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

June 30, 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: Budget 2019 Narrative

Dear Ms. Jones,

This letter serves as the narrative required to accompany the electronic budget files which have been sent under separate cover.

Executive Summary:

2019 will be a significant year for Mt Ascutney Hospital and Health Center (MAHHC), for the first time in recent history we are anticipating and budgeting a breakeven margin. MAHHC continues with its integration efforts into Dartmouth-Hitchcock (D-HH). Administrative, clinical, and other areas are reviewed and studied on an ongoing basis for change, consolidation, or to be left in current form. While many changes have been implemented over the last few years, there continues to be a steady stream of opportunity for further consideration. The organization is working on D-HH regional planning, service allocations, and expectations of clinical and financial effectiveness and efficiency. Clinical, administrative, and technological integration are paramount to the short and long-term success of the affiliation. Despite the changes and the studies, we have remained steadfast in our management of controllable expenses, minimizing the effect of uncontrollable factors, and keeping the ship steady. While the various Inpatient services and the care of our Specialty Providers have remained fairly steady and predictable over the last few years, we are experiencing mixed volumes in some Outpatient services. Additionally, our efforts to bring stability to our Primary Care units have not yet resulted in a dependable trend. We are also dealing with significant environmental changes, adoption of A.C.O models of care, and ongoing leadership transition. We expect to outperform our budgeted 2018 margin and expect our operating margin for 2019 will be a near $0 operating margin.

Payment and Delivery Reforms:

MAHHC is currently contracted with OneCare Vermont for Medicaid, during FY18. We have signed a non-binding letter of intent to contract with OneCare Vermont to add Medicare and Commercial payors for FY19. The amount that the hospital expects to receive in FPP for Medicaid attributed lives for FY19 is approximately $756,000. The data on attributed lives and risk corridor was not available at the time of the budget preparation so we have based our budget on the Medicaid experience for this year. The maximum upside and downside risk is $70,000 for Medicaid. The downside risk is reserved for as a potential liability in our accounting records. MAHHC has built a small hedge in deductions into Budget FY19 for Medicare and Commercial lives. The hospital will manage financial risk by continuing to provide team-based care and communicating about the patients by focusing on Complex Care Coordination for at-risk patients.

Community Health Needs Assessment:

A comprehensive community health needs assessment was completed in the fall of 2015. A prioritized list of top community needs was identified. The following is a summary of accomplishments in our effort to address gaps in services related to those community needs in FY18.

1. *Alcohol and drug misuse including heroin and use of pain medications*

- Monitored, tracked and distributed data from the Vermont Prescription Monitoring System. Distributed data to providers. Outcomes show Windsor area to be the lowest prescribers in the state.
- Liberal distribution of the *Consumer Guide for Substance Use Treatment* subsequent continued throughout the Hospital, community partners and community
- Medication Assisted Therapy, counseling, support and case management through Spoke services—in pediatrics, primary care, Connecticut Valley Recovery Services, Bradford Psychiatric Associates; led quality improvement projects within each site
- Implementation of a systematic and ongoing Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol for substance use within the clinics and ED
- Organized and delivered provider education regarding marijuana
- Multidisciplinary Functional Recovery Consult Team for patients with chronic pain
- Interagency Care Management through CHT
- Provider education was provided by UVM and the Vermont medical society on advanced opioid management
- Phase 2 of a Regional Youth Summit for Substance Misuse Services involving the court system, law enforcement, school, prevention, early intervention and treatment professionals to create resource guides for prevention, early intervention and treatment for youth in our region resources.

