August 9, 2019

Attn: Ms. Susan Barrett, J.D. Executive Director
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: Staff Budget Analysis 2020 – Response to GMCB Questions

Staff Analysis Questions:

1. Have the hospital's projections for FY2019 changed?
No.

2. What is the total ACO reserve on the balance sheet for Projected FY19 and Budget FY20?
Budget FY20 total ACO reserve on the balance sheet is $1,975,000. Projected FY19 total ACO reserve is $1,252,269.

Do you anticipate realizing savings or owing OneCare money when the FY18 settlements are finalized?
MAHHC only participated in the Medicaid Program for CY18. We experienced a nominal savings in domestic claims (services we rendered to our attributed Medicaid lives) but had a more significant payable to OCV for costs associated with our attributed lives receiving services at other OCV facilities. This resulted in a net loss on the Medicaid program for CY18. We had reserved for the year and rolled the positive net into income for June. We are now being told it is not final.

Are Other Reform Payments recorded in deduction from NPR, if not, where are they recorded?
Yes, under "Other Reform Payments: Other Reform Payments- Hospitals and Other Reform Payments Physicians".

3. What is your basis for booking ACO-related reserves and how do you evaluate those reserves through the year?
We book 100% of the estimated risk provided by OneCare Vermont (OCV). Current experience with OCV leads us to err on the side of caution since we have limited experience (6 months) with Medicare, there is a lag in data, and payment data is fraught with errors. This does not lend itself to establishing a reliable reserve calculation. As data is cleaned up, and a valid trend can be established, we will adjust the reserves as appropriate. Using GAAP (Generally Accepted Accounting Principles), we are required to account for reserves based on probability and reasonable estimates founded on validated and predictable sources of information. As previously mentioned, our current experience with the ACO leaves us with reserving at 100% of the maximum as provided by the ACO finance models. Additionally, our FY20 budget reflects a $1m "reserve" for the unfavorable cost report impact associated with the carve out of ACO business from the normal cost report reporting process. To date, we have been unable to get confirmation from CMS that this is concern is not founded.

4. Do you believe your ACO-related reserves affect other types of reserves (e.g., bad debt) that you carry on your balance sheet? If so, how?
No. We are able to segregate ACO related patient data from non-ACO patient data in our own system. From this analysis, we carve out Bad Debt and other reserves for each population separately.

5. MAHHC's FY19 Budget Order states the "Hospital shall consult with Vermont Information Technology Leaders (VITL) to facilitate patients' ability to electronically consent to adding their clinical data to the Vermont Health Information Exchange (VHIE)." What kind of headway has MAHHC made to facilitate this?
We consulted with VITL on 1/30/19 regarding the facilitation of patient's electronic consent to adding their clinical data to the VHIE, explaining our efforts in overcoming our technical roadblocks. Cerner will be implementing a technical solution that will enable us to move forward with the VITL optimization project, and will begin testing in late fall. We're anticipating go-live for this functionality in April/May 2020.

6. What is the value of 1 day of Days Cash on Hand?
As of 6/30/19 the value of 1 day of Days Cash on Hand is $143,742 (Cash Expenses/365).

7. What is the value of 1% of MAHHC's change in charge request? If there is a variance between MAHHC's calculation and the calculation provided by GMCB staff, please include the steps to your calculation.
$430K. GMCB calculated $442.5K, the difference being the GMCB included DSH in their calculation. DSH is not based on gross price increases and we do not believe that it should be included in that calculation. The value of 1% gross increase in charge request is equal to $202K.

8. Are Medicaid and Medicare reimbursement assumptions still valid including Disproportionate Share Payments?
To the best of our knowledge, yes. It is important to note that DSH payments are not based on recent Medicare and Medicaid reimbursement or trends. Essentially, it is based on the amount of cost that a hospital didn't get paid in a prior year and the amount of DSH funds made available by the State of Vermont. Our DSH amount is half of what it was a few years ago. DSH can be considered in our overall reimbursement rate but essentially reduces deductions from revenue without regard to rate increases, payer mix, or net reimbursement changes.

9. Does MAHHC have preliminary performance results of its new prescription drug formulary is it able to publicly share? If so, please share.
We regretfully report that we have not received the benefits that were expected. The process of change has been slow and existing D-HH contracts have hindered our adoption of an improved formulary. We have been in active discussions with D-HH to determine if this can be achieved or if we will need to look at other options to insure that our employees and their dependents receive the best outcomes at the best cost.

