Dartmouth Health

June 30, 2024

Attn: Ms. Alena Berube, Director
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: Budget 2025 Narrative

Dear Ms. Berube:

This letter serves as the narrative required to accompany the electronic budget files which have been sent under separate cover.

A. Executive Summary:

Mt. Ascutney Hospital and Health Center (MAHHC), is budgeting a 0.7% operating margin. This is lower than previous submissions in consideration of a major CON project upgrading our aging technology infrastructure; which includes replacement of financial, human resource, and electronic health records systems.

FY24 has been another year of ongoing changes, uncertainty, and challenges with leadership changes, affiliation agreements, and a major CON application in the works. Fortunately, the pandemic has equipped our staff with a strong ability to manage and adapt to changing environments.

Common themes continue year after year, which require constant attention as we manage to our mission. The Great Resignation (staff retirement, relocation, reduction in enrollment in healthcare programs, etc.) continues to have an impact on the availability of human resources. The resulting cost increases associated with travelers, employee retention, incentives, market increases, overtime, and the resulting impact on benefit costs are unprecedented. Housing costs continue to act as a major barrier to the inflow of human resources from outside Vermont. While supply chain issues have improved, we still experience shortages, freight and product inflation and project delays. The impact on our population relative to behavioral health issues, availability of behavioral health resources, reduction in nursing home availability, diminishing capacity for home health services have all led to an increase in uncompensated/poorly compensated business in order to serve our communities. Many of these themes have impacted our staff on a personal/family level as well.

Despite these headwinds, MAHHC staff and management have performed well under these circumstances. We have focused on the mission, saying "yes" to patients, managing operations effectively, looking after each other, and have come up with creative solutions to ensure that our communities and employees are getting what they need, whenever possible. Our 2025 budget builds on the lessons learned, the strengths of our providers and staff, the opportunities that we identified, the reality in which we find ourselves, our best project of the future state, and the changes we have experienced as we continue to emerge from the pandemic. All driven by our mission to improve the lives of those we serve. We continue to invest in community health with a growing Community Health Team, embedded clinical social workers, a Family Wellness team, the Windsor Resource Center, the Health Connections program, and our senior residential care facility, Historic Homes of Runnemede (HHR).

From a volume perspective, we are striving to meet the needs of our community, despite the obstacles; new patient wait-lists in primary care continue to grow, significant turnover in providers (primary care, psychiatry/behavioral health, urology, and pain management in particular) for retirement, relocation, as well as some reductions in hours as aging providers enter the glide path towards retirement. We have contracted with some providers who have arrived this spring and will be arriving in the upcoming months. We have also engaged

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locum tenens providers, and have contracted for some ongoing provider services with third parties to secure our service lines. All of this has been reflected in our budget and will assist us in meeting the needs of our community. We anticipate improved access with minimal additional costs.

Inpatient volumes are increasing slightly in total. Limitations relative to nursing homes and home health, create swing bed census growth as a percentage of our daily census at the expense of acute admissions for medical/surgical patients. Our budget reflects an increase in acute, back to historical levels, and a decrease in swing bed census. Efforts to increase our acute census are being assisted by Dartmouth Health (DH) referral center and system provider education to better understand MAHHC's capabilities. Our acute rehabilitative census is projected to be relatively unchanged, year-to-year.

Outpatient volumes will reflect the improvement in provider staffing. Most ancillary departments will be relatively unchanged year-to-year. With the ramp up of our "walk- in" clinic, emergency services have returned to pre-covid levels. Radiology and laboratory will also largely return to historical levels, following the current actual trends that we have experienced in FY24. Outpatient rehabilitative therapies are essentially full and at capacity. We have hired travelers, in addition to budgeted staffing, in order to make some ground with the increased demands. Operating room volume is decreasing primarily due to the loss of a gastroenterology surgeon and pain management provider, but helping offset those losses are increases in Urology and Ophthalmology.

Our healthcare reform efforts and participation with OneCare Vermont (OCV) are expected to continue. Our OCV engagement will continue to be limited to the core programs of Medicare and Medicaid. Our budget is based on attributed lives, risk, and reserve experience from FY24. Most notably, our reserve levels are higher than previous budgets due to recent experience. Despite the participation fees outweighing the population health management payments, we continue to invest in population health with the programs mentioned above.

Administrative and clinical opportunities continue to be reviewed and analyzed on an ongoing basis in order to determine whether programs should be modified, integrated with Dartmouth Health (DH), or remain the same to best meet our mission and the needs of our patients. While many changes have been implemented over the last few years, there continues to be a steady stream of opportunity for further consideration. Staff sharing, expertise sharing, best practices, IT services, GPO cost reductions, and rational distribution of clinical services in the system are regularly reviewed and discussed.

As outlined in our CON application, MAHHC is transitioning to DH's IT infrastructure platforms including electronic health records and business applications, as well as upgrading necessary medical and technical devices. This project will positively impact quality, access, and timeliness of care at MAHHC and the DH system, through administrative and clinical synergies, and a seamless patient experience. We are getting a better product, for less, as we share the financial expense among our system members, and leverage DH experience and workforce.

