MT. ASCUTNEY HOSPITAL
AND HEALTH CENTER
A Dartmouth-Hitchcock Affiliate

August 18, 2017

Mr. Andy Pallito
Director of Health System Finances
Green Mountain Care Board
89 Main Street, 3rd Floor
Montpelier VT 05620

Mt. Ascutney Hospital and Health Center Fiscal Year 2018 Budget Analysis Questions:

1. Narr – Mt. Ascutney and DHMC have been reorganizing and formalizing the relationship over the last few years. Describe the status of this agreement and explain how it has changed Mt. Ascutney's role in the health care system. Describe the opportunities and risks related to this new agreement.

   Answer:

   Since July of 2014, MAHHC has been affiliated with DHMC under the umbrella organization of Dartmouth-Hitchcock Health. From a legal standpoint, the affiliation has been finalized. That said, the work associated with the strategic, clinical and operational integration is an ongoing effort.

   The affiliation has benefited both hospitals immensely but there have also been unintended negative consequences as well. By partnering with a larger academic medical center 30 miles away, MAHHC has been able to complete recruitments of medical specialists (ie. replacing our recently retired Gastroenterologist) and also key managers for clinical and administrative positions. Without the resources and academic opportunities we would not be able to recruit specialists to Windsor, nor do we have the volume to justify hiring full time medical specialists or surgeons in many cases. This has allowed us to keep the care of our patients closer to home. Our Chief Nursing Officer and Director of Quality, Patient Safety, and Compliance as well as some middle managers have come from D-HH.

   We have also engaged with DHMC regarding 24/7 telehealth support in our Emergency room for our Physician Assistants and are moving forward with DH to provide 24/7 tele-psychiatry services for our ER patients in psychiatric crisis.

   Since 2014, we have received over 1500 post-acute patients from DHMC and we are the largest recipient of this class of patients from DH in either NH or VT. By "decompressing DH" we are able to focus on one of our core strengths (acute rehabilitation and post-acute care) and DH is able to open inpatient beds quicker for tertiary care needs of NH and VT and they are not losing money on patients for whom they cannot be reimbursed. This has proved financially beneficial to DH and has improved our use of existing resources. This means less cost being pushed onto patients, insurers, and employers in the region. We have played an invaluable role in

D-HH with this work and DH recognizes this value by providing financial support (System Allocation Payment).

From a clinical perspective, the risks involved with affiliation include the potential for DH to "pull back" clinical services when there are acute needs at the Academic Medical Center. We have experienced this and it can be a difficult experience for referring primary care providers and patients.

From a non-clinical perspective, our affiliation has allowed us to tap into DH resources for help with recruitment and retention of manager/director level positions and bring real expertise to several environments including Laboratory Services, Information technology, and Pharmacy. Through our affiliation we are also engaged with D-HH's departments of HR, Materials Management, Media Relations, Development, and Nursing. All of which have contributed to our bottom line and have improved our ability to more effectively meet our mission.

2. Income Statement – The hospital is $0.6 million, or 1.4% over the 2017 budget levels and within the Board's 3% target. As part of being able to make the target, the hospital has budgeted an operating loss of over $1 million. They're able to do this since DHMC will provide a subsidy to support cash flow needs. Describe this arrangement with DHMC and when the hospital will begin budgeting a surplus?

Answer:

MAHHC budgeted a $1.2m loss for FY17 and a similar loss for FY18. D-HH has committed to providing a "System Allocation Payment" in the amount of our negative margin because of the lengthy process of integration, allocating and re-allocating services within the D-HH system, and the benefit of our willingness to take sub-acute patients. MAHHC has been an earlier and aggressive adopter of the system's initiatives. This payment helps to make up for the impact of the aforementioned issues as the system works their way through the changes. While the this leaves a negative operating margin on the books, our total margin is commensurate with a hospital breaking even on operations. This allows us to maintain a reasonable balance sheet and to invest appropriately in the areas of mission, staff, and capital needs. This allocation payment is sent in quarterly installments. It is unclear at this time how soon a normal operating margin of 2-3% would be possible.

3. Rate & NPR – Mt. Ascutney has an overall rate/price request of 4.89%. Discuss the rationale and other factors that explain the reason for your price/rate increase, including the changes occurring in utilization.

Answer:

Our budgeting process drives our rate request each year. Our process and decision-making begin with determining what our volumes will be for each department. History, current results, and known changes drive the new volume budget. Once we determine how busy we will be in each department, we determine the necessary staffing levels to effectively and efficiently manage that volume. The volume also drives the changes in our variable expense (pharmacy, medical supplies, contracted services, etc.). Inflation factors, wage increases, and other considerations are added to the expense base. Changes in payer mix, payer contracts, governmental reimbursement, and the impact on our CAH cost report are determined. These factors are entered into our budget model to calculate current pricing with the projected volume. Our gain or loss on

operations is determined and we increase our prices until we reach the desired margin.

