THE University of Vermont HEALTH NETWORK

Central Vermont Medical Center

FY 2020 Budget Analysis Questions – GMCB Staff and GMCB Board Members
Central Vermont Medical Center

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

Yes, CVMC originally projected to be at a +$678K operating margin (using data through April), and now after the June close, the projection is revised to be a -$4.2M loss, due mainly to a deterioration in net patient service revenue collection rates and fixed perspective payments, a spike in salary expenses for travelers needed to care for high inpatient census in the acute care setting and nursing shortages at Woodridge Rehabilitation and Nursing, our skilled nursing facility, escalating specialty pharmaceutical costs in our infusion centers, and an increase in bad debt and collection agency fees. Please see the June GMCB monthly results for a revised projection.

INCOME STATEMENT	2018 A	2019 B	2019 B thru June	2019 YTD	2019 PROJ
Revenues					
Gross Patient Care Revenue	$ 389,142,484	$ 412,507,360	$ 308,577,999	$ 313,105,421	$ 414,104,947
Net Patient Care Revenue	**$ 165,895,188**	**$ 160,552,922**	**$ 120,597,438**	**$ 125,631,156**	**$ 166,556,484**
Fixed Prospective Payments, Reserves & Other	**$ 28,690,947**	**$ 50,834,099**	**$ 37,370,152**	**$ 28,580,275**	$ 39,133,400
Total NPR & FPP	**$ 194,586,135**	**$ 211,387,021**	**$ 157,967,590**	**$ 154,211,431**	**$ 205,689,884**
Other Operating Revenue	$ 13,579,338	$ 13,831,969	$ 10,374,167	$ 12,141,317	$ 15,446,011
Total Operating Revenue	**$ 208,165,473**	**$ 225,218,990**	**$ 168,341,757**	**$ 166,352,747**	**$ 221,135,895**
Operating Expense	**$ 216,033,931**	**$ 221,962,950**	**$ 166,253,986**	$ 169,636,321	**$ 225,417,219**
Net Operating Income	**$ (7,868,458)**	**$ 3,256,040**	**$ 2,087,771**	**$ (3,283,574)**	**$ (4,281,324)**
Non Operating Revenue	**$ 9,757,603**	**$ 4,246,649**	**$ 3,184,987**	$ 2,255,374	**$ 2,457,983**
Excess (Deficit) of Rev over Exp	**$ 1,889,145**	**$ 7,502,689**	**$ 5,272,758**	**$ (1,028,200)**	**$ (1,823,341)**
Income Statement Metrics					
Operating Margin %	-3.8%	1.4%	1.2%	-2.0%	-1.9%
Total Margin %	0.9%	3.3%	3.1%	-0.6%	-0.8%

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

In 2017 VITL provided training to patient access, and we are asking patients if they would like to consent during their admission process.

3. What is the value of 1 day of Days Cash on Hand?

Based on the FY 2020 budget, each day represents approximately $613K of operating expense. CVMC uses the following calculation: Total Expense – Depreciation / 366 days due to FY 2020 being a leap year.

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

CVMC's commercial rate increase is based on negotiated payment per service (fee schedule, DRG, etc.). In general, these payments are not impacted by changes in charge or list price. The following table shows the modeled impact of CVMC's charge increase.

IMPACT OF CHARGE INCREASE	FY2017	FY2018	FY2019	FY2020
Gross Charge / List Price Increase	**0.00%**	**0.20%**	**2.80%**	**3.00%**
Gross Revenue Impact	-	**618,300**	**11,235,609**	**12,552,918**
Medicare	0	132,413	5,027,247	5,557,315
Medicaid	0	364,247	2,010,135	2,143,483
Commercial	0	121,641	4,198,226	4,852,120
Net Revenue Impact due to Gross Charge / List Price Increase	**0**	**0**	**0**	**0**
Medicare	0	0	0	0
Medicaid	0	0	0	0
Commercial	0	0	0	0

The CVMC commercial rate calculation of $1M per 1% represents the major commercial payer 12 month equivalent, which factors contract renewal dates.

The GMCB calculated $2.6M per 1%. In their model there are 6 notable items which explain the difference between the amounts:

- GMCB calculation uses the amount of the Commercial and Non-Commercial payer rate amounts and changes in DSH
- GMCB calculation uses the change in gross charge price of 3.0%
- CVMC calculation uses only the Major Commercial payer rate amounts
- CVMC calculation uses the net revenue commercial rate increase of 5.9%
- CVMC calculation then converts it from a budget impact to a full 12 month impact

5. There is an inconsistency in the narrative regarding Medicaid reimbursement assumptions – page 17 indicates 0%, page 30 indicates 1.2% – please clarify. Based on this clarification, please calculate the impact of Medicaid's proposed reimbursement rate. Are Medicare reimbursement assumptions still valid? Are Disproportionate Share Payments assumptions still valid?