MAHHC continues to work with DH and Valley Regional Hospital (VRH) in Claremont, NH, relative to its confirmed affiliation July 1st 2024. This affiliation has been approved by the State of New Hampshire. MAHHC and VRH are moving towards a model of shared oversight and management, within the DH system. This will lead to some administrative salary reductions on both sides of the river, primarily in executive pay, where the CFO and CEO are to be split equally among both entities. Additionally, MAHHC and VRH have already begin to share and contract managers and staff where it can be mutually beneficial. We have shared staffing for a 340B analyst, laboratory management, respiratory management, respiratory float positions, rehabilitation, maintenance staff. This allows both organizations to hire a "partial" FTE, better meeting the need, as opposed to having to over hire since partial FTE's are hard to recruit. We are already experiencing savings versus contracted labor. We have discussed and planned coordinated service line changes to reduce cost and to improve access.

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Other Operating Revenues continue to be impacted. Much of this is due to the diminishing returns relative to 340B. The manufacturers continue to chip away at the benefit with no response at the federal level. 340B essentially provided our operating margin each year. Our typical year was a $1.0M+/- net benefit to the bottom line and is now around $500k per year. As we have testified in the past, the reliance on this program to make margin, as opposed to making a reasonable margin on our core business of patient care, is a concern. In collaboration with DH, we have enacted a strategy to overcome the unwarranted restrictions, utilizing a method called the Alternative Distribution Model, where DH's pharmacy logistics is leveraged to support our 340B contract pharmacy, which decreases manufacturer restrictions. The effect on our other operating revenue does not appear as drastic on a budget-to-budget level. To improve access to benefits, staff sharing, and other administrative synergies, we have recently onboarded all the staff from our subsidiary, Historic Homes of Runnemede (HHR), our senior residential care facility. This expense is treated as a passthrough, which generates approximately $1.5 million in sale of service revenue.

We have continued to focus on expense management, concentrating on controllable factors, and keeping the ship steady. To underscore this effort, management has developed a 'Back-to-Budget' initiative, some initiatives include storage facility utilization reduction, as well as nursing and leadership role restructuring. The inflation that we are experiencing is also affecting all of the partners that we contract with for staffing (though improving), services, and product. We walk a tightrope between traveler expense, over-working existing staff with overtime and extra shifts, and shuffling responsibilities between departments and individuals responsible for the work to overcome the impact of vacant positions. Despite having some of the highest employee engagement scores within DH over the last few years, as well as, the lowest employee turnover rates, we continue to be short on required staffing by double digit percentages from budget. We are experiencing short staffing in clinical, administrative, and support departments. We are currently running with 20+ FTE's-worth of travelers and are still double digit short on total bodies. Our recruitment efforts and market wage response have been appropriate and reasonable given the environment and the competition that we face. We are experiencing some degree of an unfair playing field since we are competing with New Hampshire facilities where employees do not have to pay state income tax. It puts us at an unfair disadvantage as a border hospital. Additionally, the child care tax credit implemented this July will further impact our ability to compete with New Hampshire. We have budgeted a 3% increase in wages.

DH integration efforts include a focus on workforce harmonization, namely in wages and benefits, including: health and dental insurance benefits have been consolidated and decreasing premium and risk pool exposure, which has helped keep the growth of employee insurance premiums in check. Consolidating benefits insurance has also reduced the administrative overhead in both fees and labor required to manage the programs. We believe this will improve our retention and recruitment of staff, and streamline the movement of staff between DH organizations. The most notable impact of the DH integration efforts on the FY25 budget is the revised FY25 shared services fee allocation of a $410K credit, down significantly from the FY24 expense allocation of approximately $1 million. This is due in part to the recognition of integration efforts associated with the CON project.

Compensation/market increases are managed against DH-initiated compensation studies from Sullivan Cotter generated periodically during the year. This covers all positions: staff, managers, providers and senior leaders. The Board of Trustees is kept appraised of these studies and the Compensation Committee reviews compensation in detail. Budget over actual increases in physician and non-physician salaries reflect the wage inflation realized across the industry since COVID, as well as a fully staffed budget model. Most notably, we have recently onboarded all the staff from our subsidiary, HHR, our senior residential care facility. This has added approximately $1.2 million in wages, and $300K in benefits to the hospitals budget. This is offset in other operating revenue, as the expense is passed through.

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We have largely been able to curb administrative FTE growth despite the ever-increasing administrative overhead associated with regulatory expectations, increased payer requirements, ACO work, compliance efforts and quality initiatives. Expectations and requirements increase constantly with no compensation for the effort.

Most other expenses are increasing due to inflation and current run rates. Utilities are more favorable than prior year and there is an uptick in depreciation as we try to catch up on capital expenditures, including CON related items. Supply increases reflect infusion volume trends, arguably the most cost intensive and revenue intensive service on a per unit basis. Property, professional, and miscellaneous liability insurances are experiencing an uptick affiliation-wide.

Net Revenues and FPP:

Our blended rate (price) increase is 3.5% for FY25. Facility charges will be increasing by 3.5%. Physician/provider charges are increasing 3.5%. This results in approximately a 1.6% net revenue gain from the price increase.

Our usual methodology for establishing the needed rate increase was followed: (1) forecasted volumes; (2) we determined the number of staff and amount of input required to provide those services; (3) we established an operating margin goal based on GMCB expectations, DH expectations, and our Board's expectations; (4) we reviewed our reimbursement model (trending reimbursement rates and payer mix) and applied a rate increase to deliver the desired margin.

