

**Springfield Hospital
FY 2017 Budget Request
Narrative**

A) Executive Summary

In FY 2017 Springfield Hospital plans to remain on a course that was charted during a Strategic Planning process that commenced in 2014. Access to the appropriate care in the appropriate setting for all residents of our service area remains paramount in our planning and our day-to-day operations. Given our difficult payer mix, challenging demographics, the comparatively poor health status of our residents and the ever increasing social challenges (poverty, low educational attainment, drug use, crime, etc.), this represents a formidable challenge.

Comparing the FY 2016 to the FY 2017 budget, there are no substantial changes in programs, labor or operations. Our Average Daily Census for Acute Care patients (Adult & Pediatric, Obstetrics, Swing and Observation Beds) will decrease slightly to 19.0 vs. 19.1 in the FY 2016 Budget. The budgeted census for our Distinct Part Psychiatric unit has stabilized and will remain at 7.1 for the FY 2017 Budget.

We have not obtained all of the growth planned for perioperative services in the current fiscal year. Our budgeted expectations for FY 2017 are slightly reduced from the FY 2016 budget. The major components of continuing to rebuild surgical services include:

- Recruit a new Orthopedic Surgeon
- Maintaining continuity in our Urology program which is an arrangement with Dartmouth-Hitchcock Medical Center and Springfield Medical Care Systems (the FQHC parent corporation of Springfield Hospital) for a shared position.

Maintaining continuity in our Ob/Gyn service Stabilization of our General Surgery program

Lastly, in previous Executive Summaries we described in detail the ongoing challenges of caring for Level 1 Psychiatric patients in our Emergency Department. To address the matter in the last few years we (a) instituted a “Fast Track” component in our ED, (b) increased on-site contracted security to 24/7, (c) improved the collaboration with our FQHC and other local Mental Health providers by providing consults in the ED and instituting daily rounding on Mental Health patients housed in the department, and (d) made substantial expenditures in relation to staffing and training focused on dealing with involuntary mental health patients. Early in FY 2015 we completed an ED “decompression project” whereby we expanded the department for a long over-due increase in beds and to create a Psychiatric holding/isolation area in order to decrease the amount of undue stimulus to which these patients are exposed. We have improved, to the best of our ability, the safety and efficacy of care delivered to these and our non-psychiatric ED patients and visitors.

B) Health Reform Investments

Springfield Medical Care Systems (SMCS) is an integrated community health system consisting of the SMCS FQHC Network and Springfield Hospital. We are not seeking recognition of any exceptional expenditures relating to health reform in the Springfield Hospital FY 2017 budget. Seeking to positively impact the health status of our residents and prepare for health reform are daily activities within our system and the functions are imbedded in our operations and associated budgets.

Our health reform initiatives are predominantly housed within our FQHC network all locations of which have obtained the highest level advanced practice medical home certification. Given that all primary care attributed lives are associated with our FQHC and not our Hospital, any budgeted ACO participation fees will be budgeted in the FQHC and are not included in this submission.

The SMCS Community Health Team (CHT) works seamlessly with Springfield Hospital and other service providers with our community to manage and coordinate care, develop and implement systems of care that support population health as opposed to episodic treatment of illness while still managing individual cases and ensuring that access to appropriate services is unfettered. The CHT coordinates with our ED to connect patients that present that have no identified primary care relationship with one of our primary care physicians and our medical home. The CHT is also integrally involved with the discharge planning process at the Hospital to ensure appropriate follow up as needed and successful transitions from the acute side of the continuum to community-based outpatient services.

These efforts, which once again are spear headed by our primary care network, are certainly not without cost. Over the last several years we have invested substantially in care coordinators imbedded in our CHC practices and also our centrally located CHT. Unfortunately, many of the associated costs are at best only partially reimbursed under current payment mechanisms. We continue to invest and expand these capacities based upon philosophical commitment but are also highly cognizant of the financial strain placed on our delivery system over the last several years. Given that many of the activities are actually counter intuitive under current reimbursement systems we look forward eagerly to payment mechanisms that are aligned with health reform and properly value and reimburse for these efforts. That being said, SMCS leadership has committed regular and active participation on the GMCB ACO Payment Reform Workgroup and holds a Board seat on the Community Health Accountable Care (CHAC) ACO. SMCS attributes its Medicaid and commercially insured patients enrolled in exchange insurance products to CHAC

It is extremely challenging to identify the ROI on the health reform investments contained in our 2017 budget.

C) Overall Budget to Budget Net Patient Revenue Increase

For FY 2017 we are not requesting a rate increase

From FY 2016 Budget to FY 2017 Budget **our requested Net Patient Service Revenue (NPSR) increase is 4.0%**. The components of this increase are as follows:

- .6 % attributable to the increase in our Disproportionate Share Hospital (DSH) payment
- .9% due to the decrease in charity care

- 2.50% resulting from increased reimbursement

The NPSR increase is necessary to continue to improve our financial position, which deteriorated significantly in FY 2014 and has rebounded modestly in FY 2015 and FY2016 (projected) with a budgeted Operating Margin of 3.5%--- which we are on track to obtain by year end. For Budget 2017 we are targeting an Operating Margin of 2.15%. We believe that this margin is essential to restoring our financial health including rebuilding cash reserves and refortifying our balance sheet which has been eroding over the last several years. The requested NPSR increase is essential to obtaining the 2.15% Operating Margin target. The Operating Margin is needed in order to continue to provide quality services, fund capital acquisitions, and recruit and retain high quality providers, clinicians and other professionals--all essential elements of meeting community needs.

