Healthcare Advocate Hospital Budget Questions

General

1. ***If you included a rebasing in your proposed budget, why do you believe the Green Mountain Care Board should agree to rebase your budget? How do you plan to contain your growth going forward?**

   We have not been asked to rebase our budget for FY2017.

2. **What is your expected All-Payer and/or Medicare case mix index for FY17?**

   a. **Please also provide your case mix index for FY14 (actual), FY15 (actual) and FY16 (budget and projected) along with any drivers (e.g. demographic shifts, product line additions, payer mix changes, etc.) that explain increases or decreases over time.**

Payer Mix Over Time

	Medicare	Medicaid	Comm/BX	Self Pay	Total
FY2014 Actual	50.1%	13.1%	35.4%	1.4%	100.0%
FY2015 Actual	53.6%	12.7%	32.4%	1.3%	100.0%
FY2016 Budget	50.7%	13.4%	34.5%	1.4%	100.0%
FY2016 Actual	51.7%	15.6%	31.7%	1.0%	100.0%
FY2017 Budget	51.4%	15.7%	31.9%	1.0%	100.0%

With the expansion of Medicaid in NH and Vermont, we have seen an increase in Medicaid as a payer. Medicare has been fairly consistent. Self Pay has improved a bit with the two states' Exchange offerings. Some Commercial networks in NH exclude Vermont facilities and we may also be experiencing the early stages of consumer choice. We lost two surgical providers over the last year with favorable payer mixes. We will not be replacing their services in FY2017 as part of the service line allocation process with D-HH. No new lines of business will be added at this point, and we do not anticipate eliminations of other services.

   b. **Please explain the basis for anticipated changes to your case mix index going forward from FY16, if any.**

Our Case Mix Index is fairly consistent. A majority of our Inpatients are Swing Bed patients (SNF or lower level of care) and there are very few Acute Inpatients. None of these services are paid according to case mix except Medicaid. Our Inpatient Acute Rehabilitation Unit reflects only 2 "DRG/CMG's" with similar case mix weightings. Our highest case mix patients are in this unit and we have not materially changed the volume so no material, average case mix changes are anticipated.

3. **Please explain the basis of any anticipated changes in your payer mix for FY17. What are the changes you expect to see going forward?**

   See 2.a. above

4. **As a nonprofit with a duty to benefit your community, please explain any policies your hospital has, if any, to put a reasonable cap on executive pay and on the percentage of your overall budget that is made up of administrative costs.**

   MAHHC operates within Dartmouth-Hitchcock's policy on establishing executive pay. We do not have a policy regarding the percentage of administrative costs of our total operating budget. Not knowing the definition of administrative costs, it is important to share that the administrative burdens continue to increase during this era of healthcare reform requiring greater effort and cost to measure and improve quality, access, new payment mechanisms, and the like. MAHHC manages executive compensation based on regional market studies and through our compensation committee, a sub-committee of our Board of Trustees. Since the affiliation with Dartmouth-Hitchcock, the CEO's salary has remained at or below the market mean.

5. **If you have varied your commercial rate increases by program or service, how do you determine these increases? Are they based on projected cost increases by program or service or based on something else?**

   The best way to respond to this question is to generally explain the budget process for MAHHC. As a general process, we determine how busy we will be, how many people will be needed to provide the care associated with the volumes projected, and how much stuff we will need to provide that care. We add inflationary increases to those costs. We calculate the revenue for the anticipated volume based on current pricing to establish the gross patient revenue total. We apply the current net revenue percentage, adjusted by known changes, to determine the net patient revenue. This would include DSH, Provider Tax, Medicaid cuts, etc. The expenses are subtracted from the NPR to determine the operating margin. Price increases are added across the board to determine what price increase is needed to meet our target margin. Lastly, consideration of market pressures, significant expense changes, and the like are used to determine the final price increase by department. Our price increases are applied equally to all payers across a line of business or service. If physician clinics receive a 4% increase in price, that increase is applied to all payers. Pricing is not specifically tied to expense, workload, etc.

