Mt. Ascutney Hospital and Health Center

Green Mountain Care Board Budget Presentation

August 14th, 2024

- Winfield Brown, Interim Chief Executive Officer
- Dr. Herbert Ip, Chief Medical Officer
- Celeste Pitts, Interim Chief Financial Officer
- Andrew Garami, Director of Finance

Agenda

1. Introduction
2. Who we are…
3. Quality
4. Access
5. Cost
6. Request
7. Risk/Opportunities
8. Questions

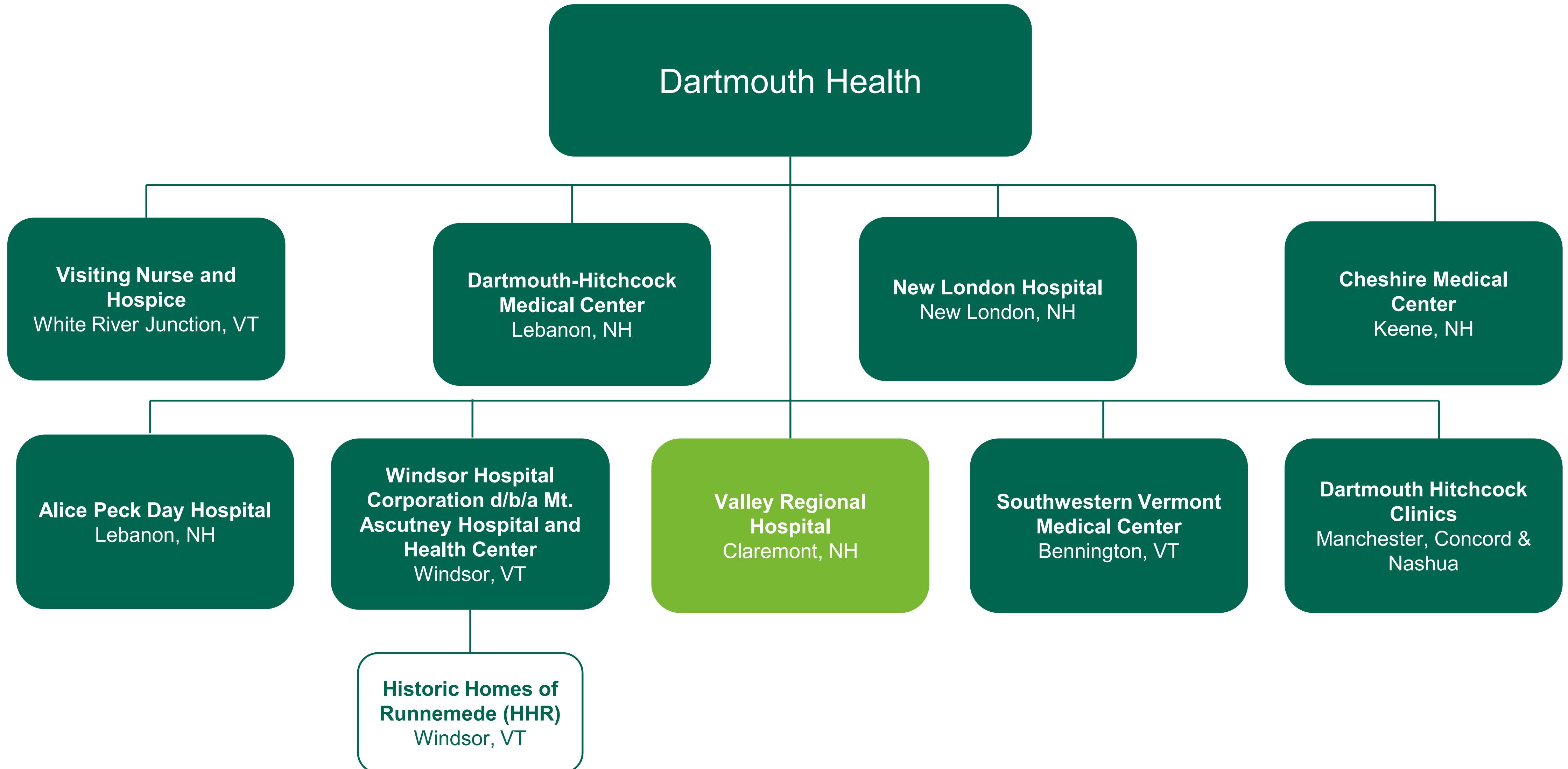
Who We Are

Who We Are

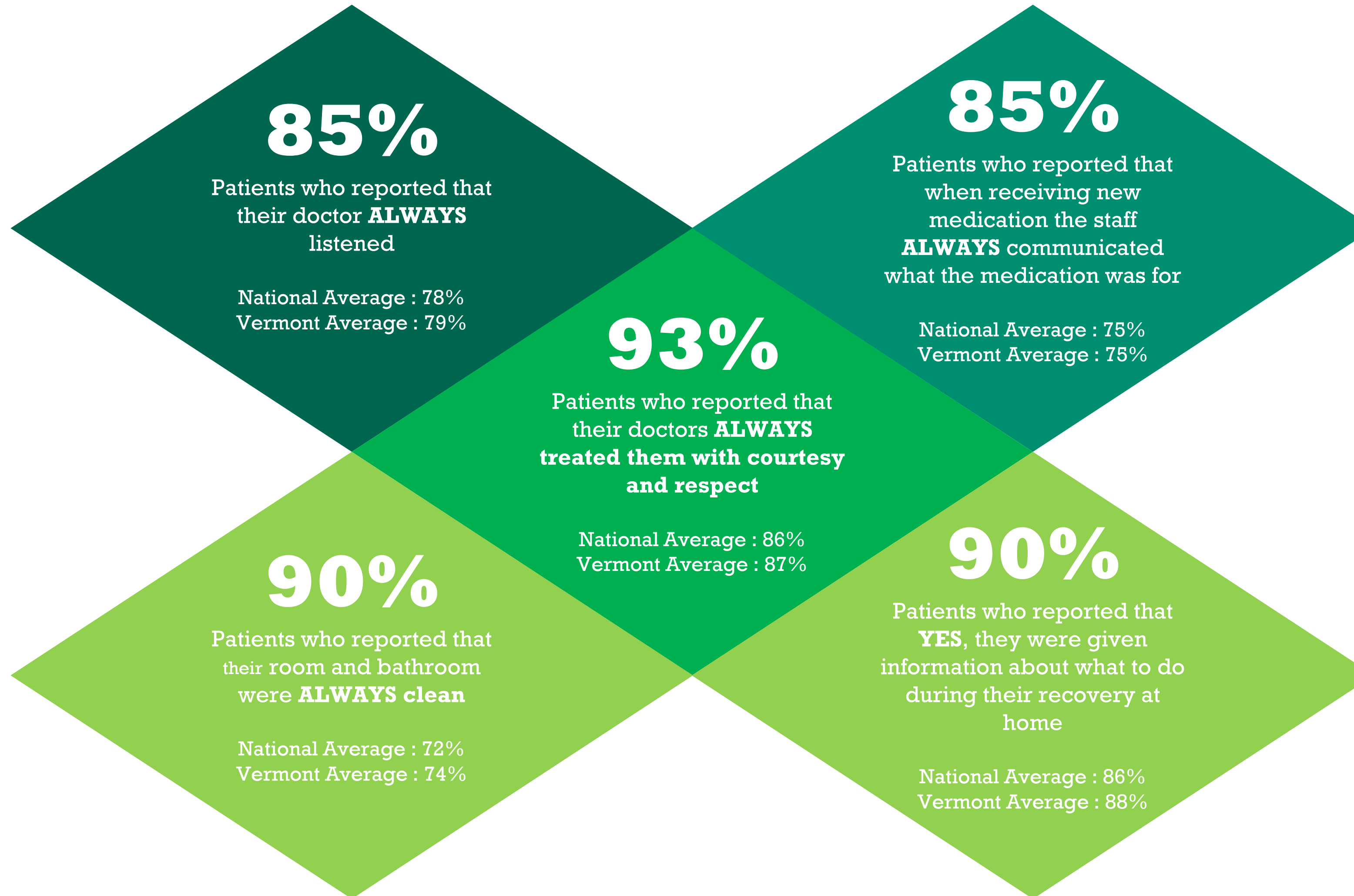
Our mission:

