

Porter Medical Center

1. INCOME STATEMENT -The hospital is \$2.6 million over the 2017 budget levels. This is within the 3% target and the 0.4% increase for health care investments. Much of this variance is described as utilization and enhanced services. Discuss these new programs and enhanced services. Describe the need and how will this improve patient care?

Answer: The two most notable programs included in the FY 2018 budget are our new Express Care service, which opened in June of 2017 and the enhancement of services we are providing in our Infusion Center.

Express Care – New Service

Our new Porter Express Care opened in mid-June on the hospital campus. The core goal of this service is to build upon our existing primary care network and ensure appropriate access to high quality, “urgent medical care”, in a setting that is both more convenient and less expensive than a traditional Emergency Department. The service is open seven days a week, including evening weekday hours. We believe that this service represents a very positive development for our patients as we continue to strive to promote access to acute care services in the most appropriate, convenient, and cost-effective setting.

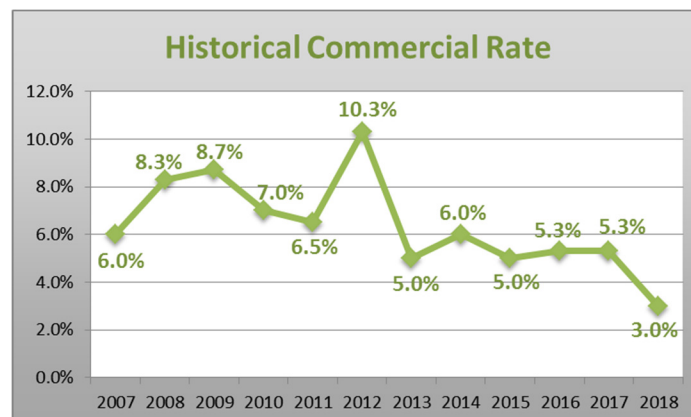
Infusion Center – Enhanced Services

During fiscal year 2016, Porter introduced its Infusion Center to the community, which originally offered services three days per week. Initially, the center offered a limited amount of infusion services that focused primarily on autoimmune disease therapy and treatment of enzyme deficiencies. We are now expanding these services to include treatments for Anemia, Heart Failure, Bacterial Infections, and Oncology Support Care. Additionally, the demand for this service within the community prompted the need to expand the hours of service, and the center is now open five days per week.

This service was designed to address the medical needs of hundreds of area patients who were having to travel outside of Addison County for various types of therapeutic infusion services. By extending the hours of operation and expanding the treatment options, we are able to better serve the needs of these patients.

2. RATE-PMC has an overall rate/price request of 0.0%, but a Commercial rate request (ask) of 3.0%. Porter's states this is because there is a disconnect between overall price/rate increase and net revenue change as only a small percentage of reimbursement affected by price changes. Discuss this strategy and explain the commercial ask. Was pricing for services a consideration in establishing this level? Also, discuss the negative Medicare NPR that is shown as a reduction in the rate request.

Answer: The 3% commercial rate increase represents the lowest increase in over ten years:



The strategy employed to develop the commercial rate increase, was primarily established based on inflationary factors, the increase in provider tax, and a cost shift component.

Commercial Rate Increase	
Inflation	2.0%
Provider Tax Increase	0.5%
GMCB Cost Shift Calculation	0.5%
	3.0%

Customarily, as a Critical Access Hospital, we settle our Medicare reimbursement on a cost report basis. This requires necessary reserves to account for the final settlement process that occurs. During the settlement process, it most often is determined, that a repayment of the over reimbursement of funds is needed. We utilize cost report models to predict the potential reserve amounts required in order to book Medicare revenues appropriately. Routinely, we have identified this reserve amount on the rate schedule to be transparent in our assumption.

3. DASHBOARD - Bad debt and free care combined as a percent of gross revenues are high compared to their Critical Access Hospital peers. Discuss the assumptions for budgeting higher (unfavorable) bad debt and free care. Explain effect of 501r on free care.

Answer: The budgeted bad debt amount for FY 2018, as it compares to our Critical Access peers, is 1.9% vs. 2.0%. This is in line with our peer group. However, as it pertains to the budgeted free care amount (1.1%), we are increasing as it compares to our peers (1.0%) and the median (0.8%) for CAH hospitals. Our rationale for the increase in the percent of free care is due to the heightened promotion of our financial assistance policy as a result of the 501r regulations that were implemented in the beginning of this fiscal year. We have experienced a considerable increase in the number of applications received, this is a 21% increase compared to last year. Additionally, we have seen a 21% increase in the amount of qualified applicants for the 100% discount category.

