

**COPLEY HOSPITAL
FY 2018 BUDGET SUBMISSION
RESPONSE TO GMCB QUESTIONS
August 11, 2017**

1. INCOME STATEMENT - The hospital proposes an (NPR) increase of 7.5% over the 2017 budget. The hospital identifies this increase as being related to prior years utilization growth specifically for surgical services, primarily orthopedic surgery. Explain this increase in utilization for surgical services, and why the hospital believes this increase is sustainable over the longer term. Describe the wait times and access improvements that have been established - how are these levels determined and benchmarked?

Continued growth in utilization is the most significant factor contributing to the increase in net patient revenue, particularly the increase in surgical utilization and related inpatient days. At Copley, surgical specialties drive well over half of its total patient revenue, including surgical revenue, inpatient routine revenue, ancillary revenue, and office visits. Over the past few years, Copley has seen a steady increase in its demand for surgical services, primarily in orthopedic surgery. As a result, the proposed FY2018 budget includes a 7.6% increase in OR procedures and a 12% increase in related OR minutes that drive revenue. This increase in surgical time is driven by growing demand for orthopedic surgeries, particularly total joint surgeries, and improved access to surgical care made possible due to increased efficiency.

Copley believes that demand for orthopedics will continue to grow along with Vermont's aging "Baby Boomer" population who hope to maintain healthy and active lifestyles. According to the "Current and Projected Future Health Care Workforce Demand in Vermont" report prepared for the State of Vermont Agency of Administration in June 2017, Vermont's population age sixty-five and older is projected to grow by about 50% between 2015 and 2030. The report indicates that demand for the orthopedic surgery specialty between 2015 and 2030 is expected to increase office visits by 12%, outpatient visits by 8%, emergency room visits by 4%, and inpatient days by 32%. Other researchers note that, in addition to the aging population, there has been a rise in conditions that contribute to arthritis, most notably obesity. (Kutscher, [Modern Healthcare](#), 9/25/12; Pittman, [Reuters](#), 9/25/12).

Although we believe that demand for orthopedic surgery will continue to grow, Copley anticipates we will be operating at full capacity in the near future and will be unable to meet the growing demand long-term. To contend with growing demand, Copley has been taking steps to improve access to surgical services. This is contributing to the increase in surgical utilization and improving key OR performance indicators. These improvements include developing new roles and managing behaviors to improve surgical block time utilization, on-time starts, and turnover time; extending the surgical day in one room as staffing allows; and decreasing no shows for appointments utilizing automated reminder text messages. Benchmarks we use in analyzing our performance related to these measures come from industry resources such as OR Manager and the Association of peri-Operative Registered Nurses (AORN).

2. INCOME STATEMENT - Gross revenue is up 10.5%, suggesting increased utilization as rates are not budgeted to increase. However, adjusted admissions utilization shows no growth. This explains the high increase of 11.9% in cost per adjusted admission. Explain this high increase - explain the apparent contradiction in utilization. (note: cost per adjusted admission % increase - the system average = 4.5%, and the system median = 7.1%. The highest is Northeastern = 12.1%, lowest is Springfield = -4.9%).

Adjusted admissions is a statistic that extrapolates the relationship of inpatient revenue per acute admission to a hospital's outpatient charges in an attempt to measure all patient care activity undertaken in a hospital, both inpatient and outpatient. We believe the usefulness of this statistic to measure all patient care activity is outdated, particularly for Critical Access Hospitals who are limited to 25 beds and often have significantly more

outpatient activity than inpatient activity. Furthermore, the average charge per unit in the inpatient setting is quite different than the average charge per unit in the outpatient setting.

Copley’s proposed Inpatient Revenue per Acute Admission is \$22,691, up 16.4% from the FY17 budget. This increase is driven by the growth in orthopedic surgery, particularly total joint procedures which have increased Copley’s inpatient acuity level and average inpatient charges. When divided into Copley’s proposed total gross patient care revenue, which is increasing at a slower rate of 10.5%, the result is a 5.1% decrease in Adjusted Admissions. Following is a table illustrating the calculation of Adjusted Admissions and the changes in the various components of the calculation to help interpret the apparent contradiction caused by the use of this outdated statistic:

	BUD17	BUD18	B-B DIFF	% DIFF
Total Patient Revenue	106,537,564	117,677,776	11,140,212	10.5%
Inpatient Revenue	34,225,644	41,773,241	7,547,597	22.1%
Acute Admissions	1,755	1,841	86	4.9%
Inpatient Revenue per Acute Admission	19,502	22,691	3,189	16.4%
Adjusted Admissions	5,463	5,186	(277)	-5.1%

