Mt. Ascutney Hospital
and Health Center
Dartmouth-Hitchcock

September 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: Hospital Hearing Follow-up Questions

Dear Ms. Barrett,

This letter and the attachment serve to respond to the post-hearing follow-up questions.

Questions from the GMCB Members:

1. Please examine your NPR/FPP estimates in light of recent downward trends in FY19 operating performance and/or new info such as better understanding of attributed lives/cost report issue.

Answer: Our downward trend is based almost entirely on ACO-related issues. Without the ACO experience, we would be at $219k operating margin YTD would be an improvement on our projection at the time of budget submission. We had been hopeful that the ACO payment and cost report issues would have been cleared up by our hearing date. We had some low volumes early in the year but have been at or above budgeted volume expectations for several months. We expect that trend to continue through the end of the year.

Attachment A reflects the impact that the ACO-related issues has had on our Profit & Loss statement. This impact includes:

- **Risk Reserves – fully funded year-to-date**
- **"Fixed Prospective Payments" activity YTD**
- **"Shadow Payment" activity YTD**
- **Reserves for a liability related to receiving FPP and FFS (currently equal to $1.1m)**
    - **Our receivable was relieved with $1.1m in FFS cash and $1.1 million in FFS contractual allowance.**
    - **We also received FPP for these same patients, so we owe Medicare the erroneous FFS payments back.**
    - **We built a liability for the obligation to Medicare, offsetting the FFS cash received in error.**

  - When Medicare takes back the erroneous FFS payments our receivables will go up by approximately $2.2m, offset by a reduction in cash of $1.1m, and the liability will be reversed.
  - These receivables will then be replaced with contractual allowances/shadow payments totaling $2.2m
  - This will add $1.1m to our shadow payment total and will eat into our risk reserve/experience YTD
    - Our budgeted risk through July is $823k
    - Our differential between FPP and the shadow payments is $-411k through July
    - This correction will cause our shadow payments to exceed our YTD FPP by $689k
- Other Health Care Reform Payments (Non-FPP funding) for community/attributed wellness, prevention, etc.
- FTE's and other operating costs associated with the above Other Health Care Reform Payments.
- Participation Fees
- Cost Report Uncertainty (only partially recognized, under-reserved) YTD

As was discussed at our hearing, because of the erroneous payments and duplication of reimbursement, we are unable to accurately estimate our accounts receivable reserves, third party reserves, our risk reserves, our cost report settlement reserves, and any possible receivable from the Springfield HSA business. These are generally the largest estimates that management makes relative to our financial reporting and places us at risk for our annual audit and close of the year. We would like to emphasize that 40+% of our largest payer, with the largest amount of deductions, has corrupt data and we are unable to mathematically determine our reserves or to assess our current financial position with any certainty.

Additionally, as of September 6th, we were able to confirm that aside from no formal instruction/confirmation from Medicare on the cost report filing methodology (carving in or carving out ACO revenues and costs), the payment reporting data (PS&R) required from Medicare in order to file a cost report has been "broken" since 1/1/19.

In overly simple terms, we need to have the erroneous payments corrected, an official report on whether the shadow payments and costs associated with ACO business should be carved in to the cost report, and a clean PS&R in order to make these areas of reserve "estimable" and/or "probable". This will allow us to run a cost report, assess our current and projected financial position, and to trend our risk reserve requirements.

G.A.A.P and F.A.S.B. standards are specifically intended to insure the "comfort" of the reader. In short, anyone depending on our audited financials for any legal or business reason should be confident that they reflect our actual financial condition. Our auditing firm was unable to

provide any meaningful assistance to us in establishing these reserves due to the large scope of these concerns and data issues. Reserves, positive or negative, are based on probability and reasonable estimation. These reserves are currently not "estimable" nor "probable".