To improve the lives of those we serve.

Who We Are



Quality



Quality

2023 recipients of the Human Experience Guardian of Excellence Award®

Hospital in the 95th percentile for patient experience, awarded annually based on survey data.

2023 recipient of the Performance Leadership Award®

Hospital in the 75th percentile for patient perspective, awarded among more than 2,000 rural hospitals nationally.

2024 CARF re-accreditation – 3 Years

Hospital Rehabilitation programs awarded for quality, patient focus and continuous monitoring of results

2023 Level 2 Geriatric Emergency Department accreditation

The MAHHC ED is the first in Vermont to earn accreditation for upholding care standards for older patients, best practices, patient education and transition to other care settings

Quality

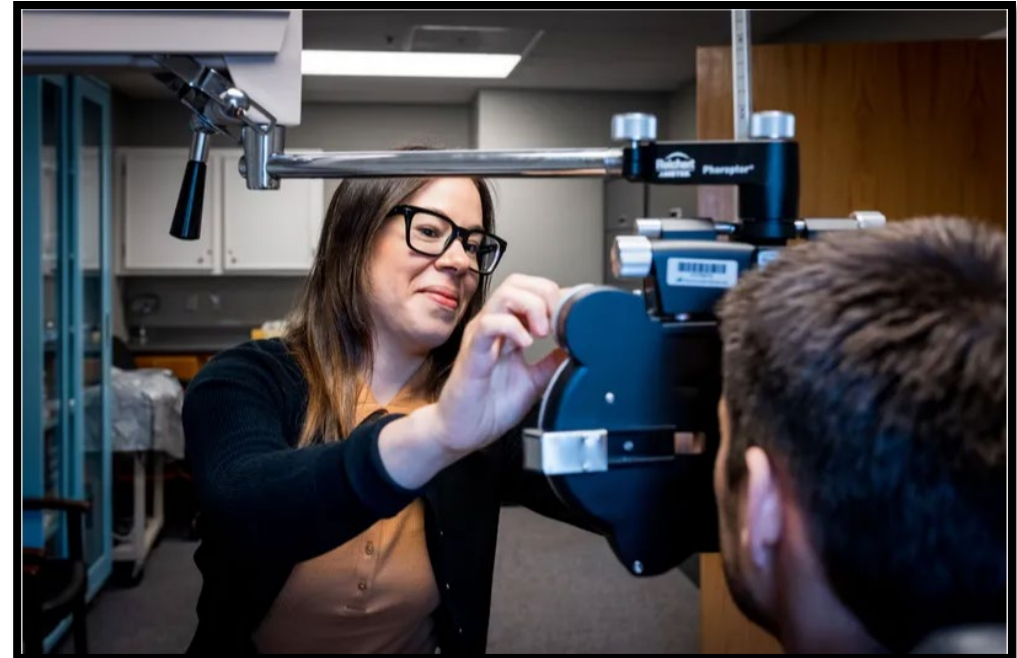
- Patient Experience
  - 94% hand hygiene compliance (measured by patient perception)
  - Top 15% in country for overall hospital rating
- Culture of Quality and Safety:
  - Zero surgical site infections, central line infections in 5 years
- Continuous Improvement Initiatives
  - Patient Safety Organization through Press Ganey along with Dartmouth Health
  - Implemented controlled substance management best practices

