August 9, 2024

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

Re: **Follow-Up Questions and Requests Related to Your Budget Submission**

Dear Ms. Berube,

1. Do you plan to track the efficiencies cited with the shared management and other structures between MAHHC and affiliates? How are you evaluating returns to your organization?

We plan to track the efficiencies with the Valley Regional Hospital (VRH) affiliation and shared management/resources. We will do this in collaboration with VRH finance, identifying all relevant/applicable savings and report this information to our Board of Directors. The returns will be evaluated by identifying shared resource programs (Lab, RT, Executive, PT, etc.) quantifying the differential between implementation and alternative staffing/resource models, in some cases comparison to historic data. The affiliation between the two organizations was completed 8/1/24, and while there has been a history of cooperation between both organizations over the years, it will take time and effort to develop demonstrable savings.

2. You've written that limitations in home health services and nursing home care will likely force the hospital to send more patients to swing beds than they would otherwise send. Yet you also predict that the total number of swing beds used (swing bed census) will decrease over the next year. How do you reconcile those two statements?

Limitations and accessibility of in-home health services and nursing home care in the community harm our ability to discharge swing patients. We could admit and care for more acute and swing patients if we could discharge more quickly. We are projecting a decrease over next year, as we seek to prioritize admissions of acute level patient.

3. What are the total pharmaceutical expenses for your hospital and its practices? Do you and Dartmouth Health make a profit of your pharmaceutical operations? If so, please explain and quantify the net impact.

Total pharmaceutical expenses for the hospital and associated practices in FY23 were $2.8M. MAHHC largely breaks even on our in-house pharmaceutical operations, with a net loss of $127K in FY23 after considering direct and indirect expenses. The net impact is highly dependent on payer mix, as there is a significant range of realized reimbursement between the payers for pharmaceuticals.

4. Why did you not include CMI in your budget considerations?

We do not include CMI in our budget considerations due to our CAH designation, as our reimbursement is largely not related to CMI. Additionally, our inpatient acuity as a CAH has been fairly consistent over the years.

5. Why do you have a smaller relative price increase for professional services?

The price increase is the same across all services and payers at 3.5%. The net impact of the price increase on professional services over hospital services is due to the reimbursement methodology employed by most payers, which is based on a fixed fee schedule, as opposed to a percent of charge or cost. Payers have various rate change agreements regarding both fee schedules and percentage of charge.

6. You've requested a high NPR in part to expand access to primary care and pediatric services. Can you please provide detail on how you're expanding access in these service areas?

We aim to expand access to primary care and pediatric services by a combination of provider recruitment and access benchmarking. We are establishing provider benchmarks with respect to access such as minimum visits per hour and quarterly MGMA RVU targets. Methods to achieve this are through 1 on 1 provider management, data and reporting transparency, action plan development, and friendly competition.

7. In Table 2 in the workbook, your referral lags for imaging procedures seem low. To your understanding, why does referral processing often take longer than three days? Can you please provide an estimate of how much longer it takes?

The previous days referrals are provided to the radiology department via the EMR in the morning. If referral orders are placed on Friday, then the radiology department received said orders on Monday morning. Complex tests, such as CT and MRI, must be referred to a radiologist for medical necessity review, which is typically a 1-day turnaround. Once confirmation from the radiologist is received, insurer authorization is sought out, which can take 6 hours to 2 weeks. Then a patient contact is attempted to schedule the appointment.

8. Please review the rate decomposition details you submitted as well as the "summary" tab and explain the following (where available, show supporting calculations):

> **a. How did you arrive at the assumed rates of growth for price, volume, and payer mix shifts by payer?**
>
> Our usual methodology for establishing budgeted price, volume, and payer mix are as follows: (1) forecast volumes in collaboration with clinical and senior leadership based on historical run rates and known changes; (2) determine the number of staff and amount of input required to provide those services; (3) we established an operating margin goal based on GMCB expectations, DH expectations, and our Board's expectations; (4) review our reimbursement model (trending reimbursement rates and payer mix) and apply a rate increase to deliver the desired margin.

With respect to the workbook, to find the rates of growth for price, volume and payer mix were found using our FY24 and FY25 Budget Revenue Model. This model utilizes revenue by department and payer derived from current payment rates and volume statistics. The model provided relied on identifying the impact of FY25 rates, volumes, and payer mix on FY24 budget NPR. We applied our FY25 assumptions to the FY24 Budget Revenue Model, one at a time holding other variables constant, and identified the % variance from the original FY24 Budget Revenue Model and applied the % to the original FY24 budget NPR. The NPR FY25 due to price, volume, payer mix, per the model provided, took the difference between the NPR FY25 Budget and the NPR FY 24 @ price/volume/payer mix.

b. For non-zero values in the "other" column, how did you derive these estimates?

Non-zero values in the "other" column consist of the NPR YOY Budget to Budget variance in FPP, Risk Reserves, Bad Debt, Free Care and DSH payments.

9. Do you think Medicaid is underfunding the cost of delivering care to your Medicaid patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.

Our overall cost to charge ratio per 2023 Medicare cost report was 48.4%. Applying said percentage to Medicaid revenue less Medicaid payments (including FPP+PHM+DSH) results in an underfunding of $3.86M.

10. Do you think Medicare is underfunding the cost of delivering care to your Medicare patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.

As a critical access hospital, our Medicare reimbursement is 101% of cost before sequestration, which is set at 2%. Therefore, we are effectively funded 99% of allowed cost. According to our 2023 filed cost report, sequestration was $325K, half of which would get us to 100% cost, therefore we are underfunded by $162.5K.

11. In the attached spreadsheet, please review the measures of financial health that we have calculated for your hospital. We have included the measure definitions. Confirm that these calculated values reflect your understanding. If your financial measures differ from our calculations, please review our formulas, provide your calculation, and explain why you believe your calculation is a better measure for your organization.

The financial health measure calculated reflect MAHHC's understanding and accurately show expected values for FY2025.

12. Question C.c (uncompensated care): Differentiate any assumptions/changes as they relate to exogenous trends (e.g. patient needs) or internal practices (e.g. changes in accounting or business processes) related to bad debt and free care. Please include a description of collection processes. Report your budgeted bad debt to free care ratio and how you derived your estimates for bad debt and free care.

The most noticeable change relevant to free care includes the adoption of ACT119 and the new eligibility standards and guidelines, of which we have adopted per HCA provided guidance. Our bad debt and free care expense are established based on historical and current run rates. We have observed a downtick in charity care compared to budget in the past two years, and had initially planned to budget this at a reduced rate, but in consideration of ACT119 we opted to keep it consistent with historical budgets in anticipation of an uptick in utilization of the program. For a complete description of the collection process, please see attached collections policy.

	Budget 2024	Projected 2024	Budget 2025
Free Care	$ 1,474,683	$ 1,235,688	$ 1,486,733
Bad Debt	$ 2,580,695	$ 3,558,527	$ 1,858,416
Total	$ 4,055,378	$ 4,794,215	$ 3,345,149
Ratio	1.75	2.88	1.25