We continue to be active in cost containment seeking supply chain savings through our group purchasing arrangement with the New England Alliance for Health (NEAH). We will also push forward identifying savings through the Lean/PI process. We have not included any inflationary factor in our budget. We are challenging our managers to hedge against inflationary pressures by pushing forward with savings that we have obtained through the “Lean” process and improvements in supply chain management.

- a) **Significant changes from the FY 2016 Budget.** As mentioned previously in the *Executive Summary* we have not budgeted for any significant operational changes in FY 2017. We are not anticipating changes in reimbursements, have no planned physician acquisitions and no CONs pending or conceived.

- b) **Cost Saving Initiatives.** In FY 2017 we will continue with the Lean re-engineering process to seek to eliminate waste from our system, will also enter our fifth year as a NEAH member where we anticipate continuing to find new savings or at the very least hedge against inflationary pressures and hope to do the same with outpatient drugs through the 340B discount pharmacy program. We have acquired a Staffing Productivity System in order to allow us to better understand our staffing and hopefully gain efficiencies beyond what is budgeted.

- c) **Increase in Net Patient Service Revenue by Payer Source.** Our budget does not anticipate significant changes in payer mix (other than a slight increase in Medicaid) or service offerings. We are not expanding the clinical scope of what we do but rather seeking to continue to retain a greater percentage of cases/services that we feel are clinically appropriate to perform in the community hospital setting and doing so in a high quality and cost-effective manner.

d)

Revenue Assumptions: Medicare. The FY 2017 budget assumes that we will continue to be reimbursed at cost minus 1% by the Medicare program for inpatient and outpatient services. We are not budgeting for Medicare Meaningful Use reimbursement in FY 2017. Our FY 2017 Budget does not include the impact of any prior year Medicare settlement activity; however, it does anticipate that our Vermont Medicaid provider tax assessment (\$3.5M) will continue to be a non-reimbursable expense unless that determination by CMS is overturned through the appeals process. We are far from optimistic that the CMS recoupments will be overturned. We are currently a party to a group appeal for FY 2011 and are weighing the cost/benefit of appealing subsequent years.

i. **Revenue Assumptions: Medicaid.** In accordance with instructions from GMCB staff we have not included:

- 1) A payment increase estimate in our Budget,
- 2) An increase in Medicaid Primary Care or Blue Print payments (which are recorded by our FQHC network anyway) nor
- 3) Any revenues associated with shared savings programs

ii. **Revenue Assumptions: Commercial/Self Pay/Other.** As more payment mechanisms are moved to prospective methodologies which do not recognize the full amount of our rate increase, our collection percentages will continue to decline. We have experienced favorable budgetary variance in FY 2016 in relation to Uncompensated Care and for all intents and purposes are budgeting for that experience to continue in FY 2017. As a factor of Gross Revenue Bad debts are budgeted at 4.1% vs. 3.60% Bud 2016 and Charity Care is budgeted at 2.1% vs. 2.5% for Bud 2016. Although we expect that we will continue to have less “pure” Self-Pay due to Medicaid expansion and the launch of the commercial exchange products we feel that our exposure to bad debt will increase as the financial responsibilities of patients increase.

D) **Rate Request**

We have not asked for any rate increase this year.

E) **Capital Budget Investments**

- 1) 1) Our FY 2017 Capital Budget of \$2.1M is very modest with no single item or projects in excess of \$500K We are discussing replacing our nuclear camera in the next few years at a cost of \$850,000. We have no CONs in the works or in the pipeline.

F) **All Outpatient Visits**

We concur with the need stated by GMCB to seek to define this measure more consistently. Our information system identifies patients registered as outpatients as “Type 2”. Historically we have quantified “outpatient visits” as the sum total of Type 2 registrations for the applicable reporting period.

G) Community Health Needs Assessment (CHNA)

Our next reporting cycle began on October 1, 2015. The implementation plan will be presented to our Board by September 30, 2016.

H) Technical Concerns

We have no technical concerns to report.

In addition we have been asked to address specific concerns outline in a letter dated May 2, 2016 from Michael Davis. Our responses are below

- 1) a. Our payer mix for NPSR for FY 2015 was 52% government payers, 6% private pay and the remainder is commercial. Rate increases return much less per percent increase than they did even a few years ago. More patients have moved to the ACA products which have a high deductible; this is leading to higher bad debts (more on this later). Our pricing is among the lowest in the State, we do not believe that our commercial rates are too high.
 - b. To come into compliance we are not asking for any rate increase for Bud 2017.
- 2) a. Free care has come down dramatically over the last two years. We attribute this to the expansion of Medicaid in the State. This is a state wide phenomena as has been reported in the monthly reports to the GMCB. Bad debt on the other hand, initially decreased with fewer private pays (moved to Medicaid) however, over the last several months we have seen a dramatic increase in bad debts and are now over budget in this area YTD. We attribute this to the high deductible plans and the charges to patients with these plans working their way through the billing system and aging out into bad debts. We see this continuing to increase.
 - b. Medicare revenue estimates will remain at 99% of allowable costs
Medicaid has proposed some changes to their payment mechanism but nothing has been finalized. We do see growth budget to budget as more people move on to Medicaid, we did temper our estimates due to the State starting to cull the rolls and remove some people.
Commercial we see no changes in reimbursement as we did not ask for a rate increase
 - c. No major payer mix changes, a slight increase in Medicaid and decrease in Private Pay.
 - d. All prior year revenue settlements have been paid to Medicare
 - e. We have built market adjustments into our wage budget as we have recently had two consecutive years with no raises (we did have raises in FY 2015) and we are falling behind in competitive wages which makes recruiting nurses (among others) a problem.
 - f. There are no unusual events to report.

