MT. ASCUTNEY HOSPITAL
AND HEALTH CENTER

A Dartmouth-Hitchcock Affiliate

August 10, 2018

Attn: Ms. Pat Jones, Director of Health System Finances
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: Staff Budget Analysis 2019 – Response to GMCB Questions

Dear Ms. Jones,

This letter serves as the response to the final staff budget analysis questions communicated 7/31/18.

Question 1: Have the hospital's projections for FY2018 changed?

No. We continue to estimate that our final operating margin will be $330,249.

Question 2. Please explain factors driving changes in Bad Debt and Free Care from FY2018 Budget to FY2018 Projections and FY2019 Budget (including policy changes if any).

Bad Debt and Free Care are budgeted and projected as a percentage of gross revenue. As such, the increase in volumes and associated revenues are a significant factor driving the changes in Bad Debt and Free Care. A second significant factor is the the anticipated effects of the annulment of the federal "Individual Mandate". With individuals dropping out of the exchange and forfeiting insurance coverage, we anticipate an increase in Private Pay individuals. As Private Pay business increases, so does Bad Debt.

Question 3. Please provide more specificity about what is included in Other Operating Expense for FY2017 Actuals, FY2018 Budget and Projections, and FY2019 Budget, and explain the variation from year to year.

The most significant expenses included in *'Other Operating Expense'* include purchased labor (28% of FY19 Other Operating Expense) and purchased services (26%). The next most significant cost factors are pharmaceuticals (10%) and medical and surgical supplies (7%). Followed by leases and rentals (5%), utilities (5%), food/office/other supplies (4%), minor equipment/software/other maintenance (4%), insurance (4%), etc. Please refer to *Appendix 1* for a more complete list of accounts included in '*Other Operating Expense'*.

The major driver of change is the growth in purchased labor. The most significant factor being the lack of an available workforce. As we've discussed in previous testimonies and Q&A sessions, adequately staffing our hospital to meet quality and regulatory requirements has been the biggest area of expense growth, mostly due to the need to resort to travelers and locums to fill in the critical workforce gaps. This has been trending up, as seen in *Appendix 1*, from $4.67 million dollars in actual FY17 actual to $4.74 million in projected FY18 to $4.85 million in the FY19 budget. Secondarily, as we continue to integrate with DHH, we have increased the number of managers and providers that we "rent" from DH. This has improved quality, patient safety, and overall healthcare value.

A measurable increase in the cost of utilities has contributed to the overall increase in other operating expenses, 11 percentage points projected FY18 to budget FY19. The increase is partly attributable to

large electric rebates from our work with Efficiency Vermont in implementing energy efficiency projects throughout the hospital. These rebates have now ended. Another factor is the rising price of gas/oil.

Pharmaceutical costs have gone down as we endeavor within our organization, Pharmacy Benefits Managers and other organizations to minimize the cost to patients. There has been 7% decrease in this cost category budget to budget, and we are projecting to come in 2% under our current FY18 budget.

Categories such as dues/fees/taxes other supplies, insurance, legal, and banking fees and other miscellaneous expenses all show decreases which exemplify our cost containment initiatives.

Question 4. Please explain the calculation of the estimated value of a 1% rate/price increase; the hospital's estimate varies from the GMCB staff estimate.

We calculate a gross increase by taking the base gross revenue (before rate increases and based on projected volume) and multiplying it by 1%. We then apply a blended deduction rate to the gross increase, resulting in the estimated value of a 1% rate/price increase. The deduction rate is based on projected payer mix and historical deduction percentage rates. Our estimate varies from the GMCB's by $8,000 or 1.6%, generating high confidence in both methodologies. See Appendix 2 for table.

Question 5. Hypertension prevalence and diabetes prevalence are two measures from Vermont's All-Payer ACO Model Agreement. The health service area that includes MAHHC has higher rates when compared to the rest of the state. Please provide detail on initiatives related to hypertension and diabetes prevalence (including initiatives with community partners.

For both diabetes and hypertension, we have actively engaged in community/regional projects to reduce prevalence. For the past 2 years we have worked with 3-4-50 through the Vermont Department of Health, reaching over 2000 community members with education around the 3 behaviors leading to 4 diseases (cancer, heart disease/stroke, Type 2 diabetes, and lung disease) that result in 50% of deaths in VT. We have encouraged healthier eating choices in the community through involvement with Veggie Van Go, a program with the VT Food Bank that provides vegetables in communities at risk for food insecurity.

