Mt. Ascutney Hospital
and Health Center
Dartmouth-Hitchcock

June 30, 2021

Attn: Ms. Susan Barrett, J.D. Executive Director
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: Budget 2022 Narrative

Dear Ms. Barrett,

This letter serves as the narrative required to accompany the electronic budget files which have been sent under separate cover. There is a fair amount of overlap between the various sections so we have done our best to not be overly redundant.

Executive Summary:

Mt Ascutney Hospital and Health Center (MAHHC), is budgeting a 1.77% operating margin.

FY21 has been a year of ongoing changes, uncertainty, and challenges. The pandemic has challenged us individually and corporately. Every day has been an opportunity in the midst of a crisis. While there have been many unpleasant and negative moments and events, one very positive and notable takeaway has risen to the top of our experience over the last fifteen or so months. Our providers, staff, and managers are resilient, creative, and dedicated to our mission and to the patients of Mt. Ascutney Hospital and Health Center.

MAHHC found creative ways to insure that patients received access to the care that they needed safely and effectively. We temporarily moved services, reallocated space, found new work flows, and revised protocols as guidance changed week to week. Providers and staff powered through care delivery changes, changes in assignments, and remote work assignments. We cared for COVID patients from Dartmouth-Hitchcock Medical Center, other hospital service areas in VT, and from out of state. We accepted COVID-positive acute rehab patients from NY state after their rehab facilities refused to admit such patients. While a number of regional providers were functionally closed to COVID patients (suspected and/or confirmed) aside from their Emergency Rooms and vaccination clinics, we safely and effectively managed COVID throughout our service lines. We established an inpatient COVID unit as well as a dedicated clinic for outpatient diagnosis and treatment for COVID patients, whether confirmed or suspected. As a result, we did not furlough or lay off staff, we outperformed our anticipated budgets, and retained nearly all of our valued staff and patients.

Our 2022 budget builds on the lessons learned, the strengths of our staff, the opportunities that we identified, and the changes we have made to manage through the pandemic. This budget reflects the ground that we have gained and the recovery efforts of the organization. We anticipate COVID-19 to continue to play a role in the operations of our hospital for the near future. Prevention, access screening, testing, and ongoing vaccine/booster clinics will remain major areas of planning and implementation.

Our healthcare reform efforts and participation with OneCare Vermont are expected to continue as will ongoing integration efforts with the Dartmouth-Hitchcock Health system. Administrative and clinical opportunities continue to be reviewed and analyzed on an ongoing basis in order to determine whether programs should be modified, integrated with D-HH or should remain the same to best meet our mission and the needs of our patients. While many changes have been implemented over the last few years, there continues to be a steady stream of opportunity for further consideration. Staff sharing, expertise sharing, best practices, IT services, cost reductions, and the rational distribution of clinical services in the system are regularly reviewed and discussed. FY 2022 will also be the first year of cost allocation across the D-HH System for services with deepening integration.

Volumes and revenues generally exceeded FY21 budgeted levels, as recovery surpassed expectations. FY21 budgets were tempered to allow for the possibility of a slower recovery, surges in the pandemic, and the reduction of elective services.

Because of our improved financial performance, MAHHC implemented a pricing reduction project. The goal of this plan was to right size, rationalize, and reduce pricing. The initial focus of the program has been ancillary charges, including radiology, laboratory, and outpatient therapies. To date, CT and MRI prices have been reduced 21% and 20% respectively. While some of our rates were in the realm of reasonable, some were not. We had hoped to have done this in 2020 but the uncertain risk surrounding the pandemic and the added workload of managing through the pandemic, forced us to kick the can down the road. Targeted reductions will be analyzed and implemented throughout the remainder of the year. Functionally, this means that our small price increase request of 2.2% will actually be a negative request in reality. This 2.2% request only includes the reductions of CT pricing and the effect of this specific reduction on FY22's budget. It will also reduce our net revenue percentage as net revenues are lost from some commercial payers for some services. This is likely our smallest rate increase request in more than a decade.

