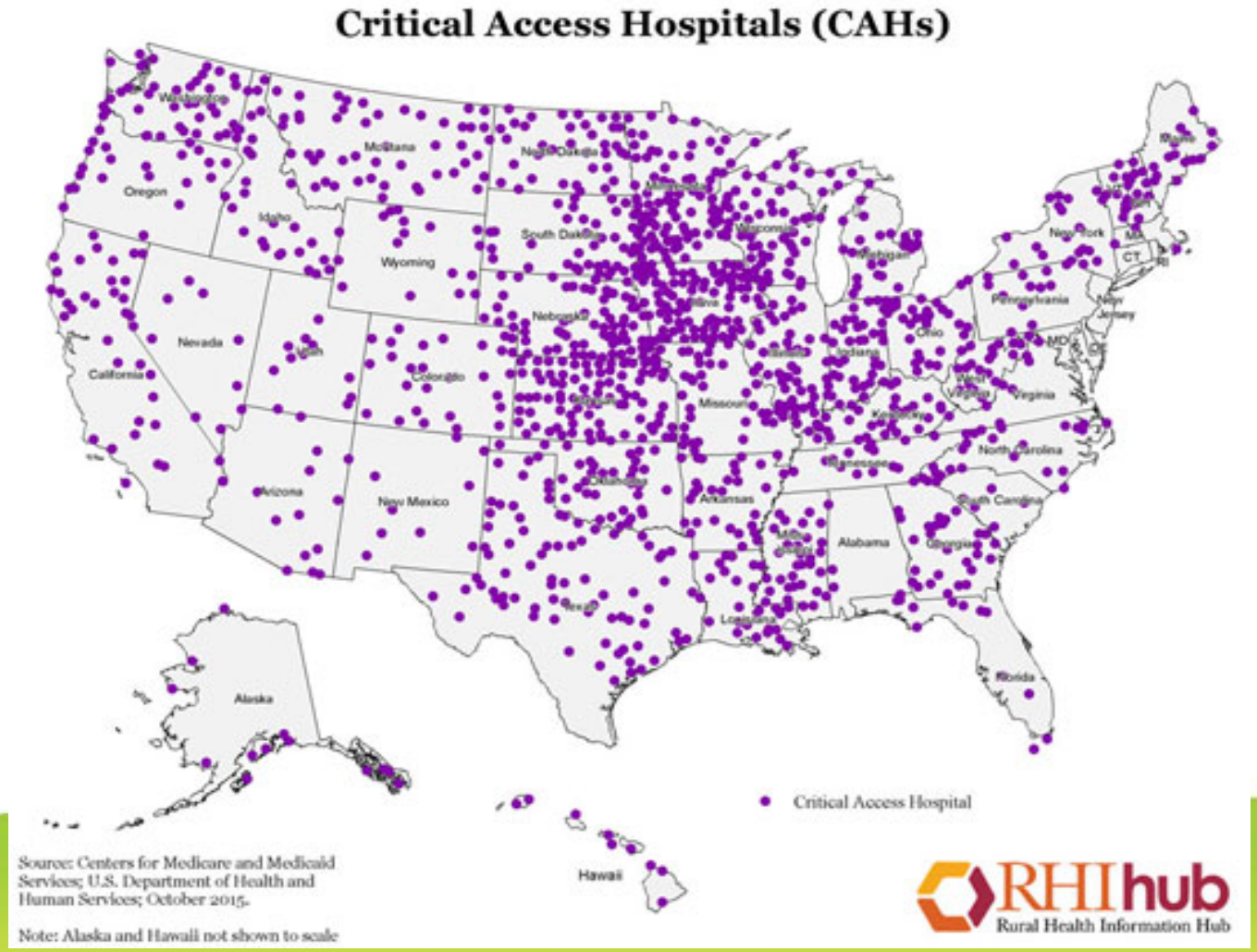
The Critical Access reimbursement model is one of the few remaining options we have to offset the trend of declining reimbursement! This model will allow us to continue to provide acute care services in a more financially sustainable manner.

"Critical Access Hospital" (CAH) is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS). This designation was created by Congress in the 1997 Balanced Budget Act in response to a string of hospital closures in the 1980's and early 1990's.

The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential rural services through **cost-based Medicare reimbursement**.

How many CAHs are there and where are they located?

As of April 6, 2016, there are 1,332 certified Critical Access Hospitals in the United States.



