I. CALL TO ORDER – Debbie Johnson, Chair, UNM Hospital Board of Trustees

II. ANNOUNCEMENTS
   • Welcome: Garrett Adcock, Student Regent
   • 2017 Most Wired Survey Winners by State/Country
   • Women’s Primary Care New Eubank Clinic Open House – Friday, August 4, 2017

III. ADOPTION OF AGENDA

IV. PUBLIC INPUT
   ATTACHMENTS RECEIVED FROM PUBLIC
   • Public Comment Paperwork: Governor Richardson's Health Care Summit on the UNM HSC Held 12/5/05
   • Public Comment Paperwork: International Journal for Equity in Health
   • Public Comment Paperwork: UNMH Mission, Vision & Core Values, Leadership, Quality Care, Mill Levy & County Support, Our History
   • Public Comment Paperwork: Anticipated Services and UNMH Income Chart for Financial Assistance
   • Public Comment Paperwork: UNMH Finance Guidelines for Surgical Cases for Providers (Non-Emergency Cases)
   • Public Comment Paperwork: UNMH Financial Assistance Program Policy Revised 11/2015
   • Public Comment Paperwork: UNMH Patient Payment Policy Revised 12/2009
   • Public Comment Paperwork: Financial Assistance Internal Procedures

V. CONSENT APPROVAL/INFORMATIONAL AGENDA
   • Consent/Approval Items (Approval)
     ▶ Delta Dental

VI. APPROVAL OF THE MINUTES
   • June 2, 2017 UNMH Board of Trustees Meeting Minutes (Approval)

VII. BOARD INITIATIVES
   • Nominating Committee Board Election (Approval) – Steve McKernan
   • State Board of Finance Meeting – Steve McKernan
   • Patient Payment Policy – Rodney McNease and Irene Agostini, MD
   • Operating Plan – Sara Frasch
   • Mission Excellence Update – Sara Frasch

VIII. ADMINISTRATIVE REPORTS
   • Chancellor for Health Sciences - Paul Roth, MD
   • CEO, UNM Hospitals – Steve McKernan
   • CMO, UNM Hospitals – Irene Agostini, MD
   • UNM Board of Regents Update – Steve McKernan

IX. COMMITTEE REPORTS
   • Quality and Safety (formerly POCEC) Committee – Dr. Raymond Loretto
   • Finance, Audit & Compliance Committee – Jerry McDowell
   • Native American Services Committee – Jerry McDowell
   • Executive Committee – Debbie Johnson

X. OTHER BUSINESS
   • May Financials – Ella Watt

XI. CLOSED SESSION: Vote to close the meeting and to proceed in Closed Session.
   a. Discussion and determination where appropriate of limited personnel matters pursuant to Section 10-15-1.H (2), NMSA.
   b. Discussion and determination, where appropriate, of matters subject to the attorney-client privilege regarding pending or threatened litigation in which UNMH is or may become a participant pursuant to Section 10-15-1.H (7), NMSA.
   c. Discussion of matters involving strategic and long-range business plans or trade secrets of UNMH pursuant to Section 10-15-1.H (9), NMSA.
   d. Vote to re-open the meeting

XII. Certification that only those matters described in Agenda Item XII were discussed in Closed Session; consideration of, and action on the specific limited personnel matters discussed in Closed Session.
ANNOUNCEMENTS
For Immediate Release

Contact: Marie Watteau, 202-626-2351

Most Wired Hospitals Use Technology to Partner with Patients on Health

CHICAGO, July 10, 2017—Technology is making it easier for patients and providers to interact, thus improving communication, safety and patient-provider relationships. New tools are helping patients become more actively involved in their care and maintaining their health, according to results of the 19th Annual Health Care’s Most Wired® survey, released today by the American Hospital Association’s (AHA) Health Forum.

According to the survey, Most Wired hospitals are using smart phones, telehealth and remote monitoring to create more ways for patients to access health care services and capture health information. This year’s results show:

- 76 percent offer secure messaging with clinicians on mobile devices.
- When patients need ongoing monitoring at home, 74 percent use secure e-mails for patients and families to keep in touch with the care team.
- 68 percent simplify prescription renewals by letting patients make requests on mobile devices.
- 62 percent add data reported by patients to the electronic health record to get a better picture of what is going on with the patient.
- Nearly half of the hospitals are using telehealth to provide behavioral health services to more patients.
- 40 percent offer virtual physician visits.
- More than 40 percent provide real-time care management services to patients at home for diabetes and congestive heart failure.

“The Most Wired hospitals are using every available technology option to create more ways to reach their patients in order to provide access to care,” said AHA President and CEO Rick Pollack. “They are transforming care delivery, investing in new delivery models in order to improve quality, provide access and control costs.”
Innovation in patient care embraces emerging technologies and underscores the need for secure patient information exchange. Hospitals have increased their use of sophisticated IT monitoring systems to detect patient privacy breaches, monitor for malicious activities or policy violations and produce real-time analysis of security alerts.

- 97 percent use intrusion detection systems.
- 96 percent perform data access audits.
- Nearly 90 percent run targeted phishing exercises to teach employees to question suspicious emails.

Most Wired hospitals are transforming care delivery with knowledge gained from data and analytics. They are investing in analytics to support new delivery models and effective decision-making and training clinicians on how to use analytics to improve quality, provide access and control costs.

- 82 percent analyze retrospective clinical and administrative data to identify areas for improving quality and reducing the cost of care.
- Three-quarters use sophisticated analytics such as predictive modeling and data to improve decision-making.
- Nearly 70 percent interface electronic health record data with population health tools for care management.
- More than 70 percent are providing data analytic tools training to physicians and nurses.
- 45 percent initiate a patient pathway using health IT to follow a care plan.
- Nearly 40 percent deliver quality metrics to physicians at the point-of-care.
- 32 percent have tools for real-time patient identification and tracking for value-based care conditions, such as chronic obstructive pulmonary disease.

HealthCare’s Most Wired® survey, conducted between Jan. 15 and March 15, 2017, is published annually by Hospitals & Health Networks (H&HN). The 2017 Most Wired® survey and benchmarking study is a leading industry barometer measuring information technology (IT) use and adoption among hospitals nationwide. The survey of 698 participants, representing an estimated 2,158 hospitals — more than 39 percent of all hospitals in the U.S. — examines how organizations are leveraging IT to improve performance for value-based health care in the areas of infrastructure, business and administrative management; quality and safety; and clinical integration.

Detailed results of the survey and study can be found in the July issue of H&HN. For a full list of winners, visit www.hhnmag.com.

**About the Most Wired Survey**

The 2017 Most Wired Survey is conducted in cooperation with the American Hospital Association and Clearwater Compliance, LLC.
About the American Hospital Association
The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the improvement of health in their communities. The AHA is the national advocate for its members, which include nearly 5,000 hospitals, health care systems, networks and other providers of care. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit www.aha.org.

About Health Forum
Health Forum is a strategic business enterprise of the American Hospital Association, creatively partnering to develop and deliver essential information and innovative services to help health care leaders achieve organizational performance excellence and sustainability. For more information, visit www.healthforum.com.

About Clearwater Compliance, LLC | https://clearwatercompliance.com/

Clearwater Compliance, LLC is a leading provider of healthcare compliance and cyber risk management solutions. Its mission is to empower hospitals and health systems to successfully manage healthcare’s evolving cybersecurity risks and ensure patient safety. Exclusively endorsed by the American Hospital Association, Clearwater solutions have been deployed within hundreds of hospitals and health systems, Fortune 100 organizations and federal government institutions. More information about Clearwater Compliance is at http://www.Clearwatercompliance.com.

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2017 Most Wired Survey Winners by State/Country

Alabama
Brookwood Baptist Health, Birmingham: Most Wired
Evergreen Medical Center, Evergreen: Most Wired
Providence Health System, Mobile: Most Wired
St. Vincent's Blount, Oneonta: Most Wired—Small and Rural
St. Vincent's St. Clair, Pell City: Most Wired—Small and Rural
UAB Health System, Birmingham: Most Wired
Washington County Hospital and Nursing Home, Chatom: Most Wired

Arizona
Banner Health, Phoenix: Most Wired
Mayo Clinic Hospital in Arizona, Phoenix: Most Wired
TMC Healthcare, Tucson: Most Wired
Yavapai Regional Medical Center, Prescott: Most Wired
Yuma Regional Medical Center, Yuma: Most Wired

Arkansas
Stone County Medical Center, Mountain View: Most Wired—Small and Rural
Unity Health, Searcy: Most Wired
University of Arkansas for Medical Sciences, Little Rock: Most Wired
White River Medical Center, Batesville: Most Improved

California
Adventist Health, Roseville: Most Wired
Cedars-Sinai Medical Center, Los Angeles: Most Wired Advanced
Children's Hospital Los Angeles, Los Angeles: Most Wired
CHOC Children's Hospital of Orange County, Orange: Most Wired
Community Hospital of the Monterey Peninsula, Monterey: Most Wired
El Camino Hospital, Mountain View: Most Wired
Henry Mayo Newhall Hospital, Valencia: Most Wired
Huntington Hospital, Pasadena: Most Wired
Kaiser Permanente, Oakland: Most Wired
Lucile Salter Packard Children's Hospital / Stanford Children's Health, Palo Alto: Most Wired
Martin Luther King, Jr. Community Hospital, Los Angeles: Most Wired
PIH Health Hospital - Downey, Downey: Most Improved
PIH Health Hospital - Whittier, Whittier: Most Wired
Pomona Valley Hospital Medical Center, Pomona: Most Wired
Sharp HealthCare, San Diego: Most Wired
Stanford Health Care, Stanford: Most Wired
Sutter Health, Sacramento: Most Wired
UC Davis Health, Sacramento: Most Wired
UC San Diego Health, San Diego: Most Wired
University of California, San Francisco, San Francisco: Most Wired
Valley Children's Healthcare, Madera: Most Wired

Colorado
Centura Health, Centennial: Most Wired
Children's Hospital Colorado, Aurora: Most Wired
Denver Health Hospital, Denver: Most Wired
Mt San Rafael Hospital, Trinidad: Most Wired
Parkview Medical Center, Pueblo: Most Wired
SCL Health, Broomfield: Most Wired
University of Colorado Health, Aurora, CO: Most Wired Advanced
Yampa Valley Medical Center, Steamboat Springs: Most Wired

Connecticut
Bristol Hospital, Bristol: Most Wired
Connecticut Children's Medical Center, Hartford: Most Wired
Danbury Hospital, Danbury: Most Wired
Middlesex Hospital, Middletown: Most Wired
Norwalk Hospital, Norwalk: Most Wired
Prospect Waterbury Hospital, Waterbury: Most Wired
Saint Francis Hospital and Medical Center, Hartford: Most Wired
Stamford Hospital, Stamford: Most Wired
The Hospital of Central Connecticut, New Britain: Most Wired
The William W. Backus Hospital, Norwich: Most Wired
Yale New Haven Health System, New Haven: Most Wired

Delaware
Beebe Healthcare, Lewes: Most Wired
Christiana Care Health System, Newark: Most Wired
Nanticoke Health Services, Seaford: Most Wired

Florida
Adventist Health System, Altamonte Springs: Most Wired
Baptist Health South Florida, Coral Gables: Most Wired Advanced
Cancer Treatment Centers of America, Boca Raton: Most Wired
Hendry Regional Medical Center, Clewiston: Most Wired
Indian River Medical Center, Vero Beach: Most Wired
Jackson Health System, Miami: Most Wired
Johns Hopkins All Children's Hospital, St. Petersburg: Most Wired
Jupiter Medical Center, Jupiter: Most Wired
Lakeland Regional Medical Center, Lakeland: Most Wired
Lee Health, Fort Myers: Most Wired
Martin Health System, Stuart: Most Wired
Mayo Clinic Florida, Jacksonville: Most Wired
Memorial Healthcare System, Hollywood: Most Wired Advanced
Mount Sinai Medical Center of Florida, Miami Beach: Most Wired
NCH Healthcare System, Naples: Most Wired
Nemours Children’s Health System, Jacksonville: Most Wired
Nicklaus Children's Hospital, Miami: Most Wired
Orlando Health, Orlando: Most Wired
Sacred Heart Health System, Pensacola: Most Wired
Sarasota Memorial Hospital, Sarasota: Most Wired
Tampa General Hospital, Tampa: Most Wired
UF Health, Gainesville: Most Wired

Georgia
Children's Healthcare of Atlanta, Atlanta: Most Wired
Grady Health System, Atlanta: Most Wired
Navicent Health, Macon: Most Wired Advanced
Northeast Georgia Health System, Gainesville: Most Wired
Piedmont Healthcare, Atlanta: Most Wired
Union General Hospital, Blairsville: Most Improved
WellStar Health System, Marietta: Most Wired
WellStar West Georgia Medical Center, LaGrange: Most Wired

Idaho
Gritman Medical Center, Moscow: Most Wired
St. Joseph Regional Medical Center, Lewiston: Most Improved
St. Luke's Health System, Boise: Most Wired
Syringa Hospital & Clinics, Grangeville: Most Wired

Illinois
Abraham Lincoln Memorial Hospital, Lincoln: Most Wired
Advocate Health Care, Downers Grove: Most Wired
Alexian Brothers Health System, Arlington Heights: Most Improved
Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago: Most Wired
Carle, Urbana: Most Wired
Carle Hoopeston Regional Health Center, Hoopeston: Most Wired
Crawford Memorial Hospital, Robinson: Most Wired
Edward-Elmhurst Health, Naperville: Most Wired
Gottlieb Memorial Hospital, Melrose Park: Most Wired
Hammond-Henry Hospital, Geneseo: Most Wired—Small and Rural
Harrisburg Medical Center, Harrisburg: Most Wired
Hospital Sisters Health System, Springfield: Most Wired
Ingalls Memorial Hospital, Harvey: Most Wired
Loyola University Medical Center, Maywood: Most Wired
McDonough District Hospital, Macomb: Most Wired—Small and Rural
Memorial Medical Center, Springfield: Most Wired
NorthShore University HealthSystem, Evanston: Most Wired
Northwestern Memorial Healthcare, Chicago: Most Wired
OSF Healthcare System, Peoria: Most Wired
Palos Community Hospital, Palos Heights: Most Wired
Richland Memorial Hospital, Olney: Most Wired
Riverside Medical Center, Kankakee: Most Wired
Rochelle Community Hospital, Rochelle: Most Wired
Rockford Memorial Hospital, Rockford: Most Wired
Rush Oak Park Hospital, Oak Park: Most Wired
Rush University Medical Center, Chicago: Most Wired
Taylorville Memorial Hospital, Taylorville: Most Wired
University of Chicago Medicine, Chicago: Most Wired
University of Illinois Hospital & Health Sciences System, Chicago: Most Wired

**Indiana**
Community Health Network, Indianapolis: Most Wired
Deaconess Health System, Evansville: Most Wired
Hancock Regional Hospital, Greenfield: Most Wired
Indiana University Health Blackford Community Hospital, Hartford City: Most Wired
Marion General Hospital, Marion: Most Wired
Memorial Hospital and Health Care Center, Jasper: Most Wired
Parkview Health, Fort Wayne: Most Wired
Reid Health, Richmond: Most Wired
Richard L. Roudebush VA Medical Center, Indianapolis: Most Wired
Rush Memorial Hospital, Rushville: Most Wired
St. Vincent Health, Indianapolis: Most Wired
St. Joseph Health System, Mishawaka: Most Wired
Union Hospital, Terre Haute: Most Wired
Union Hospital Clinton, Clinton: Most Improved
VA Northern Indiana Health Care System, Fort Wayne: Most Wired
Iowa
Broadlawns Medical Center, Des Moines: Most Wired
Fort Madison Community Hospital, Fort Madison: Most Wired
Genesis Health System, Davenport: Most Wired
Grundy County Memorial Hospital, Grundy Center: Most Wired
Mary Greeley Medical Center, Ames: Most Wired
Mercy Medical Center, Cedar Rapids: Most Wired
UnityPoint Health, West Des Moines: Most Wired Advanced
University of Iowa Hospitals and Clinics, Iowa City: Most Wired

Kansas
Lawrence Memorial Hospital, Lawrence: Most Wired
Salina Regional Health Center, Salina: Most Wired
The University of Kansas Hospital, Kansas City: Most Wired
Via Christi Health, Wichita: Most Wired

Kentucky
Baptist Health, Louisville: Most Improved
Ephraim McDowell Health, Danville: Most Wired
Highlands Regional Medical Center, Prestonsburg: Most Wired
King's Daughters Health System, Ashland: Most Wired
Norton HealthCare, Louisville: Most Wired
Our Lady of Bellefonte Hospital, Ashland: Most Wired
St. Claire Regional Medical Center, Morehead: Most Wired—Small and Rural
St. Elizabeth Heathcare, Edgewood: Most Wired
University of Kentucky HealthCare, Lexington: Most Improved

Louisiana
General Health, Baton Rouge: Most Wired
Lafayette General Health, Lafayette: Most Wired
Ochsner Health System, New Orleans: Most Wired Advanced
Opelousas General Health System, Opelousas: Most Wired
Woman’s Hospital, Baton Rouge: Most Wired

Maine
Central Maine Healthcare, Lewiston: Most Wired
Eastern Maine Healthcare System, Brewer: Most Wired
Franklin Memorial Hospital, Farmington: Most Wired—Small and Rural
Maine Medical Center, Portland: Most Improved
Southern Maine Health Care, Biddeford: Most Wired
Maryland
Atlantic General Hospital, Berlin: Most Wired Advanced
Bon Secours Baltimore Health System, Baltimore: Most Wired
Bon Secours Health System, Marriottsville: Most Wired
Frederick Memorial Hospital, Frederick: Most Wired
Johns Hopkins Hospital, Baltimore: Most Wired
MedStar Health, Columbia: Most Wired
Meritus Medical Center, Hagerstown: Most Wired Advanced
Peninsula Regional Medical Center, Salisbury: Most Wired
Union Hospital of Cecil County, Elkton: Most Wired—Small and Rural
Western Maryland Health System, Cumberland: Most Wired

Massachusetts
Baystate Health, Springfield: Most Wired
Berkshire Health Systems, Pittsfield: Most Wired
Beth Israel Deaconess Hospital, Plymouth: Most Wired
Boston Medical Center, Boston: Most Wired
Emerson Hospital, Concord: Most Wired
Hallmark Health System, Melrose: Most Wired
Lahey Health, Burlington: Most Wired
Lowell General Hospital, Lowell: Most Wired
Milford Regional Medical Center, Milford: Most Wired

Michigan
Aleda E. Lutz VA Medical Center, Saginaw: Most Wired
Aspirus Iron River Hospital, Iron River: Most Wired
Aspirus Ironwood Hospital, Ironwood: Most Wired
Aspirus Keweenaw Hospital, Laurium: Most Wired
Aspirus Ontonagon Hospital, Ontonagon: Most Wired
Battle Creek VA Medical Center, Battle Creek: Most Wired
Beaumont Health, Southfield: Most Wired Advanced
Borgess Health, Kalamazoo: Most Improved
Bronson Battle Creek Hospital, Battle Creek: Most Wired
Bronson LakeView Hospital, Paw Paw: Most Wired
Bronson Methodist Hospital, Kalamazoo: Most Wired
Bronson South Haven Hospital, South Haven: Most Improved
Covenant Healthcare, Saginaw: Most Wired
Detroit Medical Center, Detroit: Most Wired
Henry Ford Health System, Detroit: Most Wired Advanced
John D. Dingell (Detroit) VA Medical Center, Detroit: Most Wired
Lakeland Health, St. Joseph: Most Wired
Memorial Healthcare, Owosso: Most Wired
Metro Health, Wyoming: Most Wired
Munson Healthcare, Traverse City: Most Wired
Otsego Memorial Hospital, Gaylord: Most Wired
Sparrow Health System, Lansing: Most Wired
St. John Providence, Warren: Most Wired
St. Joseph Mercy Oakland, Pontiac: Most Wired
St. Mary Mercy Livonia, Livonia: Most Wired
University of Michigan - Michigan Medicine, Ann Arbor: Most Wired
West Shore Medical Center, Manistee: Most Wired—Small and Rural

**Minnesota**
CentraCare Health, Saint Cloud: Most Wired
HealthPartners, Bloomington: Most Wired
Kittson Memorial Healthcare Center, Hallock: Most Wired
Mahnomen Health Center, Mahnomen: Most Wired
Mayo Clinic Hospital, Rochester: Most Wired
Perham Health, Perham: Most Wired
RiverView Health, Crookston: Most Improved
Windom Area Hospital, Windom: Most Wired
Winona Health Services, Winona: Most Improved

**Mississippi**
Forrest General Hospital, Hattiesburg: Most Wired
King's Daughters Medical Center, Brookhaven: Most Wired
North Mississippi Health Services, Tupelo: Most Wired
St. Dominic - Jackson Memorial Hospital, Jackson: Most Wired
University of Mississippi Medical Center, Jackson: Most Wired

**Missouri**
Capital Region Medical Center, Jefferson City: Most Wired—Small and Rural
Carroll County Memorial Hospital, Carrollton: Most Wired—Small and Rural
Children's Mercy Hospital, Kansas City: Most Wired
Citizens Memorial Hospital, Bolivar: Most Wired
CoxHealth, Springfield: Most Wired
Lake Regional Health System, Osage Beach: Most Wired
Mercy, Chesterfield: Most Wired Advanced
Mosaic Life Care, Saint Joseph: Most Wired, Innovator Award—Finalist
Saint Luke's Health System, Kansas City: Most Wired
SSM Health, Saint Louis: Most Wired
Ste. Genevieve County Memorial Hospital, Ste. Genevieve: Most Wired
Truman Medical Centers, Kansas City: Most Wired
University of Missouri Health Care, Columbia: Most Wired, Innovator Award—Winner

Nebraska
Boone County Health Center, Albion: Most Wired
Chadron Community Hospital and Health Services, Chadron: Most Wired—Small and Rural
Children’s Hospital & Medical Center, Omaha: Most Wired
Community Hospital, McCook: Most Wired
Faith Regional Health Services, Norfolk: Most Wired
Nebraska Medicine, Omaha: Most Wired
Nemaha County Hospital, Auburn: Most Wired
Newark Beth Israel Medical Center, Newark: Most Wired
Regional West Medical Center, Scottsbluff: Most Improved

Nevada
Renown Health, Reno: Most Wired

New Hampshire
Concord Hospital, Concord: Most Wired
Exeter Health Resources, Exeter: Most Wired
Littleton Regional Healthcare, Littleton: Most Improved
New London Hospital, New London: Most Wired
Southern New Hampshire Medical Center, Nashua: Most Wired
Valley Regional Hospital, Claremont: Most Wired—Small and Rural

