Dartmouth Health

Mt. Ascutney Hospital and Health Center

Green Mountain Care Board Budget Presentation

August 22, 2022

Presenting

- Joseph Perras, M.D., CEO/CMO
- David Sanville, Chief Financial Officer

Agenda

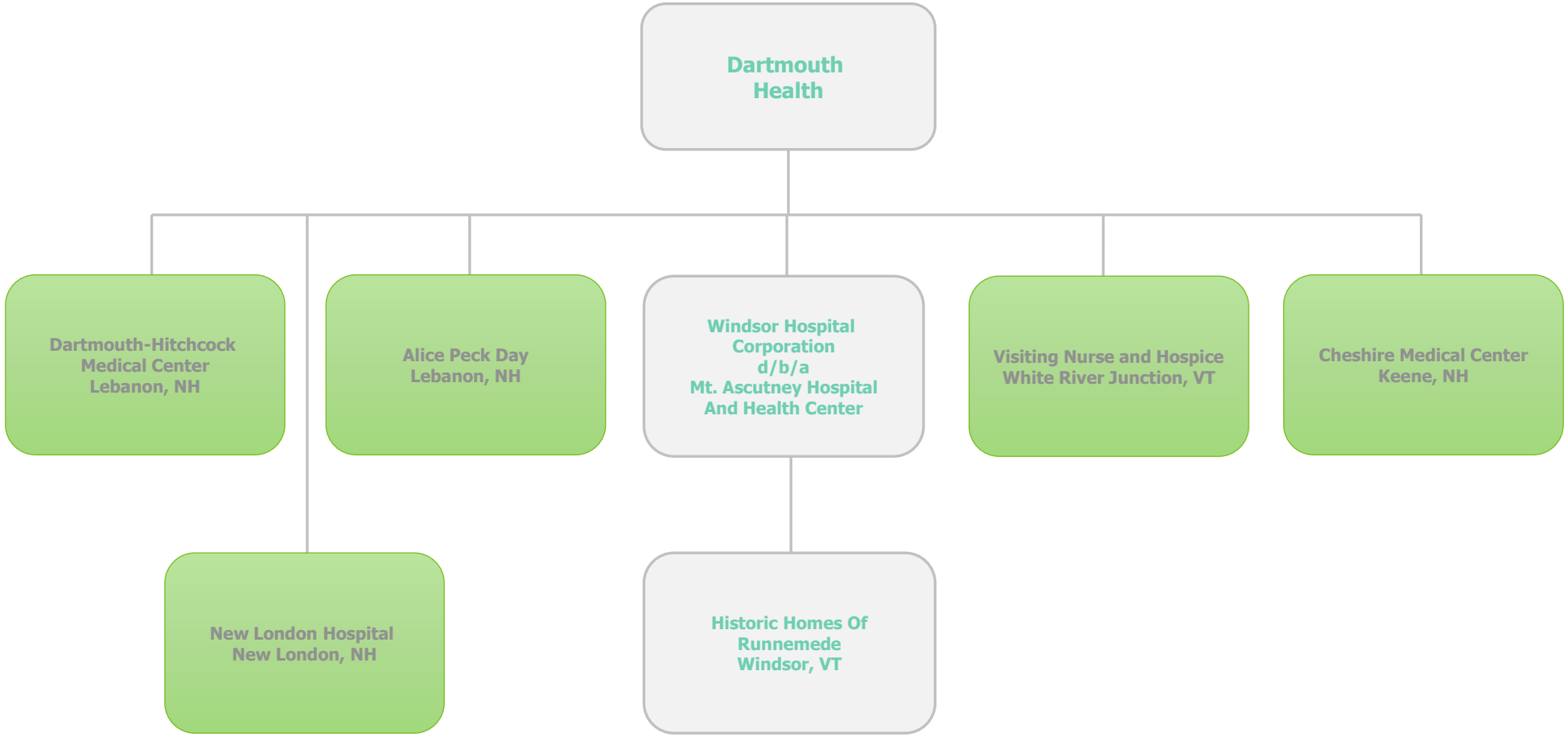
1. Overview
2. Requests
3. Financial Information
4. Equity*
5. Wait Times*
6. Risk/Opportunities
7. Value Based Participation
8. Capital Investment Plans
9. Supplemental Monitoring*
10. COVID-19

1.0 Overview

1.1 Our Mission

To improve the lives of those we serve.