There are no meaningful changes in commercial insurance contract terms anticipated for the year. That said, commercial insurers are continuing to push Medicare Part C (Medicare Advantage) products into the market, which generally have Medicare-like reimbursement rates, but require higher administrative/operating costs, and do not settle on cost. This means that the "hedge" that CAH's have on inflation diminishes returns over time. There is a delay in Medicare Advantage adjustment of rates, so increased costs per unit are not recognized for six or so months. Most concerning is that a number of commercial payers have expressed an unwillingness to share in the unprecedented inflationary increases. This is especially concerning when margins for some of these payers have been extremely positive over the pandemic. The administrative effort required to be in these relationships has become unbearable for our clinical staff and is requiring additional administrative staff just to get paid what we used to get paid, but with more effort.

A majority of our Medicare reimbursement is driven by cost and is not driven by an increase in charges. The percent of our increase that will be recognized by Medicare will be limited to Medicare's portion of the inflation of cost that is recognized via the cost reporting mechanisms. Higher volumes will generally reduce reimbursement per unit since cost per unit also diminishes with higher volumes and CAH's have a very high percentage of fixed cost. Medicare typically pays slightly less than cost. With the 2% sequestration adjustment, this will be more significant than during the pandemic. Medicaid is primarily "fee schedule" or "fixed payment" driven: DRG's, APC's, and fee schedules for providers. Medicaid pays significantly less than the cost to provide the service and any increased reimbursement will be limited to the percent increase added to these fixed payment methodologies. Historically, it will be slightly less than the medical inflation indices. We have no indication of what Medicaid reimbursement will be at this time for FY25, although we are hearing that there are no increases budgeted. Reimbursement for self-pay portions of our reimbursement is negligible and we receive less as a percentage over the last few years due to the IRS required reductions for non-insured. ACT119 will not help this situation, although we do not expect the implementation of the act to significantly affect charity care expense and have considered it in our FY25 budget. All of this pushes the need for margin to the commercial payers (cost shift). Approximately 60% of the rate increase will be realized with our commercial billing.

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B. Background:

a) The most significant change to our corporate structure will occur on or about July 1, 2024. Valley Regional Hospital (VRH) located in Claremont, NH, will become a member hospital of Dartmouth Health. VHR is located 10 miles from MAHHC and the two organizations share a long history of overlapping primary service regions, cooperation and collaboration. Beginning July 1, the Board of Trustees of both hospitals will "mirror" each other to govern the two separately incorporated entities. Together, the Boards will hire one CEO to lead both hospitals. MAHHC and VRH have already begun to share and contract managers and staff where it can be mutually beneficial. We currently share staffing for a 340B analyst, laboratory management, respiratory management, respiratory float positions, rehabilitation and maintenance staff. This allows both organizations to hire a "partial" FTE, better meeting the need, as opposed to having to over hire since partial FTE's are hard to recruit. We are already experiencing savings versus contracted labor and efficiencies. We have discussed and planned coordinated service line changes to reduce cost and to improve access. Over the course of 2024-2025 it is expected that under this shared governance and leadership model, further opportunities for collaboration and cooperation between the two hospitals will be identified and will lead to cost savings in future years.

b) Our approach in considering and participating in corporate affiliations included cultural, operational, financial, and strategic analysis. We obtain and consider all relevant demographic, institutional, financial, access and health information available. We engaged outside experts including external management consultants (BKD CPA's & Advisors), Dartmouth Health, Valley Regional management and the NH Attorney General's office, to assist with analysis.

c) MAHHC participates in numerous regional collaborations with other service organizations and providers. In our role as administrative entity for Windsor County Blueprint CHT, we collaborate with Upper Valley Pediatrics, Little Rivers Health Care and White River Family Practice in executing the Blueprint for Health program, which includes the DULCE program, MAT program, and Community Health Team program. MAHHC collaborates with the CDC by hosting a Public Health Associate. We manage the Windsor Connection Resource Center which hosts many community partner associations including, but not limited to: independent mental health counselors, Health Care & Rehabilitation Services, Senior Solutions, Turning Point Recovery Center of Springfield, Visiting Nurse and Hospice for Vermont and New Hampshire, Vermont Adult Learning, Vermont Department for Children and Families, Vermont Department of Labor, and Vermont Economic Services. Our Emergency Department collaborates with Upper Valley Addiction Recovery (CVAR) to provide education and access to Narcan. These are just a fraction of our regional collaborations and we are happy to provide more information if requested.

d) There are no service-line closures, transfers, or additions since the prior year budget review. However, we are currently seeking replacement of our Pain Clinic provider, who left the organization earlier this year.

C. Questions:

a. <u>Adjustments</u>

No adjustments requested for FY23 actuals or other considerations required for the proposed budget.

b. <u>Benchmarks:</u>

a. <u>NPR Growth 3.5%</u>

MAHHC's proposed budget NPR growth is 4.5%, excluding FPP and reserves and other reform

payments. We request consideration for this growth due primarily to provide access to essential community health services. The increases are directly related to increased provider access in pediatrics (13% budget to budget), primary care (9% budget to budget) and their associated ancillary revenues. This is being achieved by provider recruitment, operational efficiencies and referral opportunity development.

b. Commercial Rate Growth

MAHHC's budgeted FY25 change in charge and commercial rate increase is 2.9%, comprised of a 3.5% increase for technical and professional charges, and 0% rate increase for pharmaceutical charges, as these are based on a fixed cost-plus markup. As per our usual methodology, backing into the required rate, we arrived at 3.0% with an additional 0.5% per our CON application to support the project. Considering the blended rate and the CON project we believe we are within guidance of the commercial rate growth cap outlined in the GMCB FY25 guidance.

