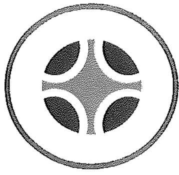


PrairieCare

October 14, 2016

Diane Rydrych
Director, Division of Health Policy
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

RE: PrairieCare 21-bed moratorium application follow-up questions

Dear Ms. Rydrych:

We are in receipt of your letter and have formatted our answers to mirror the order of questions.

(1) **The count and percentage of current patients we expect would be a candidate for a double occupancy room:** PrairieCare currently operates 4 units within our 50-bed hospital, including a 4-bed child Intensive Care Unit (ICU) and a 6-bed adolescent ICU. These 10 ICU beds contain patients that would not be clinically appropriate for double occupancy. Of the remaining 40 beds, we estimate 60% (24 patients) would be appropriate for double occupancy. This number was arrived at by asking the attending physician of each patient to determine, based on our double occupancy criteria, whether the patient in question would be appropriate for double occupancy.

De-Identified Claims Information: This information will be sent under separate cover via secured FTP. We do confirm MDH may use previously supplied claims data for 2012 and 2013 and there are no substantial changes to the data. Unfortunately, it is not possible to differentiate between single and double occupancy discharges in our claims data.

(2) **The percentage of patients referred for hospitalization from outpatient programs to non-PrairieCare facilities:** We analyzed a 6-month timeframe of this data from 12/1/15 through 5/31/16. During those months, PrairieCare's Partial Hospital Programs (PHP) transferred 4.64% of PHP patients to the PrairieCare inpatient hospital. During that same time, PrairieCare's PHPs transferred 1.86% of PHP patients to another hospital for inpatient care. As has been the case since we opened our hospital in 2011, the majority of patients admitted to our hospital for inpatient care are accepted as transfers from emergency rooms (where they frequently wait for hours or days waiting for a bed to become available).

(3) Financial information consistent with definitions in the Minnesota Hospital Annual Report for fiscal year 2015: Please note that due to the transition from the Maple Grove facility (HCCIS ID 257) to the Brooklyn Park facility (HCCIS ID 259), PrairieCare submitted two Hospital Annual Reports (HAR) in 2015. Due to the limited data required to be provided on hospital annual reports for psychiatric hospitals, only Total Operating Expenses and Net Patient Revenue are

reported on our HAR. All other financial data was calculated by PrairieCare's CFO using generally accepted accounting principles and based on our externally-reviewed financial statements.

	HCCIS ID 257 (MG)	HCCIS ID 259 (BP)	Total
Total Operating Expenses	14,905,095	10,316,992	25,222,087
Net Patient Revenue	20,098,477	10,288,992	30,387,469
Total Other Operating Revenue	175,152	84,232	259,384
Total Charges for Patient Care	53,495,854	27,755,697	81,251,551
Total Charges for State Coverage	14,708,800	8,064,387	22,773,187
Adjustments for State Coverage	10,608,878	6,208,723	16,817,601
Adjustments for Charity Care			375,733
Provision of Bad Debts	564,451	606,342	1,170,793

As the Department conducts its review and to the extent financial analysis plays a role in determining whether the proposal is in the public interest, we encourage Department staff to consider PrairieCare's unique status as a pediatric specialty hospital.

Charity Care Policy: Please see the enclosed Charity Care Policy and exhibit.

(4) Written Policy with assessment protocols to determine placement of patients in a double-occupancy room. The needs, nursing and psychiatric assessments all include assessments for those factors used to determine appropriateness of a patient for double-occupancy. The attending physician has the ultimate authority for ordering upon the patient's admission whether she/he is restricted to single occupancy or permitted for double occupancy status based on the following criteria established by the medical staff, which are evaluated upon admission and during daily treatment rounds:

Double-Occupancy criteria: Patients are generally appropriate for double-occupancy unless one or more of the following exclusionary criteria are present:

- *History of sexual perpetration.*
- *History of sexual victimization by a member of patient's peer group of the same gender.*
- *History of significant aggression perpetrated against peers within the past year.*
- *Psychotic symptoms that may be significantly disturbing to others (e.g. florid psychosis).*
- *Any medical condition, such as a communicable disease, that would implicate the hospital's quarantine protocols.*
- *Being placed on assault precautions when the underlying concern may impact the health or safety of the patient or roommate if assigned to a room with a roommate.*

Written policy for how parents may or may not have the opportunity to object to double-occupancy stays: We do not believe it is community standard to offer an opportunity to object to double occupancy per se, but we do attempt to accommodate patient wishes to the extent we are able. The following is included in our standard treatment consent form:

> *"Your care may include assignment to a double occupancy room, based on availability and clinical appropriateness. You understand and agree that single occupancy rooms are*

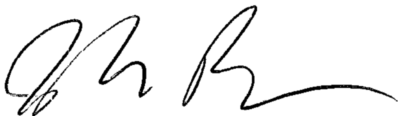
assigned based on clinical appropriateness and availability. If you object to potential assignment to a double occupancy room, please raise this objection with your needs assessment counselor or treatment team and we will attempt to accommodate your request to the extent we are able."