Although inflated by the Adjusted Admissions statistic, Copley’s Cost per Adjusted Admission is increasing largely due to:

- Growth in orthopedic surgeries, which have a higher acuity than our other service lines. The orthopedic specialty generates nearly half of Copley’s total gross patient revenue and is a specialty with a high proportion of variable costs related to implants. Growth in orthopedic services increases our costs more than in other service lines. See further discussion of OR supplies in the response to question 7.
- Copley’s new Surgical Center will add \$910 thousand of operating costs, including \$500 thousand in annual depreciation, \$44 thousand in interest on borrowing, and \$366 thousand in cost associated with operating the additional 19,560 square feet of space such as utilities, maintenance, housekeeping, and insurance, including 3.8 FTEs. This is nearly \$100 thousand less operating cost than was projected for FY2018 in the approved CON. Furthermore, we propose that funding of these costs come from utilization growth instead of the 2% rate increase projected for FY2018 in the approved CON.

3. UTIL&STAFF - Acute admissions are increasing 86 over 2017 budget, higher than we've seen in the last 3 years. What are the types of admissions you expect to see and from where is this growth expected?

The increase in acute admissions is driven by growing orthopedic surgery utilization, particularly total joints. See response to question 1 for further explanation.

4. NPR PAYER - Medicare shows less favorable reimbursement and higher utilization. Specifically describe the increase you are seeing in utilization - more patients, types of services, complexity, etc. Also, why do you expect to see less reimbursement? Provide a schedule supporting this lower reimbursement estimate.

As a Critical Access Hospital (CAH), Copley is reimbursed by Medicare for hospital services based on allowable costs, not fee-for-service. As such, Copley estimates Medicare reimbursement utilizing a CAH-specific reimbursement model that incorporates the estimated trend in the inpatient Cost per Day and ancillary Ratio of Cost to Charge.

Overall, Medicare net patient revenue is proposed to increase \$2.5 million, or 13.2%, from the FY17 budget, significantly impacted by the increase in variable costs related to the growth in inpatient orthopedic surgery utilization (see response to question 1 for further details). In a time of increased utilization, the hospital’s variable costs, such as supplies and drugs, increase along with utilization, but fixed costs remain unaffected by utilization. Since our total costs are not increasing at the same rate as our utilization and related charges, the

cost per unit decreases – In other words, the Medicare *rate* of reimbursement for a CAH goes down in a time of utilization growth. Utilization increases are proposed to raise Medicare net patient revenue by \$4.3 million, or 22.7%. The average rate of reimbursement is dropping 9.5%, reducing Medicare net patient revenue by \$1.8 million.

5. NPR PAYER - Commercial shows higher utilization. Specifically describe the increase you are seeing in utilization - more patients, types of services, complexity, etc.

The increase in Commercial utilization is driven primarily by growing orthopedic surgery utilization, particularly total joints. See response to question 1 for further details.

6. UTIL&STAFF - The narrative describes various FTE changes. The 2018 budget shows 14 travelers, the same as the 2017 budget. The 2015 actual shows 4 travelers, and the 2016 actual shows 9 travelers. Why has the hospital continued in the 2018 budget with these higher cost staff along with non-MD FTE's? What are your plans to reduce travelers, which are paid at a premium compared to other staff? What are staff salary increases in 2018?

We have taken many steps within the last year to reduce the need for travelers, especially within our nursing units. Copley performed a market analysis of compensation and adjusted the range of pay to be able to attract and also retain our nursing and other clinical staff. A new incentive program makes it attractive for our own staff to cover shifts instead of using travelers. We have been working to grow our workforce from within, providing cross-training opportunities. We have developed relationships with Vermont colleges and have recruited four new graduate nurses in our workforce. We have had to utilize travelers to provide coverage during new employee orientation and cross-training, but hope that these investments in training will result in the eventual reduction of travelers. We also find that traveler positions are necessary to cover unexpected family and medical leaves of absence, something that we do not anticipate will ever be eliminated entirely.

Staff salary increases are proposed to increase 2% for a cost of living adjustment and other market adjustments. These increases are deemed necessary to retain critical staff and prevent costly turnover such as we have recently experienced.

7. NARR - The narrative describes surgical implant and other supply costs that are increasing - they are the largest cost drivers. How do you measure these costs and what trade-offs are made to keep costs low? What options are considered when buying surgical supplies and implants?

