Southwestern Vermont MEDICAL CENTER
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August 9, 2019

Ms. Lori L Perry, CMA
Health Finance Analytics Director
Director of Health System Finance
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Dear Ms. Perry;

Please find below Southwestern Vermont Medical Center's (hereafter "SVMC", "Hospital" or "Medical Center") response to the questions in your July 31st communication and follow-up communications. The SVMC leadership team looks forward to reviewing the FY 2020 budget with the Green Mountain Care Board (hereafter "GMCB") and yourself on August 19, 2019. Below are your questions with management's response following:

GMCB Questions

1. *Have the hospital's projections for FY 2019 changed?*

Management's Response:

The FY 2019 projections submitted with the FY 2020 budget submission were based on actual operating results through May 2019 projected forward. Operational performance in June was slightly better than plan. As of this response the July actual results are not completed. But appear to be under target. Examining known factors for July, volumes are close to budget, cash receipts are under plan, operating expenses appear over plan and cash demands have been greater than plan. Management still projects FY 2019 overall operating results to be at or slightly below budget with a projected operating surplus submitted of $5.8 million compared to a budget of $6.1 million. The updated net revenue projections are slightly below budget or approximately $164.9 million, total operating revenue of $171.0 million and total expense projections of approximately $165.2 million.

Management at close of each month prepares projections and they do change each month. As we get closer to the year-end (September 30) there is less variation. As with any projection unexpected events and results may occur which can have a material impact on the projections.

2. *What is the ACO reserve on the balance sheet for Projected FY 2019 and Budget FY 2020? Do you anticipate realizing savings or owing OneCare money when the FY18 settlements are finalized? Are other Reform Payments recorded in deduction from NPR, if not, where are they recorded?*

Management's Response:

The ACO reserve on the balance sheet at June 30, 2019 is approximately $1,050,000. The expected ACO reserve, based upon current information available as of this writing, as of September 30, 2019 will be between $1.5 and $1.6 million. This amount will represent nine months of the estimated maximum claim liability for CY 2019. Management records a proportionate share of the estimated maximum claim liability on the monthly financials and **nothing was budgeted in FY 2020 for an additional potential OneCare liability or reserve in Net Patient Service Revenues.** This is subject to change depending on SVMC's participation in CY 2020 and what level of risk mitigation, if any, is available.

In June, SVMC received a favorable settlement for calendar year 2018 in the amount of approximately $258,000 from OneCare for the Medicaid program. This amount will be recorded as NPSR in FY 2019 along with the reversal of the $382,000 reserve which SVMC's management had recorded as of September 30, 2018. The gain of approximately $639,000 will reduce the effect on the $1,050,000 reserve recorded as a reserve for CY to date and the estimated reserve range of $1.5 to $1.6 million as of September 30, 2019.

3. *SVMC's FY 2019 Budget Order states the "Hospital shall consult with Vermont Information Technology Leaders (hereafter "VITL") to facilitate patients' ability to electronically consent to adding their clinical data to the Vermont Health Information Exchange (hereafter "VHIE")." What kind of headway has SVMC made to facilitate this?*

Management's Response:

SVMC has actively participated in VITL initiatives and activities over the years and SVMC has continued that support to VITL in FY 2019. SVMC automated a duplicated manual consent process in FY 2019 between SVMC's hospital information system and VITL. The volume of patient consents, October, 2018 to June, 2019, are 4,723 patients. Of the total 4,334 (91.76%) patients OPTED IN, while 389 (8.24%) have OPTED OUT. SVMC provides a wide range of secure access into the patients

Electronic Medical Record both for caregivers and for patients and will continue to work with VITL where we see a benefit.

SVMC's Chief Information Officer continues to have scheduled bi-weekly calls with the VITL team.

4. *What is the value of 1 Days Cash on Hand for the Hospital as well as Southwestern Vermont Healthcare Care?*

Management Response:

The value of one (1) day of cash on hand at SVMC is approximately $436,000, in FY 2020 the value of one (1) day of cash on hand will be approximately $453,000.