The difference is that page 17 of the narrative was referring only to the hospital and the practices, and page 30 includes Woodridge Rehabilitation and Nursing. Medicare proposed inpatient reimbursement assumptions have been made available but are not final until August and are still subject to change. Medicare OPPS proposed rules were made available on July 29, but final rules won't be published until November. CVMC budgeted DSH at $1,329,351 prior to the letter from DVHA on May 31, 2019, indicating that CVMC will receive $1,280,819. This will create a negative budget variance of $48,532.

6. Explain why the hospital didn't budget conservatively for upside or downside risk as they have estimates per Appendix V?

CVMC does not have enough historical data to make a good estimate of what the budget reserve should be. Since the risk can be either positive or negative, our approach is to budget the average of the upside and downside risk, which would be zero.

7. Is the hospital budgeting enough for bad debt and free care?

CVMC budgets bad debt and free care as a percentage of Gross Revenue. There are seasonality effects in bad debt and free care related to when patient deductibles hit (typically in the beginning of the year). CVMC 2020 budgeted bad debt and charity care combined is equal to the FY 2018 percentage of 1.9% of Gross Patient Care Revenue.

8. Explain the provider acquisition/transfers as the dermatologist was in last year's budget effective for 10/1/18, the pulmonary practice was effective for 4/1/18, and oncology is an existing service. The provider transfers are existing services within the hospital, wouldn't these providers be accounted for in the FTE schedules? Please provide a copy of the letter sent to patients pursuant to Act 143 of 2016 requiring notice of the transfer.

Dermatology in CVMC's service area was previously covered by private practices that are no longer in operation. Current wait times for access to this service is 150 days. The Dermatology practice that started in October 2018 is being expanded from our current Provider FTE of 0.4, to our budgeted Provider FTE of 0.8.

CVMC is expanding oncology coverage with the addition of a provider to meet increased need in CVMC's catchment area. This addition has a material impact on our net patient service revenue and was not in the previous year's budget or the FY 2019 base run rate. This revenue should be excluded for the purposes of calculating the NPSR cap. Current wait times for a new patient to see an oncologist is 38 days.

Included in the FY 2019 budget were inpatient pulmonology services on a limited basis with one provider acting as the sole pulmonologist at 1.0 FTE. CVMC is adding an outpatient clinic along with an expanded inpatient pulmonary service to address the increased acuity of our inpatient population. Included in the FY 2020 budget is an addition of 2 part time pulmonologists for a total of 2 FTEs. Current wait times for a new patient to see a pulmonologist is 120 days.

9. What are CVMC's expectations for Fringe Benefits for MDs, as this expense is expected to increase to 39% from FY 2019 projection to FY 2020 budget?

As mentioned in the technical portion of the budget narrative, there was an allocation difference between how the fringe benefits were broken out for the projections and for budget due to changes in accounting software and chart of account changes. Fringe Benefits in total for MD and non-MD shows an increase of 5.5% from FY 2019 projection to FY 2020 budget. CVMC utilizes Willis Towers Watson, who provides actuarial services for the medical plan, in developing the FY 2020 budget.

10. Explain the physician fees and salaries increase of 3.5% budget to budget and the decrease of 4.4% projection to budget.

Physician fees and salaries budget to budget increases are based upon normal inflationary rates. CVMC continues to evaluate our provider workforce to proactively manage turnover and retirements. As previously mentioned, we have new providers starting in dermatology, pulmonology, and oncology. These three service lines represent an increase of 2.4 provider FTEs and would be part of the budget to budget increase. The decrease from projection to budget factors in expected retirements and includes a vacancy rate, which in previous years has not been accounted for.

11. Explain the variance between FY 2019 projection and FY 2020 budget for the Non-Operating Revenue "All Other Account."

As mentioned in the technical portion of the budget narrative, there were some changes to the chart of accounts structure due to an implementation of a new general ledger, accounts payable, and materials management software system. The account changes are creating categorization issues when comparing various time periods. A comparison of the total non-operating revenue versus the "all other account" is a more accurate representation of the actual trends. The variances in total non-operating revenue are related to interest rate fluctuation, which is outside our organization's control. Market returns can be highly volatile and therefore are difficult to predict, however CVMC anticipates that the returns will be higher than FY 2019 projected and lower than FY 2019 budgeted. CVMC has their investments pooled with the UVM Health Network in order to gain efficiencies and maximize the value of the returns.