10. Does MAHHC plan to contract with OCV in calendar year 2020 for all payers? The submitted budget appears as though it is assuming full participation with a significant increase in dollars budgeted, but the narrative indicates concern with continuing with the ACO. Please show the effect on the P&L if MAHHC chose not to participate in CY20.
Yes. We are planning to participate in the Medicare, Medicaid, and Commercial programs. We say this with the caveat that if the Medicare cost report issue is not resolved favorably, we cannot manage

$1.7m of risk and an additional (estimated) $1m of lost revenue for the privilege of participating. Our Board of Trustees supports this position. We are hopeful that this will be resolved.

11. In both the narrative and in the Adaptive submission MAHHC indicates an increase in grant revenue. Please describe the work and types of grants MAHHC is applying for.
MAHHC is continuously searching for and engaging in opportunities to fund community health, collaborative care, family wellness, tobacco cessation, RISE Vermont, regional emergency preparedness, and other health reform initiatives. MAHHC has a robust, well-developed Grant staff that focuses on prevention and family wellness, led by Jill Lord. Their efforts and success yields continued external grant funding for programs and services that help us meet our mission.

12. It is noted that MAHHC is creating new positions, increasing salaries and replacing contract labor. Is this feasible in the current workforce environment? Additionally, travelers were part of the reason for purchasing a condo for housing; if you replace travelers is this investment sustainable?
As a general rule, where we have an existing contract for labor that is specific to one position and is a permanent/ongoing position, we budget that as contracted labor. For travelers, locums, and other temporary positions we budget the FTE and add the differential (contracted costs less FTE and benefits) into contracted labor. This is why our projected FTE's are usually less than our budgeted FTE most years. This year, we had folks who were finishing a contract transition to an employed status for the same position. We have also replaced some contracted labor with permanent staff and reduced the use of travelers. Currently, we are experiencing a historically low vacancy rate, hospital wide.

We anticipate having an ongoing need for this housing for off hour coverage, travelers, and/or relocating staff. To date, we have used it for travelers and for relocating staff. We have also converted space on campus to house weekend and off hour coverage staff.

Although our current staffing situation is strong and stable, we are likely to have clinical staff short-term and long-term leaves to cover. With a small and efficient staff, covering for vacations, medical leaves and emergencies will always be a necessity. There will likely always be need for travelers, and therefore there will always be a need to house them. The availability of having the condo pays for itself when there's just one occupant for 10 days a month. We currently have 2 booked for the month of August.

13. In general, utilization is budgeted to increase significantly which is also a major driver of the increase in budgeted NPR/FPP. Recent monthly YTD reports show negative variances to budget. Please explain the drivers of the increase in utilization and why FY20 will be different.
We experienced an unusual steep decline in February and early March utilization. That has affected our YTD figures adversely. We do not expect this issue next year as this experience was an outlier as compared to prior years. With the increase of acuity and volume that we have been experiencing over the last several months, we are confident in our projections for next year.

14. Days payable increased to more than 70 days. Please explain.
The calculation for Days in Accounts Payable includes Current liabilities. Our ACO reserves are included in the Current liabilities. The increase in ACO-related reserves is the reason for the increase in this ratio.

15. Page 2 narrative notes an "ongoing concern" related to $380,000 cost report audit adjustment from Medicare adjustment. What will this mean for your cash position? Is there any word on the cost report issue of $1 million that is included in the FY20 budget?

The unfavorable $380k loss per year is due to a change in interpretation for cost report settlements by the intermediary contractors. This will reduce our cost report settlement/reimbursement with Medicare every year by like amounts. Accordingly, this will lower our net reimbursement and cash. This change will apply to all CAH's to varying degrees. We generally provide a higher percentage of Swing Bed services as a percentage of our inpatient census so we are affected to a greater degree.

As it stands, there is no official resolution for this concern at this time. We are hopeful that we will have it resolved in time for our OCV contracting deadlines and for our GMCB hearing.

16. Other Operating Revenues for FY20 Budgeted are listed at $3.3 Million; you've accounted for $1.7 million in your narrative, from where is the remaining $1.6 million derived?
The majority is program revenue (Blueprint and Community Health Team funding), as well as Group Purchasing Rebates and sales of services.

17. Page 2 narrative notes a FY20 Budget increase of 6.1% over FY19 Projection but the budget submission is 6.5%; Please clarify.
It was a key stroke error. Our apologies for the unnecessary confusion.

18. What amount of Other Reform Payments does the hospital expect to receive from OneCare Vermont by the end of calendar year 2020 (e.g., payments from OneCare's Value-Based Incentive Program based on quality performance)?
Preliminary, we expect $529K. This is subject to change with the implementation of OCV's new Care Coordination Payment Model.

