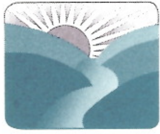

Springfield Hospital

Springfield Hospital
FY 2016 Budget Request
Narrative

A) Executive Summary

In FY 2016 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 2015 to the FY 2016 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 increase slightly to 19.1 vs. 18.5 in the FY 2015 Budget. After an actual decline in FY 2014 and a budgeted decline in FY 2015, the budgeted census for our Distinct Part Psychiatric unit has stabilized and will increase ever so slightly to 7.1 for the FY 2016 Budget.

We have not obtained all of the growth planned for perioperative services in the current fiscal year; however, we have shown growth in comparison to FY 2014 actual. Our budgeted expectations for FY 2016 are slightly reduced from the FY 2015 budget but represent growth in comparison to FY 2015 actual. This growth will not be accomplished by expanding the clinical scope of what we do but rather by retaining a greater percentage of cases/services that we feel it is clinically appropriate to perform in the community hospital setting and doing so in a high quality and cost-effective manner. The major components of continuing to rebuild surgical services include:

- Maintaining continuity in our Orthopaedic Surgery program.
- 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. Our third provider joined our FQHC network in January of 2014. This is an investment in adequate access to perinatal care and the long-term health status of newborns.
- Stabilization of our General Surgery program was far more complicated than the aforementioned specialties. For the fourth quarter of Fiscal 2014 we were down to one (1) employed General Surgeon with a goal of having three (3). As of June 1, 2015 our complement is 2.5 FTE providers---an amount that we feel is appropriate for the need in our service area and also adequate to cover provider call. We expect our Endoscopy suite in particular to be very busy in the fourth quarter of this fiscal year and to perform stronger in 2016 than it has in the last several years.

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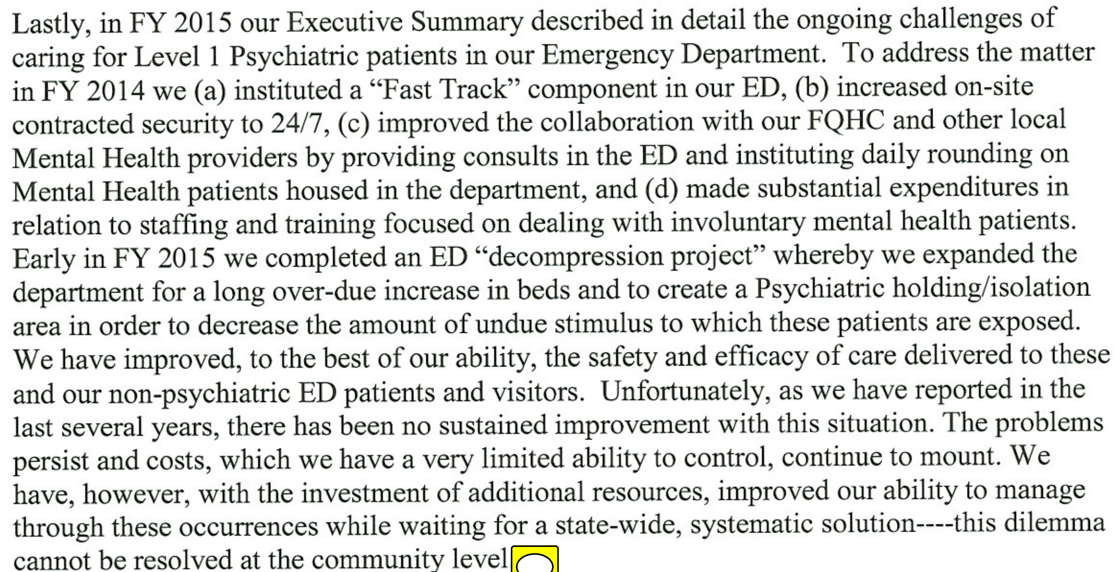
Perhaps the greatest change from budget to budget is revenue growth in our Emergency Department. Very modest volume growth is expected; however, the intensity of our patients continues to increase---not an uncommon phenomenon in states with aggressive Medicaid expansion. Additionally, in December 2014 we outsourced our Emergency Department coding and introduced a new clinical documentation system for the facility component of the ED services which has improved charge capture for services provided. This revenue increase is not the result of a pricing strategy---it is due to the combined effects of increasing service intensity combined with improved documentation leading to enhanced coding and charge capture and hence, collections.



