Northeastern Vermont Regional Hospital

Northeastern Vermont Regional Hospital (NVRH) in St. Johnsbury, Vermont is a small critical access hospital that relies on DSH funding to maintain patient access to services in its rural region.

Hospital and Market Characteristics

NVRH is a rural, non-profit, critical access hospital and the only hospital in the community. It provides inpatient and outpatient services, including preventive, primary, specialty, and surgical care, as well as birthing services and 24-hour emergency services.

NVRH received $1.3 million in DSH payments in 2012, which represented 13 percent of its total Medicaid revenue ($9.5 million) and 2 percent of its total operating revenue ($60 million).

Role in the safety net

NVRH is in Caledonia County, Vermont, a region with lower income than the statewide median for Vermont (median household income of $45,000 in the county compared to $54,000 for the state), and a lower physician-to-population ratio (154 per 100,000 compared to 347 per 100,000 in 2013). The two Vermont hospitals closest to NVRH are each approximately 40 miles away. Because it is in a rural area, NVRH must employ most of its physicians in order to retain them. In 2014, NVRH cared for a higher share of Medicaid-enrolled and low-income patients than other hospitals in Vermont and in its hospital referral region (HRR) (Table 1). Because NVRH is close to New Hampshire, its HRR is centered in Lebanon, New Hampshire, and includes hospitals in both states.

TABLE 1. Medicaid and Low-Income Utilization Statistics for Northeastern Vermont Regional Hospital and Other Hospitals, 2014

Comparison region	Medicaid inpatient utilization rate	Low-income utilization rate
Northeastern Vermont Regional Hospital (St. Johnsbury, VT)	22%	15%
Lebanon, NH, HRR average	14	5
Vermont average	20	9
National average	18	13

Notes: The Medicaid inpatient utilization rate is the percentage of hospital inpatient days that are attributable to patients who are eligible for Medicaid. The low-income utilization rate is a measure of Medicaid and charity care utilization. Because Northeastern Vermont Regional Hospital is so close to New Hampshire, its HRR is centered in Lebanon, NH, and includes hospitals in both states.
Source: MACPAC, 2017 analysis of 2014 Medicare cost reports.

Medicaid and CHIP Payment and Access Commission

1800 M Street NW
Suite 650 South
Washington, DC 20036

www.macpac.gov
202-350-2000
202-273-2452

Types of services provided

NVRH has only 25 beds but offers a broad range of services, including inpatient and outpatient services, a comprehensive care clinic, emergency services, a birth center, diabetes outpatient services, nutritional counseling services, physical therapy, and a sleep lab. In addition, two other medical centers are located on the NVRH campus: the Norris Cotton Cancer Center North, a satellite of the Dartmouth-Hitchcock Norris Cotton Cancer Center, and Fresenius Kidney Care, St. Johnsbury, a division of Fresenius Medical Care North America.

Given its limited bed capacity, NVRH has worked strategically to reduce demand for acute care and provide access to primary health care services. NVRH's primary care efforts have given the hospital a reputation as an innovator, according to one executive. For example, the hospital's patient-centered medical homes were among the first in the nation to be recognized by the National Committee for Quality Assurance, with care coordinators and behavioral health practitioners embedded in primary care offices. In addition, NVRH helped form the Caledonia Southern Essex Accountable Health Community, which has been operating since 2013 and includes a wide range of community institutions, such as the hospital, rural health clinics, FQHCs, a designated mental health agency, the affordable housing authority designated in the local area, the council on aging, community action programs, and the Vermont food bank. This partnership focuses on addressing social determinants of health and on improving population health for residents of the rural community served by NVRH.

Market characteristics

As a critical access hospital, NVRH is the only hospital in the area. Hospital executives said that being the sole hospital in a rural area requires NVRH to address its community's distinct and broad health care needs. For example, like many rural areas nationally, the community that NVRH serves is aging, and therefore has a growing demand for services like cancer care and renal dialysis. One executive noted that the NVRH region, at the junction of two major highways that connect to Montreal, Boston, New Haven, and New York City, is experiencing a severe opioid epidemic. This epidemic has increased the cost of the hospital's birthing services because of the need to provide additional care for mothers and babies addicted to opioids. The executive noted that several hospitals in NVRH's HRR have discontinued birthing services, making NVRH the only hospital in the area offering labor and delivery services.

State Context

Vermont expanded Medicaid coverage to adults with incomes below 300 percent of the federal poverty level before the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) was implemented, and in 2014, Vermont had the lowest uninsured rate in the country (5 percent).