12. Address the Operating and Total Margin for CVMC as the UVM Health Network narrative does not mention this hospital.

CVMC apologizes for this oversight. See below for explanation:

At the time of budget submission, the overall CVMC FY 2019 operating margin was projected to be 0.3%, which was below the FY 2019 budget of 1.4%, primarily due to the implemented commercial rate increases being lower than what was budgeted and higher than budgeted pharmacy expense. The FY 2020 proposed budget is expected to come in higher at 1.7%, due to commercial rates that are back in line with what is needed to cover inflation and an increase in patient acuity.

The overall CVMC FY 2019 total margin of 1.4% is projected to be below the FY 2019 budget of 3.3%, primarily due to lower market returns. The FY 2020 proposed budget of 3.4% is expected to be higher than the FY 2019 projection due to improvement in market returns, and basically on par with FY 2019 budget. It is important to point out that in addition to market returns, there are other items in total margin that are beyond the control of hospitals, which is why the focus should be on operating margin. Operating margin indicates what hospitals are generating on their core operations, which is taking care of patients. The total margin takes into account changes in our investment portfolio, and this is very difficult to predict due to changes and fluctuations in markets and interest rates.

13. Address the changes in utilization considering the hospital is budgeting at FY 2016 – FY 2017 levels for Adjusted Admissions, Tests, CT scans, and others.

Budgeted volume is determined by analyzing multiple data points. These data points include rolling 12 volume statistics and current fiscal year volume data that is annualized to project end of year utilization. The director applies their clinical and operational knowledge in determining the final budgeted volume statistic. The budgeted volume statistic should take into account regulatory changes, clinical practice changes, staffing changes, or other operational variables. This is a collaborative process between the operational leader and finance.

14. Explain the strategy for the reduction in force from FY 2019 projection to FY 2020 budget.

CVMC FY 2019 projected FTEs are 1,337.10, while FY 2020 budgeted FTEs are 1,321.20, for a difference of 16 FTEs. This reduction in FTEs will be achieved through attrition and not through a reduction in workforce. CVMC evaluates open positions, and as turnover occurs, the leadership team is responsible for evaluating the need for the position. With the implementation of Epic, the Network-wide electronic medical records system, and Workday, the payroll and HR system, there is an anticipated reduction in FTEs due to efficiencies gained by these systems. Again, any reductions will occur through attrition. In addition, the Vizient productivity analysis that was completed over a year ago comparing staffing levels to benchmarks continues to inform ongoing staffing needs.

15. Explain the large increase for Salary & Benefits per FTE – Non MD from FY 2018 to FY 2019 projection.

Per the Adaptive report 04 Key Hospital Statistics & Ratios, the Salary and Benefits per FTE – Non MD from FY 2018 to FY 2019 projection is equal to 3.7%, which represents normal salary and benefit inflationary increases across the industry. CVMC salaries in the FY 2019 budget included a COLA increase of 2%, market increases of 1%, and merit based increases of 0.5%. Because these wage increases are applied to base salaries and not total salaries, the true inflation on total salaries was budgeted in FY 2019 to equal 2.65%. Benefit increases in the FY 2019 budget were another 3.7%. When combining all salaries and benefits, the expected budget increase for FY 2019 was 2.9%. Due to changes in staffing mix, including higher than budgeted use of travelers and the actual number of FTEs, the projected increases are higher than originally anticipated during the FY 2019 budget.

16. In Appendix VI-Bridges, Table 2, CVMC listed funds under "Other Expense." Please describe what these funds are. Also, please explain the row titled "Rate Difference" in Table 1.

Other Expenses include insurance, property taxes, advertising, recruitment, minor equipment, linens, professional development, travel and reimbursement, and network shared services. The rate difference is the difference between what was budgeted for collection rates in FY 2019 versus actual collections during FY 2019.

17. Please further explain the accounting adjustment represented in Appendix VI Bridges Table, specifically the -$1.5 million from Expenses and -$2.3 million from NPR.

There are two components that make up the $1.5M variance as originally submitted between FY 2019 and FY 2020 budget under the accounting change. The collection expenses were previously netted against bad debt and in the NPSR for the FY 2019 budget in the amount of $822K. This amount was moved at the request of our auditors, so this amount shows up as a variance when comparing budget to budget or budget to actuals. The second component of this $1.5M is the OneCare Vermont deductions in the amount of $2.3M. It was later discovered that the $2.3M that was reported was for the calendar year, and this has subsequently been revised to be $1.8M, bringing the total value of the combined accounting change to be $985K in expense and $1.8M in NPR. The $1.8M is from the payment reform investments moved to deductions. The fees associated with these plans were budgeted as an expense on the P&L for the submission of the FY2019 budget. Upon the recommendation of a joint GMCB and hospital CFO workgroup along with guidance from external accounting firms, it was determined any fees associated to the APM payment initiatives plans should be budgeted as a deduction to patient revenue. This accounting practice was implemented for FY2019 actual and the FY2020 budget.

a. What is the total 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 FY 2018 settlements are finalized?