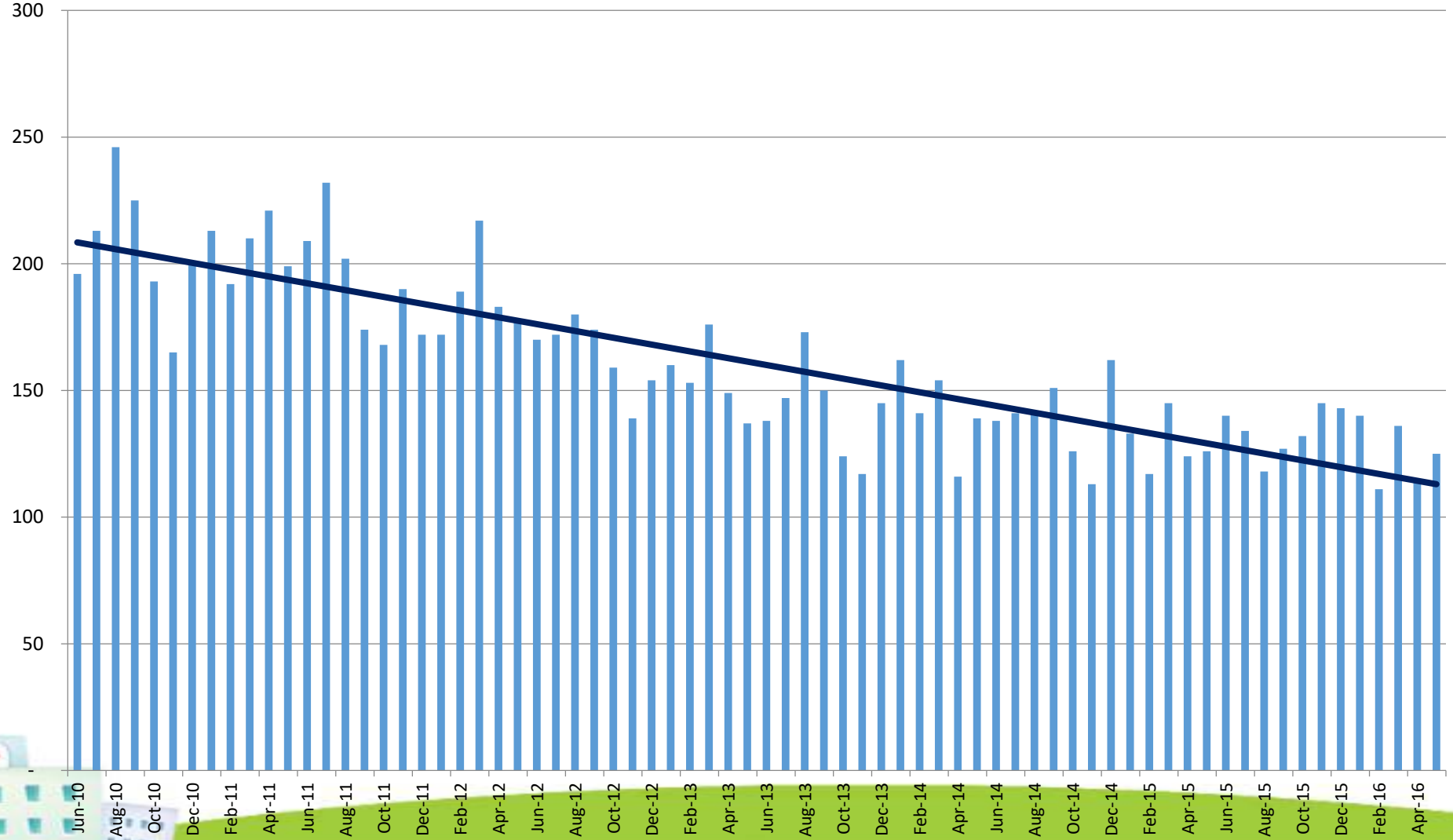
What are the CAH rules?

To ensure that CAHs deliver services to improve access to rural areas that need it most, restrictions exist concerning what types of hospitals are eligible for the CAH designation. The primary eligibility requirements for CAHs are:

- A CAH must be located more than 35 miles from another hospital (other exceptions apply that do not affect us).
- Furnish 24-hour emergency care services 7 days a week.
- We will be required to demonstrate compliance with the applicable Conditions of Participation (COP's), just as we are currently. CAH status would require us to comply with a new set of regulations.

- Maintain no more than **25 acute inpatient beds** that may also be used for swing bed services (dually licensed).
  - Our current license is for **29 acute care beds**.
    - Newborns do not count as using a licensed bed.
    - Observation patients do not have to be in a licensed bed.
    - We plan to create an observation unit next to the ED.
  - For the last year our average inpatient census has been **14.3 (FY16)** and **12.9 for FY17 YTD**.
    - During that time **we NEVER exceeded 25 inpatients!**

Holy Cross Hospital
Inpatient Admissions Trend



CAHs must network with an acute care hospital, which can provide support to the CAH and receive transfers of more acute patients.

