Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

August 5, 2020

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

Re: Budget 2021 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 0.59% operating margin.

We have had to revise our budget multiple times since our initial draft in May. As the COVID-19 guidance, mandates, and best practices have changed, we have had to rethink our ability to recover and the effect of the pandemic on FY21. Our patients' willingness to come, the resiliency of our staff, and the logistics of navigating towards normalcy have all affected our projections of this year and next. Our recovery over the last month to two months causes us to ponder another revision but the prospect of a secondary surge or at least a longer run rate for the virus has left us with a ~94-95% of normal outlook on the future.

MAHHC continues with its integration efforts into Dartmouth-Hitchcock Health (D-HH). Administrative, clinical, and other areas are reviewed and analyzed on an ongoing basis to determine whether programs should be changed, consolidated with D-HH or should remain the same. 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 and strategic planning, service line 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 D-HH system.

We have remained steadfast in our management of controllable expenses, minimizing the effect of uncontrollable factors, and keeping the ship steady. While our service lines have remained fairly steady and predictable over the last few years, we are still a small entity and small changes result in large variance percentages sometimes. Our efforts to bring stability of staffing to our Primary Care have made some progress, they have not yet resulted in a dependable or predictable trend. The recruitment and retention of primary care doctors in rural Vermont has remained more than challenging.

A few senior managers spent significant time in FY2019 and FY2020 working with D-HH to design a rational and regional allocation of services between MAH, Springfield Hospital, and Valley Regional Hospital in Claremont, NH. Effects of this work are not reflected in this budget.

D-HH requested that we take on a Urologist in the second quarter of the year, just prior to COVID-19 becoming an issue. While they were not budgeted for FY20, they are included in the FY21 budget. We have also budgeted for a part time Neurologist (sharing with the Veteran's Hospital in WRJ) and are adding providers to Ophthalmology (succession planning and a shortage of providers in the region) and to our Psychiatry program (volume and unmet need). All of these year-to-year budget changes are masking the effect of the reduction in overall volume.

With the assistance of D-HH, we were able to terminate our pension which will be reducing costs, risk, and administrative efforts for the foreseeable future. This resulted in a large non-operating “gain” on our Income Statement. We may be able to accelerate the recognition of this cost on the Medicare Cost Report.

We are also responding to significant environmental changes and issues related to our participation in OneCare VT (OCV). We have seen significant changes in our patient base due to performance issues at other area facilities. A significant concern in this budget is the effect of the cost report. Because of CMS reporting issues for OCV hospitals participating in Medicare, we were unable to adequately/accurately calculate a reimbursement settlement for FY19. This has carried over into 2020. It has also adversely affected our Medicare Advantage contract reimbursement since we could not file “new rates” with these insurers which would have likely been positive. It also led to an unfortunate reduction of our Medicare Advanced funding. The reporting issue was finally resolved at the end of June 2020 ending a 17 month run of flying by instrumentation. We immediately filed the 2019 cost report in July but could not complete an interim for 2020 for the purposes of this budget submission. We have also lost the benefit of having our prospective payment rates improved from Medicare.

Because of the significance of these issues, we chosen to not budget for participation in the AIPBP Medicare program for CY2021 through OCV. There will be three months of Medicare risk in the FY21 budget (quarter 4 of CY20). We will be participating in Medicaid for CY2021 and have not budgeted for a commercial footprint for CY21 in the ACO. Our Medicaid participation has been budgeted to best of our ability with minimal information.

Impact of COVID-19:

The impact of COVID-19 has been more than significant in a number of ways. Virtually every aspect of patient care, staffing, operations, reporting, and planning has been adversely effected.

Patient demand for services was running as expected pre-Covid. Through February 2020, volumes, payer mix, patient loads, and services were all running slightly ahead of plan. As the pandemic began to unfold, we began to experience large drops in patient volume in all areas of the hospital. Patients began cancelling appointments, referrals from other facilities dropped, and elective and preventative services were postponed. Our Incident Command was initiated and we began to work through the vast number of issues, the constantly changing expectations, and evolving standards of care. Initially we focused on protecting our in-house patients, our employees, and managing the influx of potential COVID patients. We had a limited amount of personal protective equipment (PPE), and it was immediately obvious that it would not last very long. Dartmouth Hitchcock Health was instrumental in obtaining an immediate and ongoing supply of PPE. As volumes dropped, we began to move services, adjust staffing, and modify physical space to accommodate the most important patient needs. A respiratory clinic, one of the first in the state to open, was established to manage potential COVID-positive patients. One of our inpatient units was modified for negative pressure, air filtration, and barriers to protect patients and employees. The Medicare waiver opportunity was leveraged and we began to manage inpatients in non-traditional groupings/locations to insure patient safety and to maintain the inpatient needs of our communities.

