HSF QUESTIONS FOR HOSPITALS

VERMONT
GREEN MOUNTAIN CARE BOARD

HOSPITAL 8: NORTHEASTERN VERMONT REGIONAL HOSPITAL (NVRH)

Follow-Up Questions and Requests Related to Your Budget Submission

On substantive variations from last budget

1. **What are your expected savings from switching from on-prem services to cloud?**
   There are no expected savings for switching from on-prem services to cloud based services in the FY2025 budget, but this will avoid having to add additional technical salary expense for being on-prem. There is a shift from capital costs and depreciation expense to a contracted purchased service expense, which is neutral to the overall expense budget. There will be efficiencies for our quarterly updates by being in the cloud environment. There will be less system down time and the time of day/night can be better planned for less disruption during peak hours.

On core justifications

2. **You've requested a high rate in part to invest $29 million in your facilities. Can you detail why these investments are necessary?**
   There are four major components to the facility upgrades. The four components and need for each upgrade are shown below:
   a) Expansion and renovation of the emergency department: NVRH is modernizing the emergency department (ED) to address a lack of space, lack of patient privacy and operations inefficiencies. The ED has not been significantly upgraded since the hospital was built in 1972. There were 9,000 annual ED visits in 1972. Today, there are approximately 14,000 annual ED visits. The ED currently has 9 treatment areas, and each is undersized based on FGI 2022 criteria. Based on current guidelines and utilization trends 13 treatment areas are required. Storage space in the current ED is woefully inadequate. The staff workspace is overcrowded, loud and lacks privacy. There is only one bathroom for patients. Additional information regarding the need to modernize the ED can be found in our ED and Laboratory Expansion CON application.
   b) Expansion and renovation of the laboratory department: The existing laboratory was built in 1994 and received only a minimal upgrade in 2007. The College of American Pathologists (CAP) Survey inspector's reports consistently include deficiencies related to lack of storage, inadequate staff work space and lack of patient privacy in the blood drawing area. NVRH's response to address the CAP deficiencies included our commitment to renovate and expand the laboratory as soon as practicable. Additional information regarding the need to modernize the laboratory can be found in our ED and Laboratory Expansion CON application.
   c) Expansion and renovation of the pharmacy department: The existing pharmacy space is also woefully undersized and out of compliance with current facility guidelines for a pharmacy department. There is inadequate staff workspace, inadequate storage space and the number of air exchanges in the current space do not meet current regulatory requirements. Plans to expand

the pharmacy department were first developed almost 10 years ago. It's time to finally move forward with those plans to address the numerous deficiencies in the existing space.

d) Upgrading emergency generators and chillers and new metal- structure building: New emergency generators are required to replace our 25-year-old generator and support the additional square footage resulting from the upcoming ED expansion and recent Mental Health Support Area addition. Two 450W generators will be purchased to provide redundancy in the event of a system failure. NVRH's existing chillers are 27-years-old. One of the chillers recently stopped working and is not repairable. The new chiller system and generators will service the entire hospital. Both the chillers and generators will be placed in a newly constructed metal-structure building.

3. **We commend you on your attempts to reduce wait times to your pain management clinic. Can you please provide more detail on how you've worked with North Country to avoid duplicating pain management services.**

   Leadership from NVRH and NCH have a long history of meeting to discuss opportunities to improve access to essential services without duplicating services, which would lead to inefficiencies and higher costs. For example, in 2011, the two hospitals formed an LLC to jointly operate a Sleep Disorder Clinic. The pain management clinic represents our most recent collaborative effort. NCH closed their pain management clinic. NVRH and NCH work together to efficiently coordinate care and access for NCH patients at the NVRH clinic.