1.2 Organizational Chart



1.3 DH Integration Activities

- Finance
- Supply Chain
- Pharmacy
- Regional Laboratory Services, Pathologists & Radiologists
- Medical Staff Functions - System Credentials Committee
- Regional Healthcare delivery planning
- Specialty Medical & Surgical service line coordination
- System-Wide Strategic Planning
- Operations/Shared Services/Shared Staffing
- Information Technology

1.4 Current Service Lines

- Primary Care
- General Surgery
- Podiatry
- Ophthalmology
- Psychiatry
- Hospital Medicine
- Community Health
- Pathology/Laboratory
- Pediatrics
- Physical Medicine and Rehab
- Pain Management
- Radiology
- Rheumatology
- Gastroenterology
- Cardiology
- Telehealth in Emergency Medicine and Psychiatry
- Urology
- Neurology

Red = D-HH Provider

1.5 Recent Patient Satisfaction Scores

Patients who reported that their nurses "Always" communicated well.	81%	National average: 80% Vermont average: 83%
Patients who reported that their doctors "Always" communicated well.	88%	National average: 80% Vermont average: 83%
Patients who reported that they "Always" received help as soon as they wanted.	75%	National average: 67% Vermont average: 72%
Patients who reported that the staff "Always" explained about medicines before giving it to them.	68%	National average: 63% Vermont average: 67%
Patients who reported that their room and bathroom were "Always" clean.	90%	National average: 73% Vermont average: 77%
Patients who reported that the area around their room was "Always" quiet at night.	63%	National average: 63% Vermont average: 57%
Patients who reported that YES, they were given information about what to do during their recovery at home.	93%	National average: 86% Vermont average: 90%
Patients who "Strongly Agree" they understood their care when they left the hospital.	56%	National average: 52% Vermont average: 55%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	85%	National average: 72% Vermont average: 77%
Patients who reported YES, they would definitely recommend the hospital.	87%	National average: 71% Vermont average: 76%

2.0 Requests

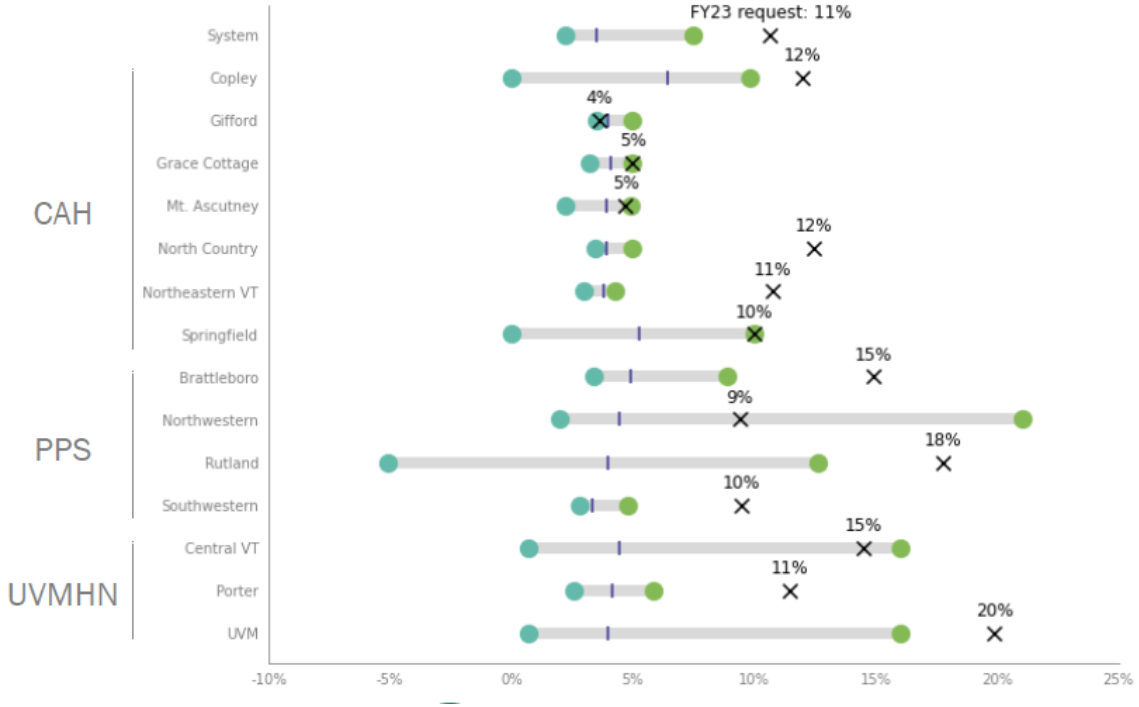
- **FY23 Price Increase:**
  - Rank 12 of 14 VT hospitals (1=highest)
  - Rank 6 of 8 VT CAH's
- **NPSR/FPP Increase**
  - Price increase plus volume

