THE University of Vermont HEALTH NETWORK
Porter Medical Center

FY 2020 Budget Analysis Questions – GMCB Staff and GMCB Board Members
Porter Hospital

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

The original projection submitted for FY 2019 reflected a 0.8% reduction in total net patient revenue and fixed prospective payment revenue as it compares to the FY 2019 budget. That projection did not include any outstanding FY 2018 cost report settlement funds related to the exclusion of claims that occurred when Porter filed its first cost report under the All Payer Model (APM). As a result, Porter did not receive the full amount of cost-based reimbursement of which it is entitled. In consideration of recent discussions with Medicare, Porter is anticipating the ability to refile its FY 2018 cost report, which will result in an additional $1.25M in net revenue for FY 2019. In addition to the above, a revised volume projection that includes actual YTD through June, combined with the remaining projection for July through September, would yield an increase of 1.4% as it compares to the FY 2019 budget, adjusted for the accounting change.

The operating expense projection submitted for FY 2019 has not materially changed.

2. PMC'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 PMC made to facilitate this?

Porter sought to facilitate the transfer of information to the VHIE; however, due to VITL being able to only accept information related to acute patients, Porter had to delay the implementation. Porter's current electronic health record (EHR) can only facilitate the transference of information for all patients and not one particular subset of patients. Had Porter attempted to move forward under the current process, it would have resulted in significant manual intervention on the part of Porter's registration/admissions staff. Therefore, it is the hope that either the new Epic platform has the ability to isolate subsets of patients to accommodate VITL's current configuration or VITL is able to modify its current configuration to accept all types of patients.

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

The FY 2020 submitted value of one day of cash equals $237K for Porter Hospital, inclusive of factoring in the leap year and removing depreciation and amortization from the calculation.

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

The value of 1% of PMC's change aligns with GMCB's calculation, which equals $374,288.

5. Are Medicare reimbursement assumptions still valid? Are your Disproportionate Share Payments valid?

For the FY 2020 budget, Porter's Medicare assumptions are still valid. Upon receipt of Porter's recent DSH information, Porter will receive $58K less in DSH funding for FY 2020.

6. What is causing the increase in Fringe Benefits for Non-MD if your FTEs are budgeted to be even with FY 2019 budget but more than your projections?

Porter's fringe benefits are budgeted at the aggregate level; historically, in order to provide MD level fringe benefit information, Porter has allocated that expense based on a percent of MD salary calculation. Due to the recent transition of Porter's physicians to the UVM Health Network's Medical Group, MD fringe benefit expense is now able to be directly allocated. Therefore, the FY 2020 budget represents a true estimation of the fringe benefit expense for both our MD and non-MD employees.

7. Does the FY 2020 CAH Medicare Settlement Rate relate to the withholds by CMS due to the unknown factors of the APM?

The FY 2020 budgeted Medicare settlement was established based on routine historical modeling assumptions and formulated prior to the information received from CMS as it pertains to the withhold. Therefore, the FY 2020 budget did not include any withhold assumptions. Porter does presume, based on our conversations with CMMI and CMS, that this will be a one-time occurrence and is merely a product of navigating a program in its infancy being that Porter and only one other CAH hospital filed its FY 2018 cost report for the first time under an alternative payment model.

8. How would the increase reimbursements for Medicaid affect your budget as these were not known at the time of budget submission?

The information that was provided to Porter by DVHA, for OPPS, is reflective of a change in reimbursement in the amount of $122K on a calendar year basis, which would approximate to $92K on a fiscal year basis. The information for inpatient and professional revenue was not received on an individual hospital level. It is important to note the unknown impact ACO attributed Medicaid patients may have on this analysis.

9. What type of physicians does the hospital expect to hire for FY 2020? Also with reduced utilization in FY 2019 what are the assumptions for hiring the additional FTEs for the FY 2020 budget?

The budgeted FY 2020 MD positions have already been filled as of the latter part of FY 2019. We do not anticipate adding additional MD FTEs from the originally submitted FY 2020 budget; however, Porter would refill any vacated positions over the course of the fiscal year, should MD turnover occur.

The additional MD FTEs that have been incorporated into the FY 2020 budget were intended to maintain core services within our community as opposed to an increase in utilization. Notably, radiology and general surgery have previously existed as hospital-based services within our community; as a result of these transitions, Porter Hospital will now integrate the professional component of these services.

Specifically, in the area of General Surgery, due to the forthcoming retirement of our community's sole remaining independent General Surgeon, Porter made the decision to employ him in the interim. This will ensure continuity of care during this significant transition and therefore facilitate seamless access for our patients while his replacement becomes established in our community.

As it pertains to radiology, Porter was faced with either substantially restructuring this service line or making the decision to employ the two existing independent radiologists in our community. Recognizing the need to maintain this invaluable service, Porter worked with the UVM Health Network to establish the necessary staffing model to support and preserve this indispensable service for the patients Porter serves.

Anesthesia salaries were budgeted as contracted physician services in FY 2019; however, FTEs were historically never quantified for those contracted physician services. During the FY 2020 budget and for FY 2019 actual reporting, Porter began quantifying and recognizing the full-time equivalent of those positions.

As for cardiology, this service line has been experiencing steady increases in volume, but is being offset by declines in other service lines.

