VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE.
BURLINGTON, VERMONT 05401
(800) 917-7787 (TOLL FREE HOTLINE)
(802) 863-7152 (FAX)

OFFICES:
BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

August 9, 2017

John Brumsted, MD
President & Chief Executive Officer
The University of Vermont Health Network
462 Shelburne Road
Burlington, Vermont 05401

Re: HCA Pre-Hearing Questions – Fiscal Year 2018 Hospital Budget Review

Dear Dr. Brumsted:

In accordance with our role in the Green Mountain Care Board's hospital budget review process under 18 V.S.A §9456(d)(3)(A), the Office of the Health Care Advocate respectfully submits the following questions in advance of your upcoming hospital budget review hearing. Please submit all responses to the email addresses listed below by Friday, August 18, 2017.

1. Please clarify the relationships among the University of Vermont Medical Center (UVMMC), Central Vermont Medical Center (CVMC), the UVM Health Network (UVMHN), and OneCare Vermont (OneCare). In particular:
    a. Is OneCare co-owned by UVMMC or UVMHN?
    b. Does UVMHN have any employees or assets other than those of its member hospitals?
    c. Do gains or losses of one entity flow to any other entities? If so, among which entities and by what mechanisms?
    d. What are the financial implications of UVM's co-ownership of OneCare? How does this relate to the financial relationships of the member network hospitals with OneCare?

2. Please clarify the relationship between UVMMC and the UVM Medical Group (UVMMG).
    a. What proportion of UVMMC-employed physicians are in UVMMG?
    b. What proportion of UVMMC physician revenue comes from UVMMG?
    c. Are UVMMG revenues and costs fully reflected in its submitted FY18 budget documents?

3. Please separate gains/losses (or revenue/costs) by capitated business from those by fee for service business.
    a. Please share calculations that support the statement "…that 40% of our revenue in FY 2018 will be reimbursed on a per-member per-month (PMPM) basis, even without statewide participation in risk-based contracts under the [All Payer Model (APM)]." [Narrative, page 2]

   b. Will UVMMC be reimbursed fee-for-service for patients who are included in the APM but attributed to other providers?
   c. Please share the source(s) for the 2014 and 2016 PMPMs included in the narrative.
      i. To what is the much higher increase in net patient revenue (NPR) as compared to PMPM attributable?
      ii. Do the PMPMs include both capitated and fee-for-service payments?

4. Your actual operating revenue has averaged 38% higher than budgeted from 2013 to 2017 (projected). Is this historical pattern reflected in the 2018 budget?

5. How would you calculate a PMPM for non-APM business? What methodology would you use to determine attribution for a hospital-wide PMPM?

6. What are the drivers of NPR going up $41 million (UVMMC budget 2017 to budget 2018), if "actual list prices will go up an average of 0% in the aggregate"? [Narrative, page 16]
   a. Why is UVMMC offsetting hospital price increases with physician price decreases?
   b. Have there been any significant changes in the net/gross ratio for commercial payments?

7. Is adding Emergency Department capacity part of a sustainable, long-term solution to the inadequate access to mental health treatment experienced by Vermonters? What other avenues are you pursuing to address this crisis in a sustainable way?

8. Please provide a copy of the report referenced on page 8 of your narrative. ("A recently-released report… showed that the number of UVM Medical Center patients prescribed an opiate dropped 9 percent from the fourth quarter of 2015 to the fourth quarter of 2016. The total number of prescriptions dropped 7 percent, and the average strength of those prescriptions dropped 4 percent during that same period." (Narrative, page 8))

9. For the savings described on page 13 of your narrative, number 5, please provide the proportion of this income and the total dollar amount paid by patients. Please detail the ways in which you plan to increase revenue from specialty pharmacy and retail pharmacy. Will these increases be from price increases, market share increases, a combination, or something else?

10. What are the hospitals' goals for participation in payment reform initiatives in 2018 and in the next five years?
    a. What steps will the hospitals take to meet these goals?

11. As the hospitals take on financial risk, how are they planning to manage that risk while maintaining access to care, high quality care, and appropriate levels of utilization?
    a. How much money will each hospital be at risk for in FY18?
       i. What will happen if a hospital loses that money?
       ii. How will the hospital fill in this gap, if necessary, without increasing rates?

b. Beyond the Accountable Care Organization-level quality measures, how will the hospitals track access to care, utilization, and quality of care to ensure that new provider incentives do not have a negative impact on patient care?
    i. Please list the specific metrics each hospital will use.
    ii. For any metric(s) currently in use for this purpose, please provide results by year by hospital for 2014 to 2017 (to date).

12. Do the hospitals participate in any capitated payment agreements directly with insurers? If yes, please describe:
    a. Whether the capitated payments save the insurer money compared to fee for service payments;
    b. Whether each hospital and/or its providers earn more profit under capitated payments or fee for service, on average;
    c. How each hospital ensures that patients continue to receive appropriate services under capitated payments.

13. Please describe the financial incentives that each hospital currently includes in provider, coder, and other personnel salaries and/or contracts. How has the use of incentives by the hospitals changed over time?

14. Do the hospitals or any of their departments or personnel receive financial or other benefits for using specific pharmaceuticals?
    a. Please list all pharmaceuticals for which the hospitals or provider receives payment when the drug is prescribed, administered, and/or when the prescription is filled.

15. With the various payment reform initiatives underway, shared decision-making is becoming increasingly important as an antidote to the potentially perverse incentives of risk-based payment models.
    a. Do you commit to implementing shared decision-making throughout your hospital system in 2018?
    b. Please describe your plan for doing so and how you will measure the plan's implementation progress.

16. What is the extent of your Choosing Wisely initiative(s), if any? Please describe the initiative(s), how you have chosen which departments participate, and which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement.

17. Please provide copies of your financial assistance policy, application, and plain language summary as well as detailed information about the ways in which these three items can be obtained by patients.
    a. Please provide the following data by year, 2014 to 2017 (to date):
        i. Number of people who were screened for financial assistance eligibility;
        ii. Number of people who applied for financial assistance;
        iii. Number of people who were granted financial assistance by level of financial assistance received;
        iv. Number of people who were denied financial assistance by reason for denial.

18. As nonprofits with a duty to benefit the community, how do the hospitals ensure that their commercial rates are in the best interest of consumers? Please provide specific metric(s) that each hospital uses to measure this. For any metric(s) currently in use for this purpose, please provide results by year by hospital for 2014 to 2017 (to date).

19. We often hear from hospitals that they charge extra for a wide variety of services in order to fund core hospital services. In light of this business model, how do the hospitals ensure that the prices of its services are set appropriately?
    a. What factors are considered in setting prices?
    b. What financial or quantitative metrics does each hospital use to ensure that its service pricing is appropriate? For any metric(s) currently in use for this purpose, please provide results by year by hospital for 2014 to 2017 (to date).

20. For the hospitals' inpatient services, please provide your all-payer case mix index, number of discharges, and cost per discharge for 2014 (actual) through the present (2017 budget and projected) and 2018 (budget).

Thank you for taking the time to respond to our questions.

Sincerely,
\s\ Julia Shaw
Health Care Policy Analyst
jshaw@vtlegalaid.org

\s\ Kaili Kuiper
Staff Attorney
kkuiper@vtlegalaid.org

\s\Eric Schultheis
Health Care Advocate
eschultheis@vtlegalaid.org