SCHNEIDER REGIONAL
MEDICAL CENTER

ROY LESTER SCHNEIDER HOSPITAL | MYRAH KEATING SMITH COMMUNITY HEALTH CENTER | CHARLOTTE KIMELMAN CANCER INSTITUTE

**TESTIMONY TO THE**
**31st LEGISLATURE OF THE VIRGIN ISLANDS**
**COMMITTEE ON FINANCE**
**Wednesday, July 13, 2016**

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Good Morning, Honorable Senator Clifford Graham, Chairman of the Committee on Finance, other Senators present, the listening and viewing audience. I am Dr. Bernard A. Wheatley, Chief Executive Officer of Schneider Regional Medical Center (SRMC). Appearing with me are members of SRMC's executive leadership team:

- Scott Nothnagel, Chief Financial Officer
- Charles Nickerson, Senior Vice President of Operations
- Dr. Luis Amaro, Chief Medical Officer
- Darice Plaskett, Chief Nursing Officer
- Tina Comissiong Dickson, Chief Compliance Officer & Legal Counsel
- Cameron Aust, Chief Information Officer
- Delphine Olivacce, Vice President of Quality and Performance Improvement

My team and I appreciate the opportunity to present SRMC's recommended Fiscal Year 2017 budget. We will also discuss some of our recent successes, challenges and plans for the future.

Schneider Regional Medical Center is the only safety net hospital system in the St. Thomas /St. John district. SRMC is the umbrella entity of three facilities; the Roy Lester Schneider Hospital (RLSH), the Myrah Keating Smith Community Health Center (MKSCHC) and the Charlotte Kimelman Cancer Institute (CKCI). Our mission is to provide comprehensive, quality healthcare to the residents and visitors of the Virgin Islands of all faiths, races, and age, in order to improve their health and wellness.

**Joint Commission and CMS Certification**

We are proud to report that our facilities are licensed to provide acute patient care services and continue to successfully maintain compliance with the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission on Accreditation (TJC), among several other regulatory agencies. Our ability to successfully complete these rigorous, unannounced surveys is a testament to the quality of care our organization provides.

## BUDGET OVERVIEW

**Projected 2017**

Based on the first 8 months of activity for FY 2016, the hospital is on track for a $14.4 Million total net loss after the budgeted Government appropriations. SRMC has improved that loss from $15.8 Million originally projected through leadership initiatives. Without further specific initiatives to enhance revenue, curtail spending and additional government support, this severe deficit will continue and exacerbate the financial situation.

**Fiscal Year 2017 Operating Budget**

SRMC's Fiscal Year 2017 Operating Budget and Financial Trends are based on the following assumptions (See Appendix 1):

1. **Revenue**

   One of the most important aspects of revenue projections in healthcare is net revenue. Net revenue is monies we expect to collect. It is gross revenue less contractual adjustments and bad debt. Contractual adjustments are revenue deductions based on negotiated rates with:

   - Insurance companies, and
   - Reimbursement rates preset by the government, such as Medicare and Medicaid.

   SRMC's contractual deductions represent approximately 51% of gross patient revenue and bad debt represents another 15% of gross revenue for total of a 66% of our gross charges. This high level of deductions is attributed to:

   - Volume and extremely low reimbursement rates for patients covered by the Medicaid program, which reimburse below cost of $5.9 million.

- Volume of Medicare encounters, which reimburse below cost of $16 million
- High level of unsafe discharges, patients remaining in the hospital setting for a long period of time where reimbursement is little to nothing.
- 40% discount given to uninsured patients (Self Pay)
- Uncompensated Care for the uninsured or those who cannot afford their co-insurances and deductibles. SRMC provided a total of $25 million in Uncompensated Care for FY 2015 and trending $22.5 million FY 2016.

SRMC is projecting net patient revenue of $48,591,000 for FY 2016 and budgeting $54,674,000 for FY 2017. This increase of $6,079,000 or 13% is due to revenue cycle improvements and collections, increased services in areas such as Urology, Gastroenterology and Cardiology. This increase will help close the financial loss from operations.

**2. Operating Expenses**

FY 2016 projected expenses are $89 million vs a budget of $91.1 million, reflecting a decrease of $2.1 million or 2.3%. SRMC is budgeting a further reduction for FY 2017 of $1.7 million for a total operating expenses budget of $87.3 million for FY 2017. The general categories (or line items) within the operating expense budget include the following:

**3. Salaries and Wages**

Salaries and Wages expense is budgeted at $39.2 million and represents 45% of SRMC's total operating expenses. We are currently evaluating our staffing levels and have set policies to reduce overtime. However, controlling overtime has been difficult given the staffing shortages we have in the clinical areas.

Included in the salaries and wages expenses are agencies staffing costs of $5.8 million. The permanent to agency nursing staff ratio is 78/22. The average permanent to agency nursing staff ratio for 2015 was 75/25. This shows some improvement in our efforts to secure more permanent staff and reduce our reliance on agency (contract) staffing.

The current vacancy rate for RNs is approximately 40%. Our goal is to be fully staffed with permanent RNs. This is a work in progress. However, recruitment of qualified healthcare professionals remains challenging under our current structure.

**RNLU Nurses Negotiations**

In the third quarter of FY16, through the Office of Collective Bargaining, SRMC renegotiated the Virgin Islands State Nurses Association (VISNA) Collective Bargaining Agreement. These negotiations concluded with an agreement between SRMC and VISNA to update the salary scale for Registered Nurses at SRMC. The salary increases that were negotiated are projected to result in an additional expense of approximately $1.5 million per year for SRMC.

This increased salary scale should assist with SRMC's recruitment and retention of permanent RNs, which will reduce the organization's reliance on temporary, more expensive contract RNs. It will take time for this recruitment and transition to happen. SRMC will need support from the central government to pay the salary increases for its current permanent RNs in the short term while that transition happens. Hopefully, within 2-3 years, SRMC will be fully staffed with permanent RNs and be able to absorb the increases on its own through the savings realized by eliminating the temporary, more expensive contract RNs.

**4. Fringe Benefits**

Fringe benefits is budgeted at $9.5 million and represents 11% of our operating expenses. The FY 2017 Budget reflects a slight increase in Fringe Benefits mainly due to the onboarding of our dietary staff.

**5. Professional Services**

Professional services is budgeted at $9.1 million and represents 10% of our total operating expenses. These expenses are related to contracted services for:

- Anesthesiologists
- Biomedical
- Collections

- Housekeeping
- Information Technology
- Legal
- Licensed Temporary Physicians (Locum Tenens)
- Maintenance services

SRMC has decreased its professional services budget by $2 million by eliminating or changing contracts, and by bringing biomedical and food service functions in-house.