New Jersey
CentraState Healthcare System, Freehold: Most Wired, Innovator Award—Finalist
Children's Specialized Hospital, New Brunswick: Most Wired
Clara Maass Medical Center, Belleville: Most Wired
Community Medical Center, Toms River: Most Wired
Cooper University Health Care, Camden: Most Wired
Englewood Hospital and Medical Center, Englewood: Most Wired
Hackensack Meridian Health, Edison: Most Wired Advanced
HackensackUMC Palisades, North Bergen: Most Wired
Holy Name Medical Center, Teaneck: Most Wired
Inspira Health Network, Bridgeton: Most Wired
Monmouth Medical Center, Long Branch: Most Wired
Monmouth Medical Center Southern Campus, Lakewood: Most Wired
Robert Wood Johnson University Hospital, New Brunswick: Most Wired
Robert Wood Johnson University Hospital Hamilton, Hamilton: Most Wired
RWJ Rahway, Rahway: Most Wired
RWJUH Somerset, Sommerville: Most Wired
Saint Barnabas Medical Center, Livingston: Most Wired
Saint Peter's University Hospital, New Brunswick: Most Wired Advanced
St. Francis Medical Center, Trenton: Most Improved
JFK Medical Center, Edison: Most Wired
Trinitas Regional Medical Center, Elizabeth: Most Wired
University Hospital, Newark: Most Wired
University Medical Center of Princeton, Plainsboro: Most Wired
Valley Health System, Ridgewood: Most Wired
Virtua, Marlton: Most Wired

New Mexico
Artesia General Hospital, Artesia: Most Wired—Small and Rural
Cibola General Hospital, Grants: Most Wired
Presbyterian Healthcare Services, Albuquerque: Most Wired
University of New Mexico Hospitals, Albuquerque: Most Wired
UNM Sandoval Regional Medical Center, Rio Rancho: Most Wired—Small and Rural

New York
Adirondack Health, Saranac Lake: Most Wired
Albany Medical Center, Albany: Most Wired
Auburn Community Hospital, Auburn: Most Wired
Canton-Potsdam Hospital, Potsdam: Most Wired
Catholic Health Services of Long Island, Rockville Centre: Most Wired
Catskill Regional Medical Center, Harris: Most Wired
Harlem Hospital, New York: Most Wired
Huntington Hospital, Huntington: Most Wired
Kaleida Health, Buffalo: Most Wired, Innovator Award—Winner
Lenox Hill Hospital, New York: Most Wired
Long Island Jewish Medical Center, New Hyde Park: Most Wired
Maimonides Medical Center, Brooklyn: Most Wired
Massena Memorial Hospital, Massena: Most Wired
Memorial Sloan Kettering Cancer Center, New York: Most Wired
Montefiore, Bronx: Most Wired
Mount Sinai Health System, New York: Most Wired
NewYork-Presbyterian, New York: Most Wired
North Shore University Hospital, Manhasset: Most Wired
NYC Health + Hospitals/Elmhurst, Elmhurst: Most Wired
NYU Langone Medical Center, New York: Most Wired
Orange Regional Medical Center, Middletown: Most Wired
Plainview Hospital, Plainview: Most Wired
Samaritan Medical Center, Watertown: Most Wired
Southampton Hospital, Southampton: Most Improved
Southside Hospital, Bayshore: Most Wired
St. Joseph's Health, Syracuse: Most Wired
St. Luke's Cornwall Hospital, Newburgh: Most Wired
St. Mary's Healthcare, Amsterdam: Most Wired
Staten Island University Hospital, Staten Island: Most Wired
Stony Brook Medicine, Stony Brook: Most Wired
SUNY Upstate Medical University, Syracuse: Most Wired
Syosset Hospital, Syosset: Most Wired
The Saratoga Hospital, Saratoga Springs: Most Wired
University of Vermont Health Network - Alice Hyde Medical Center, Malone: Most Wired—Small and Rural
Upper Allegheny Health System, Olean: Most Wired
Winthrop-University Hospital, Mineola: Most Wired

**North Carolina**
Cape Fear Valley Health System, Fayetteville: Most Wired
CarolinaHealthCare System, Charlotte: Most Wired Advanced
Carteret Health Care, Morehead City: Most Wired
Duke University Hospital, Durham: Most Wired
FirstHealth of the Carolinas, Pinehurst: Most Wired
Hugh Chatham Memorial Hospital, Elkin: Most Wired
Maria Parham Health, Henderson: Most Wired
Mission Health System, Asheville: Most Wired
Novant Health, Winston-Salem: Most Wired
UNC Health Care, Chapel Hill: Most Wired Advanced
Vidant Health, Greenville: Most Wired
Wake Forest Baptist Medical Center, Winston-Salem: Most Wired
Womack Army Medical Center, Ft. Bragg: Most Improved

**North Dakota**
Altru Health System, Grand Forks: Most Wired Advanced

**Ohio**
Akron Children's Hospital, Akron: Most Wired
Aultman Orrville Hospital, Orrville: Most Wired—Small and Rural
Blanchard Valley Health System, Findlay: Most Wired
Cincinnati Children's Hospital Medical Center, Cincinnati: Most Wired
Fisher-Titus Medical Center, Norwalk: Most Wired
Genesis HealthCare System, Zanesville: Most Wired
Grand Lake Health System / Joint Township District Memorial Hospital, St. Marys: Most Wired
Licking Memorial Hospital, Newark: Most Wired
Magruder Memorial Hospital, Port Clinton: Most Wired
Memorial Health System, Marietta: Most Wired
Memorial Hospital Union County, Marysville: Most Wired
Mercy Health (formerly Catholic Health Partners), Cincinnati: Most Wired Advanced
Nationwide Children's Hospital, Columbus: Most Wired, Innovator Award—Finalist
OhioHealth Doctors Hospital, Columbus: Most Wired
OhioHealth Dublin Methodist Hospital, Dublin: Most Wired
OhioHealth Grady Memorial Hospital, Delaware: Most Wired
OhioHealth Grant Medical Center, Columbus: Most Wired
OhioHealth Hardin Memorial Hospital, Kenton: Most Wired
OhioHealth Marion General Hospital, Marion: Most Wired
OhioHealth MedCentral Mansfield Hospital, Mansfield: Most Wired
OhioHealth Riverside Methodist Hospital, Columbus: Most Wired
OhioHealth Shelby Hospital, Shelby: Most Wired
Premier Health, Dayton: Most Wired
Summa Health, Akron: Most Wired
The MetroHealth System, Cleveland: Most Wired
The Union Hospital Association, Dover: Most Improved
The Wexner Medical Center at The Ohio State University, Columbus: Most Wired
TriHealth, Cincinnati: Most Wired
UC Health, Cincinnati: Most Wired
University Hospitals, Cleveland: Most Wired
Western Reserve Hospital, Cuyahoga Falls: Most Wired—Small and Rural
Wood County Hospital, Bowling Green: Most Wired

**Oklahoma**
Duncan Regional Hospital, Duncan: Most Wired
Oklahoma Heart Hospital, Oklahoma City: Most Improved
Oklahoma Heart Hospital, South, Oklahoma City: Most Improved
St John Health System, Tulsa: Most Wired
Stillwater Medical Center, Stillwater: Most Wired—Small and Rural

**Oregon**
Columbia Memorial Hospital, Astoria: Most Wired
Grande Ronde Hospital, La Grande: Most Wired—Small and Rural

**Pennsylvania**
Abington Hospital, Abington: Most Wired
Allegheny General Hospital, Pittsburgh: Most Wired
Aria - Jefferson Health, Philadelphia: Most Wired
Doylestown Hospital, Glenside: Most Wired
Excelsa Health, Greensburg: Most Wired
Forbes Regional Hospital, Monroeville: Most Wired
Geisinger Health System, Danville: Most Wired Advanced
Grand View Health, Sellersville: Most Wired
Heritage Valley Health System, Beaver: Most Wired
Holy Redeemer Health System, Meadowbrook: Most Wired
Lehigh Valley Health Network, Allentown: Most Wired Advanced, Innovator Award—Winner
Main Line Health, Bryn Mawr: Most Wired
Penn Medicine / Lancaster General Health, Lancaster: Most Wired
Pocono Medical Center, East Stroudsburg: Most Improved
Saint Vincent Hospital, Erie: Most Wired
St. Clair Hospital, Pittsburgh: Most Wired
St. Luke's University Health Network, Bethlehem: Most Wired
Susquehanna Health, Williamsport: Most Wired
The Children's Hospital of Philadelphia, Philadelphia: Most Wired
The Guthrie Clinic, Sayre: Most Wired
University of Pennsylvania Health System - Penn Medicine, Philadelphia: Most Wired
UPMC, Pittsburgh: Most Wired
Western Pennsylvania Hospital, Pittsburgh: Most Wired

Rhode Island
South County Health, Wakefield: Most Wired—Small and Rural

South Carolina
AnMed Health, Anderson: Most Wired
Beaufort Memorial Hospital, Beaufort: Most Wired
Bon Secours St Francis Health System, Greenville: Most Wired
Lexington Medical Center, West Columbia: Most Wired
Palmetto Health, Columbia: Most Wired
Pelham Medical Center, Greet: Most Wired
Spartanburg Regional Healthcare System, Spartanburg: Most Wired

South Dakota
Avera Health, Sioux Falls: Most Wired Advanced
Community Memorial Hospital, Burke: Most Wired
Sanford Health, Sioux Falls: Most Wired
Winner Regional Healthcare Center, Winner: Most Wired
**Tennessee**
Covenant Health, Knoxville: Most Wired
HCA, Nashville: Most Wired
IASIS Healthcare, Franklin: Most Wired
Methodist Le Bonheur Healthcare, Memphis: Most Wired
Mountain States Health Alliance, Johnson City: Most Wired
Saint Thomas West Hospital, Nashville: Most Wired
University of Tennessee Medical Center, Knoxville: Most Wired
Vanderbilt University Medical Center, Nashville: Most Wired
Wellmont Health System, Kingsport: Most Wired
West Tennessee Healthcare, Jackson: Most Wired

**Texas**
Brooke Army Medical Center, Fort Sam Houston: Most Wired
Children's Health System of Texas, Dallas: Most Wired Advanced
CHRISTUS Health, Irving: Most Wired
CHRISTUS Trinity Mother Frances Health System, Tyler: Most Wired
Cook Children's Medical Center, Fort Worth: Most Wired
ETMC Regional Healthcare System, Tyler: Most Wired
Harris Health System, Houston: Most Wired
Hendrick Health, Abilene: Most Wired
Houston Methodist, Houston: Most Wired
Memorial Hermann Healthcare System, Houston: Most Wired
Methodist Health System, Dallas: Most Wired
North Cypress Medical Center, Cypress: Most Wired
Parkland Health & Hospital System, Dallas: Most Wired
Seton Healthcare Family, Austin: Most Wired
Swisher Memorial Healthcare System, Tulia: Most Wired
Texas Children's, Houston: Most Wired
Texas Health Resources, Arlington: Most Wired
The University of Texas MD Anderson Cancer Center, Houston: Most Improved
The University of Texas Medical Branch, Galveston: Most Wired
UMC Health System, Lubbock: Most Wired
United Regional Health Care System, Wichita Falls: Most Wired
University Health System, San Antonio: Most Wired
University of Texas Southwestern Medical Center, Dallas: Most Wired

**United Kingdom**
Cambridge University Hospitals NHS Foundation Trust, Cambridge: Most Wired
Utah
Intermountain Healthcare, West Valley: Most Wired
University of Utah Health Care, Salt Lake City: Most Wired Advanced

Vermont
North Country Hospital and Health Center, Newport: Most Improved
Northwestern Medical Center, Saint Albans: Most Wired
Porter Medical Center, Middlebury: Most Wired
Rutland Regional Medical Center, Rutland: Most Wired

Virginia
Bon Secours Virginia Health System, Richmond: Most Wired
Carilion Clinic, Roanoke: Most Wired
Centra Health, Lynchburg: Most Wired
Mary Washington Healthcare, Fredericksburg: Most Wired
Riverside Health System, Newport News: Most Wired Advanced
Sentara Healthcare, Norfolk: Most Wired
Twin County Regional Healthcare, Galax: Most Wired—Small and Rural
Valley Health System, Winchester: Most Wired
Virginia Hospital Center, Arlington: Most Wired

Washington
Coulee Medical Center, Grand Coulee: Most Wired
Jefferson Healthcare Medical Center, Port Townsend: Most Wired—Small and Rural
Lake Chelan Community Hospital, Chelan: Most Wired
Lincoln Hospital & North Basin Medical Clinics, Davenport: Most Wired
Madigan Army Medical Center, Tacoma: Most Wired
Mason General Hospital and Family of Clinics, Shelton: Most Wired
Mid-Valley Hospital, Omak: Most Wired
MultiCare Health System, Tacoma: Most Wired
Newport Hospital and Health Services, Newport: Most Wired
Odessa Memorial Healthcare Center, Odessa: Most Wired
Othello Community Hospital, Othello: Most Wired
Overlake Medical Center, Bellevue: Most Wired
Pullman Regional Hospital, Pullman: Most Wired
Samaritan Healthcare, Moses Lake: Most Wired
St. Luke’s Rehabilitation Institute, Spokane: Most Wired
Sunnyside Community Hospital, Sunnyside: Most Wired
Tri-State Memorial Hospital, Clarkston: Most Wired
UW Medicine/Northwest Hospital & Medical Center, Seattle: Most Improved
UW Valley Medical Center, Renton: Most Wired
Virginia Mason Medical Center, Seattle: Most Wired
Whitman Hospital and Medical Center, Colfax: Most Wired

West Virginia
Camden Clark Medical Center, Parkersburg: Most Wired
United Hospital Center, Bridgeport: Most Wired
West Virginia University Hospitals, Morgantown: Most Wired Advanced
WVU Medicine University Healthcare - Berkeley Medical Center and Jefferson Medical Center, Martinsburg: Most Wired Advanced

Wisconsin
Agnesian HealthCare, Fond du Lac: Most Wired
Ascension | Calumet Medical Center, Chilton: Most Wired
Ascension | Mercy Medical Center, Oshkosh: Most Wired
Ascension | St. Elizabeth Hospital, Appleton: Most Wired
Ascension | Saint Clare's Hospital, Weston: Most Wired
Aspirus Langlade Hospital, Antigo: Most Wired
Aspirus Medford Hospital, Medford: Most Wired
Aspirus Riverview Hospital, Wisconsin Rapids: Most Wired—Small and Rural
Aspirus Wausau Hospital, Wausau: Most Wired
Aurora Health Care (AHC), Milwaukee: Most Wired
Columbia St. Mary's Hospital, Milwaukee: Most Wired
Fort HealthCare, Fort Atkinson: Most Wired
Froedtert Health & the Medical College of Wisconsin, Milwaukee: Most Wired
Gundersen Health, La Crosse: Most Wired
Holy Family Memorial, Manitowoc: Most Wired
Mayo Clinic Health System - NWWI, Eau Claire: Most Wired
Mercy Health System, Janesville: Most Wired
Osceola Medical Center, Osceola: Most Wired
ProHealth Care, Waukesha: Most Wired Advanced
ThedaCare, Appleton: Most Wired
Tomah Memorial Hospital, Tomah: Most Wired—Small and Rural
Watertown Regional Medical Center, Watertown: Most Wired

Wyoming
Cheyenne Regional Medical Center, Cheyenne: Most Wired
Sheridan Memorial Hospital, Sheridan: Most Wired
Star Valley Medical Center, Afton: Most Wired
West Park Hospital District, Cody: Most Wired
You are invited to a ribbon cutting and open house as we celebrate the opening of our NEW Eubank Clinic.

**WHEN:** Friday, August 4, 2017 – 9:30-11:30a.m. Ribbon Cutting at 10:00a.m.

**WHERE:** 2130 Eubank Blvd NE
Albuquerque, NM 87112

Refreshments will be provided.
CONSENT / APPROVAL ITEMS
APPROVAL OF THE MINUTES
Governor Richardson’s Health Care Summit on the

University of New Mexico Health Sciences Center

Held December 5, 2005 in Albuquerque, New Mexico

I. Introduction

The Honorable Bill Richardson, Governor of the State of New Mexico called upon the Regents of the University of New Mexico to conduct a special statewide summit to address the way in which UNM Hospital (UNMH) is fulfilling its public health mission and the funding crisis that is threatening the UNM Health Sciences Center (HSC). Two hundred thirty people participated (and 170 observed) on December 5, 2005 to share perspectives and seek consensus on the first draft of a collaborative plan that will have broad support.

The health care challenges in New Mexico are well known. There are an estimated 150,000 medically uninsured residents in the four counties comprising central New Mexico; including Bernalillo, Valencia, Sandoval and Torrance counties. In Bernalillo County, approximately 100,000 people have no health insurance coverage. That rate is growing by about two percent per year. Health care coverage options are limited for low-income individuals and whose employers do not offer insurance plans (34%). The unemployment rate in Bernalillo County is 4.8%. Risk factors and chronic disease rates rise as income and education levels fall. The highest income disparities and dropout rates are in the Southeast Heights and South Valley of Bernalillo County. Those two quadrants have the highest adult and infant death rates and highest rates of asthma, hepatitis, and HIV/AIDS. They also have the highest number of visits to UNMH, primarily to the emergency room.

The UNM HSC’s financial report presented at the Summit showed that the cost of uncompensated care in fiscal year 2005 was $131,267,834 which is $44,876,287 in excess of funds directly allocated for uncompensated care. The uncompensated care is provided by UNMH and the School of Medicine (SOM) faculty, who are the doctors for UNMH. Additional public funds are needed to adequately address the current public mission. Funding to cover the current uncompensated care gap must be addressed, as well as support to build capacity for future needs.

II. Pathways to Progress

The Academic Health Center at UNM is called the UNM Health Sciences Center. The clinical enterprise of the UNM HSC is made up of the UNMH and the SOM. The mission of the UNM HSC is to improve the health of our communities and significantly contribute to the public welfare of the larger society in which the UNM HSC resides. The UNM HSC does this in a way that sets it apart from all other entities and individuals committed to the same goal through a distinctive social mission and delivery of unique public goods:

1. Caring for vulnerable populations—due to the nature of their medical condition or their socio-geo-economic circumstances—with a special commitment for Bernalillo County indigents and Native Americans.

2. Producing the next generation of health professionals.

3. Conducting research intended to advance the health of the public through discoveries in the laboratory and translating these to cutting-edge clinical practices as well as designing and
managing new and innovative approaches to the delivery of healthcare services through health systems, outcomes and preventive medicine research.

4. Assuming a leadership role in improving health by providing guidance to policy makers in the public health and medical arenas, e.g., health disparities, responses to public health threats and ethical issues arising in health care, research and education.

At the Summit, the UNM HSC demonstrated its commitment to addressing concerns raised by Bernalillo County, the Community Coalition for Health Care Access and other advocacy groups and individuals. Executive Vice President for Health Sciences, Dr. Paul Roth, announced several policy changes and new initiatives, including:

1. Replacing the old UNMH self-pay policy requiring a 50-percent down payments with one that has the same down payments as the co-payments for UNMCare patients, thereby helping needy New Mexicans who have no reasonable alternative for their care;

2. Changing the payment/collection policy so that payment plans for self-pay patients will be appropriate to each person’s financial situation;

3. Improving the availability of interpreter services 24/7 through various means, including hiring a consultant to study UNMH’s interpreter services, and agreeing to consider the recommendations of the consultant;

4. Improving HSC UNMH/SOM relations with the community by creating an Office of Community Affairs that will report directly to the HSC Executive Vice President, by initiating the search for a director of the office, and by establishing a Community Affairs Advisory Council to advise the HSC Executive Vice President;

5. Providing transparent and regular financial information and engaging in ongoing discussions with stakeholders about financial trends and issues affecting the HSC UNMH/SOM and the constituencies they serve.

During the Governor’s address at the Summit he made a commitment to insure every child under the age of five, and to restore the 12-month Medicaid Certification.

III. Principles that Guide Recommendations

While participants represented a diversity of interests, all agreed that the UNM HSC, through the UNMH and SOM, plays a critical role in bringing health to all New Mexicans and that action is required to avert a looming crisis. The current fragmented nature of the U.S. system of health care provision and funding has created a set of conditions in which a single solution to health care issues we are facing locally is not viable. Creating and implementing a system of solutions will require broad input, participation, and commitment. The recommendations that follow acknowledge the following principles that emerged during the Summit:

1. Healthcare is a basic human right. Participants agreed that all New Mexico residents deserve good health care, regardless of their ability to pay for it, or immigration status.

2. The UNM HSC has a special obligation to Native Americans. Along with its obligation to Bernalillo County, the UNM HSC has a special obligation to provide healthcare to Native Americans.
3. The UNM HSC can only serve the public good when it does so in partnership with the public. The challenges currently faced by UNM HSC cannot be understood and resolved by UNM HSC alone. The social, cultural, and economic situations of the people in our state who are not receiving adequate healthcare due to lack of resources differ greatly.

4. The UNM HSC receives public funds and must be accountable to the public.

5. Statewide solutions are integral to resolving the issues. The communities served by the UNM HSC extend well beyond the four-county central New Mexico area and include some of the state’s most fragile populations. UNMH is the only public hospital in the four counties comprising central New Mexico and 45% of the state’s population. The unique mission of the UNM HSC has left this institution scrambling to provide care and pay for the cost of care. The challenge of uncompensated care is real. The growing funding gap is not sustainable. New Mexico is a state that can invest in a way that is fiscally responsible and that secures sustainable revenue sources for the UNM HSC.

IV. Summit Recommendations

The recommendations are compiled from the reports of each of the 23 tables, with approximately 10 people at each table. Any recommendation that was made by at least 20% of the tables has been included in this report. Recommendations are arranged by the questions considered during the Summit.

Question One Recommendations

How can coverage be provided to more patients?

1 A. Expand the Medicaid rolls in our state by increasing eligibility and outreach.

Almost all of the tables discussed ways in which Medicaid directly impacts UNMH and how UNMH will benefit if the number of New Mexicans who have Medicaid health care coverage is maintained or increased. Because Medicaid involves a three-to-one match in federal dollars, there was an overall group consensus that increasing the number of New Mexican families with Medicaid will have a positive impact on UNMH’s budget. Some tables made specific recommendations, shown here as 1B, 1C, 1D.

