Rutland Regional Medical Center
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August 14, 2024

Ms. Alena Berube, Director of Health Systems Finance
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05633

Subject: HSF Questions For Hospitals

Dear Alena,

The following information discloses Rutland Regional Medical Center's (RRMC) responses to the requested questions received on August 5, 2024.

1. What type of cost-benefit analysis was conducted to ensure that these investments were the best use of funds?

We employ a comprehensive decision-making framework that integrates multiple strategic considerations. The process begins with a thorough assessment of community needs and demands, ensuring that any initiative aligns with the broader requirements of those we serve. Next, we evaluate the prospective clinical necessity, determining the long-term viability and impact of the service being considered. Following this, we conduct an in-depth financial and return on investment (ROI) analysis to ensure that the initiative is economically practical. We then examine the operational model, focusing on our capacity to support the service from both an operational and staffing standpoint. Only after meticulously considering these factors do we arrive at a well-informed decision that aligns with our strategic plan and mission.

2. Why have you invested in a mobile MRI unit if MRI volumes were low in the beginning of FY24?

In the first quarter of FY 2024, we experienced a considerable backlog due to insufficient staffing to adequately manage the prior authorization process and scheduling demands. This shortage created delays in operations, specifically for MRI services. Over the past three quarters, we have been diligently addressing these challenges, focusing on restoring our operations to baseline levels. Our efforts have included addressing staffing vacancies, optimizing workflows, enhancing staff training, and reallocating resources to ensure that we meet our service commitments effectively to mitigate any future impacts.

Like many hospitals in Vermont, RRMC is facing increased demand for MRI scans due to the backlog of healthcare services caused by the COVID-19 pandemic. The rise in patients seeking delayed treatment from primary care providers has led to more severe cases and a corresponding increase in MRI orders. Additionally, higher patient volumes in the Emergency Department are further straining our MRI schedule. Currently, routine MRI appointments are being scheduled

five weeks out, despite operating our MRI unit seven days a week for 10 to 12 hours per day. To meet this ongoing demand, RRMC plans to utilize a mobile MRI unit to perform an additional 45 MRIs per week, totaling 2,340 annually.

Furthermore, RRMC is increasingly receiving requests for imaging services from other Health Service Areas due to extended wait times at their facilities. Despite our challenges with wait times for the standing MRI, patients are turning to RRMC as we are able to accommodate their imaging needs much sooner, offering them timelier access to essential diagnostic services.

3. You attribute a $3 million positive variance to last year's budget to "other misc. utilization changes" (page 6). Can you provide a more specific assessment of where volume has increased above FY2024 budgeted expectations. How have you recalibrated your expectations as to not underpredict your NPR for FY2025?

The miscellaneous utilization changes that comprise the additional $3M in our FY 2024 projection is attributed to laboratory volume, general diagnostic imaging, and endoscopy services. A specific assessment of those services where volume increased above FY 2024 budgeted projections are outlined in the narrative in section C. a. and C. b. The $11M of other miscellaneous utilization changes in the chart at the bottom of section C. a. includes the aforementioned $3M of other utilization changes in addition to the budgeted miscellaneous utilization changes which is primarily within the same services of lab, general diagnostic imaging, and endoscopy.

While a budget provides a valuable framework for our financial strategy, it inherently may evolve as conditions, patient demand, provider recruitment, and priorities shift. Our FY 2025 budget reflects our best estimates at the time of submission.

4. The rate decomposition sheet shows a decrease in inpatient care utilization by $6M (or 7%). Why did you experience a drop in Medicare and Commercial inpatient utilization?

For Medicare, custodial care days have risen by over 700 compared to FY 2024, with the length of stay increasing by 28% over the previous budget. Despite this, the volume statistics do not reflect a corresponding increase in revenue. Therefore, as a result, there is a decrease in revenue, as reimbursable acute care days have shifted to custodial care days, which offer little to no associated reimbursement for these patients. Additionally, the decline in commercial revenue is further exacerbated by payment policy changes by commercial payers, resulting in reduced compensation for the same level of care.

5. 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?

Rather than directly passing the 340B discounts to patients, we allocate a portion of the savings to partially support our comprehensive free care program. This program provides discounted services to individuals whose income is up to 500% of the federal poverty level, ensuring that those in need and underserved receive significant financial assistance.

The 340B program also supports inpatient and outpatient mental health and substance abuse treatment programs, as well as women's health services, all of which address significant community needs despite operating at a financial loss.

6. 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.

In our FY 2025 budget, we anticipate net other operating revenue of $1.7 million from the 340B program, after accounting for associated costs. This revenue is derived from both our contract pharmacy and in-house retail pharmacy operations.

7. Why did you choose to allocate the majority of your commercial price increase to outpatient, with a slight rate cut to professional services?

We did not apply the majority of the 3.4% price increase to outpatient services. Rather we uniformly applied the 3.4% increase across both inpatient and outpatient services. We did not apply an increase to professional services.

8. Why was the defined benefit plan discontinued? What has been the impact on your employees?

As we have discussed in previous budget presentations, RRMC made the decision in 2022 to initiate the termination of our defined benefit (DB) plan. This decision was driven by several key factors. Firstly, DB plans were originally designed for a workforce with long-term employment in mind. However, the modern employment landscape has evolved, with employees frequently changing jobs throughout their careers. Defined contribution (DC) plans, by contrast, offer the flexibility that aligns better with today's mobile workforce.

