NORTHEASTERN VERMONT REGIONAL HOSPITAL
FY 2019 BUDGET NARRATIVE

1. ***Executive Summary***. Summarize the changes in the hospital budget submission. Include any information the GMCB should know about programmatic, staffing, and operational changes.
Response: NVRH does not plan to add any new services during fiscal year 2019. NVRH will continue efforts to better serve the needs of mental health patients and patients with substance abuse disorders. The hospital will continue to add providers and as needed to meet the community's need for timely access to services. Provider time will be added to the Palliative Care program, Hospitalist service, Womens Wellness program. As part of our ongoing efforts to invest resources in value-based payments and delivery reform, NVRH is participating in a pilot project with the Department of Vermont Health Access. Conceptually, the model will be a population- based payment model for services to Medicaid patients residing in the hospital's service area. The local Designated Agency and Home Health Service will also participate in this initiative. NVRH plans to work with OneCare Vermont on this project. NVRH has also given OneCare Vermont notice of intent to participate in the Next Gen Medicaid, Medicare and Commercial products. Additional details are provided throughout the remainder of the narrative.

NVRH will experience a change in leadership for the first time in 32 years as Paul Bengtson will be stepping down as Chief Executive Officer in December 2018.

On a budget to budget basis, net patient revenue growth is 5%, which exceeds the GMCB growth target. However, using a multi-year view of revenue growth, NVRH is under the cumulative allowed NPR for fiscal years 2017 to 2019. This point is illustrated in a latter section of the narrative.

An operating margin of $1,439,200, or 1.7% of operating revenue, has been budgeted. To achieve our margin NVRH is requesting an average rate increase of 4%.

NVRH will invest $6.8 million in facility and equipment upgrades.

2. ***Payment and Delivery Reform***. Describe how the hospital is preparing for and investing in value-based payment and delivery reform and implementation of the All-Payer Model for FY 2019 and over the next five years. Include answers to the following questions:
The majority of NVRH's delivery reform efforts involve our ongoing work with the Caledonia and So. Essex Accountable Health Community. The Caledonia and So. Essex Accountable Health Community (CAHC) uses the framework of the Accountable Health Community, the elements of Collective Impact, and the principles of Results Based Accountability to guide our work and working

relationships with our communities.

Several years ago, and prior to the establishment of OneCare Vermont, CAHC was founded and is led by the CEO of the Northeastern Vermont Regional Hospital (NVRH). The CAHC leadership group includes NVRH; Northern Counties Health Care (NCHC), the area's federally qualified health center and home health and hospice provider; Rural Edge, the regional low-income housing provider and developer; Northeast Kingdom Community Action (NEKCA); the Northeast Kingdom Council on Aging; Northeast Kingdom Human Services (NKHS), the regional nonprofit mental health agency; and the Vermont Foodbank. There are also strong connections with and monthly participation from the Vermont's Agency of Human Services through the Agency's regional directors, programs of the Department of Children and Families, the Vermont Department of Health, Green Mountain United Way, and many others – including school district leaders and regional planning and economic development agencies.

As yet, an aspirational model, an Accountable Health Community (AHC) is accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An AHC supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness.

<u>Mission Statement</u>
Our Accountable Health Community is committed to our shared goal to improve the health and well-being of the people in Caledonia and southern Essex Counties by integrating our efforts and services with an emphasis on reducing poverty in our region.

<u>Priorities/Outcomes</u>
We want our population to be

- **Financially secure**
- **Physically healthy**
- **Mentally healthy**
- **Well-nourished**
- **Well-housed**

Over the past year, tangible progress has been made in each of the outcome areas:

Financially Secure – We consider this our most difficult outcome to achieve, but the one that could have the greatest impact on our community. NVRH recently supported the Knowledge, Equity, Empowerment, Partnership (KEEP) financial coaching program offered by the Green Mountain United Way. The beneficiaries of this program are individuals whose life issues are impacted or complicated by financial issues. The financial coaching helps change those outcomes for individuals receiving this training.

Physically healthy – NVRH helped launch Energize 365: Community Wide Campaign to Promote Physical Activity. Residents of St. Johnsbury and Lyndonville are participating in a friendly competition of physical activity, including bike riding, at parks located in each community. NVRH continues to co-sponsor RecFit, a community health and wellness center in St. Johnsbury.

Mentally healthy – The new highlight of work in this area is our partnership with the St Johnsbury School to sponsor a community wide showing of ScreenAgers: Growing Up in the Digital Age. NVRH also supports the Kingdom Recovery Center in St. Johnsbury.