On labor expenses

4. **Can you explain why your projected FY24 labor expenses are so much higher than budgeted?**

   The fringe benefit portion of labor expenses are much higher than budget. Projected FY24 fringe benefits are roughly 13.5% higher than the FY24 budget. Higher than expected health insurance costs are creating the majority of the unfavorable variance (NVRH's health insurance plan is self-funded)

5. **The reduction in contracted labor from FY24 (projections) to FY25 (budget) is very steep (~50% reduction). There is a ~3% increase in labor expense on the I&E which (one might expect) is on par with inflation expense and not what would be attributed to additional FTE hires. Can you explain why you've made these calculations?**

   Zero-based budgeting was used, primarily in in clinical areas, to determine appropriate core-staffing levels. This reduced the number of budgeted FTES in some clinical departments. Another reason for lower than expected FTE growth was continued implementation of staffing recommendations that were included in an Applied Management Services (AMS) report prepared in 2022.

On pharmaceuticals

6. **Does the 340B program reduce pharmaceutical prices for patients as well as the hospital? Can you please provide a sense of how much of the 340B discounts you're passing onto patients?**

   The 340B program reduces NVRH's pharmaceutical costs by $1.5 million annually. Without these savings we would need to raise an additional $1.5 million from rate increases. So essentially, all of the 340B program savings are passed on to patients in the form of lower prices for services.

7. **Do you make a profit off your pharmaceutical operations. If so, can you please specify how much. Please specify any profits made from the 340B program specifically.**

   NVRH does not receive separate identifiable reimbursement for just pharmaceuticals. As a result, there is no meaningful way to estimate reimbursement for pharmaceuticals for comparison to pharmaceutical costs.

On rate changes

8. **Why is none of price increase allocated to professional services?**
   Reimbursement for professional services is based on a fixed-fee schedule, not on the amount charged. Therefore, increasing prices for professional services does not yield any additional net patient revenue but, can result in higher co-payments for patients.

On capital expenditures

9. **Do you have a risk mitigation plan in the event that construction delays arise or in the event that unforeseen financial pressures arise related to your bridge loan?**
   We have identified opportunities to address construction delays or unforeseen financial pressures related to our bridge loan. Those opportunities will be evaluated and prioritized on an as-needed basis.

On uncompensated care

10. **What do you predict will be the financial impact of your new financial assistance policy? What do you expect will be the impact on patient utilization of financial assistance?**
    The new guidelines aren't materially different from our previous financial assistance guidelines. However, we anticipate that with the new financial assistance policy guidelines there will be some increase in the number of patients that will qualify for financial assistance. We also anticipate that as more patients qualify for financial assistance there will be a corresponding reduction in the level of bad debts. In summary, we anticipate a minimal impact in total uncompensated care write offs.

On zero-based budgeting

11. **Were the remaining expense categories given a flat rate increase? How did you determine the budget for the remaining budget items?**
    The budgets for the remaining expense categories were based on recent actual spending trends, and in some areas, adjustments were made for inflation.

On your workbook submission

12. **In Table 6 in the workbook, you attribute a high number of associated expenditures for just 5 episodes of patient boarding. Do you have a plan to prevent these expenses in the future?**
    The 5 episodes are for patients who were the most difficult to transfer to an appropriate facility. NVRH works diligently to transfer all patients from our hospital to an appropriate facility as quickly and efficiently as possible. However, delays in making those transfers are usually dependent on bed availability at other facilities and therefore beyond our control. There have been times when NVRH providers have contacted 10 or more facilities from Vermont, New Hampshire, Massachusetts and Maine, attempting to transfer a patient. We anticipate the State's efforts to improve access to mental health facilities will result in our ability to make more timely transfers of patients needing those facilities.

13. **In Table 7 in the workbook, the majority of departments fall well below even the 50th percentile. Can you explain these lower levels of productivity? What methods have you considered to improve these levels going forward?**
    We acknowledge that our departments fall below the 50th percentile, although seem to be on par with many of our peers. Efforts to improve productivity levels going forward include:
    - Continue to work on creating efficient schedules and maximize visit availability
    - Continued work on clinical documentation improvement (CDI)
    - Continue to add tools to help with efficiency: DAX, referral management tools, appointment confirmation systems

- NVRH is currently exploring opportunities to pilot AI to improve productivity
- Our CMO is developing a plan to produce and review with providers their individual w/RVU productivity as compared to benchmarks

