Dartmouth Health

August 11th, 2023

Attn: Ms. Sarah Lindberg, Director
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: Budget 2024 Narrative

Dear Ms. Lindberg,

This letter serves as the response required to address the GMCB staff questions transmitted July 27th, 2023.

1) Vermont's FY24 budget indicates an increase in Vermont Medicaid's RBRVS fee schedule to 110% of Medicare for primary care providers and a 3.8% inflation increase to specialty care providers. Have these increases been factored into your budget? If not, indicate what effect that would have on the submitted commercial rate increase.

MAHHC's NPSR budget model is based on estimated contractual allowance rates as percentage of charge. This model can be adjusted to incorporate known or anticipated changes such as reimbursement rates, service mix changes, inflation, and acuity. At the time of budget development, we had anticipated a slight increase in Medicaid reimbursement for all lines of business to somewhat cover Medicaid's share of our expense growth. However, there were no Medicaid increases in inpatient, inpatient rehabilitation, nor swing bed so the estimated increase in Medicaid provider revenues was largely offset in the model by a lack of increase in the other lines of business. As we view our FY24 budget in August, a couple months removed from budget development, we are taking risk in our overall Medicaid projection. We are appreciative of the increase for provider services but disappointed that Medicaid lost ground as a percentage of costs on our larger portion of business.

2) Does Mt. Ascutney Hospital and Health Care Center (MAHHC) provide financial support for its senior housing subsidiary, Historic Homes of Runnemede? If so, provide estimates for the past few fiscal years.

MAHHC provides limited support for Historic Homes of Runnemede (HHR), a residential care facility with capacity for 44 residents. Historically, HHR runs at breakeven or slightly worse year to year. HHR provides a unique niche of service for our communities. It is geared for lower income individuals and has the ability to provide a limited medical oversight component which allows residents to remain independent longer than many other residential or assisted living facilities.

HHR has struggled with staffing and census through much of the pandemic and also enlists the use of travelers like the hospital. During these times, the hospital has also provided administrative and medical support to ensure that HHR is able to adequately care for the residents. For staff that work for the hospital and support HHR, their salary and benefits are billed to HHR (recorded as Other Operating Revenue on the hospital's profit and loss, to offset the operating expense). Some staff are charged to HHR directly through the HHR payroll system and do not hit the hospital books at all. The hospital has leveraged savings for HHR in the areas of insurance, supply chain, and other areas when possible/appropriate. HHR reimburses the hospital for the staff, services and supplies that it receives from the hospital, that are not directly charged to HHR. In other words, the hospital's operating margin is not adversely affected by the oversight and support that it provides to HHR.

HHR is included in the consolidated and audited financials for the hospital which are provided to GMCB annually. . While HHR has periodically operated in the red over the last 15 years (most notably during the pandemic and this current year), the hospital has never provided cash to them to cover the impact of their negative margin. Fortunately, HHR has favorable

terms with their USDA loan and sufficient levels of cash on hand. The annual total income/(loss) of HHR appears on MAHHC's P&L non-operating portion of the financial statement.

Unfortunately, as the healthcare environment changes and the historical buildings age, HHR is a less viable option looking into the future. The medical component (usually Medicaid waiver funding) has become more complicated and our residents have become more fragile. Staffing has become a chronic issue and the competitive market has become too great for a small facility funded by low/fixed income residents and Medicaid. Significant facility improvements and renovation will soon be required and there will likely not be enough cash reserves or operating revenues to cover the necessary work.

3) Provide a complete response to question k.ii. in the narrative, including any third party contracts that exist to collect payments from patients. Hospitals may reach out to the GMCB to request confidential treatment of materials that are exempt from public inspection and copying under Vermont's Public Records Act.

We have attached two "collection" contracts. One is for the outsourcing of a portion of our active self-pay receivables (not yet assigned to bad debt) and the other is for our bad debt collection agency. There was no specification as to whether this question related to active receivables, bad debt or both. We have redacted these contracts for the following elements (ONLY): identification of the firms and their pricing. All of our original narrative commentary is still relevant.

