Fiscal Year 2018 Budget Analysis Questions

1) Describe your hospital corporate structure and how the hospital manages and works with related entities. Describe the hospital's historical mission and culture.

   Grace Cottage remains an independent non-profit Hospital corporation that was formed in 1949. In addition to a 19-bed Critical Access Hospital, Grace Cottage includes a Rural Health Clinic (Grace Cottage Family Health) offering both Primary Care and Behavioral Health, as well as a full-service Retail Pharmacy (Messenger Valley Pharmacy). Grace Cottage's only related entity is Grace Cottage Foundation, a non-profit fundraising entity whose sole function is raising funds for Grace Cottage.

   The mission and culture of Grace Cottage, from the day it opened through today, is to provide patient-centered care to our community. Our current mission statement as posted on our website is: *To serve the healthcare needs of our community; to promote wellness, relieve suffering, and restore health.*

2) Income Statement--The hospital is $556 thousand, 2.9% **under** the 2017 budget levels. This decrease is primarily related to reductions in utilization. Describe the changes in utilization the hospital is experiencing.

   The 2.9% budgeted decrease in Net Patient Revenue is due to both less than expected utilization and increased Bad Debt/Free Care write-offs.

   At the time the FY2017 budget was prepared in the first part of 2016, there were increased volume assumptions made in the budget for both Outpatient Care and Physician Practice revenue that did not materialize to the level anticipated. The FY2018 is built upon the volumes that did occur.

   Additionally, the combined Bad Debt/Free Care write-off percentage budgeted in 2017 was 2.4%, the write-off percentage budgeted for in 2018 (based on current projections) is 3.1%. It may be noted that our Free Care percentage is actually decreasing, however it is more a result of people being unwilling to complete the Reduced Fee Applications due to not wanting to divulge their personal financial information, the result is that those accounts end up in Bad Debt. While we work diligently to collect for services provided, as well as have a full-time Resource Advocate on staff to help patients obtain coverage, the unfortunate case is that patients are increasingly unable to pay deductibles and co-insurance due by them.

3) Rate & NPR--Grace has an overall rate/price request of 5.0%. Grace states the overall net revenue change is smaller since they only realize a small percentage of reimbursement as prices change. Explain the strategies and considerations the hospital must weigh in pricing services.

   Hospital services are reimbursed one of three ways: Encounter rates based on cost for Medicare, a fee schedule for Medicaid and some commercial payments, or percent of charges for the remaining commercial payments. Thus the rate increase only nets additional net patient revenue for those payments based on percent of charges, not an additional 5% across the board. Since such a small percentage of our reimbursements are based on the percent of charges method, it nets very little increase in net patient revenue.

   Physician services are reimbursed one of two ways: 1) An encounter rate based on cost for both Medicare and Medicaid (subject to limitations), or 2) a fee schedule for all commercial payers. The average increase in cost per encounter generally does not exceed 4%, nor does the average increase in fee schedules paid by commercial insurers. Thus increasing physician charges by anything greater than 4% would simply result in higher contractual allowances, and not adding anything to the bottom line. That being said, we need to keep our actual billed charges at least as high as what the fee schedule reimbursement is.

   The increase in pricing, which results in additional reimbursement on only those few commercial payments that are based on percentage of charges, and the small self-pay population that is able to pay their bills, would be significantly lower if reimbursement from other payers, particularly Medicaid, was even close to being a reasonable reimbursement level.

4) Dashboard--Bad debt and free care as a percent of gross revenues are higher than the VT median. Discuss the assumptions for budgeting higher (unfavorable) for bad debt and free care in 2018. Is it related to changes expected at the federal level?

   Furthering the discussion in #2 above regarding Bad Debt and Free Care, it is true that our combined percentage of 3.10% is higher than the VT median of 2.40% (Free Care by itself however is at half of the median – however as explained above, some of our Bad Debt would certainly be reclassified as Free Care if patients were willing to complete the Reduced Fee Applications).

   The 2018 budget is based on the same percentage currently being experience in 2017, not based on any changes expected at the federal level.

5) NPR Payer--Medicaid shows unfavorable reimbursement from 2017 to 2018 budget. Describe the reimbursement assumptions.

   The 2018 reimbursement was budgeted at thirty-nine cents on the dollar, the same reimbursement being received in 2017, vs the 2017 budget which was based on forty-one cents on the dollar. In hindsight, the 2018 amount should have been budgeted at an even lower number since the increase in Medicaid reimbursement rates will not be as high as the 5.0% budgeted increase to Gross Revenue.

6) Dashboard - The hospital budget, while declining in NPR growth, still shows unfavorable productivity and a 8.7% cost per adjusted admission increase. Further, operating expenses are high compared to other peers. Discuss these measures and the strategies the hospital considers when preparing the budget.