Vermont operates its Medicaid program through a unique managed care-like delivery system authorized under a Section 1115 demonstration, but this demonstration does not affect the state's DSH payments, which are relatively low compared to other states (2 percent of Medicaid benefit spending in 2014).

Effects of the Affordable Care Act

Although Vermont opted to expand Medicaid under the ACA, according to one hospital executive, the expansion had little effect on NVRH's finances, largely because Vermont already had high rates of insurance coverage due to initiatives put in place prior to the law. Hospital executives reported that NVRH experienced some small shifts in insurance coverage among its patients after the ACA was implemented, with some patients switching coverage from commercial insurance to Medicaid. These shifts led to a small increase in NVRH's Medicaid shortfall after the ACA was implemented.

More broadly, however, with at least one-third of Vermonters covered by Medicaid, changes due to the implementation of the ACA have reportedly caused some budget problems at the state level. One NVRH executive observed, "You have a state with one of the smallest GDPs [gross domestic product] in the country with one of the most generous Medicaid plans in terms of coverage, and you can conjure the math."

State policy changes affecting Medicaid supplemental payments

Fourteen of Vermont's 15 hospitals received Medicaid DSH payments between 2011 and 2015. Funds are distributed first to the state's teaching hospital (which received over half of Vermont's DSH funds in 2015); the remainder is allocated based on a formula emphasizing the cost of Medicaid shortfall and uncompensated care for uninsured patients.

NVRH executives said they thought that the hospital was disadvantaged under the hospital provider tax. The hospital tax is based on net patient revenues, which Vermont has defined to exclude revenue streams from "physician's office practices" but to include revenue for services provided by physicians employed by hospitals. According to one NVRH executive, unlike hospitals in less rural areas of the state, the only way a rural hospital like NVRH can retain physicians is to employ them, so including revenues generated by employed physicians in the hospital tax penalizes rural facilities. Thus, NVRH believes it pays more than its fair share of the tax compared to hospitals that do not employ physicians. At the same time, NVRH claims it receives smaller DSH payments because Vermont distributes them with greater emphasis on the volume of Medicaid-enrolled patients rather than the proportion, which disadvantages small hospitals where the Medicaid proportion may be larger but the volume is smaller than that of larger hospitals. Therefore, a NVRH executive stated, Vermont's DSH policy results in "money that flows out of these areas back into wealthier areas."