Our post-narrative conference with GMCB and HCA staff resulted in a number of takeaways for MAHHC. HCA believed that the collection processes would be delineated within the contracts and that they were curious about the differences between vendors and/or hospitals. They were concerned about whether hospitals were selling receivables (factoring) or not. HCA expressed curiosity about whether the contracts and processes were appropriate in the context of regulatory standards (the IRS for example). HCA confirmed that there were no specific concerns with MAHHC nor with our vendors. MAHHC iterated that MAHHC and their vendors are compliant with all regulatory expectations (IRS, FDCPA, etc.), that we were not engaged in factoring, and that we were unaware of any concerns or chronic issues. All of the HCA concerns could be easily answered under oath without the need to share proprietary documents and terms. MAHHC has an excellent and long standing relationship with our vendors and are extremely satisfied by the vendors' track record and the treatment of our valued patients. MAHHC's vendors prefer that the terms are not disclosed publically and MAHHC is not willing to put that relationship at risk when all concerns have been addressed with that conference and the attached document.

No revenue is generated from either of these contracts. We recovered approximately $440,000 of bad debt in the last twelve months. We paid approximately $105,000 in collection fees for the last year with these vendors.

We have always been more than cooperative with the HCA, the patients that they represent, and the GMCB and have often been the voice of truth inside and outside of the budget hearing process. We are more than willing to address any reported concerns and more than willing to provide more specific information about the collection processes and practices under oath in so much as it does not reveal the proprietary information. In good faith, we have provided the contracts in their entirety, redacting only the prices/costs and the vendors' identifying information. We believe that we have met the spirit of the request.

4) The sum of net revenue for inpatient, outpatient, and professional services provided in exhibit 10 does not always equal the values provided for the total change. If this is an error, update the exhibit. If accurate, why does the total differ from the sum?

A formulaic error was identified and an updated exhibit provided to Sarah Lindberg 7.24.23.

5) Elaborate on your statement: "We are experiencing some degree of an unfair playing field since we are competing with New Hampshire facilities who do not have to deal with a state income tax." (Narrative, 3)

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MAHHC competes for employees locally, regionally, nationally, and even within the DH system. As a border hospital in Vermont, the most problematic competitors are the three New Hampshire hospitals, across the river and within a short driving distance. There are other healthcare entities and non-healthcare employers across the border that we also compete with on a regular basis. We have made market appropriate/commensurate offers to candidates for the same gross wages offered by NH employers only to be turned down because the potential employee will retain greater take home pay from the NH employer. The difference is the Vermont state income tax. For a $35.00 per hour employee, with the same withhold, same benefit costs, etc. they will take home an additional $3,100 per year in NH. In order to match the take home, we would need to add $2.34 per hour ($4,867/year) to our offer. On the higher end of the scale, a $70.00 per hour employee would lose $8,215 per year in their take home pay. In order to make this right, we would have to offer an additional $6.50 per hour ($13,520/year) to the offer. Despite the highest employee engagement scores and the lowest turnover rates over the last few years in the DH system, MAHHC has lost potential employees to our system partners in NH. Not a week goes by that this issue does not present itself in our recruiting processes. It is an even bigger issue with provider/physician recruiting based on their wage levels. We currently have 25 traveler "FTE's" contracted and even with their "FTE" we are 10 FTE's below budget. Lastly, because the NH hospitals are not regulated as we are in Vermont, they have the ability to raise rates in order to improve their competitiveness in the recruiting market.

6) Provide examples of how "ACO work, regulatory expectations, and increased payer requirements" have "increased administrative overhead" (Narrative, 3)

Change requires effort, and healthcare reform is no exception. Clinical initiatives are supported on the back end administratively. Examples of administrative work includes accounting, analytics, payroll, IT, and management oversight. As the programs change reimbursement methodologies, the accounting work to track and reconcile funds has to adapt. This past year has been particularly difficult with the decrease in transparency regarding PHM payments due to the elimination of Care Navigator has greatly hindered our ability to reconcile PHM funds to internal data. Analytical work to keep management and healthcare workers informed so as to effectively implement reform efforts are an ongoing concern. OCV has shifted care coordination triannual reporting onto hospital staff, which is not a small task. Payroll and IT efforts supporting the FTE's hired to undertake said reforms cannot be forgotten. Management has an ongoing commitment to effectively deploy resources designed to deliver healthcare reform. When programs change, reporting evolves, funding changes, risk levels finalize, payers pull out, and covered lives change, management has to consider all inputs. To put it plainly, meetings are held, spreadsheets are crunched, payroll is reviewed and processed, and reports are reviewed and reconciled, and strategies and solutions are developed. Despite the increased administrative effort by the participating hospitals, OCV dues increase every year.