MD FTE Changes

	FY 2019 Budget	FY 2020 Budget	Δ
General Surgery	1.0	2.8	1.8
Radiology	-	2.7	2.7
Anesthesia	-	1.5	1.5
Cardiology	1.5	2.1	0.6
Total	**2.5**	**9.1**	**6.6**

10. Please further explain the $1 million accounting adjustment.

In the FY 2019 budget there were $1,067,391 of associate fees from OneCare Vermont related to payment initiatives within the APM. The fees associated with these plans were budgeted as an expense on the P&L for the submission of the FY 2019 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 FY 2019 actual and the FY 2020 budget. To allow apples to apples comparisons of the FY 2019 budget to the FY 2020 budget, the FY 2019 budget NPR should be reduced by $1,067,391. Porter reconciled the FY 2019 budget to arrive at the 3.5% FY 2020 budget guidelines after adjusting for physician transfers.

11. What is the full-year impact on NPR/FPP and Operating Expenses for the acquired Radiology and General Surgery practices? Please provide a copy of the letter sent to patients pursuant to Act 143 of 2016 requiring notice of the transfer.

Please reference the chart below for the full year impact of the net revenue and expenses related to the provider transfers.

FY 2020 Budget		
	General Surgery	Radiology
Gross Revenue	648,897	1,452,325
Net Revenue	361,239	749,719
Operating Expenses	413,730	1,856,229
Margin	**(52,491)**	**(1,106,510)**

Additionally, pursuant to Act 143 regarding notification to patients, patients have customarily interacted exclusively with the hospital for their radiological services. Therefore, in consideration of the episodic nature of these services and subsequently this transition not imposing a change to the current process from the patient's perspective, Porter did not believe a notification letter was necessary for the radiology transfer.

As it pertains to General Surgery, the attached letter (included as the last page of this document) was provided to those patients of Dr. Petri to notify them of the transition.

12. In Appendix VI-Bridges, Table 2, Porter listed funds under "Other (please label)." Please describe what these funds are.

The reduction of $50K, reported as "Other (please label)" in the bridges table, is comprised of budget-to-budget savings associated with Epic related consulting expenses.

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

Net patient revenue is not allocated at the department level as payments for services are not received at this level. Additionally, some expenses and some revenues are recognized at the aggregate and not department specific level due to a variety of factors. For the aforementioned reasons, determining which expenses are exceeding revenues at the departmental level is challenging to present in a fair and accurate manner.

14. 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?

A suggested statistic would be a combination of assessing a hospital's average daily census in conjunction with staffed beds. These metrics could be evaluated mutually or could be calculated as a percentage to represent capacity on a daily, monthly, or annual basis.

Average daily census is calculated by adding the midnight daily census for each day of the given period and thus dividing the total number by the days of the same period.

Staffed beds:
Cost report instructions define staffed beds as "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."

For example, Porter Hospital has 25 staffed beds; for the month of June, our average daily census was 15.1. Reflecting these two metrics as a capacity percentage would equate to a 60.5% occupancy. Please note this calculation is only indicative of capacity and not acuity.

One complexity with this metric that is worth notating is the fact it may not capture admissions and discharges that occur from 12:01 am to 11:59 pm on same date.

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

Please reference question 8.

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

Porter did not assume any increases to Medicare reimbursement for the FY 2020 budget. Porter Hospital's budget relies on a commercial rate increase of 2.6%, which is lower than medical expense inflation.

17. What is the total ACO reserve on the balance sheet for Projected FY19 and Budget FY2020? Do you anticipate realizing savings or owing OneCare money when the FY18 settlements are finalized? Are Other Reform Payments recorded in deduction from NPR, if not, where are they recorded?

Porter will conclude FY 2019 with $2.3M of risk reserves on the balance sheet; of that amount, $1.8M is specific to FY 2019 risk. Porter has budgeted $1.0M in risk reserves for FY 2020, and anticipates fluctuating reserve amounts between fiscal years based on ACO settlement activity. The CY 2018 OneCare settlement is reflecting upside shared savings for Medicare, and downside risk for Medicaid. The population health management and care coordination payments received are recognized as "Other Reform Payments" in adaptive planning. The OneCare population health management deductions are netted against the FPP in adaptive.

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

Porter's basis for booking ACO-related reserves is to account for upside and downside risk as we strive to recognize settlement impacts within the fiscal year that it is attributed to; thus, minimizing the effect on future years. This falls within customary accounting guidelines that also govern other general, IBNR (incurred but not reported), and third party reserves.

Currently, Porter is utilizing OneCare reporting data to estimate risk reserves. Porter is developing an internal model to estimate the risk reserve in real time, similar to our third party modeling.

b. 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?

Porter reflects its risk reserve separately from other general, IBNR, and third party reserves. Therefore, our ACO-related reserves would not have an impact on other reserve types.

Health Care Advocate Questions

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

Porter Hospital does not budget these volume changes at a payer level.

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. For the third consecutive year, Porter Hospital has chosen not to implement a charge/price increase.

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 Porter's FY 2020 budget commercial rate increase of 2.6% 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.

Porter does not report pharmaceutical unit cost or utilization by payer.

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

Porter is unable to provide profit margin by unit cost at this time.

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.

THE University of Vermont HEALTH NETWORK

Porter Medical Center

June 13, 2019

Dear Patient of Dr. Petri,

We are pleased to announce that Dr. Carl Petri has joined our UVM Health Network Porter Medical Group as an employed provider with our *Porter General Surgery* practice as of June 3.

Patients who are scheduled with Dr. Petri for procedures in the upcoming months will be contacted by the Porter General Surgery staff if there are any changes to your appointment.

In addition to Dr. Petri, Porter General Surgery also has two additional full time general surgeons: Dr. Ellen Davis and Dr. Elya Vasiliou. Dr. Ken Harris, an internal medicine provider, also does colonoscopies one day a week at Porter Hospital.

We are excited about all of these positive changes. If you have questions, feel free to call our practice at 802.388.9708. Thank you.

Danielle Bryant, MSM, MSN, RN, CMPE
Clinical Operations Director
Porter Medical Group