1 B. Eliminate Medicaid Auto Closure.

The current auto-closure system in Medicaid has resulted in tens of thousands of New Mexicans experiencing a lapse in their Medicaid health care coverage. Thirteen tables recommended eliminating the current auto-closure system.

1 C. Require 12-Month Medicaid Re-certification.

Change the six-month re-certification requirement to a 12-month recertification requirement in order to be less burdensome for poor families. Eleven tables recommended this change.
1 D. **Include Parents of Children up to 100% FPL for Medicaid Eligibility.**

Change the Medicaid eligibility criteria to include parents of children up to 100% of the federal poverty level. Seven tables recommended this change.

1 E. **Expand UNMCare outreach.**

Fourteen tables recommended expanding the UNMCare Program by increasing outreach. Many participants acknowledged that this good program could be expanded to include more Bernalillo County residents so they have health care coverage in a cost efficient way. Several tables recommended that UNMCare be expanded to all residents of Bernalillo County regardless of immigration status.

1 F. **Remove the current cap imposed on UNMH for State Coverage Insurance and expand SCI.**

Ten tables recommended removing the current cap imposed on UNMH for State Coverage Insurance and expanding SCI.

1 G. **Provide State-sponsored Universal Health Care.**

Nine tables recommended providing universal health care coverage through a state-wide program and recognized that this would solve UNM HSC’s financial problems.

1 H. **Expand Emergency Medical Services for Aliens. (EMSA)**

Five tables recommended that the Human Services Department policies be revised so that all emergent and routine labor and delivery services for undocumented women are covered.

**Question Two Recommendations**

What new and/or improved opportunities exist for the UNM HSC to meet the medical needs of indigents, self-paying patients, and Urban Indians?

In addition to Recommendations 1A through 1H above, which the participants recognized would provided new and improved opportunities for UNM HSC to serve Bernalillo County’s and the surrounding counties’ indigents, self-paying patients and Urban Indians, the participants made the following recommendations:

2 A. **Fulfill the intent of the 1952 contract regarding priority service at UNMH for Native Americans.**

Summit participants recognized that the UNM HSC has a special obligation to Native Americans, especially those who live in urban areas in the four-county region. Summit participants recommended that the UNM HSC provide leadership in working with Native Americans, including urban Indians, to assure that the intent of the contract is fulfilled.
2 B. Improve Interpretation and Translation Services at UNMH.

Six tables recommended that interpretation and translation services be improved to ensure that all non-English speaking patients have qualified interpreters available at every stage of their visit to UNMH. This includes interpretation and translation for financial assistance, billing and in the business office.

*Question Three Recommendations*

**What is the HSC’s responsibility to the four-county region and the state? How can the HSC fulfill this responsibility? (or, Where will the funding come from?)**

There was broad recognition at the summit that UNM HSC, through the UNMH and SOM, is a statewide public safety-net facility. Consequently, increased public funding is needed to cover the growing gap in uncompensated care, which totaled $45 million in fiscal year 2005. Because of its unique social mission and delivery of services available only at UNM HSC, participants responded to the question of: Where will the funding come from?

3 A. Create a state-wide gross receipts tax.

Thirteen tables recommended creating a statewide gross receipts tax.

3 B. Increase the number of people on Medicaid.

Eleven tables recommended increasing the number of people on Medicaid in order to pull in more federal Medicaid dollars at a three to one match.

3 C. Earmark a Portion of State Gaming Compact Funds for Urban Indian Health Care.

Seven tables recommended earmarking a portion of state revenues from gaming compact funds for Urban Indian health care.

3 D. County Mill Levy

Six tables recommended that each county create a mill levy to leverage funds for indigent care at the UNM HSC.

*Question Four Recommendations*

**How can the UNM HSC enhance its financial reporting and accountability to the public regarding the patient care mission?**

4 A. Develop an Accountability Report to be provided by the UNM HSC.

Sixteen tables recommended that UNM HSC provide to the public a report (on an annual, semi-annual or quarterly basis) detailing information which would include funding for indigent care, how money is spent on indigent care, and performance in specific programs.
4 B. Establish an Office of Community Affairs.

Fourteen tables recommended that an Office of Community Affairs be established to advocate for patient access to care and accountability at UNMH. This office would be a vehicle for community input into significant UNMH decision making.

V. Health Care Summit Background

The Governor's Request

In a letter dated July 19, 2005, to the University of New Mexico Board of Regents, Governor Bill Richardson expressed his desire to address issues and concerns raised by Bernalillo County, the Community Coalition for Healthcare Access, UNM Health Sciences faculty and staff, and other advocacy groups and individuals that UNMH is not fulfilling its public health mission and is putting financial concerns ahead of the needs of the people it serves.

The Governor recognized the delicate financial balancing act that UNMH/SOM and other public hospitals are forced to perform to attempt to meet the healthcare needs of the population while remaining fiscally viable. He acknowledged the UNM HSC's challenge of providing uncompensated care in the face of 400,000 uninsured New Mexicans. "However, the bottom line remains that these financial challenges must not improperly limit the public's access to needed healthcare, regardless of the ability to pay," the Governor further stated in his July 19, 2005 letter.

The Governor called upon UNMH and the HSC to open its books and be completely transparent regarding its fiscal performance and strategic plans. He asked that the Summit study the issue of uncompensated care and bring forth recommendations to address the gap between the costs and the public revenue allocated for this purpose, provide a clear explanation of the financial performance, and provide for public input into the hospital's management.

The Regent's Sub-committees

To that end, the Regents appointed two subcommittees to review the financial reports and to set the agenda for the Summit. The subcommittees met in September, October and November of 2005. The summit was held on December 5, 2005 in Albuquerque, New Mexico. The subcommittees represented a diversity of interests.

The Finance Subcommittee met on numerous occasions and sifted through numerous financial reports, spreadsheets and cost-to-charge ratios. This subcommittee affirmed its commitment to the core mission of the UNM HSC and urged that UNMH/SOM be an accessible, affordable, accountable and quality health care provider for the residents of the State of New Mexico, regardless of their financial status. Furthermore, the subcommittee passed a resolution preliminarily concuring with the UNM HSC's financial report for the purposes of the summit showing that the cost of uncompensated care in fiscal year 2005 was $131,267,834 which is $44,876,287 in excess of funds directly allocated for uncompensated care.

This gap threatens the financial viability of the UNM HSC. The subcommittee's resolution also recommended that the Regents adopt a resolution agreeing to provide to the public, including the NM Center of Law and Poverty and the Community Coalition for Health Care Access, the type of information described in the Governor's July 19, 2005 letter, including an annual report card analysis of uncompensated care. (This was passed by the Regents in 2005)
The UNM HSC’s Obligation to Bernalillo County Residents and Native Americans

All agreed that the UNM HSC has a de facto mission as a statewide safety net hospital, because of its status as the state’s only Level 1 Trauma center and because it offers specialty care not available elsewhere. In addition, UNMH is the only public hospital in the four counties region comprising central New Mexico and 45% of the state’s population.

UNMH has an even greater role to the residents of Bernalillo County, including those who are Native American, under a three-party lease agreement with Bernalillo County and the Department of the Interior in federal trust obligation for Native Americans. This lease requires the county to levy taxes for the hospital, subject to voter approval, and obligates the hospital to care for indigent residents at the same level that it provides care to patients with third-party payment sources.

Approaches to Health Care Coverage

There are several approaches to providing health care coverage that can be built upon. In 2003, some 65,000 children were enrolled in Medicaid, which is approximately 65% of those eligible. In addition, about 14,000 financially eligible adults were enrolled in UNMCare, a program designed to provide managed care for low-income and indigent county residents. This represents 14% of the 100,000 adults who may be financially eligible for UNMCare. The UNM State Coverage Insurance is a new opportunity to provide health care coverage to 3,500 low-income adults. All three of these programs should be expanded to help provide uninsured New Mexicans with health care and to address the problems of uncompensated care at UNM HSC, as well as other health care institutions.

Summit Methodology

The summit was divided into three segments. The first segment, in the morning, framed the issues from the perspective of state legislative leaders, Bernalillo County, UNM leadership, the Community Coalition for Healthcare Access, the Urban Indian community and patient advocacy organizations.

The second segment, in the afternoon, was small group dialogue among participants. Twenty-three tables of 10 participants each, discussed the same four questions. Each table had a facilitator and a scribe. The questions addressed were as follows:

How can coverage be provided to more patients? How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?

What new and/or improved opportunities exist for the HSC to meet the medical needs of indigents, self-paying patients and urban Indians? How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?

What is the HSC’s responsibility to the four-county region and the state and how can the HSC fulfill this responsibility? How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?
How can the HSC enhance its financial reporting and accountability to the public regarding the patient-care mission. How can we pay for the approaches and solutions we propose? How can we as a community work together to make it happen?

The third segment, at the end of the day, was a reporting of consensus findings and suggestions from individual tables to the plenary session. These findings were typed into a computer and projected on a large screen so that participants could read what was being said. This text can be found in the appendix of this document.
Effect of high up front charges on access to surgery for poor patients at a public hospital in New Mexico
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Published: 23 June 2006 Received: 02 August 2005 Accepted: 23 June 2006
This article is available from: http://www.equityhealthj.com/content/5/1/6
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Abstract

Background: A public hospital in New Mexico required collection of 50% of estimated costs prior to elective surgeries for self-pay patients. This study assesses the impact of this policy on access to elective surgical procedures.

Methods: Chi-square tests determined if there was a statistically significant difference between the number of self-pay and insured patient cancellations for financial reasons. A multivariate binomial regression model was used to calculate risk ratios and confidence limits for effects of race/ethnicity, and insurance status, controlling for gender, on these cancellations.

Results: Of the 667 cancellations, there were 99 self-pay and 568 insured patients. Cancellations for financial reasons occurred in 55.6% of self-pay and 9.3% of insured patients (p < 0.0001). Inability to pay 50% up front accounted for 76.4% of self-pay patient cancellations for financial reasons. Self-pay, non-Hispanic whites and minority race/ethnicities were 8.76 and 8.61 times more likely to cancel for financial reasons, respectively, than insured non-Hispanic whites.

Conclusion: Self-pay patients, regardless of race/ethnicity, have elective surgical procedures cancelled for financial reasons significantly more often than insured patients. The hospital's 50% up-front payment policy represents a significant financial barrier to accessing elective surgical procedures for self-pay patients.

Background

There are approximately 45 million people without health insurance in the United States [1]. The problem of the uninsured is one of special relevance to New Mexico, which ranks 2nd in the percent of the total state population that is uninsured and 5th in the percent of children 18 years old and younger who are uninsured [2]. Ethnic and racial minorities are medically uninsured at a higher rate than the national average [3]. In addition, a 2003 Institute of Medicine review of the literature on disparities in quality and access to health care, found that even when minorities are insured at the same level as whites, they may experience barriers to accessing care due to language, geography, and cultural familiarity. This review also found that the financial and institutional arrangements of health systems along with their legal, regulatory, and policy environments may have disparate and negative effects on minorities' ability to attain quality care [4].
The majority of New Mexicans are ethnic or racial minorities, 42.1% Hispanic, 9.5% Native American and 1.9% African American [5]. The majority of uninsured both nationally and in New Mexico are working individuals and their families who do not receive employer-based coverage, do not make enough money to buy their own health insurance, and make too much money to qualify for Medicaid (a federal program operated by the states to help pay costs for the very poor and financially needy citizens). A substantial portion of the uninsured population, especially in a U.S.-Mexico Border state like New Mexico are undocumented immigrants who, legally, are not eligible for federal or state entitlement programs like Medicare or Medicaid. Fearing arrest and deportation, many in this population avoid registering at clinics for basic and preventive services, leaving them vulnerable to preventable, but serious illnesses for which they subsequently seek expensive, crisis care in emergency rooms.

Over 70 percent of uninsured Americans are in families where there is at least one full-time worker; 12 percent are in families with part-time workers; and only 19 percent are in families with no connection to the workforce [6]. Without any third-party reimbursement available to help pay for needed health care, the uninsured are often forced to pay for the entire cost. This is difficult, if not impossible, for many, and carries with it financial- and health-related consequences. These consequences are compounded by the fact that the uninsured pay more for their health care at the time of service than those who are insured.

Medicare is a federal program that assists almost all elderly people and many disabled in paying their medical costs. Hospital administrators are often confused by federal Medicare regulations, and assume that they must charge all payers the same amount of money for the same services. They are unaware that they are permitted to discount services for the uninsured and for those who do not qualify for public assistance. Insurance companies and other third-party payers, like Medicaid and Medicare, negotiate discounts for their clients, while uninsured patients continue to pay the full, non-discounted rates [7]. This phenomenon is reflected in the way a public hospital in New Mexico billed "self-pay" patients, meaning those who have no third party to help pay the cost of their medical expenses. The policy stated that for self-pay patients receiving elective surgeries and admissions, "...it is the policy ... to collect 50% of estimated charges at time of service and bill patients for remaining reasonable and customary charges."

This study was undertaken to explore the impact of this 50% up-front fee policy for self-pay patients on access to medical care. The authors explored whether cancellations of elective surgical procedures were more often related to financial reasons for self-pay patients than for insured patients.

Methods

The authors reviewed records of patients who cancelled elective surgical procedures at the public hospital between March 1 and December 31, 2003. The term "elective surgery" refers to any surgery that is not an emergency. An elective surgery can be anything from a cosmetic rhinoplasty to a cholecystectomy for chronic biliary disease, to open reduction and internal fixation of a fractured limb. These records were available at the Hospital Admissions Department in paper form. Data collection was performed in person by two of the authors (WK, ASC) in the hospital admissions office between January 12th and February 6th, 2004. The data were collected initially as an internal review for the department of hospital admissions and later analyzed by the authors once the study was approved by the University’s Human Research and Review Committee.

All records listing the scheduled date of the cancelled procedure were included. The following information was recorded in a Microsoft Excel spreadsheet: race/ethnicity, age, financial code, reason for cancellation as recorded by Admission Department staff, and, when recorded, procedure being cancelled. Financial codes designate the insurance status of the patients. Reasons for cancellation were categorized as "financially related," "not financially related," and "unknown." A cancellation was categorized as "financially related" if the reason for cancellation was due to an inability to pay any upfront charge, any refusal by the patient’s insurance company to approve a procedure, or a cancellation due to a patient’s insurance status pending approval. All other recorded reasons for cancellation were categorized as "not financially related." The vast majority of cancellations that were not financially related were due either to patients not keeping their surgical appointment or to the patient or physician changing the schedule. All cancellations for which there was no recorded reason for cancellation were categorized as "unknown."

The amount of the down payment was calculated and recorded on cancellation records by the Admissions Department staff. In order to keep the records confidential and ensure that there were no errors in data collection, the authors assigned a unique number, unrelated to the medical record number, to each record form. The research protocol was reviewed and approved by the Human Research and Review Committee at the University of New Mexico Health Sciences Center.

Before data collection began, the estimated total number of cancellations in our sample was 760, with an estimated
100 self-pay cancellations and insured cancellations of 600. These sample sizes gave us 80% power for detecting a difference between payment groups if 33% of the self-pay patients cancel for financial reasons and 20% of the insured patients cancel for financial reasons. We used the chi-square test to determine if there was a statistically significant difference in reasons for cancellation between self-pay and insured patients. A multivariate binomial regression model was used to calculate risk ratios and confidence limits for the effects of race/ethnicity, and insurance status, controlling for gender, on cancellation for financial reasons. Calculations were done using SAS Version 8.2.

Results
During the study period, there were 667 patient cancellations recorded. Of these, 99 (14.8%) were self-pay and 568 (85.2%) were insured patients, including patients receiving county assistance. Of the cancellations, 55.6% (n = 55) of those for self-pay patients were for financial reasons compared to 9.3% (n = 53) for insured patients (p < 0.0001) (Table 1). Of patients who cancelled for financial reasons, inability to pay the 50% "up-front" fee was the reason given for 76.4% (n = 42) of self-pay patients.

There were a substantial number of cancellations for unknown reasons within the insured group (43.3%, n = 246) compared to the self-pay group (10.1%, n = 10). Therefore, a sub-analysis was performed which combined the unknown reasons for cancellation and the financial reasons for cancellation for each group of patients. In this analysis, 65.7% (n = 65) of self-pay patients had unknown or financial reasons for cancellation compared to 52.6% (n = 299) of insured patients. This difference remained statistically significant (p = 0.02) (Table 1).

The multivariate analysis showed that insured minority race/ethnicity patients were 2.82 times more likely to cancel elective surgeries for financial reasons than insured non-Hispanic whites (p = 0.004). However, self-pay minority race/ethnicity patients were 8.61 times more likely (p < 0.0001) to cancel elective surgeries for financial reasons than insured non-Hispanic white insured patients. And self-pay non-Hispanic whites were 8.76 times (p < 0.0001) more likely to cancel than insured non-Hispanic whites (Table 2).

Discussion
Our findings add to the literature on barriers to health care access faced by the medically uninsured. Compared to the insured, the uninsured are less likely to have a regular source of care, more likely to delay care, and less likely to report not receiving needed care [8]. Except for cases of severe trauma, the uninsured, compared to the insured, are less likely to be admitted to the hospital after being seen in the emergency room, are less likely to undergo recommended elective procedures, and are more than twice as likely to die in the hospital. Overall, the uninsured are less healthy and have a higher relative risk of death than the insured [9].

Table 1: Reasons for cancellation by payment category and demographic characteristics.

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<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Reason for cancellation</th>
<th>Chi-square p-values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Non-financial</td>
<td>Unknown</td>
</tr>
<tr>
<td>Payment category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured</td>
<td>568</td>
<td>269 (47.4%)</td>
<td>246 (43.3%)</td>
</tr>
<tr>
<td>Self-pay</td>
<td>99</td>
<td>34 (34.3%)</td>
<td>10 (10.1%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18</td>
<td>96</td>
<td>42 (43.8%)</td>
<td>40 (41.7%)</td>
</tr>
<tr>
<td>18–39</td>
<td>202</td>
<td>79 (39.1%)</td>
<td>78 (38.6%)</td>
</tr>
<tr>
<td>40–64</td>
<td>286</td>
<td>142 (49.6%)</td>
<td>107 (37.4%)</td>
</tr>
<tr>
<td>≥65</td>
<td>83</td>
<td>40 (48.2%)</td>
<td>31 (37.4%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>345</td>
<td>164 (45.0%)</td>
<td>108 (33.5%)</td>
</tr>
<tr>
<td>Female</td>
<td>322</td>
<td>139 (40.3%)</td>
<td>148 (42.9%)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>198</td>
<td>102 (51.5%)</td>
<td>79 (39.9%)</td>
</tr>
<tr>
<td>Other race/ethnicity</td>
<td>468</td>
<td>201 (43.0%)</td>
<td>177 (37.8%)</td>
</tr>
</tbody>
</table>

1Non-financial reasons compared to the combination of unknown and financial reasons.
Table 2: Multivariate risk ratios and 95% confidence limits for cancelling for financial reasons. (This table compares financial reason to non-financial reason for cancellation while controlling for gender)

<table>
<thead>
<tr>
<th>Variable</th>
<th>RR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment source and race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured and Non-Hispanic white</td>
<td>1.00</td>
<td>0.004</td>
</tr>
<tr>
<td>Insured and other race/ethnicity</td>
<td>2.82 (1.38, 5.77)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Self-pay and Non-Hispanic white</td>
<td>8.76 (4.09, 18.80)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Self-pay and other race/ethnicity</td>
<td>8.61 (4.34, 17.08)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

It has been well documented that insurance companies, along with Medicare and Medicaid, negotiate with hospitals for significant discounts when paying for the services of the patients that they cover [10]. One study of all hospitals in Illinois estimated that hospital charges were discounted about 50% on average. The same study found that the average charge for self-pay inpatients at hospitals in Cook County, including the city of Chicago, was 148% of the average amount that a major insurer had negotiated for the patients it insured [11]. The practice of charging the uninsured more is exacerbated by the fact that many hospitals maximize their charges for all patients so that they can increase the amount of reimbursement from a subset of insurance companies willing to pay the higher charges. However, while most insurance companies negotiate for their enrollees to minimize any increase in reimbursement, the uninsured patients who have no agency or company to negotiate on their behalf, are expected to pay the entire increased bill [10].

In addition to having to pay more out-of-pocket for their health care, the structure of payments can also be a barrier for self-pay patients. At times, self-pay patients are asked to pay 50% of their health care costs up front. This burdens self-pay patients, who, compared to the insured, generally have lower incomes, spend a greater portion of their income on health care, and have less ability to borrow. Consequently, they find it harder to receive medical care [12].

The higher costs for care and high up-front payments required of some self-pay patients can have serious financial consequences. One study found that safety-net hospitals have increased the aggressiveness with which they seek past due monies from self-pay patients. Bills are often passed along to collection agencies, whose aggressive collection practices are blind to the reasons these patients accrued such debt [13]. Another study found that nearly half of personal bankruptcies result from health problems or large medical bills [14]. In a study of over 7,000 uninsured patients, 60% said they needed help paying for their medical care, and 46% said they owed money to the facility where they receive their care [8].

Since the collection of data for this study, the Hospital's self-pay policy has changed. Community advocacy groups and the Governor of the State expressed growing concern about the adverse impact of this policy on access to needed services by uninsured, self-pay patients. A summit was held to address barriers to care for indigent patients at the public hospital. It was attended by the Governor, the Hospital administration, the local School of Medicine leadership, community advocacy groups, and other stakeholders in the community. One outcome was that the Executive Vice President of Health Sciences, who has authority over the hospital, reversed the self-pay policy as inappropriate for a public hospital serving a large, uninsured community. Today, self-pay patients are offered an affordable, sliding scale, up-front payment rate for doctor visits, tests, medications, hospitalizations and procedures. After receiving services, the self-pay patient is billed at a 40% reduction on reasonable charges and can arrange payment over a period of time.

The findings of this study, coupled with lessons learned from the subsequent change in this public hospital's self-pay policy in response to community advocacy, raises a broader, national health policy question. Should there be an official liaison group that could negotiate with public hospitals for affordable payment rates for the uninsured (self-pay) patients aiming to achieve comparable discounts enjoyed by the insured and by those covered by Medicare and Medicaid?

This study had limitations. The elective surgical procedure cancellation records were incomplete, for the records did not include a standardized way of recording the reason for cancellation. Many records had no reason for cancellation recorded at all. The initial intended use by the admitting department of these records was to track only the occurrence of surgical procedure cancellations. The admitting department staff was under no obligation to write down the reason for cancellation on the cover of the cancellation records. This resulted in a large number of records with no reason for cancellation recorded. This made it difficult to assess accurately the magnitude of the 50% "up-front" pay policy on access to needed surgical procedures.
The majority of unknown reasons for cancellation were within the insured group. Even when all unknown reasons for cancellation were included in the financial reason for cancellation category, self-pay patients still cancelled significantly more elective surgical procedures for financial reasons than did the insured (Table 1).

