Dartmouth Health

June 30, 2023

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

Re: Budget 2024 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 1.5% operating margin which is relatively consistent with last year's submission.

FY23 has been another year of ongoing changes, uncertainty, and challenges. The pandemic has challenged us on an organizational and individual level. While the pandemic is largely in the rearview mirror for the moment, the new normal and the current environment is radically different than what we would have expected as we emerge from the pandemic. Unexpected and uncontrollable consequences and impacts are a constant challenge for staff and management.

Common themes that you undoubtedly have heard, continue to require changes in how we manage to our mission. The Great Resignation (staff retirement, relocation, reduction in enrollment in healthcare programs, etc.) has radically changed the marketplace of human resource. The resulting cost increases associated with travelers, employee retention, incentives, market increases, overtime, and the resulting impact on benefit costs are unprecedented. While supply chain issues have improved, we still experience shortages, freight and product inflation, project delays, etc. Utility costs, alternative sourcing efforts, and housing costs all contribute negatively to the cost of running a hospital. 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.

Thankfully, 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 insure that our communities and employees are getting what they need, whenever possible.

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Our 2024 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 guess at a future state, and the changes we have experienced as we all emerge from the pandemic.

From a volume perspective, we are looking to recover to pre-pandemic levels for provider clinics. We experienced significant turnover in providers (primary care, psychiatry/behavioral health, urology, in particular) for retirement, relocation, leaving the industry, etc.), as well as, some reductions in hours as aging providers enter the glide path towards retirement after three difficult years. We have contracted with some providers who will be arriving in the upcoming months, we have engaged some locum tenens, 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 getting back to pre-pandemic levels of service in our clinics and will positively impact our surgical volumes. We anticipate improved access with minimal additional costs.

Inpatient volumes are largely consistent in total. Due to limitations relative to nursing homes and health, swing bed census has grown 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. Our acute rehabilitative census will be relatively unchanged, year to year.

Outpatient volumes will reflect the improvement in provider staffing and the reduction of COVID-related testing. Most ancillary departments will be relatively unchanged year to year. Despite opening up "walk-in" appointments for our primary care services, emergency services continue to exceed expectations even with the reduction of COVID-related encounters. Radiology and laboratory will largely return to historical levels, following the current actual trends that we have experienced in FY23. 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 increasing, primarily due to getting a stable Urology presence for the first time in two years, some partial provider FTE increases in the areas of general surgery, gastroenterology, and ophthalmology.

Our healthcare reform efforts and participation with OneCare Vermont (OCV) are expected to continue as will ongoing integration efforts with the Dartmouth Health system. 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 projections provided by OCV. Most notably, our reserve levels are a bit less (proportionately) than we have budgeted over the last several years.

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 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.

MAHHC continues to work with DH and Valley Regional Hospital in Claremont, NH relative to a potential affiliation. This affiliation request has been submitted the State of New Hampshire and we expect an answer in the coming months. If this affiliation is approved, MAHHC and VRH will move

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. Additionally, MAHHC and VRH have already begin to share and contract managers and staff where it can be mutually beneficial. We currently share managers in laboratory, respiratory, and rehabilitation. We have shared staffing for a 340B analyst, respiratory float positions, rehabilitation, etc. 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, etc. We have discussed and planned coordinated service line changes to reduce cost and to improve access.

Other Operating Revenues have been extremely impacted. Most 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 $1m+/- net benefit to the bottom line and is now down to less than $400k 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. We are now living in this concern.

We have continued to focus on expense management, minimizing the effect of uncontrollable factors, and keeping the ship steady. 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 the highest employee engagement with 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 who do not have to deal with a state income tax. It puts us at an unfair disadvantage as a border hospital. We have budgeted a 3% increase in wages.

Compensation/market increases are managed against DH-initiated studies from Sullivan Cotter generated periodically during the year. This covers all positions, staff, managers, and senior leaders. The Board if Trustees is kept appraised of these studies and the Compensation Committee reviews compensation in detail.

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

Most other expenses are increasing due to inflation and current run rates. We are migrating to the DH benefits platform in FY24 and while there are some reductions administratively, budget to budget, we are seeing an increase in our employee utilization of health benefits which is likely due to hesitancy/limitations during COVID. Utilities are more favorable than prior year and there is an uptick in

depreciation as we try to catch up on capital expenditures. Supply increases reflect infusion volume trends, arguably our most cost intensive and revenue intensive service on a per unit basis.