MAHHC
Request for NPSR and Rate Increase

	FY22 Budget	FY23 Budget	Change
NPSR	$ 59,640,912	$ 65,869,470	10.4%
Rate	2.20%	4.70%	

Requested Change in Charge (%, FY2017-2023)

VERMONT GREEN MOUNTAIN CARE BOARD



3.0 Profit and Loss

MT. ASCUTNEY HOSPITAL & HEALTH CTR PROFIT AND LOSS STATEMENT	
2023 BUDGET SUBMITTED	
GROSS PATIENT CARE REVENUE	$136,535,714
DEDUCTIONS FROM REVENUE	-$69,840,570
NET PATIENT CARE REVENUE	$63,480,412
FIXED PROSPECTIVE PAYMENTS & RESERVES & OTHER	$2,389,058
TOTAL NPR & FPP & RESERVES & OTHER	**$65,869,470**
OTHER OPERATING REVENUE	$3,587,855
TOTAL OPERATING REVENUE	**$69,457,325**
TOTAL OPERATING EXPENSE	$68,284,201
NET OPERATING INCOME (LOSS)	**$1,173,124**
NON-OPERATING REVENUE	$1,558,900
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	**$2,732,024**
OPERATING MARGIN %	1.69%
TOTAL MARGIN %	3.93%

3.1 Balance Sheet

MT. ASCUTNEY HOSPITAL & HEALTH CTR BALANCE SHEET	
2023 BUDGET SUBMITTED	
TOTAL CURRENT ASSETS	$17,265,235
TOTAL BOARD DESIGNATED ASSETS	$37,993,913
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	$18,611,554
OTHER LONG-TERM ASSETS	$8,226,195
TOTAL ASSETS	$82,096,897
TOTAL CURRENT LIABILITIES	$16,429,437
TOTAL LONG-TERM DEBT	$21,338,524
OTHER NONCURRENT LIABILITIES	$800,000
TOTAL LIABILITIES	$38,567,961
FUND BALANCE	$43,528,936
TOTAL LIABILITIES AND FUND BALANCE	$82,096,897

3.2 Cash Flow

MT. ASCUTNEY HOSPITAL & HEALTH CTR Cash Flow Statement		
2023 Budget Submitted		
Cash From Operations		
Excess Revenue Over Expense		2,732,024
Depreciation/Amortization		2,572,812
Patient A/R		(753,485)
Other Changes		574,009
Total	$	**5,125,360**
Cash From Investing Activity		
Capital Spending		
Change in Accum Depr Less Depreciation		
Change in Capital Assets		(3,581,000)
Total		**(3,581,000)**
Increase/(Decrease)		
Other LT Assets & Escrowed Bonds & Othe		(1,809,234)
Total		**(1,809,234)**
Total	$	**(5,390,234)**
Financing Activity		
Total	$	(300,000)
Other Changes		
Change in Fund Balance Less Net Income		-
Total	$	-
Beginning Cash	$	**10,733,519**
Net Increase/(Decrease) in Cash	$	**(564,874)**
Ending Cash	$	**10,168,645**

3.a.1 NPR/FPP Assumptions

- **Volume**
  - Estimated with consideration of:
    - Budget FY20 & FY21
    - Actual FY19, Actual FY20, pre-COVID FY20, Actual FY21, & YTD FY22
    - COVID-related limitations & recovery
    - Other known changes in operations, providers, staffing pressures, etc.
  - Inpatient (versus FY22 annualized)
    - Acute days increasing 9%
    - Swing days decreasing 3%
    - Inpatient Acute Rehabilitation days decreasing 3%

3.a.2 NPR/FPP Assumptions

- **Volume**
  - Outpatient (versus FY22 annualized)
    - Emergency Room down 4% to normal levels
    - Infusion decreasing 11% to normal levels
    - Laboratory decreasing 2%
    - Outpatient imaging decreasing 1%
    - Outpatient Operating Room flat
      - No anesthesia revenues
  - Outpatient Therapies (versus FY22 annualized)
    - Respiratory Therapy down 14%
    - Physical Therapy down 4%
    - Occupational Therapy down 1%
    - Speech Therapy down 6%

