Dartmouth Health

Mt. Ascutney Hospital and Health Center

July 8, 2022

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

Re: Budget 2023 Narrative

Dear Ms. Lindberg,

This letter serves as the narrative required to accompany the electronic budget files which have been sent under separate cover. There is a fair amount of overlap between the various sections so we have done our best to not be overly redundant.

Executive Summary:

Mt Ascutney Hospital and Health Center (MAHHC), is budgeting a 1.7% operating margin which is consistent with last year's submission.

FY22 has been another year of ongoing changes, uncertainty, and challenges. The pandemic has challenged us individually and corporately. While some things have seemingly become the new normal, there have been many new challenges.. Our providers, staff, and managers continue to be resilient, creative, and dedicated to our mission and to the patients of Mt. Ascutney Hospital and Health Center, despite enormous workforce stress.

In the midst of changing clinical practices, staffing concerns, supply chain issues, unprecedented inflationary increases, MAHHC has continued to develop and execute creative means to insure that patients received access to the care that they needed safely and effectively. As in 2021, we temporarily moved services, reallocated space, designed new work flows, and revised protocols as COVID-related guidance changed. Our providers and dedicated staff persevered through care delivery changes, changes in assignments, and even remote work assignments. We continued to accept COVID patients from Dartmouth-Hitchcock Medical Center, other hospital service areas in VT, and from out of state. We admitted and cared for acute rehab patients from around the state and from out of state when these services were not available in their home service area. We safely and effectively managed COVID throughout all of our service lines. As a result, we minimized the volume losses due to COVID and have not furloughed or laid off staff. Overall, our recovery efforts have been effective.

Our 2023 budget builds on the lessons learned, the strengths of our providers and staff, the opportunities that we identified, and the changes we have made to manage through the pandemic. This budget reflects the ground that we have gained/maintained and the ongoing efforts of the organization. We anticipate COVID-19 to continue to play a role in the operations of our hospital for the near future,

albeit far less than we have experienced to this point. Prevention, access screening, testing, and ongoing vaccine/booster clinics will remain significant areas of planning and execution.

Our healthcare reform efforts and participation with OneCare Vermont are expected to continue as will ongoing integration efforts with the Dartmouth-Hitchcock Health system. We are limiting our OCV engagement to the core programs of Medicare and Medicaid due to lack of clarity over the all the programs offered by OCV in 2023 and beyond. There is a possibility of some footprint in the commercial book of business but this remains to be seen. 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 D-HH, 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. FY 2023 will also be the second year of cost allocation of support services across the D-HH System as integration continues.

Volumes and revenues are generally similar to the Projected FY22. There will be some increases and decreases, department to department. Reductions of testing, treatment and evaluations related to COVID are expected due to vaccination rates, more effective treatments, and the reduced severity of the virus. However, staff and providers vacancies, community exposure to COVID for our employees, scarcity of labor, and supply chain issues will negatively impact volumes. FY21 and 22 budgets were tempered to allow for the possibility of a slower recovery, surges in the pandemic, and the periodic reduction of elective services. Accordingly, we are placing greater weight on our FY22 experience thus far in the development of our FY23 budget.

Because of our improved financial performance, MAHHC implemented a pricing reduction project prior to the FY22 budget presentation to the GMCB. The goal of this plan was to better right size, rationalize, and reduce pricing to the extent possible. The initial focus of the program was ancillary charges, including radiology, laboratory, and outpatient therapies. Reductions of more than seven figures in gross charges were implemented. We reported to the GMCB that our small price increase request of 2.2% will actually end up being a negative request due to these unbudgeted reductions in pricing. The GMCB questioned our level of confidence to still make the budget work as submitted. We are happy to report that our estimates and expected impact calculations have held up. Our pricing is not where we would like it to be, but we have made material progress in this regard and will not be requesting increases for budget FY23 to make up for these reductions in pricing made in FY2021. We are considering additional reductions before the end of the fiscal year, though not as material as the FY2021 reductions, and will notify the GMCB of any changes that we are making.

We have continued to focus on expense management, minimizing the effect of uncontrollable factors, and keeping the ship steady. As you are well aware, all areas of our supply chain have seen significant inflationary changes to the cost of production and the cost of distribution. Our service lines have remained reasonably stable and are continuing to grow incrementally relative to market share for the last four years or so. We are still a small entity with a small "n" and even small changes can result in significant variances. The mitigation of risk in our OneCare VT risk programs during the pandemic has improved our bottom line but we have lost some ground in reimbursement from the cost report in areas

due to improved volumes. The growth of Medicare Advantage plans continues to reduce the benefit of cost-based CAH reimbursement and there is always a delay in Medicare Advantage plans recognizing the changing costs.