We have continued to focus on expense management, minimizing the effect of uncontrollable factors, and keeping the ship steady. While our service lines have remained reasonably stable and are continuing to grow in market share experience in 2019 and early 2020, we are still a small entity with a small "n" and even small changes can result in significant unfavorable variances. We have received a significant benefit to the bottom line from the mitigation of risk in our OneCare VT risk programs.

Year over Year Changes:

Net Revenues and FPP:

Our weighted rate (price) increase is 2.2% for FY22. Most of the facility/hospital/physician increase is 2.5%. Pharmacy charges are priced at cost plus and therefore no price increases are applied to pharmaceuticals. This marks our lowest price increase request in recent memory. This results in approximately a 1% net revenue gain from the price increase. As noted above, with the price reduction initiative, we are going into the new fiscal year with a small and negative pricing change.

Volumes experienced a strong recovery during the COVID-19 pandemic. As the pandemic continues to wind down, pent up demand, high patient confidence, and a growing market share help drive the increase in volumes in FY21 back towards normal levels (FY2019 and the first half of FY2020). We expect this trend to continue into FY22 as we continue to build and grow our provider practices. Generally speaking, we anticipate underperforming departments' volumes to return to normal and outperforming departments to level off and normalize.

Inpatient volumes are expected to return to pre-pandemic levels. The mix of inpatient services has been changing since the end of FY19 with an increase in acute inpatient days as a percentage of total days and a reduction in swing bed/subacute days. Of note, in the recent Sustainability work spearheaded by the GMCB, Mt. Ascutney Hospital and UVMMC had the highest inpatient bed occupancy in the state. We expect this to continue but will likely regress a bit as pandemic related acute stays diminish and subacute patients can safely and confidently return to us. Emergency Room, medically necessary ancillaries supporting inpatient and outpatient services, and infusion will also return closer to pre-pandemic levels. Clinics/Provider Offices will experience a marginal increase in volume, despite a marginal decrease in the provider compliment, with the recent addition of Neurology and Urology and recently implemented provider productivity initiatives. These will help bring clinic volumes back closer to the historical norm or slightly better.

Total Gross Patient Revenues will increase 13% budget to budget. FY21 budgeted revenues were reduced in anticipation of another surge of the pandemic and slower recovery. However, recovery in FY21 has been much stronger than expected. Deductions and net reimbursement percentages fluctuated budget to budget, due to the effect of volumes on the cost report, OneCare VT risk mitigation/results, payer mix, and service mix changes. FY21 budgeted contractual rates were budgeted lower than usual due in part to the elimination of OCV risk, accelerated pension expense recognition on the cost report, and other atypical events. We expect deduction rates to return to historical and pre-pandemic levels. Bad debt and free care as a percentage of revenues remains unchanged budget to budget. The payer mix remains relatively stable budget to budget, with a marginal shift among governmental payers. We anticipate DSH figures to remain stable after an unexpected increase in FY21. Our price decrease will also reduce net revenues and the net revenue percentage.

We continue to opt out of the AIPBP component of the OCV Medicare program (no FPP), but remain in the quality/risk portions of the program. Risk booking will resume in FY22 after a reprieve was granted for FY21 due

to the pandemic. We will participate in the OCV Medicaid program so FPP, PHM, and the like have all been budgeted for FY22. We did budget for OCV commercial business for PHM, but no FPP or risk as those components of the program and the data are not available at this time. We budgeted $1,700,000 in Medicaid FPP and $30,000 in risk. We budgeted $270,000 in FY22 Medicare risk. PHM and other reform revenues are $445,000, and participation and infrastructure fees are expected to be $460,000. These are all based on preliminary estimates provided by OCV.

COVID-19 has been and continues to be a significant use of energy and resources to the organization. While infections, outbreaks, and testing are diminishing, vaccinations have taken their place. MAHHC organized and staffed a Vermont state sponsored vaccination clinic on campus administering over 12,000 vaccinations, earning $25 per shot. As seen in Appendix 5, managing the crisis on a reimbursement basis and removing grant funding, is unsustainable. Despite including grant funding in FY21, margins from testing, vaccine administration, and COVID-19 related expenses were negative contributors to an operating margin. FY22 budgets for vaccine/testing are an improvement from projected FY21 levels, but still producing a deleteriously low margin at -34%.