Regulatory expectations that have increased administrative overhead include changing GMCB reporting requirements and board expectations. Both involve efforts to align analysis, data, terminology, and communications with the expectations and direction of the GMCB. One specific example is the upcoming additional reporting being requested from the GMCB/OCV regarding health reform funding and expenditures. Increases in GMCB back-billing also add to the increase in administrative cost of the hospital. State and federal quality measures, IRS 990 requirements, CHNA changes, VT provider tax and DSH changes, IRS price transparency, Act 53 reporting, IRS census requirements, 340B compliance and reporting, legislated financial assistance adaptation, and the list goes on...

Increased payer requirements include expanded guidelines for documentation and prior authorizations. We have hired additional administrative and clinical support FTE's to meet the new requirements that allow us the opportunity to maintain what we used to get paid for the services that we provide. We receive a steady stream of detailed audits, payment denials, clinical reviews, etc. 340B manufacturers have also instituted additional requirements for reimbursement, necessitating us to hire additional FTE support to maintain some of the funding that we used to receive.

7) You note that "the ratio of free care versus bad debt" runs "fairly consistently" (i.e., more or less the same in total (Narrative, 6). However, Exhibit 9 shows a tighter ratio of free bad debt to free care in FY24 compared to FY21 and FY22. How is MAHHC shifting more uncompensated care from bad debt to free care?

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MAHHC's ten year average for total bad debt and free care is 2.5%, with a minimum of 2.1% and a maximum of 2.9%. We have generally budgeted free care and bad debt as a percentage of gross revenue at 1% and 1.75% respectively for FY21, FY22, FY23, and FY24. The COVID extension of Medicaid, the fluctuating volumes, special governmental COVID coverage and less responsive patients have reduced the free care experience during much of the pandemic and into FY23. The free care policy became more liberal in 2023 as we migrated towards next year's mandated guidelines and we have maintained the same level of staffing for financial assistance, Medicaid assistance, etc. We anticipate that the end of the pandemic, the migration from Medicaid coverage, and the next step of liberalization of our free care guidelines will increase free care as a percentage of total write-offs. The table below shows bad debt and free care as a % of gross patient revenue over the past few years. Most notably, the % of bad debt and free care are on a downward trend. We have given thought about whether our modest price increases and the price reductions that we have instituted have also contributed but cannot conclude that this is a contributing factor.

	Actual 2019	Actual 2020	Actual 2021	Actual 2022	Projected 2023	Budget 2024
Rate Increase	2.90%	3.20%	2.82%	2.20%	4.70%	5.10%
Free Care	$ 818,147	$ 797,296	$ 607,209	$ 562,795	$ 418,722	$ 1,474,683
Bad Debt	$ 2,058,532	$ 2,219,969	$ 2,263,564	$ 2,086,077	$ 2,562,276	$ 2,580,695
GPSR	$ 105,209,802	$ 103,562,680	$ 125,844,666	$ 128,016,725	$ 133,318,937	$ 147,468,272
Free Care %	0.8%	0.8%	0.5%	0.4%	0.3%	1.0%
Bad Debt %	2.0%	2.1%	1.8%	1.6%	1.9%	1.8%
Combined %	2.7%	2.9%	2.3%	2.1%	2.2%	2.8%

8) Provide examples or data to support the position that New Hampshire's "favorable regulatory and tax environments" make them "more competitive" in attracting and retaining employees (Narrative, 7)

New Hampshire provides a favorable operating environment to providers, including a lower provider tax, no state income tax, and decreased regulatory oversight. Speaking specifically to state income tax, similar wages earned in VT versus NH are effectively lower for the wage earners' marginal tax rate. This makes NH a more attractive labor market compared to VT.