c. Operating Margin

The operating margin in the proposed budget is 0.7%. In a conventional operating year we would target a 1.5% operating margin, but in consideration of our CON project and the associated expenditures, we are re-aligning expectations to 0.7%. The proposed margin allows for operating profit and cash flow to fund both operations and capital plans, while recognizing the additional expense from the CON project, as well as an improved employee benefits package to improve retention and recruitment.

c. Assumptions

a. Labor expenses

Labor Expenses are established by the following:

- Adequacy of current staffing in meeting the workload for the position/department in order to determine the necessary staffing
- Necessary staffing is adjusted to accommodate anticipated changes in workload for the position/department in order to determine the anticipated staffing
- Anticipated staffing is "priced" based on current, average rate of pay for the position (including differentials, overtime, incentives) plus anticipated wage increases (merit and market)
- Identify anticipated traveler need on an FTE basis, add differential (Traveler cost - EE wage and benefit cost) to contracted labor

b. Utilization

Utilization expectations are driven by the following:

- Current and historical utilization rates are analyzed to determine the reason for variances (referral patterns, staffing, technology changes, regional availability, etc.)
- Identify anticipated/known changes (referral patterns, staffing, technology changes, regional availability, etc.) are considered and projections are developed
- Staffing is then determined

c. Pharmaceutical expenses

Pharmaceutical expenses are based on the following:

- Review of historical and current volumes and utilization by product

- "Formulary" and anticipated volume by product is modified by known programmatic changes, budgeted volumes, and changes in practice/available product
- Inflation determined at a product level based on Group Purchasing Organization (GPO) and other trade sources
- Inflation added to expected formulary/volume by product

d. Cost inflation

Non-Pharmacy, non-salary, non-benefit expense inflation is calculated, based on the following:

- Review of contracts (allowed increases, term of contract, changes in utilization, etc.) for these types of expenses
- Any variable expense, that is not locked in or defined by contract, is reviewed at an individual level for possible inflation
  - GPO projection sources
  - Individual vendors contacted for projections
  - Consideration is made upcoming DH GPO initiatives
  - Historical and current variable costs are adjusted by known changes in volume and utilization
- Fixed expenses are reviewed in the same manner except the volume/utilization are largely irrelevant

e. CMI

MAHHC does not directly consider Case Mix Index in budgeting.

f. Rate Changes by Payer

Our price increases are made across the board relative to payers. There are not different price changes for different payers. As you know, the reimbursement for these increases are realized differently according to the payer source. The methodology for establishing our price increase is noted earlier (Net Revenues and FPP section)

g. Capital Expenses

The most notable capital expense, as discussed above (and the CON application currently in approval process), is related to our CON for the upgrade of our financial, operational and health information systems. Aside from that project, we expect to continue to invest in our facility and patient care related equipment. The most significant, and makes up much of the facility capital, is a much-needed replacement of a plant chiller. Other investments include routine replacement of surgical scopes and towers, a microscope, radiology battery replacements, a blood bank module, IV pumps, and 02/vitals monitoring devices.

Capital		Budget FY25
Facilities	$	1,468,750
Information Tech		105,637
Major Moveable		935,313
Strategic (CON)		2,290,300
Grand Total	**$**	**4,800,000**

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h. Financial Indicators

As stated earlier, our primary focus is based on producing a reasonable margin for all interested parties. Once determined, we ensure that the margin expectations will work with our financial indicators. Most importantly, we look at Days Cash on Hand (DCOH), Age of Plant, and whether our Cash Flow is adequate under the lens of key indicators and pressing needs. Given the current environment (inflationary pressures, etc.), we are most concerned about our aging plant and the financial commitment needed to address this. We have under-spent relative to capital due to COVID stealing internal bandwidth, supply chain issues (delays and lack of inventory) and contractor availability. Our budget gives us the ability to fund the necessary capital to reduce the age of plant a bit while maintaining DCOH at a reasonable level.

i. Uncompensated Care

Our bad debt and free care expense are established based on historical and current run rates. The ratio of free care versus bad debt is will move a bit year-to-year, but in total, runs fairly consistently. We have observed a downtick in charity care in the past two years, and had initially planned to budget this at a reduced rate, but in consideration of ACT119 we opted to keep it consistent with historical budgets in anticipation of an uptick in utilization of the program.

j. Community Benefit

The benefits MAHHC offers to the community, in addition to our essential service as a hospital, primary care, specialty physician practices, management and subsidizing of our local senior residential care facility HHR is a complement of community service programs. We run the Volunteers in Action, a network of volunteers that provide delivery of Meals on Wheels in the community, providing transportation to patients, among other support. We also run the Windsor Connection Resource Center, which discussed above offers a home to countless social and community service organizations, and is a citizen resource center that provides computer and internet access to community members. MAHHC staffs many of the volunteers necessary to execute the VeggieVanGo (Vermont Food Bank program) program. MAHHC is a crucial member of the Community Health Implementation Plan (CHIP), which aims to address the social determinates of health outlined from our Community Health Needs Assessment (CHNA) in collaboration with local community non-profits and social service agencies.

d. <u>Known Risks</u>

The two largest risks in the coming year relate to staffing and OneCare Vermont.

In the face of an aging Vermont population, rising demand, and staffing shortages, healthcare workers are facing an ever-increasing burden. Healthcare continues to lose workers to retirement and burnout, and the industry is unable to fill the gaps left behind. New graduates are in short supply and upwards of 30% of nursing graduates leave the profession in the first year alone. Traveler costs and wage/benefit market competition are more than concerning. MAHHC has had to increasingly rely on traveler/agency workers. As of our most recent pay period, approximately 10% of our clinical workforce is comprised of travelers. Our budget reflects an additional cost of $1.4 million for travelers/locums for the coming year, a significant increase from prior years. Note that relative to travelers, we always budget the wage and benefits for FTE's necessary to execute our budget plan and determine the likely "FTE" amount of travelers for a given department. We then add the differential (traveler cost less salary and benefit cost for an employee in that role) into purchased services. While our employee engagement scores are very strong, the concept of "grass may be greener" is influencing employees to seek out better arrangements.