Well nourished – Through our strong partnership with the Vermont Foodbank NVRH continues the once a month produce market called Veggie Van Go. This program provides over 250 families with fresh seasonal produce, recipes ideas, food demos and samples.

Well housed – Our biggest success in this area was the creation of a seasonal warming shelter in St. Johnsbury for homeless people. NVRH continues to support the warming shelter each winter.

Our most recent work on payment and delivery reform came at the request of the Department of Vermont Health Access (DVHA). NVRH and certain members of CAHC recently formed a limited liability corporation, CAHC Transformation LLC, to work with DVHA on a pilot project involving Medicaid beneficiaries in our geographic area. If successful, the pilot project will take the Accountable Care Organization concept to the next level; population based payments for an Accountable Health Community.

The DVHA pilot project will likely be a model for:

- **Allowing local empowerment for decision making on how health care dollars can be best deployed to address population health**
- **Invest health care dollars in the community by creating a prevention fund to address the social determinants of health**
- **Looking at alternative ways to auto-attribute the defined population based on geography**

Representatives from NVRH, the CAHC Transformation LLC, the local Accountable Health Community organization, and OneCare will meet on July 25th to have initial discussions on how to align the organizations to move the pilot project forward. NVRH will keep the GMCB apprised of progress with this exciting project.

A. Has the hospital signed a contract with OneCare Vermont? If yes, for which payers? If not, explain (and skip B. through E., below.)
Response: NVRH has not yet signed a contract with OneCare Vermont. However, NVRH has given OneCare notice of our intent to participate in the Medicaid, Medicare and Commercial Next Gen agreements effective January 1, 2019. NVRH is waiting on information from OneCare to evaluate the financial risks and opportunities associated with participating in each Next Gen agreement. We anticipate a relationship with OneCare and the CAHC Transformation LLC will develop as part of the DVHA pilot project described above.

B. What is the amount of FPP the hospital expects to receive in FY 2019 based on estimated attributed lives?
Response: Not applicable until details of OneCare/DVHA pilot project model are known

C. What is the maximum upside and downside risk the hospital has assumed? **Response: Not applicable**

D. How is the risk (up-and downside) accounted for in the financials?
Response: Not applicable

   i. How will the hospital manage financial risk while maintaining access to high quality care and appropriate levels of utilization?

   ii. How will the hospital track and ensure that provider financial incentives do not have a negative impact on patient care?

E. What amount of Other Reform payments does the hospital expect to receive from OneCare Vermont by the end of calendar year 2018? (*e.g.*, payments from OneCare's Value-Based Incentive Program based on quality performance)
Response: Not applicable

3. *Community Health Needs Assessment*. Describe the hospital's initiatives addressing its population health goals as identified in the CHNA.
Response: Fiscal year 2018 is the last of three years covered by NVRH's most recently adopted CHNA. The initiatives addressing the population health goals identified in that CHNA are summarized below. The complete implementation plan update for fiscal 2018 has been uploaded to the GMCB budget portal.

Community Need-Obesity: Implement diabetes prevention program, hold annual bike safety fair, expand social marketing campaign to counter marketing of sugary beverages

Community Need-Mental Health/Substance Abuse: Purchase Drug Drop Disposal Box, facilitate drug free community grant, support youth mental health first aid training

Community Need-Poverty: Expand family SASH program, provide Bridges out of Poverty Training sessions, bring Veggie Van Go to NVRH

On June 18th the NVRH management team adopted a new three-year Community Health Needs Assessment for fiscal years 2019-2021. The companion CHNA implementation plan is scheduled to be adopted by the NVRH Board of Trustees on August 29th.

4. *Quality Measure Results*. Review Appendix IV, and provide a response to health service area, county or regional performance results for each of the All-Payer Model quality measures. Discuss outcomes, goals, and plans for improvement.
Response: See table below:

Adolescent Well-care visits:	**This is a quality measure that our pediatric practice, St. Johnsbury Pediatrics has been concentrating on. The practice tries to schedule the next upcoming well-visit before patients leave the office. The practice also routinely runs reports to find out which patients are due/overdue for Well-Child checks and does outreach to schedule appointments with those individuals.**
Initiation & Engagement of Alcohol & other drug dependence treatment:	**In our Primary Care practices we perform drug and alcohol screenings regularly. When those screenings are positive providers counsel patients and help to determine if patients are ready for treatment. If so, our Care Coordinators and Community Health Workers help to get patients into treatment. We have several resources available locally and internally. One of our group practices, Kingdom Internal Medicine, prescribes Suboxone and participates as a Spoke in Medication Assisted Treatment (MAT) with BAART acting as the Hub. The MAT team works together with KIM when newly identified patients are in need of inpatient treatment or HUB services. Another primary group practice, Corner Medical, is evaluating participation in the program and hopes to be engaged and up and running by later this fall.**
30-day f/u discharge for mental health & alcohol or other drug dependence	**These are not measures that have been tracked historically. Our Care Coordinators do follow up with patients *if* they know that a patient has been discharged. Valley Vista and Brattleboro Retreat call Kingdom Internal Medicine for a follow up appointment for patients when they are discharged, unfortunately this does not happen with all practices or facilities. Many times communication is lacking from the facilities to our PCP offices. These are measures that we are looking to improve upon in the upcoming year. We plan to do so by opening lines of communication with outside facilities and developing a system of discharge notification.**
HbA1C poor control	**Both Corner Medical and Kingdom Internal Medicine are involved in the statewide Diabetic Learning Collaborative and have identified this population as a quality matrix to improve upon. The practices Initiate standardization of protocols for patients with an A1C over 9, by means of more consistent appointments, care plans in place and possibly group appointments. Participating in this project are Behavioral health specialists, providers, managers, nurses, care coordinators, our ambulatory pharmacist and diabetic educator.**

Controlling high blood pressure	**Patients are with high blood pressure receive self-management tools to provide them ownership of their care. We lend out blood pressure monitors to these patients and review logs with them. Care Coordinators also keep in constant contact with these patients.**
Appropriate Asthma med management	**We are working to improve this measure with the use of Asthma Action Plans, implementing best practice of Asthma medications and Asthma control testing.**
% of reported PCP	**Patients entering through the ED or admitted to the hospital are asked who their PCP is and it is noted in the EHR. Patients who do not identify a PCP they are referred to Care Management team, who helps establish the patient with a PCP. Patients not identifying a PCP entering our organization through Community Connections are also guided towards establishing with a Primary Care Physician. We utilize the PCMH model so know the value of a Medical Home.**
COPD:	**The Healthy Home Initiative. Working with community partners to provide home weatherization plus specific healthy home repair measures coupled with in-home patient education to reduce acute exacerbation events for low-income COPD and asthma patients and improve patient's mental health.**
Hypertension:	**Same as above under HbA1C response**
Diabetes:	**Same as above under HbA1C response**
MAT:	**Same as above under HbA1C response**

5. *Mental Health*. Provide the following information:

A. The number of mental health beds;

Response: NVRH does not have mental health beds. However, rather than keeping mental health patients in the ED for hours, days or weeks, NVRH transfers patients awaiting an available mental health bed to our inpatient medical surgical floor.

B. The number of patients who waited in the emergency department for an available mental health bed at this hospital or at another facility;

Response: There were 256 patients who waited in the emergency department for an available mental health bed

C. The range and average time patients spend in the emergency department awaiting an appropriate mental health placement;

Response: The average time patients spent in the emergency department awaiting an appropriate mental health placement was 14 hours. The range was 22 minutes to 85 hours. These results only include time spent in the hospital's emergency

department. Typically, NVRH does not keep patients in the emergency department waiting for placement for extended periods of time. When it becomes apparent a timely transfer to an appropriate mental health facility is not going to happen patients are transferred from the emergency department to our inpatient medical surgical floor.

D. Average cost per day for patients awaiting transfer;

Response: The average cost per day for patients awaiting transfer is approximately $3,600.

E. List and describe each initiative, program or practice the hospital has implemented, or plans to implement, that focuses on ensuring that Vermonters have access to high quality, timely, and appropriate mental health treatment.

Response: The programs NVRH has implemented and/or plans to implement to assure access to high quality timely and appropriate mental health treatment include: Use of behavioral health specialists in all primary care group practices, including pediatrics and women's wellness practices. NVRH hired a part time psychiatrist who has 1:1 consult sessions with mental health patients, works with providers, nurses and support staff on the inpatient medical surgical floor in the emergency room and with the Hospitalist service to develop care plans for mental health patients. NVRH will be hiring recovery coaches in partnership with the Kingdom Recovery Center and contract with the local Designated Agency to embed mental health clinicians in the emergency department. The recovery coaches will be available to patients in our emergency department who express an interest in intervention with their substance abuse disorder. Research data shows that early intervention is cost effective and one of the key factors for a successful outcome. Embedded mental health clinicians reduce unnecessary medical utilization, decrease length of time to see a mental health clinician and reduce time patient spends in the emergency department.

6. *Patient access*. Provide wait times, by medical practice area, for the "third next available appointment," as defined by the Institute for Healthcare Improvement (IHI) http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx. For hospitals that do not use this measure, describe wait times and how they are currently measured.