Another limitation arising from the use of these cancellation records was that they did not contain all pertinent information. Because we were studying the effect of a policy on financial reasons for cancellation, income of the patients would have been useful. Unfortunately, we only had permission to view confidentially the information contained on the cancellation records where income was not recorded. Future studies of this population done prospectively should include income. A final limitation was the way in which data collection was performed. The data were collected by two of the authors in person with designation of reason for cancellation category being a judgment decision of the two authors together.

Further research in this area is planned to determine the health outcomes and hospital utilization patterns of self-pay patients who did not receive elective surgery for financial reasons. Formulating a cancellation tracking form with a specific space for reason for cancellation and more strict guidelines in interpretation of category of cancellation is planned for future studies of this population.

Conclusion
Self-pay patients at the public hospital face significant barriers to accessing needed elective surgical procedures due to the hospital's policy of requiring, in advance of admission, 50% of the estimated total fee for the procedure. This study demonstrates that regardless of race/ethnicity, self-pay patients are significantly more likely to cancel elective surgical procedures for financial reasons than are insured patients. The hospital's 50% up-front payment policy for self-pay patients represents a significant financial barrier to accessing elective surgical procedures for these patients. In addition to the evidence we found that patients cancelled needed surgeries because of this policy, it is unknown how many patients, or their physicians did not schedule needed surgeries due to knowledge of this self-pay policy. This study advances the sparse but growing body of data demonstrating the negative consequences of inequalities in pricing of medical care for self-pay patients. It helps us to understand the extent to which such pricing policies create barriers to self-pay patients seeking needed care.

Competing interests
The author(s) declare that they have no competing interests.

Authors' contributions
WK and ASC conceived of the study, gathered all data, and interpreted findings. BS analyzed the data and supervised all aspects of the study. AK helped to find the source of data, interpret findings and was the final editor of the text. All authors helped develop study concepts, write and review drafts of the manuscript.

Acknowledgements
The authors thank Mary Labane for her assistance in acquiring the data, Dr. Andru Zivasimmon for bringing this policy to our attention, and Marshal Kaufman for his editorial assistance.

The authors received no source of funding for the study.

References
UNM Hospital

University of New Mexico Hospital (UNMH), the state's only academic medical center, is the primary teaching hospital for the university's School of Medicine. UNMH cares for a large, diverse population with complex and urgent health needs, providing more than $135 million of uncompensated care per year.

UNMH, home to the state's only Level I Trauma Center, annually manages more than:

- 93,000 emergency visits
- 7,000 trauma cases
- 18,000 surgeries
- 491,000 outpatient visits

Through us, thousands of patients receive advanced treatments in clinical trials. Many more patients benefit from our telehealth network that gives providers audio and video access to rural communities statewide.

Schedule an appointment: (505) 272-4866

Mission, Vision & Core Values

Discover our philosophy of care.

- Mission
- Vision
- Core Values

Our patient care mission encompasses serving as an accessible, high-quality, safety-focused, comprehensive care provider for all the people of Bernalillo County, and providing specialized services for people across the state.

Our education mission focuses on creating a patient care environment that supports the
UNM Hospital

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Our core values emphasize:

- A culture of shared expectations regarding integrity, accountability and decisiveness in commitment to excellence.
- Compassion and respect in our interaction with students, patients and colleagues.
• Diversity in people and thinking.
• Effective utilization of our resources.
• Advancement of our institutional mission while supporting professional and personal growth.

Leadership

Learn about the leadership and board of trustees who provide guidance and oversight of UNM Hospital.

Quality Care

Rest assured that UNMH provides excellent care. We’re accredited by The Joint Commission – the nation's largest independent, nonprofit health care accrediting agency – in recognition of our commitment to quality improvement and patient safety.

We also earned Healthgrades Distinguished Hospital Award for Clinical Excellence™ award in both 2016 and 2017. This distinction recognizes UNMH's performance in the top five percent nationally for overall clinical excellence – based on mortality and complication rates for common inpatient procedures and conditions.

Mill Levy & County Support

UNMH receives about $90 million annually from Bernalillo County property taxes subject to voter renewal of a mill levy every eight years. These funds support care for tens of thousands of people in need annually.

Our History

The facility now called UNMH opened in 1954 as Bernalillo County Indian Hospital, the only hospital dedicated to serving local Native Americans. In the late 1960's, the facility became part of the University of New Mexico, and in 1979, the hospital took its current name.

UNMH built an emergency/critical care addition in 1984. The facility's most recent major upgrade, the Barbara & Bill Richardson Pavilion, opened in spring 2007. The pavilion added nearly 500,000 square feet of space, including an expanded emergency department, UNM Children's Hospital, and other areas designed for efficiency, safety and the latest technology.
### Anticipated Services

#### Institutional Procedures

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Units</th>
<th># of Visits</th>
<th>Services</th>
<th>Total Charges</th>
<th>Negotiated Payer Rate</th>
<th>Line Item Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgical</td>
<td>1</td>
<td>1</td>
<td>(C) CPT: 29882:360 - (29882) ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCUS REPAIR (MEDIAL OR LATERAL)(S83512A*) SPRAIN OF ANTERIOR CRUCIATE LIGAMENT OF LEFT KNEE, INITIAL ENCOUNTER</td>
<td>$13,937.73</td>
<td>$13,937.73</td>
<td>$13,937.73</td>
</tr>
<tr>
<td>Outpatient Surgical</td>
<td>1</td>
<td>1</td>
<td>(C) CPT: 29888:360 - (29888) ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT REPAIR/AUGMENTATION OR RECONSTRUCTION(S83511A*) SPRAIN OF ANTERIOR CRUCIATE LIGAMENT OF RIGHT KNEE, INITIAL ENCOUNTER</td>
<td>$11,505.46</td>
<td>$11,505.46</td>
<td>$11,505.46</td>
</tr>
</tbody>
</table>

**Estimated Payer Reimbursement:** $62,404.09

#### Professional Procedures

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Units</th>
<th># of Visits</th>
<th>Services</th>
<th>Total Charges</th>
<th>Negotiated Payer Rate</th>
<th>Line Item Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgical</td>
<td>1</td>
<td>1</td>
<td>(C) CPT: 01400 - (29888) ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT REPAIR/AUGMENTATION OR RECONSTRUCTION(S83511A*) SPRAIN OF ANTERIOR CRUCIATE LIGAMENT OF RIGHT KNEE, INITIAL ENCOUNTER</td>
<td>$36,960.90</td>
<td>$36,960.90</td>
<td>$36,960.90</td>
</tr>
</tbody>
</table>

**Estimated Payer Reimbursement:** $62,404.09

### Estimated Patient Responsibility

Based on the services listed, it is estimated that you will owe $62,404.00 for your services.

### Discounts

We extend a(n) Self-Pay discount of 45% for patients that pay today. This would save you $28,001.89 bringing your total to $34,322.00.

### Projected Estimate for Services

Thank you for choosing Our Hospital for your healthcare. We hope this Projected Estimate helps you plan for all the health services that you need. Here are some common questions that patients have about the estimated cost of their service(s):

**How do I know if this estimate is correct?**

### Notes to the Patient:

$17,161.00
## UNM Hospital’s Income Chart for Financial Assistance

### Exhibit B

<table>
<thead>
<tr>
<th>% of Federal Poverty</th>
<th>0-138%</th>
<th>139-150%</th>
<th>151-200%</th>
<th>201-250%</th>
<th>251-300%</th>
<th>301-350%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium as a % of Income</td>
<td>2%</td>
<td>4%</td>
<td>6.3%</td>
<td>8.05%</td>
<td>9.50%</td>
<td>9.50%</td>
</tr>
<tr>
<td>Plans</td>
<td>T05, 605, 905</td>
<td>T10, G10, 910</td>
<td>T11, G11, 911</td>
<td>T20, G20, 920</td>
<td>T21, G26, 921</td>
<td>990</td>
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<tr>
<td>Clinic Co Pays</td>
<td>$5</td>
<td>$10</td>
<td>$10</td>
<td>$20</td>
<td>$20</td>
<td>$50</td>
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<tr>
<td>(Annual) Family Size</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>BASE</td>
<td>12,060</td>
<td>16,432</td>
<td>18,090</td>
<td>18,091</td>
<td>24,121</td>
<td>36,181</td>
</tr>
<tr>
<td>&lt; Income</td>
<td>12,060</td>
<td>16,432</td>
<td>18,090</td>
<td>18,091</td>
<td>24,121</td>
<td>36,181</td>
</tr>
<tr>
<td>Insur Prem</td>
<td>16,432</td>
<td>18,090</td>
<td>18,091</td>
<td>18,091</td>
<td>24,121</td>
<td>36,181</td>
</tr>
<tr>
<td>Income Range</td>
<td>18,091</td>
<td>24,121</td>
<td>36,181</td>
<td>36,181</td>
<td>48,721</td>
<td>56,840</td>
</tr>
<tr>
<td>Insur Prem</td>
<td>16,432</td>
<td>18,090</td>
<td>18,091</td>
<td>18,091</td>
<td>24,121</td>
<td>36,181</td>
</tr>
<tr>
<td>Income Range</td>
<td>18,091</td>
<td>24,121</td>
<td>36,181</td>
<td>36,181</td>
<td>48,721</td>
<td>56,840</td>
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<td>(Monthly) Family Size</td>
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<tr>
<td>BASE</td>
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<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
</tr>
<tr>
<td>&lt; Income</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
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<tr>
<td>Insur Prem</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
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<tr>
<td>Income Range</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
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<tr>
<td>Insur Prem</td>
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<td>1,005</td>
</tr>
<tr>
<td>Income Range</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
<td>1,005</td>
</tr>
</tbody>
</table>

Eligibility is based on gross income and family size. For families over 8 members, add $4,180 for each individual.

- **Asset Limitation:** up to $20,000
- **Surplus Property:** see internal policy/procedure.
- **Child Support:** add to income if receive, deduct from income if paid
- **Insurance Premiums:** deduct from income if paid
- **T Plans = UNM Care with 100% write-off minus copay.**
- **G Plans = OOCI with 100% write-off minus copay.**
- **All 9 Plans = Discount Program with 45% discount minus down payment.**

If insurance premium exceeds % of income, patient will qualify in income category.
UNM Hospitals

Finance Guidelines for Surgical Cases for Providers (Non-Emergency Cases)

This only applies to surgical procedures in the operating rooms and does not apply to clinic procedures

Financial and Prior Authorization Requirements for UNMH

- To assure correct billing and payment for non-emergent, elective surgical cases, the following procedures are to be followed. Patients need to be cleared financially, and, in appropriate cases, cleared for medical urgency of the procedure, prior to scheduling the surgical case.

Financial Clearance Guidelines

- All Patients must be financially cleared prior to scheduling for non-emergent cases.
- Patients who are currently in Self Pay Status will need to see a financial counselor to determine eligibility for Medicaid, UNM Care, other Financial Assistance Programs, or the Self-Pay Discount Program.
- Patients who qualify for Medicaid, Medicare, Commercial Insurance, UNM Care, or other third party coverage will be cleared to proceed for scheduling. Patients should be scheduled a minimum of 28 days out to allow for required prior authorization processing for Medicaid or commercial insurance patients (may be scheduled sooner based on provider determination of medical necessity).
- Patients who qualify for the Discount Program are eligible for a discount:
  - Patients who do not qualify for full financial assistance and are eligible for indigent status may receive a 45% discount to the normal billed charges for the procedure.
  - For patients qualifying for the indigent status and discount, to be cleared for scheduling must, subject to the medical urgency exception below, make a down payment of 50% of their expected remaining balance. The Financial Counselor will coordinate this process with the patient.
  - Once the down payment obligation is met, the Financial Counselor will notify the clinic that the patient is cleared for scheduling.
- Patients who do not qualify for the UNM Care Financial Assistance Program, other financial assistance, or the indigent status with discount, will be required to pay 100% of the estimated charges.

Prior Authorization Requirements

- Most surgical cases will require an authorization from Medicaid, Commercial Insurance or other payers.
- By Regulation, the Medicaid MCOs have 14 days within which to respond to authorization requests for non-urgent cases.
- In order to assure correct and timely processing of prior authorizations, cases should be scheduled at least 28 days from the date of request for the procedure patients (may be scheduled sooner based on provider determination of medical necessity).

Revised May 2, 2017 smf
Medical Urgency Exception

Patients whose proposed surgical care is determined to be non-emergent, but medically urgent may have the requirement of a 50% down payment deferred until after completion of the surgical case. To effect this deferral, this will require written approval to proceed with scheduling the surgical case. The attached non-emergent clinical procedures form will need to be completed by the financial counselor and forwarded to the Chief Medical Officer or designee for approval to proceed with scheduling the case.

Surgical cases not approved by the CMO will be referred to the patient advocate.
Non-Emergent Surgical Procedures Approval Form

Name of Patient ___________________________ MRN _______________________

Date of Surgical Procedure ____________________________

Surgical Procedure Information: ____________________________

Cost of case per Experian ___Cost after 45% discount (if eligible)

50% down payment expected from patient (27.5%) ____________________________

If the patient is not covered under insurance, Medicare, Medicaid or other payment source such as VA or IHS, did the patient get registered with the surgical services procedure self-pay discount plan? Y ___ N ___

Was the 50% down payment collected? Y ___ N ___

Will the vendor donate any medical supplies to be used for this patient? * YES  NO *

If UNMII and No, please refer to Dr. Irene Agostini for approval

To be completed by Dr. Agostini, Chief Medical Officer or designee.

Is this case deemed:

Emergent? Y ___ N ___

Elective? Y ___ N ___

Medically Urgent? Y ___ N ___

I understand that the patient was screened for financial assistance, and is not able to pay and has not paid the expected 50% down payment for the cost of the procedure. Because I believe the surgical procedure is medically urgent, I authorize the surgical procedure to be performed.

Irene Agostini, M.D., Chief Medical Officer

NOTE: For orthopedic patients only Stryker may pay for hardware for two replacement cases a year. There is a six week application process and Stryker must approve the application in advance of surgery.

Revised May 2, 2017 smf
POLICY STATEMENT
UNM Hospital offers financial assistance for the patient’s medical bill for qualified patient who:
1. Meets certain identity requirements and
2. Meets State and county residency requirements; and
3. Is not covered or is only partially covered by government or private insurance; and
4. Meets established financial requirements for establishing indigent status, defined as 300% of the Federal Poverty Guidelines or below; and
5. Meets medical necessity criteria and
6. The services are covered by the financial assistance program.

UNM Hospital will abide by the federal Emergency Medical Treatment and Labor Act (EMTALA) in providing care to patients at UNM Hospital. The UNM Hospital will abide by all federal, state, and local laws in the provision of financial assistance. Individuals will be assessed for indigent status and financial assistance eligibility when documentation is submitted to UNM Hospital Financial Services Department. UNM Care is another name for the UNM Hospital’s Financial Assistance Program. Medical services rendered to patients outside the UNM Hospital are not payable by UNM Hospital.

DETAILED POLICY STATEMENT

Identity Requirements

The patient must provide documentation to demonstrate their identity. Any of these documents may demonstrate identity: Social Security card, U.S. Passport, state issued identification, birth certificates, citizenship/naturalization records, Visa, Indian census records, certificate of Indian Blood, court records, voter registration card, divorce papers, licensed school records, licensed day care center records or a letter from a licensed physician or nurse.

Residency Requirements

The patient must be living in New Mexico and demonstrate an intention to remain in the state. Residency in New Mexico and Bernalillo County is established by living in the state and county and carrying out the types of activities associated with normal living: such as occupying a home, enrolling children in school, attaining a New Mexico driver’s license or New Mexico State issued identification card, renting a post office box, obtaining employment within Bernalillo County or the State of New Mexico.

The patient can demonstrate this residency by bank statements, home ownership, rental leases,
and letters addressed to the patient at a home address, utility bills, and proof of enrollment of self or child in an educational institution, pay stubs, income tax returns, or other similar documents.

Patients who meet residency requirements for the State, but are not residents of Bernalillo County, will only be eligible for indigent status and financial assistance if the service they receive at the UNM Hospital is not available in their county of residence, as determined by the Medical Staff of UNM Hospital. These patients should apply for their home county indigent funds before applying for UNM Hospital financial assistance program.

Financial Requirements

The patient must verify income by providing: employment pay stubs; income tax returns; letter from employers; direct bank deposits; letters or copies of checks from Social Security, Worker’s Compensation, Veteran’s Affairs, Bureau of Indian affairs, or other similar documents.

The patient must verify assets. Assets may be verified by providing bank statements, investment statements or other similar documents. Retirement funds, primary residence, and vehicles are not considered in the asset level.

Medical Necessity Criteria

Only medically necessary services as determined by the treating UNM Hospital medical staff provider will be eligible for financial assistance. All services are subject to review by the Medical Director of the Utilization Review Department.

Patients may be eligible for indigent status and financial assistance under the following circumstances:

1. A patient is treated for an emergency medical condition, as determined and documented by the treating provider;
2. A patient is treated for the signs or symptoms of a communicable disease, as determined and documented by their treating provider, whether or not those symptoms are caused by communicable disease; or
3. A patient is treated for immunizations, as documented in the medical record

The following services are services which are typically not considered covered services within the meaning of this Policy:

- cosmetic surgery,
- reversal of vasectomy,
- elective pregnancy terminations,
- tuboplasties,
- infertility studies and treatment,
- other services not routinely provided by UNMH medical staff or facilities as determined by the medical staff of UNM Hospitals.(for example, liver or cardiac transplantation)

Exceptions to non-covered services will be considered by the Medical Director and Chief Medical Officer.
Other Coverage

With limited exceptions as described below, UNM Hospital’s financial assistance program is the financial program of last resort. This means that government or private insurance will be a primary financial payment source before the UNM Hospital’s financial assistance program. Medicaid eligible individuals must apply for Medicaid and receive a denial of eligibility prior to being considered for indigent status and financial assistance.

A patient can be eligible for indigent status and financial assistance with respect to any unpaid amounts after the government or private insurance has fully paid UNM Hospital as required under the terms of that government or private insurance plan.

UNM Hospital will subrogate with a liability payer for third party tortfeasor cases.

Indian Health Service Contract health coverage is secondary to UNM HSC’s financial assistance for those Native Americans who reside in Bernalillo County and who meet the financial assistance and medical necessity criteria.

Denial and Appeal Process:

A patient will receive a letter from UNM Hospital if the patient is denied eligibility to the financial program for any reason. If a patient is not granted indigent status or financial assistance because of lack of documentation for identity, residency, income, asset or medical necessity reasons, they can appeal to the Medical Director of the Utilization Review Department and Chief Medical Officer.

Co-pay Requirements

Any patient who is not covered in whole or in part by government or private insurance and who is otherwise qualified for indigent status and financial assistance as provided in this Policy will be required to pay the following co pay amounts and will be eligible for the following levels of assistance:

<table>
<thead>
<tr>
<th>Income Level (% of FPG)</th>
<th>Asset Level</th>
<th>Clinic Visit Co-Pay / Balance Owed</th>
<th>Emergency Dept, Diagnostics Co-Pay / Balance owed</th>
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<tbody>
<tr>
<td>0 -100%</td>
<td>$20,000</td>
<td>$5 / $0</td>
<td>$10 / $0</td>
<td>$25 / $0</td>
</tr>
<tr>
<td>100 - 200%</td>
<td>$20,000</td>
<td>$10 / $0</td>
<td>$20 / $0</td>
<td>$75 / $0</td>
</tr>
<tr>
<td>200 - 300%</td>
<td>$20,000</td>
<td>$20 / $0</td>
<td>$75 / $0</td>
<td>$300 / $0</td>
</tr>
</tbody>
</table>
Native Americans who provide documentation of tribal affiliation and qualify for financial assistance will not be required to pay a co-payment for services covered under financial assistance.

Patients can, and are strongly encouraged to, make payment arrangements for monthly payments for their unpaid balance(s). UNMH will not accrue interest on any balance owed for an account with UNMH for a self pay contract account.

Other

If a patient otherwise qualifies for the indigent status but is not eligible for full financial assistance, they will be eligible to receive a 45% discount and may set up a payment plan that will not charge interest and allow for monthly payments. If the patient accumulates multiple accounts they may request that the accounts be combined.

APPLICABILITY
This policy pertains to all UNM Hospitals and Clinics including UNM Cancer Center.

POLICY AUTHORITY
Chief Executive Officer

SUMMARY OF CHANGES

RESOURCES/TRAINING

<table>
<thead>
<tr>
<th>Resource/Dept</th>
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<tr>
<td>Patient Financial Services</td>
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DOCUMENT APPROVAL & TRACKING

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<tr>
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<td></td>
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</tr>
<tr>
<td>Legal (Required)</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Official Approver</td>
<td>Christine Glidden, Secretary</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Official Signature</td>
<td>Effective Date: 10/30/2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue Date</td>
<td>11/24/2015</td>
<td>MAB</td>
<td></td>
</tr>
</tbody>
</table>
POLICY STATEMENT
All patients who received medical services at the UNM Health Sciences Center will be required to pay for those medical services. This payment liability can be met through the patient’s private insurance or government reimbursement programs. However, any remaining unpaid balance owing to the UNM Hospital will be the patient’s obligation to satisfy.

A patient whose financial liability is not satisfied by the patient’s private insurance or enrollment in government reimbursement programs, may be eligible for either UNM HSC’s financial assistance program or a discount.

UNM HSC will abide by the federal Emergency Medical Treatment and Labor Act (EMTALA) in providing care to patients at UNM Hospitals.

UNM Hospital will abide by Provider Reimbursement Manual Part, Section 310 (A) Collection Agencies.

DETAILED POLICY STATEMENT
Subject to the UNM HSC Financial Assistance Policy; a patient scheduled to receive non emergent, elective medical care may be required to make a down payment in advance for the medical care or procedure. Patients who are unable to make payment at the time for service will be triaged by the medical provider to determine if the visit is medically urgent and the payment should be deferred. HMO patients are required to pay their assigned co-payments. The co-pays below are based on the Federal Poverty Guidelines (FPG) and are revised annually. Retirement funds, primary residence, and vehicles are not considered in the asset level. The chart below indicates co-pays for financial assistance, discount program and self pay patients.