GMCB 2023 budget deliberations presentation on 8/31/2022 explicitly stated that "payments have not kept up with cost increases". As seen below, the same deliberations indicated that Vermont CAH's have lower operating margins compared to non-Vermont hospitals. Similar to provider tax, margin compression hinders our ability to effectively compete in the labor market which ultimately leads to higher use of travelers/locum tenens and/or increased wage packages.

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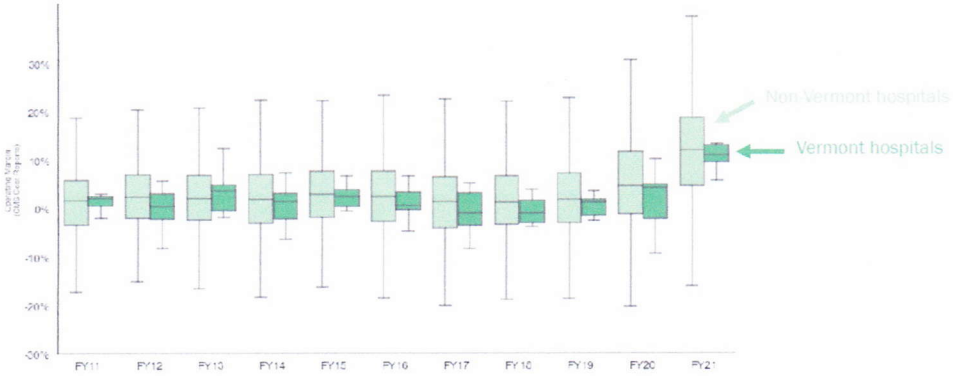

Source: Healthcare Cost Report Information System (HCRIS)

A higher provider tax adds to margin compression, and leaves less on the table for salaries and benefits for employees. NH hospitals are not regulated for cost, price, volumes or net revenues. Price increases can be implemented at any time, without approval, in order to generate necessary margin to cover market increases for wages, benefits, building projects, inflation, etc. NH has eliminated their certificate of need requirements several years ago and they have the ability to build up or institute new programs with buildings, staff and equipment based on their best judgment of need and opportunity. While it could be debated as to whether this is positive or negative, we cannot debate that it gives NH border hospitals key strategic and operational advantages over their VT counterparts. The only limitation on NH hospitals is their own performance relative to quality, access, price, and customer satisfaction. This is one of the reasons that MAHHC has remained viable in our region. We have strong employee and customer satisfaction ratings, good quality scores, and good access. The loss of volume and services over the border results in jobs, infrastructure, capital, etc. crossing the border as well. This reduces state proceeds from income tax, provider tax, and incidental revenues to local business.

Legislative and regulatory initiatives in Vermont have added staff, administrative overhead, and costs while limiting our ability to offset them. Despite our interest in supporting the healthcare reform initiatives, they have generally cost us on margin because operating expenses (analysts, support staff, fees, dues, etc.) have outpaced the delta between revenues and the cost of care.

9) How did you identify the "700 patients" to "redirect" away from the ER to a walk-in service for primary care? (Narrative, 13)

The walk-in service is not advertised. The early volumes were related to the COVID clinic and then we began to triage in the emergency room and redirect patients from there to the walk-in clinic. This lowered the costs for patients and insurers for low acuity visits and was intended to reduce emergency room volume. As COVID wound down, the volume was entirely driven by triage and re-direction from the emergency room. Currently, the volume is still predominantly coming from the emergency room along with some repeat patients who have accessed the walk-in services previously. The walk-in registrations are uniquely identified in our EMR and the visits from the emergency room are recorded as triaged in the emergency room. Because wait times and turn-around times have improved compared to other area hospitals, while maintaining quality and customer satisfaction, the emergency room continues to trend up despite the re-directed volumes and the unwinding of COVID.