2. *Access to mental health*

- An HCRS (our designated agency) embedded clinician/LADAC provided services four days a week in our Patient Centered Medical Home supported by SBIRT grant
- Distribution brochure of *Local Mental Health Counselors* in the hospital and throughout the community
- WRAP workshops delivered for skill building and self-management support for anxiety, depression and general mental health
- Partnership in interagency care management with HCRS and other partners for care coordination
- Mental health counseling sessions were provided through the Windsor Connection Resource Center
- Addition of around-the-clock telepsychiatry resources to the emergency room and inpatient units
- Other – see Question #5 below

3. *Access to dental care*

- Application of fluoride in pediatric clinics
- Dental vouchers for care through Windsor Community Health Clinic
- Dental clinic in the school, provided education to children and their parents, provided dental screening and sealant applications to children in 2018
- Community Health Team, Spoke Staff and staff of the Windsor Community Health Clinic assist patients to find dental homes, care and financing

4. *Access to affordable health insurance, cost of prescription drugs*

- Windsor Community Health Clinic assists community members with Vermont Health Connect, and Medicare and Medicaid applications
- Medication Voucher Program is offered through the Windsor Community Health Clinic

5. *Nutrition/access to affordable food*

- Membership in the Upper Valley Hunger Council
- Working with the school, three local churches, recreation department, low-income housing, Windsor Connection Resource Center and Windsor Food Shelf to provide Summer Food Program, meals served
- Implementation of 3–4–50 through outreach to towns, schools, businesses, day cares and Health and Human Services agencies
- Distributed a cookbook entitled Eat Well on $4/day-Good and Cheap through the pediatric clinic
- Provided the learning kitchen curriculum at Union Sq., Apartments led by community health dietitian and chef from MA HHC working in partnership with the Vermont Housing Association and SASH
- Implemented *VeggieVanGo* working with the Vermont Food Bank as a monthly community resource. Served 90 -130 families each month. Physicians are writing prescriptions for vegetables to families in need.

6. *Lack of physical activity, need for recreational opportunities and active living*

- Implementation of 3-4-50 reaching over 1,000 people through outreach to towns, schools, businesses, day cares and Health and Human Services agencies

7. *Income, poverty and family stress*

- PATCH services at the Windsor Connection Resource Center from October 2017 through September 2018 include visits for economic services and for mental health counseling
- Parent-to-Parent Collaborative Problem-Solving Programs
- A Family Wellness Program with wellness coaching has been embedded in the pediatric clinic based on the research effective Vermont Family-Based Approach Program after receipt of grant funding and consultation and training with Dr. Hudziak and his staff. family wellness visits from Sept. 2017 through Sept. 2018
- Promise Community—to promote kindergarten readiness and emotional and social competence of children and families through a five prong strategy
- Provided interagency care planning, coordination and management to high risk pediatric and complex chronic care patients using a best practice model and tools

8. *Access to transportation*

- Participating in Regional Transportation Coalition
- Volunteers in Action provision of rides
- Use of transportation vouchers
- Work with VTrans, The Current and local community partners on *Rides to Wellness* grant initiative
- Developed and distributed 2 transportation algorithms to maximize use of existing resources
- Develop a collaborative working relationship with 2112 provide outreach

9. *Access to primary health care*

- Implementation of a HSA wide quality dashboard and multiple quality improvements including those aimed at hypertension, substance misuse, nutrition and diabetes
- Implementation of Annual Wellness visits by the Collaborative Care Nurse
- Recruitment of primary care providers
- evolution of systems for care coordination and panel management

10. *Health care for seniors*

- Interagency care management in partnership with Senior Solutions

- Woodstock Area Adult Day Services
- Aging in Place Initiatives by ViA
- HASS at Olde Windsor Village

11. Tobacco use/smoking

- Regular cessation groups and 1:1 counseling has been provided
- Prevention activities to decrease tobacco advertising and use
- Implementation of 3-4-50 and non-smoking pledge cards
- Community education about the impact of vaping provided

Quality Measure Results:

We want to preface our response to question #4 by stating that we do not have full confidence in the accuracy or reliability of the data as presented by the Blueprint. We have registered our dissatisfaction with Blueprint data and VITL yearly since 2013.