Change in Charge Request:

Our weighted rate (price) increase is 2.2% for FY22.

Our usual methodology for establishing the needed rate increase was followed. We determined how busy we would be. We determined the number of staff and amount of "stuff" required to provide those services. We established an operating margin goal based on GMCB expectations, D-HH expectations, and our Board's expectations. We review (and revise if necessary) our reimbursement model and apply a rate increase to deliver the desired margin.

There are no meaningful changes in commercial contract terms anticipated for the year. That said, commercial insurers are continuing to push Medicare Part C (Medicare Advantage) products into the market, which generally have Medicare-like reimbursement rates, require higher administrative/operating costs, and do not settle on cost. There is a delay in their adjustment of rates so increased costs per unit are not recognized for six or so months. Non-ACO Medicaid reimbursement is expected to improve from 2021 levels in part because of a substantial decrease in ACO risk reserves budget to budget.

Due to our strong operating performance in FY21, and in recognition of need, we have been able to implement a Price Reduction Plan. Starting with our diagnostic imagine service line, a systematic review of CT and MRI prices were conducted. On average, CT and MRI prices were reduced 21% and 20% respectively. The Price Reduction Plan also includes reviews for other ancillary service lines, such as therapies and laboratory. This work is ongoing through the remainder of FY21.

Overall, our net reimbursement change is down 3% from budget 2021 to 2022. For the purposes of discussing the impact of a rate increase on payers, the net effect of OCV ACO business is ignored. A majority of our Medicare reimbursement is driven by cost and not driven by an increase in charges. The percent of our increase that will be recognized by Medicare will be limited to Medicare's portion of the inflation of cost that is recognized via the cost reporting mechanisms. Higher volumes will generally reduce reimbursement per unit since cost per unit also diminishes with higher volumes. Medicare typically pays slightly less than cost. Medicaid is primarily "fee schedule" or "fixed payment" driven...DRG's, APC's, and fee schedules for providers. Medicaid pays significantly less than the cost to provide the service and any increased reimbursement will be limited to the percent increase added to these fixed payment methodologies. Historically, it will be slightly less than the medical inflation indices. We have no indication of what Medicaid reimbursement will be at this time. Reimbursement for self-pay portions of our reimbursement is negligible and we receive less as a percentage over the last few years due to the IRS required reductions for non-insured. All of this pushes the need for margin to the commercial payers (cost shift). Approximately 60% of the rate increase will be realized with our commercial billing.

Adjustments:

The addition of a community-based Neurology clinic has been a blessing for our patient population and has contributed positively to improved ancillary testing. We have worked to recruit a neurologist for years to support our acute rehabilitation mission as the majority of our patients have suffered significant brain injury from stroke, trauma or neurodegenerative disease. However, by co-locating our neurology and physiatry programs, we are utilizing our existing fixed overhead more often and lowering our cost per unit; creating a slight reduction in cost report reimbursement. As we normalize our primary care and specialty clinic service lines post-COVID, our patients' quality of care will improve as we take a comprehensive approach to their needs. In combination with our

ACO health reform initiatives, patients are increasingly seeking out care at MAHHC. Neurology has helped bring in approximately $830,000 in net revenues when considering physician and ancillaries' revenues.

Other Operating and Non-Operating Revenue:

Other Operating Revenue (OOR) will increase 15% budget over budget due to inflation and 340B. A recently contracted 340B vendor has helped increase 340B revenue significantly as they have gained market share. This has helped mitigate the limitations placed on the program by various manufacturers. Grant revenues are leveling off, as COVID-19 funding comes to an end. Budget FY22 Other Operating Revenue is in line with projected FY21, due to COVID-19 funding supplementing the partial year impact of the new 340B vendor. Lobbying efforts by the pharmaceutical industry put 340B revenues at risk, as they apply systematic pressure to erode and dismantle the 340B program. The continued and increasing reliance on other and non-operating revenues to fund hospital operations is a growing concern. Inflation, risk, reform, lackluster growth in governmental funding, are all factors that contribute to this increased reliance on non-patient revenues.