As a border hospital, we are competing against NH facilities that have the ability to remain highly competitive due to their regulatory and tax environments.

Vacancy rates at MAHHC are as high as they have ever been, but are below the average in the DH system. Turnover is also a concern as well. More concerning is the reduced fill rate due to lack of available bodies in the market place. As mentioned earlier, retirement, leaving the industry altogether, lack of new graduates. have contributed to this fill rate issue. Much of the voluntary turnover relates to us cannibalizing each other in healthcare because there is no replacement market. This too, is driving up costs as we are now competing with each other for the same people, more than ever.

We are executing different strategies to improve staffing, including:

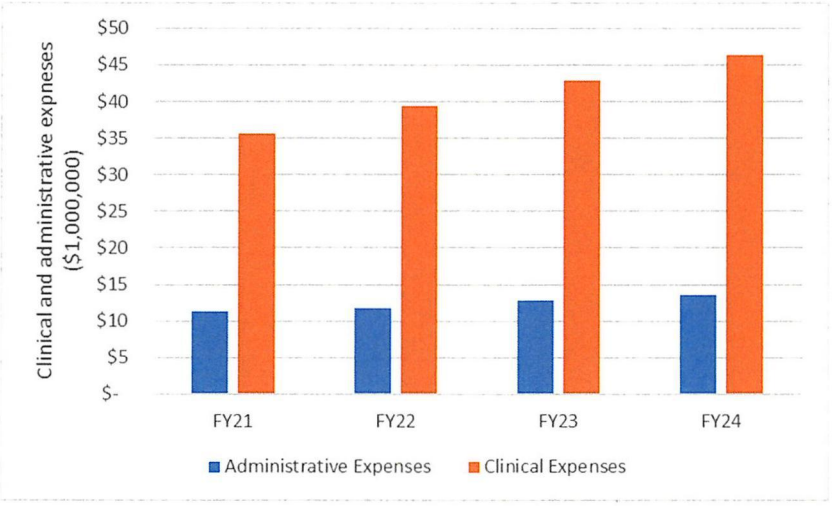
- Increased tuition benefits (building our own…LPN/LNA to RN, etc.) **$48K**
- Leverage external tuition reimbursement programs **$24K**
- Short Term Disability **$150K**
- 403B contribution system alignment **$0.7M**
- Loan forgiveness **$38K**
- Signing and longevity bonuses **$50K**
- National/international recruiting **$115K**
- Hiring students to work in areas/jobs related to their degree that do not require licensure
- Developing shared labor pools with DH system and neighboring hospitals
- International travelers
- Revamping work schedules
- Incentive pay for critical shifts
- Expanded support of healthcare teaching institutions (clinical experience)
- Employee appreciation events/gifts **$54K**
- Employee wellness programs **$87K**
- Job Fair **$5K**
- Childcare center in Lebanon, NH, for health system employees.

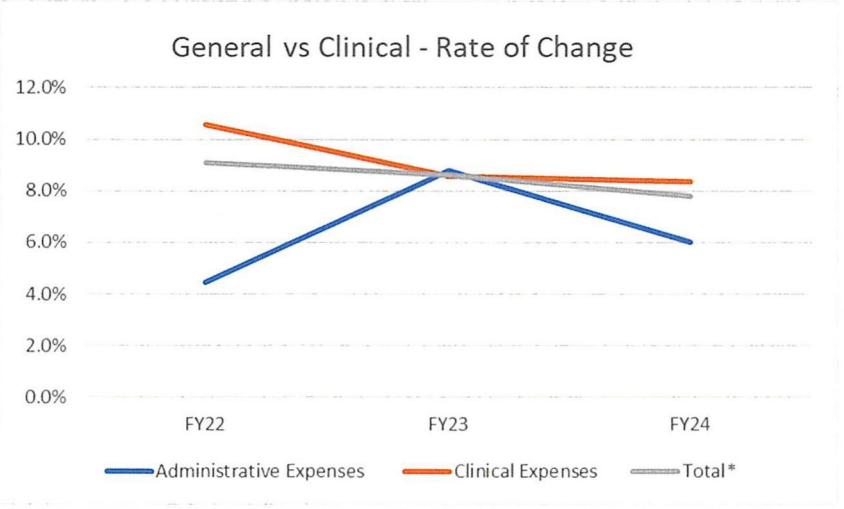
Participation with OneCare Vermont (OCV) presents the other significant risk in our budget proposal. Program risk, payer participation, incentive alignment, availability of data, evolving programs, regulatory requirements, administrative lift are all major concerns in the coming year. With Medicare and Medicaid programmatic risk on the table, it places a significant financial stress on a traditionally lean organization. We will need to recognize this risk via reserves ($0.6 million), which limits resources that could otherwise go to patient care. The data and reporting provided by OCV to improve healthcare outcomes is neither timely, nor consistent, or communicated effectively. The incentives provided, Population Health Management (PHM) payments ($220K) and bonuses, are eaten up by participation fees and risk pool fees ($452K). The costs of health reform, such as embedded social workers in clinics ($85K), family wellness programs ($204K), clinic care management and coordination teams ($241K), patient insurance liaisons ($85K) and so much more, far outweigh the ACO's PHM and other direct support. As such, operational income funds the majority of the programs. We recognize these are long term investments, with long term returns, and we ask that the financial burden be acknowledged and the incentives aligned with the interests of those providing the care. The end goal of improving the lives of those we serve, and improving healthcare outcomes are one we all share, yet hospitals are facing the financial burden of providing the service, and the financial fallout from success. On top of financial pressures, regulatory pressure to reduce costs and increase investments creates a conflicting and uncertain operating environment, and only adds additional administrative efforts and costs. ACO viability is a concern, as the movement to global budgets, payer participation withdrawal, and provider withdrawal, and program

timelines looming, all increase risk in the system and provide unstable footing for forward progress.