As the most urgent and emergent needs were met, we moved to more elective services. More staffing changes, accommodations of clinical workflow, and space modification continued. Telemedicine was initiated in a relatively small amount of time with some success. Chemotherapy and infusion, some of our sickest patients, were moved to a more protected location. Accommodations were made for acceptance of inpatient transfers from Dartmouth Hitchcock, nursing homes, and other facilities. Administrative space was emptied (staff sent offsite) and re-allocated as clinical space in order to provide creative solutions for patient and staff safety, A “Swab and Go Clinic” was added and temporary mechanical, facility and workflow changes were put in place to provide triaging, screening, and patient waiting outside of the building.

Initially, the Operating Room was geared to urgent and emergent cases only. Most of our normal volume is elective and not urgent (colonoscopy, endoscopy, cataract surgery, etc.). Volumes plummeted to 20-30% of normal in this area. Upgrades in air handling, PPE, and patient flow were implemented and slowly we moved from urgent and emergent to more elective services. Clinics functioned at 50% or below for an extended period. This reduced ancillaries, future surgical interventions, therapies and the like.

We received stabilized COVID-positive patients from D-HH. We took in patients from out of state and from area nursing homes and assisted living facilities. We also supported the local EMS and other healthcare partners. It is also important to note that our census of “boarders” (inpatients who no longer require hospital services) grew throughout this period since it was impossible to place them or to return them to nursing homes, assisted living facilities, or even to home (reduced availability of home health). MAH received the most transfers (still a small number) from D-HH and other regional facilities.

Patient, visitor and employee screening changed on a seemingly daily basis to follow the mandates, orders, best practices, and “lessons learned”. Laboratory COVID testing sources changed multiple times. PPE protocols have changed weekly. Schedules for patients and staff were changed to accommodate appropriate spacing of patients. Virtually every aspect of patient care has been changed from pre-COVID.

Our most valuable resources, our providers and staff, have been amazing. They have essentially done whatever was needed. Back-office employees were sent home to work and the Information Technology staff made sure that this was possible. Staff in most departments took new assignments, worked in different settings, and volunteered to do other work. Folks were trained in new skills and retrained in old skills. Shifts were changed, low census and call off requirements became more aggressive as time went on. Open positions were frozen and folks in slower departments were re-assigned to fill in for the open positions, new positions to facilitate changes driven by COVID, or to help in busier departments. Most managers and staff were involved in the execution and implementation of projects and changes coming out of Incident Command and often performed double duty in addition to their normal duties. Some did triple duty and did patient care as well. We were also committed that we would keep our work force as whole as possible. All of this was implemented with the expectation that we needed to address the backlog of patient care as soon as possible and needed to have staff readily available to manage the recovery volumes. We knew that the accommodations and changes would require us to have more bodies to do the same work that we had always done with less. Recovery has gone reasonably well for us because of the choices that we made relative to staffing and because of our staff’s commitment to the patients, the mission, and their calling.

Operations has been turned on its head. Back office people have had to learn how to do their job from offsite. The use of technology has been changed forever. Departments have been moved, revised, reconfigured, and retooled. Patient flows and work flows have been radically changed. Protocols for patient and employee safety have been implemented in every patient setting. Security, maintenance, housekeeping, and other support services have had to develop new ways of doing business. It is hard to imagine one job, one function, or one department that has not had to re-think how they do business.

Scheduled market increases, scheduled merit increases, and retirement contributions have all been eliminated since March. Relative to capital spending, we only completed purchases/projects that were already in process when COVID-19 hit and are only considering capital that is emergent (equipment failure) or will assist us with recovery of necessary services and volume.

Financially, we have lost $5m in Net Patient Service Revenue since the end of February. Most of this loss came from the loss of outpatient volume. Nearly every outpatient department or clinic experienced double digit unfavorable variances. Referrals from D-HH and other facilities slowed during this period as they worked through the logistics and issues in their own workflows. They also experienced complications in discharging and transferring patients. Other key contributors to the unfavorable variances were the growing census of “boarders” mentioned earlier and the reduced throughput due to all of the accommodations put into place. While we managed our salaries and non-salary expenses down to the extent possible during this period, a Critical Access Hospital is approximately 80% fixed cost so we were not able to reduce costs as much as needed. We have also incurred approximately $300,000+ in additional costs associated directly with the needed response to the pandemic. This includes facility and mechanical changes, staffing, supplies, communication costs, information technology costs (software, devices, etc.), etc.