14. **Please review the rate decomposition details you submitted as well as the "summary" tab and explain the following (where available, show supporting calculations):**
    a. **How did you arrive at the assumed rates of growth for price, volume, and payer mix shifts by payer?**
    Detailed calculations supporting our rate increase were provided in Adaptive and summarized below:

NVRH		
FY 2025 Budget		
NPR Rate Increase Justification		
Net Expense Increase		(6,465,737)
Net Increase Other Operating Revenue		1,490,720
Total NPR Change Excluding Rate		2,528,618
Operating Margin Change		273,728
Required NPR From Rate		**(2,172,671)**
NPR Per 1% rate increase	547,024	
Rate increase	4.50%	
NPR From Rate		2,461,610
Less Uncompensated Care Increases From Rate		(288,939)
Net NPR Increase From Rate		**2,172,671**

    The 2.5% volume increase was determined by looking at actual volume through May 2024 and estimating volume for the months of June- September using historical trends. The payer mix shift by payer is the difference is between FY24 to FY25 NPR minus change in NPR from rate and volume increases.
    b. **For non-zero values in the "other" column, how did you derive these estimates?**
    The $52,762 shown in the "other" column is an error. That amount should have been deducted from the amount in the payer mix column.

Other

15. **Do you think Medicaid is underfunding the cost of delivering care to your Medicaid patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.**
Yes, Medicaid is underfunding the cost of delivering care to our Medicaid patients. Per the Oliver Wyman report presented by Bruce Hammery, Medicaid reimbursement covers 65% of the cost of delivering care**.** Based on our calculations for FY23, Medicaid reimburses NVRH only 57% of the cost of delivering care to our Medicaid patients. The calculation is shown below:

	FY 2023
	Actual
Total Gross Revenue	249,483,133
Medicaid Gross Revenue	49,877,655
Medicaid % Gross Revenue	20.0%
Total Operating Expenses	120,953,743
Medicaid % Operating Expenses	20.0%
Allocated Medicaid Expenses	24,181,551
Allocated Medicaid Expenses	24,181,551
Medicaid NPR/FPP	13,684,658
Medicaid Operating Gain (Loss)	**(10,496,893)**
Medicaid NPR/FPP % Of Costs	**57%**

16. **Do you think Medicare is underfunding the cost of delivering care to your Medicare patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.**

Yes, Medicare is underfunding the cost of delivering care to our Medicare patients. Medicare reimburses Critical Access Hospitals at roughly 98% of cost (Cost + 1% less sequestration). The Medicare reimbursement for our Rural Health Clinics (Primary Care) is at cost, but the reimbursement for all of our other physician practices are at fee schedule level, which is below cost. Also, Medicare does not reimburse hospitals for their share of certain significant expenses, including the Health Care Provider Tax. Based on our calculations for FY23, Medicare reimbursed NVRH only 95% of the cost of delivering care to our Medicare patients. The calculation is shown below:

	FY 2023
	Actual
Total Gross Revenue	249,483,133
Medicare Gross Revenue	108,282,560
Medicare % Gross Revenue	43.4%
Total Operating Expenses	120,953,743
Medicare % Operating Expenses	43.4%
Allocated Medicare Expenses	52,497,260
Allocated Medicare Expenses	52,497,260
Medicare NPR/FPP	49,873,841
Medicare Operating Gain (Loss)	**(2,623,419)**
Medicare NPR/FPP % Of Costs	**95%**

17. **In the attached spreadsheet, please review the measures of financial health that we have calculated for your hospital. We have included the measure definitions. Confirm that these calculated values reflect your understanding. If your financial measures differ from our calculations, please review our formulas, provide your calculation, and explain why you believe your calculation is a better measure for your organization.**

We agree with all measures of financial health except Days in Accounts Receivable. The spreadsheet shows 166.7 Days in Accounts Receivable. Per our calculations, Days in Accounts Receivable are 32.9. Here is our calculation:

A	Net patient revenue (NPR)	125,024,468
B	NPR per day (A/365)	342,533
C	Net A/R	11,272,698
D	Days in A/R (C/B)	32.9