In our testimony, MAH management iterated our willingness to make whatever appropriate adjustments to our budget or even a mid-year adjustment to reflect any gains realized from the resolution of these issues. In our assessment of the situation, all of these items are completely fixable but time is of the essence for all of us. Our unfavorable cost report impact estimate of $1m is a best guess based on what we and our cost report consultant could piece together. It could be more or it could be less. Without an interim cost report estimate, it will be difficult for us to accept any cuts in our NPSR since no one can determine the impact.

2. Please explain the jump in Medicaid revenue in 2020 budget ($1.9 million to $4.1 million, 109% increase, from staff analysis)?

Answer: In reviewing the "Net Payer Revenue Changes - Payers" schedule (NPRC-P) and the "Appendix VI NPR Bridges – FY19 Approved Budget to FY2020 Proposed Budget", (Bridges) we identified a few issues. The first was that we completed these schedules incorrectly last year. This is best exemplified by the change in Medicaid net revenue % of gross Medicaid revenue from FY18 to FY19. Given the opportunity to have more time, we could figure out what we had done last year.

Relative to FY2020's budget, our analyst is unavailable this week and is therefore unable to show us where these numbers flow from in Adaptive and where they flow from on our internal documents. In comparing these numbers to our internal numbers, we identified that Medicare, Medicaid, and Commercial should all be changed as follows. The Medicare change relates to the cost report. The Medicaid change appears to be the reversal of last year's error in duplicate, and the Commercial figure is the plug. These reflect our internal workpapers. We apologize for the confusion and additional effort on your part.

		B2020 As Filed	Error	B2020 As Filed
Comm	NPSR	$19,758,535.00	$ 1,764,996.55	$21,523,531.55
	GPSR	$35,299,931.00		$35,299,931.00
	NPSR%	**56.0%**		**61.0%**
MDCD	NPSR	$ 4,100,538.00	$ (986,255.82)	$ 3,114,282.18
	GPSR	$10,958,398.00		$10,958,398.00
	NPSR%	**37.4%**		**28.4%**
MDCR	NPSR	$30,808,244.00	$ (778,740.73)	$30,029,503.27
	GPSR	$61,626,449.00		$61,626,449.00
	NPSR%	**50.0%**		**48.7%**

3. Please further justify FY20 budgeted increases in utilization. How do you plan to achieve the 9% increase in utilization shown in your bridges table?

Answer: The NPR Bridges matrix has been problematic for us. While some of the categorization is cut and dry (bad debt, free care, changes in DSH) some of the categories overlap and it is difficult to translate our modeling into this format. That said, we probably overstated the amount in that bucket and understated the amounts in the other buckets. Some of the 9% is more like intensity. For example, our budget reflects more acute stays and less swing bed stays. Acute stays involve surgery more often and more ancillary services all of the time. It is difficult to determine a specific amount for intensity. The old reporting format (Volcost tab) tried to address this but it was also problematic. Aside from the intensity, we are experiencing these changes in our current year:

- **Physician volume was running below expectations (-3.0%) in March but is now on budget for volume through July (0.0% variance)**
- **Acute stays are up 11% YTD**
- **Rehabilitation stays are up 3%**
- **Swing stays are down by 8.5% but this loss of revenue has been more than made up with the higher volume of acute stays**
- **Emergency Room is up 7.8% YTD but the positive variance has been growing monthly. In July, volume was up 21%. This is primarily due to other regional situations (other facilities)**
- **Imaging (Radiology) is up 41% YTD, again, mostly due to other regional issues**
- **Laboratory is up 7%, relating to increased acuity on the inpatient units**
- **Outpatient therapies are up 5%, relating to other regional issues**
- **Our volume from NH and from other Vermont HSA's is growing and we see no reason that this will diminish in the upcoming year.**
    - **Services to Springfield HSA patients has grown by 25% from prior year**
    - **Services to NH patients is growing has grown by 13% from prior year**

Based on the increased intensity and the volume growth that we are currently experiencing, the 9% seems right.

4. 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?