Background information detailing the possible impact on patient outcomes and experience, both positive and negative, of using double-occupancy rooms: We performed an analysis after concluding the double occupancy waiver at the Maple Grove facility. The average weekly occurrence rate per 1,000 patient hours was 3.35 with 25 beds and an average daily census of 23 patients. There were 4.55 occurrences per 1,000 patient hours with 30 beds and an average daily census of 27.56. The difference in occurrence rate (1.2) is not statistically significant (P=.1995) at the 95% confidence interval. This finding suggests that differences in occurrence rate between these two periods are not likely to be from a difference in number of available beds or seasonality but other factors outside the scope of the analysis, such as patient acuity, mix, diagnosis and average age.

We did not formally survey patients or former patients on their views specifically related to double occupancy. Anecdotally, we found that some patients self-reported they preferred to have a roommate and that it might have served as a protective factor against self-injurious behavior for adolescent females.

Describe how the identified single-occupancy rooms to be converted to double-occupancy comply with any state, federal, and industry standards for psychiatric care: The rooms in question are of sufficient size (greater than 80 square feet per patient) to accommodate two patients as specified in Minnesota Rules 4645.1600 and Section 2.5-2.2.2.1 of the Facility Guidelines Institute (FGI) Guidelines for Design and Construction of Hospitals and Outpatient Facilities. We are not aware of any state, federal, or industry standards that would preclude double occupancy in these rooms.

Sincerely,



John Ryan, JD
General Counsel

c: Stefan Gildemeister

POLICY/PROCEDURE

Title: Financial Assistance Program	Policy Number: PA.009 Date Approved: 5/6/13 Review/Revision Authority: Chief Financial Officer Approving Body: Senior Management

Policy:

To provide a mechanism for determining the amount of a patient's balance that is eligible for charity care when patients do not have the ability to pay some or all of their outstanding financial obligation.

Procedure:

1.0 Prior to admission to Inpatient, PHP or IOP the Needs Assessment Counselor (NAC) verifies insurance coverage. (***See IM.091, Gaining Insurance Authorization)***.

2.0 NAC provides guarantors with a Financial Assistance Application Packet (FAA) (PA.009.F01) when they express concern about whether they will be able to afford the patient liability portion of their bill.

3.0 In Inpatient, PHP or IOP, Social Workers provide guarantors with a Financial Assistance Application Packet (PA.009.F01) when concerns about ability to pay are raised during treatment.
  3.1 Other staff notify Social Workers if these concerns are raised in their interactions with patients or guarantors.

4.0 In Clinic, Receptionists provide guarantors with a Financial Assistance Application Packet (PA.009.F01) when concerns are raised during clinic visits about ability to afford the patient liabilities, including clinic co-pays.
  4.1 Receptionists notify treating clinicians through email if such concerns are raised and to confirm that the FAA has been given to guarantor.

5.0 Forward all requests for financial assistance to the Business Office Supervisor for review. Include:
  5.1 Completed Financial Assistance Application (PA.009.F01)
  5.2 Documentation required, as outlined on FAA

13.1.1.2 Business Office Supervisor creates plan with guarantor and informs Billing Representative of payment plan agreed upon.

13.1.2 Billing Representative provides patient/guarantor with completed Time Pay Agreement, PA.009.F06, outlining payment expectations.

13.2 A Time Pay agreement involves:

13.2.1 Equal installment payments

13.2.2 A specific amount

13.2.3 A set day of each month

14.0 CFO updates PA.009.ExA, Table 1 according to HHS Poverty Guidelines each February to reflect most current guidelines.

Prior approval date: 11/6/09, 4/19/10, 5/1/12, 11/12/12

<u>Associated Forms:</u>
PA.009.F01 Financial Assistance Application
PA.009.F02 Authorization for Financial Assistance Form
PA.009.F03 Financial Assistance Application Response Letter: Full Discount
PA.009.F04 Financial Assistance Application Response Letter: Partial Discount
PA.009.F05 Financial Assistance Application Response Letter: Not Eligible for Discount
PA.009.F06 Time Pay Agreement

<u>Associated Exhibit:</u>
PA.009.ExA Guidelines to Determine Amount of Financial Assistance

<u>Associated Policies:</u>
IM.091 Gaining Insurance Authorization
PA.006 Uninsured Patients Accessing PHP and IOP Services
PA.007 Uninsured Patients Accessing Clinic Services

6.0 Consistent with community standards, the base self-pay charge for all services is 50% of the chargemaster charge. Any eligible Charity Care % discount is applied to this base charge.