We have had a fairly predictable utilization in the various "inpatient" lines of business (acute inpatient, acute inpatient rehabilitation, and swing bed) so we are not expecting any material utilization changes in that area. Budget to budget, we have budgeted for a reduction in Emergency Department services, primary care, and ancillary services. We have experienced a great deal of turnover in primary care (retirement, relocation, etc.) and this has had an adverse effect on volumes in the areas of ancillary services. The Emergency Department has been trending down for a few years, presumably due to efforts in the areas of CHT, Blueprint, Primary Care office hours, etc.

4. NPR Payer – Medicaid shows unfavorable reimbursement and loss of utilization from 2017 to 2018 budget. Describe the reimbursement assumptions the hospital has made. Also, describe what is happening with Medicaid utilization.

Answer:

Overall utilization is down, budget to budget. Generally, this is in the areas of clinics and outpatient ancillaries. Much of this is due to our recent struggles in primary care (referenced in question #3) and the system service allocation initiatives at D-HH. Therefore, utilization in all payer mix groups is diminishing. In addition, year to date, Medicaid has been running lower as a percentage than what we have seen in the past. While there is no blatantly obvious reason for this, we do believe that patient access in primary care and the changes in N.H. Medicaid administrators are contributors. Not all administrators contracted with all out of state facilities.

5. Income Statement – Retail pharmacy (340B) of $725,000 is recorded in operating revenue. Describe this program and the risks involved operating the program.

Answer:

We actually utilize three opportunities in the 340B arena. All three generate improved financial margins based on our qualifying to participate in this Federal program due to our Critical Access Hospital status. As a covered entity, we are able to purchase many pharmaceuticals at prices lower than what is/was available to us as a non-340B provider.

The first opportunity is that we are able to reduce costs for many drugs administered in outpatient settings. This includes our Emergency Department, observation unit, clinics, and other outpatient departments. This lowers our cost to operate, even after the administrative costs for this program, and helps us reduce the request for price increases. This program is worth $150,000 in savings per year. This savings is reflected in our supply costs.

The second opportunity is that we are able to provide access to our employees for mail order pharmaceuticals. Providing these pharmaceuticals at a lower cost to our employees lowers our operating costs since we are self-funded. This savings is passed on to our employees and ultimately reduces our costs to the patients, insurers, and employers. This aspect of the program is worth just over $100,000 per year. This savings is reflected in our benefits line under expense.

The third opportunity is the retail pharmacy program. Essentially, the prescriptions that qualify (qualifying patient, qualifying provider, qualifying retailer, and qualifying medicine) are purchased at the retail pharmacy by the patient/insurer. The pharmaceutical is able to be purchased at a lower cost, the pharmacy is paid to administer the transaction and the purchasing for the hospital, and the hospital keeps much of the margin created by the lower purchasing cost. The net (revenue less all costs) of this aspect is booked in Other Operating Revenue ($725,000).

The benefits are that the hospital is able to offset the effect of the cost shift, create a new source of revenue at no additional cost to the consumer, their insurer, and their employer, and the hospital is able to maintain high-subsidy services necessary for the community. The risk is that this program is not popular with "big pharm", it is continuously at risk in Washington, and is in constant flux relative to regulations and compliance.

The less obvious risk is that hospitals have been leveraging this to drive necessary margins and balance sheet positions. If one considers the growth in the area of Other Operating Revenue, it is obvious that Other Operating Revenue has grown as a contributor to the operating margin over the last several years. The two key areas are Meaningful Use Funds (EMR implementation reimbursement) and 340B. Meaningful Use will be down to a trickle for most hospitals soon, if not already. If 340B goes away, there will be no way to cover operating expenses, to expand revenues, or to produce a margin without large price increases. The NPR pie shrinks every year with commercial payers looking for relief from the cost shift and governmental payers looking for relief for tax payers and budget pressures.

6. Income Statement – Are the 2017 projections still valid? If not, please describe material changes?

Answer:

At the time of our budget filing, we were expecting a $288k positive margin versus a budgeted margin of negative $1.2m. Currently, we are anticipating an improvement from our last projection and to achieve a positive operating margin of $650k. This would be a favorable variance of approximately $1.9m. This favorable variance is driven by a few factors:

- ***Our self-funded health insurance is running 20% below actuarial expectations. Currently, we expect that this will continue through the end of year creating an improvement of $1.0m by itself.***
- ***Supplies are trending towards a $400k favorable variance due to lower volumes in outpatient settings and access to D-HH supply chain pricing.***
- ***Depreciation is favorable due to purchasing less capital than anticipated and our Fair Market Adjustment depreciation beginning to be "retired". ($400k)***
- ***Slightly favorable payer mix than budgeted and a bump from the cost report due to lower volumes improving net revenue realization.***

7. Refer to the Act 53 price and quality data schedules that were included in the presentation of FY 2018 Hospital Budget Submissions-Preliminary Review on July 27, 2017 and be prepared to address questions the Board may have concerning that information.