<table>
<thead>
<tr>
<th>Income Level (% of FPG)</th>
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<td>$20</td>
<td>$75</td>
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</tr>
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<td>$20,000</td>
<td>$50</td>
<td>$150</td>
<td>$500</td>
</tr>
<tr>
<td>Self pay</td>
<td>NA</td>
<td>$50</td>
<td>$200</td>
<td>50% estimated charges</td>
</tr>
</tbody>
</table>

Patients are responsible for the balance of accounts after discounts have been taken.
Patients can, and are strongly encouraged to, make payment arrangements for monthly payments for their unpaid balance(s) without interest. Patients with multiple accounts may request that all accounts be combined into a single account.

**EXTENDED BUSINESS OFFICE**
The UNM HSC will use an Extended Business Office (EBO) program to follow up on self pay accounts and self pay balances. The EBO has the authority to combine accounts and set up payment arrangements. If a patient is approved for financial assistance after an account has been referred to EBO, the account will be adjusted to financial assistance.

**COLLECTION AGENCY**
The UNM HSC will engage and use one or more collection agencies to follow up on unpaid patient accounts after a six month period in which a patient has an unpaid balance or has not met agreed upon payment arrangements for three consecutive months. The collection agency is not allowed to pursue judgments on accounts, place liens on patient’s property or charge interest. The collection agency will follow all applicable state and federal laws including the Fair Debt Collections Practices Act. Accounts approved for financial assistance or indigent status will not go to a collection agency for pursuit of the co-pays.

**APPLICABILITY**
This policy pertains to all UNM HSC Hospitals and Clinics including UNM Medical Group, and UNM Cancer Center.

**POLICY AUTHORITY**
Chief Executive Officer

**SUMMARY OF CHANGES**
This policy replaces Self Pay Collection and Self Pay Patient Payment, last revisions 9/2005 & 4/2007 respectively.

**RESOURCES/TRAINING**

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<td></td>
<td>Effective Date: 10/30/2015</td>
<td></td>
</tr>
<tr>
<td>Issue Date</td>
<td>2/11/2010</td>
<td></td>
<td>ar</td>
</tr>
</tbody>
</table>

Title: Patient Payment Policy
Owner: Board of Trustees
Effective Date: 10/30/2015
Doc. # 2619
FINANCIAL ASSISTANCE INTERNAL PROCEDURES

OVERVIEW
This guideline is to be followed by all staff that are trained to complete financial assistance applications for patients who are applying for financial assistance or discounts to billed charges. For patients living in Bernalillo county financial assistance is often referred to as “UNM Care”. This process will include the completion of Medicaid applications or the referral to other government programs. If a patient cannot qualify for full financial assistance, a PSR will set up the patient on a reasonable payment plan.

AREAS OF RESPONSIBILITY

Patient Financial Services (PFS) is responsible for the financial assistance process. The management of PFS will work with the IT department in regard to updates needed to FAST (financial assistance) for eligibility requirements. PFS will be responsible for implementation of any procedural or process changes. Admitting Departments, ASAP, Native American Health Services, Care One, and the Emergency Room will complete financial assistance applications using these guidelines. The Supervisors or Directors from those departments are responsible for training and quality control.

GUIDELINE PROCEDURES

PSRs will complete financial assistance applications using the online FAST system during the interview process. As the interview is conducted, the PSR will make an appropriate referral to the Income Support Division for programs such as:

- MAWC Medical Assistance for Women and Children
- Medicaid for Pregnant Women
- TANF Temporary Assistance for Needy Families
- EMSA Emergency Medical Services for Undocumented Aliens

PSRs will ensure that the patient’s financial situation appears “reasonable” (i.e. a person earning $500 with a $1,000 house payment must explain/verify the situation) during the interview.

RESIDENCY INFORMATION

The PSR should complete the guarantor, spouse and dependent demographic information in FAST. In order to qualify for financial assistance, the patient must be living in New Mexico and demonstrate an intention to remain in the state. Below are some examples that can be used to determine intent to stay.
*Renting a home or apartment
*Purchasing a home
*Enrolling self or children in a NM school
*Obtaining a driver’s license or ID from the State of New Mexico
*Obtaining employment
*Voter registration

If none of these are applicable, the PSR should ask the patient about their intent. Patients paying out of state tuition do not qualify. Temporary Visas will not be considered a demonstration of intent to stay in the County or the State. If a patient is on a VISA and their permit has expired they may qualify for a discount.

Patients who live outside of Bernalillo County but in the State of New Mexico may qualify only if the services they need are not available in their home county. The PSR will review the online list of services in the patient’s home county or verify with UR that the service is not offered in the home county.

Patients who are not US Citizens, not lawful permanent residents, or not present in the United States under color of law may be eligible for Limited Financial assistance only under the following circumstances:

*A patient is treated for an emergency medical condition as approved by medical staff.
*A patient is treated for the signs or symptoms of a communicable disease whether or not the symptoms are caused by communicable disease-approved by medical staff.
*A patient needs to be immunized

If the medical services above are not present, patients are eligible for a 45% discount on billed charges with low down payments as long as payment arrangements are made at the time of the discount.

HOUSEHOLD SIZE

For purposes of financial assistance a household is defined as immediate family (husband, wife, children under 18 or still in high school). Eligibility applications are filed under the head of household’s last name, first name, date of birth and then the spouse’s first name. Couples who live together should each have their own application unless they have children together. Both incomes will be used in determining eligibility on the children of non-married couples who live together and have children together. Children living with relatives are only counted as dependents if relatives have legal custody.

FINANCIAL: Income and Expense

The PSR should complete the income and expense portion of the FAST system indicating the source of income of the guarantor and spouse. Financial assistance determinations will be made based on a client’s gross income using a sliding fee schedule. Schedules will be updated annually as new Federal Poverty Guidelines become available.
To determine monthly income, add wages, self-employment income, social security checks, pension, VA checks, unemployment compensation, child support received, alimony received, workers compensation checks, interest or dividend payments as well as any other miscellaneous income received by the household. School loans are not considered income since they must be paid back. School grants and scholarships are considered income after tuition is deducted.

If child support/alimony is paid out, subtract from income to determine gross income. The patient must show supporting documentation to prove child support/alimony is being paid. If the family unit is paying health insurance premiums, deduct the verified monthly premium from gross income.

Compare the income and assets to the guidelines based on family size (see income chart) to determine eligibility and the appropriate co pay.

**ASSETS**

The PSR should complete the Assets portion of the FAST application indicating any assets the patient may have. Assets to be considered would be bank accounts, stocks, bonds, CDs, money market accounts, trust funds, etc. A family may have assets up to $15,000. PSRs should compare assets against the income guidelines. When reviewing the size of checking accounts, PSR’s must consider non cleared checks.

Retirement funds, cars, or primary residence will not be considered assets. If a patient's asset (i.e., CD or stock) is being used as collateral for an outstanding debt that asset will not be counted.

Surplus real estate property is defined as a second piece of real property that the patient owns or is buying. If a patient owns a second piece of real property they could be denied financial assistance depending on circumstances.

For example:

* Family lives in their home and pays mortgage and they own a second home that they rent and have no intentions of selling. The family does not qualify due to real estate asset.
* Family owns a lot and on the lot are 2 small homes. The first home is their primary residence and they rent out the second home. The lot cannot be divided up to sell. Therefore, this is not surplus property. However, the rent must be included as income.
* Family has a second home or land they have on the real estate market and it is not selling. Financial assistance can be given while the family waits for the home to sell.
* Family owns a second piece of property that is one acre in an undeveloped area. Value of property must be considered, and the decision to approve or deny should be based on the value of the land.

**DOCUMENTATION**

A patient must verify income, residency and assets. The following documents can be used, as applicable, to determine eligibility for financial assistance:
- Tax forms for the self-employed to include form 1040 and schedule C, W-2 forms, paycheck stubs, unemployment benefits approval letter, government award letters, social security award letters, and bank statements showing direct deposits.
- Proof of child support alimony and amount (canceled checks, child support enforcement documentation).
- Award letter for student grants / scholarships
- Current rent receipts, utility bills, property taxes, mortgage payments with an address

- Bank statements, financial documents
- Divorce papers
- Legal guardianship papers
- Letter of support

This is not an all-inclusive list. Verifications will depend on the patient’s situation. Situations can vary and patients may not be able to bring in the types of verifications listed. The PSR should work with the patient to determine what types of verifications are available. For instance, a homeless patient or a patient in a domestic violence shelter may not be able to verify their residency in the manners listed above.

If a patient is on Food Stamps, General Assistance, or has a family member on SSI or QMB, bank statements are not necessary.

DENIALS

Patients who decline to participate in the financial evaluation process or fail to provide complete information or verification of their situation will be denied financial assistance. The patient will be given a Letter of Ineligibility and the Patient Appeal Process. The Letter of Ineligibility should be checked off for all criteria that the patient did not meet. For example, if the patient is offered medical insurance from their employer and is over income and assets, all three boxes should be marked. Patients are required to sign an affidavit that they have not withheld any information and have disclosed all their assets.

APPEALS

Patients may be deemed ineligible if they do not meet one or all of the requirements for financial assistance. A letter of ineligibility will be given to the patient with instructions on how to file an appeal. Review with the patient the denial reason/reasons and verbally explain the instructions on how to file an appeal.

OUTSIDE RESOURCES

Patients will always be screened for any other third party payer source such as Medicare, HMO/PPO’s, insurance, liability coverage, Medicaid or any other resource prior to being approved for financial assistance. PSRs will work with a patient to complete a Medicaid application. The completed applications will be given to the ISD worker at the hospital or 1131 University for processing. If a patient/guarantor refuse to apply for or follow up on an alternative resource, they will not be eligible for financial assistance and will be responsible for the bill. If group health insurance is available through an employer, the
All eligibility is to be given for time specified by defined by PFS management. Approvals for patients outside of Bernalillo County will be given for six months. Certain exceptions to the one year eligibility may apply based on the patient’s pending insurance, Medicare or Medicaid, etc.

COPAYS/DOWN-PAYMENTS

Co pays/Down-payments are payable at the time services are rendered. See the co-pay chart. UNM Hospitals will not send any co-pays/down-payments due from financial assistance patients to a collection agency. If a patient cannot pay a clinic co pay, the medical director or their designee have the authority to defer the co pay or down payment. Each clinic visit requires a co pay/down-payment. Emergency Room co pays are waived if a patient is admitted. Physical Therapy, Occupational Therapy and Speech Therapy departments may collect one co-pay/down-payment for a course of treatment. Patients with third party coverage will not be required to pay co-pays with the exception of clinic visits. Patients with third party coverage will pay the lower of the two co-pay amounts for clinic visits. For example, patient’s insurance co-pay is $25.00 for a clinic visit and the patient is on the TOS UNM Care plan, the patient would pay the $5.00 co pay.
UNM Hospital Board of Trustees
July 2017
Recommendation to HSC Committee

Approval

(1) Delta Dental Plan of New Mexico, Inc

Ownership: Delta Dental Plan of New Mexico, Inc.
2500 Louisiana Boulevard N.E., Suite 600
Albuquerque, New Mexico 87110

Officers Information: Genia Chambellan
505-872-5323

Source of Funds: UNM Hospital Operational Budget for the Claims Administration services and employee payroll deductions for claims paid

Description: Request to contract with Delta Dental to provide dental claims administration and customer service to enrollees covered under the UNMH Dental Services Plan. Delta Dental also has an established network of participating dentists for dental services provided to UNMH participants.

Process: The University of New Mexico Hospitals requested proposals for RFP P364-17 Employee Dental Claims Administration Services. The respondents were as follows;
1. Blue Cross Blue Shield
2. MetLife
3. United Concordia Dental
4. Delta Dental

Previous Contract: Delta Dental Plan of New Mexico Inc.
Previous Term: Eight years spanning from August 1, 2009 - July 31, 2017
Previous Contract Amount: $3.04 per claims for a total of $203,263 in annual administration fees with dental claims of $2,599,841 annually

Contract Term: Agreement is a three year agreement, with the optional to renew on August 1, 2020 for an additional 5 years.

Termination Provision: UNMH may cancel this Agreement with or without cause, with a thirty (30) day advance written notice to Delta Dental.

Contract Amount: Total Estimated cost annually is as follows; $2.89 per claim for a total annual estimate of $193,503 in administration fees with dental claims of approximately $2.6M annually dependent on employee usage of dental services.
<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Subject/Discussion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Voting Members Present</td>
<td>Debbie Johnson, Jerry McDowell, Christine Glidden, Joseph Alarid, Erik Lujan, Raymond Loretto, and Aimee Smidt</td>
<td></td>
</tr>
<tr>
<td>Ex-Officio Members Present</td>
<td>Stephen McKernan and Jennifer Phillips</td>
<td></td>
</tr>
<tr>
<td>County Officials Present</td>
<td>Monica Roybal</td>
<td></td>
</tr>
<tr>
<td>I. Call to Order</td>
<td>A quorum being established, Ms. Debbie Johnson, Chair, called the meeting to order at 9:02 AM</td>
<td>Mr. Jerry McDowell made a motion to adopt the agenda. Ms. Christine Glidden seconded the motion. There being no objections, the motion carried.</td>
</tr>
<tr>
<td>II. Adoption of Agenda</td>
<td>Ms. Debbie Johnson, Chair, requested a motion to adopt the agenda.</td>
<td>Ms. Christine Glidden requested a motion to approve the Intuitive Surgical, Inc. and Philips Healthcare consent items. Dr. Raymond Loretto seconded the motion. There being no objections, the motion carried.</td>
</tr>
<tr>
<td>III. Announcements</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>IV. Public Input</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>V. Consent Approval</td>
<td>Mr. Steve McKernan gave a briefing on the Consent Items: Intuitive Surgical, Inc. and Philips Healthcare, which were reviewed by Finance &amp; Audit Committee and recommended to be taken to the Board for approval. Ms. Debbie Johnson, Chair, asked if there were any comments from the Finance &amp; Audit Committee or any Board Members. Dr. Raymond Loretto would like to receive feedback on the pros and cons in a few months. Ms. Christine Glidden asked Ms. Sheena Ferguson her opinion of the system. Ms. Sheena Ferguson said there were extensive on-going presentations for months before a final decision was made and everyone is excited; this will give the hospital monitoring capabilities that we currently do not have such as EKG history. Ms. Debbie Johnson, Chair, requested a motion to approve as submitted.</td>
<td>Mr. Jerry McDowell moved to approve the Intuitive Surgical, Inc. and Philips Healthcare consent items. Dr. Raymond Loretto seconded the motion. There being no objections, the motion carried.</td>
</tr>
<tr>
<td>VI. Approval of Minutes</td>
<td>Ms. Debbie Johnson, Chair, requested a motion to approve the April 28, 2017 UNM Hospital Board of Trustees Meeting Minutes and the May 19, 2017 UNMH Special Board of Trustees Meeting Minutes.</td>
<td>Dr. Raymond Loretto made a motion to approve the April 28, 2017 UNMH Board of Trustees Meeting Minutes and the May 19, 2017 UNMH Special Board of Trustees Meeting Minutes. Mr. Jerry McDowell seconded motion. The motion passed unanimously.</td>
</tr>
<tr>
<td>VII. Board Initiatives</td>
<td>UNMH Quality and Safety Committee Policy: Mr. Steve McKernan indicated that the Board of Trustees reviewed the draft policy at their Special Board of Trustees Meeting on May 19th. The comments made by Board Members were implemented into the policy and also follows through on some of the recommendations from Mr. Larry Gage. This particular recommendation has been advanced for approval because there is a provision within that policy that allows the UNMH Board of Trustees to delegate the Committee to review and approve medical staff credentialing and privileging decisions for Medical Staff of the UNM Hospitals. Approving this policy will allow the doctors into the clinic environment quicker and all parties believe this is a benefit to patients and doctors.</td>
<td>Mr. Jerry McDowell made a motion to approve UNMH Quality and Safety Committee Policy. Dr. Raymond Loretto seconded motion. The motion passed unanimously.</td>
</tr>
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<td><strong>UNMH Executive Retirement Design. 401(a) Plan 4th Amendment and 415(m) Executive Retirement Plan:</strong> Ms. Sara Frasch presented the UNMH Executive Retirement Plan. Mr. Steve McKernan indicated that there has to be a profit before these plans are funded. These plans can be a recruitment tool. Mr. Jerry McDowell believes the UNMH Board of Trustees would appreciate a periodic review of the process of these funds. Mr. Jerry McDowell also requested a briefing on the non-Executive employee’s retirement plans. Ms. Sara Frasch indicated leadership is reviewing employee contribution and retirement plan, executive plan and 401(b). Mr. Steve McKernan said Mercer is engaged on a continuing contract and they are constantly reviewing plans available for employees to invest, they advise on fees and who has the best fee structures, which includes employees not just management. Ms. Christine Glidden asked how UNMH compares to other health care institutions. Ms. Sara Frasch indicated a presentation will be given at a future Board of Trustees Meeting.</td>
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<td>Mission Excellence: Ms. Sara Frasch gave a Mission Excellence Update (report in packet).</td>
<td>Mr. Jerry McDowell made a motion to approve 401(a) Plan 4th Amendment and the 415(m) Executive Retirement Plan. Dr. Raymond Loretto seconded motion. The motion passed unanimously.</td>
</tr>
<tr>
<td>VIII.</td>
<td>Administrative Reports: &lt;br&gt; <strong>CEO Report:</strong> The CEO (report in the packet). &lt;br&gt; <strong>CMO Report:</strong> The CMO (report in the packet). &lt;br&gt; <strong>UNM Board of Regents:</strong> Mr. Steve McKernan gave an update on UNM Board of Regents. &lt;br&gt; <strong>Chief of Staff Update:</strong> Dr. Jennifer Phillips gave an update (report in the packet).</td>
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<td>IX.</td>
<td>Updates: Dr. Richard Larson, Executive Vice Chancellor, gave a presentation on UNM Health Sciences Center Vision and Strategy (report in packet).</td>
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<tr>
<td>X.</td>
<td>Committee Reports: &lt;br&gt; <strong>Performance Oversight &amp; Community Engagement Committee:</strong> The Performance Oversight &amp; Community Engagement Committee met on May 19, 2017. Dr. Raymond Loretto gave a brief summary (Community Engagement Report in packet). &lt;br&gt; <strong>Finance, Audit &amp; Compliance Committee:</strong> The Finance, Audit &amp; Compliance Committee met on May 24, 2017. Mr. Jerry McDowell gave a brief summary (minutes in packet). &lt;br&gt; <strong>Native American Services Committee:</strong> The Native American Services Committee met on April 26, 2017. Mr. Jerry McDowell gave a brief summary (minutes in packet). &lt;br&gt; <strong>Executive Committee:</strong> No meeting this month. No report.</td>
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<tr>
<td>XI.</td>
<td>Other Business: May Financials: Mr. Steve McKernan gave a brief updated on the May Financials.</td>
<td></td>
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<tr>
<td>XII.</td>
<td>Closed Session: At 10:53 AM Ms. Debbie Johnson, Chair, requested a motion to close the Open Session of the meeting.</td>
<td>Mr. Jerry McDowell made a motion to move to Closed Session. Dr. Raymond Loretto seconded the motion. The motion passed unanimously.</td>
</tr>
</tbody>
</table>
### Agenda Item: Certification

After discussion and determination where appropriate, of limited personnel matters per Section 10-15-1.H (2); and discussion and determination, where appropriate of matters subject to the attorney-client privilege regarding pending or threatened litigation in which UNMH is or may become a participant, pursuant to Section 10-15-1.H (7); and discussion of matters involving strategic and long-range business plans or trade secrets of UNMH pursuant to Section 10-15-1.H (9), NMSA, the Board certified that no other items were discussed, nor were actions taken.

### Agenda Item: Vote to Re-Open Meeting

At 12:53 PM, Ms. Debbie Johnson, Chair, requested a motion be made to return the meeting to Open Session.

Ms. Debbie Johnson, Chair, requested a motion be made to approve the April 21, 2017 Performance Oversight Committee (POCEC) Meeting Minutes as presented in Closed Session to acknowledge, for the record, that those minutes were, in fact, presented to, reviewed, and accepted by the Board and for the Board to accept/approve the recommendations of those Committees as set forth in the minutes of those committees meetings and to ratify the actions taken in Closed Session.

Mr. Jerry McDowell made a motion to return to Open Session. Mr. Erik Lujan seconded the motion. The motion passed unanimously.

Mr. Joseph Alarid made a motion to approve the POCEC Meeting Minutes. Dr. Raymond Loretto seconded the motion. The motion passed unanimously.

### Agenda Item: Adjournment

The next scheduled Board of Trustees Meeting will take place on Friday, July 28, 2017 @ 9:00 AM at the University of New Mexico Hospital in the Barbara & Bill Richardson Pavilion 1500. There being no further business, Ms. Debbie Johnson, Chair, requested a motion to adjourn the meeting.

Mr. Jerry McDowell made a motion to adjourn the meeting. Mr. Erik Lujan seconded the motion. The motion passed unanimously. The meeting was adjourned at 12:55 PM.

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Christine Glidden, Secretary  
UNM Hospital Board of Trustees
BOARD INITIATIVES
Paul Roth, left, chancellor of the University of New Mexico Health Sciences Center, and UNM interim President Chaouki Abdallah, right, answer questions about UNM’s new hospital proposal during a state Board of Finance meeting on Tuesday in Santa Fe. (Eddie Moore/Albuquerque Journal)

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SANTA FE – The board that essentially killed the University of New Mexico’s last bid to build a new hospital is raising questions about its latest hospital proposal – chief among them: Is now the right time?

With the future of U.S. health care laws in flux, members of the state Board of Finance on Tuesday expressed doubt about whether UNM should proceed with plans to build what it is calling a “modern medical facility” on land north of Lomas and east of University. The project would ultimately replace what UNM officials argue are out-of-date and inefficient adult care facilities at its existing hospital, located east of the proposed new site, while also providing much-needed additional capacity.
As currently envisioned, the multi-phase project would have 408 beds (48 of them for psychological treatment) and could cost an estimated $700 million.

UNM has focused its attention on the first phase: a 120-bed facility and medical office building that would total 372,000 square feet and cost an estimated $230 million to $250 million. UNM has not determined the best financing route but has enough in reserves to cover the cost.

It needs permission from its Board of Regents to hire an architect and draft construction documents, something it says would cost about $12 million. But board President Rob Doughty said the regents removed the request from their May meeting agenda so UNM could first present its proposal to the Board of Finance. The board, led by Gov. Susana Martinez, would have the final say before hospital construction could start.

The school took a proposal to build a new hospital to the board in 2012, but the board never held a vote on the project and thus prevented UNM from moving forward.