During the third quarter of FY16, Aramark ended its contract with SRMC. To date we have successfully transitioned the vast majority of the employees who were working under Aramark into the organization. SRMC seamlessly maintained its inpatient food service, dietary program and biomedical program. A few cost-saving modifications were made to the Cafeteria and retail program. SRMC continues to be a place where the community can have a nutritious breakfast or lunch at a very affordable price.

**6. Materials and Supplies**

Materials and supplies is budgeted at $16.1 million and represents 18% of our total operating expenses. This is a $400,000 reduction compared to FY16 projections. We will continue to review our inventory procedures to ensure efficiency and to reduce costs. Food, drugs, other medical and non-medical supply costs continue to increases nationwide.

**7. Other Services and Charges**

Other services and charges is budgeted at $5.6 million and represents represent 6% of the total operating expenses. This expense category includes:

- Communication
- Freight
- Housing and Rental Costs (for Temporary Contract Staff and Licensed Physicians or Locum Tenens)
- Repair & Maintenance
- Transportation
- Travel

Repair and Maintenance costs are high due to SRMC's aging facility and equipment. Our fiscal challenges continue to make it difficult to reinvest in the infrastructure. The estimated cost for repairs and maintenance in FY 2016 is $2.1 million.

Freight costs are also extremely high. In FY 2015, SRMC spent $577,000 to ship supplies. The estimated cost for FY 2016 is $612,000.

**8. Utilities**

Utility expenses is budgeted at $4.2 million and represents 5% of our total operating expenses. SRMC's average monthly invoice from WAPA is $345,000. Our current outstanding account payable to WAPA totals $5,800,000. We are grateful for FY'16 special appropriation of $4 million that helped to reduce our aging account payables to WAPA.

**9. Depreciation**

Depreciation expenses is budgeted at $3.6 million and represents 4% of our total operating expenses. $3.6 million is the minimum capital necessary to maintain and/or improve the infrastructure. The average age of the physical plant at SRMC is 26 years, whereas, the age should be closer to 10 years with proper funding of depreciation. This illustrates the need to replace and upgrade our aging equipment and infrastructure.

Examples of impactful facilities failures in FY 2016 include:

- Generator Failure
- Chill Water Pipe System Ruptured
- Steam Leak
- Cistern leak
- Air Handler Failure
- Electrical Switch Gear Failure

**10. Overall**

SRMC's consolidated statement of operations shows a projected overall loss from operation (loss before appropriations) of $36.9 million in FY 2016 and an Operational Loss of $14.4 million after the budgeted allotment. SRMC's budget for FY 2017 shows an overall loss from operation (loss before appropriations) of $29.8 million and an operational loss of $7.2 million after the current budgeted allotment. This is a reduction of $7 million mainly driven by revenue and cost savings initiatives. SRMC will continue aggressive efforts to further reduce this deficit, but we need your help. If we sustain another fiscal year with a loss, major decisions will have to be made regarding what SRMC's future will look like regarding services provided.

## FINANCIAL CHALLENGES

**1. Operating Loss**

SRMC's deficit of revenue and gains over expenses and losses for the past 5 year's average over ($37,603,000) in losses before Government appropriation and average ($9,964,000) after Government appropriation. See chart below (Figure 1).

| **Figure 1** | | | | | |
|---|---|---|---|---|---|
| **Operating Losses Before Government Appropriation:** | | | | | |
| **2015** | **2014** | **2013** | **2012** | **2011** | **Average** |
| -$47,313,012 | -$36,731,239 | -$33,146,301 | -$33,212,688 | -$37,610,114 | -$37,602,671 |
| | | | | | |
| **Operating Losses After Government Appropriation**: | | | | | |
| **2015** | **2014** | **2013** | **2012** | **2011** | **Average** |
| -$17,508,765 | -$1,484,887 | -$11,723,430 | -$9,857,435 | -$9,243,011 | -$9,963,506 |

These losses are not sustainable. SRMC had days cash on hand at fiscal year-end September 30, 2015 of 8.6 and currently has days cash on hand at May 31, 2016 of 2.1. SRMC's has total current liabilities at fiscal year-end September 30, 2015 of $40,401,942 and currently at May 31, 2016 has total current liabilities of $46,787,574.

The organization cannot sustain itself without support for the large amount of uncompensated care and underpayments by Medicaid and Medicare and is currently in a severe financial crisis. Accounts payable to SRMC's vendors alone totals $31,385,341 as of 06/15/16, which has caused a critical situation in obtaining supplies and services in order to operate. See Chart 2 for detail. Vendors are no longer extending credit to the organization and are increasingly engaging in litigation in order to obtain payment.

The main factors that drive the financial instability for an acute care hospital in our economic and geographical environments include the following:

## 2. Uncompensated Care And Underpayments From Medicare And Medicaid

The organization treats a large number of patients with little to no insurance and lack of financial ability to pay their medical bills as well as a large number of patients enrolled in programs that pay below cost such as Medicare and Medicaid. In fiscal year 2015 SRMC had the following payer mix based on charges billed for services rendered. See chart below (Figure 2)**:**

**Figure 2**

**Payor Mix by Gross Revenue**

| Primary Ins Group | YTD 2015-16 % | FY 2015 % | FY 2014 % | FY 2013 % | FY 2012 % | FY 2011 % |
|---|---|---|---|---|---|---|
| Medicare | **41.5%** | **42.2%** | **40.6%** | **38.8%** | **36.3%** | **39.4%** |
| Medicaid | **20.5%** | **14.1%** | **13.4%** | **11.4%** | **12.6%** | **12.3%** |
| Self-Pay | **12.0%** | **16.7%** | **16.8%** | **18.4%** | **17.1%** | **16.1%** |
| Cigna | 12.0% | 13.9% | 15.0% | 17.9% | 19.0% | 18.1% |
| Commercial | 7.6% | 7.1% | 6.7% | 6.0% | 7.1% | 7.5% |
| Blue Cross | 4.6% | 3.7% | 4.2% | 4.1% | 4.0% | 3.0% |
| Other Insurances | 1.6% | 1.9% | 2.7% | 2.6% | 3.2% | 2.6% |
| Workers' Compensation | 0.2% | 0.3% | 0.5% | 0.7% | 0.5% | 0.9% |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |
| Total Self Pay, Medicare & Medicaid | **74.0%** | **73.0%** | **70.8%** | **68.6%** | **66.0%** | **67.8%** |

The chart (Figure 2) also demonstrates that currently 74% of our business is provided to payers that represent uncompensated care or payers that reimburse below cost. (Self-Pay & Uninsured 12%, Medicare 41.5% and Medicaid 20.5%). You can also see the decrease in the Cigna insurance business which is currently only at 12%.