We did not realize or book any benefit of Provider Relief Funds in FY21 and FY22 since our overall financial performance has been solid as compared to prior years and budget (periods used by HRSA to evaluate need and retention of these funds). Our Medicare Advanced funding has been completely paid back and was not used. We are currently carrying a reserve against the Provider Relief Funds that we received in FY20 as we wait for HRSA to approve of our modified reporting method to accommodate our FY19 experience with OCV.

Year over Year Changes:

Net Revenues and FPP:

Our weighted rate (price) increase is 4.7% for FY23. Most of the facility charges will be increasing by 6.0%. Our pharmacy prices are based on acquisition cost so no price increases are applied to pharmaceuticals. Physician/provider charges are increasing 3.0%. This results in approximately a 2.2% net revenue gain from the price increase. As noted previously, with the price reduction initiative from last summer, budget to budget to budget (FY21-23), we are going into the new fiscal year with a smaller pricing change (cumulative) than documented in our budget materials.

Volumes experienced a quicker recovery than anticipated, during the COVID-19 pandemic in FY21 and FY22. As the pandemic (hopefully) winds down, pent up demand, reduced patient hesitancy, will likely flatten out the growth that we have experienced against budget during the pandemic. In projected FY22, Primary Care, total inpatient days, and the operating room have actually tailed off YTD but most other areas have met or exceeded expectations.

Inpatient volumes are expected to be similar to our current FY2022 projected volumes in total. The mix of inpatient services has been changing since the end of FY19 with an increase in acute inpatient days as a percentage of total days and a reduction in swing bed/subacute days. We expect this mix to reverse a bit with the % of Swing Bed days increasing and the % of Acute days diminishing a bit. Total Acute and Swing days will diminish by a 1.0+% from Projected FY22 and ancillaries for those areas will follow suit. Of note, in the recent Sustainability work spearheaded by the GMCB, Mt. Ascutney Hospital and UVMMC had the highest inpatient bed occupancy in the state. Acute Inpatient Rehabilitative days and the associated ancillaries will likely remain flat.

Emergency Room and outpatient ancillaries will likely return closer to pre-pandemic levels. Clinics/Provider Offices will experience a 3.7% increase in volume over FY2022 projected despite a marginal decrease in the provider compliment. Neurology will grow as the practice matures, as will our Physiatry practice.

Our inpatient occupancy was budgeted at 80% for FY22 and we are running at 77% for actual YTD FY22. Our FY23 budget is at 78%. This includes our 25 inpatient beds (CAH limit and license) and our

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10 inpatient acute Rehabilitation beds (CAH limit and license). Generally, we staff at 20 inpatients for Acute/Swing and 8 inpatients for the Acute Rehabilitation Unit.

Total Gross Patient Revenues will increase 11.7% budget to budget and 7.6% projected to budget. FY22 budgeted revenues were reduced in anticipation of another surge of the pandemic and slower recovery. However, recovery in FY22 has been better than expected. Deductions and net reimbursement percentages fluctuated budget to budget, due to the effect of volumes on the cost report, OneCare VT risk mitigation, payer mix, and service mix changes. FY22 budgeted contractual rates were budgeted lower due in part to the reduction of OCV risk and anticipated payer mix changes. FY22 projected trends in payer mix reflect an increase in Medicare and Medicaid. Bad debt and free care as a percentage of gross revenues remains stable budget to budget. We anticipate DSH figures to remain stable after a small and unexpected increase in FY22. The methodology has changed this year for DSH filings and so we are not entirely confident that we will retain a like-sized piece of the pie.

We expect to opt out of the AIPBP component of the OCV Medicare program (no FPP), but will remain in the quality/risk portions of the program. Risk booking will resume in FY23 after a reprieve was granted for FY21 and FY22 due to the mitigation of same during the pandemic. We will participate in the OCV Medicaid program with FPP payment methodology. We did budget for OCV commercial business (upside only). We do not have final budgeted numbers for CY2023 and have not executed contracts at this point. Total Risk reserves for FY2023 will be $500k versus the budget of $$300k in FY22. This is based on the "middle of the road" estimates provided to us by OCV. It is anticipated that our attributed lives will be increasing significantly year to year so there is a bit of risk in this area.

Change in Charge Request:

Our weighted rate (price) increase is 4.7% for FY23.