Quality

- Commission on Accreditation of Rehabilitative Facilities (CARF)
  - We achieved our 3 year re-accreditation for our Acute Rehab with a Stroke specialty designation
  - First time 3 year accreditation for our Outpatient Therapies program
  - CMS satisfaction survey score of 99.4% of patients were satisfied with stay
  - 96% overall assessment of the facility
  - 90.5 % of all our patients from Acute Rehab return to the community/home
  - 87.9% of our stroke population returned home
  - 97.3 % of our patients felt prepared for discharge

Quality

- Successful CMS Recertification Survey
  - Surveyors complementary about maintaining an aging plant so well
    - Requires effort and retrofitting to stay in compliance
    - UV treatment in HVAC protects patients and staff: 90% of air is sanitized
  - Staff confident/competent in speaking with surveyors
    - Share what they are best at: caring for patients
  - 1 wording change in a policy
  - Constant readiness, for the next patient



Quality

- Consistently strong performance, year over year
  - DH System Quality Measures
  - NCQA, CAP, ACR-Mammo, ACR-CT, MQSA, MBQIP
  - Comes with a price
    - Management
    - Data and Analytics
    - Mock Audits
    - Software
  - Direct correlation to:
    - Employee engagement, retention, recruitment
    - Safety and Risk
    - Patient satisfaction and customer service effectiveness

Access

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

DH Employed
DH & MAH Employed
MAH Employed

Appointment Access Statistics

Visit Lag					
	2 Weeks	1 Month	3 Month	> 3 Month	Total
FY22 MAY	25%	44%	6%	25%	100%
FY23 MAY	61%	37%	2%	0%	100%
FY24 MAY	52%	22%	15%	11%	100%

Access Initiatives

- Ongoing monitoring of clinic and ancillary productivity
- Monitoring of wait times, DH initiative <14 days to appt
- Periodic review of regional need
- Coordination with DH system partners
- Identify barriers and remove/minimize
  - Staffing levels
  - Competitive market-based compensation
  - Provider recruitment
  - Hours/Schedules
- Walk-in services hours expanded

Act 167

High Impact Actions

- ✓ Increased use of telehealth for Emergency Room/UrgiCare and specialists
- ✓ Increased use for remote monitoring and patient follow-up
- ✓ Expand rural outreach programs for primary care and preventative services
- ✓ Expand primary care/Urgent Care hours to permit access for working people
- ✓ Contract full-time paid professional Emergency Medical Services organizations
- ✓ Develop state-wide bed availability monitoring – *DH implemented*
- ✓ Develop regional service line specialization with other hospitals – *DH process underway*
- ✓ Create multi-hospital support services (e.g. back office, specialty physician group)
- ✓ Establish programs targeted at high needs groups/ individuals – food insecurity, long term care, medication assisted therapy, etc.

Cost – Cost Control (Local and System)

- Finance
- Supply Chain
- Pharmacy
- Regional Laboratory Services, Pathologists & Radiologists
- Medical Staff Functions - System Credentials Committee
- Quality/Compliance/Risk Resources
- Financial Action Planning Team
- Regional Healthcare delivery planning
- Specialty Medical & Surgical service line coordination
- System-Wide Strategic Planning
- Operations/Shared Services/Shared Staffing
- Information Technology
- CHNA Support

Cost Management

- Largely fixed expense ~80%
  - Conditions of participation
  - Staffing metrics
  - Community-based services
- Volume matters…cost per unit
- Monthly Department P&L, FTE's, etc.
- Position Control - weekly
  - Just because it was anticipated/justified in budget, doesn't mean we hire for it
- Leveraging DH system GPO and contracting pricing
- Cost Report Optimization
- DH System Integration (next slide)

