Gifford Medical Center

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To: Kevin Mullin, Chair, Green Mountain Care Board

From: Daniel Bennett, Chief Executive Officer
Jennifer Bertrand, Chief Financial Officer

Date: August 5, 2022

Subject: Gifford Medical Center Supplemental Monitoring Responses & Wait Time Metrics Request, Fiscal Year 2023

Market Share Report

1. No, for the net revenue actuals that are reflected in the report, we do not consider them material fluctuations. There is variability in the data, but not enough detail in the reported information to draw conclusions that account for the many factors that must be considered when evaluating net revenue.
2. Additional components that must be considered are: shifts in procedural mix within the service lines, new service lines, patient days, length of stay, changes in providers (i.e. vacancies and filled positions), changes in provider compliment, changes in negotiated payer contracts, payer policy changes, cost report settlements, MCR interim rate changes, and volume changes.

Reimbursement Analysis

1. Below is a summary, by category, of observations and a reimbursement assessment:
   <u>Inpatient & Outpatient – Case Mix Adjusted Payment Per Service:</u>
   a. Observations – we appear to be an outlier in three categories for inpatient and six categories for outpatient. The underlying contributing factor to this is the use of the case mix adjustment in the analysis. Two issues were observed when using the case mix adjustment: 1). The case mix utilized is significantly lower than our actual case mix for inpatient, and for outpatient we do not track case mix for APCs, and 2). as a CAH, we are purposefully not reimbursed on case mix (please refer to the reimbursement section for further discussion). Additionally, because there is only summary level information and not the detailed information being provided, it is difficult to determine any specific accounts that could be significantly influencing the case mix being utilized for those service lines. In small hospitals a very small number of accounts can create large swings in the data. Furthermore, we cannot compare it to our own internal data as we do not

have the detail to reconcile or compare to. Lastly, we do not believe this is representative of all the information over a three-year period. For example, with deliveries, the number provided would indicate that we average 144 deliveries per year when in actuality we average over 200. Again, without the detailed information it is difficult to isolate what is missing and how that could change the presentation of the data.

b. Reimbursement Considerations – CAH reimbursement structures are designed to account for the inherently lower acuity and volumes compared to those of PPS hospitals. In the inpatient setting, MCR pays off of an interim per diem rate, MCD reimburses off of a DRG, and commercial reimbursement is dependent on individual contract negotiation. In the outpatient setting, MCR pays off of an interim percent of charge, MCD pays off of varying fee schedules, and commercial is again dependent on individual contract negotiation. Of the three inpatient areas that were highlighted, there are only two commercial payers, that makeup a very small portion of our payer mix, that have a different payment mechanism based on service line. All other reimbursement is service line agnostic.

<u>Inpatient & Outpatient – Case Mix Adjusted MCR Allowable Cost Per Service:</u>

a. Observations – we appear to be an outlier in one category across the three payer groups for inpatient and four categories for outpatient. As referenced above, the case mix observations are still applicable. As it pertains to the Medicare cost per service, only allowable costs are being represented in the analysis. Allowable costs only account for those costs that are considered allowable under cost-based reimbursement and do not capture all of the costs associated with operating a hospital. As an example, the provider tax assessment and physician expenses are not allowable costs. Furthermore, hospitals apply varying methodologies for the allocation of overhead expenses. Individual hospitals may report and use different statistics for the allocation of overhead expenses and are able to choose the statistic that best represents their facility. Another factor for consideration is the assignment of revenue codes, which will vary by facility. In addition, not all revenue codes are directly assigned to one cost reporting line, some revenue codes can be allocated between multiple cost reporting lines. These differences in approach would not be captured or represented in this analysis.
b. Reimbursement Considerations – aside from the reimbursement considerations listed above, the inpatient category that is highlighted is service line agnostic for all payers. Outpatient categories follow the reimbursement considerations listed above.

<u>Inpatient & Outpatient – Case Mix Adjusted Payment to MCR Allowable Cost Ratio:</u>

a. Observations – we appear to be an outlier in one category for two payers for inpatient and two categories for outpatient. When analyzing and evaluating the information from a cost coverage perspective, all of the aforementioned observations that were outlined in the MCR allowable cost per service section is still applicable.

b. Reimbursement Considerations – same as above.

2. In the absence of the detailed supporting information for the summary data that was provided, we are unable to provide an opinion on any errors or further inconsistencies in the data set. We can appreciate the desire to have a method to compare hospitals from a consistent perspective; however, when you take variable data and normalize it you create a new data set, which then presents limitations within the normalized data. Therefore, it is important to recognize that you lose the integrity of the data when attempting to normalize a large portion of the variability that is inherent to the different structures of healthcare reimbursement and types of hospitals. Additionally, it is important to understand how the modified data can actually be used to inform different analyses and potential decision making. One needs to be cognizant of what that data does and does not represent.