Our usual methodology for establishing the needed rate increase was followed. We determined how busy we will be. We determined the number of staff and amount of "stuff" required to provide those services. We established an operating margin goal based on GMCB expectations, D-HH expectations, and our Board's expectations. We review (and revise if necessary) our reimbursement model and apply a rate increase to deliver the desired margin.

There are no meaningful changes in commercial 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, require higher administrative/operating costs, and do not settle on cost. This means that the "hedge" that CAH's have on inflation, etc. is a diminishing return over time. There is a delay in their 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.

Overall, our net reimbursement change is down 1% from budget 2022 to 2023. It is expected to be down 1.2% from the YTD basis used for the budget model. This is the result of ACO risk mitigation ending, sequestration coming back into play for Medicare, and a small hit in payer mix. For the

purposes of discussing the impact of a rate increase on payers, the net effect of OCV ACO FPP/non-FPP business is ignored and risk reserves are considered. A majority of our Medicare reimbursement is driven by cost and 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 hit, this will be more significant than FY22. 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. 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. 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.

Adjustments:

There are no adjustments to mention relative to accounting changes and the purchase/transfers of physician practices. It should be noted that our compliment of Pain Management services will be cut in half due to a shortage of available providers at DH.

Other Operating and Non-Operating Revenue:

Other Operating Revenue (OOR) will decrease (-17.9%) budget over budget due to a decrease in grant funding and ongoing reductions in 340B benefit from manufacturers. Grant revenues are falling off, as COVID-19 funding comes to an end and reduced availability of funding for non-COVID related initiatives. Lobbying efforts and self-determined interpretations by the pharmaceutical industry put greater 340B revenues at risk on an ongoing basis. In order to slow this reduction, we may have to increase the administrative effort associated with this business as complexity and potential compliance issues grow. The continued and increasing reliance on other and non-operating revenues to fund hospital operations is a growing concern. Inflation, risk, reform, lackluster growth in governmental funding, are all factors that contribute to this increased reliance on non-patient revenues.

Non-operating revenues are lagging budget significantly in FY22 primarily due to poor performance in the investment markets. However, we have budget a 4.5% return for FY23 per our investment professionals. With recent market volatility and the Fed's discussion of interest rate increases, these revenues are not predictable. These estimates were provided by treasury management at D-H.

Operating Expenses:

Overall, expenses will be increasing by 8.5% budget to budget. Increases in inflation, salaries, benefit costs, traveler expenses, other contracted increases, and liability insurance increases are the key drivers. Wage increase packages are budgeted in FY23 at 3%, which is commensurate for the area and the D-HH system, and a key factor in attracting and retaining staff in our highly competitive

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landscape. In light of current market events, insurers have radically increased premiums and retention levels for the industry. Double digit premium increases and increased deductible and attachment points are drivers of this inflation. Even with the buying power of D-H and the fact that some of these lines of business are part of the D-H captive, we are experiencing significant inflation. Pharmaceutical inflation at close to 3.3% in FY22 and is expected to continue. This is primarily based on market inflation but also considers the new mix of pharmaceuticals associated with best practice. There is an increase in supplies associated with COVID for PPE, testing kits, etc. which may not be covered with new funding sources for this ongoing expense. Supply chain interruption, supply and demand pressures, and freight/delivery cost growth are also significant contributors to supply growth. Provider Tax is increasing in relation to the increase in revenues. Depreciation and amortization will not increase due to supply chain delays in capital purchases that were delayed during the pandemic and continue to limit our ability to implement or put items into service.

In the coming year we expect a C.O.N. to be filed for the implementation of D-H's IT platforms in FY24. Other capital is generally for routine replacement of equipment, mechanical systems, plant maintenance, and Information Technology infrastructure which will help protect our existing platforms/data for the immediate future and will help us be in better position to transition to the D-H platforms. Costs for capital is also increasing at unprecedented levels.

Operating and Non-Operating Margin:

Overall, we expect to generate a reasonable operating margin of 1.7% or $1,173,000 and a total margin of 3.9%, or $2,732,000.

Equity:

We have modified our most recent community health needs assessment to assess for inequities across community groups. We work in conjunction with DH leadership to develop a System wide approach to health equity for both our staff and our patients. Locally we have started employee resource groups for underserved populations among our staff. We have focused areas of our Prevention work (through the Mt Ascutney Prevention Partnership) on surveys for LGBTQ+ teens. We have distributed grants to multiple community partners, ranging from school districts to local court systems to support their efforts around health equity and restorative justice.