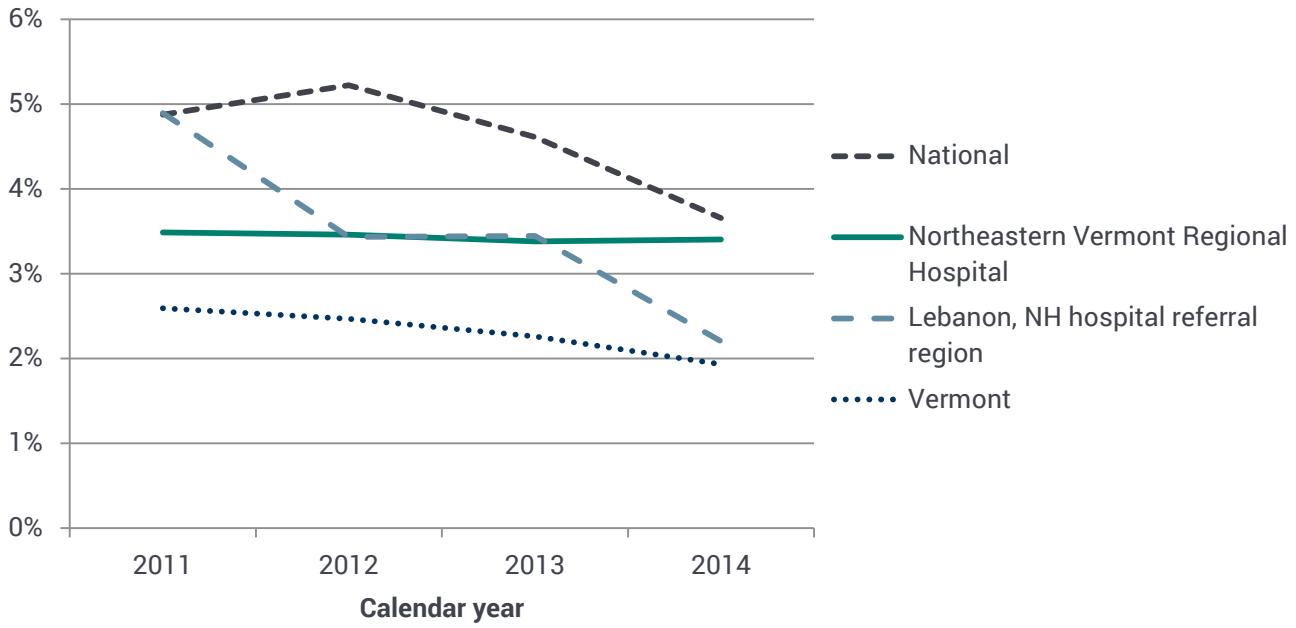
Hospital Financial Information

Uncompensated care

Reflecting Vermont's high level of insurance coverage, NVRH's bad debt and charity care is low compared to national levels—particularly when comparing levels from before the ACA was implemented (it is between 3 percent and 4 percent of operating costs), and levels remained the same between 2011 and 2014 (Figure 1). Still, NVRH's bad debt and charity care has been consistently higher than that of Vermont hospitals overall during the same period. In relation to other hospitals in its HRR during this time, NVRH's bad debt

and charity care was comparable until 2014, and then the HRR rate declined. This drop in the level of bad debt and charity care in the HRR likely reflects the effect of New Hampshire's implementation of the ACA Medicaid expansion, given that some New Hampshire hospitals fall within NVRH's HRR.

FIGURE 1. Uncompensated Care as a Share of Hospital Operating Expenses, Northeastern Vermont Regional Hospital versus Other Hospitals, 2011–2014



Notes: Medicare cost reports define uncompensated care as charity care and bad debt. Because Northeastern Vermont Regional Hospital is so close to New Hampshire, its HRR is centered in Lebanon, NH, and includes hospitals in both states.
Source: MACPAC, 2017 analysis of Medicare cost reports

Medicaid payment shortfall

According to Vermont's 2012 DSH audit, regular Medicaid payment for inpatient and outpatient care (before accounting for Medicaid DSH payments) covered approximately 68 percent of NVRH's Medicaid costs.

Medicaid DSH payments

Although NVRH's DSH payments appear to have increased in recent years, NVRH reports variation in DSH payments from year to year and no consistent trend. Vermont funds the non-federal share of DSH payments through a hospital provider tax, which NVRH pays. In 2012, NVRH received $1.3 million in DSH payments, which one executive said equated to a net of roughly $200,000 after accounting for the tax paid to finance the state share of the payments.

Other Medicaid supplemental payments

NVRH did not receive Medicaid supplemental payments aside from DSH payments in 2012, and hospital executives said that no other Medicaid supplemental payments were received in 2016.

Role of DSH Funding

According to NVRH executives, DSH payments have played a critical role in making up for Vermont's low Medicaid base payment rates. As mentioned above, Medicaid covers about two-thirds (68 percent) of NVRH's costs of caring for Medicaid-enrolled patients, who account for roughly one-quarter of NVRH's patients. Executives said that the hospital used DSH payments primarily to help cover this shortfall as well as its costs of uncompensated care. The hospital also used DSH payments to help cover financially challenging medical services, such as birthing services, and to help support community programs and services, such as connecting patients with community resources and developing partnerships with various community organizations.

NVRH executives reported that cutbacks in DSH payments would result in the hospital having to reduce or eliminate these community programs and services. Executives explained that although its Medicaid patient volume is similar to other hospitals in the state, its Medicaid-enrolled patients make up a larger share of the patient population. Because of this, executives said, NVRH is less able to cover the cost of its Medicaid shortfall than facilities with a higher share of commercially insured patients, NVRH is less able to cover the cost of its Medicaid shortfall with revenue from its commercially insured patients. Thus, NVRH would find any cuts in DSH payments particularly challenging.

Data and Methods

The information in this profile comes from interviews with hospital executives during the summer and fall of 2016 and MACPAC's analysis of Medicare cost reports, DSH audits, and other publicly available data. For a summary of the findings from all seven DSH hospitals that we profiled and more information about our methods, please see MACPAC's issue brief, *Profiles of Disproportionate Share Hospitals*.

MACPAC would like to thank Teresa Coughlin and Christal Ramos at Urban Institute for designing and conducting the interview with Northeastern Vermont Regional Hospital that was the basis for this profile. The interview was one of seven interviews with executives from safety-net hospitals across the country that occurred between June and October of 2016.