Choosing Health
Northeastern Vermont Regional Hospital

BUDGET NARRATIVE

A. EXECUTIVE SUMMARY

Provide a high-level overview of key considerations for the proposed budget. Include discussion of variations from the current year approved budget, including any assumptions about current year projections relative to the approved budget. Indicate areas where the proposed budget deviates from parameters specified in this Guidance, providing justifications for such deviations, including credible and substantive evidence to support those justifications.

FY 2025 BUDGET SUMMARY

NVRH's FY25 budget, approved by the Board of Trustees, aims for a balanced approach to growth and sustainability. Below is a comparison of key financial metrics from FY23 actual results, FY24 budget, FY24 projected outcomes, and the proposed FY25 budget:

Metric	FY25 Budget	FY 24 Projected	FY24 Budget	FY23 Actual
Net Patient Revenue	125,024,468	120,203,900	120,323,189	112,163,926
Other Operting Revenue	7,201,219	7,149,630	5,747,496	9,378,436
Total Operating Revenue	132,225,687	127,353,531	126,070,685	121,542,362
Total Operating Expenses	131,313,371	128,298,006	124,847,637	120,953,743
Net Operating Margin	**912,316**	**(944,475)**	**1,223,048**	**588,619**

Main Themes of FY25 Budget

1. Improving Access: Enhancing access and reducing patient outmigration within our service area.
2. Strengthening Partnerships: Building on existing partnerships to improve service availability and operational efficiency, with a special focus on our collaborative relationship with North Country Hospital.
3. Financial Stability: Implementing measures to achieve financial recovery and sustainability, targeting a 1% operating margin with a long-term goal of 3%.
4. Control cost growth: Part of NVRH's plan to achieve financial stability is our ongoing efforts to control expense growth and to create operational efficiencies.

STRATEGIC OVERVIEW

Northeastern Vermont Regional Hospital (NVRH) continues to evolve to meet the dynamic healthcare landscape. The post-pandemic era has underscored the need for accelerated organizational change to address significant industry-wide trends. Our strategic efforts focus on:

- Improving operating performance.
- Forming strategic partnerships.
- Enhancing the value of care for our patients (better outcomes at lower costs).
- Facilitating collaboration with community organizations.
- Broadening community benefits through increased access to care.

NVRH remains dedicated to patient-centered care and community benefit, evidenced by the following recognitions and initiatives:

1. Continued high patient satisfaction scores.
2. Recognition for excellence in rural healthcare delivery.
3. Strong partnerships with regional health organizations to enhance service availability.

Caledonia County faces several socioeconomic challenges that impact healthcare delivery and financial planning:

1. Demographics: The population of Caledonia County is aging, with a significant proportion of residents over the age of 65. This demographic trend increases demand for healthcare services, particularly chronic disease management and long-term care.
2. Economic Conditions: The County has a median household income lower than the state average, with a notable percentage of the population living below the poverty line. This economic reality can limit access to healthcare and increase reliance on hospital services.
3. Workforce Challenges: There is a shortage of healthcare professionals in the region, exacerbated by competitive job markets and the need for higher wages to attract and retain staff.
4. Housing: Affordable housing remains a critical issue, with many residents struggling to find stable and affordable living conditions. This impacts overall community health and well-being, influencing hospital admissions and outpatient service needs as well as impacting our ability to attract and recruit the workforce needed to care for our patients.

Despite our historical financial stability, the pandemic and other industry conditions have significantly impacted our financial performance. This narrative outlines our approach to navigating these challenges and positioning NVRH for a sustainable future.

For hospitals that are part of a network, affiliation, or have a financial arrangement with another legal entity (e.g. nursing home), explain any differences in what is happening at the hospital versus the network level, and quantify any financial impact on the hospital budget as a result of the relationship with any non-hospital entities.

Not Applicable to NVRH

B. BACKGROUND

a) Explain any changes that occurred to your corporate structure within the last year.

There have been no changes to our corporate structure in the past year.

b) Explain your approach to considering and participating in any corporate affiliations in which you or the other organization may have a financial stake.

NVRH currently engages in a corporate affiliation with the sleep center in partnership with North Country Hospital (NCH). We are focused on expanding and strengthening this relationship. Future affiliations will be considered based on their potential to enhance patient care, support long-term sustainability, and provide community benefit.

c) Describe and quantify the impact of any participation in regional collaborations with other service organizations or providers.

NVRH continues to foster strong regional collaborations to improve service delivery:

1. North Country Hospital (NCH): NVRH and NCH are working collaboratively to enhance service availability and patient care for the entire Northeast Kingdom, and have an active LLC partnership in providing sleep services. In recognition that we are stronger together, NVRH and NCH have embarked on an initiative to expand collaboration in our administrative services, clinical specialties, and training and education for our staff. Our goal is to identify and implement at least 3 collaborative opportunities and pilot/implement them in FY25, and we are meeting regularly to achieve this goal. We believe this collaborative effort will help stabilize access to specialty services, improve operations by sharing best practices, policies and procedures, and expand education/training opportunities for both our staff.
2. Northern Counties Health Care (NCHC): We maintain a strong collaborative partnership with the FQHC serving our region, including "Northern Express Care," which supports urgent and walk in primary care to ease utilization of hospital emergency services. NCHC is also an active member of NEK Prosper!.
3.Community Partners: Through NEK Prosper!, the regional Accountable Community for Health, we work with Northeast Kingdom Human Services, the NEK Council on Aging, Green Mountain United Way, and RCT. Collectively we lead initiatives supporting community wellbeing and addressing the social drivers of healthcare equity.
4. Littleton Regional Hospital: Our two hospitals, separated by the Connecticut River, have had a long-term partnership for ENT and allergy services.
5. Dartmouth Hitchcock (DHMC): As the closest tertiary care facility to NVRH, DHMC provides us cardiology services and telehealth services such as neurology. We are implementing a new lab services collaboration that supports the Norris Cotton Cancer Center and will bring more clinical trial opportunities to the North Country, supporting health equity.

d) **Explain and quantify any service-line closures, transfers, or additions since the prior year budget review, please explain.**

There have been no service line closures, transfers, or additions since the last budget review.