3.a.3 NPR/FPP Assumptions

- **Volume**
  - Clinics (versus FY22 annualized)
    - GIM increasing 11%
    - Pediatrics increasing 5%
    - OHC increasing 22%
    - Psychiatry decreasing 23%
    - Rheumatology increasing 6%
    - Oncology down 6%
  - Clinics continued (versus FY22 annualized)
    - General Surgery increasing 5%
    - Pain Management decreasing 50%
    - Physiatry increasing 48%
    - Podiatry decreasing 12%
    - Ophthalmology decreasing 15%
    - Neurology is increasing 17%
    - Urology is flat

3.a.4 NPR/FPP Assumptions

- **Payer**
  - Commercial – No significant changes expected in reimbursement rates
  - Medicare – Predominantly cost-based reimbursement, should track with costs/inflation except for…
    - Sequestration 2% reinstated
    - IRF/IPPS for Rehab Unit expected to be less than inflation
    - Provider fee schedule expected to be less than inflation
  - Medicaid – Our assumptions are that Medicaid maintains the same overall reimbursement level
    - Medicaid does not historically cover inflation

3.b Change-in-Charge Request

Charge Master Increase Schedule (Charge Increase)				
Area of Service	FY 22 Budget Total Charge Master Increase ($)	FY 22 Budget Total Charge Master Increase (%)	FY 23 Budget Total Charge Master Increase ($)	FY 23 Budget Total Charge Master Increase (%)
Hospital Inpatient (Incl. SNF & Rehab)	$ 734,027	2.2%	$ 1,807,072	5.5%
Hospital Outpatient	$ 1,390,387	2.2%	$ 3,687,262	4.9%
Professional Services	$ 490,991	2.2%	$ 696,205	3.0%
Other (specify)	$ -	0%	$ -	0%
Overall Increase in Gross Revenues Across All Categories	$ 2,615,405	2.2%	$ 6,190,538	4.7%

3.c Adjustments

- **iii Adjustments (provider transfers and/or accounting adjustments)**
  - No provider transfers
  - No changes in reporting/accounting

3.d Other Operating and Non-Operating Revenue

- 340B = decreasing 7% from FY22 (Manufacturers)
- Blueprint Funding – Reduced reimbursement & additional uncertainty
- Rentals, cafeteria, etc. = FY22 + inflation
- Grants change according to contracted revenues/contracted commitments
  - Grant revenues down versus FY22 budget and projections
  - $210,000 subsidy
  - No signed agreement, not considered
- “Rented” Staff on par with FY22
- Investment Income:
  - 4.5% return (realized and unrealized) BDF
  - 1.0% return (realized and unrealized) Restricted
- Fundraising: $250k

3.e.1 Expenses

Salaries/Wages/Benefits:

- 3% increase entered for all employees (effective 10/1/2022)
  - 2% merit/COLA
  - 1% market/replacement
- Small increase for health benefits better than industry trend
- 3% employer contribution for 403b
- FTE's…
  - Budget 2022 to 2023 = flat
  - COVID-related – 6 FTE's

3.e.2 Expenses

Non-Salary/Benefit Expenses:

- Supplies @ 8% inflation adjusted by volume
- Purchased Labor up 11%, inflation + increased usage
- Purchased Services are increasing 8.6%
  - Shared Services Assessment from DH $1,121k (from $328K)
- Utilities up 21%
- Interest decreasing slightly
- Depreciation increasing 11%
- Provider Tax = increase by net revenue increase and service mix

3.f Operating Margin and Total Margin

MAHHC Margins			
	FY22 Budget	FY22 Projection	FY23 Budget
Operating Margin	1.7%	1.0%	1.7%
Total Margin	3.6%	0.3%	3.9%

FY22 Projection Impact Items (revenues):

- ED Boarders
- Subacute Boarders
- Discharge restrictions
- Increasing Medicaid %
- 340B revenues cut by manufacturer actions

3.f Operating Margin and Total Margin

MAHHC Margins			
	FY22 Budget	FY22 Projection	FY23 Budget
Operating Margin	1.7%	1.0%	1.7%
Total Margin	3.6%	0.3%	3.9%

