SVMC

1) Page 8 of your narrative details the elimination of graduate medical education payments from Medicare. Why will these payments be eliminated?

The Graduate Medical Education payments previously received were from a Podiatry Residency Program that was phased out at the end of FY 2022.

2) Provide more detail about how you expect the cost of treatment will compare for patients treated at SVMC for your expanded services as compared with where they are receiving treatment today?

In most cases SVMC management believes that SVMC can provide care at a lower cost than is provided by in most cases by out of State providers. SVMC borders both New York and Massachusetts and can provide more cost effective and convenient care to the patients we serve. This is based upon the review of high-volume procedures comparing to what it would cost if performed at SVMC. If successful in improving primary care access and reducing out migration it will reduce the cost of care to Vermonters and benefit the Hospital.

3) The narrative discusses your approach to assessing boarding episodes in your emergency department. However, it looks as if the table summarizing the information is missing. Are you able to provide it?

Table below:

SVMC Emergency Department Boarding Episodes (Defined as patients in the ER for over 12 hours)

Fiscal Year	Diagnosis	#ED Encounters	Total Patient Days	Total Charges
FY22	Non-Mental Health	442	366	$2,885,702
	Mental Health	354	906	$1,296,027
FY22 Total		796	1272	$4,181,729
FY23	Non-Mental Health	267	271	$1,970,739
	Mental Health	175	377	$761,262
FY23 Total		442	647	$2,732,001

4) Provide more detail about planned or potential savings to be generated through "process improvement and consolidation" with DH.

Significant supply cost savings have been identified through group purchasing contracts at DH that are now available to SVMC as an affiliated hospital under DH. These supply contracts provide savings on medical surgical supplies and drugs. In addition, potential savings in service contracts are being explored. Additional savings are being realized from consultation with DH staff on the 340B Program. There are other examples of opportunities that SVMC and DH are collaborating on from fees for investment advisors, copiers costs, insurance costs, as well as many others are being explored.

Current contracts for contracted staff with DH to cover positions in Infection Control, Quality and Cancer Center management are being rewritten to remove markup and overhead cost allocations to SVMC now that SVMC is a member of DH Health.

5) "This volume management is focused on improving access, reversing out migration of patients to New York and Massachusetts. It is well documented that this will reduce the cost of care to Vermonters since many of the services SVMC offers are less costly to the patients than in neighboring states. Additionally,

patients who receive care closer to home, in most cases according to the literature, the outcomes are generally more positive." Why do you think that you have experienced an out migration of patients to other hospitals, if services at SVMC are less costly? (Narrative, 11)

There are many causes. First, the availability of primary care in the region continues to be a challenge. There have been several independent primary care providers who retired or left the service area. Second, many of SVMC's employed primary care practices have been closed. Effective early this past spring the goal was to have all practices open for new patients. This was going to be accomplished by revising the scheduling practices and improving processes in each practice to reduce administrative activities of the providers to provide additional time for the providers to see patients. Third provider vacancies, an example of provider vacancies in Oncology services. As of August, SVMC will be fully staffed with two full time Oncologists as well as Mid-level providers to meet needs of patients in our service area. SVMC has been using locums over the past years and has only had one provider when the need in our service area is three. Many patients needing to see Oncologist have had to go elsewhere.

6) Explain the increase in bad debt from FY22 to FY24 (Exhibit 9).

SVMC continues to see an increase in self-pay and high deductible cases which places higher level of payments from individuals. Where possible the financial counseling team works with patients who are eligible for financial assistance, Medicaid and Charity Care. In the FY 2024 budget management has provided a modest increase.

7) Where is Medicare Advantage business in exhibit 9? Update the exhibit to separate it. If necessary, provide an estimate and indicate what challenges your systems present for tracking Medicare Advantage revenue separately.

The Medicare Advantage revenue is broken out on the resubmitted exhibit 9. See attachment A below.

8) Explain why the number of traveling nurses is projected to increase from 5 to 19 (Exhibit 11).

Exhibit 11 does not reflect number of traveling nurses. It reflects change in median hourly rate, per the header on the schedule.

SVMC does not plan to utilize traveling nurses in the FY 2024 and has not budgeted for traveling nurses in the FY 2024 Budget. SVMC was able to minimize the use of traveling nurses over the past two years, in FY 2023, from a high of 8 nurses during May-July 2022 to about 3 in FY2023 all to be phased out by August.

9) Explain the primary driver(s) of the 715% increase in net assets from 23B to 24B % (Balance Sheet).

The increase in net assets from 23B to 24B on the balance sheet is primarily due to the transfer of donated funds raised by the SVHC Foundation (a separate corporation) to SVMC to be used for the ED Modernization project.

10) Explain the 179.5% increase in long-term interest expense (Summary Income Statement).

The primary driver of the increase is due to the ED Modernization project and the need for working capital due to payment delays by the insurance companies. The new construction is scheduled to be completed in August of FY 2023 and renovation of the existing ED space to be completed in FY 2024 resulting in interest becoming an operating cost instead of a capital cost during construction.

11) Explain the 1495.6% increase in total non-operating income and 714.7% excess of revenue over expense (Summary Income Statement).

This response is the same as question #9 above. The transfer of donated funds from the SVHC Foundation to SVMC to fund the cost ED construction project.

12) "SVMC in the FY 2024 budget uncompensated care is budgeted close to the FY 2023 budget and slightly higher than the projected amounts. The FY 2024 budget compared to FY 2022 there is an increase mainly due to increase delays in payments SVMC is seeing. This is demonstrated by the increase in the days in accounts receivable which SVMC is seeing both in self-pay and commercial insurance payment practices." (Narrative, 10) Explain how delays in accounts receivable impacts uncompensated care projections.

With the increase in self-pay receivables and high dollar deductible commercial insurances generally drives increases in uncompensated care. The longer it takes to collect an outstanding balance the more likely the claim is to be uncompensated.

Attachment A

Exhibit 9. Payer and Case Mix

	FY21 Actual	FY22 Actual	FY23 YTD Actual (Oct to Mar)	FY24 Budget
Case Mix Index	1.190	1.270	1.350	1.350
Gross Patient Service Revenue	403,028,513	433,654,824	227,926,651	502,952,280
Traditional Medicare	158,988,454	155,448,178	80,958,430	182,700,485
Medicare Advantage	48,032,629	63,753,936	35,366,364	77,335,273
Medicaid	66,101,712	74,873,757	40,091,937	85,681,895
Commercial	129,905,718	139,578,953	71,509,920	157,234,627
All other	$	$	$	$
Net Patient Service Revenue and Fixed Prospective Payments	175,796,812	186,729,147	93,698,498	203,459,707
Traditional Medicare	51,384,235	50,312,250	23,793,890	52,565,393
Medicare Advantage	15,850,768	21,676,338	10,256,246	22,427,229
Medicaid	20,649,132	21,775,275	10,745,386	20,552,253
Commercial	94,688,041	98,145,055	52,855,842	117,181,767
Bad Debt	(5,282,457)	(5,171,384)	(3,449,278)	(7,650,000)
Free Care	(2,252,809)	(1,774,483)	(945,121)	(2,500,000)
Disproportionate Share Hospital	759,902	1,766,096	441,533	883,065
All other	$	$	$	$