C. BUDGET QUESTIONS

a) **Concisely describe substantive variations from current year approved budget to current year projected, and to the proposed budget, in terms of service line changes (differentiate between new or divested services, and volume changes that necessitate changes in staffing), physician transfers, accounting adjustments etc.**

There are no substantive variations from the FY24 budget to the FY24 projected or to the proposed FY25 budget resulting from new or divested services or physician transfers. There are substantive variations due to a volume increase in our pain management clinic and an accounting adjustment.

In the FY25 budget, NVRH replaced fully depreciated, on-premises storage hardware with cloud-based storage applications. Annual depreciation expense for the on-premises hardware, which became fully depreciated in FY24, was $500,000. This drop in depreciation expense was offset by a $1.2 million increase in operating expenses for the cloud-based storage. The result of this quasi-accounting adjustment was a $700,000 net operating expense increase.

On a budget-to-budget basis, pain management clinic volume is budgeted to grow almost twofold. Reasons and justification for this growth are provided in our response to item (c) (b) Utilization, below. This growth has a material effect on NVRH's net patient revenue and expense growth as follows:

Pain Management Clinic	NPR	Increase to FY 25 Budget
FY25 Budget	1,947,519	0
FY24 Projected	927,480	1,020,039
FY24 Budget	1,196,971	750,548

Pain Management Clinic	Expenses	Increase to FY 25 Budget
FY25 Budget	1,748,363	0
FY24 Projected	854,911	893,452
FY24 Budget	731,316	1,017,047

b) **For each of the *Section I* benchmarks not met in the budget submission, explain and justify the deviation using credible and sufficient evidence.**

Benchmark # 1 – NPR growth 3.5% or less – From budget FY24 to budget FY25 NVRH's NPR growth is 3.9%. To enhance patient access, NVRH has staffed the pain management clinic with more personnel. Volume and NPR are consequently rising sharply. Budget-to-budget NPR growth is only 3.28% when the additional NPR from the additional pain management clinic volume is taken out.

Metric	Amount
FY25 Budget NPR	125,024,468
Less: FY24 to FY25 pain clinic NPR growth	(750,548)
Adjusted FY25 NPR	124,273,920
Approved FY24 NPR	120,323,189
Increase FY24 NPR to adjusted FY25 NPR	3,950,731
% Increase	3.28%

Pain Management Clinic	NPR	Increase to FY 25 Budget
FY25 Budget	1,947,519	0
FY24 Projected	927,480	1,020,039
FY24 Budget	1,196,971	750,548

Benchmark #2 – Commercial rate growth equal to PCE price index plus 1% (3.6% as of April 30, 2024) –
NVRH is requesting a 4.5% increase in commercial rates, which is .9% higher than the GMCB benchmark. In order to strengthen NVRH's balance sheet as we begin a $29 million investment in our facilities, a higher rate increase is necessary. An operating loss of $900,000 is projected for FY24. Our goal is to reach a breakeven from operations for FY24 and FY25, combined. We won't reach our target despite our best efforts to control expense increases, maximize other operating revenue streams, especially 340B revenue, and a rate increase of 3.6%. The additional .9% increase, a total increase of 4.5%, will get us to breakeven for FY24 and FY25, combined.

Controlling expense growth was a primary objective throughout the FY25 budget process. Our efforts included:

- Using zero-based budgeting for significant expense categories.
- Achieving savings to offset inflation increases in all but a few expense categories.

- Use of grant funds to offset operating expenses for strategic planning, a revenue cycle improvement study and a charge master review.

These, and other efforts, resulted in a case-mix adjusted cost per patient decrease of 2.8% from budget FY24 to FY25.

METRIC	FY 2025 BUDGET	FY 2024 PROJECTED	FY 2024 BUDGET	FY 2023 Actual
Total Gross Revenue	278,869,628	263,147,201	269,633,599	249,482,961
Inpatient Gross Revnue	53,355,968	50,568,426	52,393,125	47,492,883
adjustment factor	5.23	5.20	5.15	5.25
Total patient days	6,245	6,214	6,151	6167
Adjusted patient days	32,642	32,338	31,655	32,396
% Change FY25 budget to:		100.94%	103.1%	
CMI	1.2367	1.2367	1.1784	1.1784
CM Adjusted patient days	40,369	39,993	37,303	38,175
Total Cost	131,313,371	128,298,006	124,847,637	121,080,036
Cost per CMAPD	3,252.86	3,208.05	3,346.90	3,171.71
% Change FY25 budget to:		1.4%	-2.8%	2.6%

In addition to controlling expense growth, NVRH has worked strategically to maximize 340B retail revenue. On a budget-to-budget basis, 340B revenue will increase by approximately $2 million. As previously stated, our efforts to control expense growth and maximize other operating revenue left us $500,000 short of attaining our breakeven goal for FY24 and FY25 combined. That goal is tied to our need to strengthen our balance sheet as we make significant investments to modernize our facilities. Our request for an additional .9% rate hike gets will help us achieve our short-term goal for FY24 and FY25 and strengthen our balance sheet in preparation for the challenging years to come.

c) **Explain the assumptions embedded in your proposed budget for the following, providing evidence to support your assumption(s), as well as any substantive variations from FY24 (budget & projected). Please list any other factors not included below that may be material to your budget along with supporting material. This includes any assumptions that are uncertain but could have a potential budgetary impact. For such assumptions that are not reflected in your budget, please quantify the range of potential impact.**

   a. **Labor expenses. Differentiate between the use of employed versus contracted labor, separating nursing from other clinical, and non-clinical staff. Please highlight any trends that are specific to particular clinical domains.**

   NVRH is constantly striving to improve its efforts in workforce development, personnel recruitment, and retention. We go into more detail about some of our initiatives later in this budget narrative. Our FY25 budget assumes there will be fewer open positions for nurses, other clinical staff, and non-clinical personnel as a result of our efforts to recruit, retain, and grow our workforce. A corresponding assumption is a decrease in the utilization of travelers and locum tenens to cover critical vacant positions, as shown in the table below.