The FY 2018 settlements were finalized in the month of June. This settlement had no financial impact

to CVMC's FY 2019 financials, as the entry to book the settlement reserve was made during FY 2018. Currently, there is a $500K reserve for FY 2019 on CVMC's balance sheet.

Are Other Reform Payments recorded in deduction from NPR? If not, where are they recorded?

Yes, Other Reform Payments are recorded as a deduction in the FPP section of the P&L.

b. What is your basis for booking ACO-related reserves, and how do you evaluate those reserves through the year?

For FY 2018 the basis of the reserve was a settlement report provided by the ACO in September. The reserve for the entire fiscal year was booked in the month of September. The ACO is on a calendar year basis, and CVMC is on a fiscal year basis, which makes the timing of the available information difficult, as it takes time for claims to run through the adjudication process. CVMC has booked a small reserve for FY 2019 so that when information becomes available, the entire reserve does not have to be booked in one month.

c. Do you believe your ACO-related reserves affect other types of reserves (e.g., bad debt) that you carry on your balance sheet? If so, how?

CVMC has general reserves, cost report reserves, and ACO reserves. These reserves are all for different purposes and are independent of one another.

18. For FY 2019 projections, what departments are expenses exceeding revenues?

This question is difficult to answer as net revenue is not posted at a departmental level. When a claim gets paid, the payment is typically in a lump sum based upon DRG for inpatients, and for outpatients the payments for several services are often bundled together, making it challenging to allocate the reimbursement at the departmental level.

19. 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?

The occupancy rates would give the GMCB an understanding of how often the units within the hospital are full. CVMC is licensed for 122 beds, has 92 available beds, and is staffed for 60 beds in the FY 2020 budget. Patient days and/or admissions are common metrics to use when evaluating inpatient statistics, and adjusted patient days would be the best metric to use for evaluating both inpatient and outpatient statistics. These metrics are already reported to the GMCB.

20. What is the impact of the now known Medicaid reimbursement increases? Any update on inpatient Medicaid reimbursement changes?

The impact of the known Medicaid outpatient and professional rate increases is an additional $183K that was not in the submitted FY 2020 budget. Medicaid IPPS rates have not been finalized.

21. If you assumed Medicare increases, what is the value, and what would a reduction in commercial be to maintain your NPR?

The rate assumption on traditional Medicare for CVMC was 0% for the FY 2020 budget.

Health Care Advocate Questions

1. Please provide your budgeted changes in utilization by payer and service category (e.g., inpatient, outpatient, professional).

CVMC does not budget utilization changes at a payer level of detail.

2. Commercial Charge/Rate Change and Net Patient Revenue
a. Please explain in detail how you plan to implement your commercial charge or rate change, if applicable.

Changes are implemented based on contract renewal dates.

b. What is your anticipated commercial charge/rate change for each service area (e.g., inpatient, outpatient, professional)?

Please see the table on page 30 of the budget narrative.

c. What commercial utilization assumptions for each service area were used to determine how the commercial charge/rate change translates to the commercial net patient revenue change included in your budget?

Please refer to Appendix VI.

i. Do these utilization assumptions align with those in the Green Mountain Care Board's 2020 Vermont Health Connect rate filings? If no, please explain any differences.

In order to fairly respond to this question, there would need to be much better alignment between the hospitals' and Vermont Health Connect's rate setting processes to determine how CVMC's FY 2020 budget commercial rate increase of 5.9% aligns with BCBSVT's 12.4% and MVP's 10.1% approved 2020 Vermont Health Connect rate increases.

3. Pharmacy Costs
a. Please provide your budgeted medical pharmacy trend for commercial payers, separated by unit cost and utilization.

CVMC cannot provide unit cost by payer.

b. Please separate any change in unit cost by expense (cost of obtaining the drug) and profit margin.

The budget is not built by unit cost.

c. How does the hospital determine its profit margin for each drug (e.g., flat fee, percent of cost)?

There is no clear way to determine the profit margin for each drug. There is a tiered pricing algorithm for drugs, which incorporates direct and indirect pharmacy costs.

4. How would you approach splitting your expenses into medical, administrative, and other categories?

For us to approach this in a common manner, there would have to be an agreed-upon, single definition for any of these categories. Those definitions would need to be consistent across 990 reporting, Medicare cost settlement reporting, and internal hospital reporting. Once those definitions are clear and consistent, we would be in a better position to respond to this question.