GMCB questions ahead of UVMHN FY24 budget hearing
August 22, 2023

LABOR

1. *What benchmarking do you use for salaries? Productivity? Other performance-based benchmarks?*

   The UVM Health Network uses a variety of surveys to determine base salary benchmarks for roles across the Network. Depending on the level of the positions, we look at market data based on the size of the organization (revenues) or on regional data (generally Northeast or New England).

   There are four main third-party market survey providers, and each provider has multiple surveys that the Network participates in and receives results from:

   - Gallagher/Integrated Healthcare Strategies
     - National Healthcare Staff Compensation Survey
     - National Healthcare Leadership Compensation Survey
     - National Nursing Compensation Survey
     - National Advanced Practice Provider Compensation Survey
     - New England and Boston Teaching Hospitals
     - Northern New England Healthcare Organization Survey
     - UNC Academic Medical Center Survey
   - Mercer
     - US IHN Healthcare System and Hospital Compensation Suite (includes around 10 surveys)
   - Sullivan Cotter
     - Healthcare Workforce Survey Suite Bundle (includes four surveys)
   - Willis Towers Watson
     - Healthcare Executive Compensation Survey
   - Healthcare Middle Management, Professional and Support Compensation Survey

   In addition to the above, the UVM Health Network participates in numerous salary planning surveys and "instant surveys" for particular positions.

   To the extent the GMCB needs to explore particular salary benchmarking, we will seek to address it in executive session, given the competitively sensitive nature of the information.

   UVMMC uses external benchmarking for physicians and APPs (Sullivan Cotter) and National Database for Nursing Quality Indicators (NDNQI) and Labor Management Institute (LMI) for inpatient nursing clinical areas. Other clinical and non-clinical areas benchmark internally using worked hours per unit of service.

   Productivity benchmarking for CVMC and Porter services is similar to other Network health care partners. Ancillary and clinical support staff levels are benchmarked based on volume and population health initiatives. Physician and APP productivity are based on Sullivan Cotter benchmark data, which is consistent with other Network partners. Benchmarks are reviewed and updated annually.

   As we shared with you in our follow-up question responses that we submitted on August 1, our Network has started to use Syntellis to evaluate how we compare on shared service total costs. Below is a chart from our Syntellis system showing the median expense per total organizational expense for select shared service areas. While we are still working on creating a more accurate apples to apples comparison, the areas listed below align closely with what we include as a shared service at the UVM Health Network. The total of the medians for these areas is 12.7%, which is approximately the same percentage as our FY24 shared service budgeted costs ($416M figure in chart on page 45 of the budget narrative).

Syntellis Functional Area Metric Comparisons

Description	Standard Classification	Measure	50th Percentile
Health System - CompAn Only	ADMIT AND SCHED	Admit and Centralized Sched Expense as % of Total Expense	0.46%
Health System - CompAn Only	CARE COORDINATION	Care Coordination Expense as % of Total Expense	0.72%
Health System - CompAn Only	EDUCATION	Education Expense as % of Total Expense	0.30%
Health System - CompAn Only	FISCAL SERVICES	Fiscal Services Expense as % of Total Expense	0.68%
Health System - CompAn Only	GENERAL ADMIN	General Admin Expense as % of Total Expense	4.38%
Health System - CompAn Only	HIM	HIM Expense as % of Total Expense	0.32%
Health System - CompAn Only	HUMAN RESOURCES	HR Expense as % of Total Expense	0.47%
Health System - CompAn Only	INFORMATION TECH	Information Technology Expense as % of Total Expense	2.77%
Health System - CompAn Only	LEGAL	Legal Expense as % of Total Expense	0.22%
Health System - CompAn Only	MARKETING	Marketing Expense as % of Total Expense	0.46%
Health System - CompAn Only	QUALITY	Quality Expense as % of Total Expense	0.49%
Health System - CompAn Only	REVENUE CYCLE	Revenue Cycle Expense as % of Total Expense	0.63%
Health System - CompAn Only	STRATEGY	Strategy Expense as % of Total Expense	0.17%
Health System - CompAn Only	SUPPLY CHAIN	Supply Chain Expense as % of Total Expense	0.59%
Health System - CompAn Only	VIRTUAL CARE	Virtual Care Expense as % of Total Expense	0.03%
		Total	**12.7%**

2. *Is the PHSO Care Management structure funded with resources for the Blueprint CHTs in Chittenden, Washington **and** Addison Health Service Areas? If yes, how many of the positions included on page 14 of the response to staff questions are located in each county/health service areas?*

   Yes – to ensure a consistent, equitable, payer agnostic population health and care management approach for all patients, UVM Health Network (Porter, CVMC, and UVMMC) CHT payments are used to help fund the PHSO Care Management teams. The CHT funds help offset the expense of Care Managers, Health Coaches, and Dietitians assigned to UVMHN practices in the respective HSAs. As the Blueprint's administrative entities, Porter, CVMC, and UVMMC report the names, positions, and FTE percentages of all staff that are supported by Blueprint CHT funds, including the PHSO Care Management resources.