Position	FY24 Budget	FY24 Projected	FY25 Budget
RN	1,627,590	2,458,800	1,589,000
Other Clinical	66,500	1,315,000	310,000
Non Clinical	-	-	-
Total	1,694,090	3,773,800	1,899,000

b. **Utilization. Explain and quantify any anticipated changes in utilization across care settings (e.g. inpatient/outpatient), or any other expected deviations from historical trends. Indicate the method(s) used to derive utilization changes in proposed budgets. If utilization assumptions include increases associated with hiring additional staff or other capacity changes, provide evidence to support estimated impact on utilization.**

   The majority of services are expected to have increases in utilization of 2.5% over FY24 budget levels and .5% over FY projected volume. This assumption was made using current trends that have been modified for particular expected changes. The expected changes were made in the emergency and pain management departments. We anticipate ED visits will remain at FY24 projected levels during the expansion and renovation project, which will begin during FY25.

   A second physician and support staff have been added to our pain management clinic to improve access to this service. These positions will be filled by the end of FY24. With the addition of a second physician, volume is budgeted to increase almost twofold over current levels. Currently, pain management is scheduling new consults 10 weeks out, into late August and early September. Procedures are also scheduled about 10 weeks out. Follow-up appointments are being scheduled 30 days out. We currently have 97 new referrals that are being processed, and we receive about 30 new referrals a week. It is noteworthy that approximately 50% of new referrals are coming from the Newport service area. NVRH and North Country Hospital have collaborated to avoid duplication of pain management services in the NEK. These trends support our budgeted pain management clinic growth.

c. **Pharmaceutical expenses. Differentiate assumptions regarding growth due to price from volume, or product mix. Please estimate reimbursements received in excess of the cost of pharmaceuticals (FY23 actuals, FY24 budget, projection, & proposed budget noting how you arrived at those estimates. Include estimates for rebates associated with the 340B program.**

   On a budget-to-budget basis, pharmaceutical expenses will increase by only .5%, due to fewer patients requiring high cost infusion related medications. On a projected FY24 to budget FY25 basis, pharmaceutical expenses will increase by 4.3% due to inflation (3.8%) and volume changes (.5%). 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.
   Leadership in NVRH's pharmacy department does an excellent job of optimizing 340B savings on outpatient and employee pharmaceuticals, saving over $1.5 million per year.

d. **Cost inflation. Please explain any substantive changes and break out by medical and non-medical supplies and isolate the price effect separately from the utilization effect.**

   During the FY25 budget process, department leaders were challenged to achieve cost savings to offset inflationary increases. As a result, inflation as a percent of non-salary expenses is only 1.02%. Below are the only inflation allowances included in the FY25 budget:

CATEGORY	INFLATION %
FRINGE BENEFITS	0.7%
PROFESSIONAL FEES	2.3%
MANAGEMENT FEES	0.6%
UTILITY	3.7%
MEDICAL SUPPLIES	0.0%
DRUG EXPENSE	**3.8%**
NON MEDICAL SUPPLIES/INCL FOOD	6.1%
INSURANCE	4.6%

e. Case Mix Index (CMI). Explain any substantive changes in CMI by Payer, providing evidence to justify anticipated changes. Quantify any impacts on your budget by payer.

NVRH does not track case mix index by payer. Below is our CMI trend for all payers. Only a minimal amount of our total net patient revenue is based on case mix. Therefore, any impact on NVRH's FY25 budget is immaterial.

Fiscal Year	CMI
FY25 Budget	1.237
FY24 YTD	1.237
FY24 Budget	1.178
FY23 Actual	1.178
FY22 Actual	1.169

f. Rate Changes by Payer. Explain any assumptions related to rate changes for Medicare, Medicaid (e.g. In State/Out of State), and Commercial Payers overall and by setting of care (inpatient, outpatient, professional services).

The following rate change assumptions were made for the FY25 budget:
Medicare: As a CAH, NVRH receives cost-based reimbursement for inpatient and outpatient services. Rates will increase based on cost increases for those services. Four of our medical practices are Rural Health Clinics. Rates for professional fees in the RHC will increase based on the RHC's cost increase. Medicare rate increases were not budgeted for any other professional fees.
Medicaid: The budget assumes zero Medicaid rate increases for all services.
Commercial Payers: Commercial rates will increase by an average of 4.5%. The 4.5% average will be achieved by increasing rates for inpatient and outpatient services by 5% with no increase in professional services fees. Our rate request exceeds the GMCB's guideline. Justification for the higher rate request is provided in our response in Section C (b)4.

g. Capital Expenses. Explain any anticipated capital expenditures in the proposed budget, including a description of funding sources.

The total FY25 capital budget is $20,591,148. There are three categories of capital expenditures: Routine capital, CON project related and non-CON project related.

Routine Capital	FY25 Budget
Medical	1,240,170
IS	707,852
Plant Operations	145,431
Other Non Medical	13,815
Sub Total	2,107,268
Contingency	250,000
Total Routine Capital	**2,357,268**
CON Project Related Budget	FY25 Budget
ED Addition	7,224,505
ED Renovationns	578,529
Bond Issue and Cap. Interest	427,102
Total CON Project Related	**8,230,136**
Non-CON Projects Budget	FY25 Budget
Pharmacy	2,123,550
Chiller Building/Infrastructure	7,880,193
Total Non-CON Projects	**10,003,744**
Total FY 2025 Capital Budget	**20,591,148**

Funding for routine capital expenses will come from hospital operations. Funding for the CON and non-CON projects will be provided as follows:

- "Bridge" Loan $ 8,402,698
- Philanthropy $ 4,531,182
- Operations/Investments $ 5,300,000

Total $18,233,880

A bridge loan will be used to finance our facility expansion/renovation projects until all projects are completed in FY27. Terms of the bridge loan are currently being finalized. NVRH has secured a USDA Rural Development Community Facilities Program direct loan. There is a $16.5 million loan in total. The loan term is 36 years. For the 36-year loan term, an interest rate of 3.75% has been set in stone. Once all projects are finished in FY27, the "bridge" loan will be repaid with the USDA loan.

h. Financial indicators. Explain any changes (key drivers) to your Operating Margin, Days Cash on Hand, and Debt Service Coverage Ratio relative to your FY24 projections, as well as any other key financial indicators that are important to consider in relation to your budget request.