Net Revenues and FPP:

Our blended rate (price) increase is 5.1% for FY24. Most of the facility charges will be increasing by 6.5%. Physician/provider charges are increasing 3.5%. This results in approximately a 2.5% net revenue gain from the price increase. Our pharmacy prices are based on acquisition cost so no price increases are applied to pharmaceuticals. As noted previously, with the unapproved price reduction initiatives from prior years, we are going into the new fiscal year with smaller pricing changes (cumulative) than documented and approved.

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, DH expectations, and our Board's expectations. We review (and revise if necessary) our reimbursement model (trending reimbursement rates and payer mix) 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. The administrative effort required to be in these relationships has become unbearable for our clinical staff and is forcing us to add staff just to get paid what we used to get paid with less 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 hit, 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 FY24. 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.

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Questions:

a. **Adjustments**

No adjustments requested for FY22 actuals or other considerations required for the proposed budget.

b. **Factors used in proposed budget**

i. **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.

ii. **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

iii. **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 and other trade sources
- Inflation added to expected formulary/volume by product.

iv. **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

v. Commercial price changes

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)

vi. Financial indicators

As stated earlier, our primary focus is based on the producing a reasonable margin for all interested parties. Once determined, we insure that the margin expectations will work with our financial indicators. Most importantly, we look at Days Cash on Hand, Age of Plant, and whether our Cash Flow is adequate under the lens of key indicators and pressing needs. Given the current environment (deflated investment market, 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.

vii. Known pricing changes for Medicare and Medicaid

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).

viii. Uncompensated care

Our bad debt and free care expense is 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, run fairly consistently. Obviously, the pandemic has affected norms so we made our best estimate based on history and our current trend.

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c. **Risks**

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

In the face of an aging Vermont population, rising demand, and staffing shortages, healthcare employers are facing an ever increasing burden. Healthcare continues to lose workers to retirement and burnout, and the industry is unable to fill the gaps they 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 $1.4m for travelers and locum tenens staffing for the coming year, a significant increase from prior years. Note that relative to travelers, we always budget the wage and benefits for the FTE's necessary to execute our operational plan and then 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 labor.

Vacancy rates at MAH are as high as they have ever been, but MAHHC has the lowest turnover rate in the D-H system. While our employee engagement scores are very strong, the concept of "grass may be greener" is influencing employees to seek out other possibilities. As a border hospital, we are competing against NH facilities that have a greater ability to remain competitive due to their favorable regulatory and tax environments. Our "re-fill rate" is really the problem with a smaller market for available resources and the competitive disadvantage that we have on this side of the river. Housing (inventory of homes for sale and rental properties) is another major contributor. Our C.E.O. and DH leadership are actively involved in trying to address this local and regional issue. We have purchased three units over the last two years to assist with traveler costs and to provide temporary housing for new providers and staff while they search for housing.

Much of the voluntary turnover relates to hospitals cannibalizing each other because there is a limited pool of candidates. This results in increasing costs as we are now competing with each other for the same people, now more than ever.

We are executing a number of strategies to improve staffing, including:

- Increased tuition benefits (building our own…LPN/LNA to RN, etc.) **$50K**
- Leverage external tuition reimbursement programs **$24K**
- Loan forgiveness **$75K**
- Signing and longevity bonuses **$20K**
- National/international recruiting **$60K**
- 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 (in traveler budget)
- Revamping work schedules (no cost)

- Incentive pay for critical shifts **$70K**
- Expanded support of healthcare teaching institutions via educational/clinical experience
- Employee appreciation/benefits **$50K**
- Enhanced employee wellness programs **$60K**

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. As Medicare and Medicaid programmatic risk comes back on the table, it places a significant financial stress on a traditionally lean organization. We will need to recognize this risk via reserves ($500K), which limits resources that could otherwise go to patient care. The incentives provided, Population Health Management (PHM) payments ($160K) and bonuses, are eaten up by participation fees ($450K) and risk pool contributions. The costs of health reform, such as embedded social workers in clinics ($188K), family wellness programs ($195K), community health coordination ($52K), clinic care management teams ($209K), patient insurance liaisons ($85K), and so much more, far outweigh the ACO's PHM and other direct support. Additionally, our small 'n' drives volatility.