Response: The wait time for the third next available appointment varies by specialty. Please see summary below:

Orthopaedics	**3 weeks**
ENT	**3 weeks**
Audiology	**4 weeks**
Palliative Care	**1 week**
Psychiatry	**4 weeks**
General Surgery	**2.5 weeks**
Corner Medical (Primary Care)	**Acute: 1 day ; Well Check: 1 week**
Kingdom Internal (Primary Care)	**Acute: 2 days ; Well Check 1 week**
Cardiology	**New Patient: 4 months ; Follow Up: 3 months**
St. Johnsbury Pediatrics	**Well Child: 11 weeks ; Acute: 1 week**

Womens Wellness	**New Patient: 1 week ; Follow Up: 1 day**
Urology	**New Patient: 1.5 weeks ; Follow Up: 2 weeks**
Neurology	**New Patient: 2 weeks ; Follow Up: 1.5 weeks**

7. *Substance use disorder treatment programs*. Describe the hospital's substance use disorder (SUD) treatment programs, and provide the following information:
    A. A description of the hospital's full range of SUD treatment programs;
    Response: NVRH's participation in substance use order treatment programs is as follows. Kingdom Internal Medicine, a primary care physician practice, participates as a Spoke in the Hub and Spoke program. The Medication Assisted Treatment (MAT) team from BAART comes to the office to meet with patients. Corner Medical is investigating possible participation in this program and hopes to be up and running by later this fall. The MAT team has become integral in connecting newly identified Substance Use Disorder patients with inpatient & HUB services.
    B. The number of patients currently enrolled in medication-assisted treatment (MAT) programs and other SUD programs; and
    Response: There are currently 8 patients enrolled in the MAT program at Kingdom Internal Medicine and 2 additional patients that are prescribed suboxone but are not eligible for the MAT program (non-Medicaid).
    C. The number of MAT providers and other SUD providers employed by the hospital.
    Response: There are 3 MAT providers at the Kingdom Internal Medicine group practice.
8. *Health Reform Investments*.
    Part I: Provide updates on all health reform activities submitted under the GMCB's extended NPR cap for FYs 2016 - 2018 including:
    A. The amount of the investment;
    B. The goals of the program;
    C. Metrics and other evidence demonstrating the program's ability to meet these goals, highlighting metrics and other evidence that demonstrate alignment with the goals of the All-Payer Model;
    D. Any other program outcomes, positive or negative;
    E. Whether the program is ongoing or of limited duration, and why;
    F. For any program that has been discontinued, describe how ending the program has or will be accounted for in past, current or future budgets.
    Response: The following summary is provided in response to this question:
    FY 2016

Health Reform Investment: Ambulatory Pharmacist
Amount: $160,000
Goals: Reduce health care costs by assisting primary care providers with medication management, coordination of care, wellness and health promotion, patient education and self-management. Additional goals include optimizing safe medication use and optimizing medication therapy for patients with chronic conditions. The ambulatory pharmacist also improves access to primary care by focusing on patient's medication management concerns/needs thereby freeing up primary care provider time that would otherwise have been spent with patients on medication issues.
Evidence Goals Met: Specific examples include patients with improved medication management that have returned to work, lowered their HbA1c levels, lost significant weight and are now able to exercise regularly.
Other Outcomes: Removing unused medications from homes decreasing likelihood of mis-use
Ongoing or Limited: Ongoing
Budget impact, if discontinued: N/A.

<u>FY 2017</u>
Health Reform Investments: Cal-Essex Accountable Health Community Organization; Emergency Department care manager; Community Mental Health Specialist; Expansion of Palliative Care Program
Amount: $272,000

Goals: The goal of the Cal-Essex Accountable Health Community (CAHC) is to improve the health and well-being of the people in Caledonia and southern Essex Counties by integrating our efforts and services with an emphasis on reducing poverty in our region. CAHC's priorities and desired outcomes include a population that is:

- **Financially secure**
- **Physically healthy**
- **Mentally healthy**
- **Well-nourished**
- **Well-housed**

The work of CAHC was described in detail in response to Question 2.

The goal of the care manager is to reduce unnecessary visits to the emergency department by linking ED patients to a primary care provider when one isn't indicated during the ED visit.

In lieu of the community mental health specialist, NVRH expanded the emergency department care manager from 1.0 to 1.4 FTE.

The goal of the Palliative Care Program is to provide medical emotional, social, spiritual and comfort care to patients who are dealing with a serious or challenging illness in an appropriate setting. A successful Palliative Care Program will reduce visits to the emergency department and use of other health care services.