When buying surgical supplies and implants, it is Copley's policy to select suppliers on the basis of factors such as price, quality, performance and suitability of products or services, quantity, delivery, service, and reputation. Copley selects products that our surgeons have the most confidence in to deliver a quality outcome for our patients. We have been successful in aggressively renegotiating volume discounts on our supply costs. For example, we have achieved a 25-35% reduction on implant costs. Patient choice is also a factor in selecting supplies as many patients are more educated about their options and are asking for a custom implant. While we are working on driving supply costs down, we are also respecting patient choice.

8. UTIL&STAFF - Explain the physician transfers out of the budget, and how these transfers are affecting the budget, specifically FTEs, net patient revenue, and utilization.

Copley's proposed FY2018 NPR budget includes the impact of \$431 thousand related to two transfers of services out into either another facility or a private practice.

- Effective June 1, 2017, our employed Urologist has gone into private practice, but will remain in our community and continue to perform surgeries at Copley. This divesting of a physician practice is proposed

to reduce professional fee net patient revenue by \$156 thousand and reduce operating expenses by \$344 thousand, including the reduction of 2.1 FTEs (1.0 MD, 1.1 Staff).

- Copley's Oncology program is currently operated under a collaboration agreement with University of Vermont Medical Center (UVMCC) who provides an Oncologist to oversee the program and visit with our patients on-site. This Oncologist is retiring and UVMCC is unable to replace her at Copley. Effective July 1, 2017, Copley has entered into a collaborative agreement with Central Vermont Medical Center (CVCC) for oversight of its Oncology program; however, their Oncologists will not be on-site at Copley. Copley's proposes a decrease in net patient revenue totaling \$275 thousand for infusion services and related oncology drugs, and a decrease in operating expenses of \$113 thousand with no changes in staffing.

9. NARR - The hospital discusses savings of over \$1.8 million. This is related to changes in FTEs identified by Quorum and the transfer of the urology practice out of the hospital budget. Describe the savings related to urology and whether other savings might be achieved from other practices.

Copley has committed to \$1.8 million in strategic cost savings for FY2018, the equivalent of a 5% rate change. This includes savings related to workforce efficiencies, divesting of a physician practice, better price negotiation and management of waste in supplies and drugs, and other cost savings.

The savings identified in urology, which is a physician transfer, is the result of our employed Urologist going into private practice effective June 1, 2017. She will remain in our community and continue to perform surgeries at Copley. This divesting of a physician practice is proposed to reduce expenses by \$344 thousand, including the reduction of 2.1 FTEs (1.0 MD, 1.1 Staff). Physicians who are moving from a hospital affiliation into private practice is not the expected trend. We do not anticipate any other providers going into private practice.

10. BALANCE SHEET - Copley has low Board Designated funds and the narrative talks about trying to improve their cash position in the future. The hospital notes that this will be challenging while staying within the net patient revenue cap. Explain the options the hospital is considering to improve their cash position.

Copley's Board Designated funds represent its Funded Depreciation account – money set aside for the purpose of funding capital acquisitions. These funds are transferred from operations in the amount of Copley's annual depreciation, along with any donor contributions received for capital acquisitions. \$1.2 million of the \$12.5 million in project costs for Copley's new Surgical Center was funded from working capital, temporarily depleting this Funded Depreciation account.

In order to improve its cash position, Copley will continue to focus on increasing its operating margin over time by implementing strategic cost containment efforts that support the provision of efficient, high quality care. We have demonstrated a commitment to cost containment in proposing savings of \$777 thousand (1.2%) in FY2017 and \$1.8 million (2.7%) in FY2018 related to workforce efficiencies, better price negotiation and management of waste in supplies and drugs, and other cost savings. We will continue these efforts; however, this heightened rate of cost savings will not be sustainable in the long-term and our focus will remain on maintaining the efficiencies we've gained. It will become increasingly challenging to improve our operating margin under an unsustainable cap on net patient revenue growth that does not adequately keep pace with the rate of inflation, address utilization pressure, or capital needs of each individual hospital.

We will also continue to invest prudently in capital improvements, without taking on additional debt, as we have done in the past with our boiler plant replacement and emergency room renovation. Over the last year, Copley has established a new strategic plan, which includes developing a master plan to prioritize its facility, technology, and equipment needs in the coming years. We will face difficult decisions in prioritizing these needs as we evaluate each investment and its ability to provide a safe patient environment, high quality care, and seamless coordination of care amongst providers.

11. CAPITAL - The hospital shows an increase of 3.8% to 4.4% in capital costs as % of expenses. Is all depreciation and interest from the recent CON budgeted in 2018?