For the Health System the value of one day of cash on hand is approximately $506,000.

5. *What is the value of the 1% of SVMC's change in charge request? If there is a variance between SVMC's calculation and the calculation provided by GMCB staff above, please include the steps to your calculation.*

Management Response:

The estimated value of a 1% rate/price increase is calculated using SVMC's revenue budgeting model that calculates the impact of increasing rates in a particular service with historical charges and collection rates grouped by payer. SVMC calculation is based on the commercial increase *only* and does not include the estimated regulatory Medicare and Medicaid increases. The Medicare and Medicaid increases are not dependent on raising charges as with the commercial payers.

The rate increase provided by the GMCB staff is approximately $951,000 on page 5 of the analysis dated July 31, 2019. Reviewing the method provided is simple and reasonable. Utilizing this method SVMC's management believes the value is approximately $926,000 since the change in Disproportionate Share should be $183,000, not the $111,785, as reported.

Realization of the actual dollars proposed is dependent on the payer mix and service mix of patients in FY 2020.

6. *Are Medicaid and Medicare reimbursement assumptions still valid including Disproportionate Share Payments?*

Management Response:

At this time management believes Medicaid and Medicare reimbursement assumptions, including Disproportionate Share Payments are still valid. However, the Medicare IPPS and OPPS rules have not been approved by CMS as of this writing. Each year in the budget process assumptions are made in the April/May time frame and the IPPS and OPPS rules are typically approved in the August/September and November/December time frames, respectively.

The Disproportionate Share Payment amount included in SVMC's budget submission was $839,000. This is based upon on the notice of Disproportionate Share Payment SFY 2020 letter from the Deputy Commissioner of the Department of Health Access, dated May 31, 2019.

7. *Pinnacle Healthcare Consulting has been retained for $500,000 in FY 2020 with a goal of achieving $1 million of operating expense reductions. Please explain the impact on FY 2020 operating expenses and, future engagement with Pinnacle and future savings.*

Management Response:

SVMC is in the process of completing its 2019 Strategic Plan. The Strategic Plan is focusing on the future with an emphasis on what our community needs. The plan will not be completed until later this fall when it will be presented to the Board of Trustee's for approval.

In the budget preparation in the spring, management provided a provision for additional expenses for the sole purpose of executing initiatives in the plan. That provision was $500,000. In order to pay for these initiatives, $1 million of cost savings was also provided in the budget.

The cost savings will be achieved in several areas:

a. Inpatient services – the plan is to leverage the Medical Center's Magnet designation to accelerate change to right size the staffing to support fluctuations in patient volumes and the clinical requirements of the patients;
b. Emergency services – redesign the processes and workflows to create efficiencies and reduce variation in the assessment and treatment of patients; A significant focus is on Behavioral Health patients in the Emergency Room;
c. Ancillary services – improve the scheduling and through-put in many of the outpatient ancillary services. Continue to find ways to eliminate redundancy and duplicative testing;

d. Physician practices – restructure the current model and structure of the practices as SVMC possibly continues down the journey of Population Health in the risk model with OneCare;
e. Partnering and outsourcing – as part of the Strategic Plan opportunities are being examined to partner with other organizations and or outsource services to improve access and quality of services and improve the cost of care to our community;

The operational improvement plan long-term will need to be greater than $1 million, in future years, in order to fund the execution of the Strategic Plan and implement the modernization projects.

8. SVMC's narrative discrepancies with Adaptive - please clarify:

- *Narrative indicates a 1.0% increase in Medicare and Medicaid, however Appendix VI Bridges table includes $0;*
- *Narrative FTE's is 792, Adaptive FTE is 887.*

Management Response:

The narrative is correct, 1% rate increase for Medicare and Medicaid is included in the FY 2020 Budget. The Medicare rate increase of $673,000 and Medicaid rate change increase of $138,000 were included on the "Reimbursement/Payer Mix" line of the Appendix VI Bridges table.