1) Medicaid well child visits — we do not believe this data accurately reflects our pediatric practices
2) Initiation alcohol and other drug dependence treatment- we have initiated SBIRT programs in our ER and primary care clinics
3) 30 day follow up after discharge for mental health services – we have exceeded the state target
4) Controlling High blood pressure- we have exceeded the state target through education efforts directed toward our provider and nursing staff, and improved data collection
5) Appropriate asthma medication management – we are engaged in an ongoing QI project targeting all our COPD/asthma patients. We have reduced ED visits and admissions for this cohort, which is likely a better metric than simple medication management. We continue to manage a small, outpatient, pulmonary rehabilitation program.
6) Percentage of adults reporting that they have a usual primary care provider- we are below the state average (slightly) due to extensive physician departures over the last 3 years. We have had 50% turnover in the primary care clinics and limited success with replacing physicians, we have had greater success with hiring associate providers.
7) Prevalence of chronic disease — we do not understand the utility of this data or the target metrics

Blueprint for Health Hub and Spoke Profiles:

We have coordinated with our local MAT providers (both within and outside of MAHHC) and there is NO waiting list for MAT in Windsor. It is important to note that as a border health system, a number of patients also seek care in NH. Through targeted outreach to all medical providers, we continue to have the LOWEST rate of new opioid prescriptions in VT, and the second lowest rate of benzodiazepine prescribing. This work is in response to death rates related to overdose. Lastly, in review of the All-Payer Model Quality measures, we have had a decrease in mental health and substance use related ED visits. This is due to our efforts with SBIRT, local and external MAT providers, coordination of care with our DA (HCRS), and continued support of a psychiatry service at MAHHC.

Mental Health:

MAHHC has 0 mental health beds. MAHHC has implemented several initiatives and programs targeted to ensure Vermonters have access to high quality, timely and appropriate mental health treatments and solutions. We have invested in 24/7 tele-psychiatry support. In addition to our full time psychiatrist and close work with our designated agency (HCRS) for onsite alcohol and drug counseling, we are actively recruiting for a Psychiatrist Nurse Practitioner for the hospital setting. We are engaged with the Vermont Family Wellness Program providing counselling to families of our pediatric patients. We have hired a full time wellness coach for our pediatrics practices. The average cost per pay for ED patients awaiting transfer is approximately $2,500.

MAHHC
Emergency Department Key Performance Indicators

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Behavioral Health Transfers	2	3	1	1	1	0	4	2	4	6
Length of Stay Psych Discharges (Hours)	30.6	15.5	39.3	42.8	61	0	20.8	11	21.8	23.3
BH Max Length of Stay (Hours)	74	51	100	109	117	0	45	13	26	96
BH Min Length of Stay (Hours)	14	5	6	15	9	0	3	9	14	5

Patient Access:

See table below for requested measures.

MAHHC
Third Next Available Appointment

Medical Practice Area	Number of Days Wait
General Internal Medicine	
New Patient Physical	2
Routine Exam	2
Return Visit Exam	2
Pediatrics	
New Patient Physical	1
Routine Exam	1
Return Visit Exam	1
General Surgery	
New Patient Physical	5
Routine Exam	5
Return Visit Exam	5

Substance Use Disorder Treatment Programs

Substance Use Disorder treatment programs implemented by MAHHC include 4 (2 contracted and 2 employed) Medication-Assisted Therapy providers: Dr. Steve Smith at OHC, Drs. Kim Aakre and Mary Bender at the Windsor Campus, and Erin Boxer with our Designated Agency in HCRS. There are approximately 15-20 patients enrolled in our MAT programs at any given time.

