Springfield Hospital
FY 2018 Budget Request
Narrative

A) Executive Summary

In FY 2018 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, economic outlook, 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 2017 to the FY 2018 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 2017 Budget. We are anticipating adding to our Swing Bed days to accomplish this. The budgeted census for our Distinct Part Psychiatric unit has stabilized and will remain at 7.1 for the FY 2018 Budget.

We have not obtained all of the growth planned for perioperative services in the current fiscal year. Our budgeted expectations for FY 2018 are slightly reduced from the FY 2017 budget. The major components of continuing to rebuild surgical services include:

- New Orthopedic Surgeon incorporated into the established practice
- 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.

The majority of our efforts in areas of mental health and substance abuse take place in our parent organization (Springfield Medical Care Systems, Inc) an FQHC which has LICSW's imbedded in every primary care location in our system.

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 2018 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.

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 are spearheaded 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 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 Medicare and commercially insured patients enrolled in exchange insurance products to CHAC at this time. This will change if we participate in the All-payer program.

It is extremely challenging to identify the ROI on the health reform investments contained in our 2018 budget.

C) Overall Budget to Budget Net Patient Revenue Increase

For FY 2018 we are requesting a 6.5% rate increase

From FY 2017 Budget to FY 2018 Budget **our requested Net Patient Service Revenue (NPSR) increase is 0.39%**. This is due to Projected FY17 NPSR not hitting the budgeted target and budget to budget will remain flat in regard to NPSR.

The rate increase is necessary to continue to improve our financial position, which deteriorated significantly in FY 2016 and Projected 17. For Budget 2018 we are targeting an Operating Margin of 1.7%, which is well below industry standards but we believe is obtainable. The Operating Margin is needed 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. In addition we need to increase days cash on hand to meet new loan covenants due to refinancing our bond.

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 2017 Budget.** As mentioned previously in the *Executive Summary* we have not budgeted for any significant operational changes in FY 2018. We are not anticipating some changes in reimbursements have no planned physician acquisitions and no CONs pending or conceived.

b) **Cost Saving Initiatives.** In FY 2018 we will continue with the Lean re-engineering process to seek to eliminate waste from our system, will also enter our sixth 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 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. As it pertains to NPSR, our payments as a percentage of our charges still continue to deteriorate as payment updates do not keep pace with our rate increases.

Revenue Assumptions: Medicare. The FY 2018 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 2018. Our FY 2018 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.

Revenue Assumptions: Medicaid. 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 in any case) nor
3) Any revenues associated with shared savings programs

We have included the decrease in DSH payments (50%) for FY 2018

i. **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 2017 in relation to Uncompensated Care and for all intents and purposes are budgeting for that experience to continue in FY 2018. As a factor of Gross Revenue Bad debts are budgeted at 3.7% vs. 4.2% Bud 2017 and Charity Care is budgeted at 2.0% vs. 2.1% for Bud 2017. Although we expect that we will continue to have less "pure" Self-Pay due to Medicaid expansion and the commercial exchange products we feel that our exposure to bad debt will increase as the financial responsibilities of patients increase(in pure dollars).

D) Rate Request

We have asked for a 6.5% rate increase this year compared to no rate increase for FY 2017.

E) Capital Budget Investments

1) 1) Our FY 2018 Capital Budget of $1.8M 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, 2016. The survey identified three major areas of concern: mental health/substance abuse, dental and obesity. Mental health/substance abuse has been of ongoing concern and address constantly in the hospital and FQHC. We do have a ten bed DPU for Inpatient Psychiatry. We have made some staffing changes in the DPU and have increased the number of patients being treated. For dental the FQHC acquired a dental practice in Chester, Vermont last summer

and we are looking to add one more dentist to the practice. Obesity is an ongoing concern and again is addressed in the FQHC with dieticians and PCP's.

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 March 31, 2017 from Michael Davis. Our responses are below

Concerning physician transfers and acquisitions we have none anticipated nor planned.

In regard to the All-payer Model, at this time we have expressed interest and have tentatively committed to participating. We are waiting for firm numbers from the ACO before fully committing. We have not included and ACO activity in our budget as presented. The current plans are for the ACO to commence operations under the All-payer waiver on January 1, 2018.