Wait Times:

We are prepared to submit this requested information on or before the August deadline.

Risks and Opportunities:

The two largest risks in the coming year relate to staffing and inflation. Relative to staffing, healthcare has lost an incredible number of workers over the last two years. New graduates are in short supply and there seems to be a down turn in healthcare careers in many clinical disciplines. Traveler costs and wage/benefit market competition are more than concerning. As a border hospital, we are competing against NH facilities that have no regulatory limitations on expense and rate increases. While our employee engagement scores are very strong, the concept of "grass may be greener" is influencing

employees to seek out better arrangements. Typically, we are a bit tight in staffing and we may be forced to increase staffing to insure that we attract and retain employees to provide for a perceived "better" work environment. Our budget reflects an additional cost of $376K for travelers/locums for the coming year. 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.

Inflation in virtually all areas (equipment, supplies, staffing, purchased services, etc.) is at unprecedented levels with no end in sight. We have seen supply and demand issues increase the cost of contrast material 1,700% as one example. Pressures on product produced in other countries is not only a supply and demand issue, but also reflects an opportunity for these producers to just increase their cost without repercussions. Freight and delivery costs are sky rocketing. Literally any supplier can increase prices without consequence.

Barring radical changes in the severity of the virus, we have become relatively stabilized in managing COVID as it relates to access and care. We have a limited footprint in telehealth and telemedicine. It has not been well received by patients nor providers.

Vacancy rates at MAH are as high as they have ever been, but are the lowest in the D-H system. Below is the vacancy rate and turnover rate by discipline:

CURRENT VACANCIES

Department	Position		# Positions	# Vacancies	% Vacant	
CARE MANAGEMENT	CASE MANAGER	NURSING	3	1	33.3%	TRAVELER(S)
EMERGENCY DEPARTMENT	NURSE (RN)	NURSING	7	3	42.9%	TRAVELER(S)
INPATIENT ACUTE/SWING	NURSE - LICENSED NURSE ASSISTANT	NURSING	8	2	25.0%	TRAVELER(S)
INPATIENT ACUTE/SWING	NURSE (RN)	NURSING	22	4	18.2%	TRAVELER(S)
INPATIENT REHABILITATION	RN CARE COORDINATOR	NURSING	1	1	100.0%	
LABORATORY	LAB ASSISTANT/SPECIMEN PROCESSOR	CLINICAL	3	1	33.3%	
LABORATORY	MEDICAL TECHNOLOGIST (MT)	CLINICAL	7	1	14.3%	TRAVELER(S)
MAINTENANCE	General Maintenance	GENERAL/ADMINISTRATIVE	6	1	16.7%	
NURSING ADMINISTRATION	HOUSE SUPERVISOR RN	NURSING	4	1	25.0%	
NURSING FLOAT	NURSE - LICENSED NURSE ASSISTANT	NURSING	1	1	100.0%	
NURSING FLOAT	NURSE (RN)	NURSING	1	1	100.0%	
NUTRITIONAL SERVICES	DIETARY AIDE II	CLINICAL	3	1	33.3%	
OPHTHALMOLOGY	OPHTHALMOLOGIST	PHYSICIAN	2	1	50.0%	
OPHTHALMOLOGY	OPTOMETRIST	PHYSICIAN	2	1	50.0%	
OPHTHALMOLOGY	OPHTHALMOLOGY TECHNICIAN	CLINICAL	3	1	33.3%	
OR/SAME DAY SURGERY	CENTRAL STERILE TECHNICIAN	CLINICAL	1	1	100.0%	
OR/SAME DAY SURGERY	NURSE (RN)	NURSING	6	1	16.7%	TRAVELER(S)
PHYSICAL THERAPY	PHYSICAL THERAPIST	CLINICAL	8	1	12.5%	
PHYSICAL THERAPY	PHYSICAL THERAPY ASSISTANT CERTIFIED	CLINICAL	2	1	50.0%	
PRIMARY CARE OHC	MEDICAL ASSISTANT (CERTIFIED-CMA)	CLINICAL	3	1	33.3%	
PRIMARY CARE OHC	SECRETARY	GENERAL/ADMINISTRATIVE	3	1	33.3%	
PRIMARY CARE WINDSOR	PRIMARY CARE COORDINATOR	NURSING	1	1	100.0%	
PRIMARY CARE WINDSOR	MAPP INR RN	NURSING	1	1	100.0%	
PSYCHIATRY	PHYSICIAN	PHYSICIAN	1	1	100.0%	
PSYCHIATRY	NURSE PRACTIONER	NURSE PRACTITIONER	1	1	100.0%	
RADIOLOGY	TECHNOLOGIST	CLINICAL	7	1	14.3%	TRAVELER(S)
REGISTRATION	PATIENT ACCESS REP/REGISTRAR	GENERAL/ADMINISTRATIVE	5	1	20.0%	
RESPIRATORY THERAPY	REGISTERED RESPIRATORY THERAPIST (RRT)	CLINICAL	5	2	40.0%	TRAVELER(S)
SPECIALTY CLINIC	UROLOGIST MD	PHYSICIAN	1	1	100.0%	LOCUM
SPECIALTY CLINIC	CLINICAL SECRETARY	GENERAL/ADMINISTRATIVE	3	2	66.7%	
	TOTAL		121	38	31.4%	
	TOTAL FTE's (NOT BODIES) VS. OPEN POSITIONS:		364.66	38	10.4%	