As outlined in the narrative, the amount included on this line in the Medicare column includes several items:

- 1% increase for non-OneCare, fee for service, Medicare regulatory increase;
- 3.5% increase for the OneCare Medicare, risk based;
- Regulatory reimbursement change related to provider based billing for Medicare effective January 1, 2020 that will cost the Medical Center over $750,000 in cash receipts/revenues in FY 2020.

The narrative refers to total FTE's of 792. The 792 FTE's consists of 783 of non-MD FTE's and 9 Physician FTE's, which are residents and dentists. The staff analysis received on July 31, 2019, on page 6, 783 non-MD FTE's and 104 MD FTE's which consists of the 9 FTE's paid via SVMC's payroll and the remaining 94 MD FTE's are contracted through the Dartmouth Hitchcock PSA.

9. *The narrative states Days of Cash on Hand at 20.3; budget documents indicate it closer to 36. Please explain the discrepancy.*

Management Response:

The 20.3 days of cash on hand calculation is based on "cash and cash equivalents" ***only***, as labeled in the narrative, and does not include "Assets Whose Use is Limited" in the calculation. The 36 days calculation includes "Assets Whose Use is Limited" on the Medical Center's balance sheet. This is not a discrepancy just a different use of terms. SVMC operating cash balance utilized day to day is cash and cash equivalents and the sentence in the narrative was intended to show that.

10. *Consolidated cash on hand days are "projected" to be 161; what are the "Actual" days and are the parent company's cash reserve and are the parent company's cash reserves easily accessible to the Medical Center should the need arise? Additionally, is the 161 projected days cash on hand based/calculated upon the daily need of the Medical Center or the Parent Company? E.G. if it is the parent company only spends $10,000/day compared to $471,000/day for the Medical Center projected days cash on hand would be significantly less for the M.C.*

Management Response:

As of June 30, 2019 The Consolidated Days of Cash on Hand were 160 days. The Parent Company, Southwestern Vermont Health Care (hereafter "SVHC") activities include managing the investments of the System as well as being the sole member of SVMC and other subsidiaries. The investments of all subsidiaries are consolidated at the System/Parent. The "cash reserves", at SVHC are available to the subsidiaries should the need arise, at managements request and at the discretion of the SVHC Board of Trustees.

The days cash on hand calculation for SVHC is based on the total consolidated operating expenses requiring cash of all the entities. At June 30, 2019 the value of one (1) day of cash on hand at SVHC was $506,000 compared to $436,000 at SVMC.

11. *In Appendix V - Participation in Health Reform, SVMC stated the risk for CY 2020 had not been determined. We understand OneCare provided some risk mitigation for CY 2019. If you have a risk estimate without the backstop for CY 2020, please provide it, along with any update on any OneCare (or other entity) provided risk mitigation you may consider for CY 2020.*

Management Response:

SVMC received the CY 2019 Maximum Risk Addendums from OneCare on July 18, 2019. The maximum risk for each of the risk-based products is as follows:

Program	***Maximum Risk Limit***
Blue Cross Blue Shield of VT	$363,839
Vermont Medicaid	714,264
Medicare	3,073,524
Subtotal Maximum Risk Limit CY 2019	*4,151,627*
Less: Risk Mitigation Agreement	(2,000,000)
Total Maximum Risk Limit CY 2019	***$2,151,627***

Assuming attribution is similar in CY 2020 the estimated risk without risk mitigation could be $5 million before additional programs and payers are added.

12. *Would not receiving any risk mitigation force SVMC to reconsider participating in the three major OneCare payer programs in CY 2020?*

Management Response:

SVMC is committed to support the OneCare payer programs and the intent of the ACO's initiatives. If risk mitigation is not in force in FY 2020, management would need to reconsider participation in the three major payer programs. This decision management would be discussing with the Medical Center's Board of Trustee's. Supporting the OneCare Population Health model has to be balanced against the possible negative financial implications. On the other side of the ledger there is upside that will be considered in the discussions between management and the Board of Trustees.

Green Mountain Care Board Member Questions

13. *For the FY 2019 projections what departments are expenses exceeding revenues?*

Management Response:

This question is not clear. To direct answer to the question as written Management's response would be "none". SVMC's management is requesting further clarity related to this question.

