THE TAOS NEWS
Best U.S. Weekly Paper- NNA 2007,2008, 2010
Inland Press Nation's Best Weekly Newspaper 2009

Holy Cross: 'Critical access' would mean more money, few changes

By J.R. Logan, *jrlogan@taosnews.com*

The Taos News, 1/5/2017

Officials at Taos' Holy Cross Hospital say they want to make changes that will improve revenue, but won't "significantly change" the type of care the facility offers.

For months, hospital administrators have been selling the idea of converting Holy Cross to a "critical access hospital" — a federal designation that changes how the hospital gets paid for treating Medicare patients.

The hospital has spent months trying to convince its own staff that the change is the right move. Now it's planning public meetings to do the same with the community.

Holy Cross CEO Bill Patten told reporters at a presentation Jan. 3 that better reimbursement rates could bring in another $750,000 a year to the hospital, which is still trying to find stable financial footing after years of multimillion-dollar losses.

The hospital currently generates around $56 million in annual revenue. Last year, it had a profit of $1.1 million. It was the first time in years that Holy Cross didn't lose money.

Becoming critical access would qualify the hospital for "credits" tied to capital improvements. If Holy Cross were a critical access facility and spent $1 million on medical equipment, for example, it would get a $330,000 reimbursement.

"In many respects, we're already a critical access hospital, but we don't get any of the critical access advantages," Patten said. He said others have suggested the fact that the hospital has not already sought re-designation means Holy Cross is paying a "dumb tax."

The designation requires hospitals to meet a list of requirements. Among them are:

• Hospitals can have no more than 25 licensed inpatient beds, not including beds for newborns or patients under observation. The hospital currently has 29 licensed beds.

• Doctors must "certify" that an admitted patient will be discharged or transferred within 96 hours after admission. The hospital must also maintain an annual average length of stay of 96 hours or less. Patients who will likely have a longer length of stay must be transferred to another hospital.

• Medicare patients who receive outpatient services must pay 20 percent on what Holy Cross charges for a procedure. Today, those patients pay 20 percent of what the hospital actually gets paid through Medicare, which is usually far less.

The numbers

Patten presented data to show that the hospital had, on average, 14.3 occupied beds last year. It has never, as far back as hospital officials can tell, exceeded 25 inpatients at any one time, Patten said.

Data also showed the current average patient stay is about 74 hours, and the average stay for Medicare patients is a little more than 86 hours. Patten acknowledged that the 96-hour rule would mean some patients would have to be sent to other hospitals, but he said a doctor at Holy Cross who looked into it said it would only be “a handful.”

Of all the changes needed to become critical access, the higher copays will likely be the most controversial, though it will only apply to a limited number of patients.

Patten gave the example of a CT scan: Holy Cross charges $1,000 for the procedure, but the government pays just $300. Today, a Medicare patient pays $60 (20 percent of $300). Under critical access, the cost would go to $200 (20 percent of $1,000).

Figures from the hospital show a total of 2,400 Medicare outpatients were billed $107,000 last year. Only 639 of them paid, for a total of $58,000. With the higher copay, the amount billed would have been $485,000. If collected at the same rate, Holy Cross would expect to bring in $262,000 and not collect the remaining $223,000.

The hospital expects critical access to generate around $1 million in new revenue, though it also expects to lose about a quarter of that (the $223,000) to Medicare patients who don’t pay.

It’s also not clear how much payment levels might change if more patients chose not to shell out for the higher copay.

A presentation given by Patten said the hospital would “beef up” an existing program to help low-income patients affected by the increase.

He first suggested the hospital move toward a critical access designation at a hospital board meeting a year ago. Six months later, Patten asked the board to vote on whether to pursue the change, only to slow down the process after hospital employees and community members voiced concerns that the change was coming too quickly and without sufficient input.

Patten said this week he regretted that initial tack. He said he originally saw the idea as a “slam duck,” but as soon as he realized the scale of the opposition, he pulled back. Instead, administrators have spent the last several months meeting with staff members, soliciting input and arranging visits to three critical access hospitals so doctors, nurses and other staff members could see the difference for themselves.

The hospital CEO said those efforts have brought most staff members around to the idea. He said doctors who originally voted in opposition recently expressed unanimous support. The hospital is now planning a public outreach campaign that will include at last two public forums, plus smaller meetings with local governments and business and civic organizations.

Patten said it could take four to five months to become a critical access hospital when and if the board makes a final decision.

‘Critical access’ public forums

• Jan. 11, 5-7 p.m., (KTAOS Solar Center)

• Jan. 24, 5-7 p.m., (KTAOS Solar Center)

For more information, call (505) 862-1367 or emailivandever@taoshospital.org.