Furthermore, the 501r IRS regulation that went into effect on October 1st 2016, requires an average discounted amount (Referred to as the Average Generally Billed or AGB discount), which is to be applied prior to patients qualifying for free care. The AGB discount is reflected in our contractuals for Self-Pay. However, if this discount was not applied, the free care percent would have been estimated at 1.3% for the FY 2018 budget year.

4. NPR Payer - Medicaid shows unfavorable reimbursement from 2017 to 2018 budget. Describe the reimbursement assumptions the hospital has made.

Answer: The budgeted NPR is reflective of Porter's current Medicaid trends and representative of the sustained reductions to reimbursement. Another facet of the current reimbursement trend, and the relevant shift in payer mix, is attributable to our aging Medicaid population. Porter also acknowledges the need to anticipate the possibility of future cuts with the level of federal uncertainty.

5. INCOME STATEMENT - Retail pharmacy (340B) of \$2.6 million is recorded in non-operating revenue instead of operating revenue like other hospitals-discuss why the hospital records it in this manner. Describe this program and the risks involved operating the program.

Answer: Within our current operating environment, certain reimbursement streams can unexpectedly be impacted at any time. Therefore, sizeable risk can be associated with a heavy reliance on those

revenues. In an effort to keep our focus on controlling expenses in relationship to our net patient revenue, Porter Hospital records 340B revenues purposely as non-operating income. Additionally, our auditing firm has affirmed the statement of this revenue in this manner, which complies with financial reporting guidelines.

Porter Hospital became a 340B eligible entity in 2010 when Critical Access Hospitals were granted access to 340B drug pricing. In January of 2011 Porter Hospital entered into its first contract pharmacy agreement. Porter Hospital now has formal agreements with 13 contract pharmacies which serve patients in Addison County, Northern Rutland County, VT and Essex County, NY. Our community pharmacy partners fill prescriptions for Porter Hospital patients whom receive services at the hospital location as well as our practice locations.

As a result of its participation in the 340B program Porter has been able to expand its primary care network, placing more providers in underserved regions; expand emergency medical services to better meet community needs; create a safe room for more appropriate treatment of mentally ill patients in crisis; create a clinic devoted to the treatment of narcotic abuse and addiction (endemic to this region); and provide over one million dollars' worth of free care each year. Porter Hospital also proudly supports the Open Door Clinic which provides free healthcare to the uninsured. These are just some of the ways in which Porter Hospital has expanded the provision of healthcare and improved the lives of residents in Addison County with the help of 340B.

Some of the risks involved in operating this program are the following:

Unpredictability: 340B resources could change year to year based on a number of circumstances such as; number of participating pharmacies, increased drug costs, and increases in administration fees and or dispensing fees.

Compliance: The entity is solely responsible for the operations of their individual program, if any components of the program are found to be non-compliant; it not only puts the entity at risk of losing their 340B designation, it can put the 340B community at risk.

Education: To avoid further risks, it is vitally important that our Communities, Providers, Administrators, and Lawmakers are properly educated and informed about the 340B program. This program is designed to provide 340B designated hospitals the opportunity to purchase drugs at significant savings. These savings are then reinvested in the form of services, resources, capital purchases, and free care.

Regulatory Changes: Although this is not a federally funded program, it is overseen by the federal government. Consequently, this program is evaluated on a regular basis and changes are implemented. Those changes can certainly have an impact on the funds 340B eligible hospitals receive. Any negative impacts may force hospital providers to make difficult decisions about the future of the services they render.

Additionally, we have included a copy of our 340B story for your reference, please see attached.

6. UTIL&STAFF -The hospital explains significant changes in their nursing program that is designed to reduce temporary staff and save money. Discuss this change. Reconcile the submitted FTE changes with the information described in the narrative.

Answer: For FY 2017, Porter is trending to spend \$3M in temporary labor expense. As a result, we would have been compelled to suppose this trend, or a good portion thereof, for the FY 2018 budget had we not resourcefully developed the new nurse staffing strategy as a means of reducing this large expense, which has an unsustainable impact on our finances. Therefore, we are recruiting to fill an additional 7.0 FTE positions across our four primary hospital nursing departments:

Nurse Staffing Model	
Medical Surgical Unit	3.0
Emergency Department	1.0
Operating Room	2.0
Obstetrics	1.0
	<u>7.0</u>

The amount of salary expense for these additional positions equates to \$412K; thus, an overall savings of approximately \$2.5M as it compares to current trend.