The proposed FY2018 budget includes the full annual impact of Copley's new Surgical Center of \$910 thousand in operating costs, including \$500 thousand in annual depreciation, \$44 thousand in interest on borrowing, and \$366 thousand in cost associated with operating the additional 19,560 square feet of space such as utilities, maintenance, housekeeping, and insurance, including 3.8 FTEs. This is nearly \$100 thousand less operating cost than was projected for FY2018 in the approved CON. Furthermore, we propose that funding of these costs come from utilization growth instead of the 2% rate increase projected for FY2018 in the approved CON.

12. INCOME STATEMENT - Are the 2017 projections still valid? If not, please describe material changes?

As of June 30, 2017, net patient revenue is slightly lower than anticipated; however utilization can fluctuate and be difficult to predict. Overall, we do not anticipate that the FY17 results will be materially different than projected.

13. INCOME STATEMENT - The non-operating revenue for the 2017 budget shows \$2,603,000, while the same figure for the 2018 Budget shows \$370,900. The difference between budget 2017 and 2018 for non-operating revenue is -\$2,232,100. Explain the change in non-operating revenue between the 2017 and 2018 budgets.

Non-operating revenue in the 2017 budget included donor contribution income from the capital campaign for the surgical suite of \$2.5 million.

14. You should refer to the Act 53 price and quality data schedule that is included in the staff analysis and be prepared to address questions the Board may have concerning that information.

We welcome the opportunity to discuss the price and quality data at the hearing. Please consider in your analysis of the Act 53 pricing from 2015 that Copley has a cumulative rate decrease of 7.7% since 2015 while the system average cumulative rate increase is proposed to be 8.6% thru 2018. This results in a 16.3% difference in Copley's proposed prices compared with the system over the last 4 years.

15. In the March 31 GMCB hospital guidance, the Board allowed up to 0.4% for new health care reform. The Board directed each hospital to provide a detailed description of each new health care reform activity, investment or initiative included within the designated 0.4%, provide any available data or evidence-based support for the activity's effectiveness or value, and identify the benchmark or measure by which the hospital can determine that the activity reduces costs, improves health, and/or increases Vermonters' access to health care. With this in mind, please describe how you are investing for new health care reform activities in the four approved areas:

- **Support for Accountable Care Organization (ACO) infrastructure or ACO programs;**
- **Support of community infrastructure related to ACO programs;**
- **Building capacity for, or implementation of, population health improvement activities identified in the Community Health Needs Assessment, with a preference for those activities connected with the population health measures outlined in the All-payer Model Agreement;**
- **Support for programs designed to achieve the population health measures outlined in the All-payer Model Agreement.**

As part of our strategic plan, Copley is increasing coordination with our primary care community partners. With this in mind, Copley is proposing net patient revenue of \$32,500, or 0.1%, to fund new health reform investments related to cost sharing with our local FQHC for a social worker in Emergency Services. In collaboration with Community Health Services of Lamoille Valley (CHSLV), our local FQHC, we have placed a

social worker in the Emergency Department (ED) to reduce avoidable hospital visits and ultimately reduce healthcare costs. Referrals made by the social worker, on behalf of our patients, address unmet healthcare needs along with social determinants that affect the patients' health. From January through June 2017, 434 patients were referred to the ED social worker, and she made 556 referrals on the patients' behalf.

Copley is an active participant in OneCare Vermont's (OCV) Unified Community Collaborative (UCC), working to reduce readmissions and improve transitions in care among providers in the community, with our Cardiologist and Co-CMO, Dr. Adam Kunin, serving as Chair of this committee. To address population health goals as identified in the Community Health Needs Assessment, the hospital works collaboratively with a number of local health care organizations, including two FQHCs, Home Health and Hospice, Lamoille County Mental Health, and other substance abuse treatment facilities, and long-term skilled nursing facilities, along with social service organizations, in addition to the UCC. Overall, we have focused on connecting our patients with needed services, improving transitions in care, and supporting and amplifying existing population health based initiatives, activities and events in our community.

With these partners, Copley continues to move toward meaningful participation in value-based payment and health care delivery reform with initiatives that are not included in the request for an exception to the net patient revenue cap. Examples include:

- American College of Surgeons National Surgical Quality Improvement Program® (ACS NSQIP®) to measure and improve the quality of surgical care and decrease costs
- Implementation of the LACE risk assessment tool to reduce readmission
- Ongoing participation in the Blueprint for Health program, including the Women's Health Initiative
- Antibiotic Stewardship Program (ASP) to optimize the treatment of infections and reduce adverse events associated with antibiotic use.
- Implementation of Shared Decision Making program for Cardiology services
- Continuation of the Orthopedic Shared Decision Making program
- Implementing a telemedicine-based rheumatology service with Dartmouth Hitchcock to replace a retired visiting University of Vermont Medical Center (UVMCC) Rheumatologist.
- Restructuring our new Oncology partnership with CVMC to include a telemedicine pilot program.