**Uncompensated Care**

The American Hospital Association (AHA) defines uncompensated care as “an overall measure of hospital care provided for which no payment was received from the patient or insurer.” The AHA further states that uncompensated care “is the sum of a hospital's bad debt and the financial assistance it provides.” The AHA defines financial assistance as “care for which hospitals never expected to be reimbursed and care provided at a reduced cost for those in need.” The AHA defines bad debt as debt that a hospital incurs “when it cannot obtain reimbursement for care provided; this happens when patients are unable to pay their bills, but do not apply for charity care, or are unwilling to pay their bills.” SRMC and the American Hospital Association emphasize the fact that the definition of uncompensated care “includes only two components within the universe of benefits that hospitals provide to their communities.” The AHA recognizes that hospitals are left to “bridge the gaps created by government underpayments from Medicare and Medicaid.”

The AHA also recognizes that “the payment rates for Medicare and Medicaid are currently set below the cost of providing care resulting in underpayment.” The uncompensated care provided in fiscal year 2015 amounted to $25,347,572 of which only $22,472,518 was funded by the local government leaving a shortfall of $2,875,054.

The underpayments for fiscal year 2015 from the Medicaid and Medicare programs based on the calculation defined by the American Hospital Association amounted to $21,975,440 which was solely absorbed by SRMC. (See Appendix 1 & 2).

**Medicaid Program Underfunding**

The Medicaid program for FY 2015 had underpayments to SRMC’s cost by $5.9 million.
The Medicaid program has a federal and local component to the payment which is based on an IP and OP per-diem rate. The federal share is 57.2% and the local share is 42.8%. The Medicaid IP per-diem per patient day up to a maximum of 10 days is $1,654.52. The Department Human Services (DHS) only pays SRMC the federal portion of the payment which is the 57.2% of the per-diem rate which is only $946.38. The remaining $708.13 of the per-diem rate is considered in the allotment. For OP services the per-diem rate is only $143.36 and the 57.2% of the per-diem rate is only $82.00, even for an OP surgery case.

The remaining $76.34 of the per-diem rate is considered in the allotment. In FY 2015 the Medicaid payments for the local match totaled $2,705,773 which was not paid directly to SRMC as it is considered in the allotment. An organization with a payment structure such as this Medicaid plan that makes up over 20% of the services provided cannot financially reach profitability.

The current share between federal and local of 57.2% and 42.8% was respectively reduced beginning January 1, 2016 to 55% and 45%, meaning the payments to SRMC will be further reduced and the portion considered in the allotment will be increased further reducing the revenue to SRMC. The Medicaid rates are based on the 2012 cost report and SRMC is working with DHS to have the cost reports from 2012 to 2015 audited as to allow for rate adjustments based on actual costs per these cost reports. This may possibly change the rate amounts favorably for SRMC.

**Medicare Program Underfunding**

The Medicare program for FY 2015 had underpayments to SRMC's cost by $16 million. The Medicare TEFRA program is also based on an IP per-diem rate and an OP cost based rate. The rates were established based on the 1996 cost report and have not been re-based since due to the regulations regarding re-basing. The program does not have any cost carve outs for high cost cases such as implants or the use of high cost drugs. SRMC is also based on a suburban setting instead of a rural setting which also impacts the rates negatively.

As Medicare makes up over 41% of SRMC's business. We need to aggressively try to have regulations changed to allow proper reimbursement to the program. SRMC is the sole source of Inpatient services for St. Thomas and St. John. The geographical challenges of providing care on an island include but not limited to:

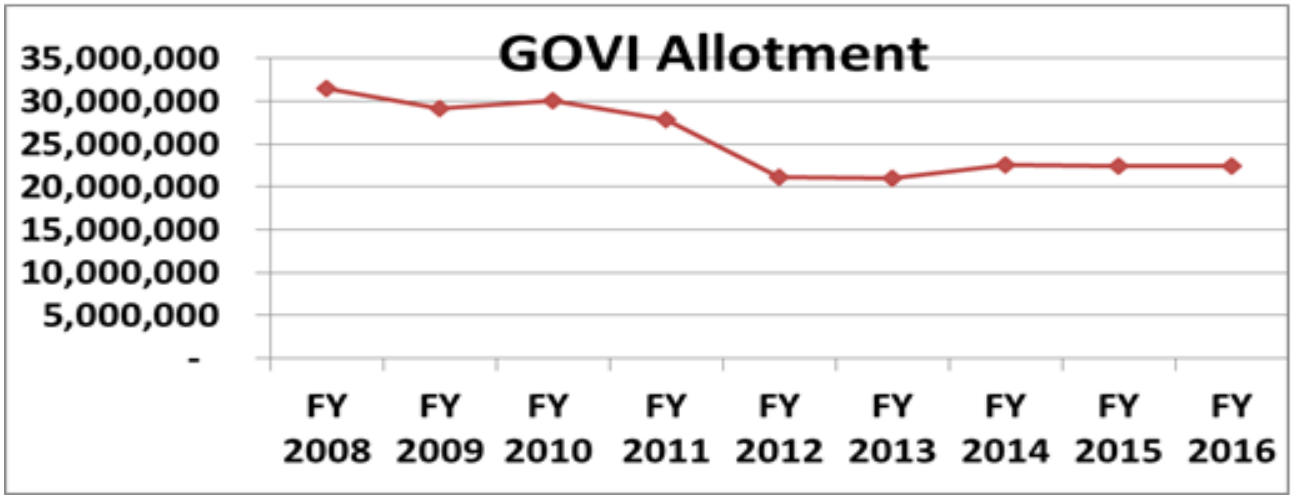
- The high cost of outside clinical labor inclusive of Nurses, Ambulatory clinical staff and Physicians. The labor pool of St. Thomas does not support these highly trained clinical positions and therefore must be outsourced from off-island.
- An aging plant in need of constant upgrades and repairs. SRMC's current capital needs total an estimated $20,000,000.

- The organization is also faced with the high costs of supplies and materials as well as the high costs of shipping such on-island. The lack of Funding for Disproportionate share (DSH) as the TEFRA reimbursement system does not allow for DSH payments or a 340B drug discount program.

**3. Decreased Appropriations from Central Government**

Our financial situation is compounded by the decrease in appropriations to SRMC over the past 8 years. As shown in the chart below (Figure 3) allocations have decreased from $31,527,175 in Fiscal Year 2008, to $22,472,518 for Fiscal Year 2016. This represents a reduction of $9,054,657 or 29% decrease in appropriations to SRMC. Significant reductions to SRMC's appropriations negatively impact our goal of achieving a balanced operating budget. These financial challenges also inhibit the hospitals ability to pay critical vendors in a timely manner. Vendors are consistently placing the hospital on credit hold or threatening to do so and many are now seeking legal action.

**Figure 3**




**4. Unsafe Discharges**

The lack of secondary healthcare facilities or the space available to place patients ready for discharge from the acute care setting to another facility able to provide the level of care they need is a major problem for the territory. SRMC has a population of long term patients who are unable to be discharged (unsafe discharge) that have collectively been at our facility for 5,522 days from their admission day through to the end of June 30, 2016.

