Porter Hospital – responses to follow-up questions from budget hearing
Submitted to GMCB on September 6, 2024

1. **In response to your answer to question #7 in GMCB's initial set of follow up questions, can you please estimate the NPR impact of your new clinical hires?**

   The estimated FY25 NPR impact of the new clinical hires is $2.9 million.

2. **Original Queston #2: There was a line item on the medical payment health network about a settlement payment from MVP to the health center. What was the subject and purpose of that line item?**

   Amended Question #2 per Chair Foster via N. Montemarano email dated 9/3/2024 at 1:08pm: Can you please describe direct and indirect renumeration the health network and its hospitals have received from MVP Healthcare? Renumeration is not inclusive of reimbursements for care.

   UVMHN providers contract with MVP for Medicare Advantage on a Fee for Service (FFS) basis. The FFS rates are not more favorable to MVP and are consistent with our FFS rates with the other contracted Medicare Advantage payers. UVMHN providers are subject to the same payment policies, and clinical and medical prior authorization policies as other providers in the MVP network.

   Since 2022, UVMHN has received $3.2M from MVP for purposes of accelerating certain capabilities to be successful in value-based care and population health delivery. This funding is not restricted for use with UVM Health Advantage members or enrollees because MVP recognized that its investment should drive broad-based improvements. Instead, the use of these funds are payer agnostic and support patients in both New York and Vermont. To date, these funds have been used for expanding the UVMHN Population Health Service Organization (PHSO) Care Management programs, with particular emphasis on addressing high utilizers of inpatient or Emergency Departments through our Working to Reduce Admissions program and our Post-Discharge Follow-Up program. In addition, through these investments, UVMHN has funded a network-wide “Patient Fund” to provide support to patients who screen positive for Social Determinants of Health (SDoH) and have a finite need. Consistent with all other uses of these funds, SDoH funds are distributed to patients regardless of payer status.

   Payer funding of this nature allows a provider to invest and build in capabilities to serve not only our UVMHN patients, but also our broader patient population in ways that are not otherwise supported by fluctuating FFS reimbursements.

3. **Does the network or any of its hospitals receive remuneration from MVP in connection to its Medicare Advantage plan? If so, can you please detail the renumeration amount?**

   Please see the response to question #2 above.

4. **How much of the pharmacy overage ($1.8M) is due to markup from the cost of the drugs?**

   As previously communicated, we cannot provide the exact breakdown, but the mark-ups have not changed in 10+ years. The variance is driven by utilization of more expensive medications in the outpatient setting. In addition, the pay terms are negotiated for commercial payers as part of the overall GMCB guidance/approval, and they are dictated by government payers.

5. **In your revenue variance figures, why is the category "facility providers" under budget by $1.7M?**

   The below budget NPR for facility providers is primarily due to below budget Anesthesia and Emergency Room Professional revenue. These areas were below budget due to limited visibility to volume data as Porter had only 3.5 months of historical data to base the FY23 budget on because Porter went live on Epic in November 2021. Note that the legacy system did not provide standalone Emergency Room Professional revenue; rather, Porter ExpressCare stat data was commingled, resulting in FY23 stats being best estimates for the FY23 budget.

   Further complicating the data was the delay in the Epic system to track the ASA units for Anesthesia, as Epic was unable to capture the stat data until early 2023.

6. **Related to your revenue variance figures, please provide month-by-month data on your overage in the "practices" category and the "professional revenue" category.**

   For mid-year actual to budget reporting, we provide monthly actual and remaining months projection based on the GMCB required reporting and due dates by hospital. In the monthly information provided, there are actuals and projections for high level P&L categories, high level payer information, and key volume stats.

7. **You posted a revenue overage in outpatient care of $10.3 million. Can you please provide a breakdown of that overage by insurance type (commercial, Medicaid, and Medicare)?**

   We do not have that information available just for outpatient by payer. We do have the FY23 bridges by payer which has utilization as a separate row for total NPR changes.

NPR	Total	% over/under	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY 2023 Approved Budget	$ 104,464,068						
Utilization	$ 9,724,820	9.3%	$ 3,776,481	$ 1,003,321	$ 3,715,018	$ 1,230,000	
Rate	$ (1,118,443)	-1.1%	$ 3,693,476	$ (2,766,058)	$ (2,969,542)	$ 923,681	
Payer Mix	$ 1,169,982	1.1%	$ 295,339	$ 561,043	$ 3,635,571	$ (3,321,970)	
Bad Debt	$ 2,828,280	2.7%	$ (115,702)	$ (4,324)	$ (318,369)	$ 3,266,675	
Free Care	$ (189,147)	-0.2%	$ (412,340)	$ (2,007)	$ (167,076)	$ 392,275	
Changes in DSH	$ (3,712)	0.0%					$ (3,712)
Administrative Write-Offs	$ (1,411,473)	-1.4%				$ (1,411,473)	
	$ -	0.0%					
FY 2023 Actual Results	$ 115,464,374	10.5%	$ 7,237,255	$ (1,208,026)	$ 3,895,603	$ 1,079,188	$ (3,712)

8. **In your expense variance data, you've stated that Porter Medical Center's bad debt and free care were $2.3 million favorable to budget. Can you please specify how you budgeted for each expense (bad debt and free care)?**

   Bad debt and free care are based on prior year's actual experience adjusted for factors known at the time of budget preparation, as well as consideration of the relationship between prior year actual to the following year's budget as a % of total GPSR.