Evidence Goals Met: For CAHC one key indicator the goal has been met is the Veggie Van Go program. Our strong partnership with the Vermont Foodbank continues with the once a month produce market called Veggie Van Go. Each month we supply over 250 families with fresh seasonal produce, recipe ideas, and food demos and samples.

Evidence of the ED care manager program goal has been met is the 700 follow up appointments with primary care providers, annually, after a visit to the ED by patients that previously did not have a primary care provider.

Evidence the Palliative Care program goal has been met is the dramatic increase in program visits. Since 2016 the average number of monthly visits has doubled, from 38 visits per month to 76 visits per month.

Other Outcomes: Not determined yet.

Ongoing or Limited: All of these programs are ongoing
Budget impact, if discontinued: Not applicable

<u>FY 2018</u>
Health Reform Investments: Registered nurse for home skilled nursing; community paramedic service; mental health screening and referral services in Emergency Department
Amount: $180,000
Goals: The hospital used the funds originally set aside for the home skilled nursing program to expand staffing of the Emergency Department care manager by adding a .4 FTE position. The goals for the ED care manager were previously described.
The goal of the community paramedic service is to provide in house follow up following discharge from the hospital for inpatients and Emergency Department patients meeting certain criteria, thereby reducing avoidable hospital readmissions and visits to the Emergency Department.
NVRH's plans for the mental health screening and referral services were set aside when we had an unexpected opportunity to hire a local psychiatrist. The goals for this position include; supporting providers to better meet needs of mental health patients; provide consulting and outpatient mental health services to individuals and to help reduce number of suicides

Evidence Goals Met: The community paramedic service will be piloted in July. NVRH will track rates of readmissions to hospital and Emergency Department for patients visited by the paramedics help determine effectiveness of the paramedic program.
Evidence the goals for the new psychiatrist are being met include include the significant number of patients she has counseled 1:1, her work with primary care practice to reduce the risk of suicide and strengthening of patient relationships with their primary care provider. Patients with co-prescriptions for benzodiazepines and opiates are at significantly higher risk of accidental death. Combining these medications can also be used as means for death by suicide. She is working with providers to create awareness of these risks with the goal of reducing the number of co-prescriptions of benzodiazepines and opiates. Weekly meetings with providers in each of primary care, pediatric and women's health practice have led to the strengthening of relationships between providers and patients with mental health needs. Patients with a strong relationship with their providers are more likely to regularly seek care early on when the need arises.
Other Outcomes: None expected
Ongoing or Limited: The community paramedic program, employed psychiatrist and expanded staffing of the emergency department care manager will be ongoing services.
Budget impact, if discontinued: Not applicable

Part II: Complete the Table at Appendix V.
Response: The Table at Appendix V, 2019 Hospital Health Care Reform Investments, has been completed. It is attached to this narrative.

9. *Reconciliation*. Provide a reconciliation between FY 2018 approved budget and FY 2018 YTD, showing both positive and negative variances. Explain the variances.
Response: The following tables provide a reconciliation of net patient revenue and operating expenses between FY 2018 approved budget and FY 2018 projected results for FY 2018

NET PATIENT REVENUE (NPR)	AMOUNT	EXPLANATION
FY 2018 Approved NPR	**$77,077,400**	
Additional NPR volume Increase	**749,400**	**More flu-related admissions; higher number of patients awaiting placement in mental health facility; expanded Hospitalist service so fewer transfers to tertiary care; tertiary care beds full so unable to transfer patients**
Projected FY 2018 NPR	**$77,826,800**	

OTHER OPERATING REVENUE	AMOUNT	EXPLANATION
FY 2018 Budget Other Operating Revenue	$ 2,955,000	
Increase 340B Revenue	676,900	Increase in eligible providers
Recovery of Sheriff Coverage Costs	155,000	Partial reimbursement for 1:1 coverage for a patient
Unbudgeted Meaningful Use Revenue	140,000	Newly eligible providers successfully meet MU criteria
Projected FY 2018 Other Operating Revenue	$ 3,726,900	

OPERATING EXPENSES	AMOUNT	EXPLANATION
FY 2018 Budgeted Operating Expenses	$78,579,100	
Volume Related Additional Expense (non-salary)	225,000	
Additional Security Costs (Reimbursement received)	155,200	1:1 Sheriff and staff coverage for long-stay patient. Billed to patient, reimbursement expected
Increased staffing costs	245,000	Mental health patients; CMS requirements
Increased employee health insurance expense	273,900	
Additional providers to improve access to services	277,000	Hospitalist, CRNAs, Womens Wellness; Infusion therapy
Locum tenens expense	300,000	Several nursing vacancies as well as pediatrician, general surgery and primary care provider vacancies
Depreciation Expense	388,000	$200,000 cut as "placeholder" for final budget order; $188,000 anticipated CIP projects at year end actually completed and depreciated during fiscal year 2018
Provider Tax Increase	(94,500)	Lower NPR base
Interest Expense	(120,000)	New bond issue postponed until FY 19
Reference lab expenses over and above original estimate	(412,800)	Reference lab related expenses were recalculated. Original estimate significantly understated
FY 2018 Projected Expenses	$79,815,900	