FY22 Projection Impact Items (expense):

- Travelers, locums and contracted labor
- Wage pressures (recruitment/retention)
  - Smaller work force, limited market, more competition, The Great Retirement, etc.
  - Fill rate lagging normal-ish turnover rate
- Inflation
- Supply Chain (supply & demand)

4.0 Equity

- Mt. Ascutney Prevention Partnership devotes significant resources to increasing health equity in the communities we serve
- MAPP receives funding from several sources: about 20%, from 3 grants, ($112,000 in 2021) supports work on diversity, equity, and inclusion.
- Trainings over the past several years have developed our understanding of key issues such as implicit bias and the importance of applying an equity lens to our work.
- MAPP helps to strengthen community connections and build environments that promote health and well-being for all. Recent initiatives to promote diversity, equity and inclusion are highlighted below.

4.0 Equity (con't)

- The Prevention Center of Excellence (PCE) at MAHHC is a joint initiative of MAPP and the Health Care Collaborative. A Primary PCE goal is to reduce disparities in substance use rates and increase protective factors for youth
  - Dashboard built to track indicators in several areas related to youth substance and to highlight comparisons for disparate populations
  - Sub-awards made to numerous organizations over the past 3 years, many focused on reducing disparities and promoting equity (restorative justice programs, LGBTQ+ programs)
  - Please see formal responses to HCA questions as submitted previously for extensive review of Health Equity Initiatives sponsored or led by MAHHC, MAPP and the PCE

4.0 Equity (con't)

- Sharing Data with Stakeholders
- The Windsor JEDI committee invited MAPP to present Youth Risk Behavior Survey data on health disparities in risk and protective factors in Windsor County schools.
- Presentation highlighted health disparities, particularly around substance use and mental health, among LGBTQ+ students and Students of Color
- Presentation led to invitation to present the data to the Mt. Ascutney School Board in December 2021. Conversations continuing with the JEDI committee and school board.
- Concrete follow-up activities include providing feedback on a draft policy for preferred names/pronouns in Mt. Ascutney school district & working to support WSESU participation in the Getting to Y program, involving students in changing outcomes.

5.0 Wait Times

Clinics	New Patient/Long Appointment	# Days	Follow Up/Short Appointment	# Days
Cardiology	10/18/2022	127	7/27/2022	44
Gastroenterology - NP	6/21/2022	8	6/20/2022	7
Gastroenterology - MD	7/7/2022	24	6/30/2022	17
General Surgery	7/7/2022	24	6/30/2022	17
Oncology	6/22/2022	9	6/15/2022	2
Ophthalmology	1/10/2023	211	6/28/2022	15
Optometry	7/7/2022	24	6/30/2022	17
Pain Medicine	10/10/2022	119	9/26/2022	105
Pediatrics	6/22/2022	9	6/24/2022	11
Podiatry	7/12/2022	29	7/8/2022	25
Primary Care	7/13/2022	30	6/15/2022	2
Psychiatry	8/2/2022	50	6/30/2022	17
Rheumatology	3/6/2023	266	1/3/2023	204
Urology	7/8/2022	25	7/6/2022	23
Neurology	7/14/2022	24	7/5/2022	15
Physiatry	6/24/2022	4	6/23/2022	3
	Average	**61**	**Average**	**33**

5.0 Wait Times

Radiology Modalities	3rd Appt available	# Days	Follow Up/Short Appointment	# Days
Routine X-ray	7/11/2022	3	N/A	N/A
Fluoroscopy	8/11/2022	14	N/A	N/A
CT	7/12/2022	4	N/A	N/A
Ultrasound	7/18/2022	10	N/A	N/A
Echocardiogram	8/30/2022	53	N/A	N/A
Bone Denosty	7/18/2022	10	N/A	N/A
Mammography Screening	7/13/2022	5	N/A	N/A
Mammography Diagnostic	7/19/2022	11	N/A	N/A
MRI	7/18/2022	10	N/A	N/A
	Average	**13**		

5.0 Wait Times (con't)

- We do not routinely/systematically report on wait times for scheduling appointment
  - We do routinely solicit feedback on wait times for scheduled appointment (waiting/exam room)
- We routinely look at improving wait times for scheduling
  - No shows/cancellations
  - Can make incremental improvements
  - Material improvements require add'l providers, staffing, etc. increasing costs and NPR
  - Difficult to recruit 0.1 or 0.2 FTE in providers/staff to increase capacity
  - Regional/national issues for some specialties
  - Limited market for recruiting
  - DH contracted providers based on availability and tertiary/quaternary facility needs