We have received approximately $5m in Federal Stimulus funds to date. We received $4m in Medicare Advanced Funding (which is essentially a loan). Our Medicare Advanced funding was 1/3 of what other similar sized hospital received because our OneCare FPP payments were not considered in CMS’s calculation of historical payment amounts. Countless hours have been spent to rectify this with no success. We expect to receive at least $200k from other sources (FEMA, ASPR, SHIP, FLEX) to offset some of the $300k in COVID-related expenses.

Our expectation, despite the impact of COVID is to finish at a 1.6% margin for 2020. This is primarily driven by the booking of $5m in stimulus funds and our ongoing recover efforts. Without these funds, we would be losing approximately $4m for the year. Additionally, this will deplete these COVID-related funds and this cash will have to carry us through the impact of COVID in 2021 should we have another surge or a more extended and flattened curve.

Year over Year Reconciliation:

Net Revenues and FPP:

Our weighted rate (price) increase is 4.3% for FY21. Most of the facility/hospital increase is 6%. Pharmacy charges are priced at cost plus and therefore no price increases are applied to pharmaceuticals. Physician/Provider charges were only increased 3%.

2.1% is our "normal" increase and brings us to the 3.5% threshold. The remaining 2.2% rate increase is related to COVID impact. This replenishes cash, gives us room for capital, provides cash to repay the Medicare Advanced Funding, and allows us to sustain a longer and flattened curve.

Volumes are a mixed bag. The general concept that we applied was that the more urgent or emergent the service was, the more normal the volume as compared to historical levels. The more preventative or elective the services are, the less we expect to do as compared to historical norms. Despite our effective implementation of safety for our patients and employees, elective volumes are essentially dependent on our patients' willingness to receive the services. Urgent and Emergent services take most of the patient willingness factor out of the equation.

Inpatient volumes will be similar to prior year levels since they are necessary and not optional for patients. However, the mix of inpatient services has been changing since the end of FY19. We have had an increase in acute inpatient days as a percentage of total days and a reduction in swing bed/subacute days. Emergency Room, medically necessary ancillaries supporting inpatient and outpatient services, and infusion will also remain largely unchanged. Clinics/Provider Offices will experience a reduction in volume with primary care being the most challenging and surgical specialties closer to the historical norm. This will cause a reduction in many support service areas from what we would have trended towards pre-COVID. The only growth in the clinic areas will be in Psychiatry, Ophthalmology, Neurology, and Urology.

Total Gross Patient Revenues will increase 3% budget to budget. Deductions and net reimbursement percentages will change. Due to complications with the OCV Medicare program, we did not budget for participation in CY2021 and therefore only reflect 3 months of activity in the fiscal year (last calendar quarter of 2020). This will improve our reimbursement percentage for Medicare because we will not be booking risk. This gain will be offset with conservative Cost Report results since CMS reporting was not available in time for our budget work. We are also concerned about inflation factors for non-cost reimbursed services for fee schedules given the Federal funding response to COVID. We will participate in the OCV Medicaid program so FPP, PHM, and the like have all been budgeted for FY21 for Medicaid. We did not budget for any OCV commercial business. We budgeted a loss of Blueprint funding of approximately 50%. DSH figures were not available so we carried over our 2020 amount. A 1% gross price increase nets us approximately $454,000 based on our current reimbursement rates and payer mix.

Other Operating Revenue:

Other Operating revenue will increase due to inflation, 340B, increased grant funding (offset by expense) and staff/provider rental (offset by expense).

Operating Expenses:

Overall, expenses will be increasing by 4.7%. Increases in salaries (new providers, support staff for the providers; COVID-related staffing, etc.), benefit costs, traveler expenses, other contracted increases, and liability insurance increases are the key drivers. Supplies and Pharmaceuticals are also increasing in anticipation of ongoing impact of COVID, chemotherapy/infusion pharmaceutical costs, increased laboratory testing, growing acuity (inpatient acute days as a percentage of total days) and other supply related expenses. Some of these are offset in revenues (pharmaceuticals, laboratory expenses, etc.). Provider Tax is essentially flat. Depreciation and Amortization will increase due to the economic life associated with our capital investment plans. Interest is increasing significantly due to the loan that D-HH provided to us in order to help us terminate our pension plan. Other operating expenses is significantly reduced due to the new GMCB reporting requirements and less ACO participation.

