Questions from the Green Mountain Care Board Members to the University of Vermont Health Network

1. Why were the only hospitals really affected by unexpected patient volume all within UVMMC network? These significant increases in utilization affected UVM, CVMC, and Porter but most, if not all other hospitals (except to a small degree Ascutney) seem to be insulated from this utilization effect so it can't be a state-wide health event (e.g. flu) or a demographic shift (e.g., aging). Nor is it a localized effect since three different communities were affected (Burlington, Middlebury, Berlin). So, what is driving increased utilization at only network hospitals? And what role might an increase in self-referrals within the network play in the UVMMC network - specific utilization increases?

2. How close does the excess utilization by payer track to the corresponding payer mix at each hospital (e.g., excess commercial utilization accounts for 45% of total UVM overage. Is commercial typically close to 45% of overall UVM expenditures)? In other words, which segments are seeing more than proportionate increases in utilization, at each hospital. And what can explain these deviations if they exist?

3. For Porter, is the increase in "more efficient urgent care" coming at the expense of ED visits or primary care visits and what is the overall impact on expenditures (assuming ED visits are more expensive than urgent care, but primary care visits are less expensive than urgent care). Might be one way to assess whether this is "good" utilization or "bad" utilization…

4. At both UVMMC and Porter, increased patient revenues exceeded associated expenses, leading to greater margins. At CVMC, expenses outpaced revenues. We need more context on what is driving the unsustainable expense growth at CVMC. Would be helpful to see metrics such as cost/adjusted admission, by hospital. Other expense metrics most welcome. What is CVMC doing to get a handle of costs?

5. Is the table on page3 of the narrative for the whole network or just UVMMC?

6. On that table, much of the predicted revenue reductions for FY18 are driven by estimates of Bad debt and Free care based on Q1 projections. Would be helpful to review Q1-AFY17, Q1-AFY16, Q1-AFY15 and compare estimates for each FY based on Q1 only with what they actually ended up being. This will help assess the credibility of the FY BD/FC projections that based on only Q1 data. (Maybe Q1 is a great predictor, maybe it is not).

7. The narrative describes the need to keep mentally ill patients in the hospital beyond the optimal discharge date due to lack of beds elsewhere in the system. Has this cost to the overall system ever been quantified (e.g., average inpatient expenditures/day *extra days * number of affected patients)?

8. Why should we wait until FY19 versus doing a rate cut midyear? I think this is implied by the unbudgeted FY17 changes described in the memo, but it would be helpful to know the impact of a midyear rate change would have on the budget.

9. If we applied what we did last year (1/2 of margin that was overbudget to do a rate cut), what would that be for FY18 or FY19?

10. Are the Medicaid ACO revenues/expenses on target for FY17 or are they also over?

11. Are the bonus metrics for senior executives aligned with regulatory targets for NPR?

12. Please provide bonus targets and specific calculations for executive team for the key financial, operational and quality metrics.

13. Explain how the one-time $18 million pension liability charge is flowing through financial statements and when the decision was made during the year to expense this.

14. Beyond the pension liability are there any other 1x charges impacting the financial statements?

15. Please address the accrual/reserve increases that unfavorably impacted NPR.

16. Excluding any 1x charges how much Operating Profit is attributed to the NPR over budget?

17. Why didn't the hospitals/network take/propose to GMCB corrective action during the year?

18. How do we stop this cycle – for the past three years UVM has significantly been over NPR, yet at budget the network comes in right at the regulatory targets seemingly postponing any action until actual results come in and state that any rate action at that time would not benefit policy holders?

19. You have put forward one proposal to use the excess NPR, please provide a proposal based solely on rate reduction and one on a combination of rate reduction and programs that would benefit your service areas and reduce medical costs.

20. Specify how much 1% rate reduction is in $ for your commercial payers.

21. What are the implications on your 2018 budget due to the 2017 actual performance?

22. You exceeded NPR by $28 Million in 2015, $25 in 2016 and $38 in 2017 (UVM only) – defend why we should rebase you at 28 million higher (this is carrying the 2015 forward) for 2017 basis and then recalculate 2018. (not sure we want to go here yet but if you feel it is appropriate in your meeting with them then do so)