The trend of key indicators is shown in the table below.

Key Indicator	FY 25 Budget	FY24 Projected	FY24 Budget	FY23 Actual
Operating Margin	0.7%	-0.7%	1.0%	0.5%
Days in A/R	33	34	34	33
Days cash on hand	86	95	101	98
Debt service coverage ratio	4.82	2.57	6.48	5.07
Cash to long term debt	6.7	6.1	5.52	5.09

An operating gain of $1,223,048, or 1%, was budgeted for FY24. However, due primarily to higher costs for health insurance, travelers, and locum tenens an operating loss of $944,475, or

(.7%), is projected for FY24. A series of expansion, renovation, and facility upgrade projects will begin in the fall of 2024 and continue into fiscal 2027. In total, these projects will cost over $29 million. It is imperative that NVRH generate a positive operating margin in FY25 and beyond to rebuild cash reserves and support loan debt service payments. Our efforts to return to profitability in FY25 include:

- Making strategic changes to increase 340B retail revenue by $1 million over FY24 projections.
- Increasing access to services that will improve the operating margin.
- Taking a zero-based approach to budgeting for several high-expense categories, including staff salaries and the use of travelers.

These efforts, combined with a 3.6% commercial rate increase, will generate an operating margin of .25%. However, in order to strengthen our cash position and support future debt service payments, we are requesting a rate increase that is .9% higher than the GMCB guideline for FY25.

i. **Uncompensated care. Differentiate any assumptions/changes as they relate to exogenous trends (e.g. patient needs) or internal practices (e.g. changes in accounting or business processes) related to bad debt and free care. Please include a description of collection processes. Report your budgeted bad debt to free care ratio and how you derived your estimates for bad debt and free care**.

There were no changes to our uncompensated care assumptions due to exogenous trends. Changes were made to our financial assistance policy, effective July 1, 2024, to comply with Act 119. Those changes include: income eligibility changed from 200% of the federal poverty level getting 100% assistance to 250% of the federal poverty level now getting 100%. Under the old policy, patients at 250% were getting an 85% reduction. As a result of the above changes, we also modified other levels of assistance.

New Guidelines:

FPLG	<=0%-250%	251%-300%	301%-350%	351%-400%
Reduction	100%	70%	60%	50%

Old Guidelines:

FPLG	Up to 200%	201%-250%	251%-300%	301%-350%	351%-400%
Reduction	100%	85%	70%	57%	47%

Also, the liquid assets test to determine eligibility changed from $50,000 to equal 400% of federal poverty level.

Collection process: When the patient’s balance become self-pay they will receive their first statement within 10 days. This gives the biller’s time to make sure the balance is correct before the patient receive their bill. Patients receive three statements, one every 30 days. The patients will then receive a final notice letter giving them 30 more days to contact the billing department to set up a payment plan or apply for our financial assistance program. If neither of these steps are taken after those 30 days the account is turned over to our outside collection agency.

The outside collection agency will try to collect for another 6 months. If the patient doesn’t set up a payment plan or pay the balance in full the account is returned to us. At that time the balance is written off as a bad debt.

Uncompensated care trends, as a percent of gross revenue, are:

Metric	FY25 Budget	FY 24 Projected	FY24 Budget	FY23 Actual
Gross revenue	278,869,628	263,147,201	269,633,599	249,483,133
Bad debts	5,159,088	4,872,154	4,840,483	4,404,639
Free care	2,514,261	2,499,898	1,864,689	1,861,033
Bad debts % gross revenue	1.8%	1.9%	1.8%	1.8%
Free care % gross revenue	0.9%	0.9%	0.7%	0.7%

The slight uptick in projected FY24 bad debts is a result of a catch-up period created by changing collection agencies in FY23. Our FY25 uncompensated care budget was based on current trends. We anticipate the new requirements of Act 119 will increase free care write offs with a corresponding decrease in bad debt write offs.

j. Community Benefit. Differentiate between the various drivers of community benefit.

NVRH has a long-standing reputation for its commitment to whole-person wellness, focusing on need for healthcare and social care to create conditions that allow individuals to prosper. NVRH's commitment and investment in community health dates back well over 20 years, recognizing the substantial impact of the social drivers of health.

The Northeast Kingdom (NEK) is a region in which collaboration is the norm and organizations are committed the notion of collective impact, leveraging local resources and capacity to achieve common goals. The NVRH Accountable Health Community model—NEK Prosper!—predates the Blueprint for Health's community collaborative requirement, and is the primary vehicle in which continued engagement and collaboration occurs. The work of NEK Prosper! is focused specifically on health equity and multi-sectoral partnerships. The mission of NEK Prosper! is to "leverage relationships and collaborative action to build community health equity." The vision that drives this work is to achieve a "community where everyone is Financially Secure, Mentally Healthy, Physically Healthy, Well Housed & Well Nourished."

NVRH has developed the Community Health Needs Assessment (CHNA) process to align with NEK Prosper! for the current CHNA cycle, we've developed a Steering Committee to coordinate one NEK-wide CHNA, collaborating with North Country Hospital and many community partners. This approach furthers the commitment to a shared vision, creates efficiencies, and is affords substantial cost-savings as we have not hired consultants.

NVRH informs community benefit spending through the CHNA process, patient experience information, social determinants of health screening data, ACO population health measures, and via other informative opportunities. The aforementioned health priority information guides NVRH's community benefit spending to include sponsorships and donations for community organizations and wellness efforts; informs programming needs, such community health workers who are trained Vermont Health Connect Navigators; and illuminates priorities for funding provided in the way of community grants, including substance misuse prevention and health equity. The Lown Institute Hospital Index has ranked NVRH as number one in Vermont—and in the top 15 percent nationally—for community benefits. Using data from 2019, the Lown Institute Hospital Index community benefit metric took into account NVRH's spending on charity care, community health initiatives and Medicaid revenue as indicators for the top status.

NVRH also seeks grant support to further community health initiatives. For example, NVRH is slated to receive just under $951,000 in federal, state, and foundation grants to support community health

improvement work, including substance misuse prevention, health insurance enrollment, Blueprint for Health program staffing, and school-based community health worker programming.

d) Briefly summarize known risks in the budget as submitted, including the potential impact of and any known timelines associated with the risk, as well as any risk mitigation efforts, and their cost or potential benefit.