The board on Tuesday heard an “informational” presentation from a UNM leadership contingent that included interim President Chaouki Abdallah, Health Sciences Chancellor Paul Roth and UNM Hospitals CEO Steve McKernan. No vote was scheduled or taken.
But some board members, including Martinez, showed skepticism. The three-hour discussion veered frequently into other areas, with the board repeatedly peppering UNM officials with questions about exactly how the hospital uses, and accounts for, the roughly $90 million in property taxes it gets from Bernalillo County mill levy collections each year. It even included talk of federal patient privacy laws and the substance abuse crisis.

But Medicaid – and possible cuts to the program under current Republican leadership – emerged as a recurring concern as it pertains to the hospital plan. About 40 percent of UNMH revenue comes from Medicaid reimbursements, and Martinez suggested it might be “prudent” to wait a year or two to get more clarity about the national picture. Board member Michael Brasher said he would hold off, while fellow member Del Archuleta asked whether pursuing such a project now could ultimately “embarrass” the state.

“Can you see a situation that we would regret this action?” Archuleta asked.

“Absolutely not,” Roth responded, adding that he actually views it as “almost irresponsible” for UNM to continue with a status quo that keeps it from meeting the needs of New Mexicans.
In 2014, UNMH took in 5,300 patients from other New Mexico hospitals; that number jumped to 6,100 in the past 12 months, Roth said, thanks to a more efficient system that allows it to transfer out less-critical patients to places like Lovelace to make more room for cases that only UNM could handle. But greater need still exists, Roth said, noting that UNM did turn away 1,000 requested transfers in the past year – 25 percent of whom were critically ill or injured and either stayed in a facility that might not have the capacity to treat their condition or had to go to another place even farther away. UNM is the state’s only Level 1 trauma center and academic medical center, and it boasts some specialties and expertise some other New Mexico facilities do not.

“That is not the level of care any of us would want for our mother, or loved one or constituent. That is sub-standard care, and what I worry about, although I have no data to support it, is I think there were many cases in which either morbidity or mortality for citizens of the state of New Mexico were compromised, because they did not have access to the right level of care,” Roth said.

The governor fired back about making “a statement that strong without data,” and reiterated her concerns about proceeding without knowing how national health care changes might negatively impact hospital revenue.

“The devil is in the details,” she said.

In an interview after the meeting, Roth said health care is always changing and UNM could adjust its plans as necessary. It should wait no longer to pursue the project, he said.

It’s unclear when the UNM regents might hear the request to hire an architect. Doughty said late Tuesday that he was waiting to discuss the matter with Roth before deciding how to proceed.

**UNM’s ‘Modern Medical Facility’ proposal**

According to UNM numbers presented Tuesday, the first phase of its proposed new hospital would include:

- 120 adult care beds
- six operating rooms
- estimated construction costs of $232 million
- 2,000 construction jobs
- 300 permanent new positions for health care workers (once open)
MEMORANDUM

TO: UNMH Board of Trustees

FROM: Rodney McNease

DATED: July 28, 2017

RE: UNM Hospitals Financial Assistance Policy and Patient Payment Policy

In response to the Board of Trustee’s request to review the current Financial Assistance and Patient Payment Policies, this memo outlines what management believes to be the current issues raised by the Community Advocates.

The current Financial Assistance and Patient Payment policies adopted by the Board of Trustees in October 2015 have not changed and are attached for your reference.

In order to address issues brought forward by the Medical Staff and concerns raised by patients, a new procedure was put in place as of May 2017 to assure patients receive financial counseling services prior to non-emergent procedures. This procedure change was also based upon the increasing delays with managed care companies providing timely authorization for surgical cases.

The Patient Payment Policy provides that for non-emergent, elective surgical procedures involving an inpatient stay or day surgery, self-pay patients would be expected to make a down payment of 50% of the estimated charges in advance of the medical care or procedure. However, the Patient Payment Policy also provides for an exception in those cases where a patient is unable to make payment at the time for service. In those cases, the medical provider is supposed to triage the patient to determine if the visit or procedure is “medically urgent” and if so the payment should be deferred.

For patients who have qualified to be in indigent status and have provided information to be placed on the Self Pay Discount Program there will be a 45% discount from estimated billed charges provided to patients for that episode of care. The indigent status provision was added to the policy approved by the Board in October 2015. Patients may set up a payment plan related to the remaining balance for the procedure. If the patient is unable to set up a payment plan the case will be referred to the medical provider to determine if the procedure is considered medically urgent and if so, that the 50% down payment should be deferred and the patient would be responsible for the balance which would be the full charges less the 45% discount.
The Financial Policy adopted in October 2015 also raised the resource limits for assets that a patient can have and still qualify for assistance.

There have been assertions that this procedure change may create a barrier for indigent patients receiving elective, non-emergent cases. Management would like guidance from the Board related to the patient payment policy in regards to elective, non-emergent cases.

As with many new procedures and guidelines, there are opportunities for improvement and UNM Hospital is reviewing those procedures and guidelines to ensure they adhere to the Patient Payment Policy and do not impinge on a patient’s access to emergent or medically urgent surgical procedure. Each day, we remember our mission to provide compassionate care for our patients and our obligation to be good stewards of our operations.

Management recommends that the Board refer this matter back to the UNMH Management to analyze and make recommendations back to the Board.

Attachments:

Financial Assistance Discussion for Surgical Cases PowerPoint Presentation
Patient Financial Assistance Policy 2015
Patient Financial Assistance Policy 2009
Patient Payment Policy 2015
Patient Payment Policy 2009
Surgical Guideline for Non Emergent Cases
Letter from Center on Law and Poverty
Financial Assistance Discussion for Surgical Cases

UNM Hospitals Board of Trustees
July 28, 2017
Guiding Principles

- Provide medical service that patients need
- Provide emergent care as soon as possible and in accordance with federal EMTALA law
- Provide financial assistance for emergent medically necessary care as permitted
- Provide care to the vulnerable
Guiding Principles

- The Board is responsible to provide guidance to management on major policy matters.

- Financial Assistance is a complicated policy matter that management has worked with the Board over 12 years to make these policies meet the mission of the hospital.

- Policies can be modified based on the Board’s guidance.
Policy History

• Pre 2005
  – Financial Assistance
  – Self Pay – 100% of billed charges, up front payments

• 2005
  – Financial Assistance expanded to 300% of Poverty Levels
  – Patient Payment provided for payment schedule

• 2009
  – Financial Assistance asset levels increased
  – Patient Payment allows for 45% discount for qualified patients

• 2015
  – Financial Assistance – separate definition of indigency from financial assistance
  – Patient payment provision on collection agency
Recent Process

- Surgical Directions consultation related to operating room process and patient flow

- Desire to assure greater transparency for patients around cost of procedures (Experian implementation)

- Desire to assure patients receive all assistance they are eligible for

- Authorization delays by Medicaid Managed Care Companies

- Desire to improve patient and provider satisfaction and to assure maximum use of resources
History

• Cases were sometimes scheduled without ensuring a prior authorization was on file or authorization was provide so late in the process that procedures needed to be rescheduled.

• Patients with insured through the Health Exchange and other high deductible insurance plans were often not aware of the financial out of pocket costs for surgical procedures.

• Patients were often not reviewed for UNM Care, Medicaid or other financial assistance before cases were scheduled resulting in potential lost reimbursement opportunities for both the patient and the institution.
Surgical Scheduling Procedure

• The revised procedure was not intended to supersede or modify the existing Financial Assistance or Patient Payment Policy.

• Was intended to deal with these issues earlier in the process as opposed to operating room staff trying to navigate at the time of the procedure.

• Was intended to increase patient and provider satisfaction by reducing last minute delays or reschedules based on insurance authorization issues.

• Medical staff determination of urgency and medical necessity.
Surgical Scheduling Procedure

• Applies only to non-emergent cases

• Implemented in May 2017

• Extended the scheduling window for these cases out to 28 days from 14 days to allow time for processing required prior authorizations

• Requires patients without an identified payment source for the procedure to meet with a financial counselor prior to scheduling the procedure
Patient Pathways

- **Emergent Case** - The case proceeds without prior authorizations or any requirement around financial assistance screening. Any financial obligations are determined after the procedure has occurred.

- **Medically Necessary (Urgent) Non Emergent Case** - Provider makes determination of Medical Necessity. Prior authorizations are obtained and financial assistance screening is required. Patient notified of financial obligations and a Patient Payment Plan is worked out prior to the procedure. The case may proceed to be scheduled.

- **Elective Case** - The case is not considered to be medically necessary. Insurance will not pay for elective cases so any authorization attempt will likely be denied. Patient would be expected to complete financial assistance screening and make a down payment.
UNM Hospital Management is seeking guidance from the Board of Trustees around the implementation of the Surgical Services Procedure, Financial Assistance Policy and Patient Payment Policy to assure that these align with the Mission of the Hospital.
Questions?
POLICY STATEMENT
UNM Hospital offers financial assistance for the patient’s medical bill for qualified patient who:
1. Meets certain identity requirements and
2. Meets State and county residency requirements; and
3. Is not covered or is only partially covered by government or private insurance; and
4. Meets established financial requirements for establishing indigent status, defined as 300% of the Federal Poverty Guidelines or below; and
5. Meets medical necessity criteria and
6. The services are covered by the financial assistance program.

UNM Hospital will abide by the federal Emergency Medical Treatment and Labor Act (EMTALA) in providing care to patients at UNM Hospital. The UNM Hospital will abide by all federal, state, and local laws in the provision of financial assistance. Individuals will be assessed for indigent status and financial assistance eligibility when documentation is submitted to UNM Hospital Financial Services Department. UNM Care is another name for the UNM Hospital’s Financial Assistance Program. Medical services rendered to patients outside the UNM Hospital are not payable by UNM Hospital.

DETAILED POLICY STATEMENT

Identity Requirements

The patient must provide documentation to demonstrate their identity. Any of these documents may demonstrate identity: Social Security card, U.S. Passport, state issued identification, birth certificates, citizenship/naturalization records, Visa, Indian census records, certificate of Indian Blood, court records, voter registration card, divorce papers, licensed school records, licensed day care center records or a letter from a licensed physician or nurse.

Residency Requirements

The patient must be living in New Mexico and demonstrate an intention to remain in the state. Residency in New Mexico and Bernalillo County is established by living in the state and county and carrying out the types of activities associated with normal living: such as occupying a home, enrolling children in school, attaining a New Mexico driver’s license or New Mexico State issued identification card, renting a post office box, obtaining employment within Bernalillo County or the State of New Mexico.

The patient can demonstrate this residency by bank statements, home ownership, rental leases,
and letters addressed to the patient at a home address, utility bills, and proof of enrollment of self or child in an educational institution, pay stubs, income tax returns, or other similar documents.

Patients who meet residency requirements for the State, but are not residents of Bernalillo County, will only be eligible for indigent status and financial assistance if the service they receive at the UNM Hospital is not available in their county of residence, as determined by the Medical Staff of UNM Hospital. These patients should apply for their home county indigent funds before applying for UNM Hospital financial assistance program.

**Financial Requirements**

The patient must verify income by providing: employment pay stubs; income tax returns; letter from employers; direct bank deposits; letters or copies of checks from Social Security, Worker's Compensation, Veteran’s Affairs, Bureau of Indian affairs, or other similar documents.

The patient must verify assets. Assets may be verified by providing bank statements, investment statements or other similar documents. Retirement funds, primary residence, and vehicles are not considered in the asset level.

**Medical Necessity Criteria**

Only medically necessary services as determined by the treating UNM Hospital medical staff provider will be eligible for financial assistance. All services are subject to review by the Medical Director of the Utilization Review Department.

Patients may be eligible for indigent status and financial assistance under the following circumstances:

1. A patient is treated for an emergency medical condition, as determined and documented by the treating provider;
2. A patient is treated for the signs or symptoms of a communicable disease, as determined and documented by their treating provider, whether or not those symptoms are caused by communicable disease; or
3. A patient is treated for immunizations, as documented in the medical record

The following services are services which are typically not considered covered services within the meaning of this Policy:

- cosmetic surgery,
- reversal of vasectomy,
- elective pregnancy terminations,
- tubaplasties,
- infertility studies and treatment,
- other services not routinely provided by UNMH medical staff or facilities as determined by the medical staff of UNM Hospitals.(for example, liver or cardiac transplantation)

Exceptions to non-covered services will be considered by the Medical Director and Chief Medical Officer.
Other Coverage

With limited exceptions as described below, UNM Hospital’s financial assistance program is the financial program of last resort. This means that government or private insurance will be a primary financial payment source before the UNM Hospital’s financial assistance program. Medicaid eligible individuals must apply for Medicaid and receive a denial of eligibility prior to being considered for indigent status and financial assistance.

A patient can be eligible for indigent status and financial assistance with respect to any unpaid amounts after the government or private insurance has fully paid UNM Hospital as required under the terms of that government or private insurance plan.

UNM Hospital will subrogate with a liability payer for third party tortfeasor cases.

Indian Health Service Contract health coverage is secondary to UNM HSC’s financial assistance for those Native Americans who reside in Bernalillo County and who meet the financial assistance and medical necessity criteria.

Denial and Appeal Process:

A patient will receive a letter from UNM Hospital if the patient is denied eligibility to the financial program for any reason. If a patient is not granted indigent status or financial assistance because of lack of documentation for identity, residency, income, asset or medical necessity reasons, they can appeal to the Medical Director of the Utilization Review Department and Chief Medical Officer.

Co-pay Requirements

Any patient who is not covered in whole or in part by government or private insurance and who is otherwise qualified for indigent status and financial assistance as provided in this Policy will be required to pay the following co pay amounts and will be eligible for the following levels of assistance:

<table>
<thead>
<tr>
<th>Income Level (% of FPG)</th>
<th>Asset Level</th>
<th>Clinic Visit Co-Pay / Balance Owed</th>
<th>Emergency Dept, Diagnostics Co-Pay / Balance Owed</th>
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<tr>
<td>0 - 100%</td>
<td>$20,000</td>
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<td>200 - 300%</td>
<td>$20,000</td>
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<td>$75 / $0</td>
<td>$300 / $0</td>
</tr>
</tbody>
</table>
Native Americans who provide documentation of tribal affiliation and qualify for financial assistance will not be required to pay a co-payment for services covered under financial assistance.

Patients can, and are strongly encouraged to, make payment arrangements for monthly payments for their unpaid balance(s). UNMH will not accrue interest on any balance owed for an account with UNMH for a self pay contract account.

Other

If a patient otherwise qualifies for the indigent status but is not eligible for full financial assistance, they will be eligible to receive a 45% discount and may set up a payment plan that will not charge interest and allow for monthly payments. If the patient accumulates multiple accounts they may request that the accounts be combined.

APPLICABILITY
This policy pertains to all UNM Hospitals and Clinics including UNM Cancer Center.

POLICY AUTHORITY
Chief Executive Officer

SUMMARY OF CHANGES

RESOURCES/TRAINING

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<thead>
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<td>Owner</td>
<td>Board of Trustees</td>
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<tr>
<td>Official Approver</td>
<td>Christine Glidden, Secretary</td>
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<td>Official Signature</td>
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<td>Effective Date: 10/30/2015</td>
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<tr>
<td>Issue Date</td>
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POLICY STATEMENT
The UNM Health Sciences Center offers financial assistance from the patient’s medical bill for any qualified patient who:
1. Has met certain residency requirements; and
2. Is not covered or is only partially covered by government or private insurance; and
3. Has met established financial criteria; and
4. Has met medical necessity criteria and
5. The services in question are covered by the financial assistance program.

UNM HSC will abide by the federal Emergency Medical Treatment and Labor Act (EMTALA) in providing care to patients at UNM HSC.
UNM Care is another name for the UNM HSC’s financial assistance program. Medical services rendered to patients outside the UNM HSC facilities are not payable by UNM HSC.
Patients who are denied financial assistance will be given a letter of ineligibility indicating why they were denied financial assistance and how they can appeal the decision.

DETAILED POLICY STATEMENT
Residency Requirements
The patient must be living in New Mexico and demonstrate an intention to remain in the state. Residence in New Mexico is established by living in the state and carrying out the types of activities associated with normal living: such as occupying a home, enrolling children in school, getting a NM driver’s license or ID, renting a post office box, obtaining employment, etc. within Bernalillo County or the State of New Mexico and show an intent to remain a resident of Bernalillo County or the State of New Mexico. The patient can demonstrate this residency by bank statements, home ownership, rental leases, utility bills, pay stubs, income tax returns, or other similar documents.
Temporary Visas will not be considered a demonstration of intent to stay in the County or the State.
Patients who are not US Citizens, not resident aliens or not present in the United States under color of law may be eligible for financial assistance under the following circumstances:
1. A patient is treated for an emergency medical condition
2. A patient is treated for the signs or symptoms of a communicable disease whether or not those symptoms are caused by communicable disease
3. A patient is treated for immunizations
If the medical circumstances above are not present the patient is eligible for a 45% discount on billed charges and the same low down payments if they meet the criteria defined in this policy.
Patients who meet residency requirements for the State, but are not residents of Bernalillo County, will only be eligible for financial assistance if the service they receive at the UNM HSC is not available in their county of residence, as determined by the medical Staff of UNM Hospital. These patients should apply for their home county funds before approval for UNM HSC financial assistance.

**Financial Requirements**
The patient must verify income by providing check stubs, income taxes, letters from employers, direct bank deposits, letters from Social Security, or other similar documents. The income of the immediate family is then compared to the guidelines to determine eligibility. Guidelines are based on the Federal Poverty Guidelines (FPG) and revised annually. The patient must verify assets by providing bank statements, investment statements or other similar documents. Retirement funds, primary residence, and vehicles are not considered in the asset level.

**Medical Necessity Criteria**
Medically necessary services, as determined by the medical attending and UNM Hospital’s utilization department may qualify for financial assistance. The following services are not covered services within the meaning of this Policy:

- cosmetic surgery,
- reversal of vasectomy,
- elective pregnancy interruptions,
- tuboplasties,
- infertility studies and treatment,
- and other services determined from time to time as determined by the medical staff of UNM Hospitals.

**Other Coverage**
With limited exceptions as described below, UNM HSC’s financial assistance program is the payer of last resort. This means that government or private insurance will be a primary financial payment source before UNM HSC’s financial assistance program. A patient can be eligible for financial assistance with respect to any unpaid amounts after the government or private insurance has fully paid UNM HSC as required under the terms of that government or private insurance plan. UNM HSC will subrogate with a liability payer.

Indian Health Service Contract health coverage is secondary to UNM HSC’s financial assistance for those Native Americans who reside in Bernalillo County and who meet the financial assistance and medical necessity criteria.

**Co-pay Requirements**
Any patient who is not covered in whole or in part by government or private insurance and who is otherwise qualified for financial assistance as provided in this Policy will be required to pay the following co-pay amounts and will be eligible for the following levels of assistance:

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Native Americans who provide documentation of tribal affiliation and qualify for financial assistance will not be required to pay a co-payment for services covered under financial assistance.
Patients can, and are strongly encouraged to, make payment arrangements for monthly payments for their unpaid balance(s) without interest.

APPLICABILITY
This policy pertains to all UNM HSC Hospitals and Clinics including UNMMG, and UNM Cancer Center.

POLICY AUTHORITY
Chief Executive Officer

SUMMARY OF CHANGES
This policy replaces: Bernalillo County Financial Assistance, Out of County Medically Indigent Financial Assistance, Medical Services and Financial Assistance for Non-United States Citizens, Low Income Uninsured Patient Discount.

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<td>Michelle Melendez, UNMH Board of Trustees</td>
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<tr>
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POLICY STATEMENT
All patients who received medical services at the UNM Health Sciences Center will be required to pay for those medical services. This payment liability can be met through the patient’s private insurance or government reimbursement programs. However, any remaining unpaid balance owing to the UNM Hospital will be the patient’s obligation to satisfy.

A patient whose financial liability is not satisfied by the patient’s private insurance or enrollment in government reimbursement programs, may be eligible for either UNM HSC’s financial assistance program or a discount.

UNM HSC will abide by the federal Emergency Medical Treatment and Labor Act (EMTALA) in providing care to patients at UNM Hospitals.

UNM Hospital will abide by Provider Reimbursement Manual Part, Section 310 (A) Collection Agencies.

DETAILED POLICY STATEMENT
Subject to the UNM HSC Financial Assistance Policy, a patient scheduled to receive non emergent, elective medical care may be required to make a down payment in advance for the medical care or procedure. Patients who are unable to make payment at the time for service will be triaged by the medical provider to determine if the visit is medically urgent and the payment should be deferred. HMO patients are required to pay their assigned co-payments. The co-pays below are based on the Federal Poverty Guidelines (FPG) and are revised annually. Retirement funds, primary residence, and vehicles are not considered in the asset level. The chart below indicates co-pays for financial assistance, discount program and self pay patients.

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<tr>
<td>Self pay</td>
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<td>$50</td>
<td>$200</td>
<td>50% estimated charges</td>
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Patients are responsible for the balance of accounts after discounts have been taken.
Patients can, and are strongly encouraged to, make payment arrangements for monthly payments for their unpaid balance(s) without interest. Patients with multiple accounts may request that all accounts be combined into a single account.

EXTENDED BUSINESS OFFICE
The UNM HSC will use an Extended Business Office (EBO) program to follow up on self pay accounts and self pay balances. The EBO has the authority to combine accounts and set up payment arrangements. If a patient is approved for financial assistance after an account has been referred to EBO, the account will be adjusted to financial assistance.

COLLECTION AGENCY
The UNM HSC will engage and use one or more collection agencies to follow up on unpaid patient accounts after a six month period in which a patient has an unpaid balance or has not met agreed upon payment arrangements for three consecutive months. The collection agency is not allowed to pursue judgments on accounts, place liens on patient’s property or charge interest. The collection agency will follow all applicable state and federal laws including the Fair Debt Collections Practices Act. Accounts approved for financial assistance or indigent status will not go to a collection agency for pursuit of the co-pays.

APPLICABILITY
This policy pertains to all UNM HSC Hospitals and Clinics including UNM Medical Group, and UNM Cancer Center.

POLICY AUTHORITY
Chief Executive Officer

SUMMARY OF CHANGES
This policy replaces Self Pay Collection and Self Pay Patient Payment, last revisions 9/2005 & 4/2007 respectively.