The Live Well Lamoille blog was created as a collaborative community effort to address the need to reduce chronic conditions in our area and to support community capacity for population health initiatives in general. It serves as a convener, aggregating information and pushing it out, amplifying work already underway and resources available to community residents. Bloggers representing Copley and a variety of social service agencies, entities, and community leaders embracing all the social determinants of health, post tips, promote healthy events and activities, provide information, and generally encourage making healthy choices. This free community resource has almost ten thousand views and is promoted primarily via social media. We have also invested in our employee wellness program given that Copley is one of the largest year-round employers in the area and the ripple effect this has on our community.

To help build community capacity for population health initiatives, the hospital also contributed to the local Bike Share program, providing residents free access to bicycles for recreation and transportation, and to the Hunger Council of Lamoille Valley to support their initiatives around food security. We also created an annual 5K Run for the Heart and 1-Mile Fitness Walk to promote use of the Lamoille Valley Rail Trail for recreation and exercise. The event is part of the town's Rocktoberfest activities. In addition, the hospital granted funds to Healthy Lamoille Valley to assist with their community advocacy efforts, promoting substance-free events and activities, promoting drug take-back locations, and healthy town planning.

16. Please identify which ACO(s) you will have a contractual relationship with in 2018. If your hospital plans (or already is) in a risk-bearing contract with OneCare, please explain the effect of the risk on your financial statements. Please explain specific strategies your hospital is developing to move toward population-based

payment reform. Finally, what tools does your hospital employ to ensure appropriate, cost effective, quality care when working with providers outside the CHAC or OneCare network?

Copley continues to participate in Accountable Care Organizations, including OneCare Vermont (OCV) and Community Health Accountable Care (CHAC). We are active participants in OCV's Unified Community Collaborative (UCC), working to reduce readmissions and improve transitions in care among providers in the community, with our Cardiologist and Co-CMO, Dr. Adam Kunin, serving as Chair of this committee.

While Copley is not taking on risk thru FY19, we are contributing data to the ACOs for analysis and actively working in partnership with providers, social services organizations, and community leaders on a variety of reform initiatives. These health improvement and population health initiatives, as outlined in question 15, help move toward population-based payment reform.

At this time, neither ACO has been able to specify if Critical Access Hospitals' (CAH) enhanced cost-based reimbursement¹ will be retained by each designated hospital. Once more details are provided concerning the ACO's payment methodology – in particular its impact on CAHs – Copley looks forward to evaluating the financial implications of taking on risk and its impact on our financial stability or vulnerability as a CAH.

Copley does not differentiate care based on provider participation status with an Accountable Care Organization. Our Utilization Review Committee monitors and evaluates inpatient and surgical care using MCG Health evidence-based care guidelines. Two additional key tools we use to ensure the highest quality, most appropriate, most cost efficient care at Copley are our NSQIP (National Surgical Quality Improvement Program) and ASP (Antibiotic Stewardship Program), which we are just starting.

NSQIP is the gold standard in tracking and evaluating surgical outcomes. The primary mission of NSQIP is to reduce surgical complications. A 2015 study showed that hospitals participating in NSQIP had reduced postoperative complications by 79%. NSQIP not only tracks outcomes and compares these with regional, national, and international benchmarks, but actively collects best practices from hospitals showing superior outcomes - the promulgation of these best practices is an important part of NSQIP. The utilization of NSQIP is new to Copley this year and we are currently in the initial data collection phase. We expect to have statistically meaningful and useful data and analysis by spring 2018.

The goal of the ASP is to reduce ineffective use of antibiotics. Experience in other hospitals with ASPs has shown that this results in significant reductions in antibiotic usage, less complications associated with antibiotic usage, and the cost savings that accompanies both of these reductions. We are partnering with the Infectious Disease Department and Pharmacy at UVMHC to use their expertise to facilitate our ASP. We are developing tools to track our antibiotic usage and evaluate, in real time antibiotic therapies at Copley to make recommendations and changes where appropriate. We expect to have our ASP fully operational by the start of 2018.

¹ Per the Rural Health Information Hub, "Critical Access Hospital is a designation given to certain rural hospitals by CMS. This designation was created by congress in the 1997 Balance Budget Act in response to a string of hospital closures in the 1980's and early 1990's. The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to health care by keeping essential services in rural communities. This is accomplished through cost-based Medicare reimbursement."