Health Reform Investments

Most of our historical and current health care reform costs are embedded in our budget and operations. This is due to the fact that often times, these expenses were already part of our expense base or that they are comprised of small percentages of specific jobs or program expenses and therefore difficult to identify for purposes of reporting. However, we have only requested an extended NPR cap once, in FY16, to engage a full time staff Psychiatrist and support staff at an investment of $333,000/year. The goal of the program was to enhance psychiatric care and access to these services in the Windsor health service area. Metrics and other evidence demonstrating the program's ability to meet these goals and other evidence that demonstrate alignment with the goals of the All-Payer Model include reduced visits to ER, timely discharge from Acute IP stays, reduced long stays in the ER and other hospital settings. Additionally, the program helped reduce the load on primary care providers, performed inpatient consultations, and improved the general safety of the patient and hospital employees. This program is ongoing due to the significant need in the community, which has not abated.

Reconciliation:

The following table reconciles the variations between the FY 2018 approved budget and the YTD FY 2018 performance. NPSR came in above budget by 1.1%, other revenues were 4.4% above budget,

expenses were 0.7% below budget, and non-operating revenues and expenses came in 47.7 percentage points below budget. Included in the table is the explanation/causes of the variances.

Net Patient Service Revenue			Other Revenue			Expenses			Non-Operating Revenues and Expenses		
	$	%		$	%		$	%		$	%
FY18 YTD Approved Budget	$ 28,398,014		FY18 YTD Approved Budget	$ 1,952,343		FY18 YTD Approved Budget	$ 30,881,149		FY18 YTD Approved Budget	$ 1,190,545	
Utilization	1,540,000	5.4%	Grant Income	10,000	0.5%	Cost Savings	(745,000)	-2.4%	DH Allocation	(600,000)	-50.4%
Payer Mix	(665,000)	-2.3%	Other	75,000	3.8%	Purchased Labor	400,000	1.3%	Contributions	120,000	10.1%
Bad Debt/Free Care	(530,000)	-1.9%	Rounding	110	0.0%	Salaries	200,000	0.6%	Investments/Securities	175,000	14.7%
Changes in DSH	(30,000)	-0.1%				Interest	(25,000)	-0.1%	Other	(275,000)	-23.1%
Rounding	(274)	0.0%				Volume	70,000	0.2%	Rounding	11,694	1.0%
						Depreciation	-100000	-0.3%			
						Rounding	(11,669)	0.0%			
FY18 YTD Actual	$ 28,712,740	1.1%	FY18 YTD Actual	$ 2,037,453	4.4%	FY18 YTD Actual	$ 30,669,480	-0.7%	FY18 YTD Actual	$ 622,239	-47.7%
Difference	$ -	0.0%		$ -	0.0%		$ -	0.0%		$ -	0.0%
Utilization - increased volume **Payer Mix** - decrease commercial volume **Bad Debt/Free Care** - increase in non-insured patients **Changes in DSH** - lower than budgeted DSH reimbursment			**Grant Income** - increasing successful grant submissions **Other** - EHR incentives, sale of services, 340B			**Cost Savings** - tight fiscal controls, management training, product optimization and negotiation, energy rebates, etc. **Purchased Labor** - ever increasing need for travellers and locums to manage volume **Salaries** - staffing to volume **Interest** - successful negotiations for high value leases **Volume** - 7% increase in overall statistics **Depreciation** - significant assets at end of depreciable life			**DH Allocation** - not receiving expected allocation **Contributions** - increased success of fundraising campaigns **Investments/Securities** - greater than expected investment performance and profitable sales of securities **Other** - decrease in release of restricted assets		

Budget-to-Budget Growth:

Net Patient Revenues

The budgeted FY19 Net Patient Revenue increase over the approved FY18 budget is 5.8%. As an overall percentage, Net Patient Revenue will look a lot more like Actual FY18 YTD than Budget FY18.

Volumes as an aggregate are up 8.0% over FY18 budget. Inpatient Acute, Swing Bed and Rehabilitation are all expected to increase 3% budget over budget. Inpatient Ancillary services will follow suit. Outpatient volumes are increasing, with growth in Operating Room procedures, Emergency Department visits, Physical and Occupational Therapy visits, Chemotherapy/Infusion, and Diagnostic Imaging and Laboratory testing. Offsetting this will be reductions in Cardiac Rehabilitation, Speech Therapy and Psychiatry. Physician clinics will grow as we continue to add to our roster of providers from FY17 and FY18. Primary Care will have similar volumes.