Operating and Non-Operating Margin:

Overall, we expect to generate a small operating margin of 0.6% or $352,000. Non-operating revenues will be related to development and fundraising efforts ($250K) and the remainder from investment returns ($745K) for a total margin of 2.2%.

Change in Charge Request:

Our usual methodology for establishing the needed rate increase was followed with a few changes. 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 to rate increase to deliver the desired margin.

The changes related to not having a current, year-to-date cost report due to the OCV/CMS issues. This prevented us from accurately updating our reimbursement model. Additionally, as mentioned earlier, we spent a great deal of time trying to determine how best to "guess" at the impact of COVID on volumes, service lines, and staffing.

The measures of this on the "Payer Mix" sheet of the budget analysis are a bit convoluted due to a change in reporting in the periods reported and our changes in reporting internally. There are no meaningful changes in commercial contract terms anticipated for the year. Non-ACO Medicaid is expected to degrade from 2020 levels due to the increase of "boarders" who's services are reimbursed at 10-15% of charges. We have had an incredibly challenging time discharging and placing these folks in appropriate settings. Bad Debt and Free Care will be reasonably close to unchanged as a percentage of Gross Patient Revenue from FY2020 levels.

Overall, our net reimbursement change is +1% from 2020 to 2021. For the purposes of discussing the impact of a rate increase on payers, 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 the inflation of cost recognized. 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. 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.

Risks and Opportunities/Service Line Changes:

As a Critical Access Hospital, our small "n" is always our biggest ongoing risk. The departure of one key provider or staff member could create a great deal of difficulty. Taking risk with small numbers of lives can be problematic. Small changes in volumes can change reimbursement and cost allocations quickly. As discussed previously, employee/provider recruitment and retention is an ongoing risk.

Covid-19 is the largest risk presented in our budget for FY2021. Revenues and expenses are all susceptible to dramatic change with no notice. This affects our entire organization as outlined above. Participation in OCV's payer programs is the next largest risk. Aside from the significant financial risk, there has been a great deal of financial and administrative time and resources expended for this relationship with little or no return on the effort and investment.

The biggest opportunities in the budget are the Urology and Neurology service lines, as well as expanded provider compliment in Ophthalmology and Psychiatry. We have made conservative bets on volume and success in these areas. There are no other material changes in the services that we offer.

The budget proposal reflects strategies for addressing these risks and opportunities. Conservatism relative to volumes, standing pat on overall reimbursement levels, and holding the line on staffing/expenses will help us achieve this budget. Elimination of wage increases and reducing retirement benefits will also help. Planning and execution will be critical moving forward. We are currently developing and implementing the aforementioned opportunities, making them realistic and achievable. Relative to mitigating the OCV program risks, we are withdrawing from the Medicare and Commercial programs.

OneCare Vermont Participation:

We will continue our participation in OCV's Medicaid program, without interruption. As described above, the ongoing issues, difficulties, and costs in participating with the Medicare and Commercial ACO programs has influenced our decision to withdraw from those programs. Complete budget information for the FY21 budget submission were not available, therefore, we had to rely on historical experience and previously reported data from OCV. We budgeted $1,200,000 in Medicaid FPP and $160,000 in risk. We budgeted $566,667 in Q1 FY21 Medicare risk. PHM and other reform revenues are $94,000 and participation fees are expected to be $151,000. Infrastructure fees are $115,000. We are still considering whether we could expand or maintain our current level

of engagement with OCV but for the sake of the budget submission timeline, we did not have the necessary financial data for our Board to review and discuss.

Capital Investment Cycle:

Capital spending for FY21 has also been reduced from what had been planned in our five year planning process. It will not make up for our minimalistic capital investment this year and puts us at some risk, especially in the area of facility/mechanical upgrades. In the coming year we expect no CONs to be filed, as the planned purchases are for routine replacement of equipment, mechanical systems, and plant maintenance. Significant items include chemistry analyzer, clinical space renovations, C-Arm imaging, IT workstation/device replacements/upgrades, switch additions, telephone system upgrade, wi-fi upgrade, D-HH affiliate integration projects, rooftop repairs and HVAC updates, generator replacement, among others. As expected, increased capital purchases increase depreciation for purchased items and costs to finance.

Please let us know if there are additional questions or concerns. We apologize for the delay in submitting the required materials.

Sincerely,

David C. Sanville
C.F.O.