   The root of this issue is that the Adjusted Admissions and Cost Per Adjusted Admission statistic are no longer accurate reflections of Grace Cottage's line of business (and likely not for many, if not all, of the hospitals in Vermont). It is a statistic that is based entirely on trying to equate all lines of business to an artificial number of Acute admissions. Back when the statistic was developed 30+ years ago when Inpatient revenue was the larger portion of all budgets it may have made sense, however now that Inpatient is such a small percentage, it is a very skewed calculation. Based on the preliminary summary of all 2018 budgets, Inpatient is only 28% of the overall gross revenue for all Vermont hospitals. These statistics are trying to equate all services (services which vary greatly among the 14 hospitals) to something that is just over a quarter of all business lines.

   For Grace Cottage, Acute admissions/Inpatient Revenue is only 4.8% of our overall revenue.

   Grace Cottage is continually looking at ways to decrease costs wherever possible, as well as maximizing productivity. While it is true that budgeted NPR is a decrease, overall Operating Expense is also budgeted at a decrease, despite what this statistic eludes to. And while this imperfect statistic shows an 8.7% increase, it should also be noted if we are going to use the statistic, that our cost per adjusted admission is still only 75% of our peers.

   Grace Cottage's overhead expense as a percentage of total operating expense being higher compared to peers is due to our being the smallest facility. Many fixed overhead expenses are divided over a much smaller overall operating base.

7) Income Statement--Retail pharmacy (340B) of $670,199 is in operating revenue. Describe this program and the risks operating the program.

   The 340B program is a critical part of Grace Cottage's budget; without this program, our budgeted operating loss would be that much higher – and likely threaten our continued existence. The program has two primary components: the ability to purchase some of the drugs used in the outpatient setting of the Hospital, as well as the ability to contract with retail pharmacies for drugs used by outpatients of our facility.

   The money above that is included in operating revenue is from the retail pharmacy contracting component. These funds help to offset the increasing level of uncompensated care discussed above – continuing the intent of the program.

8) Util. & Staff--The hospital explains changes in their reliance on agency/traveler staff which is a savings. Discuss the cost related to hiring travelers.

   Over the past few years, Grace Cottage has had to rely on having agency/traveler staff to maintain appropriate staffing levels in the Nursing department. We have also at different times had agency/traveler staff in Diagnostic Imaging, Laboratory, and Physical Therapy.

The additional costs related to hiring travelers equates to roughly $60,000-$65,000 per full-time equivalent, when factoring in the excess cost per hour being paid to the agency and the additional orientation hours since most travelers change every twelve weeks or so.

As of today, Grace Cottage does not have any travelers in the building.

9) Income Statement--Are the 2017 projections still valid? If not, please describe material changes?

Yes, the projections are still on track.

10) Refer to the Act 53 price and quality data schedules that were included in the presentation of FY 2018 Hospital Budget Submissions-Preliminary Review on July 27, 2017 and be prepared to address questions the Board may have concerning that information.

Grace Cottage does not have any data included in the Inpatient or Outpatient Surgical Procedures data, but will be happy to answer any questions related to outpatient procedures pricing data or quality data.

11) 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;

  We have adopted our ACO's 22 clinical goals, have installed them into our EMR Health Maintenance menu and have released them to our providers. Our ACO will be measuring our progress.

- Support of community infrastructure related to ACO programs;

  Our Community Health Team has active outreach endeavors to reach patients to meet our ACO goals in:
  - hypertension
  - diabetes
  - colorectal cancer screening

  Our Community has a small pilot project involving telemedicine, tracking patients with hypertension/BP issues.

  We are collaborating with UVM on development of a self-reporting Quality of Life survey tool that is specific to the effectiveness of the CHT involvement with our patients.

- 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;

  We are working as indicated toward the following APM clinical goals:

  1) Substance use disorder
     - SPOKE program, 3 integrated counselors
  2) Suicides
     - Depression screenings; Crisis Text line education to staff & advertised on campus; continued education for staff on suicide prevention
  3) Chronic conditions
     - ACO & CHT focus on chronic conditions with care plans introduced for COPD, CHF, Diabetes
  4) Access to care
     - We are always open: same day visits, walk-in openings, ED

- Support for programs designed to achieve the population health measures outlined in the All-payer Model Agreement.

  Continuing our attention to top priorities from our Community Health Needs Assessment, Grace Cottage adopted Blueprint and ACO guidelines with intense focus on the top 4 goals of diabetes, hypertension, colorectal screening & depression.

12) 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?

    Grace Cottage plans to continue its relationship with CHAC in 2018. We are educating our staff on value vs volume parameters and how value measures will be the hallmark for future employment.

    The number one priority of outside providers is quality. The next most important parameter is whether or not they send them back to us for follow-up or keep them. The latter is unacceptable. If we get them back when they have recovered or had their procedure, we can have more control over cost-effective healthcare.