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 is one that we all share, yet hospitals are facing the financial burden of providing the service, and the implication of financial fallout from success.

On top of regulatory pressure to reduce costs, we are expected to maintain community-based services (most of which produce negative margins), improve access, and improve quality. While these are all clearly priorities that we can all agree on, they come with a cost not currently built into our system. They create a conflicted and uncertain operating environment, and only adds additional administrative efforts and costs.

In addition to these two major risks, we are dealing with all many risks that have been ongoing for many years: increasing dependence on Other Operating Revenue, diminishing returns on our core business, increasing administrative costs due to regulatory requirements, reductions in DSH payments, increases in Provider Tax, the costs of new technology and best practices, little control over the labor market, inflation, provider departures, etc.

d. <u>Corporate Structure</u>

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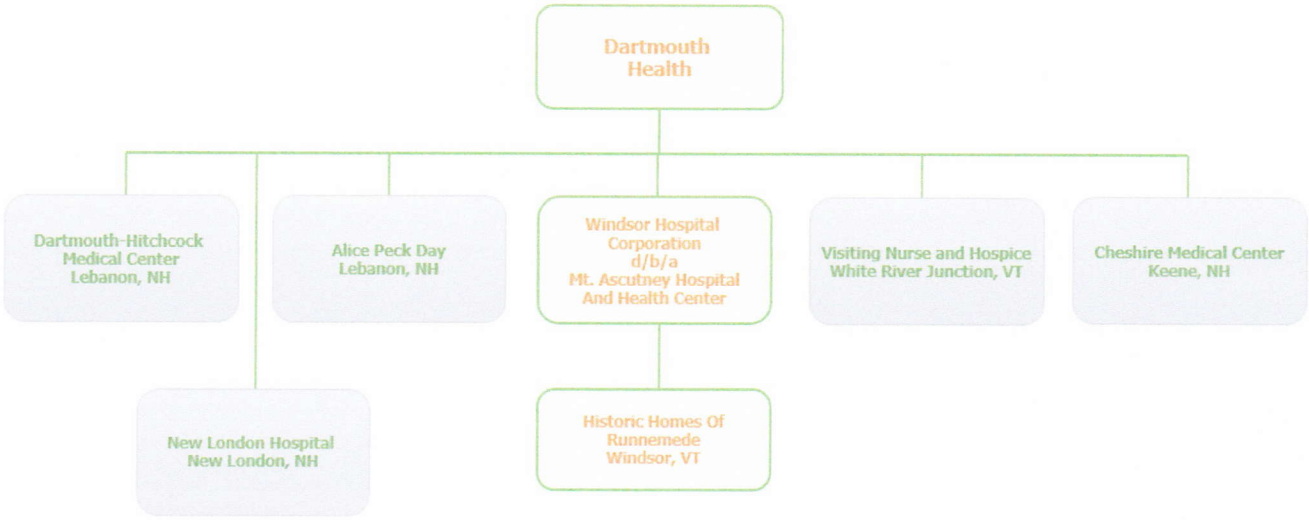

e. 1. **Referral Lag –** Percentage of appointments scheduled within 3 business days of referral

Referral Lag

Service	%
MAHHC-OHC-Psychiatry	63%
MAHHC-Windsor-GeneralSurgery	87%
MAHHC-Windsor-GI	75%
MAHHC-Windsor-HemaOncologyInfusions	50%
MAHHC-Windsor-Neurology	71%
MAHHC-Windsor-Opthalmology	100%
MAHHC-Windsor-PainManagement	100%
MAHHC-Windsor-Physiatry	45%
MAHHC-Windsor-Podiatry	62%
MAHHC-Windsor-Psychiatry	89%
MAHHC-Windsor-Respiratory	100%
MAHHC-Windsor-Rheumatology	100%
MAHHC-Windsor-Urology	89%
CT Abdomen/Pelvis (MAH)	20%
CT Chest (MAH)	43%
MR Brain (MAH)	45%
MR Spine (MAH)	39%
US Abdomen (MAH)	50%
Grand Total	**66%**

2. **Visit Lag –** Percentage of new patient appointments scheduled for the patient to be seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling days.