Cost Management - DH System Integration

- DH System improvements
  - Health Benefit Platform Harmonization – increased risk pool and level playing field
    - Budget to Budget increase based on full complement of FTE's – integration of Historic Homes of Runnemede
  - Enterprise Resource Planning (ERP) Integration
    - Infrastructure security across all locations
    - Best in Class Accounting, Analytics, Human Resource Tools
      - Synergies achieved in accounting and HR
    - Phase 2 – Electronic Health Record/EPIC Integration (2026)
  - 340B Alternative Distribution Model
    - Budgeted revenue increased $120k from current year
  - Shared Services through DH affiliation
    - 340B, Quality, HR, Pharmacy, Health Information

Costs – DH System Integration w/ VRH Affiliation

Average Annual Savings

Inflationary Increase from Study	MAH	VRH	Comments
Staff FTE Reductions	$ 337,366	$ 863,573	Salary and Benefits
Management Reductions	$ 401,551	$ 401,551	Salary and Benefits
Supply Chain Reductions		$ 142,182	Move from NEAH to Affiliate
Insurance Reductions		$ 35,940	Move from NEAH to Affiliate
PSA Reductions	$ -	$ 27,034	Move from NEAH to Affiliate
Total	$ 738,917	$ 1,470,279	

Cost – VT ACT 119

2024				
Household Size	INCOME EQUAL TO OR LESS THAN			
_	250%	300%	350%	400%
1	$37,650	$45,180	$52,710	$60,240
2	$51,100	$61,320	$71,540	$81,760
3	$64,550	$77,460	$90,370	$103,280
4	$78,000	$93,600	$109,200	$124,800
5	$91,450	$109,740	$128,030	$146,320
6	$104,900	$125,880	$146,860	$167,840
7	$118,350	$142,020	$165,690	$189,360
8	$131,800	$158,160	$184,520	$210,880
_	_	_	_	_
Each additional Person	$13,450	$14,795	$16,140	$17,485
_	_	_	_	_
_	100% FREE CARE	75% DISCOUNTED CARE	50% DISCOUNTED CARE	40% DISCOUNTED CARE

MAHHC – Profit & Loss

MT. ASCUTNEY HOSPITAL & HEALTH CTR PROFIT AND LOSS STATEMENT	
2025 BUDGET SUBMITTED	
GROSS PATIENT CARE REVENUE	$148,673,268
DEDUCTIONS FROM REVENUE	-$76,993,088
NET PATIENT CARE REVENUE	$71,680,180
FIXED PROSPECTIVE PAYMENTS & RESERVES & OTHER	$1,670,000
TOTAL NPR & FPP & RESERVES & OTHER	**$73,350,180**
OTHER OPERATING REVENUE	$4,411,698
TOTAL OPERATING REVENUE	**$77,761,878**
TOTAL OPERATING EXPENSE	$77,232,044
NET OPERATING INCOME (LOSS)	**$529,834**
NON-OPERATING REVENUE	$3,365,180
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	**$3,895,014**
OPERATING MARGIN %	0.68%
TOTAL MARGIN %	5.01%

MAHHC – Balance Sheet

MT. ASCUTNEY HOSPITAL & HEALTH CTR BALANCE SHEET	
2025 BUDGET SUBMITTED	
TOTAL CURRENT ASSETS	$26,302,533
TOTAL BOARD DESIGNATED ASSETS	$36,980,938
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	$19,629,816
OTHER LONG-TERM ASSETS	$11,476,273
TOTAL ASSETS	**$94,389,560**
TOTAL CURRENT LIABILITIES	$14,720,368
TOTAL LONG-TERM DEBT	$21,151,539
OTHER NONCURRENT LIABILITIES	$546,774
TOTAL LIABILITIES	**$36,418,681**
FUND BALANCE	$57,970,879
TOTAL LIABILITIES AND FUND BALANCE	**$94,389,560**

Benchmarks – Overview/Justification

1. **Net Patient Service Revenue Growth – MAHHC 4.3% vs GMCB 3.5%**
   - Meeting community needs, providing community care
   - Includes volume/service mix, payer mix, price impact

2. **GMCB Commercial Rate Growth – MAHHC 2.2% vs GMCB 3.4%**
   - Realization rate of price increase for commercial payers
   - CON consideration
   - Gross price increase for all payers 3.5%