- Traditionally this support is seen in the areas of credentialing and quality programs.

- We will also need to develop formal patient transfer agreements with hospitals. Such agreements will not limit our ability to transfer to other facilities; they will simply facilitate our transfer to the networked hospital.

What are the benefits of CAH status?

The biggest advantage of being designated as a CAH is that we would be paid based on a **cost-based reimbursement model**, which has the potential to increase our net revenues.

- Keep in mind that this reimbursement only applies to Medicare patients – for all other patients we are paid the same as we are currently. As of January 1, 2004, CAHs are eligible for allowable costs plus 1%.
- There is also the potential for increased/positive reimbursement for physician billing (15% above current fee schedule). This has not been factored into the estimates provided in this presentation.

CAHs are paid for most inpatient and outpatient services for Medicare patients at **101 percent of reasonable costs*.**

With regard to our cost to charges and how that compares to our Medicare reimbursements, consider the following:

- Current reimbursement to HCH from Medicare to provide services to their beneficiaries
  - Only **34% of what we charge**
  - Only **79% of our *COST***

Capital improvement costs (medical equipment purchases and large repairs to our building) are included as allowable costs for determining Medicare reimbursement. Current estimates show that we would **receive a "credit" of about 33%** of the value of such purchases.

- This means that if we spend $1,000,000 on medical equipment, our Medicare reimbursement for the following year would increase by $330,000.
- Looking at the mill levy money, the multiplier effect is huge!
    - **33% of $5,000,000 = $1,650,000!**

The 2 big issues we have been discussing are:

- The 96-hour rule (length of stay and physician certification)
- The 20% copayment requirement

The 96-hour rule:

- CAH payment rules **require a physician to certify** that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission.

- A CAH must maintain an **annual average length of stay of 96 hours or less** for acute care patients (excluding swing bed services and observation patients).

- To be clear, if we are designated as a CAH there will be a few patients that we will not be able to provide care for, especially those that we know will have a long length of stay.

- A few examples of patients that we will consider for transfer (patients that we **currently** consider for transfer) includes:
  - Cardiac conditions
  - Neurologic conditions
  - Some patients who need renal dialysis or require platelet transfusions
  - Some elective surgical patients

- Our average length of stay for all patients over the last year (10/1/15 to 09/30/16) was **3.07**. For Medicare patients only the average length of stay for that same time period was **3.59**.
  - Our current practices will be updated to fully take advantage of the swing bed option.

- A “swing bed” is a lower level of care than acute care. It can be thought of as a “step down” bed or a “skilled nursing facility” level of care.
  - The use of swing beds provides a great deal of flexibility in the treatment of acute care patients and often will remove the need to transfer the patient away from Holy Cross.

As we have explored the idea of becoming a CAH, we have found **that we currently have a license for swing beds** but that we have not used it for many years. Whether we convert to CAH status or not, it makes sense for us to verify that we meet all the swing bed requirements and begin making use of its benefits.

For example, in our current PPS model, when a patient stays for an extended period of time, we only get paid the base DRG amount. If we had swing beds, we could transfer the patient to that status and continue to get paid for their extended stay (this is especially important for those patients for whom we are attempting to find a suitable placement).

20% co-pay issue

This rule applies only to **Medicare Outpatient** services

- The change is how the copay is calculated by Medicare
  - Under current PPS system, calculated based on ***payment*** amount
  - Under CAH system, calculated based on ***gross charges***

- Only impacts conventional Medicare Outpatient patients that do not carry a secondary insurance (such as BCBS, Presbyterian, Medicaid, etc.)
  - Does not impact Medicare Advantage Plan patients
  - Does not impact patients with commercial insurance
  - Does not impact patients with any other insurance or payer

- Co-payments
  - Due from patients: $106,886
  - Received from patients: $57,679
  - 639 accounts made payments averaging $90
  - 1,754 accounts made no payments at all (most of the accounts went to charity care or bad debt)

- New co-payment rules would increase the patient responsibility from $106,886 to $485,387
  - If the collection rates are similar, we would expect to collect $261,930 from patients
  - Increase in unpaid of $223,457

Holy Cross Hospital Statistics from FY2015

- Total conventional Medicare patient OP:
  - Visits: 20,591 (7,068 unique patients)
  - Charges = $25,293,413
- Total conventional Medicare OP patient visits with no secondary insurance:
  - 2,393 (854 unique patients – 12.1%)
- Total charges: $2,426,933 (9.6% of total)
  - Medicare payments: $427,544

Under our current PPS status, our patients are sometimes confused about an observation stay being billed as an outpatient type of care. It doesn't make sense to them that they are not an inpatient – after all they are in a regular inpatient bed.