e. <u>Administrative vs Clinical Expense</u>

Administrative vs. clinical expenses, as calculated and described in Wang & Bai's article titled 'U.S. Hospitals' Administrative Expenses Increased Sharply During COVID-19', using FY22, FY23, and an interim FY24 cost report yielded the results below:





Both clinical and administrative expenses are seen to be increasing year over year. The impact of wage and supply inflation, increasing investments in retention and recruitment strategies, investment in community health and population health management (all discussed in the narrative), are apparent in these graphs. A general rise in expense across the board is experienced. However, the rate of change is generally improving, as the rate of growth of total expense has decreased in total year over year since 2021.

*Please note, as Wang & Bai did not discuss the treatment and/or impact of NRCC's, these figures were not incorporated into the data above.

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f. Facility Fees

As interpreted by VAHHS, facility fees are understood to be the provider-based billing facility fee to Medicare in physician outpatient clinics. The fee amount is a set rate, which is 40% of the total fee. Projected FY24 facility fees are $1.75 million and budgeted FY25 facility fees are $1.87 million must comply with all of the Medicare requirements and therefore, are subject to all the same regulatory requirements as the main hospital. Facilities fees are not additional fees, rather a single fee split into two components. The combination of Medicare professional and the facility fee equals the same amount as is charged under professional billing to Commercial and/or Medicaid.

g. Consumer Affordability

Our budget request considers consumer affordability and we recognize is an important factor in the social determinants of health. To echo Chair Foster in a recent VT Digger article, "when care is really expensive, you don't have care". According to the U.S Bureau of Labor Statistics, May 2024 12-month inflation for the Northeast was 3.9%. BCBS of VT has proposed rates of around 15%, roughly 500% greater than MAHHC's requested increase. MAHHC is proud to present a rate request lower than average inflation and insurer premium growth. MAHHC has developed programs in collaboration with regional partners to address affordability in and out of the hospital. From the recent implementation of our ACT119 policy providing greater financial assistance to those in need, to supporting patients with transportation and paid medications, our stocked food pantry in the Windsor Community Resource Center, to our community health general fund, we are always mindful of our patient's financial health and aim to help wherever possible. These rate increases enable us to help improve the lives of those we serve.

h. Contingency Plan

If our proposed rate and/or NPR increase request were to be reduced, the two options are to either reduce volumes, which is synonymous with access, or reduce expenses. Reducing rates in the current operating environment and with our reimbursement mechanisms do far more harm than good to the organizations financial health and sustainability. Reducing volumes would harm our community, as we provide only what the community health needs require. This leaves reducing expenses, which depending on the rate cut, the two viable options are reduce FTE's or reduce benefits. As staffing is already lean, and we only budget for necessary FTE's, wages and benefits would likely be the initial target. Salaries, retention, recruitment, retirement, insurance, and development are unfortunately the only true options. Given our operating environment: heavy competition, and limited human capital resources, we are risking quality and access, which would be detrimental to our mission and our shared collective goals for access and improved health outcomes.

i. Lobby/Marketing/Advertising/Branding

The following tables include costs associated with lobbying and marketing (including advertising, and branding) which identify the amount paid to each entity that performed services on our behalf.

MARKETING EXPENSE	FY2023A	MAY2024 YTD
COMMUNICATORS GROUP	139,031	52,304
SALARIES	105,826	28,425
CRONIN GROUP HOLDINGS LLC	74,869	48,626
DARTMOUTH-HITCHCOCK	48,000	97,880
OTHER	36,979	42,633
TOP STITCH EMBROIDERY INC	12,307	1,044
SPECTRIO LLC	11,015	0
R. C. BRAYSHAW & COMPANY INC	6,152	6,726
IPA CONNECT LLC	5,303	2,225
FRONT PORCH FORUM	3,111	4,278
DESIGN COMMUNICATIONS LTD	0	129,356
Grand Total	**442,593**	**413,497**

LOBBYING EXPENSE	FY2023A	MAY2024 YTD
VAHHS	9,346	6,449
Grand Total	**9,346**	**6,449**

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j. Fundraising

MAHHC maintains an active focus on fundraising efforts, and enters into FY25 with a consolidated strategy to achieve our various targets. The development team has developed a strategic outreach plan to connect with over 200 in area individual/major gift prospects. MAHHC's goals are to raise $500K in restricted and unrestricted funds from individuals, organizations, foundations and corporations. Of the $500K, $200K is expected to be unrestricted, and $300K for restricted to donor intent programs. These programs include the continued support of the Family Wellness Program, pediatric vision screening equipment, and other Community Health programming. We are also working collaboratively with DH development, which enables us to leverage the fundraising experience, technical infrastructure and capacity of DH.

k. Investment Income

The table below demonstrates past and projected performance for our investment portfolio, which is largely comprised of deposits in the DH Master Investment Plan (MIP), which is a DH system wide investment pool. This enables our relatively small CAH investment portfolio to access world class investment opportunities and advice.