3. **Operating Margin - >0%**
   - Budgeting a 0.7% operating margin

Request – NPSR + (FPP + RR + PHM)

- Total NPR+ Increase **4.3%**

- 3.5% Rate Increase
  - Medicare realization of 49% (1.8%)
  - Medicaid realization of 27% (1.0%)
  - Commercial realization of 61% (2.2%)
  - Self Pay realization of 0% (0%)
  - Total Realization of 55% **(1.9%)**

- Payer Mix/Volume/Other **2.4%**

Request

- 1.9% in realized price increase is lower than inflation rate for most expense categories
  - Salary and Wages 3%
  - Benefits 8% + HHR
  - Pharmacy 3-10% with highest cost meds ~4%
  - Medical supplies 3.4%
  - Food 3.5%
  - Travelers increase budget to budget
  - Utilities flat

Request

- Increasing quality has a cost
- Increasing access has a cost
- Healthcare reform has a cost
- Necessary margin
  - Board of Trustees
  - DH
  - GMCB
  - Capital
- Incremental and ongoing improvement in quality and access
- One of the lower requests, year to year (not including $2.5m price decrease in 2020)
- Operating margin over 10 years is 1% margin

Request - Capital

- 2025 budgeted at $4.8M
- Enterprise Resource Planning Software Integration - $2.3M
- Remainder = Routine Replacement
- ~$3m in capital under-spending from FY20-FY23
    - Bandwidth, supply chain, etc.
- IT CON for 2025
    - Submitted in FY24

Capital Budget FY25 By Category

Category		Amount
Facilities	$	1,468,750
IT Technology	$	105,637
Major Moveable	$	935,313
Strategic (CON)	$	2,290,300
	$	4,800,000

Significant Investments

Investment		Amount
Chiller & Transformer	$	1,000,000
Masimo 02/Vitals	$	155,000
Pentacam	$	145,000
MAK Blood Bank	$	100,000
Baxter IV Pumps	$	100,000
	$	1,500,000

Request - Overview

MAHHC
Request for NPSR and Rate Increase

	FY22 Budget	FY23 Budget	FY24 Budget	FY25 Budget	Change
NPSR	$ 57,823,629	$ 63,480,412	$ 68,584,234	$ 71,680,180	4.5%
FPP/Reserves/PHM	$ 1,817,283	$ 2,389,058	$ 1,749,116	$ 1,670,000	-4.5%
Total	$ 59,640,912	$ 65,869,470	$ 70,333,350	$ 73,350,180	4.3%
Rate	2.20%	4.70%	5.10%	3.50%	
Op Margin	1.7%	1.7%	1.5%	0.7%	

Risks

- Healthcare workforce
  - Significant regional wage pressures as region competes with other states (e.g. Massachusetts) for talent.
  - Limited Market
    - New DHMC patient tower in 2024 at (requires hundreds of nurses and other staff)
    - Great Resignation/Retirement/Turnover
    - Aging workforce
    - Reliance on Travelers
  - Competing with NH hospitals and non-hospitals
- Healthcare Reform and ACO participation
  - Reliant on Medicare/Medicaid risk
  - Incentives (PHM and bonuses) less than the cost (Infrastructure fees)
- Dependence on Other Operating Revenues
  - DSH
  - 340B

Opportunities

- Regional Planning
  - VRH Affiliation
  - Rational distribution of services in region
  - Growth in DH system (leverage, GPO, NEAH, etc.)
  - Continued DH integration (IT platforms underway)
  - Staff sharing
- CON – Enterprise Resource Planning system synergies
- Primary Care provider additions
- 340B Alternative Distribution Model
- Revenue Cycle Improvement Initiative
- Clinical Documentation Improvement Initiative
- Market share
  - Migration to MAHHC for quality and customer satisfaction
  - Ophthalmology

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Questions?

Thank you.