   While PHSO Care Management resources are administered centrally to ensure a consistent care model, individual Care Management FTEs are assigned to each UVMHN primary care practice to ensure streamlined points of contact and communication for clinic teams.

   From the grid referenced on page 14 in the question responses UVMHN sent back to GMCB on 8/1/23, Table 1 below highlights the FTEs from the PHSO FY24 budget who are supported by Blueprint CHT funding.

Table 1: Positions from Page 14 funded by Blueprint CHT

		CHT Funded FTEs			
PHSO Job Title/Category	**FY24 FTEs**	**Barre**	**Burlington**	**Middlebury**	**CHT Total**
Director, PHSO Care Management					
PHSO Manager, Care Management					
PHSO Care Manager	47.8	4.49	11.00	1.80	**17.29**
PHSO CM Implementation Specialist					
PHSO, Resource Coordinator					
PHSO, Clinical Diabetes Educator					
PHSO, Community Health Worker					
PHSO Health & Wellness Coach	6.9	0.00	0.24	0.00	**0.24**
Community Health Improvement Assistant					
Community Health Improvement Administrator					
Care Management Department Assistant					
PHSO Care Management Quality RN					
Blueprint Program Manager					
Self-Management Program Coordinator					
Community Health Improvement Supervisor					
Total		**4.49**	**11.24**	**1.80**	**17.53**

For additional clarity, Table 2 references CHT funded FTEs supporting Porter and CVMC practices that are not part of the PHSO.

Table 2: CHT resources supporting CVMC and Porter Practices not in PHSO

	Barre	**Burlington**	**Middlebury**	**Total**
Blueprint-funded CHT staff (not in PHSO) supporting UVMHN practices	4.30	0.00	1.05	**5.35**

3. *What type of staff positions are included in "staff other" in Exhibit 11 - Staffing Summary? If that varies by hospital, please provide answers specific to each hospital.*

   Categories are fairly similar across hospitals, but are not exact. This should provide a fair understanding for the general job type for each category. If more detail is necessary, we can work with the GMCB staff to provide.

	FY2024 Budget			
	UVMMC	CVMC	Porter	Examples of Some of the Major Employee Classes in Category
Staff Other Category				
Professionals	1,593	161	89	Patient Access/Service Specialists, Physical Therapists, Pharmacists, Lab Scientists, Lab Specialists, Epic Analysts, Case Workers, Speech Pathologists
Service Workers	1,215	236	61	LNAs, MAs, Environmental Service workers, LNA/Unit Secretaries, Food Service workers, Clinical Care Associates, Material Handlers, Line Chefs, Orderlies, Security Officers
Office and Clerical	777	104	n/a	Surgical COA, Op Support Specialist, Unit Secretary, Precertification Assoc, Program Administrator, Patient Benefit Assoc, Executive/Admin/Staff Assistant, Patient Acct Reps, Therapy Support Specialist, Inventory control, Patient/Customer Service Rep
Other Staff	268	218	108	Medical Lab Scientist, Pharmacy Patient Care Coordinator, Pharmacy Tech, Radiation Therapist, Phlebotomist, Surgical Room Specialist, Other/Educators RN , MA Clerical Assistant, Maintenance Techs, Vacancy Savings FTEs
Total	**3,854**	**718**	**258**	

UTILIZATION

4. *On page 20-21 of the narrative, you discuss the use of actual volumes from Oct to Jan for utilization efforts and discuss information from the Dartmouth Atlas data (2019). It's unclear from the narrative if you used the Atlas in refining your budgeted utilization or if you are simply providing observations from the Atlas, unrelated to your assumptions. Please explain.*

   We are simply providing observations from the Dartmouth Atlas unrelated to our assumptions.

5. *What are the clinical FTEs visit counts by month for UVMMC, CVMC and PMC by specialty for 2021, 2022, and 2023 YTD? What are the corresponding annual benchmarks (the 25th, 50th and 75th percentile and what is the benchmarking source)?*

   Please see attached files. Benchmarks: Historically we utilized MGMA and no longer subscribe to that database. We do utilize both Sullivan Cotter and Vizient for benchmarking data, and neither have this benchmark.