Investment Activity	FY2022A	FY2023A	FY2024P	FY2025B
Dividends/Interest	229,255	440,808	367,685	224,234
Realized Gain (Loss) from Sale of Investments	1,243,111	1,239,899	193,674	224,234
Unrealized Gain (Loss) on Investments	(4,371,333)	718,667	1,980,628	1,046,426
Grand Total	**(2,898,967)**	**2,399,374**	**2,541,987**	**1,494,895**

l. Quality Reduction Payments

MAHHC experienced a -$19,075 reduction of payment from OneCare Vermont in May 2023. The reduction was due to quality results from December 2021 related to MAHHC's share of the ACO-level quality adjustment in the Medicaid program. Under the contract with DVHA, when the ACO achieves shared savings, the savings amount to the ACO is subject to adjustment based on the entire network's performance on a host of quality and performance measures. Back in 2021, the settlement was calculated differently in the sense that OCV apportioned the shared savings to each HSA and then deducted each HSA's "share" of the quality adjustment. Beginning with 2022, we reflect the quality adjustment at the ACO-wide level, and then apportion the remaining shared savings per our settlement policy. This method is more reflective of the nature of the adjustment, which is based on the entire network's performance, and not any one HSA or hospital. While this was technically a quality adjustment, it was a reduction to our shared savings earned. Moreover, it was not the result of anything MAHHC individually did or did not do, but rather, was the result of the entire network's performance.

m. Workforce Development

In addition to the investments discussed in section (D), MAHHC was an integral partner in establishing the VT Nurses in Partnership (VNIP) Program and the pilot location for the program in 2000. VNIP is a nurse leadership coalition that institutes resources for nursing workforce development. Since inception, the collaboration has grown from the initial 45 Vermont-based members, to a coalition of over 300 nurse leaders from across the nation and around the world. The programs developed by VNIP promote a workplace culture of nurture, support and professional growth for novice nurses or those in transition to a new specialty. The VNIP model demonstrates the importance of the workplace culture to long-term recruitment and retention of nurses in clinical practice.

More recently, and on an ongoing basis, we have been a practicum site for two Licensed Practical Nurse (LPN) programs, for two River Valley Community College locations and for the VT Technical College (VTC) program. We also provide shared faculty support for these programs as well as the RVT Center in Springfield. Prior to the pandemic, we hosted 9 students per cohort (River Valley and VT Tech) and saw those numbers double between 2019 and 2020. We are also a sponsored state testing and evaluator site for several local LNA programs.

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Lastly, to further demonstrate our dedication to the development of healthcare careers and the nursing workforce, we meet with schools, career exploration counselors, and provide shadow experiences. We are a practicum site for Southeast VT Area Health Education (SVAHEC) MedQuest and College Quest programs. RN Pathways, tuition reimbursement, staff education efforts/classes.

Working with VT State University (VTSU) Nursing program, MAHHC is implementing the Nursing Pathways program. Our vision is that this Pathways program will help us to recruit at least three entry-level position people, interested in Nursing, from our local communities who otherwise cannot afford college, or afford to stop working to go to college, and allow them to build a career. While taking the time to advance their education, we will simultaneously provide wrap-around support so that their studies do not create hardships in other areas of life. Supports will include being paid while they are learning, staff support to ensure academic success, and peer mentoring.

We will work with area high school counselors to recruit interested students who would not otherwise be able to go to college that we will support in getting into a career. As an employer, we are limited to making decisions based on demographics but we can work with community partners to assess persons with aligned interests in what we are offering. We want this selection process to be fair and equitable without jeopardizing employer/employee guidelines law.

This example of offering personal care attendant positions shows how someone can get in the door as an MAHHC employee and once they are here, they can start the program. Paid release time from work for school, educational debt-free after six years with a very decent paying job. This program has tremendous potential to break the cycle of generational poverty and lack of educational attainment in families.

n. Workforce Retention

In addition to the investments discussed in Section (D), in partnership with the Dartmouth Health system, we selected a new carrier for our medical plans with new plan designs that allow access to a broader regional provider network. The plan design offers a low-deductible plan in addition to a high deductible, account-based plan, which will include a health savings account option for employees to offset medical expenses. These changes reduced the out-of-pocket exposure for 96% of our employees.

For our retirement savings plans, we transitioned to Vanguard with the Dartmouth Health system. Vanguard was our first choice because of their superior recordkeeping capabilities and ability to service our best-in-class investment plan offerings to enhance retirement readiness, and their experience with bringing together multiple retirement plans across systems like ours. Through this transition, MAHHC modernized our employer contribution process to enable per pay period employer contributions for the first time. This change guaranteed the benefit of up to 4% employer contributions to our employees.

We have redesigned our employee wellness program to support retention efforts. Some examples of new offerings: beekeeping classes, gardening how-to, tension and trauma release exercises workshop, yoga classes.

MAHHC purchased a 2-bedroom condo on Mt. Ascutney to help ease housing challenges that our employees often face when relocating for a position at our organization. We have also allowed for short term rentals for our employees at our other resident sites to help with challenges unrelated to relocation.

Dartmouth Health has partnered with the Carter Community Building Association (CCBA) in Lebanon to open a new childcare center for health system employees in the fall of 2024. This new center will be open to all Dartmouth Health families and will serve just over 40 children aged 18 months to 5 years old.