Lastly, in FY 2015 our Executive Summary described in detail the ongoing challenges of caring for Level 1 Psychiatric patients in our Emergency Department. To address the matter in FY 2014 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. Unfortunately, as we have reported in the last several years, there has been no sustained improvement with this situation. The problems persist and costs, which we have a very limited ability to control, continue to mount. We have, however, with the investment of additional resources, improved our ability to manage through these occurrences while waiting for a state-wide, systematic solution----this dilemma cannot be resolved at the community level

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 2016 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.

Health reform efforts include a comprehensive range of activities focused on process and continuous improvement of prevention and chronic care management strategies. These include everything from screening programs for depression, obesity, tobacco use, physical activity, and vaccinations to ongoing monitoring and data reporting at monthly meetings. This quality improvement work operationalizes CDC guidelines, and coordinates implementation of Medical Home, Meaningful Use, and ACO Measure requirements.

The SMCS Community Health Team (CHT) works seamlessly with Springfield Hospital and 185 service providers with our community to:

- manage and coordinate care;
- develop and implement systems of care that support population health, rather than episodic treatment of illness, while still managing individual cases; and,
- ensure access to "the right care at the right time at the right place."

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.

In addition, we are involved in Springfield's efforts to build a healthier community via Project Action, which began in January 2015, and now includes three major workgroups covering Crime and Safety; Treatment, Prevention and Recovery; and Community and Neighborhoods. We are also leading efforts to combat Adverse Childhood Experiences (ACES) and coordinating these efforts with those of Project Action. A workgroup meets monthly with a mission of "building a healthy community using trauma informed prevention, education, consultation and education." Training sessions have been held for area professionals including counselors, police and fire professionals, and school staff, as well as our area emergency medical technicians and paramedics. Work is underway to continue training throughout the community on the long-term impact of ACES and the cost to society and the healthcare system.

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. Both the Hospital and the FQHC participate in the OneCare ACO for attributed Medicare patients.

It is extremely challenging to identify the ROI on the health reform investments contained in our 2015 budget. One compelling measure is that SMCS was recently awarded $134K in Affordable Care Act funding by the U.S. Department of Health and Human Services (HHS) to recognize health center quality improvement achievements. SMCS was one of only 57 recipients nationwide to earn the "National Quality Leader" designation for exceeding national clinical benchmarks for chronic disease management, preventive care, and perinatal/prenatal services.

C) Overall Budget to Budget Net Patient Revenue Increase

For FY 2016 we are requesting a weighted overall rate increase of 2.83%. The weighted increase is derived by applying a 3% across the board increase to Hospital Inpatient and Outpatient services with no increase proposed for Professional Services (Hospital Specialty Provider practices).

From FY 2015 Budget to FY 2016 Budget **our requested Net Patient Service Revenue (NPSR) increase is 2.9%**. The components of this increase are as follows:

- -2.54% attributable to the decrease in our Disproportionate Share Hospital (DSH) payment
- 4.77% resulting from utilization/intensity changes
- 0.67% derived from our rate increase

Simply stated 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 with a budgeted Operating Margin of 2.0%--- which we are on track to obtain by year end. For Budget 2016 we are once again targeting an Operating Margin of 2.0%. We are *adamant* 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 2.0% 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 2015 Budget.** As mentioned previously in the *Executive Summary* we have not budgeted for any significant operational changes in FY 2016. We are not anticipating changes in reimbursements, have no planned physician acquisitions, and no CONs pending or conceived.

