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September 5, 2019

Patrick Rooney
Director of Health Systems Finances
Green Mountain Care Board
144 State Street
Montpelier, VT 05620

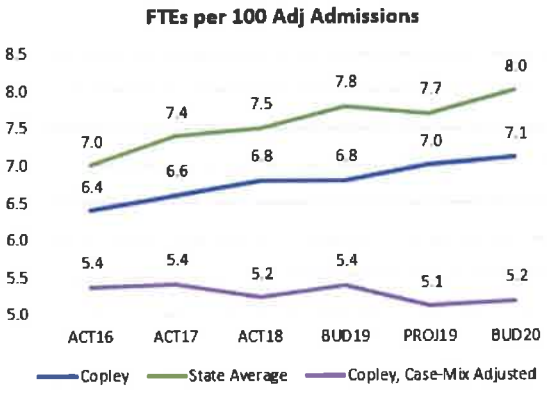
RE: Copley Hospital FY2020 Proposed Budget

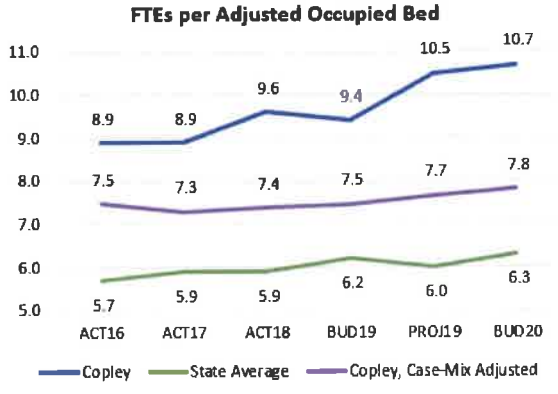
Mr. Rooney:

On August 30, 2019, we received some additional clarifying questions from your team and follow-up items from our hearing on August 21, 2019. We appreciate the opportunity to provide you with additional information to support the budget approval process. Below are our responses to the questions posed.

Board Member Follow-up

1. **Your FTE per adj bed is 11. State average is 6. Why is your staffing ratio nearly twice as high as state average?**
   Illustrated in the charts below, please note that there are inconsistent results in two of the measures the GMCB uses to evaluate staffing levels. FTEs per Adjusted Occupied Bed of 10.7 is higher than the state average of 6.3. However, FTEs per 100 Adjusted Discharges of 7.1 is lower than the state average of 8.0. One measure indicates that our staffing level may be higher than the state average, while the other indicates that our staffing level may be lower than the state average.





We believe the inconsistency in the result of these two measures, and the reason Copley's FTEs per Adjusted occupied Bed is 70% higher than the state average, is because of Copley's low Acute Average Length of Stay (ALOS). Copley's acute ALOS is the lowest in the state at 2.4 days, nearly half of the state-wide average of 4.6 days.

Each hospital's unique service mix impacts their staffing levels and the results of these productivity measures. Since we cannot speak to the service mix of the other hospitals, Copley's focus has been to make an impact on the trend in these measures through our efforts to improve workforce efficiencies and align our staffing with the needs of our increasingly complex patients and Copley's strategic goals. As illustrated in the purple lines in the charts above, Copley's case-mix adjusted trend in both of these measures is favorable, either going down or remaining relatively flat.

2. **Please provide three years of out-of-state revenues in relationship to total NPR.**
Regrettably, we are unable to provide this information at this time due to technical difficulties with our decision support software and limitations of our EMR.

3. **Please give us a breakdown of labor cost by FTE type (MD, non-MD, Admin) your Slide 13**
Following is a breakdown of the labor cost data included in the chart on Slide 13, segregating salaries related to general and administrative services. This data illustrates that our strategic cost reduction efforts are proposed to curb the rate of growth of total labor costs.

	ACT15	ACT16	ACT17	ACT18	Historic Annual Growth	PROJ19	BUD20	5-YR Annual Growth
Non-MD Salaries - General Services	7,121,185	7,817,918	8,005,355	8,280,015	5.4%	8,257,019	9,045,604	4.6%
Non-MD Salaries - All other Services	13,946,244	14,464,357	14,926,329	15,778,535	4.4%	16,043,465	16,504,080	3.2%
Non-MD Contracted Labor	1,190,510	2,194,980	2,128,790	2,199,310	28.2%	1,613,379	1,530,153	3.1%
Non-MD Fringe benefits	5,214,356	5,111,466	5,128,666	4,971,578	-1.6%	5,634,347	5,880,216	2.7%
MD Salaries and fees	8,001,718	8,493,875	8,990,189	9,378,369	5.7%	8,611,523	9,159,999	2.5%
MD Fringe benefits	568,176	612,050	761,667	469,878	-5.8%	675,753	745,761	7.6%
Total Labor Costs	36,042,189	38,694,646	39,940,996	41,077,685	4.7%	40,835,486	42,865,813	3.3%