10. *Budget-to-budget growth.*

A. Net patient revenues:

Response: Appendix VI Table 1A provides an excellent reconciliation of budget to budget net patient revenue growth from fiscal year 2018 to fiscal year to 2019 and responsive to questions A (i) through A (iv c). Table 1A is reproduced below

i. Provide the budgeted FY 2019 NPR increase over the approved FY 2018 budget. If the GMCB rebased the hospital's budget for the purpose of calculating FY 2019, provide the budgeted increase in NPR for FY 2019 measured from the hospital's rebased budget.

ii. Describe any significant changes made to the FY 2018 budget (including, but not limited to, changes in anticipated reimbursements, physician acquisitions and certificates of need) and how they affect the FY 2019 proposed budget.

iii. Describe any cost saving initiatives proposed in FY 2019 and their effect on the budget.

iv. Explain changes in NPR/FPP expected for each payer source:

   a. Medicare revenue assumptions: Identify and describe 1) any significant changes to prior year Medicare reimbursement adjustments (*e.g*. settlement adjustments, reclassifications) and their effect on revenues; 2) any major changes that occurred during FY 2018 that were not included in the FY 2018 budget, and 3) any anticipated revenues related to meaningful use and 340B funds in FY 2019.
   b. Medicaid revenue assumptions: Budget for net patient revenues expected from rate changes, utilization and/or changes in services.
   c. Commercial/self-pay/other revenue assumptions: Commercial insurance revenue estimates should include the latest assumptions available to the hospital and any other factors that may explain the change in net patient revenues.
   d. Other operating revenue: Other operating revenue changes are:

FY 2018 Budget Other Operating Revenue	**$2,955,000**
340B increase	**950,000**
Meaningful Use Increase	**140,000**
Reference Lab Decrease	**(355,600)**
Pharmacy Sales to Employee Increase	**3,300**
FY 2019 Other Operating Revenue	**$3,692,700**

Complete Appendix VI, Tables 1A and 1B. If the hospital categorizes revenue differently than as indicated in the tables, provide such categories, including labels and amounts, in the "Other" rows.

Response: It is not possible to complete Table 1B with meaningful information. Reimbursement to hospitals is not made on individual line item basis (e.g. an amount for imaging, a separate amount for drugs, medical supplies etc) for the majority of services. Services with lump sum payments and no line item breakdown include medical and surgical

inpatient admissions, ambulatory surgeries and emergency room visits. NVRH is available to work with GMCB staff to develop a similar schedule that hospitals can complete with meaningful information.

Table 1A:

NPR Bridges - FY 2018 Approved Budget to FY 2019 Proposed Budget

NPR	Total	% over/under	Medicare	Medicaid-VT	Medicaid-OOS	Commercial-Maj	Comm - Self/Sml	Workers Comp
FY 18 Approved Budget	$77,077,400		$28,808,600	$11,401,300	$ 79,900	$ 32,148,900	$ 2,149,500	$ 2,489,200
Commercial Rate	1,537,600	2.0%				1,324,700	113,500	99,400
Rate - Non Commercial	-							
Utilization	1,491,768	1.9%	576,200	228,000	1,600	642,978	42,990	
Reimbursement/Payer Mix	424,329	0.6%	2,001,357	1,082,860	(7,200)	(1,371,498)	(200,990)	(1,080,200)
Bad Debt/Free Care	100,200	0.1%				100,200		
Physician Acq/Trans (Full Year)	129,700	0.2%	90,800	13,000		25,900		
Changes in Accounting	-							
Changes in DSH	(122,300)	-0.2%		(122,300)				
Medicare CAH NPR Change	-	0.0%						
Barrier Day NPR	300,000	0.4%	125,000	125,000	0	0	50,000	0
FY 19 Budget	$80,938,697		$31,601,957	$12,727,860	$ 74,300	$ 32,871,180	$ 2,155,000	$ 1,508,400

B. Expenses:

i. Provide the budgeted FY 2019 net expenditure increase over the approved FY 2018 net expenditure increase.

ii. Describe any significant changes made to the FY 2018 budget (including, but not limited to, changes in costs of labor, supplies, utilization, capital projects) and how they affect the FY 2019 proposed budget. Provide assumptions about inflation and major program increases.

iii. Describe any cost saving initiatives proposed in FY 2019 and their effect on the budget.

iv. Complete Appendix VI, Table 2. If the hospital categorizes expenses differently than as indicated in the tables, provide such categories, including labels and amounts, in the "Other" rows.