In MAHHC clinics, most of our work has been concentrating on getting accurate data in the development of a quality dashboard for our Health Service Area (HSA). Hypertension and diabetes are both key outcome measures for our HSA and internal dashboard. In this work we are developing accurate registries of patients followed by outreach by individual providers and nurses.

<u>Hypertension</u>
We have completed a pilot with SASH and one of our primary care doctors. In this process, SASH selected at risk patients, closely monitored them, systematically communicated the results to the doctor and sought needed adjustments in their regimes to improve their control. Six educational classes were provided to patients covering DASH/Mediterranean diet, sodium intake, exercise, and reading labels. On average, systolic blood pressure (SBP) decreased 1.92mmHg, the range of SBP decrease was -23mmHg to +52mmHg the median SBP was 15mmHg. Four SASH participants decreased their blood pressure during the pilot and two participants had an increase.

We are also cross referencing our newly developed internal patient registries with data from Blueprint and One Care Vermont.

<u>Diabetes</u>
We have started a self-management workshop for prediabetes called 'Prevent T2' that we offer on an ongoing basis. Currently we have a committed class of 10 participants. This program already has made a difference for participants in terms of weight loss, exercise and improved education. This class is taught by our dietician/certified diabetes educator.

Question 5.1 Please elaborate on comments made in the narrative regarding the reliability of Blueprint data

VITL is the repository for health information across the state of VT, and Dartmouth Hitchcock. The information is intended to be fed from all participating hospitals and clinics on a daily basis (either as stand-alone HL7 data feeds, or as nightly feeds of CCD, continuum of care documents). The expectation is that the providers would use VITLAccess as a data source for seeing information on a patient that may have been recorded and sent by another institution. There are no providers at MAHHC who are using the VITLAccess system. It is simply not tenable to ask busy providers to log onto another software platform for patient information that is neither accurate nor reliable. They already spend far too much time entering data and staring at screens; in fact, EMR usage is now considered to be a leading contributor to physician burnout in the U.S. Additionally, the patients were required to opt-in to allow the provider to see their profile in VITLAccess which adds to the burden of the institution to collect/monitor/administrate these additional consents.

Mt. Ascutney Hospital sends a nightly (real-time) HL7 ADT feed (this is a feed of demographic /encounter information on our patients). We were not successful in our attempts to create a CCD from Cerner (our Electronic Medical Records system) that was acceptable to VITL (missing some information like rxnorm terminology and had 'bugs' that added extra characters to blood pressure data). This led to inaccurate data in our Blueprint Practice Profile regarding simple data points such as BMI and blood pressure. This data was published annually without explanation of the data limitations thereby painting a picture of poor quality care in MAHHC clinics.

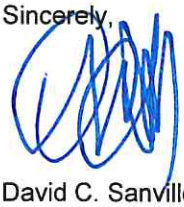
We have since corrected the issue by adding another task to our Quality Team, who now must manually send a flat file to VITL each quarter with labs and vital signs data.

Most of the information in the blueprint practice profiles is derived from claims data, with the exception of a few mentioned above. Before we started sending this quarterly file, the BMI/BP data were always extremely low for our practices.

Question 6. Please complete the table that has been provided to clarify accounting of ACO-related revenue and expenses.

See Appendix 3 for table and attached as an excel file in the response email dated 8/10/18 titled: "*Staff Budget Analysis 2019 – Response to GMCB Questions*"