Answer: We acknowledge that the methodology employed by DVHA and their consultants is appropriate. However, this increase is based on historical mix of services and volumes. Because it is based on a prior period's mix of services and volumes, the fact that Medicaid

enrollments and coverage may change, this may or may not be realized as projected. As a CAH with a small 'n' of patients and services, the projected increase for outpatient reimbursement of $26,000 is approximately a 1% increase of our total Medicaid reimbursement if it happens as projected. It is likely offset in part by no increase in inpatient reimbursement (our reimbursement model translates payment experience into percent of charges for modeling). We did not consider the net gain or loss to be material enough to change our reimbursement model or to run detailed studies.

5. Please confirm whether the CMS wage index final rule has an impact on your hospital? If so, please quantify.

Answer: As a Critical Access Hospital, we are not affected by the CMS wage index changes. However, our Inpatient Rehabilitation Unit is a Distinct Part Unit and is not paid on cost like the rest of the hospital. These inpatient stays are paid by CMG's (Rehabilitation version of a DRG) and these payments are calculated using the wage index as one of the factors. Therefore, a decrease in the wage index will decrease payments if all other factors do not change. Our calculations indicate that CMG payments from Medicare will decrease 2.1%. Based on Medicare NPSR for this unit, $3.4m, we expect to lose $68,000 in reimbursement for 2020.

6. 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?

Answer: This question was addressed in our response to the Health Care Advocate questions. "With Medicare set at 1.0, Medicaid and Commercial payers' reimbursement ratios are 0.75 and 1.3 respectively."

GMCB Staff Follow-up:

1. Please explain the shift between Commercial and Medicaid NPR/FPP, specifically as it relates to contractual allowances and the ACO.

Answer: See the answer to question 2 in the GMCB Member section.

Please let me know if there are further questions or concerns.

Regards,

David Sanville, Chief Financial Officer

ATTACHMENT A

MAHHC
OPERATING MARGIN; IMPACT OF ACO
FY19 - YTD JUL19

	Year to Date JUL19	(10 months) OCV Medicaid	(7 months) OCV Medicare	(7 months) OCV Commercial	D Other HC Reform (M'care, M'caid)	Year to Date without OCV	Year to Date Budget	subtotal OCV
GROSS REVENUE	86,198,043					86,198,043	83,828,633	
DEDUCTIONS FROM REVENUE	(50,249,315)	A 824,923	A 5,251,271			(44,173,121)	(41,829,443)	6,076,194
Net, PATIENT SERVICE REVENUE	35,948,728	(824,923)	(5,251,271)			42,024,922	41,999,190	
OTHER OPERATING REVENUE	8,141,975	B 605,550	B 3,922,427	B (48,296)	178,603	3,483,691	3,296,543	4,658,284
TOTAL OPERATING REVENUE	44,090,703	(219,373)	(1,328,844)	(48,296)		45,508,613	45,295,733	
EXPENSES	45,703,177	C	C	C		45,289,408	45,035,187	
(OCV Fees)		84,955	45,040	17,346	266,428			413,769
OPERATING MARGIN	(1,612,474)	(304,328)	(1,373,884)	(65,642)	(87,825)	219,205	260,546	(1,831,679)

A "Shadow" payments (T.Graves) & Risk Reserves
B Fixed Prospective Payments (FPP) (excludes other healthcare reform)
C OCV infrastructure fees
D Care Coordination & Population Health Management Revenue & Expense

RESERVES		OCV Medicaid	OCV Medicare		
Reserve for Overpayment		-	1,109,333		
Risk Reserves	Jan19-Jul19	58,331	822,440		
Risk Reserves	Jan18-Dec 18	-	-		
		58,331	1,931,773	1,990,104	As of Jul 31, 2019
Risk Reserves	Aug19-Dec19	41,665	823,050	864,715	Remainder of Cal Year 2019
	CAL YEAR 2019	99,996	2,754,823	2,854,819	TOTAL