Answer: ***Acknowledged.***

8. In the March 31 GMCB hospital guidance, the Board allowed up to 0.4% for **new** health care reform. The Board directed each hospital to provide a detailed description of each new health care reform activity, investment or initiative included within the designated 0.4%, provide any available data or evidence-based support for the activity's effectiveness or value, and identify the benchmark or measure by which the hospital can determine that the activity reduces costs, improves health, and/or increases Vermonters' access to health care. With this in mind, please describe how you are investing for new health care reform activities in the four approved areas:
    - Support for Accountable Care Organization (ACO) infrastructure or ACO programs;
    - Support of community infrastructure related to ACO programs;
    - Building capacity for, or implementation of, population health improvement activities identified in the Community Health Needs Assessment, with a preference for those activities connected with the population health measures outlined in the All-payer Model Agreement;
    - Support for programs designed to achieve the population health measures outlined in the All-payer Model Agreement.

Answer:

All of the health care reform costs associated with the initiatives identified below are baked into our budget and our operations.

Support for ACO infrastructure or ACO programs

- ***We created a director position for Quality and Patient Safety and have developed a Quality Dashboard that shows progress toward ACO quality goals. We provide a stipend for primary care physicians to develop and implement QI projects designed to address deficiencies as noted on OCV quality metrics. In 2017 we completed a project that reduced COPD admissions to MAHHC and in 2018 we plan to design a program to reduce CHF admissions***

Support of community infrastructure related to ACO programs

- ***We provide the leadership and infrastructure for the Windsor HSA. Our quarterly meetings bring together SNFs, SSASH, VNA, Designated agencies and other community resources.***
- ***We created a senior leadership level Director of Community Health and Outreach whose focus is to implement the Community Health Needs Assessment and design programs in response issues identified.***

Building capacity for population health improvement activities

- ***We have hired a data analyst and have provided DA2 training so she can generate reports from our EMR that show real-time practice performance toward APM measures***
- ***We have hired a nurse informaticist to optimize the way we enter and extract data from EMR to allow for ACCURATE and TIMELY reporting of our clinical activities***
- ***We have retrained nursing staff in our clinics to allow for practice at the tops of their licenses. This will allow them to perform Medicare Annual Wellness Visits for our patients.***

Support of Programs designed to achieve the population health measures

- ***While we have implemented the 3-4-50 Program over the last year, we will be moving to adoption of the RiseVT program as it becomes embedded in the ACO/APM model***

- ***We currently have ongoing regular outreach and classes to address tobacco use/intervention***
- ***We have started an SBIRT program in our clinics and ER to address early intervention on alcohol and drug dependence***
- ***We currently meet the goal of 30 day follow up mental health care after an ED or hospital visit***
- ***We have a patient experience committee that addresses deficiencies in CG CAHPs and HCAHPS scores, Current improvement efforts revolve around Hand Hygiene, Noise reduction, and provider communication***
- ***We have started a Six Sigma Green-belt project with the Dartmouth Value Institute to improve the documentation and work-flows around vaccination administration in our clinics***
- ***With the hire of our analyst, we are working to develop real-time reporting on hypertension control and HbA1c measures***

9. Please identify which ACO(s) you will have a contractual relationship with in 2018. If your hospital plans (or already is) in a risk-bearing contract with OneCare, please explain the effect of the risk on your financial statements. Please explain specific strategies your hospital is developing to move toward population-based payment reform. Finally, what tools does your hospital employ to ensure appropriate, cost effective, quality care when working with providers outside the CHAC or OneCare network?

   Answer:

   For 2018 we are likely to engage with Vermont Medicaid Next Gen ACO. We are awaiting more details about the program AND will review the experience of Porter Hospital, a similar-sized critical access hospital. We continue to have questions regarding risk contracting and the interface with cost-based reimbursement as a CAH. We will likely move to a full risk model with OCV in 2019 if those questions can be answered. Virtually all of our the tertiary care that is required by patients attributed to MAHHC is provided by DHMC. This means that our highest spend patients (our highest utilizers) receive their care at DHMC, which is currently not in a risk bearing contract with VT. This puts MAHHC in a challenging position and we work diligently to keep our patients local, have expanded our hospitalist program, and work with DH to provide specialty care in Windsor which can help control costs. We also work with DH to ensure that our patients quickly move to MAHHC once their tertiary needs are met at DHMC.

Please let us know if there are questions or concerns. We look forward to seeing you in person.

Sincerely,

David C. Sanville
C.F.O./V.P. Finance

cc: J. Perras, M.D.; C.E.O.
GMCB FY18 File