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	Visit Lag			
Service	2 Weeks	1 Month	3 Month	Grand Total
MAPP Neuro	0%	67%	33%	100%
MAPP-Gastro	100%	0%	0%	100%
MAPP-GIM	0%	100%	0%	100%
MAPP-OHC	22%	78%	0%	100%
MAPP-Ophth	48%	48%	4%	100%
MAPP-Ophth-Hano	65%	35%	0%	100%
MAPP-Peds	80%	20%	0%	100%
MAPP-Physiatry	71%	29%	0%	100%
MAPP-Pod	100%	0%	0%	100%
MAPP-Surg-Wind	94%	6%	0%	100%
MAPP-Urology	100%	0%	0%	100%
MR Brain (MAH)	100%	0%	0%	100%
MR Spine (MAH)	83%	17%	0%	100%
US Abdomen (MAH)	100%	0%	0%	100%
CT Abdomen/Pelvis (MAH)	26%	74%	0%	100%
CT Chest (MAH)	85%	15%	0%	100%
Grand Total	61%	37%	2%	100%

f. Capital Expenditures

	FY24 Capital
Facilities	**$ 650,000**
Information Tech	**$ 125,000**
Major Moveable	**$ 2,475,000**
	$ 3,250,000

We underspent capital by $3.5m in FY22 and a projected $1m in FY23. While we have the financial capacity to catch up, our internal bandwidth, supply chain issues (availability and delays), unprecedented inflation, and a lack of availability of contractors have made it difficult to catch up. Major investments (>$200k) are for Surgical Equipment, CSR/Sterilization (required upgrades to meet increased regulatory standards), and facility/mechanical replacement (roof top units) comprise two thirds of the FY24 Capital spending.

g. Cyber Security

MAHHC resides within the DH network and therefore gets the benefit of cyber security of a tertiary care facility in a CAH.

Planned expenditures on Cyber Security include investments to expand multifactor authentication (MFA) to include our cloud-based applications including project management and EHR applications. The integration of MFA with Cerner access will allow us to expand the same

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level of security protections we have for our internal network to this hosted solution. D-H and affiliates will also be expanding our secure internet gateway application to provide additional protections from malware sites and be able to isolate Internet-based malicious code and prevent it from being able to run on our network. We are also looking at expanding current data loss prevention (DLP) protections to include the secure Internet gateway platform. The D-H system will continue with our cybersecurity assessment programs that include 3rd party penetration testing, incident response, and disaster recovery. Much of the investment in cybersecurity in the next year will be in labor. The D-H security team and IT departments are working together to reduce the number of staff reliant on VPN resources, eliminating/reducing the number of privileged accounts, and seeking ways to reduce our attack surface, and improve on our vulnerability management workflows.

That said, our security team is not in favor of broadcasting specifics on cyber security investments to protect our assets, as it also announces where we are most vulnerable. The expenses are realized at MAHHC through a shared service allocation from D-H, which is approximately 2% of the system expense.

h. Transfer Expense

With reductions in home health and nursing home availability (COVID impact), MAHHC has experienced an increase in boarders, patients who no longer require hospital-level services. Initially, most of them required acute/acute rehabilitative services or skilled swing bed services but discharge was not possible when the time came. As a result, they were unable to be discharged timely. Some patients were dropped off at the Emergency Room and were not able to be safely discharged. Many have complicated home and/or social situations that prevented discharge to home. For those that qualify, Vermont Medicaid may make the minimum payment of $250 per day. MAHHC cannot be paid by NH Medicaid due to being over the state line. Some patients, transferred from DH can be paid by DH under certain circumstances. Below is a chart outlining the basic economics of the situation.

Year	Patients	Boarder Days	Average Days/Patient	MCR Cost	Billed Charges	Payer Payments	Loss on Cost
2021	8	429	53.6	$1,057,446	$ 1,380,810	$ 172,886	$ (884,560)
2022	15	1,351	90.1	$3,609,940	$ 1,648,385	$ 561,289	$ (3,048,651)
2023 Proj.	23	1,239	53.9	$3,310,670	$ 2,101,636	$ 527,626	$ (2,783,044)

Relative to Emergency Room boarders, limitations in the behavioral health network (bandwidth, access, available beds, etc.) result in these stays. This, coupled with increased need during COVID, resulted in more boarders in the ER than in pre-COVID years. Below, the chart outlines the information requested.