Response: Appendix VI, Table 2 provides an excellent summary of budget to budget expense changes from fiscal 2018 to fiscal 2019. Table 2 is reproduced below.

Table 2:

FY 2018 Approved Expenses to Budget FY 2019

Expenses	Amount	% over/under
FY 18 Approved Budget	$ 78,579,100	
New Positions	350,000	0.45%
Inflation Increases	1,653,084	2.10%
Salaries (non Inflationary)	535,555	0.68%
Fringe	412,378	0.52%
Physician Contracts	908,080	1.16%
Contract Staffing	(400,000)	-0.51%
Supplies	63,000	0.08%
Drugs	377,000	0.48%
Facilities		0.00%
IT Related	169,000	0.22%
Health Reform Programs	300,000	0.38%
Depreciation	431,000	0.55%
Interest	(36,000)	-0.05%
Health Care Provider Tax	18,000	-0.05%
New Costs for CMS Compliance - Mental Health Patients	110,000	-0.05%
Cardiology Transfer Full Year	128,000	-0.05%
Cost Savings	(406,000)	-0.05%
FY19 Budget	$ 83,192,197	

11. *Bad Debt.*

A. Provide the amount of bad debt carried by the hospital at the close of FY 2017 that was incurred prior to FY 2016.
Response: The amount of bad debt carried by the hospital at the close of FY 2017 incurred prior is FY 2016 is $790,200.

B. If the hospital contracts with a collection agency, provide the name of the agency
Response: NVRH contracts with Stevens Business Service, Inc.

C. In your opinion, explain whether the agency adheres to "patient friendly billing" guidelines. *See* http://www.hfma.org/Content.aspx?id=1033
Response: Yes, in my opinion the agency adheres to the HFMA patient friendly guidelines.

12. *Rate Request*.

A. Provide the hospital's budgeted overall rate/price increase or decrease. Explain how the rate was derived and what assumptions were used in determining the increase or decrease.

Response: The requested overall rate/price increase is 4%. Of the 4% increase .4% is requested to cover the cost of new health care reform initiatives and 3.6% is required to cover inflationary and market salary increases. The 4% increase is an average. It will be achieved by increasing rates/prices for hospital services by 4.6% and only minimally increasing or not increasing at all rates/prices for professional fees.

In considering the requested rate increase the following assumptions were made:
Commercial insurance: No material changes to existing contracts between NVRH and commercial insurers
Medicare: No changes to regulations for Critical Access Hospitals
Uncompensated Care: A slight decrease to the current levels, as a percentage of gross revenue, of Free Care and Bad Debts, has been budgeted for fiscal year 2019
Medicaid: No changes to current levels of reimbursement. However, a $150,000 reduction was made in anticipation of lower Medicaid revenue resulting from participating in either the OneCare Next Gen agreement or the CAHC Transformation LLC risk-based agreement.

Volume, as measured by adjusted acute patient days, will increase by 2.6% on a budget to budget basis. We project fiscal year 2018 volume will be 2% higher than budget. This variance is due to: Higher volume of patients with flu or flu like symptoms, full-staffed Hospitalist service that resulted in keeping patients at NVRH that may previously have been transferred to a tertiary hospital, unavailability of tertiary beds for some patients that could have been transferred, "barrier" patients that could not be transferred to an appropriate mental health facility and increased use of NVRH versus other hospitals due to improved access to NVRH's services, including orthopedics and urology and upgrades to other services including the Emergency Department. The fiscal 2019 net patient revenue assumes fewer patients with flu or flu like systems.

B. For each payer, if the net patient revenue budget-to-budget increase or decrease is different than the overall rate/price change—for example, if the requested commercial "ask" differs from the rate/price change—explain why they differ.

Response: The requested rate increase will be applied equally to all payers. However, rate/price changes only increase or decrease net revenue from commercial insurers and self-pay patients. As a Critical Access Hospital, Medicare net revenue changes are based on year to year changes in operating costs. Medicaid net revenue is based on fixed payment per unit of service and is completely unrelated to rate/price changes. The completed and uploaded rate schedule provides detailed information on changes in net revenue from fiscal 2018 to fiscal 2019 by payer.

C. In April/May, the GMCB will provide a rate schedule for reporting the rate/price change for each major line of business and the gross and net revenues expected from each payer as a result of the rate/price change.
Response: The rate schedule has been completed and uploaded to the GMCB portal.