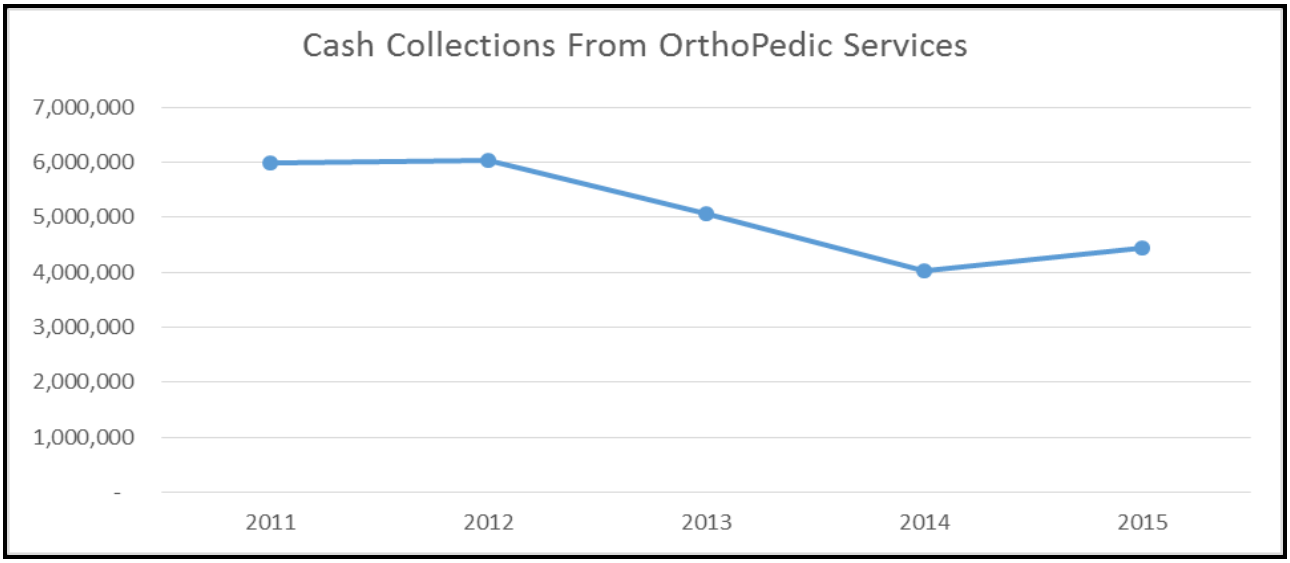
Unreimbursed cost for these long term patients exceeds $5 million and not only creates a financial hardship but it also increase the patient to nurse ratio impacting our staffing needs. SRMC and the other agencies are aggressively working together to place as many of these unsafe discharges as possible.

A newly formed intergovernmental agency committee developed by the SRMC utilization review committee has been moderately successful in placing some of these unsafe discharges and continues to strive to place the remainder. To date, of the 10 initial unsafe discharges that bordered SRMC prior to the committee, 6 have been placed to permanent facilities. We, however, continue to obtain new unsafe discharges due to the lack of long term care facilities that exist in our community for the aged and disabled.

**5. Competition from Outpatient Centers**

SRMC faces increased competition from USVI ambulatory surgical centers. Significant numbers of surgeries have migrated away from the hospital's operating rooms to external surgical facilities. SRMC's commercial business has dropped 21% over the past two years. The graph below (Figure 4) shows the decrease in cash generated by the orthopedic service line due to the outflow of insured patients to freestanding ambulatory surgery centers.

**Figure 4**



Since 2012, SRMC has seen a decrease of cash collections from this service line of $2,000,000 annually. The dramatic loss of this service line led to the suspension of the elective implants for Hips and knees due to the organizations inability to purchase the implants.

The cost of Hip and Knee implants alone range from $7,000 to $10,000 and due to the payer mix of the patients receiving the implants which consist of 60% of our patients that have reimbursement plans, which include Medicare at 50% and Medicaid at 5%, that do not cover the cost of the implant itself let alone the operating room services and the 2 to 3 day In-Patient stay.

## 6. Accounts Payable

The proposed FY'16 general fund appropriation of $22,472,518 and makes it difficult to render the full scope of services expected by the community and visitors, and impacts our ability to keep current with our vendors. As shown in the table below (Figure 5), SRMC currently has an outstanding Accounts Payable and Accrued Liability of $31,385,341.

**Figure 5**

| **Accounts payable liabilities as of 06152016** | | | | |
|---|---|---|---|---|
| | | **Description** | **Amount** | **Comments** |
| I. | **Current liabilites: Medical Supply:** | | | |
| | 1 | Open Invoices processed ready for payment | $ 25,851,678 | Summarized part II |
| | 2 | Open Purchase Orders delivered supplies & services | $ 4,068,025 | |
| | 3 | Accrued expenses not yet processed | $ 1,465,638 | |
| | | **Total current liabilities** | **$ 31,385,341** | |
| II. | **Invoices processed for payment by category:** | | | |
| | 1 | Construction | $ 177,029 | |
| | 2 | Refunds | $ 4,479,876 | |
| | 3 | Dietary Service | $ 4,540,641 | |
| | 4 | Maintenance | $ 518,678 | |
| | 5 | Medical Supply | $ 1,482,052 | |
| | 6 | Orthopedic | $ 560,411 | |
| | 7 | Other | $ 916,458 | |
| | 8 | Other Supplies | $ 116,761 | |
| | 9 | Oxygen & Gas | $ 667,693 | |
| | 10 | Professional Service | $ 3,112,337 | |
| | 11 | Staffing Agency | $ 3,307,095 | |
| | 12 | Utility | $ 133,154 | |
| | 13 | WAPA | $ 5,787,228 | |
| | 14 | Waste | $ 52,264 | |
| | | **Total invoices processed for payment:** | **$ 25,851,678** | |

SRMC does not intentionally withhold payment to vendors; difficult decisions are made based on our cash on hand. Our executive team meets regularly to assess which vendor payments can be delayed or paid. This process is done to ensure we have critical medical supplies available to provide safe, quality healthcare.

## 7. Capital Funding

The total capital needs of SRMC's 5-year capital plan currently exceeds $21 million. See table below (Figure 6). Our capital spending is inadequate to keep pace with improvements and upgrades in technology and to address the aging plant and infrastructure needs. Each year, SRMC has had to defer capital improvements or use operating funds to meet "emergency" capital needs. Unlike other similarly positioned hospitals, SRMC does not have the ability to "set aside" funds for regular capital improvements. The continued inability to fund capital items will continue to affect operating costs as maintenance costs increase.