4. **Please add detail to wait times for OB/GYN, specifically midwifery.**
As of March 1, 2019, The Women's Center clinic, which includes OB/GYNs and Certified Nurse Midwives, had an average wait time of 69 days, measured based on the third next available appointment for all appointment types. This average wait time was higher than normal for this clinic at that time due to the departure of one of our Certified Nurse Midwives. Since that time, we have been successful in recruiting a replacement for the departed midwife and decreased the average wait time in the clinic to 29 days in August. In October, we will onboard another Certified Nurse Midwife and expect that the average wait time will decrease further.

5. **Please confirm Commercial/Medicare reimbursement ratio.**
The table to the right is a summary of the average ratio of each major payer's reimbursement rate as compared to Medicare. It illustrates that for every $100 we receive from Medicare, we would receive $163 from commercial sources for the same services, on a blended average basis. This significant difference in reimbursement rates, coupled with the shift in Copley's payer mix from commercial sources to more Medicare sources, is the most significant factor contributing to our NPR shortage in FY19.

Payer	Ratio to Medicare
Medicare	1.00
Medicaid w DSH	0.85
Commercial	1.63
Workers' Comp	1.43
Self pay	0.64
Total	1.25

Please keep in mind that, as a Critical Access Hospital, we do not receive reimbursement from Medicare under the traditional fee-for-service model for hospital services; only our physician services are reimbursed

under a Medicare fee schedule. We receive cost-based reimbursement for hospital services provided to Medicare beneficiaries. As a result, I would caution you that it may not be meaningful to compare this data to Prospective Payment System hospitals.

6. **Do you agree with DVHA's assessment (attached) of the financial impact of increased Medicaid reimbursement will have on your NPR? If not, why and what is your estimate? What impact does the Medicaid reimbursement increase have on your requested NPR and change in charge and commercial price increases?**
   Copley does not have any reason to disagree with DVHA's estimates, which are estimates based on historical claims. For further details on the financial impact on NPR and rates, please see the response to question 14 on page 5 of Copley's response to GMCB questions dated August 9, 2019.

7. **Please confirm whether the CMS wage index final rule has an impact on your hospital? If so, please quantify.**
   The CMS wage index is not applicable to Critical Access Hospitals.

8. **To give us a sense of relative pricing, please answer the following: if Medicare reimburses $100 for a particular service, what would your commercial payers and Medicaid reimburse on average for the same service? Or in other words, what is the ratio of commercial and Medicaid payment to Medicare payment for the same service?**
   Please refer to the response to question 5 above.

GMCB Staff Follow-up

1. **How do you plan to fund capital investments and deferred maintenance?**
   We fund capital investments and deferred maintenance largely through operations, supplemented by philanthropic support from our community. Historically, we have been prudent stewards of our limited financial resources and have shown a commitment to strategic cost reduction and efficient operations. We are at a point financially where we believe our rates have been cut too far and need the GMCB's help, by approving our FY20 budget as proposed, in order to generate a positive operating margin to fund necessary investments in capital equipment, technology, and infrastructure.

2. **Please confirm participation in Medicaid ACO program for CY20.**
   On July 30, 2019, Copley's Board Finance Committee voted to take the next steps toward participating in the OneCare Vermont ACO for its Medicaid program only for CY20, subject to the final approval by our full Board of Trustees at its next meeting on September 16, 2019. Copley submitted its participation agreement on July 31, 2019, with the express written agreement that we could withdraw the participation agreement in the event that our Board of Trustees does not approve our participation. Submission of the participation agreement will allow OneCare to submit the necessary information to Medicaid in order to obtain more recent claims data on which to base updated estimates of the financial impact of participation. Preliminary estimates from OneCare in July indicated that dues cost would be $195k and our maximum risk, net of 50% risk mitigation, would be $197k. Additionally, there is an estimated $18k in potential value based incentive funds we could earn depending on the ACO's quality scores.

   The proposed FY20 budget does not include any financial impact of Medicaid ACO participation. As such, we are in the process of evaluating our options to fund the dues and new risk reserves. We will develop a

revised budget, reflecting an estimated 9-month financial impact of participation in the Medicaid ACO program, for our Board to approve before submitting to the GMCB for final approval.

We thank you for providing us with the opportunity to provide clarifying information. Respectfully, we ask that the GMCB work with us to achieve financial stability by approving our FY20 budget as proposed so that Copley can make a seamless transition to a new healthcare payment model and ensure that we are properly positioned to deliver high quality healthcare in our community for many years into the future.

Sincerely,

Jeff White
Interim Chief Executive Officer, Copley Hospital