RESOURCES/TRAINING

<table>
<thead>
<tr>
<th>Resource/Dept</th>
<th>Internet/Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Financial Services</td>
<td><a href="http://hospitals.unm.edu/pfs/">http://hospitals.unm.edu/pfs/</a></td>
</tr>
</tbody>
</table>

DOCUMENT APPROVAL & TRACKING

<table>
<thead>
<tr>
<th>Item</th>
<th>Owner</th>
<th>Contact</th>
<th>Date</th>
<th>Approval</th>
</tr>
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<tbody>
<tr>
<td>Legal (Required)</td>
<td>UNMH Board of Trustees</td>
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<td>Y</td>
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<tr>
<td>Official Approver</td>
<td>Christine Glidden, UNMH Board of Trustees</td>
<td></td>
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<tr>
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<td></td>
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<tr>
<td>Issue Date</td>
<td>2/11/2010</td>
<td></td>
<td>ar</td>
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</table>
POLICY STATEMENT
All patients who received medical services at the UNM Health Sciences Center will be required to pay for those medical services. This payment liability can be met through the patient’s private insurance or government reimbursement programs. However, any remaining unpaid balance owing to the UNM Hospital will be the patient’s obligation to satisfy.

A patient whose financial liability is not satisfied by the patient’s private insurance or enrollment in government reimbursement programs, may be eligible for either UNM HSC’s financial assistance program or a discount.

UNM HSC will abide by the federal Emergency Medical Treatment and Labor Act (EMTALA) in providing care to patients at UNM Hospitals.

UNM Hospital will abide by Provider Reimbursement Manual Part, Section 310 (A) Collection Agencies.

DETAILED POLICY STATEMENT
Subject to the UNM HSC Financial Assistance Policy, a patient scheduled to receive non emergent, elective medical care may be required to make a down payment in advance for the medical care or procedure. Patients who are unable to make payment at the time for service will be triaged by the medical provider to determine if the visit is medically urgent and the payment should be deferred. HMO patients are required to pay their assigned co-payments. The co-pays below are based on the Federal Poverty Guidelines (FPG) and are revised annually. Retirement funds, primary residence, and vehicles are not considered in the asset level. The chart below indicates co-pays for financial assistance, discount program and self pay patients.

<table>
<thead>
<tr>
<th>Income Level (% of FPG)</th>
<th>Asset Level</th>
<th>Clinic Visit Co-Pay</th>
<th>Emergency Dept, Diagnostics Co-Pay</th>
<th>Inpatient stay, Day Surgery Co-pay</th>
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<tr>
<td>0 - 100%</td>
<td>$5,000</td>
<td>$5</td>
<td>$10</td>
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Title: Patient Payment Policy
Owner:
Effective Date:
Doc. #
Patients are responsible for the balance of accounts after discounts have been taken.

Patients can, and are strongly encouraged to, make payment arrangements for monthly payments for their unpaid balance(s) without interest. Patients with multiple accounts may request that all accounts be combined into a single account.

EXTENDED BUSINESS OFFICE
The UNM HSC will use an Extended Business Office (EBO) program to follow up on self pay accounts and self pay balances. The EBO has the authority to combine accounts and set up payment arrangements. If a patient is approved for financial assistance after an account has been referred to EBO, the account will be adjusted to financial assistance.

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The UNM HSC will engage and use one or more collection agencies to follow up on unpaid patient accounts after a six month period in which a patient has an unpaid balance or has not met agreed upon payment arrangements for three consecutive months. The collection agency is not allowed to pursue judgments on accounts, place liens on patient’s property or charge interest. The collection agency will follow all applicable state and federal laws including the Fair Debt Collections Practices Act. Accounts approved for financial assistance will not go to a collection agency for pursuit of the co-pays.

APPLICABILITY
This policy pertains to all UNM HSC Hospitals and Clinics including UNM Medical Group, and UNM Cancer Center.

POLICY AUTHORITY
Chief Executive Officer

SUMMARY OF CHANGES
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<td>Committee(s)</td>
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<td>[Y or N/A]</td>
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Title:
Owner:
Effective Date:
Doc. #
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<tr>
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<tr>
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<td>[Day/Mo/Year]</td>
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<tr>
<td>Origination Date</td>
<td>[Month/Year]</td>
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<tr>
<td>Issue Date</td>
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</table>
UNM Hospitals

Finance Guidelines for Surgical Cases for Providers (Non Urgent Cases)

This only applies to surgical procedures in the operating rooms and does not apply to clinic procedures

Financial and Prior Authorization Requirements for UNMH

➢ To assure correct billing and payment for non-emergent, elective surgical cases, the following guidelines are to be followed. Patients need to be cleared financially, and, in appropriate cases, cleared for medical urgency of the procedure, prior to scheduling the surgical case.

Financial Clearance Guidelines

• All Patients must be financially cleared prior to scheduling for non-emergent cases.
• Patients who are currently in Self Pay Status will need to see a financial counselor to determine eligibility for Medicaid, UNM Care, other Financial Assistance Programs, or the Self-Pay Discount Program.
• Patients who qualify for Medicaid, Medicare, Commercial Insurance, UNM Care, or other third party coverage will be cleared to proceed for scheduling. Patients should be scheduled a minimum of 28 days out to allow for required prior authorization processing for Medicaid or commercial insurance patients (may be scheduled sooner based on provider determination of medical necessity).
• Patients who qualify for the Self Pay Discount Program are eligible for a discount:
  o Patients placed on the Self Pay Discount Program will automatically receive a 45% discount to the normal billed charges for the procedure.
  o For patients qualifying for the Self Pay Discount Program to be cleared for scheduling, they must, subject to the medical urgency exception below, make a down payment of 50% of their expected remaining balance. The Financial Counselor will coordinate this process with the patient.
  o Once the down payment obligation is met, the Financial Counselor will notify the clinic that the patient is cleared for scheduling.
• Patients who do not qualify for the UNM Care Financial Assistance Program, other financial assistance, or the Self-Pay Discount Program, will be required to pay 100% of the estimated charges. Subject to the medical urgency exception below, the patient must make a down payment of 50% of the estimated charges prior to being scheduled for the procedure.

Prior Authorization Requirements

• Most surgical cases will require an authorization from Medicaid, Commercial Insurance or other payers.
• By Regulation, the Medicaid MCOs have 14 days within which to respond to authorization requests for non-urgent cases.
• In order to assure correct and timely processing of prior authorizations, cases should be scheduled at least 28 days from the date of request for the procedure (patients may be scheduled sooner based on provider determination of medical necessity).
**Medical Urgency Exception**

Patients whose proposed surgical care is determined to be non-emergent, but medically urgent may have the requirement of a 50% down payment deferred until after completion of the surgical case. To effect this deferral, this will require written approval to proceed with scheduling the surgical case. The attached non-emergent clinical procedures form will need to be completed by the financial counselor and forwarded to Dr. Agostini at UNM Hospital for approval to proceed with scheduling the case.

---

**Non-Emergent Surgical Procedures Approval Form**

Name of Patient______________________________       MRN___________________

Date of Surgical Procedure___________________

Surgical Procedure Information: _____________________________________________
_______________________________________________________________________

Cost of case per Experian______________Cost after 45% discount (if eligible) _____________

50% down payment expected from patient (27.5%)______________________________

If the patient is not covered under insurance, Medicare, Medicaid or other payment source such as VA or IHS, did the patient get registered with the surgical services procedure self-pay discount plan?  
Y___ N_____ 

Was the 50% down payment collected?  Y___N______

Will the vendor donate any medical supplies to be used for this patient?  * YES__ NO__

If UNMH and No, please refer to Dr. Irene Agostini for approval

---

To be completed by Dr. Agostini or her designated acting Medical Officer

Is this case deemed:

Emergent?  Y___N___  
Elective?  Y___ N____  
Medically Urgent?  Y___N __

I understand that the patient was screened for financial assistance, and is not able to pay and has not paid the expected 50% down payment for the cost of the procedure. Because I believe the surgical procedure is medically urgent, I authorize the surgical procedure to be performed.

_______________________________
Irene Agostini, M.D., Chief Medical Officer

---

NOTE: For orthopedic patients only Stryker may pay for hardware for two replacement cases a year. There is a six week application process and Stryker must approve the application in advance of surgery.
June 29, 2017

Steve McKernan
Chief Executive Officer, UNM Hospital
2211 Lomas Blvd NE
Albuquerque, NM 87106

Dr. Irene Agostini
Chief Medical Office, UNM Hospital
2211 Lomas Blvd NE
Albuquerque, NM 87106

Chamiza Pacheco
UNM Health Sciences Center
1 University New Mexico
Albuquerque, NM 87131-0001

VIA EMAIL

Dear Mr. McKernan, Dr. Agostini, and Ms. Pacheco,

We are deeply disappointed by your response to concerns about UNM Hospital’s 50% down payment policy for low-income, indigent patients. Please review the Hospital’s policy guidelines that were finalized in May 2, 2017, attached here for your reference, as it appears you did not review or acknowledge them yesterday before accusing community members of being misinformed.

The guidelines clearly state that the Hospital will require all indigent patients that qualify for discount payment plans to pay down payments amounting to 50% of their expected charges for any surgical cases that are not emergencies. The only exception is for medical urgency, in which case patients must seek special permission from Dr. Agostini, Chief Medical Officer of the Hospital.

In other words, the Hospital knows that these patients are indigent and cannot afford medical care, and yet is charging them with exorbitant upfront fees or canceling their surgeries. They have already been qualified for a discount program. However, the discount is now meaningless because it does not apply to the down payment as it used to in the past. A patient we spoke to last week had his surgery canceled for a painful knee condition, because he was unable to afford $16,000 upfront in down payments. His family is living near poverty and he had already been enrolled in the discount program.

The practice is especially egregious from a hospital that takes public funding to care for the indigent and people who cannot afford insurance. The Hospital is allowing patients to get care right away if they have health insurance or can afford the down payment, while low-income patients that cannot afford the care are being turned away. They must go through a bureaucratic process to get special permission from the Chief Medical Officer by proving the care is “urgent”, creating further burdens for patients who are already facing sickness and hardship.
Even if they get through the process, they cannot get these approvals for all other medically necessary care that every other patient has access to, potentially impacting their livelihood, ability to work, take care of their children, or suffer a worsening condition that will become an emergency if left untreated. Again, no other patient is asked to go through this process and would be seen right away for any medically necessary care if they could afford insurance or the down payment.

This policy is a major reversal from a long-standing commitment of UNM Hospital not to impose these 50% down payments. In 2005, Governor Richardson held a healthcare summit to address how UNM Hospital is fulfilling its public health mission. One major outcome of the summit was an agreement by Dr. Roth and the Health Sciences Center that UNMH would no longer charge a 50% down payment for uninsured patients and to instead charge them the same co-payments as UNM Care patients. Dr. Roth also assured us in a meeting last year that any patient who was eligible for the discount program would have the same access to care as everyone else.

UNM Hospital receives over $90 million in public funding each year in taxpayer dollars to support its role as a safety net provider in our community. We expect the Hospital to provide indigent care to the most vulnerable residents, not sending them out the door. Please fix this policy immediately.

Sincerely,

Sireesha Manne
Attorney
New Mexico Center on Law and Poverty

Cc: Paul Roth, Chancellor of UNM Health Sciences Center
Operating Plan Update

UNM Hospitals Board of Trustees
July 28, 2017
## Strategic Framework: UNMHS Vision

<table>
<thead>
<tr>
<th>UNMHS Vision</th>
<th>UNM Hospital Vision</th>
<th>UNM Hospital Mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>As UNM HSC helps New Mexico make more progress in health and health equity than any other state, New Mexicans will choose UNMHS as their gateway to advancing patient care, clinical innovation, and continuous healthy living.</td>
<td>UNMH will be the leader in improving New Mexico's health outcomes through both our academic specialty programs and our community responsive, culturally competent, patient care, education, and clinical research programs.</td>
<td>Exceptional care for all of New Mexico through compassion, learning and discovery.</td>
</tr>
<tr>
<td>UNM Hospital Vision</td>
<td>UNM Hospital Mission</td>
<td>UNM Hospital Vision</td>
</tr>
<tr>
<td>UNMH will be the leader in improving New Mexico's health outcomes through both our academic specialty programs and our community responsive, culturally competent, patient care, education, and clinical research programs.</td>
<td>Exceptional care for all of New Mexico through compassion, learning and discovery.</td>
<td>UNM Hospital Vision</td>
</tr>
<tr>
<td>We aspire to be one of the nation's leading university hospitals which captures the synergy in being both an excellent academic institution and an innovative, community oriented public teaching hospital. UNMH will set the standard for excellence in quality and patient safety in public teaching hospitals.</td>
<td>Exceptional care for all of New Mexico through compassion, learning and discovery.</td>
<td>UNM Hospital Vision</td>
</tr>
</tbody>
</table>
Strategic Framework: Integration with the University

University Mission, Values, Vision

HSC Mission, Values, Vision

Clinical
Teaching
Research

Health System Vision

SRMC
UNMMG
UNMH
School / Colleges*

*Clinical components within the School of Medicine of Colleges of Nursing and Pharmacy
UNM Health System

MISSION: Excellence

People | Service | Quality | Finance | Growth | Community | Academic

Pillars of Excellence
Connection

Define the cascade among:

– Health System Strategy
– UNMH Mission Excellence Pillars
– Strategic Priorities
– Unified Operating Plan Goals
– Mission Excellence Tactics
Strategic Growth & Partnerships
Replacement Hospital

- Health System Strategic Goals
- UNMH Pillar
- Strategic Priority
- Replacement Hospital
- Complete plan
- Involvement and engagement

MISSION: Excellence Tactics

Tactics
- Involvement and engagement

99/145
Strategic Growth & Partnerships
Ambulatory Access

Health System Strategic Goals
- Strategic Growth & Partnerships

UNMH Pillar
- Growth

Strategic Priority
- Increase Ambulatory Access & Throughput

UOP Operating Goal
- Increase UNMH clinic visits by 4%

MISSION: Excellence Tactics
- Outpatient Experience Team
- AIDET
- Rounding
- LEM
Strategic Growth & Partnerships
Transfer Network

Health System Strategic Goals

• Strategic Growth & Partnerships

UNMH Pillar

• Growth

Strategic Priority

• Increase Inpatient Capacity & Throughput

UOP Operating Goal

• Increase CMI by 3.5%

MISSION: Excellence Tactics

• Discipline
• Documentation
• Communication
Strategic Growth & Partnerships
Inpatient Access

• Strategic Growth & Partnerships

UNMH Pillar

• Growth

Strategic Priority

• Increase Inpatient Capacity & Throughput

UOP Operating Goal

• Increase UNMH daily adult without OB discharges by 2%

MISSION: Excellence Tactics

• Leader Rounding
  • LEM
  • Patient Rounding
  • Stoplight Report
Strategic Growth & Partnerships
Improve Information Systems

- Health System Strategic Goals
- UNMH Pillar
- Strategic Priority
- UOP Operating Goal
- MISSION: Excellence Tactics

• Strategic Growth & Partnerships
• Growth
• Increase Health System Surgical volume
• Increase surgical cases by 5%
• Leader Evaluation Manager
• Rounding
• Stoplight Report

MISSION:
Excellence
Tactics

103/145
Strategic Growth & Partnerships

Information Technology

Health System Strategic Goals

• Strategic Growth & Partnerships

UNMH Pillar

• Growth

Strategic Priority

• Information Technology Implementation

UOP Operating Goal

• Implementation of Population Health in Electronic Medical Record

MISSION: Excellence Tactics

• Physician Leadership Involvement
Strategic Growth & Partnerships

Information Technology

Health System Strategic Goals

• Strategic Growth & Partnerships

UNMH Pillar

• Growth

Strategic Priority

• Information Technology Implementation

UOP Operating Goal

• Implement the Quality Surveillance system

MISSION: Excellence Tactics

• Stoplight Report
• Physician Leadership Involvement
• Leader Evaluation Manager

12
Patient Experience / Quality Safety

Health System Strategic Priorities

• Patient Experience

UNMH Pillar

• Quality & Safety

Strategic Priority

• Improve Patient Safety and Outcomes

UOP Operating Goal

• CMS License
• TJC Accreditation

MISSION: Excellence Tactics

• 90-day Action Plans
• Leader Evaluation System

106/145
Patient Experience / Quality
Reduce Mortality

Health System Strategic Goals

• Patient Experience

UNMH Pillar

• Quality

Strategic Priority

• Improve Mortality Index

UOP Operating Goal

• Mortality Index < .93 (UHC 2016 Mortality Model)

MISSION: Excellence Tactics

• Leader evaluation system
• Aligned goals
• Stoplight Report
Patient Experience / Quality
Harm Events

- **Health System Strategic Goals**

- **UNMH Pillar**

- **Strategic Priority**

- **UOP Operating Goal**

- **MISSION: Excellence Tactics**

- **Reduce Severe Patient Harm Events (SPHEs)**
  - Reduce non-infection related Severe Patient Harm Events (SPHEs)

- **Patient Experience**

- **Quality**

- **Leader evaluation system**
- **90-day action plans**
- **Aligned goals**
Patient Experience / Quality
Harm Events

- Patient Experience

- Quality

- Reduce Severe Patient Harm Events (SPHEs)

- Reduce infections

Health System Strategic Goals

UNMH Pillar

Strategic Priority

UOP Operating Goal

MISSION: Excellence Tactics

- Leader evaluation system
- 90-day action plans
- Aligned goals
Patient Experience / Quality
Harm Events

- Patient Experience
- Quality
- Reduce Readmissions
- Leader evaluation system
  - Patient Rounding
  - Pre and Post Visit Communication

UNMH Pillar
Health System Strategic Goals
Strategic Priority
UOP Operating Goal
MISSION: Excellence Tactics

110/145
Patient Experience / Service
Patient Satisfaction

Health System Strategic Priorities

UNMH Pillar

Strategic Priority

UOP Operating Goal

MISSION: Excellence Tactics

- CGCAHPS – 35th Percentile
- HCAHPS - 38th Percentile
- Patient Experience Teams
- 10/5 Rule
- Standards of Behavior
- AIDET

• Improve Patient Experience

• Service

• Service

• Service
Patient Experience / Service

Health System Strategic Priorities

UNMH Pillar

Strategic Priority

UOP Operating Goal

MISSION: Excellence

• MISSION: Excellence

• Achieve >=80% compliance with M:E initiatives

• Cascading goals

• Leader Evaluation Manager

• Rounding

112/145
Culture of Excellence / People Employee Engagement

- **Health System Strategic Goals**
  - Culture of Excellence

- **UNMH Pillar**
  - People

- **Strategic Priority**
  - Improve Faculty & Staff Engagement and Satisfaction

- **UOP Operating Goal**
  - Turnover rate for Non-RN & RN Staff less than 14%

- **MISSION: Excellence Tactics**
  - Leader Rounding
  - Thank you Notes
  - Peer Interviewing
  - Reward & Recognition
Culture of Excellence / People
Medical Staff Engagement

- **Culture of Excellence**

- **UNMH Pillar**

- **People**

- **Strategic Priority**

- **Improve Faculty & Staff Engagement and Satisfaction**

- **UOP Operating Goal**

  - Provider Voice Pulse Survey for Engagement of all providers as of June 2018 Press Ganey Survey at 25th%ile increase of 10%

- **MISSION: Excellence Tactics**

  - Re-recruit high performers
  - Provider Selection
  - Behaviors of Excellence
  - Rounding
Operations / Finances

Finances

Health System Strategic Goals

• Operations

UNMH Pillar

• Finance

Strategic Priority

• Strong Financial Performance

UOP Operating Goal

• Health System Net margin > 1%

MISSION: Excellence Tactics

• Leader evaluation system
• Aligned goals

115/145
Health System Strategic Goals

• Operations

UNMH Pillar

• Finance

Strategic Priority

• Prepare for Transition to Value Based Care

UOP Operating Goal

• Increase Medicare Advantage and Managed Care Organization Value Based Care

MISSION: Excellence Tactics

• Quality Measures
• Shared weighted quality goals
• Patient Experience
Health System Strategic Goals

UNMH Pillar

Strategic Priority

UOP Operating Goal

MISSION: Excellence Tactics

- Operations
- Finance

- Manage the Capital Planning and Expenditure Process
- Invest to level of depreciation expense
- Sr. Leader Rounding
- Stoplight & Scouting Reports
Operations / Finance

Improve Revenues

• Operations

Health System Strategic Goals

UNMH Pillar

• Finance

Strategic Priority

• Improve the Revenue Cycle through Billing Improvements and Organization Structure

• FOM Collections per wRVU increase by >=2%

• Objective weighted goals
• Pre and Post Visit Communication

UOP Operating Goal

MISSION: Excellence Tactics

118/145
Operations / Finance

Improve Revenues

- Health System Strategic Goals
- UNMH Pillar
- Strategic Priority
- UOP Operating Goal
- MISSION: Excellence Tactics

• Improve the Revenue Cycle through Billing Improvements and Organization Structure
  • Increase in net revenue/CMI adjusted patient day by >=2%
  • Objective weighted goals
  • Pre and Post Visit Communication

• Operations
• Finance

MISSION: Excellence Tactics
GOAL
Better than 50%

Safety
Efficiency
Experience

Rating in each category

More ↔ Better ↔ Less

121/145
# Unified Operating Plan

**University of New Mexico Hospital**  
Operating Plan  
**FY 18**

## Pillar: Growth

<table>
<thead>
<tr>
<th>Pillar</th>
<th>HS Strategy</th>
<th>FY 18 Goal</th>
<th>Leader</th>
<th>FY18 Metric/Target</th>
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<tr>
<td>UNMH 1</td>
<td>Finalize Plan for Adult Replacement Hospital</td>
<td>Complete plan</td>
<td>Mike Richards/Mike Chicorelli</td>
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<td>Increase ambulatory access and throughput</td>
<td>Increase UNMH clinic visits by 4%</td>
<td>Michael Gomez/Kori A Beech</td>
<td>759/703</td>
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<td>Implementation of Population Health in Cerner</td>
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## Pillar: Quality & Safety