Year	Patients	Boarder Days	Billed Charges	Beh. Health Dx
2021	62	162	$ 106,020	100%
2022	69	126	$ 117,990	100%
2023 Proj.	40	141	$ 68,400	100%

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The impact of boarders for inpatient and emergency room stays is included in our FY24 budget. We trend patient volumes, payer mix, reimbursement rates, etc. from actual 2023 (with an eye to the history). These trends are baked into our models. Thankfully, we are projecting an improvement for both categories for 2023 and therefore, an improvement in FY24. It should be notes that CAH's receive cost for "stand by time" in the Emergency Room. This is downtime where there is no patient to care for. A study we did a few years ago showed that we lost $10,000 of cost report reimbursement for one patient who stayed for 9 days waiting for a bed placement in Brattleboro.

i. **Pharmaceuticals**

FY20	($1,085,934.71)
FY21	($931,983.17)
FY22	($416,543.65)
FY23 Ann'l	($343,944.39)

The 340B chart above, reflects our net income on our contracted pharmacy business (retailer arrangements). These are net income amounts (income less pharmaceutical cost, less administrative costs, etc.) after all associated expenses. This net revenue is booked in Other Operating Revenue. In addition to this, we receive 340B discounts on medications administered in outpatient settings within the hospital. The annual amount of discounts on in-house medications that qualify for the 340B program generally run ~$200k per year. This is netted against pharmacy expenses (supplies) on the profit and loss statement.

The 340B program was initiated to provide benefit to rural and CAH hospitals, as well as other provider types to assist with the subsidy for offering primary care and other community-based services that are not profitable but necessary. Many of us have to rely on Other Operating Revenues to produce an operating margin since our core businesses do not produce margin. Because it falls into operations, it helps reduce price increases and makes up for services that we might not otherwise be able to sustain.

Over the last couple of years, pharmaceutical manufacturers began restricting 340B access to their products. It began with orphan drugs and now affects many of the most important and highly used medications that we all depend upon. These restrictions have crippled organizations who have depended upon this program to limit price growth and to support unprofitable but necessary service lines. These restrictions come at a time when many hospitals have struggled with margins during the pandemic and when some of the manufacturers have posted record margins. There is no meaningful support in Washington (draw your own conclusions) and there are no signs that this will change or be reversed. The new requirements to claw back this funding provide the manufacturers with new marketing data, pharmacy benefit managers with data to revise formulas and to maximize their rebates from the manufacturers. None of this helps patients, tax payers, employers, etc. We have budgeted based on the current trend. The newest wrinkle is manufacturers restricting how many retailers you can access 340b through.

j. **Facility Fees**

Emergency Rooms typically charge for the following:

- Facility Charges – 5 levels of charges based on time, acuity, complexity and a level charge for constant attendance
- Professional Charges - 5 levels of charges based on time, acuity, complexity and a level charge for constant attendance
- Ancillary testing, pharmaceuticals, IV's, etc.

Any patient who utilizes the ER is required to be charged for use of the department based on Medicare regulations. As a Critical Access Hospital, were are required to adequately staff an emergency room 24/7 as a condition of participation. The facility fees reflect the costs associated with meeting that condition. While there is an argument that it is the "cost of walking in the door", it is overly simplified. The facility level and professional level charges are charged on the actual services received by the patient by the provider, the nurse, ER technicians, LNA's, Patient Sitters, etc. Through our ACO-related efforts to reduce costs we have been making efforts to engage with patients in more cost effective (for everyone) settings. For the last eighteen months, we have re-directed over 700 patients away from the ER to a walk in service in primary care. We did not increase the facility fees to make up for 10% migration. Boarder bill payments are essentially capitated at the level charge and hospitals absorb the remainder. Patients waiting for transfer to Dartmouth or to our own floor are also capitated at the level charge, regardless of how long they stay. The facility costs include the care and attendance of the nurse and other non-provider staff. It also covers all of the overhead. Virtually all hospital charges reflect the overhead associated with the department, the care that was rendered, and the people who attended to the patient in the department. The ER is no different. A chart with the revenue associated with the facility charges is below.