13. *FY 2017 overages*. For those hospitals that received a letter regarding their FY 2017 budget-to-actual overages results, specifically address the issues and requirements outlined in the letter.
Response: Not applicable. NVRH did not receive a letter regarding FY 2017 budget-to-actual overages as the hospital's FY 2017 actual NPR was less than approved NPR.

14. *Capital budget investments*. Describe the major investments, including projects subject to certificate of need review, that have been budgeted for FY 2019 and their effect on the FY 2019 operating budget.
Response: The fiscal year 2019 capital budget totals $6.8 million dollars. The significant capital investments include:
- **MRI replacement project ($3.1 million) - A certificate of need application to replace an existing fixed mobile MRI with a new scanner and construction of space to house the new scanner is in Green Mountain Care Board review process. The technology for the existing scanner is nearly 18 years old.**
- **Replacement of diagnostic imaging equipment ($1.0 million) – Existing diagnostic equipment is past useful life expectancy. The new equipment will use digital radiography instead of the current computed radiography. Digital radiography is more efficient and produces the same image quality with lower doses of radiation.**
- **Replacement of surgical endoscopy equipment ($.5 million) – Existing endoscopy equipment is past useful life expectancy creating need for more frequent repairs.**
- **Information technology ($.6 million). To meet ongoing needs including upgrades to existing email and telephone systems.**

The fiscal year depreciation expense on the above projects totals $300,000. There are depreciation expense decreases for assets fully depreciated in fiscal 2018 that offset the expense on these new assets. If the Certificate of Need is approved the MRI project will reduce fiscal year 2019 operating expenses by $105,700.

15. *Technical concerns*. Explain any technical concerns or reporting issues the GMCB should examine for possible changes in the future.
Response: One suggested change would be a review of net patient revenue growth compliance on a multi-year basis rather than budget year to budget year basis. With a multi-year rather than budget to budget focus NVRH's NPR growth from FY2017 approved NPR to FY 2019 budget NPR, as adjusted for factors discussed above in Question 10, complies with GMCB guidelines during this period, as shown in the table below:

FY 2017 Appoved NPR after Rebasing	**77,069,500**
FY17-FY18 Approved Growth Rate	**103.40%**
FY 2018 Base	**79,689,863**
Add Cardiology Transfer (Full Year)	**389,000**
FY 2018 Adjusted Base	**80,078,863**
Less: Reference Lab Transfer Off	**(2,000,000)**
FY 18 Final Base	**78,078,863**
FY18-FY19 Approved Growth Rate	**103.20%**
FY 2019 Sub Total - Allowed NPR	**80,577,400**
Add: NPR for "Barrier" Patients	**300,000**
Add: New Services Above Cap	
Recovery Coaches	**75,000**
Mental Health ED Phase I	**100,000**
FY 2019 Allowed NPR	**81,052,400**
FY 2019 Budgeted NPR	**80,938,700**
Under (Over) Allowed NPR	**113,700**

SALARY INFORMATION:

Response: NVRH has uploaded the most recent Form 990, including Schedule H.

A. The requested salary table is below

B. The hospital's policy is for the Board of Trustees to set the compensation for the Chief Executive Officer. Salaries for all other employees are set by management. The CEO compensation is based on salaries for comparable hospitals and tenure use Form 990 compensation information. Salaries for all other employees, including providers, is based on the New Hampshire/Vermont/ Annual Salary Survey. Salaries for non-management are based on average compensation for NH/VT hospitals for comparisons. Salaries for management employees are based on average compensation for hospitals with 350-800 FTEs.

C. As noted above the hospital uses Form 990 and the annual NH/VT wage survey for benchmarking salaries. NVRH targets the median of the salary range for each position, adjusted for employee's tenure. We do not use outside consultants for benchmarking

Northeastern Vermont Regional Hospital, Inc.

Salary Information

Provide Headcount & Box 5 Wages from 2017 W2s			yer Portion (allocation method all	
Salary Range	Total # of Staff	Total Salaries (includes incentives, bonuses, severance, CTO, etc.)	Health Insurance Coverage	Retirement Contributions
$0 - $199,999	669	$ 28,764,007	$ 7,344,576	$ 1,260,240
$200,000 - $299,999	15	$ 3,670,937	$ 311,405	$ 146,735
$300,000 - $499,999	8	$ 2,982,092	$ 174,590	$ 122,725
$500,000 - $999,999	1	$ 648,766	$ 28,830	$ 24,698
$1,000,000 +	0	$ -		

ORGANIZATIONAL STRUCTURE:

Response: NVRH's organizational chart has been uploaded to the GMCB portal.