23. What process do you propose to monitor 2018 more closely and take action if needed during the year?

24. What is your quarterly internal review process on performance to budget and forecasts for balance of the year?

25. What actions are take if performance is projected to be higher or lower than budget for NPR?

26. Please provide reconciliation for 2017 Actual to both Budget and 2016 Actual.

27. For fiscal years 2015 to 2017 respectively, net operating income for the UVM Medical Center is stated at $75.6 million, $74.0 million and $68.6 million; Non-operating revenue is stated at ($23.7 million), $11.1 million, and $21.2 million respectively and resulting in Excess Revenue over Expenses at $51.9 million, $85.1 million and $89.8 million. Comparable data from UVM Health Network audits is stated at Income from Operations at $74.8 million, $79.1 million, and $67.3 million; Non-operating Gains, net at $9.3 million, $5.7 million, and $93.6 million and resulting in Excess Revenues over Expenses at $84.1 million, $84.8 million, and $161.5 million. On an expenditure basis, the UVM Medical Center comprises about 67 percent of the UVMHN's expenditures in 2017. Please explain the wide variation in Non-Operating Gains and Excess Revenues between the two entities for fiscal 2017.

28. Similarly, the 2017 audit of the UVM Health Network shows expenses at $1.865 billion and $1.669 billion respectively for 2017 and 2016 for a year-over-year growth rate of 11.7 percent. UVM's submitted 2017 financials show expenses at $1.245 billion and $1.172 billion for 2017 and 2016 respectively for a year-over-year growth rate of 6.3 percent. For 2017, UVMMC's expenses comprised 67 percent of UVMHN's expenses. Given these parameters, the year-over-year expense growth rate of the non-UMVMC affiliates in the Network must have been extraordinarily high for the overall all growth rate to be at 11.7 percent. Please advise as to whether this comparison of UVMMC and UVMNW financials, covering the same fiscal year, has merit and if so, please explain the basis for the non-UVMMC growth in expenses.

29. Actual 2017 Total Operating Revenue is up 5.46 percent or $67.97 million over actual 2016 Total Operating Revenue and up 3.9 percent or $48.9 million over 2017 budgeted amounts. However, the path to these Totals consists of wide variations in Actual to Actual and Actual to Budget metrics. For example, on an Actual to Actual basis, while Gross Patient Care Revenue was up 4.69 percent or $118.7 million year-over-year (and relative to Budget up 5.7 percent or $142.4 million), Deductions from Revenue, Bad Debt, and Free Care were down $74.5 million, $1.9 million and $4.3 million or on a budgetary basis down 8.2 percent, 18.4 percent and 66.4 percent respectively. Please provide an accounting definition of "Deductions from Revenue" and an explanation of why the budgeted amounts for Gross Patient Care Revenue, Bad Debt, Free Care, and Deductions from Revenue were significantly at variance to actual results.

30. Other Operating Revenue was up $13.4 million or 15 percent year-over-year and 11 percent over Budget. The three significant movers were 340B Retail Pharmacy (over Budget by $3.9

million or 31 percent), Specialty Pharmacy (up $8.1 million over Budget or 36 percent) and Institutional Services Revenue (down $3.8 million or 32 percent relative to Budget). Please explain the source of Institutional Services Revenues and provide UVMMC's analysis of the basis for these three large divergences from budget.

31. Regarding non-MD salaries and Fringe Benefits, inclusive of 2017 actuals, the 2015-2017 growth trend in these two areas has been 6 percent and 6.6 percent respectively. For 2017 over 2016, the respective increases are 8.4 percent and 16.9 percent respectively and totaling $51.5 million. Utilization and Staffing data provided by UVMMC shows a 2.6 percent increase or 141 FTE's in the Non-MD category on a base of 5,389 FTE's. This compares to a 2 percent growth trend since 2015. Given this context, please explain the 2017 over 2016 increases noted above of 8.4 percent for salaries and 16.9 percent for fringe benefits. Further, the actual expenditures in 2017 for non-MD salaries and benefits total $551.3 million while a calculation of average salary by FTE's totals $501.9 million. Please explain this gap.

32. The budget category "Other Operating Expense" of $382.7 million in 2017 includes two subcategories "other non-salary expense" and "other services". The first showed expenses of $61.9 million, decreasing relative to 2016 by $9.7 million and the second showed expenses of $221.2 million, increasing by $10.5 million. What is the accounting definition of these two subcategories and what do these expenditures support?

33. The Non-Operating Revenue for 2017 shows a $21.2 million contribution to revenues comprised of a $39.6 million investment loss and a $60.8 million "All other" gain. Please describe the circumstances of the loss and what is included in the subcategory of "all other" that totals $60.8 million.

34. The Utilization and Staffing presentation provides a profile of FTE's and associated salary and fringe benefit expenditures. Please provide a similar profile for medical staff. Further, the presentation includes data that shows in 2017 there were 2,819,321 "physician office visits" and 1,320,280 "visits", totaling 4,139,601 such events. Please provide definitions for "physician office visits" and "visits" as well as data profiling the size of the population served by such events.