	Gross Revenue	Payer Mix	Reimb $	Reimb %
Medicare	$ 1,892,926	42%	$ (681,453.36)	-36%
Medicaid	$ 969,803	22%	$ (223,054.69)	-23%
Commercial	$ 1,371,057	31%	$ (877,918.50)	-64%
Self Pay	$ 239,745	5%	$ -	0%
Total	$ 4,473,531	100%	-1,782,426.55	-40%

k. Patient Financial Access

i. Guarantors are advised of the availability of financial assistance with every billing. Additionally, when our receivables staff speak with guarantors and an inability to pay is identified, the guarantor is advised of our financial assistance program.

ii. We have collection contracts. The rates that we pay are market commensurate. It is a highly competitive industry and rates are typically established based on the amount of receivables received. There is likely very little variance between like-sized hospitals and different collection agencies. There is no revenue received. Any recovery from bad debt is netted against the bad debt expense (reducing expense). At this time, we are unwilling to provide this proprietary information without additional understanding of what problem we are trying to solve. We have a long-standing relationship with this firm, have excellent results, high customer satisfaction, and near zero valid complaints. A meeting has been scheduled to discuss this with HCA.

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iii. We have a standardized collection process that bills guarantors monthly for 120+ days along with a specific number of telephone attempts, based on account balance. If there is no response, the account is eligible for bad debt and assigned within the next couple of weeks after finishing the 120 days cycle. If there are mail returns and new addresses cannot be determined, the account will be assigned earlier than the normal time table. Applications for free care, payment arrangements, questions or complaints will likely extend the cycle until resolution is achieved.

iv. Recovered bad debt debts are not revenue. They are credited in the month that they are recovered against bad debt expense. If a prior year bad debt is recovered in this year, they are credited against this year's bad debt expense.

v. The hospital makes no effort to "credit score" a patient/guarantor" nor do we attempt to determine their ability to pay unless they request financial assistance or payment arrangements. We treat all patients who require medically necessary services without regard to their ability to pay.

vi. The hospital prefers to identify and qualify patients for financial assistance (Free Care, Payment Arrangements, Medicaid eligibility, COBRA-assistance, etc.) in advance of service being provided. Providers and staff are encouraged to refer patients when the patients are being scheduled or are seeking services if they learn that the patient is un- or under-insured. Patients are more likely to get the care that they need when they are less concerned about the financial implications. Our receivables people will also refer patient at any point in the collection process if they suspect or learn that there are financial concerns. Once approved for financial assistance, the approval/arrangement will stay in place for up to six months automatically if the patient/guarantor situation does not change.

vii. The hospital has not performed testing of their FPL ranges. We are unaware of any valid testing methodology to determine the benefit or detriment of alternative levels.

I. <u>Administrative Costs</u>

i. Admin Costs

Dartmouth Health

ADMINISTRATIVE COST BY ACTIVITY TYPE		
Business Unit Id	Business Unit	Amount Total
1448	BILLING	$ 816,446
1449	REGISTRATION	$ 351,128
1450	ADMINISTRATION	$ 2,155,093
1451	ACCOUNTING	$ 1,248,121
1453	NUTRITION SERVICES	$ 1,518,240
1454	HOUSEKEEPING	$ 960,173
1455	COMMUNICATIONS	$ 181,625
1456	MAINTENANCE	$ 2,219,417
1457	ON-CALL HOUSE & CONDO	$ 44,576
1459	STAFF EDUCATION	$ 438,758
1460	QUALITY /RISK MANAGEMENT	$ 1,104,345
1461	HEALTH INFORMATION	$ 437,116
1464	EMPLOYEE BENEFITS	$ 9,695,114
1466	PURCHASING	$ 481,010
1467	DEVELOPMENT	$ 226,092
1469	MARKETING	$ 428,761
1470	HUMAN RESOURCES	$ 650,609
1474	INFORMATION SERVICES	$ 1,778,078
Grand Total		$ 24,734,704

ii. FTEs

	FTE	Wages and Salaries	Average Salary
CLINICAL TOTAL	277.63	$ 25,626,801	$ 92,306
ADMINISTRATIVE TOTALL	95.75	$ 7,091,298	$ 74,061

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

Sincerely,

David C. Sanville
C.F.O.