We will **"beef up"** our own **support program** to help people who are negatively affected by the 20% issue.

Are we already a Critical Access Hospital?

1. In several respects, we already function like a CAH hospital
   - Our length of stay is within the CAH requirements
   - Our number of beds is almost at the 25 limit
   - We transfer patients who need a higher level of care
2. But we don’t get any of the CAH reimbursement advantages!
   - It has been suggested that we are paying a "dumb tax“
   - Some have suggested that we risk making the hospital financially vulnerable if we do not change our status.

3. Financially and clinically, there is no apparent advantage to remaining a PPS hospital (prospective payment system).

Our process…

1. In July, we held special All Staff meetings, providing an overview of what it means to be a Critical Access Hospital and we answered staff/management questions.

2. There continued to be concerns so we sent 3 teams to 3 different large Critical Access Hospitals. The teams included:
    a. A Hospitalist
    b. An ER physician
    c. A nurse
    d. A case manager
    e. A financial person/biller
    f. A member of ATM

Team Reports…

- We have asked members of the 3 teams to talk about their visit.

- We want them to give you a report on what they learned and share with you their opinion regarding this topic.

From our Hospitalists (Dr.'s Foster, Jaramillo, and Yong)…

- The Hospitalists believe that **we will still be able to admit and place into Observation status the large majority of our patients that we currently keep.**
  - We anticipate **only a handful of patients** that may have stayed currently that would be transferred based on the initial certification that the patient may be reasonably discharged or transferred within 96 hours. For example, an intubated pneumonia patient that is septic.
  - As evidenced by the CAH trips, **it is rare to need to transfer patients at 96 hours** if they are continuing to improve, it seems that most hospitals justify that they only need 1 or 2 more days in the hospital.

- We will need to utilize our observation and swing beds efficiently, and be more pro-active with Case Management in order to avoid maxing out on the 25 bed capacity.

  - As previously mentioned, we think that it will make sense to develop an observation unit close to the Emergency Department.

    - ✓ More planning will be necessary (staffing, medical oversight, etc.) before this unit is built.

- We feel that the extra reimbursement that will be received by converting to a CAH could certainly be used to benefit the community with expanded medical services in other ways.
  - It is difficult to ignore this prospect in order to keep a handful of patients that may be transferred each year.

- Examples of how this additional money will be used includes:
  - Our new EMR (Meditech replacement)
  - Funding projects that the Mill Levy won't completely cover
    - ✓ Hospital repairs/structural improvements (i.e., current OR issues)
    - ✓ Updating our inpatient rooms

- Other examples of how this additional money will be used that are currently being explored includes:
  - Bring inpatient dialysis back
  - Expansion of our infusion service (possibly including chemo)
  - Creation of a hyperbaric therapy program

- The money will also allow the hospital to be more financially stable which means **more stable compensation and benefit programs.**

- The 20% Copayment issue
  - The 3 hospitals we visited indicated that the 20% copayment rule **had not been an issue for them**.

  - The hospitals reported that they help patients who cannot afford the copayment **using their existing charity programs**.

Our Mission…

To provide our community with high quality health care choices close to home, in an environment of continual improvement and service excellence.

Our Vision…

Taos Health System is a progressive organization committed to improving the health of our community.

Converting to Critical Access status will help us fulfill our mission!

In some peoples' minds the normal CAH model is a small rural hospital that is viewed as a band aid station.

It is clear that Holy Cross Hospital does not fit that "model"! We offer a robust menu of services that can quite easily conform to the CAH model.

We want to increase our services. But given the limited population that we serve, we cannot grow our way out of our financial problems. More care is being provided in the outpatient setting so our need for inpatient beds is not expected to grow over time.

The 3 site visits helped us understand that the Critical Access model will not significantly change the way we provide care but it will improve our Medicare reimbursement!

The Board has directed us to do two things:

1. Begin the process to convert to Critical Access Hospital status.

2. Reach out to the community and educate them:
   A. What a Critical Access Hospital is;
   B. How the care we provide will not significantly change;
   C. Why the reimbursement model will help us be financially viable; and
   D. Our plan to assure that patients who are negatively affected by the new copayment rules will be protected.

Questions?

Thank You!