6. **What is your margin target, and how was it determined?**
   a. **Is this a long-range target for your hospital?**

   Our operating margin target would normally be 1-2%. We believe that this is a reasonable range for a not-for-profit CAH to operate at and would generally provide adequate funding for MAHHC to maintain quality, access, employee retention, and capital investment. That being said, our budgeted margin is -2.5%. This is a reflection of the ongoing re-organization and integration process with D-HH. As service lines are re-allocated within the D-HH system, there are winners and losers from a revenue and margin standpoint. As the planning stood at the time of our budget development, a reduction of specialty provider, an ongoing commitment to provide sub-acute services to the D-HH system, and some increases in expense categories related to the affiliation put a great deal of pressure on the organization in FY16 and FY17 budget. These changes, coupled with reductions in Medicaid reimbursement brought us to this margin. In recognition of the impact of the affiliation changes and the MAHHC commitment to support the system with less profitable services,

D-HH provides a system allocation support payment in the amount of our negative margin. Since this net asset transfer is booked below the line, it does not help our operating margin. Functionally however, we will have the cash resources to maintain quality, access, employee retention, and capital investment as if we were a break-even organization.

7. **Please describe how your budget process would differ if a 3- or 5- year net patient/revenue cap were used rather than a yearly cap.**

Our budget process would likely remain fairly similar. We would still need to estimate volumes, the staff necessary to support the volumes, the supplies and services necessary to provide the needed services, inflation, market pressures, reductions in reimbursement rates, and the like on an annual basis. If the cap was an annual cap, we would manage our price increases accordingly. If the cap was a cap for total growth over multiple years, we would need to adjust future year increases based on previous year performances

8. **What is your budgeted amount for Medicaid underpayment for FY17?**

The amount calculated, using FY17 budget amounts, for the underpayment from Medicaid is $4,565,000. The calculation included computing the costs for delivering care to Medicaid patients, using a ratio of costs to charges, summed with Medicaid Provider Taxes. This amount was netted against budgeted amounts expected to be collected from Medicaid.

9. **What is the extent of your Choosing Wisely initiative(s), if any?**

   a. **Please describe the initiative(s) and how you have chosen which departments participate.**

   b. **Which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement?**

While we considered the Choosing Wisely initiatives almost two years ago, we elected to manage to similar goals internally and through our regional affiliation instead. We initiated more specific protocols and order sets in the inpatient setting via our hospitalist service aligning our clinical practices with the DH hospitalist services. We then adopted similar standards in the outpatient setting. We extended hours in the clinics and reduced unnecessary Emergency Room visits and reduced ancillary testing. As we began to see improvement in these areas, we integrated our laboratory with the DHMC laboratory. We adopted their order sets, their standards for reflex testing, etc. We saw continued reductions in the number of lab tests ordered. Additionally, the results of patients who had lab tests done in Windsor and who end up at DH for specialty care or tertiary care, are now readily available to DH providers reducing testing at that facility for our patients as well. In FY15, Lab testing was reduced by 16% in total and Emergency Visits were reduced by 24%. While this initiative did not account for all of these reductions, it clearly contributed a large percent of these reductions. Currently, we are working on integration of our PACS with 3 area CAH's and with DH. This would make imaging at one facility available across all 5 organizations further reducing duplicate testing across the region.

Community Benefit

10. Please explain how the federal regulations on nonprofit hospital financial assistance policies and billing practices that go into effect on October 1, 2016 affect your budget proposal for FY17 as compared to FY16.

The new regulations did not affect our budget. We estimated the impact of not being able to collect on 100% of self-pay cash to be less than $150,000. We believe that the risk is low for 100% of those collections to be written off due to policy revisions. See further commentary below.

a. Include how you anticipate the regulations affecting your bad debt and charity care.