5.0 Wait Times (con't)

- Guiding principles for scheduling:
  - Urgent and acute same day slots "reserved" for providers
  - Walk-in services available weekdays/business hours
  - Patients have option of seeing another provider if availability exists
  - Urgent needs are prioritized (new acute issue or existing/exacerbated issue)
  - Mid-level providers and other support staff enlisted to assist for better throughput/access

5.0 Wait Times (con't)

- Guiding principles for referrals:
  - External e-referrals, phoned referrals, self referrals, & paper referrals are all made electronic so that they can be tracked
  - Internal referrals are electronic so that they can be tracked
  - Referrals are triaged and managed according to urgency
  - Outstanding/unresolved referrals are reviewed by the clinic daily
  - Varying protocols based on condition, specialty, etc.

5.0 Wait Times (con't)

- Recommendations:
  - Simple measure over time, periodic measurements
  - Not sure that it makes sense to invest in this effort without the approved flexibility in cost and revenue
  - Some specialties will be difficult to address due to availability in market, regardless of tracking/reporting
  - Regionally-determined, rational service allocation would help
    - Border hospitals are problematic with little or no limitations on neighboring states
    - Buy-in will be near impossible

6.0 Risks

- **COVID-19**
  - New Variants
  - Sustain testing, evaluation and vaccination efforts (boosters, younger age groups) in a time of acute and chronic labor shortages?
- **Healthcare workforce**
  - Significant regional pressures as DHMC competes with Boston for talent.
    - Driving wage and benefit expense up locally
    - New patient tower in 2023 at DHMC which will require hundreds of nurses and other staff to operate

6.1 Risks

- **ACO engagement**
  - Requested to remain in 2 Core programs for 2022 (Medicare, Medicaid) as approved by our BOT
  - Waiting on OCV BOM vote on whether that will be allowed or not
  - If not, we won't participate in any ACO programs for 2023.
    - There is no organizational enthusiasm to increase engagement
  - Downside risk could be a concern when National Emergency declaration ends
  - Specialty (expensive) care occurring elsewhere
    - No controls nor influence
    - Largest spend in orthopedics, psychiatric care, and all specialty care at DHMC.
    - Most of our region's ortho care occurs in NH
- **Staffing recruitment and retention**
  - Wage pressures continue
  - Housing
- **Uncontrollable inflation**

6.2 Opportunities

- **Regional Planning**
  - We are continuing to work closely with Valley Regional Hospital in Claremont, NH and that work will accelerate in 2023
  - Rational distribution of scarce health care resources and necessary services is imperative if we are to continue serving our communities
  - Significant regional instability in workforce, housing, and access to care

- **Increasing and Improving Services Lines**
  - Working to stabilize and grow Urology program to meet regional need
  - No other immediate plans to add to our current portfolio of clinical service lines

7.0 Value Based Care Participation

Value-Based Care Program	Participating in Program in Calendar Year (CY) 2023? (Yes/No)	Budgeted Number of Attributed Lives (monthly average for CY 2023)	Budgeted Amount of FPP (monthly average for CY 2023)	Budgeted Maximum Upside/Downside Risk for CY 2023
Medicaid	Yes	1,894	$ 2,314,058	$ 74,643
Medicare	Yes	1,672	$ -	$ 425,357
Commercial	No			
BlueCross BlueShield	No	0	0	0
MVP	No	0	0	0
Self-Insured	No	0	0	0

7.1 Value Based Care Participation

i. Referencing the data submitted in Appendix 5, if there are any value-based care programs that the hospital is **not** participating in for CY 2023, **please explain why and describe any barriers that exist.** What changes, if any, to each of these programs would need to be made in order to facilitate your participation?