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o. Held Harmless Expenses

Hospital management, is ultimately responsible for all expenses. There are however, expenses in which management has little or marginal control over, including the following:

- ED bad debt expense,
- Health insurance expense inflation
- Additional payroll taxes (Vermont Child Care Credit)
- State specific tax (Provider tax)
- Medical supply inflation
- Service mix (pharmaceutical infusion expense for example)

D. Hospital & Health System Improvement

a. Access

Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, we are actively recruiting for psychiatrists and primary care physicians to help improve patient access to mental health and primary care services for our communities. As mentioned above, our investments in health delivery reform include embedded social workers in our clinics to provide additional care for patients, family wellness programs, clinic care management and coordination teams, and employ patient insurance liaisons. Our Emergency Department also partners with Connecticut Valley Addiction Recovery and Turning Point to provide Medication Assisted Therapy and counseling services for new patients so we can extend access to treatments for substance use disorder. Additionally, we are looking into partnering with Dartmouth Hitchcock to bring Gynecology and Women's Health services here in the Windsor community. We continue to manage and subsidize our senior living facility HHR, to provide long term care for the community.

b. Collaborations

Please see Executive Summary and Section B (a), Section C (c) (j), Section D (a).

c. Performance Improvement Plan

N/A

d. Hospital Networks:

As a member of the DH system MAHHC participates in the Shared Services Program. Shared Services are currently allowing for a reduction in administrative staff as well as savings in compliance services, human resources, pharmacy, supply chain, quality and many contracts for purchased services. MAHHC also achieves savings from the sharing of positions with DH in areas such as Health Information Management (HIM) and Clinical Documentation Improvement (CDI).

The method used for the Shared Services allocation was designed to favor the smaller DH entities especially the Critical Access Hospitals (CAHs). In brief, the methodology sums all the costs in each Shared Service area across all the entities including DH. Each entity is allocated their share of the total then reduced by the cost incurred at each entity. This methodology leverages the scale of DH to MAHHC's benefit. MAHHC's FY2025 budget request is the perfect example of the favorable methodology. MAHHC has a credit of over $0.4 million in Shared Services expenses in the areas mentioned above.

Information Services and certain accounting functions will become part of Shared Services beginning in FY2025 with System Integration Project (related to the ERP component) currently in the GMCB CON process.

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E. Other

a. Zero-Based Budgeting

This budget is a combination of zero-based budgeting and historical spend. Most expenses, save medical supplies in the OR, ED, and inpatient units, are zero-based. Our current financial software has a well-established, manager friendly budgeting module. Every line item over $1000 is required to have a "scratchpad", where managers enter line-item explanations for budgeted figures. These are then reviewed and approved by senior leaders and finance separately. Line items that are currently too cumbersome to detail by line item are medical supplies in the OR, ED, and inpatient units, where historical experience, anticipated volumes, and inflation are applied.

b. Financial Assistance Policy

a) Please note, bad debt recoveries are not revenues, but a reduction in expense. No changes to these contracts were made since the discussion from the FY24 budget hearing. We continue to pay market commensurate rates, have a long-standing relationship with these firms, have excellent results, high customer satisfaction, and near zero valid complaints.

BAD DEBT	2022A	2023A	2024P
BAD DEBT RECOVERIES (GROSS)	653,788	465,360	506,636
COLLECTIONS FEES	147,623	105,077	114,397
BAD DEBT RECOVERIES (NET)	**506,165**	**360,284**	**392,239**

The return on investment in outsourcing our bad debt recoupments is in reduced salary, benefits, and legal fees. It also comes from leveraging the collection firm's expertise. In general hospital/healthcare salaries and the cost to run the business are greater than the collections industry.

b) Financial Assistance applications are available in all registration areas, mailed for free and available at www.mtascutneyhospital.org. Outside of the application process, we also speak to patients over the phone (or in person) and ask if they are interested in applying for financial assistance if they have a high dollar bill or indicate they do not have funds to pay for a bill. We also have posters, brochures, and advertise using social media. We work with registration when scheduling surgeries if the patient is underinsured and mail out applications.

The MAHHC screening process starts with completed application. Customer Service reviews all questions to make sure the application is complete, signed and dated. MAHHC follows Vermont Act 119 guidelines for accessing financial assistance eligibility. Federal Poverty Limit guidelines for household income and household family size are evaluated. Customer Service makes a final determination and fills out the Financial Assistance Policy approval/denial form and put on the shared file for the Director of Revenue Cycle to review and sign and date. Once approved/denied a letter is sent to the patient, a registration alert is put on the account letting Registration know that the patient has approved Financial Assistance, with the amount and termination date. The letter is scanned into the patient's account in the EMR.

c) There are instructions and information on each statement for patients on our Financial Assistance Policy and how to apply.

c. Boarding Estimates

Long Term Boarders are tracked monthly, and the total number of discharged boarding patients for the

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particular fiscal year were identified. With those specific patients consolidated, reimbursement totals for the individual patients were identified. For fiscal year 2024 the total reimbursement number was annualized to get a projected reimbursement amount.

ED boarders are identified by ALOS, which is calculated using admit and discharge data from the EMR. A proxy is established for cost, using the cost report and clinical encounters. Reimbursement is calculated by taking the average revenue per ED encounter and applying a proxy payment rate derived from an analysis of the ED boarder population.

Please let us know if there are additional questions or concerns.

Sincerely,

Winfield Brown
Interim C.E.O.