NVRH
Response to GMCB Staff Questions
August 9, 2019

1. Have the hospital's projections for FY2019 changed?
No, the projections for FY 2019 have not changed.

2. What is the total ACO reserve on the balance sheet for Projected FY19 and Budget FY20? Do you anticipate realizing savings or owing OneCare money when the FY18 settlements are finalized? Are Other Reform Payments recorded in deduction from NPR, if not, where are they recorded
The ACO reserve is on the balance sheet under Other Current Liabilities. For Projected FY19 the amount is $434,300. For Budget FY 20 the total amount is $1,013,300. NVRH did not participate in any ACO programs during FY18. The only Other Reform Payment will be a Value Based Incentive Fund payment from OneCare Vermont for 2019. Whether or not this incentive payment will be made next year is unknown at this time. Therefore, NVRH did not budget anything for Other Reform Payments in either 2019 or 2020.

2a. What is your basis for booking ACO-related reserves and how do you evaluate those reserves through the year?

Estimates provided by OneCare VT (OCV) are the basis for booking ACO related reserves. OCV estimates the maximum risk/reward limit. Based on advice from our independent auditors, NVRH reserves 100% of the estimated ACO maximum risk. The reserve will be evaluated whenever updated information on risk levels is received from OCV. Further, during FY 20 NVRH will evaluate the calendar year 19 reserve levels when we receive the actual CY 19 ACO-Medicaid program performance results from OCV. At that time an adjustment to the risk reserve and contractual allowances will be made to recognize the difference between the CY 19 program reserve amount and the amount of actual risk/reward for the calendar 2019 plan year.

NOTE: Subsequent to filing the GMCB FY20 budget OCV re-evaluated NVRH's maximum risk and increased the risk level from $579,000 to $679,000 for plan year 2019 and to $739,900 for plan year 2020.

2b. Do you believe your ACO-related reserves affect other types of reserves (e.g. bad debts) that you carry on your balance sheet.

No. There is no connection between ACO-related risk reserves and any other reserve on NVRH's balance sheet

3. NVRH's FY19 Budget Order states the "Hospital shall consult with Vermont Information Technology Leaders (VITL) to facilitate patients' ability to electronically consent to adding their clinical data to the Vermont Health Information Exchange (VHIE)."What kind of headway has NVRH made to facilitate this?
When NVRH patients are registered they are asked the consent question and the patient's response is entered into our information system, Meditech. The patient's response is then automatically fed to the HIE Portal via the admissions, discharges and transfers interface.

4 What is the value of 1 day of Days Cash on Hand?
For FY20 the value of 1 day of Days Cash on Hand is $235,900.

5. What is the value of 1% of NVRH's change in charge request? If there is a variance between NVRH's calculation and the calculation provided by GMCB staff above, please include the steps to your calculation.
NVRH agrees with the GMCB staff calculation. A 1% change in charge request yields approximately $376,300 of net patient revenue.

6. Are Medicaid and Medicare reimbursement assumptions still valid including Disproportionate Share Payments?
Yes, Medicaid and Medicare reimbursement assumptions are still valid, including Disproportionate Share Payments.

7. What are the hospitals assumptions for the ER visits and exams
NVRH is budgeting an increase in ER visits for fiscal 2020. Having an emergency room staffed by providers who are all board certified/eligible in emergency medicine has had an impact on volume levels. Patients who once drove to another facility no longer do so. Further, we are seeing an increase in the number of patients who were injured mountain biking or doing other outdoor activities.

Sometime during fiscal 2020 NVRH plans to open a modified urgent care/convenient care service. For budgeting purposes we considered this program an extension of the Emergency Department. Providers will rotate through the ED and the urgent care/convenient care site. At budget time details were, and still are, developed. For budgeting purposes, 1,000 visits were assumed. These visits were included with ED visits. We will keep GMCB staff apprised on this initiative throughout FY20.

Exams refer to MRI exams. A total of 1,400 exams were budgeted for FY19. The new MRI machine will be operational in January 2020. The number of exams will increase slightly to 1,410, because of the new MRI scanner, which is consistent with the assumptions made in the MRI CON application.

8. What are the hospitals assumptions for increasing from 438 Non MD FTEs & MLPs (FY 19P) to 463 (FY 20B)?
There are a few reasons for the FTEs increasing from 438, (projected FY 19) to 463 (FY 20 budget). Broadly, the reasons relate to filling vacant positions, the need for additional staff due to patient volume/acuity increases, new providers and adding non-clinical support.

There were several budgeted positions that were vacant for all or a portion of fiscal year 2019. There were 22 FTE vacant/partially vacant positions during FY 19. These vacancies were in large part the reason the cost of locum tenens and temporary staffing rose from a budget of $277,000 to projected total of $3.2 million. .

A total of 12 FTES were budgeted to meet volume and increased patient acuity. Of these 12 FTEs, 4.6 FTEs are needed to either improve patient care or expedite turnaround of exam rooms in the ED and inpatient units to eliminate backlog of ED patients waiting for an exam room to be available.

We note that every vacant position and every request for new positions is closely scrutinized by the entire senior leadership team before being approved. A total of 10 FTEs that became vacant during FY19 were not replaced. And, several requests for new FTEs in FY20 were not approved.