6. *Provide data from the clinical access dashboard "% patients seen within 2 weeks" for UVMMC, CVMC and PMC from March 2021, July 2021, Dec 2021, March 2022, July 2022, Dec 2022, March 2023, July 2023. Along with annual benchmarks and the source of the benchmarks.*

   Please see attached file. Benchmarks: We will pursue an NDA with Vizient to be able to provide the benchmark data.

7. *Define what the Vizient expected ALOS represents. Is this compared to other similar hospitals?*

   The arithmetic and geometric mean length of stay by hospital diagnosis is provided each year by the Centers for Medicare and Medicaid Services (CMS) to allow for benchmarking and calculating certain Medicare payments. Vizient

uses this information and several other data elements to calculate an expected length of stay for each DRG. Those elements include diagnoses, procedures, demographic information, complications, comorbidities admit/discharge source, and primary payer/socioeconomic status. For UVMMC, the Vizient comparison group we use is Academic Medical Eenters, and for CVMC it is similarly sized community hospitals.

PHARMACEUTICAL EXPENSES

8. *You highlight the distinction between retail pharmacy and other pharmaceutical expenses. What are the corresponding revenues associated with these expenses? How do these expenses relate to the requested rates?*

   Retail pharmacy expense relates to our mail order, retail and specialty pharmacy business that is provided through our retail pharmacy operation. Any expense inflation associated with retail pharmacy is excluded from the rate request calculation. There is approximately $240M in retail pharmacy revenue budgeted in FY24.

   Other pharmaceutical expense relates to any pharmaceuticals provided as part of a patient care encounter through inpatient, outpatient, or physician office site of service. Expense inflation on these pharmaceuticals is included in our rate request. We are not able to provide an exact estimate of the patient encounter related pharmaceutical revenue, as payment for most of these pharmaceuticals is through DRG or episode of care reimbursement, but using our aggregate inpatient, outpatient and professional collection rates, the estimated revenue in our FY24 budget is $284M.

9. *May be questions related to change in 340B rebates over time.*

COMMERCIAL PRICE CHANGES

10. *You note challenges with commercial reimbursement (page 29 of the narrative) and provide an example related to BCBSVT (answers to questions). Are these challenges more widespread and which payers are the most challenging? Is it possible to estimate the financial impacts?*

    All payers implement payment policy changes and changes to prior approval programs throughout the year. The payer creating the administrative challenge at any moment can vary based on the nature of policies and whether a rollout was thoughtfully executed. Currently the largest burden is BCBSVT recently implemented Cotiviti edits. The policy implementing these edits includes numerous changes, hence making the impact difficult to assess. One example is an edit for modifier 59. BCBSVT is now editing/denying these claims, requiring medical records to be provided for every claim denied. BCBSVT then has 30-60 days to respond, and thus we do not know if they will get paid. As of this week at UVMMC we have had 935 hospital claims denied with a modifier 59. We have provided medical records, with one record per each claim, for 281 claims. Of those claims 44 were paid, 46 denials upheld and pending decision on 191. We are working the reimaging denial on a claim by claim basis. The impact at only UVMMC on the hospital side of this one code is estimated to be $1.29M, and that does not count for the administrative burden. Over five FTEs are involved, and that is only at UVMMC. We are working with our entire Network to flesh out this problem.

    Prior to this policy change by BCBSVT, we would categorically say the policy changes in Medicare Advantage were the more prevalent payer issues. However, the reality is there is an across the board policy burden by all payers that results in patient barriers to care, provider burnout and frustration and financial performance below contracted expectations.

11. *In your discussion of the impacts of Medicaid redeterminations, you mention modifying the case mix. Please explain in more detail how you did that or explain your assumptions. Were the assumptions the same for each hospital? Why or why not?*

Medicaid redetermination assumptions in the FY24 budget:

- University of Chicago Analysis of Urban Institute Estimates: VT approximately 33,000 of 192,319 losing Medicaid coverage, or 17%
- Estimate 20% move to CHIP or other plan with similar payment assumptions as Medicaid, so no assumed impact from current payment levels
- Of the remaining 13.6% (17%*80%), it assumes the following percentages to the following payer categories:
    - 75% to commercial
    - 25% to self-pay
    - Used blended average based current payment levels for each payer category
    - Movement to commercial based on prior Affordable Care Act implementation
- Then applied a reduction factor to account for:
    - Not knowing when the migration would be fully complete
    - Not having firm migration numbers
    - Not having exact payer splits and payment levels
    - Adjustments for coverage gaps, change in utilization rates, and the reality that there would be free care and bad debt on this population, which previously had none
- Net impact on FY24 budgets:
    - UVMMC - increased patient revenue by $12.9M
    - CVMC - increased patient revenue by $1.6M
    - Porter - increased patient revenue by $0.4M

12. *What business is included in the "All other" bucket in exhibits 9 and 10?*

Please see below.