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<tr>
<th>Pillar</th>
<th>HS Strategy</th>
<th>FY 18 Goal</th>
<th>Leader</th>
<th>FY18 Metric/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNMH 2.1</td>
<td>Maintain accreditation and deemed status</td>
<td>Maintain TJC Accreditation Status</td>
<td>Steve McKerman</td>
<td>yes/no</td>
</tr>
<tr>
<td>UNMH 2.1</td>
<td></td>
<td>Maintain CMS License</td>
<td>Steve McKerman</td>
<td>yes/no</td>
</tr>
<tr>
<td>UNMH 2.2</td>
<td>Improve Mortality Index</td>
<td>Mortality Index &lt; .335 (UHC 2016 Mortality Model)</td>
<td>Richard Croswell MD</td>
<td>0.39</td>
</tr>
<tr>
<td>UNMH 2.3</td>
<td>Reduce severe patient harm events [SPHEs] [July-December 2017]</td>
<td>Reduce non-infection related SPHEs (PSI 98) without PSI 4</td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>UNMH 2.3</td>
<td></td>
<td>CLABSI events</td>
<td>Richard Croswell MD</td>
<td>21</td>
</tr>
<tr>
<td>UNMH 2.3</td>
<td></td>
<td>CAUTI events</td>
<td>Richard Croswell MD</td>
<td>27</td>
</tr>
<tr>
<td>UNMH 2.3</td>
<td></td>
<td>SSI Colon Resections</td>
<td>Richard Croswell MD</td>
<td>5</td>
</tr>
<tr>
<td>UNMH 2.3</td>
<td></td>
<td>SSI Hysterectomy</td>
<td>Richard Croswell MD</td>
<td>3</td>
</tr>
<tr>
<td>UNMH 2.4</td>
<td>Reduce readmissions</td>
<td>Reduce readmission</td>
<td>Richard Croswell MD</td>
<td>&lt; 9%</td>
</tr>
</tbody>
</table>

## Pillar: Service

<table>
<thead>
<tr>
<th>Pillar</th>
<th>HS Strategy</th>
<th>FY 18 Goal</th>
<th>Leader</th>
<th>FY18 Metric/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNMH 3.1</td>
<td>Improve Inpatient Experience</td>
<td>UNMH Rate the hospital stay for HCAHPS</td>
<td>Richard Croswell MD</td>
<td>38%de</td>
</tr>
<tr>
<td>UNMH 3.1</td>
<td></td>
<td>UNMH Rate the Hospital stay for HCAHPS Percent Score</td>
<td>Richard Croswell MD</td>
<td>38%de</td>
</tr>
<tr>
<td>UNMH 3.2</td>
<td>Improve Outpatient Experience</td>
<td>UNMH Recommend this Provider Office for CQCAHPS &gt; or ≥ to 50th pctl</td>
<td>Richard Croswell MD</td>
<td>38%de</td>
</tr>
<tr>
<td>UNMH 3.2</td>
<td></td>
<td>UNMH Recommend this Provider Office for CQCAHPS Percent Score</td>
<td>Richard Croswell MD</td>
<td>38%de</td>
</tr>
<tr>
<td>UNMH 3.3</td>
<td>MISSION:Excellence</td>
<td>Achieve ≥93% compliance with MIEx Initiatives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Pillar: People

<table>
<thead>
<tr>
<th>Pillar</th>
<th>HS Strategy</th>
<th>FY 18 Goal</th>
<th>Leader</th>
<th>FY18 Metric/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNMH 4.1</td>
<td>Improve Faculty and Staff engagement and satisfaction</td>
<td>Staff turnover &lt; 14%</td>
<td>Steve McKerman</td>
<td>4%</td>
</tr>
<tr>
<td>UNMH 4.2</td>
<td>Improve the pulse</td>
<td>Provider Voice Pulse Survey for Engagement of all providers as of June 2018 Press Ganey Pulse Survey</td>
<td></td>
<td>25%de</td>
</tr>
</tbody>
</table>

## Pillar: Finance

<table>
<thead>
<tr>
<th>Pillar</th>
<th>HS Strategy</th>
<th>FY 18 Goal</th>
<th>Leader</th>
<th>FY18 Metric/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNMH 5.1</td>
<td>Strong Financial Performance</td>
<td>Health System net margin &gt; 1%</td>
<td>Ella Watt</td>
<td>&gt; 1%</td>
</tr>
<tr>
<td>UNMH 5.2</td>
<td>Prepare for transition to value based care</td>
<td>Increase MA and MCO Value Based Care</td>
<td>Ella Watt</td>
<td></td>
</tr>
<tr>
<td>UNMH 5.3</td>
<td>Manage the capital planning and expenditure process</td>
<td>Invest to level of depreciation expense</td>
<td>Ella Watt</td>
<td></td>
</tr>
<tr>
<td>UNMH 5.4</td>
<td>Improve the revenue cycle through billing improvements and organization structure</td>
<td>PGM collections per visit/encounter increase by &gt; 2%</td>
<td>Ella Watt</td>
<td>&gt; 2%</td>
</tr>
<tr>
<td>UNMH 5.4</td>
<td></td>
<td>Increase in net revenue/CMII adjusted patient day by &gt; 2%</td>
<td>Ella Watt</td>
<td>&gt; 2%</td>
</tr>
</tbody>
</table>
QUESTIONS?
MISSION: Excellence

UNM Hospitals Board of Trustees
July 28, 2017
LEADing to Excellence

- Two-day session
- June 5-6
- Keynotes
  - Stretching through Connection
    Dr. David Rakel
  - Tough Conversations
    Lynne Cunningham (Studer)

<table>
<thead>
<tr>
<th></th>
<th>UNMH</th>
<th>HSC</th>
<th>UNMMG</th>
<th>SRMC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>568</td>
<td>154</td>
<td>66</td>
<td>23</td>
<td>811</td>
</tr>
</tbody>
</table>
**MISSION: Excellence Roadmap**

**Where We’ve Been (Foundational)**
- Assessment and Planning
- Steering Team Development
- Foundational and Sub-Team Development
- LEADING to Excellence Sessions
- MISSION: Excellence Quarterly Forums

**Where We Are (Current Priorities)**
- Goal Setting and Alignment
- Rounding and Thank You Notes
- Provider Pulse Surveys
- Expectations of Behavior
- AIDET/Key Words at Key Times
- Use of Rounding Tool
- Use of Leader Evaluation Manager

**Where We’re Going (Up Next!)}
- Senior Leader Rounding
- Internal Customer Rounding
- Leader Rounding on Patients
- Support Services Surveys
- HighSolidLow™
People Update

- AIDET
- Patient Rounding
- Senior Leader Rounding
- Employee and Provider Rounding

*Is rounding making a difference?*
I was rounded on by my leader in the past 6 months*

Source: 2017 Provider Pulse Survey
## Service Update

<table>
<thead>
<tr>
<th>Patient Satisfaction Scores</th>
<th>Jan-March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNMH</strong></td>
<td></td>
</tr>
<tr>
<td>Rate the Hospital 0-10 (HCAHPS)</td>
<td>70.3%</td>
</tr>
<tr>
<td>Recommend this Provider Office (CGCAHPS)</td>
<td>86.8%</td>
</tr>
<tr>
<td>Cancer Center</td>
<td>89.5%</td>
</tr>
<tr>
<td><strong>SRMC</strong></td>
<td></td>
</tr>
<tr>
<td>Rate the Hospital 0-10 (HCAHPS)</td>
<td>80.4%</td>
</tr>
<tr>
<td>Recommend this Provider Office (CGCAHPS)</td>
<td>83.0%</td>
</tr>
</tbody>
</table>
Growth Update

• Health System adult discharges increased 3%
• Total outpatient visits are up 4%
• Surgeries are up 4%
• Physician work RVU's are up 5.7%
• Health System net revenues are breakeven before Meaningful use revenues of $7.6M
Growth and Community Update

Lovelace UNM Rehabilitation Hospital – May 31st Ribbon Cutting Ceremony
Growth and Community Update

New!

• Women’s Primary Care Clinic
  – Located on Eubank in NE Heights
  – Grand Opening: August 4th
Up Next!

• Senior Leader Rounding
  – 1 hour/week CEO’s, CMO’s, CNO’s round in units using the Scouting Report
• Leader Evaluation Manager Training
• LEADING to Excellence—September 18 & 19
THANK YOU!
ADMINISTRATIVE REPORTS
MEMORANDUM

To: Board of Trustees

From: Stephen McKernan
Chief Executive Officer

Date: July 24, 2017

Subject: Monthly Activity Update

The Hospital has been involved in a variety of activities and this report will focus on services delivered through June.

Quality: Quality indicators are stable with the prior year and have shown some improvement recently. The focus is around those events that are also tracked by CMS and Vizient. The principal issues are related to infections and other events like lacerations and punctures. We will continue to provide updates at the Board and Committee meetings. We believe that the Mission Excellence project will hold the organization to higher standards for patient safety outcomes. The goals are to move to a three star rating in the Vizient quality and safety measurement system within a year.

Statistics: UNMH has stable and increasing patient activity. Patient days were the same as the prior year. Discharges are running 3% higher than the prior year. Clinic visits increased 1% above the prior year. The Case Mix Index is 6% above the prior year. The Emergency Room increase is 4% above the prior year. The number of surgeries increased 5%. The number of births has decreased 2%. Overall activity is being recorded at about 8% greater than the prior year with a significant proportion of that increase represented by the Case Mix Index increase of 6% above the prior year.

Financial: The finances are stable for the Hospital. The income statement and balance sheet will be presented at the next meeting after year end close.

Strategic Planning: The Board has been working with a consultant on its governance processes and the Executive Committee met to review the recommendations and will report at the July meeting.

The management presented to the State Board on July 18. The presentation was for information only and there was no decision from that meeting. The next step is for the University to make a decision on how to proceed with moving forward on retaining architecture services for the Phase 1 of planning of the Modern Medical Facility.

Management is also reviewing the last Strategic Plan that was presented about 4 years ago and after discussing with the Board has issued a RFP to engage a firm to initiate this process this summer with a target date for completion by the end of the calendar year.

Human Resources: The turnover rates are now around 15% for the full workforce and 14% for nurses as a subset, about the same for the past year. We have almost 133 less employees on a base of 6,265 from the past year. We have decreased the total compliment of nurses by 62 on a base of 2,088 from the past year.

UNM Health System is continuing the journey on Mission Excellence and is using the Studer Group as a consultant. The organization has another quarterly Leadership Training Session next week, which will be
a two day event that will feature significant skill building sessions. A briefing will be provided at the meeting to review the status of the engagement.

**Native American Liaison:** UNM Hospital Board created the Native American Liaison Committee to review compliance with the condition of the 1952 Contract, the Lease and the two Consents to amend the Lease. There is a request to review the Hospital compliance with the 100 bed provision of the Contract. We have provided a legal opinion about UNM’s interpretation of the provision and have a draft of the policy to present to the Native American Liaison Committee. We have gotten a request on the areas of focus for service from the IHS for the budget for Fiscal Year 2018. We hosted the All Pueblo Council of Governors on June 15 and provided an update from the Hospital.

**Bernalillo County:** Management has been interacting with the County and the Indian Health Service on the next steps to develop the Memorandum of Understanding. Legal is working on a new draft of the MOU for review by the parties.

If there are any questions on this or other matters, please feel free to contact me.
To: Board of Trustees

From: Irene Agostini, MD
UNMH Chief Medical Officer

Date: July 28, 2017

Subject: Monthly Medical Staff and Hospital Activity Update

1. The average wait time for a patient from the Adult Emergency Department to be placed after admission for the month of June was 9 hours. This time has increased from 2016 time of 6 hours and 36 minutes. UNMH remains greater than 90% capacity on average. We continue to ensure surgeries are not canceled due to capacity.
   - We sent 21 patients to an SRMC Inpatient unit instead of placing at UNM Hospital.

2. The Community Partnership with Lovelace Health system continues to be successful in putting the needs of the “Patient First”, allowing continued access to those patients that can only be cared for by UNMH. In the month of November:
   - 51 patients were triaged from the UNM Health System to Lovelace inpatient units.

4. Our ALOS (average length of stay) for June 2017 was 6.38 as compared to June 2016 which was 6.08. However for FYTD 2017 our ALOS is 6.63 which is an improvement from FYTD 2016 when it was 6.93. We continue to hardwire our new processes to decrease our ALOS despite accepting higher acuity patients.

5. The Physician Advisory Group (PAG) provider engagement and satisfaction work continues. Our first two day “Mission Excellence” retreat occurred June 5th and 6th this was the first of its kind for our organization and is a best practice recommended. Mission Excellence Quarterly Forums begun on July 6, 2017 with offerings on eighteen different days to accommodate schedules and encourage participation. Last year at this time we had just begun our journey and offered five open forums.

6. UNMH and Surgical Directions consultants continue the passionate work of optimizing our Surgical Services with a solid foundational structure. The work of creating reliable and consistent process to serve the needs of New Mexican’s has shown good results. In the month of June, the UNMH OR has a 75% On-Time start of all cases, which has been stable for the last several months.

The team has begun to monitor and measure the time it takes to turn an OR room over (TOT) to be available for the next scheduled patient surgery. The overall target is 60 minutes, for the month of June, the TOT was 59 minutes for the UNMH OR. We will continue to monitor and report this vital step in creating efficiency and safety for our patients.
COMMITTEE REPORTS
Performance Oversight and Community Engagement Committee (POCEC)

Community Engagement Report

Patient Financial Services Advisory Committee Report

June 23, 2017

I. Executive Summary

The State Medical Assistance Division has released their concept paper for the next version of Medicaid called Centennial Care 2.0. The State waiver for the current system ends in 2018, and they are in process of working with CMS to obtain approval for a new waiver going forward.

There are some significant changes recommended in the Centennial Care 2.0 Concept Paper that has the potential to significantly impact the Medicaid system and UNMH. These include:

- Proposal to eliminate retroactive eligibility for Medicaid Applicants. Currently Medicaid can be retroactive for up to three months.
- Increased emphasis on Value Based Purchasing Arrangements
- Changes around care coordination and the increased delegation of care coordination activities from the MCO level to providers.
- Changes related to allocation of Safety Net Care Pool Funding with increased funding shifted to quality outcomes.

During the last several months there has also been extensive work to update and revise financial assistance documents and information for patients. This includes revision of the Financial Assistance Brochure and development of frequently asked question tools for the UNM Care and Self Pay Discount Program. The Center for Law and Poverty has had extensive input into the updating of these documents.

II. Data from Reporting Committee

N/A
III. **Accomplishments**
   - Patient Financial Assistance Brochures have been updated
   - Frequently asked questions have been added to assist patients with more detailed information as separate documents
   - Documents are being reviewed to assure they are more user friendly

IV. **Action Items**
   1) Continue to monitor access and trends data related to Patient Financial Services.
   2) Complete education and outreach on document revisions.
   3) Continue community outreach.
UNM HOSPITAL BOARD OF TRUSTEES
Finance, Audit and Compliance Committee Meetings

Wednesday, July 26, 2017  11:00 a.m.
UNM Hospitals Administration, Large Conference Room

Objectives

- Provide compliance oversight of UNM Hospitals.
- Provide audit oversight of UNM Hospitals.
- Provide financial and human resources oversight of UNM Hospitals.

Compliance Committee Meeting:

I. Approval of meeting minutes from June 20, 2017

II. Compliance Update – presented by Purvi Mody

Audit Committee Meeting: No meeting

Finance Committee Meeting:

I. Approval of meeting minutes from June 20, 2017

II. Consent Item – Presented by Ella Watt
   a. Delta Dental

III. Revenue Cycle 2017 in Review – Presented by Ella Watt

IV. CEO Update – presented by Steve McKernan
   - State Board of Finance Meeting held 7/18, intention to put request for architect on August BOR agenda
   - MOU with Bernalillo County and IHS is being reviewed by legal counsel

V. Human Resources Update – presented by Sara Frasch
**UNM Hospital Board of Trustees**  
**Native American Liaison Committee**

**Date**  
June 28, 2017

**Time**  
1:00 PM

**Location**  
CEO Conference Room, UNM Hospital Administration

**Meeting Attendees**  
Rodney McNease, Christine Glidden, Erik Lujan, Scot Sauder, Ray Loretto, Misty Saliz

<table>
<thead>
<tr>
<th>Agenda # /Subject</th>
<th>Status / Discussion</th>
<th>Action / Next Step</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Call To Order – I.</td>
<td>Ms. Glidden brought the meeting to order</td>
<td></td>
</tr>
<tr>
<td>II.</td>
<td>Approval of Agenda-</td>
<td>Motion made by Mr. Lujan</td>
<td>Approved</td>
</tr>
<tr>
<td>III.</td>
<td>Approval of Minutes</td>
<td>Motion made by Mr. Lujan</td>
<td>Approved</td>
</tr>
<tr>
<td>IV.</td>
<td>Public Comment-</td>
<td>There was no Public Comment</td>
<td></td>
</tr>
<tr>
<td>V.</td>
<td>Mr. Sauder gave an update on the 100 bed language discussion. He and Mr. Padilla met on June 14th and were substantially in agreement on all of the issues. The next steps are for Mr. Sauder to send a final opinion to Mr. Padilla for concurrence. At that point a new policy document can be drafted.</td>
<td></td>
<td>Scot Sauder, Pablo Padilla</td>
</tr>
<tr>
<td>VI.</td>
<td>Bernalillo County Update- Brief discussion of the status of the proposed MOU with Bernalillo County and IHS around the hospital lease. The MOU is still in discussion between the parties.</td>
<td></td>
<td>Accepted as information</td>
</tr>
<tr>
<td>VII.</td>
<td>Discussion of 100% FMAP and initial opinion from CMS that UNMH does not meet the requirements to be considered an IHS like facility. UNMH Management is working with the Medical Assistance Division and All Pueblo Governors Council on how to proceed.</td>
<td></td>
<td>Accepted as information</td>
</tr>
<tr>
<td>VIII.</td>
<td>New Business-</td>
<td>There was no new business</td>
<td></td>
</tr>
<tr>
<td>IX.</td>
<td>Adjournment –</td>
<td>Meeting was adjourned</td>
<td></td>
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OTHER BUSINESS
### Finance and Audit Committee Dashboard Report

#### Year To Date as of May 2017

<table>
<thead>
<tr>
<th>Metric</th>
<th>No. Trend</th>
<th>Desired</th>
<th>Actual</th>
<th>YTD</th>
<th>YTD Budget</th>
<th>Prior YTD</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Days for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>103,140</td>
<td>104,484</td>
<td>103,855</td>
<td>IP Days Down from PYTD and budget in ICU and Med Surg</td>
</tr>
<tr>
<td>Adult Discharges for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>10,010</td>
<td>17,393</td>
<td>16,459</td>
<td>Discharges up from PYTD</td>
</tr>
<tr>
<td>Adult Average Length of Stay for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>6.06</td>
<td>6.01</td>
<td>6.31</td>
<td>LOS for Adult Days and Adult OBS has decreased from Prior YTD</td>
</tr>
<tr>
<td>UHC Risk Based Adj Adult LOS for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>6.69</td>
<td>6.06</td>
<td>7.26</td>
<td>Current YTD is thru Feb. 2017, PYTD is thru Feb. 2016</td>
</tr>
<tr>
<td>Adult Observation Equivalent Patient Days</td>
<td></td>
<td></td>
<td></td>
<td>9,441</td>
<td>8,959</td>
<td>10,246</td>
<td>SAC/MS Emergency increased from budget</td>
</tr>
<tr>
<td>Pediatric Days for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>37,800</td>
<td>37,572</td>
<td>37,255</td>
<td>Pediatric days up from PYTD and budget</td>
</tr>
<tr>
<td>Pediatric Discharges for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>4,102</td>
<td>4,034</td>
<td>4,111</td>
<td>Pediatric discharges better than budget</td>
</tr>
<tr>
<td>Pediatric Observation Discharges</td>
<td></td>
<td></td>
<td></td>
<td>1,490</td>
<td>1,184</td>
<td>1,413</td>
<td>Pediatric OBS Discharges up from previous year</td>
</tr>
<tr>
<td>Outpatient Clinic Visits for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>476,230</td>
<td>479,370</td>
<td>468,542</td>
<td>Outpatient Visits up from PYTD and budget</td>
</tr>
<tr>
<td>Emergency Department Visits for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>73,087</td>
<td>69,075</td>
<td>74,567</td>
<td>Emergency Department Visits up from budget</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
<td></td>
<td>15,934</td>
<td>21,450</td>
<td>13,737</td>
<td>Urgent care Visits up from PYTD</td>
</tr>
<tr>
<td>Operations</td>
<td></td>
<td></td>
<td></td>
<td>19,982</td>
<td>19,168</td>
<td>18,117</td>
<td>Operations up from PYTD</td>
</tr>
<tr>
<td>Newborn Days for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>4,810</td>
<td>4,678</td>
<td>4,872</td>
<td>NB days down from PYTD and budget</td>
</tr>
<tr>
<td>Births</td>
<td></td>
<td></td>
<td></td>
<td>2,641</td>
<td>2,749</td>
<td>2,746</td>
<td>Births decreased from PYTD and down from budget</td>
</tr>
<tr>
<td>Days for all Behavioral Operations</td>
<td></td>
<td></td>
<td></td>
<td>21,436</td>
<td>22,064</td>
<td>21,326</td>
<td>Decreased from budget in UNMPC and CPC</td>
</tr>
<tr>
<td>Visits for all Behavioral Operations</td>
<td></td>
<td></td>
<td></td>
<td>141,426</td>
<td>137,512</td>
<td>129,435</td>
<td>Increased from PYTD and budget</td>
</tr>
<tr>
<td>UNM Case Enrollment</td>
<td></td>
<td></td>
<td></td>
<td>6,634</td>
<td>6,582</td>
<td>8,632</td>
<td>18,930 Medicaid applications processed</td>
</tr>
<tr>
<td>Net Income (Loss) for all Operations</td>
<td></td>
<td>&gt; 20</td>
<td></td>
<td>5,583</td>
<td>2,513</td>
<td>12,937</td>
<td>PY reflects $0.8m of non recurring OPEB reversal</td>
</tr>
<tr>
<td>Case Mix Index (CMI) - wo newborn</td>
<td></td>
<td></td>
<td></td>
<td>1.973</td>
<td>1.864</td>
<td>1.863</td>
<td></td>
</tr>
<tr>
<td>Re-Admission Rates</td>
<td></td>
<td></td>
<td></td>
<td>10.41%</td>
<td>9.50%</td>
<td>8.00%</td>
<td>Patients re-admitted within 90 days of discharge, thru Jan. 2017, PY through Jan. 2016 as reported by UHC</td>
</tr>
<tr>
<td>Days Cash on Hand for UNMH</td>
<td></td>
<td></td>
<td></td>
<td>75.95</td>
<td>33.27</td>
<td>88.23</td>
<td></td>
</tr>
</tbody>
</table>

### Human Resources:

- **FTEs (Worked) per adj patient day for all Operations:**
  - 5.55
  - 5.59
  - 5.79

- **Hours of Care - UNM Nursing:**
  - 17.55
  - 17.04
  - 17.84

- **Paid FTEs for UNMH and BHOs - Cancer Center:**
  - 6,089
  - 5,919
  - 5,906

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