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Turnover is also a concern as well. While we track total turnover and "voluntary" turnover, we do not track by position per se. We have provided the following table to illustrate the changes over the last few years as requested. In discussing this issue, our biggest concern is not necessarily our turnover rate. 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, etc. 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.

Turnover FY18 - FY21

Volutary/Non-retire

	FY18			FY19			FY20			FY21		
	Terms	FTE	Turn Rate %	Terms	FTE	Turn Rate %	Terms	FTE	Turn Rate %	Terms	FTE	Turn Rate %
Primary Care MI	1	20.5	5%	1	21.0	5%	2	22.7	9%	5	22.9	22%
Speciality MD	0	9.5	0%	0	9.0	0%	0	9.0	0%	3	10.6	28%
RN	9	62.3	14%	11	65.0	17%	9	66.9	13%	8	67.6	12%
Nurse Support	8	39.4	20%	10	38.8	26%	8	36.8	22%	5	35.2	14%
Other	18	204.0	9%	23	206.8	11%	39	216.7	18%	16	216.5	7%
Total	36	335.7	11%	45	340.6	13%	58	352.0	16%	37	352.8	10%
Invol/Retirement	-3	335.7	-1%	-13	340.6	-4%	-28	352.0	-8%	-4	352.8	-1%
Adj. Total	33	335.7	10%	32	340.6	9%	30	352.0	9%	33	352.8	9%

We are leveraging many different things to improve staffing (recruitment and retention). Here is a partial list of the initiatives that we have done and are doing:

- Increased tuition benefits (building our own…LPN/LNA to RN, etc.)
- Leverage external tuition reimbursement programs
- Loan forgiveness
- Signing and longevity bonuses
- National/international recruiting
- 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)

Value Based Care Participation:

We are asked to consider participation in APM programs without any clear detail regarding the programs; this is untenable for an organization with small margins and without any evidence of benefit from participation in OCV programs for the last 5 years. Partnering with BCBS and other private insurers whose focus is clearly cost containment and not clinical outcomes is also challenging. The most recent public communication from BCBS regarding cost control in the face of financial challenges faced by virtually every hospital in VT is evidence of where that organization sees it role

We would need predictability and the ability to generate revenue to meet current rising expenses to consider additional engagement with OCV beyond the current Medicare and Medicaid programs

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In general, our investment in provider practices and outpatient care management preceded our engagement in OCV, largely through Blueprint funding. That said, Blueprint funding does not cover all the necessary investments needed for complex care management and we have continued to hire nurses and social workers to meet our community needs. We have relied on grant funding outside of OCV and blueprint to sustain our Family Wellness Program. We have budgeted less for Blueprint in FY23. We have also hired an analyst to assist with analysis for all of our programs, value based or otherwise. We have also invested in a Physician champion for all of these programs.

As the pandemic has progressed, we have begun addressing Substance Use Disorder, suicide prevention, and social drivers of health (housing, access to mental health services, etc.). These initiatives have already begun to be integrated in our HSA's community health groups. The measures of these initiatives are continued reduction of overdose and deaths in Windsor County, lowered rates of suicide within our service area, improved workforce housing, and successful recruitment of more mental health providers in our service area.

OCV quality reporting is reviewed and discussed in our quarterly Primary Care Quality meetings. Strategies, insights, and adjustments are determined and appropriate responses are implemented.

Supplemental Data Monitoring:

We will be prepared to submit this requested information on or before the August deadline.

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

Sincerely,

David C. Sanville
C.F.O.