We expect that FY17 charity care will remain at consistent levels with prior periods. We follow current Federal Poverty Guidelines and provide readily available Hospital Financial counselors to assist uninsured patients in understanding Financial Assistance at our organization. The Hospital was not utilizing the extraordinary collection efforts that have been the subject of the new regulations.

b. Which charges did you base your financial assistance discounts upon in FY16?

Our Financial assistance discounts are based on all medically necessary services. These discounts are applied against gross charges.

11. *For all community benefits that you listed on your Form 990 Schedule H, what is the dollar amount you are budgeting for each benefit by year (FY14 Actual, FY15 Actual, FY16 Budget, FY16 Projection, and FY17 Budget)?

Schedule H, Community Benefits

		FY14A	FY15A	FY16B	FY16P	FY17B
A	FINANCIAL ASSISTANCE AT COST	695,837	393,325	**	**	**
B	MEDICAID	2,501,744	4,198,020	4,280,264	4,057,226	4,565,378
C	COSTS OF OTHER MEANS TESTED GOVERNMENT PROGRAMS	-	-			
D	TOTAL	3,197,581	4,591,345	4,280,264	4,057,226	4,565,378
	COMMUNITY HEALTH IMPROVEMENT SERVICES AND					
E	COMMUNITY BENEFIT OPERATIONS	348,179	215,283	**	**	**
F	HEALTH PROFESSIONS EDUCATION	55,104	58,939	**	**	**
G	SUBSIDIZED HEALTH SERVICES	5,113,540	5,909,551	6,261,258	5,721,041	7,010,642
H	RESEARCH	-	-	-	-	-
I	CASH AND INKIND CONTRIB FOR COMMUNITY BENEFIT	7,337	8,410	5,299	6,359	7,000
J	TOTAL	5,524,160	6,192,183	6,266,557	5,727,400	7,017,642
K	TOTAL	8,721,741	10,783,528	10,546,821	9,784,625	11,583,019

** buried within budget detail, not specifically budgeted for

12. *What is your current level of community benefit as a percentage of revenues?

Community Benefit as % of Net Revenue, (excluding Medicaid underpayment)

	FY14A	FY15A	FY16B	FY16P	FY17B
Total Net Revenues	44,459,623	45,132,772	47,770,461	46,424,380	47,207,083
Total Community Benefit	6,219,997	6,585,508	6,266,557	5,727,400	7,017,642
Community Benefit as % of Revenue	13.99%	14.59%	13.12%	12.34%	14.87%

Community Benefit as % of Revenue

	FY14A	FY15A	FY16B	FY16P	FY17B
Total Net Revenues	44,459,623	45,132,772	47,770,461	46,424,380	47,207,083
Total Community Benefit	8,721,741	10,783,528	10,546,821	9,784,625	11,583,019
Community Benefit as % of Revenue	19.62%	23.89%	22.08%	21.08%	24.54%

a. *What percentage level are you willing to commit to on an ongoing basis?

Approximately 20%.

b. *Please provide a detailed breakdown of the programs and other components you include in your community benefit calculation.

Community Health improvement services & Community Benefit Operations	FY14A	FY15A
Windsor Community Health Clinic	7,716	5,808
School Nurse Program/Athletic Trainer	54,472	27,596
Community Outreach	9,962	9,042
Medical Support of Community Events	13,730	4,811
Community Flu Shots	97,028	2,344
VT100- Provided Medical Services	13,738	16,332
Support and Services at Home (SASH) Program	18,200	13,494
Director of Community Health Activities	87,128	100,341
Support Group Space Donation	19,423	18,933
Daring To Care Program and Volunteers In Action	26,782	16,582
Worksheet total	**348,179**	**215,283**

Note: We do not specifically budget by community benefit program, and therefore, are reporting Actual amounts in the past two complete fiscal years. Much of this is "baked" into departmental budgets and programs.