Response: We have limited clinical/admin bandwidth to engage in any programs beyond the well-run Medicaid program and challenging Medicare program. Assumption of any additional down-side risk in a time of great uncertainty was not tenable for our Board of Trustees. As hospital margins continue to shrink, our leadership felt strongly that this was a time to tighten operations and focus on the core functions that will sustain our safety net hospital. I remain convinced that rural CAHs are not meant to be the “tip of the spear” when it comes to significant health care reform that puts already tenuous finances at risk

7.2 Value Based Care Participation

ii. Understanding that the pandemic has just started to recede, what changes in **each** of the hospital's cost centers that relate to value-based care initiatives (e.g. population health management, care coordination, chronic condition management, etc.) have been made as a result of participating in the ACO? Be specific in describing each cost center and how it has changed since joining the ACO. **Additionally, speak to how the fixed payments or other ACO payments from OCV are or are not advancing value-based care at your hospital.**

Response: The foundations for complex care management were established by the Blueprint for Health, years in advance of OCV. Funding for community health teams (nurses, care managers, social work) have been partially covered by Blueprint and PHM funding with the hospital carrying a significant subsidy to sustain these efforts. All of this funding directly funds operations in our Primary Care and Pediatric Clinics including the aforementioned teams. The pandemic, waning or not, has not effected our efforts in complex care management. We focus our interventions in complex care management on the high and very high risk patients in the Medicare and Medicaid programs as attributed by OCV

7.3a Value Based Care Participation

iii. a. As the pandemic recedes, what specific population health priorities are emerging for the hospital?

Response: Our population (or Payer mix) has not changed except for a trend upward in Medicaid patients. In the adult population we continue to focus on general internal medicine care with a focus on preventative screening (mammography, colonoscopy, pre-diabetes). Our pediatric care has an ever-increasing focus on the social drivers of health with behavioral health, food insecurity, housing, substance use/misuse We pursue > $1,000,000 in grant dollars each year to support efforts around family wellness for our high risk patients

7.3b Value Based Care Participation

iii. b. How will each of these priorities be conveyed to providers to in order to impact care delivery?

Response: Our adult practitioners are given data each month regarding their/our performance on OCV population health measures. They design interventions to improve, where possible, performance measures. Workforce issues are hindering clinic operations and it can be challenging to focus on higher level care management when you don't have support staff, nursing, etc… to care for patients in the clinic setting.

Most of our grant funding serves to support programs that we have developed in response to provider requests for more resources to meet the needs of their patients/families.

7.3c Value Based Care Participation

iii. c. How will success be measured for each of these initiatives?

Response: We have readily available and actionable data from OCV for our Medicare and Medicaid attributed lives, our performance is easily assessed within that dataset

For our pediatrics population we also have OCV performance measures but much of our work around the social drivers of health will take a generation to see significant improvement.

7.4 Value Based Care Participation

iv. As of CY2022, OCV is providing each HSA with quarterly quality reports. How are the results of these reports being communicated to providers in a way that will impact care delivery and quality outcomes?

Response: see prior answer, this data is shared regularly with providers and specific responses to the data are initiated

7.4 Value Based Care Participation

v. A. Regarding the CY2020 settlement information for the hospital (Separate tables will be provided by GMCB), what are the planned investments of those dollars in furthering the hospital's health care reform goals? If no investments in health care reform were made with these dollars, how were they invested?

Response: Again, these dollars go directly into funding hospital operations and the subsidies required in Primary Care and Pediatrics, as well as covering gaps in funding for programs critical to mitigating the social drivers of health

7.4 Value Based Care Participation

v. b. If the hospital experienced a net shared loss during this time period, how is the hospital using that information to inform change to the delivery system?

Response: We did not suffer a shared loss

8.0 Capital Budget 2023

- 2023 budgeted at $3,581,000
- No CON's for 2023
- Potential CON to be filed in 2023 for 2024 (DH IT project)
- $4.5m in capital under-spending from FY20-FY22 (AoP up 14%)
  - Mostly facility/facility improvement
  - Bandwidth, supply chain, etc.
  - 38% less than budgeted

Capital Budget - FY23

Investment Type	Amount
Building and Building Improvement	$ 2,595,000
Land and Land Improvement	$ -
Major Moveable	$ 986,000
Total	$ 3,581,000

9.0 Supplemental Data

- Market Share
  - Market share is relatively important to us and we look at it since OCV inception
  - Difficult to respond accurately to questions/be helpful without a better understanding of data
- Reimbursement
  - Also need to better understand the data in order to provide a meaningful answer
  - Inpatient includes some distinct differences than our peers and other Vermont hospitals
  - Pricing Issues
- Demographic Data
  - Definitions of HSA (service area) are significantly different
  - Tend to budget from actual trend and not so much from these types of data sources

10.0 COVID-19 Impact

Previously addressed

Dartmouth Health

Mt. Ascutney Hospital and Health Center

Thank you.