FY2024 Budget			
Net Patient Service Revenue and Fixed Prospective Payments			
All Other Payer Category	**UVMMC**	**CVMC**	**Porter**
Employee Self-Insurance Plan	61,750,500	8,232,738	2,953,791
Small & Non-Contracted Commercial	109,904,607	9,729,382	5,286,890
Public Agency	24,074,428	5,835,382	1,644,300
Workers-Comp	12,120,691	4,688,795	1,614,156
Self-Pay	20,355,349	5,447,114	5,556,237
Other	12,933,812	1,119,370	1,307,613
Payer Denials (prior auth, timely filing, medical necessity, etc.)	(44,466,047)	(3,282,169)	(4,779,309)
Total All Other Payer Category	**196,673,341**	**31,770,611**	**13,583,678**

OTHER

13. *Are you participating in an ACO next year? Do the Blueprint for Health PMPM payments and the OCV PMPMs for primary care support the PHSO or another part of the network?*

Yes – it is UVMHN's intention to participate in both OneCare Vermont ACO and Adirondacks ACO next year.

14. *Do the Blueprint for Health PMPM payments and the OCV PMPMs for primary care support the PHSO or another part of the network?*

    The Blueprint and OCV PMPM payments for primary care flow directly to primary care.

    The PHSO supports work to ensure practices meet the requirements for Blueprint for Health PMPM and OCV PMPMs (i.e., NCQA PCMH re-certification, Quality Reporting, Quality Improvement, and OCV PHM Quality Performance), however, these revenues do not flow to the PHSO to support PHSO expenses. Those payments continue to flow to Network health care partners and support primary care.

15. *How do you ensure that the Blueprint CHT is available to all primary care offices, including those who are not part of the UVMHN?*

    The Blueprint's Community Health Team (CHT) funds are administered by the local administrative entity to be re-distributed among all participating Patient Centered Medical Homes (PCMH) in the HSA. The PHSO within the UVM Health Network is the acting administrative entity in the Barre, Burlington, and Middlebury HSAs. This alignment creates consistent practices, documentation, tracking and reporting across the HSAs.

    Each year the same methodology is used to predict the amount of CHT funding that will be available for participating practices in the HSA. The average of the last four payments received is used to project next year's total CHT funding for the HSA.

    PCMHs are required to submit quarterly Total Unique Patient counts, using an algorithm provided by the Blueprint. Then, each practice receives a portion of the CHT funding based on their percent attribution of the total HSA. For example, in the Burlington HSA, UVMMC's 10 primary care practices account for 37.6% of attributed lives (per TUP calculations) and so receive 37.6% of annual CHT funding. This leaves 62.4% of the Burlington HSA's funding for the 25 community practices.

    Practices can elect to access centralized staffing hired by the administrative entity or to receive pass-through funds to recruit, hire, and supervise their own staff person with their allocated portion of the funding. The funding and staffing options are reviewed at minimum annually with each practice, or more frequently if there are significant changes to their practice, such as a change in the number of providers or patients.

    Annually, the administrative entity's Blueprint Program Manager reaches out to primary care practices that are not yet participating in the Blueprint to inform them about the opportunity. Primary care practices must be recognized by NCQA as a PCMH to participate in the Blueprint.

16. *How do you ensure that the Blueprint QI facilitation resources are available to practices outside of the network?*

    To ensure all practices are engaged in performance and quality improvement and initiatives are aligned and coordinated, Blueprint QI facilitation moved into the PHSO as of June 2023. To avoid a separate and duplicative QI structure, Blueprint QI two facilitators were integrated into the PHSO.

    The two QI facilitators, now part of the PHSO, meet all Blueprint QI requirements and will participate in the statewide QI network and all associated meetings, community collaborative, etc.

    The Barre HSA is the only HSA for which UVMHN QI facilitators have an external responsibility. The QI facilitator assigned to Barre has responsibility for supporting two non-UVMHN practices and their QI facilitation needs. This resource was hired in July, and meetings between the QI facilitator and these practices have already begun. It is our expectation and requirement that the PHSO meet the QI facilitation needs of these two practices, and we will work in coordination with the practices themselves and the Blueprint for Health to ensure this occurs.