13. How does the money you plan to spend on community benefit align with the top five issues identified in your most recent Community Health Needs Assessment (CHNA)? If your assessment of your top five issues has changed since your last Community Health Needs Assessment, please explain the change as part of your answer.

The top five issues that were identified in our most recent CHNA, in order from one through 5, were Alcohol and Drug Misuse (Including heroin and use of pain medications), Access to Mental Health Care, Access to Dental Care, Access to Affordable Health Insurance and Prescription Drugs, and Nutrition/Access to Affordable Healthy Foods. Two of these five were in the top five in the 2012 CHNA and the other three were previously in the top ten.

Regarding the top scoring Alcohol and drug Misuse, our budget reflects costs associated with our work and partnership with HCRS including leading the PATCH network, Interagency Care Management, the Windsor-area Drug Task Force, the Peer Learning Collaborative, and others.

Our operating budget includes costs incurred for hiring a full time psychiatrist and a counselor from HCRS who both function in our Patient-Centered Medical Home model. We have also increased awareness of other mental health counselors in the area and helped develop materials to assist with the referral process to these other providers. We are currently working to develop a pediatric mental health provider in our pediatric practices in Windsor and Woodstock.

MAHHC has implemented a screening program in the local schools to insure that children receive sealant for their teeth and other necessary services. We have also begun providing screening in our pediatric clinics for children six months to five years for flouride varnishing. Our Community Health funding will assist with emergency dental costs as funds are available.

MAHHC was one of the first hospitals to embed the "community free clinic" within its normal operations. As this initiative grew, we added grant funded financial counselors, navigators, and Medicaid Out-stationing services to our un/under-insured population. They also assist with access to pharmaceutical programs for discounted access to medications. As the needs have grown, we now provide in kind space, overhead, salary, and benefits in addition to the funding that we do receive. We are currently piloting a change to our retail 340B program with one retailer. This program will allow patients who are un/under insured to purchase medications at our 340B pricing levels (far below retail) and will offer a sliding scale for those who qualify on that 340B pricing.

MAHHC has been a long time partner, sponsor, and contributor to the local food pantries. We have also initiated nutrition and wellness programs throughout the community for many years.

a. Are there needs identified in your CHNA that you would like to address, but feel that additional cooperation by outside entities is required for an effective solution?

Mental Health is still a big concern in the area and funding is limited for all organizations who are working on this issue. The limited progress in this area costs the system a great deal of money, limits access for all patients, and does not serve these folks well.

Health Information Technology

14. Do you anticipate needing to replace your electronic health records system in the next five years?

MAHHC did a complete system replacement at the end of FY12. We implemented Cerner Community Works for all of our clinical and revenue cycle functions. This was augmented with a financial package from Multiview and a timekeeping/payroll system from Optimum. This system has allowed us to qualify for every stage of meaningful use for every qualified provider and for the hospital itself. In July 2016, MAHHC received a "Most Wired" Award from the American Hospital Association. Our system is efficient, stable, and effective. Of the currently affiliated D-HH entities, we are in excellent shape relative to IT. That said, D-HH is currently developing an integrated IT plan for the system. While it is not likely that we would be first on the list to convert to the D-HH systems in total, it is likely that at some point we will all be on one integrated platform. There is no final plan or timeline at this point.

15. Do you use any of the services offered by VITL (Vermont Information Technology Leaders)?

a. If so, which services?

MAHHC submits data for the HIE. Laboratory results, radiology results, CCD's and Admission/Demographic information is sent daily. We also implemented the immunization interface and registry. We also collect data for Blueprint/CHT but do not submit it currently.

b. To what extent are VITL's services integrated into the hospital's care delivery?

MAHHC has limited integration, systematically or otherwise, into our delivery of care. Clinicians are concerned about opening and utilizing an additional system during patient encounters. Additionally, there are concerns about what is NOT there. Occasionally, the providers or their support staff access the systems for specific patient inquiries but it is not routine.

c. Has the hospital experienced any cost savings or quality improvement from VITL's services?