NVRH has identified several significant risks that could impact the FY25 budget:

1. *Inflationary Pressures:*
   - Small hospitals like NVRH are particularly vulnerable to inflationary pressures. While the budget assumes an inflation rate between 3-5%, certain items, such as medications and medical supplies, may experience higher inflation rates. This unpredictability poses a risk to our financial stability.
2. *Workforce Challenges:*
   - Wage Increases: We have budgeted a 2% wage increase. However, this may not be sufficient to remain competitive with market rates, especially for hard-to-recruit positions such as nursing and medical technicians (e.g., diagnostic imaging, lab technicians).
   - Clinical Professional Turnover: Turnover among clinical professionals poses a significant risk. When a specialty provider, particularly in areas with only one or two providers, leaves or retires, recruiting replacements and maintaining these services can be challenging.
3. *Fringe Benefits:*
   - The utilization-driven nature of fringe benefits presents a difficult-to-plan budget risk. Variations in benefit usage can lead to unexpected financial impacts.
4. *Healthcare Reform Efforts:*
   - Ongoing healthcare reform efforts in Vermont introduce uncertainty. This uncertainty can affect staff and provider retention, as individuals may consider relocating due to potential changes. It also complicates strategic planning efforts.
   - The FY25 budget assumes our 340B revenue will increase by almost $2 million on a budget-budget basis. Our 340B budget is based on solid assumptions, however the future of the federal 340B program and associated risks may negatively impact the budget.
5. *Other Industry-Wide Risks:*
   - The broader healthcare industry faces several risks that impact NVRH, including:
     - Labor Market Challenges: The labor market remains competitive and challenging.
     - Cybersecurity Threats: The risk and cost associated with preventing cyber-attacks are increasing.
     - Government Funding: Uncertainties around the funding of government programs can affect financial stability.
     - Rising Technology Costs: The cost of adopting and maintaining advanced technology continues to rise.
     - Workplace Violence: Increasing incidents of violence in healthcare settings pose both a safety and financial risk.

In summary, while NVRH has implemented strategic measures to mitigate these risks, the identified challenges require continuous monitoring and adaptive strategies to ensure financial stability and quality patient care.

e) Administrative vs. Clinical Expenses: using the Medicare Cost Report definition of administrative clinical, and mixed expenses in Wang & Bai (2023)[2], also defined in the Uniform Reporting Manual, please comment on the relative trends in each of these expense categories over time. If you believe the Medicare Cost Report definition does not accurately reflect your organization, please articulate how you would adjust the calculation and why, and provide an alternative estimate with sufficient detail that it can be cross-walked to the standard definition. Further, to the extent you make

modifications specific to your hospital, indicate which of your peers require such modification and the impact of such modification on each such hospital.

Trended expenses by category are shown in the table below. There are no material changes in the trends over this four-year period.

Fiscal Year	Clinical	Admin	General Services	Mixed	Total
FY25 Budget	54.4%	18.7%	4.3%	22.6%	100.0%
FY24 Budget	55.4%	19.3%	4.5%	20.8%	100.0%
FY23 Actual	55.5%	20.0%	3.9%	20.6%	100.0%
FY22 Actual	56.3%	18.5%	4.1%	21.2%	100.0%

f) Facility Fees: Please describe the methodology your hospital uses to establish any facility fees and how much they totaled in FY24 and are expected to total in FY25.

Six of NVRH's outpatient medical practices are provider-based. Patients at provider-based practices are billed for both a facility fee and a professional fee.

NVRH uses the following methodology to establish facility fees: For Medicare patients, the total fee is split between a facility component and a professional component. The professional fee component is roughly equal to 2x the Medicare fee schedule. The facility fee equals the total fee minus the professional fee. This methodology complies with Medicare requirements for hospital-owned provider-based outpatient medical practices. For non-Medicare patients, only the total charge is billed, as a professional fee. The total of the professional and facility fee billed to Medicare patients equals the total fee billed to non-Medicare patients. Details of our fees for Medicare and non-Medicare patients are in our price transparency file, which is available on the NVRH website.

In FY23, facility fees totaled $647,143. As of May 31, 2024 facility fees totaled $467,098. NVRH does not have a separate projection or budget for facility fees.

g) Does your budget increase request consider consumer affordability, and if so, how?

As with previous years' budgets, NVRH's has taken consumer affordability into consideration in its FY25 budget request. Among the examples are:

- Requesting the lowest rate request increase since FY22.
- Slowing expense growth and in fact decreasing the cost per adjusted patient day.
- Adding $2 million of 340B retail revenue. While raising 340B revenue reduces the amount of net patient revenue needed to produce a positive operating margin, it does not raise consumer expenses.
- Using grant income to pay for costs that would have otherwise been passed on to customers for charge master reviews, revenue cycle optimization, and strategic planning.
- Our patient accounting and community connections teams work hard to help patients qualify for insurance or our patient assistance program whenever there is a patient-responsible balance.

h) If your proposed rate and/or NPR increase request were to be reduced, provide a high-level description of your hospital's contingency plan for maintaining access to essential services and generating a positive margin.

If our proposed rate and/or Net Patient Revenue (NPR) increase request were to be reduced, Northeastern Vermont Regional Hospital (NVRH) would implement a high-level contingency plan to maintain access to essential services and strive to generate a positive margin. The contingency measures would include:

1. *Evaluation and Adjustment of Non-Essential Services:*
    - Service Line Assessment: Conduct a thorough evaluation of all service lines to identify non-essential services that could be reduced or temporarily suspended. This would ensure that resources are redirected towards maintaining essential healthcare services.
    - Program Reprioritization: Reassess and prioritize programs based on their impact on patient care and community health. Programs with lower impact or those that are not critical to immediate patient care may be adjusted.
2. *Operational Efficiency Improvements:*
    - Cost Reduction Initiatives: While opportunities are limited, we would implement cost-saving measures across the organization, focusing on areas such as administrative expenses, supply chain efficiencies, and energy use reductions. Explore opportunities to renegotiate vendor contracts for better terms.
3. *Revenue Enhancement and Workforce Management Strategies:*
    - Partnerships and Collaborations: Strengthen partnerships with local healthcare providers, community organizations, and stakeholders to leverage shared resources and support services. Collaborative efforts can help fill gaps and maintain essential services during financial constraints.
    - Selective Hiring Freezes: Implement selective hiring freezes for non-critical positions to control labor costs, while ensuring that essential clinical roles are filled to maintain patient care standards.
    - Flexible Staffing Models: Utilize flexible staffing models such as per diem and part-time staff to adjust workforce levels according to patient volume fluctuations, thus optimizing labor costs.
4. *Monitoring and Adjustment:*
    - Regular Financial Monitoring: Establish a robust financial monitoring system to track performance against the contingency plan. Regular reviews will allow for timely adjustments to strategies based on evolving financial conditions.
    - Feedback Mechanisms: Implement feedback mechanisms from staff and patients to identify potential issues early and make necessary adjustments to maintain service quality and accessibility.

By implementing these contingency measures, NVRH aims to preserve the quality and accessibility of essential healthcare services, even in the face of reduced rate or NPR increase approvals. This proactive approach will help ensure the hospital's financial health and its ability to serve the community effectively.

i) Provide all costs associated with (i) lobbying and (ii) marketing, advertising, and branding, and identify the amount paid to each entity that performed such services on your behalf.

NVRH does not directly spend any money for lobbying. However, of the total dues paid to VAHHS, roughly 7.8%, or $8,185, is reported to the State of Vermont as going toward lobbying. Also, of the total dues paid to the AHA, roughly 27.29%, or $6,427, is considered as going toward lobbying. Those expenses are used to create awareness of very important issues impacting the healthcare industry.

NVRH's marketing team is small, including 1 FTE Marketing Manager and .75 FTE Communication Liaison. The VP of Marketing and Community Health Improvement oversees and supports this team with the strategic vision, budget management, and alignment of objectives with the strategic plan at NVRH. The marketing team leverages the diverse skillset of each staff person to manage the majority of ad development, design, and other marketing and communication needs in-house. NVRH only utilizes our local graphic design partner, Flek, for specific needs. NVRH has worked with Flek for

decades, and relies on this partnership to maintain ads and placement, patient collateral, annual report development, and high-level branding, website, and design needs. Flek manages the ad placement based upon identified budget caps for these purposes, having long-standing relationships with local newspapers and other periodicals. Flek also manages the payment invoicing, streamlining it with their current invoicing schedule with NVRH. This payment process alleviates administrative burdens on NVRH's finance department, creating additional efficiencies. The cumulative costs during fiscal year 2024 that includes Flek's design services, ad placement, ad development, collateral development and printing, annual report development, website support, and other various needs totaled $105,287.71.

Overall, the marketing strategy at NVRH emphasizes low-cost opportunities to reach our community and target audiences, taking the most conservative budget approach. We maximize the use of social media, email networks, digital monitor displays, and other low- to no-cost channels for marketing and communication opportunities.

j) Describe planned fundraising efforts and anticipated donations for FY25.

All fundraising to benefit NVRH is tax receipted and held by its parent organization, the Northern Vermont Regional Corporation (NVRC), and as such is reflected in the financials for NVRC, not NVRH. Generally NVRC receives between $450,000 and $600,000 per year (not including pledges or estate commitments), with most donations restricted by donors for specific uses, and a portion permanently restricted for endowment. NVRC is currently engaged in a capital campaign for the Emergency Department and Laboratory Renovation, Construction, and Expansion Project until December 2025. The campaign goal is $5.5 million. To date, a total of $4.7 million has been received in cash and pledges toward our goal. Cash-in gifts for FY25 may be higher than the $450,000-$600,000 range as donors will be contributing to this significant expansion and renovation project.

Cash from the campaign will be transferred from NVRC to NVRH and recorded as a temporarily restricted net asset until the project is completed in 2027.

k) Describe projected investment income and, if projected to be zero, please provide a 3-year summary of annual investment income.

NVRH does budget operating investment income, interest income, as Other Operating Revenue. NVRH does not budget non-operating investment income, the majority of which is realized and unrealized gains, or (losses), on investments. Here is a 3-year summary of non-operating investment income (losses):

FY24 Projected: $3,000,000
FY23 Actual: $1,111,305
FY22 Actual: ($3,737,355)

l) Has your hospital experienced a reduction in payment from any payer based on quality performance in the last two years? If so, please explain the nature of the penalty, the revenue impact, and steps taken to remediate the situation.

NVRH has not experienced any payment reductions from any payer based on quality performance in the past two years.

m) Describe the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors, residency programs, and any other workforce development initiatives in which you are

participating. Include a description of the program and where the accounting entries show up in your proposed budget (income statement and balance sheet).

Career Advancement Program:
Workforce development continues to be a critical investment, through budgeted funding and successful philanthropic efforts. Our Career Advancement Program (CAP) saw 6 existing employees graduate as Certified Medical Assistants (CMA). We have 4 employees enrolled in the upcoming Licensed Practical Nurse, (LPN) and Associate Degree Nurse (ADN) Programs. Partner schools include Community College of Vermont, Vermont State University, White Mountains Community College, River Valley Community College.

Throughout the first year of the CAP, we were able to streamline the administrative and additional educational supports by utilizing existing internal clinical educators and leadership staff. Our Workforce Development Coordinator is also an experienced nursing educator. Utilizing existing resources decreased the projected FTE need from 3.4 to 2.6 budgeted for 2025.

The CAP is designed as a workforce development ladder, allowing staff to enter, at any level, to advance their career with significantly reduced or eliminated debt. It provides paid study time, educational support, and job placement upon completion. We are also seeing early indications CAP is helping with recruitment at the entry-level, with only 2 current vacancies for LNAs, and several entry-level positions filled with recent local high school graduates. Salaries for the CAP are included in the income statement as part of Salaries Non MD.

In addition to CAP, 5 existing LPNs utilized our tuition assistance benefit to continue their education and became RNs in the last year. NVRH also covers the cost for any employee who takes one of the local LNA programs, and provides schedule flexibility for class and study time. Tuition assistance is a fringe benefit and included in the income statement as part of Fringe Benefits Non MD.