**Figure 6**

| **CAPITAL NEEDS (1 to 5 Years)** | | |
|---|---|---|
| **Category** | **Amount** | |
| Building Infrastructure | $ | 9,633,600 |
| Cardiology | $ | 3,500,000 |
| Diagnostic | $ | 1,685,550 |
| Equipment | $ | 921,407 |
| Hemodialysis | $ | 211,500 |
| Information Systems | $ | 2,407,000 |
| Laboratory | $ | 1,208,100 |
| Nursing | $ | 738,000 |
| Operating Room | $ | 774,200 |
| Pharmacy | $ | 107,000 |
| Respiratory Care | $ | 20,920 |
| Support Services | $ | 75,000 |
| Therapy | $ | 10,349 |
| **Total Capital:** | **$** | **21,292,625** |

It is not strategic to address capital needs at the time when they become critical or urgent, because one will have to pay premium rates for the short turnaround period required.

The FY'17 recommended appropriation of $22,472,518 is insufficient to meet the mandate of operating an acute care hospital, a cancer center, and an urgent care clinic on a twenty-four hour basis.

## CHARLOTTE KIMELMAN CANCER INSTITUTE (CKCI)

The Charlotte Kimelman Cancer Institute is the only comprehensive cancer institute in the Territory. CKCI's operating loss for FY 2015 was approximately $1.8 million. Patients treated at the CKCI facility in Fiscal Year 2015 were 1,915; most of these patients were covered by either Medicare or Medicaid, which accounts for 54% and 15% respectively. This unfavorable payer mix, the effects of competition and the high cost of chemotherapy medication continues to negatively impact its operating margin.

The institute offers medical oncology (adult and pediatric), hematology and radiation oncology services and have a full complement of other clinical and professional staff. CKCI also offers prosthesis fittings at the Lynne Cohen Boutique, educational seminars, cancer support groups, and provides a host of free or low cost cancer screenings, which includes Cervical, Prostate, Colorectal, Skin and Breast Cancer Screenings. CKCI is also equipped with advanced technology in cancer detection and treatment.

SRMC needs to care for the community, but cannot operate programs with extreme losses such as CKCI.

## MYRAH KEATING SMITH COMMUNITY HEALTH CENTER (MKS)

For Fiscal Year 2015, Myrah Keating Smith Community Center (MKS) operating loss was $2,014,000. MKS is the only health care facility offering 24-hour urgent care on the island of St. John. MKS offers a variety of primary health care services to include adult, pediatric and high-risk prenatal care and specialty services in endocrinology, ophthalmology, and orthopedics. MKS also provides nutrition and diabetes consultations and support.

MKS provides access to services for approximately 10,000 patients (both residents and visitors) per year. The center's payer mix indicates that a large percentage of individuals who were treated during Fiscal Years 2015 did not have insurance or had limited coverage by Medicaid.

Based on our documentation, approximately 36% of all patient visits were made by the uninsured, 10% were covered by Medicaid and 18% were covered by Medicare.

Given its financial status, MKS cannot continue to provide services at its current levels without additional financial support and resources. If funding is not provided, MKS must take measures to curtail services in order to reduce its operating expenses.

## MARGIN IMPROVEMENT / OPPORTUNITIES

1. **Service Expansion**

   Our team is working to implement new services to keep pace with healthcare advances nationwide. Some recent additions to the services we provide include: Outpatient Physical Therapy, Occupational and Speech Therapy and Telemetry Services. Providing a full array of full time cardiology services to include pace-maker insertion, cardiac nuclear medicine services, and chest pain program services as well as expanding our various catherization procedures previously provided over the last 11 years. In addition, we plan to provide full time Pulmonary/Critical care services allowing our patients to receive all their cardio/pulmonary care on island.

   SRMC is committed to providing excellent comprehensive care to our community and these services not only create a revenue stream previously unseen in our institution but also provides much needed services in our community that allows our patients to remain at home.

2. **Surgical Technician Program**

   In January 2016, an in-house Surgical Technician Program was established to increase the number of permanent Surgical Technicians on-staff, to reduce the expense and reliance on contracted Surgical Technicians to fill critical vacancies, and to provide opportunity for training and career advancement.

   On June 7th, nine (9) students successfully completed the training and are now employed as Surgical Technicians. With the successful implementation of an in-house Surgical Technician Program, we went from utilizing four to five Surgical Technicians

on contract, to having the full complement of Surgical Technician Positions filled with permanent staff.

The Surgical Technician Program prepared the students to assist surgeons, registered nurses and other members of the surgical team with performing duties that are vital for surgical patient safety and care during operative procedures.

3. **Fast Track Service**

Fast Track service is designed to improve the efficiency and decrease the waiting time in the Emergency Department when the greatest numbers of people tend to seek emergency treatment. Fast Track service allows patients with acute but non-life-threatening conditions to be treated more quickly and then released. This service has been a great benefit to the community. However, staffing to maintain consistent operating hours has been a challenge. When staffing is available, the Fast Track operates from Monday through Fridays from 11am to 5pm. A full time Nursing Administrative Care Coordinator was assigned to oversee operations and to provide nursing care. We are actively recruiting additional registered nurses, advance practice nurses, and physician assistants to expand to hours of operations.

4. **Wireless Medical Telemetry Service**

Wireless Medical Telemetry is the remote monitoring of a patient's physiological parameters, such as vital signs and cardiac rhythm. In response to the rising acuity levels of patients on medical/surgical floors and the need for closer surveillance of these patients, some hospitals are investing in wireless telemetry devices or ECG capable monitors for their general care beds.

At SRMC, we believe, the implementation of this system allow us to safely care for higher acute level patients in the general medical setting such the ICU, Medical/Surgical Units, and Emergency Department through the continuous monitoring of patient condition. SRMC is near the completion stage of a newly developed telemetry program that will have the capability to monitor our patients on telemetry from any clinical area in the hospital.

**5. National Council Licensing Examination for Registered Nurses (NCLEX – RN) Prep.**

On June 13th, a NCLEX-RN Preparation Program was established in collaboration with the renowned NCLEX-RN Prep Program-Kaplan. Currently, there are 10 students participating in the program. The program include classroom instruction, clinical preceptor-ship and a structured Kaplan (NCLEX-RN) review course designed to build confidence, experience and to facilitate successfully completion of the RN licensure exam. Three curriculum options are offered:

1) The NCLEX-RN Prep Student /Graduate Nurse- to provide new graduate nurses with the opportunity to gain clinical experience as a "Graduate Nurse" while participating in the Kaplan (NCLEX-RN) preparation course. A nursing student can only work as a "Graduate Nurse" for one year post completion of an Accredited Nursing Program.

2) The NCLEX-RN Prep Student/Employee- to provide graduate of a RN Nursing Program already employed with SRMC an opportunity to continue employment while participating in the Kaplan (NCLEX-RN) preparation course.

3) The NCLEX-RN Prep Student- to provide graduate of a RN Nursing Program that are not employed with SRMC to participate in the Kaplan (NCLEX-RN) Preparation course.