Secondly, there has been a clear and sustained market shift toward DC plans, reflecting their adaptability and alignment with current employment trends. Lastly, from a financial perspective, DC plans present a more cost-effective and predictable option. They not only reduce the long-term financial liabilities associated with DB plans but also provide greater clarity in budgeting and forecasting.

RRMC took a highly disciplined approach, ensuring the plan was fully funded, earning recognition as a model plan. In contrast, many organizations face challenges in terminating similar plans due to consistent underfunding, which often necessitates substantial financial contributions to meet obligations.

9. What was the driving factor to your debt service coverage ratio improvement? Long term bond/mortgage debt is increasing $7M, current portion of debt is dropping $1.8M, and interest expense is only increasing $14. Can you explain what happened and what drove that financial decision and planning moving forward?

RRMC's calculation of the debt service coverage ratio, which accounts for the current portion of long-term debt (please refer to our response to question 15 for details on calculation differences),

indicates a decline from projected FY 2024 to the FY 2025 budget. This decrease is primarily driven by the rise in the current portion of long-term debt, which increases the denominator in the ratio calculation, thereby reducing the overall ratio. For FY 2025, RRMC anticipates incurring approximately $7 million in new debt to fund significant strategic capital needs, as outlined in our sources for capital expenditures.

10. How are you decreasing the variable cost structure to shield RRMC from unpredictable volumes?

We leverage our Premier benchmarking tool to actively manage and monitor labor productivity, ensuring that our staffing levels are optimally aligned with patient census fluctuations. This approach enables us to maintain operational efficiency and allocate resources effectively, ultimately supporting high-quality patient care while controlling labor costs.

11. Do the "primary care-type services" cost more as a result of being delivered through a hospital rather than at a designated primary care facility?

The answer to this question does provide some degree of conjecture. While the structures may be recognized as different, the financial commitments are in essence the same. Remaining consistent with fair market value standards, we principally pay the same in rental square footage value, utility costs, and compensate staff and providers at comparable wage ranges. Conceivably, due to our scale and purchasing power, the hospital may benefit from its access to more competitive pricing on supplies and pharmaceuticals.

It is also important to recognize that FQHC's benefit from a more favorable reimbursement structure compared to hospitals for providing some of the same services. FQHC's also receive specified grant funding to offset the expense of certain staff and provider positions. In contrast, one expense hospitals incur that does not apply to FQHCs is the provider tax.

12. Please review the rate decomposition details you submitted as well as the "summary" tab and explain the following (where available, show supporting calculations):

We would like to clarify that there appears to have been some misunderstanding regarding the correct rate decomposition workbook for RRMC. The RRMC workbook was submitted in a timely manner by the July 8th deadline, both under confidentiality via email to GMCB counsel as well as a redacted PDF version submitted through the Adaptive software platform. This was noted within the example workbook. However, it seems the example workbook was inadvertently referenced rather than our intended submission. Additionally, a non-confidential Excel version was provided on July 16, 2024. As a result, some of the information used in evaluating RRMC's data may have been inaccurate, as it was based on the incorrect, example workbook.

a. How did you arrive at the assumed rates of growth for price, volume, and payer mix shifts by payer?

To establish budgeted utilization and payer mix trends, a baseline is developed by applying the annualization of year-to-date volume and payer mix data through February. This baseline is then compared to a two-year historical lookback to validate the assumptions. After establishing the baseline, any anticipated changes for the upcoming fiscal year are integrated into the budgeting process.

Regarding changes in charges, we assess our pricing by comparing it with that of our peers within the state using price transparency data. Additionally, we review our anticipated pricing structure against both national and regional benchmark data for similar hospital classifications, while also considering patient affordability.

b. For non-zero values in the "other" column, how did you derive these estimates?

RRMC's initial and complete submission reported values of zero.

13. 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, we believe that Medicaid is underfunding the cost of delivering care to our Medicaid patients. Using our FY 2023 filed cost report, we calculated the total cost of care provided to Medicaid patients by aggregating all relevant direct and indirect expenses. We then compared this total with the reimbursement received from Medicaid. The difference between these two figures represents the shortfall, or the underfunding, by Medicaid. In FY 2023, the shortfall equated to $16.3M.

14. 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, we believe that Medicare is underfunding the cost of delivering care to our Medicare patients. Using our FY 2023 filed cost report, we calculated the total cost of care provided to Medicare patients by aggregating all relevant direct and indirect expenses. We then compared this total with the reimbursement received from Medicare. The difference between these two figures represents the shortfall, or the underfunding, by Medicare. In FY 2023, the shortfall equated to $22.9M.

15. 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.

RRMC's calculations are aligned with the methodologies required under our bond covenants, in accordance with our banking institution's requirements. Additionally, RRMC utilizes standardized calculations that align with industry standard practices. Please refer to the accompanying spreadsheet, which outlines the differences between our calculations and the GMCB staff's calculations.

We remain available to answer questions or inquiries you may have as it pertains to our fiscal year 2025 budget.

Sincerely,

J. Bertrand

Jennifer Bertrand
Chief Financial Officer
Rutland Regional Medical Center