7.0 Business Office Staff review each Financial Assistance Application and determine eligibility for a Charity Care % discount based on PA.009.ExA, Table 1, Guidelines to Determine Amount of Financial Assistance.
- 7.1 A clinician may believe that extenuating clinical context justifies a discount outside of that suggested by PA.009ExA, Table 1.
  - 7.1.1 Clinician shall discuss with CFO
  - 7.1.2 CFO consults with CEO and provides a determination to the clinician and patient

8.0 Billing Representative enters discount percentage into billing software.

9.0 Third party vendor sends statements for patient responsibility amounts to patient/guarantor after PrairieCare receives payment by insurance company.
- 9.1 Payment of patient responsibility portion is due within timeframe listed on statement.
  - 9.1.1 When Financial Assistance Application has been submitted and approved in advance, discount percentage is reflected on current statement.
  - 9.1.2 Statements direct guarantors to contact Billing Representative concerning installment plans or Financial Assistance Program.
    - 9.1.2.1 When Financial Assistance Application has not been completed, Billing Representative provides guarantor with application.
    - 9.1.2.2 Completed applications are forwarded to Business Office Supervisor.
    - 9.1.2.3 Follow 5.0 – 8.0 above.

10.0 Billing Representative applies the discounts to the patient balances in the applicable billing system and generates a revised statement(s).
- 10.1 Mail appropriate letter and updated statement(s) showing any remaining patient responsibility to the patient/guarantor.
  - 10.1.1 Full discount – no balance to be paid (PA.009.F03).
  - 10.1.2 Partial discount – contact Patient Accounts to set up payment plan (PA.009.F054.
  - 10.1.3 No discount – contact Patient Accounts to set up payment plan (PA.009.F05).

11.0 Patient Accounts keeps the Financial Assistance Application (PA.009.F01) and Authorization for Financial Assistance (PA.009.F02) with the adjustment batch that reflects the discount provided.

12.0 Patients/Guarantors complete new Financial Assistance Application (PA.009.F01) for each episode of care or annually.

13.0 When a patient and/or family is unable to pay amount due in full (with or without discount applied), Billing Representative and patient/guarantor develop an installment payment plan.
- 13.1 Billing Representative has the authority to create payment plans in which full payment is made in preferably three, but no more than six, months.
  - 13.1.1 When a longer timeframe is requested by patient/guarantor, Billing Representative informs guarantor they will need to discuss with Business Office Supervisor.
    - 13.1.1.1 Forward guarantor contact information

Guidelines to Determine Amount of Financial Assistance

Table 1.

2015 Federal Poverty Guidelines:

	% of Poverty Level	<160%	160%	220%	250%	280%	310%	340%	370%	400%
Family Size	2015 Federal Poverty Level Guidelines	100% Discount	80% Discount	60% Discount	50% Discount	40% Discount	30% Discount	20% Discount	10% Discount	0% Discount
1	$11,770	$18,832	$18,832	$25,894	$29,425	$32,956	$36,487	$40,018	$43,549	$47,080
2	$15,930	$25,488	$25,488	$35,046	$39,825	$44,604	$49,383	$54,162	$58,941	$63,720
3	$20,090	$32,144	$32,144	$44,198	$50,225	$56,252	$62,279	$68,306	$74,333	$80,360
4	$24,250	$38,800	$38,800	$53,350	$60,625	$67,900	$75,175	$82,450	$89,725	$97,000
5	$28,410	$45,456	$45,456	$62,502	$71,025	$79,548	$88,071	$96,594	$105,117	$113,640
6	$32,570	$52,112	$52,112	$71,654	$81,425	$91,196	$100,967	$110,738	$120,509	$130,280
7	$36,730	$58,768	$58,768	$80,806	$91,825	$102,844	$113,863	$124,882	$135,901	$146,920
8	$40,890	$65,424	$65,424	$89,958	$102,225	$114,492	$126,759	$139,026	$151,293	$163,560
	* For families with more than 8 persons, add $4160 for each individual person and emulate formula pattern									

**Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (http://aspe.hhs.gov/POVERTY/13poverty.shtml)

Explanation:

- This table is used to determine discounts for all patients, whether or not they have insurance.
- Uncovered amounts vary from insurance policy to insurance policy. Uncovered amounts due to a high-deductible insurance plan's deductible not being met are not subject to charity care discounts, but coinsurance amounts after insurance are eligible.
- Family size includes all members living in the household.
- Income levels listed are for the total of all members' incomes in the household and are based on gross (before tax) income.
- To read the table:
  - Find the number of people in your household under "Family Size"
  - Look across the row corresponding to your family size for the income level closest to yours. The discount for the income number closest to yours is your anticipated discount.
- Proof of income is required, in addition to completing Financial Assistance applications, before discounts are finalized.
- A Billing Representative will need to provide the anticipated charge subject to the discount.

For additional information call our Billing Representative at: 952-826-8460.