All students are required to sign a two years employment agreement with SRMC as a RN post successful completion of the NCLEX-RN. The commitment of two years employment is an effort to increase the number of permanent RNs, reduce the reliance on travel nurses, and is in alignment with the organization's mission of improving health and wellness by providing comprehensive, quality healthcare to the residents and visitors of the Virgin Islands.

**6. Capital Projects**

The Florida Light & Power infrastructure upgrade project, if implemented, is estimated to yield a savings of $2.1 million in operating costs. The project has an estimated capital investment of $11.3 million. This project has a return on investment of 5.4 years.

By moving forward with the energy initiative put forth by Florida Light & Power, SRMC's costs to WAPA will be reduced by $2.1 million further alleviating the liability due to WAPA.

Other energy savings projects SRMC would like to pursue requires a capital investment of $1.2 million to yield an annual savings of $1 million. This is a return on investment of 1.2 years. The combined costs savings from these projects can help to close the financial deficit by another $3.1 million if completed, but SRMC does not have the ability to fund these projects.

**7. Hospital Designation and Efforts to Improve Reimbursement**

SRMC is in need of support to change its reimbursement structure for uncompensated care, Medicare and Medicaid. Although currently SRMC does not meet all the criteria for a change in designation, SRMC feels the designation of the Hospital should be classified as a Critical Access Hospital (CAH) which would allow for cost based reimbursement for IP and OP, or a Sole Community Hospital (SCH) which would allow for the higher reimbursement rate as well as qualify as a Disproportionate Share Hospital (DSH) and the 340B drug discount program. These changes are currently not available to SRMC under current regulations.

Local and Federal support is needed to implement these designations and changes. All of these designations may provide the financial means to continue to provide the quality care for the residents of St. Thomas and St. John USVI.

**8. Information Technology**

The Information Services Department of the facility continues to drive towards modernizing the IT Infrastructure of the hospital. The physical infrastructure has been partially upgraded, allowing the clinical application suite (Meditech) to be upgraded to a more current level. Approximately $1 million of EHR Incentive funding has been secured from the federal government to move the facility towards Phase 1 Meaningful Use (MU) Compliance. This funding has allowed the facility to move forward with MU related projects such as:

- Data Reporting Repository
- Computerized Physician Order Entry
- Bedside Medication Verification
- Patient Access Portal
- Document Scanning and Archiving
- Electronic Prescribing

Additional capital funding will be needed to continue with improvement projects not related to MU such as expansion of the hospital wireless network, replacement of aging switching equipment and other components of the infrastructure that have become dated as well as information security improvements. These initiatives are helping to keep SRMC on par with comparable facilities stateside and provide our patients with the same level of care that they would find there.

**9. Foundation**

The Foundation was reestablished in fiscal year 2015. The original Roy Lester Schneider Hospital Foundation was dissolved on December 30, 2015 and was officially reestablished under the new title of Schneider Regional Medical Center Foundation on March 11, 2016.

The Schneider Regional Medical Center Foundation, through its philanthropic activities, assists Schneider Regional Medical Center in attracting the resources required to fulfill and enhance the quality of healthcare for the community and visitors. The purpose of the foundation is to obtain funds through charitable giving, to administer those funds, and to allocate them to Schneider Regional Medical Center.

The SRMC Foundation has five committees that are chaired by community volunteers: Signature, Special, Business, Annual and Employee Gifts Giving Committee. Each committee has a projected capital raising goal.

The Foundation board in conjunction with the Hospital Governing Board and the leadership team of SRMC have identified four major focus areas of enhancement.

These include the renovations to:

- Emergency Department
- Labor and Delivery Birthing Rooms
- Myrah Keating Smith Community Health Center Lobby
- Private Rooms on the Surgical Unit

The goal for the Emergency Room/Department is $2.5M. Currently, the foundation has $436,188 that was transferred over from the old foundation account. Since the inception of the new foundation, $110,112 has been received through employee contributions and from the community. Additionally, the foundation has received $97,571 in earmarked funds for specific projects and $48,039 in donated equipment and supplies.

We would like to thank our employees for believing in the mission and vision of SRMC by contributing to the Foundation and our community partners such as:

- Charlotte Amalie High School Class of 1987
- Inner Wheel
- International Capital and Management Company
- Medical Staff
- Miracle Babies
- Partners For Health
- Sanctuary Choir & People Ministry of the Seventh Day Adventist Church

**Community Benefit**

Despite our financial challenges, SRMC remain committed to providing community benefit. SRMC has provided free services, screenings, and have participated in numerous community events, to include:

- Collaborated with the American Cancer Society (ACS) to Provide Mammograms.
- Six (6) teams from SRMC participated in this year's Relay for Life. The employees raised nearly $12,000 through fundraisers and community donations, all to benefit ACS.

- Hosts Monthly Educational lectures and seminars on health topics impacting our community. Topics range from Strokes, Trauma Care, Breast Cancer, Reconstructive Surgery, Electroconvulsive Care and more.

## SUMMARY

Based on our projected Fiscal Year 2017 Operating Budget & Financial Trends (Appendix 1), SRMC would need an additional $7.2 million of additional funding to breakeven. Furthermore, SRMC's capital needs are approximately $21 million (Appendix 2), which are currently not funded and has vendor liabilities of $31.4 million that if SRMC is not generating a profit cannot pay down this liability. Based on the aforementioned, SRMC is requesting further consideration to increase the organization's budgetary allotments to offset its operating loss and to fund depreciation.

SRMC will continue to work on addressing the aforementioned issues to address the financial situation and if successful feels the financial gap can be considerably closed.

I need to note, If SRMC realizes another fiscal year with a loss; major decisions will have to be made regarding what SRMC's future will look like regarding services provided. SRMC is in danger of not being able to operate financially if funding is not addressed.

## CONCLUSION

I would like to take this opportunity to recognize the St. Thomas / St. John District Governing Board, the Territorial Board, Executive Leadership Team, the Medical Staff and employees of SRMC for their hard work and on-going commitment to our organization. Most importantly, I would like to thank the patients and their families who have entrusted their healthcare to SRMC. Be assured that we will continue to improve our services to not only meet but exceed your expectations.

Thank you, Mr. Chairman and members of the Committee on Finance for the opportunity to present our FY 2017 Budget; we appreciate the support and assistance the Legislature and Administration have provided to us over this past year.

My team and I are prepared to take your questions.