b) **Cost Saving Initiatives.** In FY 2016 we will continue with the Lean re-engineering process to seek to eliminate waste from our system, will also enter our fourth 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 anticipate acquiring a Workforce Productivity System through NEAH to allow us to better understand and bench mark our department-level 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.

i. **Revenue Assumptions: Medicare**. The FY 2016 budget assumes that we will continue to be reimbursed at cost plus 1% by the Medicare program for inpatient and outpatient services. However, we have also factored in continued 2% sequestration. We are not budgeting for Medicare Meaningful Use reimbursement in FY 2016. Our FY 2016 Budget does not include the impact of any prior year Medicare settlement activity. However, it does anticipate that our Vermont Medicaid provider tax assessment ($3.4M) will continue to be a non-reimbursable expense unless that determination by CMS is overturned through the appeals process (CMS is in the process of recouping previously reimbursed Provider Tax expenses from Vermont Critical Access Hospitals beginning with the 2010 cost reporting period). 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. Our FY 2014 Operating Results were severely adversely impacted by the need to record liabilities for recoupments from 2010 – 2014 for what had previously been considered a reimbursable expense.

ii. **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

iii. **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 2015 in relation to Uncompensated Care and for all intents and purposes are budgeting for that experience to continue in FY 2016. As a factor of Gross Revenue, Bad Debts are budgeted at 3.63% vs. 3.60% FY 2015 Projected and Charity Care is budgeted at 2.46% vs. 2.43% projected. 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 could increase as the financial responsibilities of patients increase.

D) Rate Request

We will submit the GMCB provided *Rate Increase Schedule* which details the components of our rate request and the payer specific impact. For FY 2016 we are requesting a weighted overall rate increase of 2.83%. The weighted increase is derived by applying a 3.0% across the board increase to Hospital Inpatient and Outpatient services with no increase proposed for Professional Services (Hospital Specialty Provider practices). This request, when applied to

budgeted volume and our payment mechanisms and a substantial decrease in our DSH payment, yields an NPSR increase of 2.9%.

Our budget process includes developing a targeted operating margin. An operating margin is essential in order to maintain quality, provide funding for capital, and to recruit and maintain top quality providers and professionals. We feel it is essential to strive for a 2% Operating Margin in 2016. Margin supports mission......

Given our payment mechanisms, our net to gross yield for each percent of rate increase is very low. That is because we are paid on a cost basis by Medicare, prospectively by Medicaid and some insurers and have an ever dwindling percentage of payments based upon our actual charges and even those methodologies cap our allowable rate increases. Springfield Hospital has a challenging payer mix with a high dependence on government payers--- which is the primary determinant of poor financial health according to industry experts and bond rating agencies.

E) Letter regarding FY 2014 budget to actual overage – N/A

F) Capital Budget Investments

1) Our FY 2016 Capital Budget of $2.1M is very modest with no single item or projects in excess of $500K nor do we currently anticipate major additions between 2017 and 2019.
2) We have no CONs in the works or in the pipeline.

G) 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.

H) Community Health Needs Assessment (CHNA)

Federal requirements of the Patient Protection and Affordable Care Act of 2009 required Springfield Hospital, as a tax-exempt hospital, to conduct a community health needs assessment (CHNA) and adopt plans to meet identified needs every three years. Our CHNA and implementation plan were approved by our Board of Directors for implementation effective 9/30/13. Prioritized needs included:

- Improve overall access to care with an emphasis on primary and preventive care;
- Improve the health and wellbeing of those living with mental illness/substance abuse; and,
- Improve access to oral health care for children and adults.

Work is progressing well in the areas of access to care and mental health/substance abuse. An additional operatory was added to our Dental Clinic, and a work study group is working to assess the dental needs and to develop strategies. Our next CHNA cycle will begin on October 1, 2015. The next three-year implementation plan will be presented to our Board of Directors for approval by September 30, 2016.

I) Technical Concerns

We have no technical concerns to report.