In the prior two fiscal years, Medicare has significantly increased as a percentage of total revenue and we budgeted accordingly. Over the beginning of this fiscal year, Medicaid was down as a percentage of total business, but has since been increasing towards budgeted levels. Blue Cross and other Commercials have all gone down. Accordingly, our contractual allowances have worsened from anticipated levels with the increase in governmental payors. Additionally, higher volumes coupled with a higher percentage of fixed cost and the higher Medicare payer percentage has improved our expected cost report reimbursement. This gain is mitigated with sequestration and variable expense offsets. Over the last few months, the payer mix has increasingly trended in this way. Our budget for 2019 anticipates payer mix levels falling between the Budget and the Actual 2018 levels. No material change in Bad Debt and Charity Care are anticipated. Fixed prospective payments are in booked other operating revenue, according to auditor instructions and industry standards.

As a critical access hospital, we often experience swings in reimbursement from Medicare based on Medicare volumes and hospital expenses. Accordingly, we completed an interim cost report at the mid-point of our fiscal year, to obtain expected payment rates from Medicare and to attempt to reduce large shift surprises at year end. Those results are included in this budget.

MAHHC did not include any meaningful use revenues in the FY19 budget. The 340b revenues were level-funded at approximately $660,000.

We have identified a significant trend in the increase of out-of-state patients and a decrease in Vermont patient's year-over-year.

MAHHC

FY 18 MAR YTD ENCOUNTERS		%	FY 17 MAR YTD ENCOUNTERS		%	Change	% Change
VT	35,163	74%	VT	35,748	86%	(585)	-2%
NH	11,457	24%	NH	5,337	13%	6,120	115%
Other	623	1%	Other	403	1%	220	55%
Total	47,243	100%	Total	41,488	100%	5,755	14%

Expenses

Salaries and Benefits:

We have budgeted a 3% annual merit increase and a 0.5% market increase for our staff. There is some FTE growth in clinical areas due to the increased focus and demand for collaborative accountable care and volumes. We expect to continue to experience the frequency of more complicated patients who require additional oversight (Emergency Department and all Inpatient settings), some administrative increases to address regulatory and reimbursement changes (Quality, Compliance, Analytics), and some related to volume (OHC and Diagnostic Imaging). As part of our continuing integration, some key clinical and managerial positions are now contracted services from Dartmouth-Hitchcock as well as advantageous pricing for reference labs and pharmacy sourcing, as well as the benefits of participating in their Group Purchasing Organization. Their related expenses are reflected as purchased services instead of salaries. Provider salaries growth is higher than previous years as a result of salary increases to primary care providers for their increasing roles and efforts engaging in collaborative care and continued recruitment efforts, as well as, a slight increase of FTE's.

We had expected to be budgeting for Benefits from the Dartmouth-Hitchcock platform but found that another year on the glide path was advisable. We were not able to mitigate some key differences in wages and benefits to make the transition reasonable for our stakeholders. While we have integrated to a small degree, another year or more will be needed to make the transition. We have had two very positive years relative to health insurance costs for our employees. Given the likelihood of that not continuing, we budgeted according to market trend. That, the increases in wages, the increase in FTE's, and overall inflation has dictated a material increase in Benefits Actual to Budget. The change Budget to Budget is nominal.

Depreciation and Interest:

- Depreciation is steady budget to budget due to the mix of new capital purchases and the end of depreciable value certain large dollar depreciable assets. It is up from Projected 2018.
- Budget to Budget, Interest is flat due to a major refinancing of our debt through the D-HH Obligated Group. It is decreasing budget to budget due to the payment, in full, of the line of credit and successful negotiations on the lease of a new CT Scanner that was implemented last fiscal year. Interest is increasing from Actual FY18 due to the lease of a new medication distribution system.