## Appendix 1

Fiscal Year 2017 Operating Budget & Financial Trends

| | A | B | C | D | E | F |
|---|---|---|---|---|---|---|
| | **May 2016 YTD** | **Projected FY 2016** | **Budget FY 2016** | **Variance to Budget (B-C)** | **FY 2017 Budget** | **Variance to Projected FY 2016 (E-B)** |
| **Operating Revenue:** | | | | | | |
| **Total Gross Patient Revenue** | $ 98,271,742 | $ 147,407,613 | $ 145,294,890 | $ 2,112,723 | $ 153,303,918 | $ 5,896,305 |
| **Contractual Adjustments** | (54,724,395) | (77,186,593) | (72,647,445) | (4,539,148) | (76,354,847) | 831,746 |
| **Provision for Bad Debt, Net** | (11,751,222) | (21,626,833) | (16,000,000) | (5,626,833) | (22,275,426) | (648,593) |
| **Net Patient Revenue** | **31,796,125** | **48,594,187** | **56,647,445** | **(8,053,258)** | **54,673,645** | **6,079,458** |
| | | | | | | |
| **Prior Year Revenue** | 1,022,261 | 1,022,261 | - | 1,022,261 | - | (1,022,261) |
| **Other Revenue** | 1,683,214 | 2,524,821 | 2,895,619 | (370,798) | 2,799,821 | 275,000 |
| **Total Operating Revenue** | **34,501,600** | **52,141,269** | **59,543,064** | **(7,401,795)** | **57,473,466** | **5,332,197** |
| | | | | | | |
| **Operating Expenses:** | | | | | | |
| **Salaries & Wages** | 25,438,193 | 38,642,523 | 37,000,000 | 1,642,523 | 39,199,083 | 556,560 |
| **Benefits** | 5,965,723 | 9,137,286 | 9,200,000 | (62,714) | 9,535,726 | 398,440 |
| **Professional Fees** | 7,911,116 | 11,095,341 | 13,084,832 | (1,989,491) | 9,098,675 | (1,996,666) |
| **Medical and Other Supplies** | 10,119,595 | 16,499,393 | 17,822,785 | (1,323,393) | 16,099,393 | (400,000) |
| **Other Expenses** | 3,756,334 | 5,839,653 | 5,265,860 | 573,793 | 5,621,653 | (218,000) |
| **Utilities** | 2,783,030 | 4,174,545 | 5,160,000 | (985,455) | 4,174,545 | - |
| **Depreciation** | 2,404,670 | 3,607,005 | 3,562,661 | 44,344 | 3,557,005 | (50,000) |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Total Operating Expenses** | **58,378,661** | **88,995,746** | **91,096,138** | **(2,100,393)** | **87,286,080** | **(1,709,666)** |
| | | | | | | |
| **Income (Loss) from Operations:** | **(23,877,061)** | **(36,854,477)** | **(31,553,074)** | **(5,301,403)** | **(29,812,614)** | **7,041,863** |
| | | | | | | |
| **Non-Operating Income & Expenses:** | | | | | | |
| **Budgeted Tax Appropriations from U.S. VI Government** | 15,489,495 | 22,471,620 | 22,471,620 | - | 22,471,620 | - |
| **Income (Loss) from Operations after Budgeted Allotment** | **(8,387,566)** | **(14,382,857)** | **(9,081,454)** | **(5,301,403)** | **(7,340,994)** | **7,041,863** |
| | | | | | | |
| **Special Appropriations** | 4,000,000 | 7,425,000 | - | 7,425,000 | - | (7,425,000) |
| **Other Non-Operating Revenue and Expense** | 88,887 | 133,331 | 340,000 | (206,669) | 133,331 | - |
| **Change in Net Position** | **(4,298,679)** | **(6,824,526)** | **(8,741,454)** | **1,916,929** | **(7,207,663)** | **(383,137)** |
| | | | | | | |
| **Requested additional allotment:** | | | | | **$ (7,207,663)** | |

Appendix 2

## I. Introduction/Summary

SRMC maintains that the Government of the Virgin Islands must meet its explicitly stated responsibility of covering the cost of uncompensated care and of paying the “local match” for services provided to Medicaid patients.

In FY2015, the cost of uncompensated care using the standardized AHA calculation is $22,641,799. The “local match” payment for services provided to Medicaid patients in FY2015 is $2,705,773. Therefore, the Government of the Virgin Islands total responsibility for FY2015 is $25,347,572. The Government of the Virgin Islands current allotment to SRMC for FY2015 is $22,472,518. The Government of the Virgin Islands is $2,875,054 short of meeting its explicitly stated responsibility for FY2015.

SRMC urges the Government of the Virgin Islands to also consider increasing its financial support to SRMC include covering a portion of the $21,975,440 of underpayment by Medicare and Medicaid for the services provided to VI residents for FY2015.

## II. Government of the Virgin Islands Responsibility for Compensating SRMC for Uncompensated Care

The Virgin Islands Code sets forth the obligations of the Government of the Virgin Islands for compensating the hospital for providing otherwise uncompensated care. Per the Virgin Islands Code, "Payments from the general revenues of the Government of the Virgin Islands are intended to compensate the facilities for otherwise uncompensated care, in order to ensure the availability of quality, comprehensive health care to indigent as well as other residents of the Virgin Islands..." 1. The Virgin Islands Code defines uncompensated care as "the sum of unpaid or unreimbursed costs for health care services provided by the hospitals or health facilities after due diligence to collect.” 1.

The Virgin Islands Code goes on to state that the definition for uncompensated care “does not include contractual adjustments in reimbursement for services based upon an agreement with a payer, such as Medicaid and Medicare." 1.

The American Hospital Association (AHA) similarly defines uncompensated care. According to the AHA, uncompensated care is “an overall measure of hospital care provided for which no payment was received from the patient or insurer.” 2. The AHA further states that uncompensated care “is the sum of a hospital's bad debt and the financial assistance it provides.” 2. The AHA defines financial assistance as “care for which hospitals never expected to be reimbursed and care provided at a reduced cost for those in need.” 2. The AHA defines bad debt as debt that a hospital incurs “when it cannot obtain reimbursement for care provided; this happens when patients are unable to pay their bills, but do not apply for charity care, or are unwilling to pay their bills.” 2. The AHA’s definition of uncompensated care “excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.” 2.

The AHA publishes a fact sheet for “Uncompensated Hospital Care Cost” (attached). This fact sheet sets a standardized method for calculating uncompensated hospital care cost that is used by hospitals nationwide. Schneider Regional Medical Center (SRMC) has used this standardized method to calculate the amount of uncompensated hospital care cost provided by SRMC in FY2015. SRMC is providing this information to support its request for funding from the Virgin Islands Government.

AHA METHOD FOR CALCULATING UNCOMPENSATED CARE COSTS FOR FY2015

Uncompensated care is calculated on a hospital by hospital basis.

a. Uncompensated Care Charges = Bad Debt Charges + Charity Care Charges
b. Cost-to-Charge Ratio = Total Expenses Exclusive of Bad Debt/(Gross Patient Revenue + Other Operating Revenue)

c. Uncompensated Care Costs = Uncompensated Care Charges x Cost-to-Charge Ratio

SRMC UNCOMPENSATED CARE COSTS FOR FY2015

a. Uncompensated care charges = Bad Debt Charges ($38,260,017*) + Financial Assistance Charges ($115,913) = $38,375,930.
b. Cost-to-Charge Ratio = Total Expenses Exclusive of Bad Debt ($96,675,039) / (Gross Patient Revenue ($140,802,295) + Other Operating Revenue ($23,330,917) = 59%.
c. Uncompensated Care Costs: Uncompensated Care Charges ($38,375,930) x Cost-to-Charge Ratio (59%) = $22,641,799.