New Graduate RN Program
This formalized program transitions the new nurse from an academic program into practice. The new nurse works with an assigned preceptor who guides, supervises and coaches the nurse through the program. We are contracting with an external partner for individual new grad RN preceptorship. We currently have 4 new graduate RNs starting in this program. Fees charged by the external partner as reported in the income statement as Other Purchased Services-Misc.

n) Please describe the hospital's investments in workforce retention such as housing, day care, and other employee benefits. Include a description of the program and where the associated accounting entries show up in your proposed budget (income statement and balance sheet).

Some of our primary investments in workforce retention focus on employee professional development and educational benefits. We were one of the first hospitals to offer a loan repayment benefit program, BenefitEd, for all employees who have college-level student loans. In addition, we offer physician and advanced practice provider loan repayment benefits tied to a minimum employment commitment of 5 years. All benefitted employees are eligible for our tuition assistance program for employees enrolled in classes which pertain to their careers at NVRH. We support and match any state-level clinical loan repayment programs for employees who apply and are awarded loan forgiveness packages. These programs are budgeted in the Fringe Benefit Tuition and Loan Reimbursement. We provide leadership development programs for leaders at all levels, both internally, and through St. Johnsbury Academy Adult Education.

NVRH is known for its competitive overall benefits package, which includes 3 health plan options, dental, vision, hospital-paid life insurance, and short-term and long-term disability. NVRH offers a 401k retirement plan with immediate vesting; the hospital contributes 3% for all employees, plus a 1.5% match.

Working to keep wages as competitive as possible, keeping aware of the market, and open communication with employees regarding their compensation is another area contributing to our retention. Compensation levels are consistently reviewed with local and regional healthcare compensation surveys, and this survey information is reviewed with employees when discussing wage levels.

o) For what drivers of expense growth do you feel hospitals should be "held harmless" and why?

Examples of expense growth drivers that hospitals should be "held harmless" include:

- Legislatively mandated new cost increases such as the Child Care Tax as hospitals have no control over these new expenses.
- Market driven increases required to recruit and retain staff. Maintaining a viable workforce is critical to hospitals ability to providing access to essential services. Providing market driven increases is required to recruit and retain staff and therefore to maintain access to services.
- Costs in excess of reimbursement related to patient boarding and transfer issues.
- Expense increases related to improving community access to services. An example is the additional expenses to expand our pain management clinic, which will significantly reduce wait times and improve access.
- Expenses related to community health improvement programs. These investments will, over time, improve the health of communities we serve and reduce health care expenditures.

D. <u>HOSPITAL & HEALTH SYSTEM IMPROVEMENT</u>

a) Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, please share any investments you are making and/or the steps you are taking to improve access in each of those areas, with specific ties to your budget, where appropriate.

Given the critical access challenges related to mental health, substance use disorder, long-term care, and primary care, NVRH is committed to making strategic investments and implementing initiatives to improve access in these areas. These efforts are tied directly to our budget and operational planning:

1. *<u>Mental Health:</u>*
    - <u>Investments in Behavioral Health Services:</u> We have applied for grants and allocated funds to continue to support our behavioral health team. This effort will help ensure patients have access to timely mental health services.
    - <u>Telehealth Expansion:</u> Investments have been made to enhance our telepsych infrastructure, enabling greater access to mental health services, particularly to address emergent needs.
    - <u>Collaborative Programs:</u> Partnering with local mental health agencies, such as Northeast Kingdom Human Services (NKHS), to co-develop programs that address community-specific mental health needs, including suicide prevention. Additionally, NVRH has a unique role to other HSAs that is designed to work closely with community-based organizations to address transitions of care gaps, enhancing care coordination, and establishing suicide prevention pathways. This position supports reporting and quality improvement work related to ACO clinical and population health measures, building a culture of Team Based Care, and engagement to identify and address systems-level gaps between health and social care.
    - <u>Blueprint for Health Community Health Team Expansion Pilot:</u> NVRH, as the administrative entity for the St. Johnsbury Health Service Area, has worked diligently to ensure that all NVRH primary care practices, as well as Northern Counties Health Care, participate in this expansion pilot program. This program ensures capacity for screening, brief intervention, and referral to treatment for patients who present with mental health challenges and/or are experiencing substance use disorder.

2. *Substance Use Disorder (SUD):*
    - SUD Treatment Programs: We continue to expand our substance use disorder treatment programs, including medication-assisted treatment (MAT), which is integrated into primary care services. Additionally, we offer Rapid Access to Medication (RAM) in our Emergency Department (ED), and have an established Recovery Coach in the ED program in collaboration with Kingdom Recovery Center.
    - Integrated Care Models: Participation in the Hub & Spoke model that allows individuals with SUD comprehensive care within the walls of the primary care office.
    - Substance Misuse Prevention: Since the early 2000s, NVRH has led substance misuse prevention programming efforts aimed at reducing risk factors and increasing protective factors for substance misuse among area youth. Other programming aims to increase prevention capacity across all community sectors, such as schools and other youth-serving organizations. Since 2023, NVRH serves as one of four Vermont Prevention Lead Organizations through the Division of Substance Use Services.
3. *Long-Term Care:*
    - Partnerships with Long-Term Care Facilities: Collaborating with local long-term care facilities to ensure seamless transitions and continuity of care for patients discharged from the hospital.
    - Palliative Care Program: Our Palliative Care practice continues to grow, supporting patients with life-altering diagnoses. In FY23 the Palliative Care practice saw 1599 visits, a 38% increase in visits compared to FY19.
    - Caregiver Support Programs: Allocating funds for caregiver support and education programs to assist families in managing long-term care needs at home.
        1. NVRH publishes a HealthyChoices newsletter tri-annually to offer caregiver support resources and information, along with an array of free and low-cost resources regarding food access, support groups, self-care, recreation, and creative arts programming. This newsletter is directly mailed to all homes within the NVRH health service area.
4. *Primary Care*:
    - Expanding Primary Care Access: Investing in the recruitment and retention of primary care physicians and advanced practice providers to maintain good access.
    - Patient-Centered Medical Home (PCMH): Building on our years of experience as PCMHs by providing coordinated, comprehensive care, supported by a dedicated portion of our budget.
    - Preventive Care Initiatives: Funding preventive care programs to reduce the incidence of chronic diseases and improve overall community health outcomes.
        1. As an early participant in the Blueprint for Health Model, NVRH has coordinated and facilitated self-management programming that aims to either reverse the onset of chronic disease, such as diabetes, or to empower patients with the skills and knowledge to manage their chronic disease, ensuring better health behaviors, health outcomes, and disease management. NVRH primary care practices refer and recruit patients for these programs, supported by My Healthy Vermont.
        2. Practices have provided and resources for patients to self-monitor at home, including scales, blood pressure cuffs, and other resources that empower patients to be in control and proactive.