19. Are the hospital's employees attributed to OneCare, either through participation in a OneCare self-insured program or, if fully-insured, through the hospital's insurer? If not, why not?
No, we are not participating in the One Care Program for self-insured employers. We have been in a multi-year process of standardizing with the D-HH benefits platform. With the ongoing migration efforts, we have not considered this opportunity in earnest.

BOARD MEMBER QUESTIONS:

20. For FY19 projections what departments are expenses exceeding revenues?
Using an indirect overhead allocation methodology, the following departments have expenses exceeding revenues: Anesthesia, Cardiac Rehab, Emergency Room, Respiratory Therapy, Acute/Swing, Inpatient Rehabilitation, and Provider Practices.

21. Please suggest a statistic the GMCB can monitor to better understand the trends in the total number of staffed beds in the hospital versus the number of beds available for use, and how full or empty those beds are from month to month?
Generally speaking, the greatest number of beds that a facility can have is the number of licensed beds. Many hospitals operate below their licensed number due to the migration of inpatient treatments to outpatient settings. The next level of counting could be done at the "physical bed" level. For a CAH, this is limited to 25, regardless of the license number unless there is a distinct part unit (MAHHC Inpatient Rehab Unit in addition). Staffed beds refer to the actual number of beds that can be utilized by available staff to care for the patients. Actual occupied beds (patient in beds) can never exceed staffed beds. Most facilities do not track staffed beds because many times our normal staffing patterns change based on availability of staff and the census. Most, if not all, CAH's flex their % of acute beds to swing beds based on patient need so there is no valid way to measure occupancy against staffing or licensed beds. A

distinct part unit can be measured against itself since it is a specific number of available beds. Observation patients also factor into census and staffing for acute/swing patients levels.

The best measure for a CAH would be (acute days + observation days + swing days)/(acute beds + observation beds + swing beds). For a distinct part unit, a DPU, (psychiatric or inpatient rehabilitation) it would be simply be DPU patient days/DPU beds.

Note that in the case of a CAH, a normal daytime staffing pattern might be 4 patients to 1 nurse. If a census runs at 20, the facility could run perfectly efficiently with 5 nurses. If the census moves to 21, an additional nurse may be required to be added to the staffing which would make them less efficient until they reach 24.

22.What is the impact of the now known Medicaid reimbursement increases? Any update on inpatient Medicaid reimbursement changes?
The projected increases were around 3% for Outpatient and less than that for the providers but this based on a similar payer mix, similar volumes, and similar services being rendered as in the base year. The impact is expected to be nominal. Outpatient projections, the biggest portion of our business, were $20+k. The increases for provider fee schedules vary by specialty so a detailed study would need to be done. Again, this is a smaller area of business and based on payer mix, service mix, and volume...as well as provider type. Overall, since Medicaid pays significantly below cost we don't believe that it has a material impact our budget.

23. If you assumed Medicare increases, what is the value and what would a reduction in commercial be to maintain your NPR?
We did not increase our Medicare reimbursement percentage due to the ACO cost report issue and the swing bed issue.

24. Can you estimate the impact of the swing bed patients from DHH and why they are not subsidizing any losses?
This system allocation was designed as an interim safeguard for MAHHC as D-HH developed its overall service allocation plan. MAHHC has opportunity to take subacute patients to help de-compress the system and was ready to take the steps needed to implement this opportunity quickly. The annual amount that we received in that first year was $1.2m. As D-HH's service allocation plan rolled out across the system, other facilities took more of these types of patients from their own service area reducing the need for MAHHC to take them. At the same time, we got more efficient and effective with our intake processes, our discharge planning, and our efforts to find coverage for these patients. Currently, if we are unable to find coverage for the patient, D-HH pays us a fixed amount per day for the patient days that we cannot obtain coverage. This is done on a case by case basis and typically runs about three patients per year. The daily rate that D-HH pays us is between the Medicaid ICF (nursing home) rate and the costs for a SNF (skilled level) patient.

25. Your reconciliation from FY19 budget to FY19 projection show $1.3 million for ACO. Your bridges reconciliation from FY19 budget to FY20 budget shows the FY20 risk reserve of $2 million. Shouldn't the change from budget be $3.3 million?
We had no ACO reserves in the approved FY19 budget because we had not yet received modeling information in time for budget. Total budgeted ACO reserves for FY20 are $1,975K. The change from budget to budget is $1,975K as noted in the bridges reconciliation.

Regards,

David Sanville, Chief Financial Officer