COVID-19 supplemental funding was received in FY20 in various forms. The Cares Act provided $5,300,000 in funds to support our efforts in combatting COVID-19 and to protect our patient population and community. The changing rules were, and continue to be, ambiguous with respect to allowable and/or recognizable expenses. Our interpretation in FY20 resulted in recognition of $2,500,000 in revenue and $2,700,000 in liability. At the same time, Medicare opted to advance $5,700,000 of payments to support MAHHC and ensure liquidity in what was an uncertain and critical time. While we were underfunded as compared to other CAH's in the region due to CMS reporting issues related to our OCV participation, our effective recovery efforts rendered this issue mute. Medicare has begun recuperating these funds in April of 2021, at a rate of approximately $500,000 per month. This recuperation rate is projected out in FY21 and accounted for in the FY22 budget, and is expected to be fully refunded by the end of that fiscal year. Other smaller COVID-19 grant funding were recognized in FY20 and FY21, such as VT Healthcare Stabilization Grant and the VT Hazard Pay Grant. These were recognized as revenues in the year in which they occurred.

Non-operating revenues continue to outperform expectations as FY21 and are projected to contribute $3,600,000 in total margin, largely driven by investment gains (realized and unrealized). Budget FY22 non-operating revenues will be related to development and fundraising efforts ($250K) and a continuation of favorable investment returns ($975K) of approximately 5%. With recent market volatility and the Fed's discussion of interest rate increases, these revenues are not predictable. These estimates were provided by treasury management at D-HH.

Operating Expenses:

Overall, expenses will be increasing by 5.2%. Increases in salaries (new providers, support staff for the providers; ongoing COVID-related staffing, etc.), benefit costs, traveler expenses, other contracted increases, depreciation, and liability insurance increases are the key drivers. Wage increase packages are budgeted in FY22 at 3%, which is commensurate for the area and the D-HH system, and a key factor in attracting and retaining staff in our highly competitive landscape. In light of current market events, insurers have radically increased premiums and retention levels for the industry. For cyber coverage, FY22 premiums and deductibles are increasing 313% in annual premiums to $50,000 and a 500% increase in the deductible to $500k. D-HH has identified pharmaceutical inflation at 7.3% in FY22 which includes straight inflation and a change in the mix of pharmaceuticals associated with best practice. Supplies and Pharmaceuticals are also increasing due to the ongoing impact of COVID, inflation, chemotherapy/infusion pharmaceutical costs, increased laboratory testing, and other supply related expenses. Supply chain interruption, associated with the effect of the pandemic are key contributors to increased costs. Some of these are offset in revenues (pharmaceuticals, laboratory expenses, etc.). Provider Tax is increasing in relation to the increase in revenues. Depreciation and Amortization will increase due to capital purchases that were delayed during the pandemic being added to a "normal" year of capital investments. This is being mitigated by the longer economic life associated with our planned capital investments. Interest remains unchanged due to the loan that D-HH provided to us in order to help us terminate our pension plan. ACO dues are slated to increase by 27% year over year.

As mentioned above, capital spending for FY22 has been increased to recognize and make up for the lack of necessary capital improvements and replacements in FY20 and FY21 that were postponed during the pandemic. In the coming year we expect no CONs to be filed for implementation in FY22. The planned purchases are for routine replacement of equipment, mechanical systems, plant maintenance, and urgent care. Other significant items include autoclaves, clinical space renovations, diagnostic imaging equipment, EEG, IT workstation/device replacements/upgrades, D-HH integration projects, rooftop repairs and HVAC updates, chillers, transformers, among others. As expected, increased capital purchases increase depreciation for purchased items and costs to

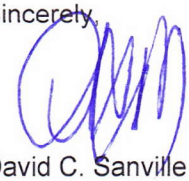
finance. We anticipate filing a CON in the coming months for the D-HH IT integration project slated for implementation in FY2023.

Operating and Non-Operating Margin:

Overall, we expect to generate a reasonable operating margin of 1.77% or $1,058,000 and a total margin of 3.8%, or $2,282,000.

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

Sincerely,



David C. Sanville
C.F.O.