Other Expenses:

- Most Supplies and Contracted Services are increasing with 2-3% inflation factors, adjusted by volume.

- Telepsych was added to this category for FY18 at an annual cost of $30,000.
- Contracted Labor is expected to increase, partially offset by a reduction of FTE's, as a number of employees are now contracted from Dartmouth-Hitchcock.
- Insurance (Liability) will be near flat from current premium rates due to favorable conditions and experience within the D-HH Captive Insurance Program.
- MAHHC continues to look for additional opportunities to collaborate with D-H to save money on medical supplies and medical equipment, through the Group Purchasing Organization (GPO) and in conjunction with inter-facility initiatives in technology for medical equipment and information technology infrastructure.

Bad Debt:

Bad debt expense in FY17 was $1,726,000, of which, $658,000 represented patients cared for with dates of service prior in FY16 and earlier. We utilize EMA for our selfpay statements. These statements are "Patient Friendly". We send our bad debt accounts to eManagement Associates and Levi Associates. eManagement utilizes a patient friendly bill, and sends several communications in advance of a 120 day notice (when it's at bad debt status). Both Levi and EMA handle post 120 day collections. Both strongly adhere to the FDCPA.

Rate Request:

The budgeted overall rate/price increase for FY19 is 2.94%. Inpatient Room and Board for Acute Inpatient, Swing Inpatient, and Acute Rehabilitation are all increasing by 4%. Additionally, all Inpatient Ancillaries are increasing by 3%. All Outpatient charges and ancillaries are increasing by 3% as well. Physician charges are increasing by 2.5%. Pharmaceutical charges are indexed to inflation at 2%. Volumes drive staffing levels and variable expense. Inflation factors, wage increases, etc. are added to expense. Changes in payer mix, payer contracts, governmental reimbursement, and the impact on our CAH cost report are studied and added. 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 "inpatient" lines of business. Expectations from our internal board and the D-HH board are to produce a break even operating budget. Therefore, as previously described we had to set a rate/price increase of 2.94%, a 40% decrease from FY18 price/rate increase. Please note it is illegal to have different prices for different payers.

FY 2017 Overages

N/A

Capital Budget Investments:

In the coming year we expect no CONs to be filed, as most of the planned purchases are for routine replacement of equipment, mechanical systems, and plant maintenance. Significant items include a call bell system, industrial chiller, ultrasound machine, telephone system, security system, windows, roof repair, bone density scanner, behavioral health room in the ED, roof repairs, and parking lot repairs. As expected, increased capital purchases increase depreciation for purchased items and costs to finance.

Financial - Other

Other operating revenue is up slightly due to fixed prospective payments from OneCare and other contract revenues that are not related to direct patient care.

Our Operating Margin will be 0%. This is significantly better than the 2018-budgeted operating loss of -2.2%. This represents a milestone of fiscal responsibility at Mt Ascutney Hospital and we are proud to be able to deliver a responsible budget.

Investment income assumptions are fairly conservative as the organization moved its assets into D-HH's investment plan. The D-HH Master Investment Program is fairly conservative. The significant decrease budget to budget is due to the one-time 1.2 million in net asset transfers from Dartmouth Hitchcock received in FY18, which has not been received because of our improved financial performance.

Technical Concerns:

We appreciate the opportunity to comment on technical and reporting issues. While there are relatively minor technical problems, the reporting burden for submitting the budget to the Green Mountain Care Board is rigorous and we estimate that this year's requirement has cost us an additional 30 person-hours beyond last year's efforts. For small organizations, this significant burden does not improve care, access or quality. Much of the required narrative and data is repetitive year-to-year, and has not borne fruit**.**

Please let us know if there are additional requests or concerns. Thank you.

Sincerely,

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