Demographic Report

1. The population characteristics of our HSA would be reflected in our budgeted payer mix and with an aging population we would account for the shifts between payers, predictably to Medicare. A complete analysis and evaluation of shifts in other payer groups are always incorporated into our budget process. We do not evaluate disabled persons separately in our budget, the care of these patients would be reflected in our payer mix based off of their individual payer source. The proportion of poverty level associated with our HSA is reflected in our charity care and Medicaid payer mix assumptions. When budgeting for payer mix, we analyze our current experience versus historical trends and make adjustments as appropriate.
2. When budgeting, we analyze our current experience versus historical trends and make adjustments as appropriate, and any changes in the make-up of our HSA would be incorporated into this process.

Wait Times

A. Please reference the tables below for the information Gifford was able to provide:
   i. Referral Lag:

	Referral Lag	
	Within 3 Days	Over 3 Days
Primary Care	97%	3%
Specialty Care	98%	2%
Top 5 Imaging	N/A	N/A

The above information is only representative of internal referral data, as external referral information is not available to us.

   ii. Visit Lag:

	Visit Lag				
	Within 2 Weeks	Within 1 Month	Within 3 months	Within 6 Months	Over 6 Months
Primary Care	27%	31%	42%	0%	0%
Specialty Care	60%	27%	13%	0%	0%
Top 5 Imaging	32%	27%	41%	0%	0%

B. We were not able to extract from our current EMR, the referral lag information for the top five imaging procedures.

Current State:

- Currently, Gifford is still utilizing the third next available for both measurement and benchmarking. However, we recognize there may be other metrics that are more meaningful.
- We are evaluating optimization strategies specific to provider scheduling and are performing an assessment of the provider ratios for each of our practice locations in an effort to increase access to care.
- Currently, we use multiple EMR platforms within our organization. For the outpatient ambulatory Primary Care and Specialty Care practices, Gifford utilizes E Clinical Works (eCW). For outpatient hospital services, Gifford utilizes CPSI. Due to the lack of efficient interoperability between the systems, it makes evaluating metrics such as wait times very difficult and time consuming as it is a manual process to measure. With the implementation of our new EMR, we anticipate this metric will be more accessible and measurable.

Processes:

- Currently, each individual practice schedules for their respective clinicians. For clinicians who provide services in multiple locations their schedules are managed by their home practice. New patients are offered multiple available appointment options, regardless of the location to provide the patient with as many appointment options as possible. In the future, Gifford is strongly considering centralized scheduling after implementation and stabilization of the new EMR.
- Referrals are accepted into our system via fax. The referrals are distributed to the appropriate designated staff who reviews the information pertaining to that referral. The patient is then researched in the system to determine whether the patient is a new or established patient and patient information is verified. Once, the referral has been validated, the patient is contacted and available appointments are offered. If the patient is unable to be contacted after multiple attempts the referring provider, or the PCP are contacted to inform them of the inability to reach the patient. The referring provider or PCP then determines the next step for the specific patient.

Recommendations:

- Two useful qualitative metrics that can be utilized to assess and track wait times would be the evaluation of patient surveys and patient feedback that is collected on an ongoing basis. Other than the quantitative metrics already considered, we have not encountered alternative metrics that would substantively address wait times. We would certainly be amenable to exploring alternative methods of tracking and benchmarking.
- In order to obtain a balanced representation of factors impacting access, several metrics would need to be evaluated together: the visit lag, referral lag, new vs. established patients, wait times/access by service line, cancellation and reschedule rate, and no show rate. Evaluating multiple metrics would help to derive a meaningful interpretation of what is occurring. Additionally, it would be very important to clearly define each metric and how it should be evaluated.

Data:

- For the current fiscal year-to-date, we have not received any direct patient feedback regarding wait times. However, patients do occasionally mention frustrations with access to primary care when providing feedback regarding other patient care matters. Additionally, wait time was listed as a barrier to primary care during our last Community Health Needs Assessment. During our recent Listening Tours across our HSA we also received feedback regarding access to primary care.
- Below is the summarized, aggregated patient survey data that is captured through our CAHPS PCMH annual primary care patient survey.

Patient Experience Survey - Getting Timely Appointments		
Primary Care Adult Visits	**Top Box Score (Always)**	**CAHPS Database 2019 Average**
Always got appointment as soon as needed for urgent care	59.3%	66.0%
Always got appointment as soon as needed for check-up or routine care	69.7%	71.0%