9. NVRH listed its maximum up/downside risk as $579,000 for CY20. That amount is recorded in Adaptive both under FY19 Projection and FY20 Budget. Please explain why the full amount of risk is being recorded in both years rather than making a smaller adjustment to the reserves to bring it up to the maximum risk level for CY20.
For FY19 the maximum risk should be have been reported as $434,300. The wrong number was pulled out of contractual allowances and allocated to ACO risk on the GMCB schedule. Table 1 of the Narrative does show the correct amount for FY19 projected ACO risk. The reclassification needed to make this correction does not affect either net patient revenue or the operating margin. NVRH will work with GMCB staff to correct the budget schedules.

The full amount of risk, $579,000, is reported for FY20. Until the results of CY 19 Medicaid ACO program are known, which will be sometime in the Spring 2020, a reserve for both years must be established. Please refer to our response to Question 2a. for additional details on how/when NVRH will adjust the risk-reserve amount during FY 20.

10. For FY19 projections what departments are expenses exceeding revenues?
For FY19 projections expenses do not exceed gross revenues in any departments. NVRH doesn't budget net patient revenue at the department level as it's impossible to do so accurately. Stating the obvious, expenses exceed gross revenues in all non-revenue producing departments.

11. Please suggest a statistic the GMCB can monitor to better understand the trends in the total number of staffed beds in the hospital versus the number of beds available for use, and how full or empty those beds are from month to month?
NVRH can provide information monthly that captures staffed versus beds available and percent of beds available and percent of beds staffed. The real need is for a new statistic that measures outpatient equivalent activity and replaces the antiquated adjusted patient days and adjusted patient admissions. The formula that generates these measures was relevant when developed in the 1970s. At that time inpatient revenue represented 75-80% of all revenue. Today that percent is in the 25-30%.range, making the metric inaccurate as a measure of total inpatient and outpatient volume. We have thought about but have not come up with a replacement, yet.

12. What is the impact of the now known Medicaid reimbursement increases? Any update on inpatient Medicaid reimbursement changes?

DVHA has not notified NVRH of any Medicaid reimbursement increase for inpatient or outpatient services.

13. If you assumed Medicare increases, what is the value and what would a reduction in commercial be to maintain your NPR?
During FY20 budget Medicare reimbursement will increase as a result of higher volume, higher Medicare payer mix percentage and increase in total expenses. These assumptions have been built into the FY20 budget as shown in Appendix VI, Bridges, Table 1. Rate/charge increases or decreases do not have any effect on Medicare reimbursement. As a Critical Access Hospital, Medicare reimbursement is cost based for hospital services. As hospital expenses change Medicare reimbursement increases or decreases proportionately. The amount of Medicare reimbursement change is equal to approximately 38% of the change in total expenses. Some, but not all, of the physician practices are also cost-reimbursement based for Medicare. If there was a reduction in our commercial rate request, and total expenses remained the same, NVRH's net patient revenue, and therefore operating margin, would decrease by $376,300 for every 1% reduction in rate request. And, because of the drop in Medicare reimbursement when expenses decrease, for every 1% reduction in commercial rate request, NVRH would need to cut operating expenses by $520,000 in order to maintain the budgeted operating margin.

14. Discuss new ACO attribution pilot
NVRH, in collaboration with several community partners, One Care Vermont and the Department of Vermont Health Access, is piloting a geographic attribution model. Traditionally, Medicaid beneficiaries are attributed based on primary care provider. The pilot expands the attribution to include all residents in the HSA, regardless of where their primary care provider is located. We believe being responsible for entire population in our geographic area, whether or not they are attributed to one of our primary care providers, is essential to improving the health of our community over the next five years and beyond. For example, the geographically-attributed additional beneficiaries will be added to Care Navigator allowing their care to be coordinated between NVRH, our community partners and the entire OneCare VT network.

NVRH is also using this pilot to move at-risk Medicaid FFP health care dollars upstream to invest in prevention and social determents of health. These funds, called Healthy Cents, will provide sustainable financing for programs designed to have all community members: Well Nourished, Well Housed, Mentally Healthy, Physically Healthy and Financially Secure.

15. **For 2019 projection where were the loan repayments shifted from and how much are they?**
This was an incorrect reference made in the narrative. NVRH will be implementing a new student loan repayment assistance program in fiscal 2020. In addition, several newly hired providers will receive loan repayment assistance. The combination of the new program and increased number of those receiving assistance will increase the total benefit by approximately $230,000 on a budget to budget basis.

16. For 2019 projection what are the corresponding expenses to the reference lab work that was understated?
The corresponding understated expenses total approximately $300,000

17 Itemize Year Over Year cost savings
The year over year cost savings/changes are as follows:

- Locum tenens/temporary agency costs will decrease by approximately $2 million from projected FY19 to budget 2020. Below is trended costs for locum and other temporary staff.$-$xx
    - FY19 Bud $ 277,000
    - FY19 Proj $ 3,200,000
    - FY20 Bud $ 1,252,000
- Trended 340B savings from FY 16 to FY 20 are as follows:
    - FY16 - $ 450,600
    - FY17 - $ 596.700
    - FY18 - $ 786,700
    - FY19Bud $ 800,000
    - FY19Proj $ 900,000
    - FY20Bud $1,000,000
- The FY 20 budget includes $90,000 related to maximizing medical supply primary vendor savings and medical supply provider standardization.