14. *Please suggest a statistic the GMCB can monitor to better understand the trends in the total number of staffed beds in the hospital versus the number of beds available for use, and how full or empty those beds are from month to month.*

Management's Response:

SVMC's Management believes that the average daily census is a good statistic to get a sense of the actual inpatient census from month to month. However, the outpatient statistics of observation patients and outpatients in a bed should be considered.

Over the past year the Hospital has had an average daily census of 32.1 patients. The range of the daily census is from a high of 51 to 19. There were 28 days where the census was above 40 patients and 23 days were the census was below 25 patients.

Licensed beds and available beds are two reported numbers but using them is misleading.

Here at SVMC inpatient services generate slightly over 20% of the Medical Center's cash collections and slightly under 20% in charges. The inpatient service volumes for many years has been a cornerstone of monitoring hospital volumes and success. As healthcare continues to change and population health initiatives continue to mature, inpatient services will continue to be reduced and less important in monitoring success.

15. *Why was Budget in FY 2019 $0 for pension funding with a forecast now at $3.8 million? An additional $4.5 million forecasted for FY 2020 and FY 2018 had $3.5 million. What is the pension funding for the future?*

Management's Response:

In the FY 2019 budget it was planned to terminate the Defined Benefit Pension Plan (hereafter "the Plan"). The significant drivers in the thought process was that investment performance was up and long term interest rates were trending up and as a result it was a good environment for SVMC to terminate its Plan in the spring of 2018. Management and its consultant were planning to finalize the pricing of the termination in the fall of 2018, however, investment performance and investment value significantly declined, interest rates trended slightly down and the cost of annuities increased adding over $5 million to the termination cost, to nearly $15 million. SVMC decided not to terminate the Plan in FY 2019 and will revisit the decision, annually. In the interim, it was decided, to continue with the historical strategy to annually fund the current year's projected benefit obligations. Included in the FY 2019 projection is that funding and in FY 2020 budget that course of action is budgeted to continue. The annual projected benefits payments are calculated and provided by the Plan's actuary.

As part of Management's and the Board of Trustee's oversite of the Plan there is an annual review with the actuary to review the Plan performance and to estimate the cost to terminate the plan.

Funding over the next three (3) years will be at 2020 budget levels and subject to change.

16. *If you assumed Medicare increases, what value and what would a reduction in commercial be to maintain your NPSR.*

Management's Response:

The table below has four components that were included in the FY 2020 related to Medicare "rate".

Medicare "rate" items		***Amount***
Medicare proposed rate increase		$673,000
1% Payer mix shift to Medicare		(424,000)
Medicare case mix index--change		0
Medicare provider based payment		(762,000)
	Total	***($513,000)***

- Medicare proposed rate increase – included in the budget is an increase in non ACO Medicare reimbursement of 1% and 3.5% for Medicare ACO volumes. The two amount to approximately $673,000 above FY 2019 approved Medicare reimbursement rates;
- 1% Payer mix shift to Medicare – included in the budget is slightly greater Medicare volumes. This $424,000 represents the estimated reduction in reimbursements that SVMC will receive from Medicare compared to Commercial payers;
- Medicare case mix index – in the FY 2020 budget the Medicare case mix index was budgeted not to materially change, thus no funds were added or subtracted from the 2020 operating budget;
- Medicare provider based payment – included in the FY 2020 is a reimbursement change related to provider based billing where effective January 1, 2020 over $750,000 ($762,000) in FY 2020 will be reduced in payments based upon current volumes. The annual impact is over $1 million.

If the commercial rate request which management has submitted was reduced than the Medical Center's NPSR would be reduced. The reduction would have a negative effect on cash flows, operations and continue to put overall pressure on the operations of the Medical Center and create greater pressures in the future with SVMC's planned Modernization.

If there are follow-up questions or information needed please arrange a call through my administrative assistant Theresa Smith at 802-447-5002.

Sincerely,

Stephen D. Majetich
Chief Financial Officer