b) Describe how you work with other providers in your community, including the FQHC, designated agencies, other community-based services etc., being sure to include opportunities and obstacles to ensuring smooth transitions of care along the care continuum.

NVRH works closely with various providers and community-based organizations to ensure seamless transitions of care and comprehensive support for our patients. These collaborations present both opportunities and obstacles, which we continuously work to address:

1. *Federally Qualified Health Centers (FQHCs):*
    - Partnerships: Strong partnerships with FQHCs such as Northern Counties Health Care (NCHC) to coordinate care and provide comprehensive services to underserved populations.
    - Shared Resources: Collaborating on shared resources and joint training programs, to enhance service delivery, especially with Northern Express Care, our walk-in primary care solution and our Community Health Team model.
    - Challenges: Ensuring consistent communication and data sharing between NVRH and FQHCs can be challenging due to differing electronic health record (EHR) systems and privacy regulations.

2. *Designated Agencies and Community-Based Services:*
    - Integration with Designated Agencies: Working with agencies like NKHS to integrate mental health and substance use disorder services into our care continuum. This includes joint care planning and shared case management for complex cases.
    - Community-Based Partnerships: Partnering with organizations such as the Council on Aging, Northeast Kingdom Community Action Programs, schools, and other social service providers to maintain and grow a culture of Team Based Care to address social determinants of health that impact patient outcomes.
    - Opportunities: These partnerships allow for a holistic approach to patient care, addressing not just medical needs but also social, emotional, and economic factors.
    - Obstacles: Coordination across multiple agencies requires robust communication channels and mutual agreements on care protocols, which can be resource-intensive to maintain.

3. *Smooth Transitions of Care:*

    - Care Coordination Teams: Enhancing dedicated care coordination teams to manage patient transitions from hospital to home or other care settings, ensuring continuity and reducing readmissions.
    - Discharge Planning: Building on comprehensive discharge planning processes that involve collaboration with primary care providers, home health agencies, and social services to support patients pre- and post-discharge.
    - Opportunities: Establishing HIPAA compliant arrangements that enhance care coordination and timely transitions of care communication.
    - Barriers: Barriers include varying levels of resources among partner organizations and the need for continuous training and support to align care practices.

By addressing these challenges through targeted investments and fostering strong community collaborations, NVRH aims to enhance healthcare delivery and ensure smooth transitions along the care continuum. These efforts are critical to our mission of providing high-quality, patient-centered care to the communities we serve.

c) If your hospital was asked to submit a Performance Improvement Plan, please provide an update on progress or challenges relative to that plan.

Does not apply to NVRH.

d) Hospital Networks: Explain your shared services strategy, any additional revenues associated with such investments and methodologies for allocating associated costs.

Quantify any efficiencies to date, and when you expect to achieve any future efficiencies.

Does not apply to NVRH.

F. OTHER

a) **Is this a zero-based budget? If not, when was the last time your organization developed a true zero-based budget (creating a budget from scratch and then justifying every expense rather than basing the budget on prior spending)?**

The FY25 budget process included NVRH's initial approach to zero-based budgeting. Zero-based budgeting was used for significant expense categories as follows:

- Departmental staffing: Department leaders prepared their FY25 salary budget based on an actual needs model rather than budgeting based on current staffing levels to assure staffing levels matched activity levels hospital-wide.
- Purchased services: Purchases of all services from outside organizations were re-evaluated, and leaders were required to justify why alternative options were not available.
- Service contracts: All service contracts were re-evaluated, and if the cost of service contract was close to or exceeded the value of the equipment covered, the contract cost was not budgeted.
- Use of travelers and locum tenens: Every budgeted traveler or locum tenens position was evaluated and approved only after department leaders used a zero-based budgeting approach for staffing.

We will build upon our initial zero-based budgeting success in all future budgets.

b) **Patient Financial Assistance**

a. **If a contract with a third party exists to collect payments from patients, please provide this contract and disclose the amount paid for such collection efforts and the revenue generated therefrom**.

NVRH has a contract with Marcam Associates for self-pay Collections. The collection fees for Oct-May are $29,212.62. Revenue generated is $126,001.51.

b. **If you have a contract with a third party, please describe the return on investment for this decision compared to managing these activities internally as a part of Patient Financial Assistance Programs?**

The return on investment for the period studied is 331% or $96,800. NVRH would not have collected this $96,800 if the accounts were kept in-house and managed internally. Accounts are managed in-house for 120 days before being turned over to the third party. During this 120-day period patients made no effort to make payments or start the application process for patient financial assistance.

c. **Please describe how patients are screened for Patient Financial Assistance at your hospital.**

When the billing staff speak with patients about their outstanding balances, they review the available assistance programs. If an inpatient admitted to the hospital does not have insurance our Community Connection team works with the patient to help obtain insurance, advises them of our Financial Assistance program and assist with the application processes for either insurance or financial assistance.

d. **When patients receive a bill – either paper or electronic – are they made aware of the**

hospital's patient financial assistance policy and how to apply?

Yes, all statements include information about our Financial Assistance program. On the statement a phone number to call for more information is provided. The statements also provide a website address where patients can get the information about our assistance program as well as a copy of the application.

In conclusion, NVRH remains dedicated to providing high-quality healthcare services while navigating financial challenges. Our FY25 budget reflects NVRH's commitment to prudent financial management, strategic investment, and regional collaboration to enhance healthcare outcomes for our community.