Below is a complete reconciliation of the FTE changes for budget FY 2018:

FTE Changes Budget-to-Budget	
Express Care	5.0
Express Care Providers	2.0
Nurse Staffing Model	7.0
Porter Medical Group	8.0
Porter Access Center	3.0
Practice Mid-Level Adds	2.0
ENT MD	1.0
	<u>28.0</u>

7. NARR -The hospital narrative explains that they recently recruited an Otorhinolaryngologist which took over two years to recruit. Is this normal for this type of physician? Is the hospital paying a premium for recruiting a specialist of this type? What is the compelling information that supports this recruitment?

Answer: Porter’s experience over the last ten years has evidenced that it requires approximately 12 months to recruit a Primary Care physician, and approximately 18-24 months to recruit a Specialty physician. Accordingly, the two year recruitment effort to employ our new Otorhinolaryngologist is not atypical.

We have compensated our incoming physician in the same manner as our existing Otorhinolaryngologist, exclusive of any premium wages. Consequently, both providers are on the same productivity/quality based compensation model.

Prior to April 2015, our ENT practice employed two physicians. Since that time, we have been operating with only one physician (and on occasion utilizing Locum coverage) in this practice. Subsequently, the average annual visits for this practice have decreased by over one thousand, even though our existing

physician increased his capacity during this time. The need for this service is evident as we have not been able to accommodate all of the needs of the local market.

8. DASHBOARD - The hospital dashboard shows high cost per adjusted admission relative to your Critical Access Hospital peers. Discuss this measure and reasons the hospital may be higher than your peers.

Answer: As the services and depth of services offered at Critical Access hospitals can vary widely from facility to facility, a more appropriate comparison would be that of hospitals with similar volume, provider FTEs, and services offered. An alternative comparison would be the growth in the cost per adjusted admission. Porter, as it compares to the average growth of its CAH peers, is 3.5% budget-to-budget versus 6.5%.

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

Answer: The 2017 projected submission is still reasonably in line with expectation. As of July 31, 2017, actual results are performing 1.4% below forecasted Net Patient Revenue projections; however, as it pertains to YTD actual vs. budgeted NPR, it reflects a 2.9% increase inclusive of risk payments. Operating expenses are trending 0.7% lower than projections due to the slow decline of the reliance on temporary labor.

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.

Answer: The Act 53 report card includes pricing data that quantifies high level groupings of procedures. There are several factors that should be considered when comparing the pricing structures of each hospital facility. Those factors include: the case complexity, the price of supplies, which vary from hospital to hospital, the associated drug expense, which vary based on the dosage amount, and patient demographics.

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;
- 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.

Answer: We plan to address the above questions, in detail, as part of our budget presentation.

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?

Answer: Porter Hospital will contract with OneCare Vermont as its ACO of choice in 2018. In December of 2016, Porter Hospital made the decision to participate in the Vermont Next Generation Medicaid Risk program. Porter Hospital plans to expand participation in FY 2018 with risk contracts for Medicare and possibly Blue Cross Blue Shield of Vermont. As a risk bearing entity, we assume the risk that is associated with the APM and as stated in our budget narrative, we have not incorporated reserves into our budget. In accordance with FASB (Financial Accounting Standards Board) guidelines we recognize the fixed payment revenue in other revenue. For our budget submission we have reported all associated revenues as Net Patient Revenue.

As outlined in our narrative submission, we have described our population health strategies, which enhance our mission to improve the health of our community, one person at a time.

340B In Action:

The 340B prescription drug program is a vital lifeline for safety-net providers, supporting critical health services in our communities. The program is narrowly tailored to reach only hospitals that provide a high level of services to low-income individuals or that serve isolated rural communities. 340B hospitals provide more money-losing vital health services on average than non-340B hospitals.

340B by the numbers – 2016

\$2,973,000 Net 340B Savings

40 Miles away from the next closest institutions providing similar services

\$1,359,592 Uncompensated Care (Free Care)

5.2% Community Benefit as a percent of expense

\$140,132 Support to Open Door Clinic for Uninsured

Our 340B Savings Help Support:

- Operating Room Upgrades
- Purchase of Cardiac Monitors
- Expanded Services including the Infusion Center
- Creation of the Patient Access Center
- Purchase of Ultra Sound Machines

Porter Hospital

Middlebury, Vermont



Our 340B Story

- In 2006, Porter Hospital became a "Critical Access Hospital" allowing us to care for up to 26 acute care patients at any given time.
- Porter Hospital became a 340B eligible entity in 2010 when Critical Access Hospitals were granted access to 340B drug pricing.
- Porter Hospital is the sole community hospital in Addison County and provides a variety of health care and hospital services (inpatient acute, obstetric, primary, orthopedic, surgical, ancillary and emergency care) to our entire population regardless of their financial circumstances or insurance.
- New in fiscal year 2018 was the Porter Hospital Infusion Center which serves patients needing specialty drugs, transfusions, and other infusion services in Addison County.