MAHHC has increased cost with IT support, implementation costs, and ongoing maintenance of these services and interfaces.

d. Do VITL's services compliment your other health information technology initiatives? If so, how?

MAHHC does not find that these services compliment our patient care delivery systems in any way.

16. *What percent of your employed primary care providers are participating in the Hub and Spoke program?

100% of our employed Primary Care providers participate. Of that, MAHHC has a total of three primary care providers participating in this program who prescribe medication and provide assisted therapy. These services are available in our Windsor and Woodstock locations and are provided by two Pediatricians and one Internal Medicine provider.

a. *What is the average number of substance abuse patients that those providers treat?

The total number of substance abuse patients in our system/panel is unknown. We have plans to study that and to understand the effect on our system. The Pediatricians have 8-10 active patients in their panel and the Internal Medicine provider has 10-12 active patients.

b. *How many additional providers would be required to fully meet your community's needs in a reasonable amount of time?

Currently, there are other providers in our HSA who are not employed by MAHHC who participate in this program. Dr. Fred Lord, Green Mountain Family Practice, and Habit OPCO all participate and there is no waiting list currently. No additional providers would be required at this time.

c. ***If your hospital is involved in any medication assisted treatment programs, do you have any information on your costs for these programs versus savings to your hospital?**

MAHHC manages this program as well as a number of other programs within the confines of our Primary Care Clinics. We do not manage a separate budget per se. We do fund a majority of the estimated costs with Hub and Spoke funding, and the remainder is funded by operations and in kind services/supplies from the hospital

17. *Please explain to what extent mental health patients presenting at your Emergency Department impacts your budget?

a. ***Please explain how mental health patients are handled when they present to your Emergency Department or other triage location, including a description of any holding or isolation areas that you use, and how often you expect to use this type of area in FY17.**

MAHHC estimates that 5% of our emergency room volume have a chief (or secondary complaint) relating to mental health. These patients account for 13% of treatment time in this department. The average stay for these patients is 9.2 hours versus the average stay for other patients is about 2 hours. Our longest stay in the last year was 8 days. Our top 10 longest stays for the year average 2.5 days each.
As with all patients arriving in the Emergency Room, they are screened and triaged appropriately. If necessary, HCRS is contacted to provide a crisis evaluation. If the patient is expected to safely discharge within hours, the patient is treated and managed within one of the Emergency Exam rooms. We have special space available for these patients. There is video survellence and sitters or additional stadd are brought in as needed. If the patients require a transfer to an inpatient mental health facility, they will also likely wait in the Emergency Room since bed availability is a problem. It may take up to seven days to obtain an inpatient bed placement for the patient. Because we have limited base staffing, when mental health patients are held in the Emergency Room, whether it is for hours or days, additional bodies are needed to keep everyone safe. Based on the patient's condition, the additional staffing might be an RN or clinical worker, a non-clinical sitter, or even law enforcement.

All of this is an additional cost for MAHHC. We typically run about 1,200 paid hours per year for sitters and much of this is paid at overtime and off shift rates. This amounts to a 0.6 FTE and direct costs in the vicinity of $23,000. A seldom discussed concern is that CAH's receive reimbursement from Medicare for downtime in Emergency Rooms. One patient who stayed for 8 days awaiting placement cut our reimbursement by $10,000 on the cost report since there was no claimable downtime for seven days. In exchange, we received Medicaid reimbursement for a level 5 ER visit.

b. ***How do you train your security staff, contracted or in-house, on handling situations involving people experiencing mental health crisis? If some security staff members have been trained but not all, please explain which ones and why.**

MAHHC E.R. staff has received a great deal of training from HCRS. Care-givers in the Inpatient Acute, Inpatient Rehabilitation, and Emergency Room departments have received

MOAB (Management of Aggressive Behavior) training. All sitters and our facility/maintenance staff who work after hours have received MOAB training. We have no dedicated security staff. We have 2 employees who are certified MOAB trainers.