* Bad Debt Charges = Net Bad Debt ($22,956,010)4 + Self-Pay Patient Discount ($15,304,007) = $38,260,017

III. <u>Government of the Virgin Islands Responsibility for Compensating SRMC for Care Provided to Medicaid Patients (Local Match)</u>

The Virgin Islands Government has an obligation to pay to SRMC the “local match” for the care provided by SRMC to all Medicaid patients until the Medicaid base funds and Affordable Care Act funds for the territory are exhausted. Currently, the Government of the Virgin Islands includes this “local match” payment in the annual allotment that is given to the SRMC.

As background, the Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures. The local government pays a specified percentage of program expenditures. The Medicaid program in the United States Virgin Islands differs from Medicaid programs operating in each of the 50 states and the District of Columbia in three important ways:

- The United States Virgin Islands Medicaid delivery system is a subset of the larger public government healthcare delivery system for most of the island’s population. The United States Virgin Islands Department of Human Services is the single state agency.

- Through section 1108 of the Social Security Act (SSA), each territory is provided base funding to serve their Medicaid populations. For the period of July 1, 2011 through September 30, 2019, section 2005 of the Affordable Care Act provided an additional $273.8 million in Medicaid funding to the United States Virgin Islands.
- For the 50 states and the District of Columbia, the federal government will match all Medicaid expenditures at the federal matching assistance percentage (FMAP) rate based on the state's per capita income. For the United States Virgin Islands, all Medicaid expenditures are matched until the Medicaid base funds and the Affordable Care Act funds are exhausted. The statutory FMAP local matching rate increased from 50%/ 50% to 55% federal /45% local, effective July 1, 2011. From January 1, 2014 to December 31, 2015 there is a temporary 2.2% FMAP increase for all Medicaid enrollees, bringing The United States Virgin Islands' FMAP to 57.2%.

[From Medicaid.gov https://www.medicaid.gov/medicaid-chip-program-information/by-state/usvi.html]

At the current Medicaid contracted rates, SRMC should have received a total of $6,321,900 for treatment provided to Medicaid patients in FY2015. Based on the statutory FMAP local matching rate, the federal government is responsible for 57.2% for the "federal match" and the Government of the Virgin Islands is responsible for 42.8% for the "local match." In FY2015, SRMC received $3,616,127 from the federal government for the "federal match." In FY2015, SRMC should have received $2,705,773 for the "local match" from the Government of the Virgin Islands.

## IV. SRMC's Requests for the Government of the Virgin Islands to Compensate SRMC for a Portion of the Underpayment by Medicare and Medicaid

SRMC and the American Hospital Association emphasize the fact that the definition of uncompensated care "includes only two components within the universe of benefits that hospitals provide to their communities." 2. The AHA recognizes that hospitals are left to "bridge the gaps created by government

underpayments from Medicare and Medicaid." 3. The AHA also recognizes that "the payment rates for Medicare and Medicaid are currently set below the cost of providing care resulting in underpayment." 3.

The AHA publishes a fact sheet for "Underpayment by Medicare and Medicaid" (attached). This fact sheet sets a standardized method for calculating underpayments by Medicare and Medicaid that is used by hospitals nationwide. Schneider Regional Medical Center (SRMC) has used this standardized method to calculate the amount of underpayment by Medicare and Medicaid. SRMC is providing this information to support its request for increased funding from the Virgin Islands Government.

AHA METHOD FOR CALCULATING UNDERPAYMENTS

Payments received by hospitals for Medicare and Medicaid services are reported for each hospital in the AHA Annual Survey. Hospitals also report their gross charges for Medicare and Medicaid services provided. Gross charges for these services are then translated into costs. This is done by multiplying each hospital's gross charges by each hospital's overall cost-to-charge ratio, which is the ratio of a hospital's costs (total expenses exclusive of bad debt) to its charges (gross patient and other operating revenue).

a. Payment = Amount Received
b. Cost-to-Charge Ratio = Total Expenses Exclusive of Bad Debt/(Gross Patient Revenue + Other Operating Revenue)
c. Costs = Gross Charges x Cost-to-charge Ratio

The resulting payment and cost figures are aggregated across all hospitals for Medicare and Medicaid. Payments are then compared to costs. Underpayment occurs when aggregate payments are less than costs.

d. Underpayment = Amount by Which Payment is Less than Costs

SRMC UNDERPAYMENTS FOR FY2015

a. Payment = Amount Received (from Medicare = $19,088,032) + (from Medicaid/federal match = $3,616,127) + (from Medicaid/local match = $2,172,498) = $24,876,658.
b. Cost-to-Charge Ratio = Total Expenses Exclusive of Bad Debt ($96,675,039) / (Gross Patient Revenue ($140,802,295) + Other Operating Revenue ($23,330,917) = 59%.
c. Costs = Gross Charges* ($79,410,334) x Cost-to-Charge Ratio (59%) = $46,852,097.
d. Underpayment = $46,852,097 - $24,876,657 = $21,975,440.

*Gross Charges = Medicare $59,510,489 + Medicaid $19,899,845

## V. Summary

The current allotment, which by law is required to cover the cost of uncompensated care, and by operation is supposed to also cover the “local match” payment for services provided to Medicaid patients is inadequate. SRMC urges the Government of the Virgin Islands to meet its explicitly stated responsibility of funding SRMC for uncompensated care provided to residents and visitors of the Virgin Islands and of paying SRMC the “local match” for services provided to Medicaid patients.

The cost of uncompensated care using the standardized AHA calculation is $22,641,799. The “local match” payment for services provided to Medicaid patients is $2,705,773. Therefore, the Government of the Virgin Islands total responsibility is $25,347,572. The Government of the Virgin Islands current allotment to SRMC is $22,472,518. The Government of the Virgin Islands is $2,875,054 short of meeting its explicitly stated responsibility.

That shortfall exists before even taking into considering the underpayment by Medicare and Medicaid. Using the standardized AHA calculation, SRMC was underpaid by Medicare and Medicaid by $21,975,440 in FY2015.

SRMC requests that the Government of the Virgin Islands provide additional funding, above and beyond its current statutory obligation, to assist with the underpayment by Medicare and Medicaid. Further, SRMC encourages the Legislature to expand the legislation in VI Code, Title 19, Chapter 16, Section 240, Subsection (i) to obligate the Government of the Virgin Islands to fund these costs.