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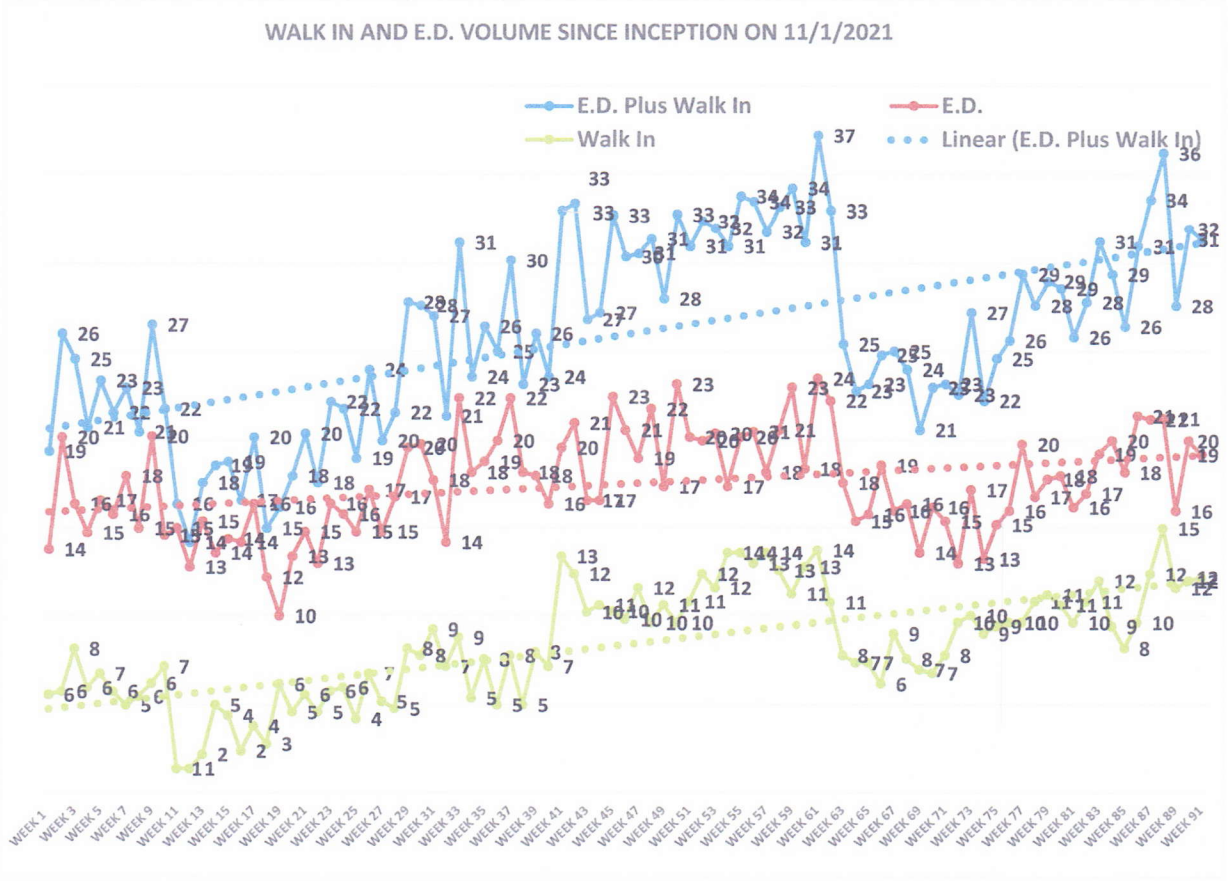

10) Explain the substantial decrease in estimated third party settlements (-119% 23B to 24B %) (Balance Sheet)

Favorable cost report settlements have been experienced with the settling of the FY22 fiscal year. Additionally, management found lost opportunity in some prior years and refiled those years as well, which offset some of the anticipated payables. Cost report settlements during the pandemic resulted in a net payable to CMS as interim payments were greater than net cost. Strong expense management and lower Medicare revenues resulted in a decreased settlement and interim payment rates the following fiscal year. As business resumed, pent up demand was realized, and Medicare volumes, inflation, and nursing shortages costs all increased dramatically, the Medicare cost report drew significantly more cost and resulted in a large receivable versus payable. With the radical changes in volumes and costs, we have increased the frequency of interim cost estimates. All of this contributed to the calculation of a much more favorable FY24 reimbursement modeling.

Please let us know if there are additional questions or concerns.

Sincerely,

David C. Sanville
C.F.O.