Sincerely,



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

Appendix 1

	FY17 Actual		FY18 Budget		FY18 Projections		FY19 Budget		FY17 A - FY18 B	FY18 B - FY18 P	FY18 P - FY19 B	FY18 B - BY19 B
Account	Amount Total	Percent Total	Amount Total	Percent Total	Amount Total	Percent Total	Amount Total	Percent Total	% Change			
PURCHASED LABOR*	*$4,670,246*	28%	$4,282,959	25%	$4,736,414	28%	$4,853,251	28%	-8%	11%	2%	13%
PURCHASED SERVICES - RAD, LAB, IT	$3,957,412	24%	$4,410,197	26%	$4,275,790	25%	$4,421,861	26%	11%	-3%	3%	0%
PHARMACEUTICALS	$1,806,619	11%	$1,912,544	11%	$1,817,838	11%	$1,786,577	10%	6%	-5%	-2%	-7%
MEDICAL/SURGICAL SUPPLIES	$1,173,705	7%	$1,101,490	7%	$1,185,467	7%	$1,234,556	7%	-6%	8%	4%	12%
UTILITIES	$650,942	4%	$714,000	4%	$684,598	4%	$791,120	5%	10%	-4%	16%	11%
LEASE AND RENTAL	$767,759	5%	$800,046	5%	$795,100	5%	$790,925	5%	4%	-1%	-1%	-1%
FOOD, OFFICE, AND OTHER SUPPLIES	$671,875	4%	$761,943	4%	$774,914	5%	$714,068	4%	13%	2%	-8%	-6%
EQUIPMENT/SOFTWARE/OTHER MAINTENANCE	$508,369	3%	$706,399	4%	$687,450	4%	$706,696	4%	39%	-3%	3%	0%
INSURANCE	$955,747	6%	$737,272	4%	$640,362	4%	$663,943	4%	-23%	-13%	4%	-10%
STAFF EDUCATION	$141,074	1%	$239,560	1%	$221,449	1%	$273,151	2%	70%	-8%	23%	14%
DUES/FEES/TAXES (EXL. PROVIDER TAX)	$497,415	3%	$616,697	4%	$570,073	3%	$268,406	2%	24%	-8%	-53%	-56%
MARKETING EXPENSE	$229,434	1%	$212,930	1%	$267,068	2%	$262,403	2%	-7%	25%	-2%	23%
BANKING FEES, OTHER MISC	$244,886	1%	$266,722	2%	$246,557	1%	$230,863	1%	9%	-8%	-6%	-13%
TRAVEL/MILEAGE	$67,980	0%	$109,480	1%	$101,203	1%	$107,097	1%	61%	-8%	6%	-2%
LEGAL SERVICES	$54,237	0%	$60,000	0%	$55,464	0%	$50,000	0%	11%	-8%	-10%	-17%
TOTAL	$16,397,702	100%	$16,932,239	100%	$17,059,746	100%	$17,154,917	100%	3%	1%	1%	1%

**Includes re-classed 'Salary - Traveller' (FY17)*

Appendix 2

Mt. Ascutney Hospital & Health Ctr

Approximate NPR amount equal to 1% Rate/Price

Approximate NPR amount equal to 1% Rate/Price Input amount into cell D6 → $ 497,379

Please show your calculation below (use as much space as needed).

		2019	
a.	Gross Revenue	$ 98,686,266	
b.	Rate Increase	1%	
c.	Gross Revenue	$ 986,863	a*b
e.	Blended Deduction from Revenue %	49.6%	
f.	Net Payer Revenue	$ 497,379	c*(1-e)

Appendix 3

	2018 Budget ($)	Adaptive Account Name	2018 Projection ($)	Adaptive Account Name	2019 Budget ($)	Adaptive Account Name
Gross Home Hospital Spend for OCV Lives*						
Gross Value Based Incentive Payments*						
(Value Based Incentive Deduction)*						
(Participation Deduction)*				**Medicaid**		**Medicaid**
				Medicaid In-State		**Medicaid In-State**
				Fixed Prospective Payments-Hospital		**Fixed Prospective Payments-Hospital**
Gross Revenue Entered into Adaptive**			160,467	Fixed Payments-Inpatient	207,300	Fixed Payments-Inpatient
			295,597	Fixed Payments Outpatient	392,200	Fixed Payments Outpatient
				Fixed Prospective Payments-Physician		**Fixed Prospective Payments-Physician**
			147,195	Fixed Payments - Physician	156,500	Fixed Payments - Physician
			603,259		756,000	
				Allowances - Hospital		**Allowances - Hospital**
Contractual Allowances Entered into Adaptive**			340,564	Allowances	447,674	Allowances
				Allowances - Physicians		**Allowances - Physicians**
			109,917	Allowances	116,866	Allowances
ACO Risk Accounted for (if any)			60,000	Estimated Third-Party Settlements - Balance Sheet	72,000	Estimated Third-Party Settlements - Balance Sheet
Total ACO Risk***			60,000		72,000	
Attributed Lives (#)			1,071		1,000	

*Please indicate the Adaptive account used (Revenue accounts can be found on the 'Payer Revenue (Input)' tab on this spreadsheet). If anything is recorded in an expense account or on the balance sheet, please indicate where in Adaptive it is recorded.

**In order to account for the claims associated with OneCare attributed lives, many hospitals have included the total gross revenue related to the attributed lives by payer, then took a deduction through contractual allowances. If your hospital did this, please enter the dollar value and accounts used.

***Please list the risk amount regardless of whether you are recording anything.