QI facilitation for non-UVMHN practices in Burlington and Middlebury HSAs is provided by contracted QI facilitators that do not have a direct affiliation with UVMHN.

17. *On page 10 of the answers to staff questions you indicate "the PHSO has worked collaboratively with the Blueprint for Health, OneCare Vermont, the UVMNH Medical Group and our UVMHN health care partner organizations to ensure that there is not duplication, but rather alignment and efficiency…" Please elaborate on how this works in practice.*

    The PHSO has meetings with each stakeholder listed to ensure organization, coordination, and strategic alignment. Examples of discussion topics include:

    - PHSO and Medical Group:
        - Leaders meet weekly to:
            - Align implementation of Primary Care Redesign and PHSO services
            - Ensure PHSO services are effectively embedded into UVMHN practices
            - Develop training and communication materials
            - Implement Performance Reporting and Performance Improvement approach
            - Review IT and data request to ensure alignment and prioritization
            - Budget development to ensure consistent approach and avoid duplication
            - Co-develop strategies to operationalize HVC initiatives in UVMHN practices
            - Clarify roles and responsibilities
    - PHSO and OneCare Vermont:
        - Monthly alignment meetings to discuss:
            - Opportunities or potential conflicts
            - Program design
            - Key priorities
            - Examples:
                - SDOH screening alignment between UVMHN, OneCare Vermont, Blueprint
                - UVMHN HVC Primary Care Redesign and PHSO implementation updates
                - Performance monitoring and reporting alignment (when appropriate)
                - New program opportunities (i.e., mental health screenings)
    - PHSO and Blueprint:
        - Ad-hoc, but recurring meetings and communication
        - Examples of discussions include:
            - PHSO education and updates
            - UVMHN HVC approach and Primary Care redesign efforts
            - Implementation of CHT, QI facilitation, Blueprint program management across UVMHN via PHSO
            - Opportunities and challenges (i.e., recruitment for Blueprint funded roles)
            - Community practice support and community collaboration
            - CHT expansion funding strategy and approach

18. *Has UVMMC Executive Services, LLC been active since 2014?*

    While UVMMC Executive Services, LLC remains registered with the Vermont Secretary of State, it has not done business, held assets, generated revenue, or incurred expenses since 2011.

19. *How do the FY24 budgets support UVMHN's master facilities plan? Provide a copy of the current plan.*

    The FY24 budget supports the UVMHN's long term facility plan (LTFP) in that it would start to rebuild our finances, giving us the resources needed to reinvest. The FY24 budgets, if approved, would allow us to generate a margin that would bring us only to the bottom of the benchmark target range. Our cash reserves, even with this improved operating margin, would increase only slightly, as we need to start addressing in FY24 the backlog of capital projects that have built up the last few years from our need to conserve cash. The FY24 budgets would also give us the ability to borrow

$150M, which would be used to invest in our LTFP.

At the present time, the UVM Health Network does not have one Network-wide LTFP; we have individual LTFPs for each partner hospital, but these plans were completed in 2014 (UVMMC) and 2017 (PMC and CVMC), so are quite dated, given all that has transpired in our health care facilities during the intervening years. We can follow-up and provide the 2014 UVMMC plan if the GMCB truly wants to see it, but it will need to be marked as confidential and not included in the publically available documents on the GMCB website.

In 2018, we held our first Network-wide LTFP retreat, where Network partner organizations shared their highest priority projects. Many of priorities remain today, with common themes including ED expansions, renovating/expanding/adding primary care sites, and inpatient bed unit renovations.

Our three Vermont partner hospitals are in various stages of refreshing their LTFPs, with UVMMC the farthest along at the present time. UVMMC will wrap up its Phase 1 of the process this fall. Important phases of the process remain before the new version of the LTFP is considered complete.

Recognizing the need to bring a Network perspective to the LTFP process, the UVM Health Network has recently created a Network Facility and Real Estate Planning Team to bring together the individual partner plans into one Network plan to ensure efficient utilization of resources, to avoid duplication, to match facilities to current and future community needs, and to ensure alignment with Network clinical service delivery plans.

Our current capital plan reflects the highest priority needs from a Network perspective for the five year planning period stemming from these individual LTFPs; detailed facility programming and planning begins once a project receives Network prioritization approval. Our capital budget submission reflects many of these priorities.