   While FY23 actual to budget experience for bad debt and free care was favorable to budget, FY24 actual to budget is trending unfavorable. The FY24 actual experience was used for the FY25 budget, which is why in the rate decomposition file for the crosswalk of FY24 budget NPR to FY25 budget NPR reflects an increase in bad debt and free care as a combined total.

9. **You've stated that your contract staffing expenses were $8.3 million over budget. Can you please provide a month-by-month breakdown of these overages?**

The University of Vermont Health Network

Traveler/Agency Fees

Acct.Acct = 6640855 and (Dept.Entity in (1200, 2200) or Dept.ORG I

Entity	GMCB	Variance Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	TOTAL
Expenses - 6640855 Traveler/Agency Fees														
Porter Hospital	Anesthesiology	21,600	30,200	27,400	(14,400)	-	-	-	-	-	-	-	-	64,800
Porter Hospital	Clinics	(24)	-	-	-	-	-	-	-	-	-	-	-	(24)
Porter Hospital	Dietary	-	-	-	-	-	4,200	24,265	34,863	18,948	48,853	16,911	20,326	168,365
Porter Hospital	EKG	19,773	19,309	17,734	30,537	10,596	24,131	17,903	(1,588)	(1,597)	(1,650)	(1,650)	(1,597)	131,901
Porter Hospital	Emergency Room	143,854	119,875	231,813	218,877	183,786	147,863	132,360	97,286	103,918	163,150	149,320	121,165	1,813,268
Porter Hospital	Inhalation Therapy	19,353	25,450	60,007	94,383	43,304	70,981	62,211	72,833	61,813	57,217	52,675	76,124	696,349
Porter Hospital	Laboratory	(19,382)	(9,396)	(9,372)	(14,898)	(9,096)	13,357	21,843	28,224	23,130	19,407	30,895	26,074	100,785
Porter Hospital	Medical/Surgical	205,450	378,413	244,612	272,707	206,082	250,914	243,145	285,028	250,060	136,224	288,690	198,500	2,959,826
Porter Hospital	OB/GYN	90,340	128,470	159,977	95,128	95,552	22	(4,124)	58,299	173,867	51,417	59,806	69,559	978,312
Porter Hospital	Operating Room	28,408	30,433	70,632	37,975	53,755	77,933	54,500	42,543	83,628	15,092	16,012	7,081	517,993
Porter Hospital	Radiology_Diagnostic	30,850	41,380	61,305	51,125	44,000	36,600	28,860	41,848	53,460	37,575	43,591	39,661	510,255
Porter Hospital	Recovery Room	18,969	24,661	32,968	64,168	63,984	48,675	6,790	30,843	63,348	30,827	40,311	1,011	426,555
TOTAL Porter Hospital		**559,191**	**788,795**	**897,075**	**835,603**	**691,962**	**674,674**	**587,752**	**690,178**	**830,575**	**558,112**	**696,561**	**557,906**	**8,368,385**

10. **You've stated that your expenses for the "other" category were $2M over budget. Can you please provide a month-by-month breakdown of these expense overages?**

   The Other expense category is over budget by $2 million due to the following:

Porter Hospital	VARIANCE BY MONTH												
Q 10- Expenses-Other	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	TOTAL
Interest Exp	$ (26,306)	$ 10,807	$ (10,527)	$ (9,946)	$ (9,788)	$ (9,839)	$ (8,680)	$ (9,946)	$ (8,734)	$ (10,182)	$ (9,833)	$ (8,532)	$ (111,507)
Shared Services	$ 246,336	$ 31,735	$ (338,583)	$ 144,307	$ 3,589	$ 353,345	$ 169,000	$ (6,293)	$ 122,226	$ 260,137	$ 238,634	$ 189,776	$ 1,414,209
All Other-Staff Professional Development and Travel, Medical Minor Equipment, and Other	$ (128,719)	$ (62,978)	$ (60,654)	$ 421,674	$ 31,882	$ 60,094	$ 70,453	$ 70,307	$ 87,677	$ 34,888	$ 168,213	$ 43,264	$ 736,101
													$ 2,038,803

11. **Do your contract staffing overages correlate to the higher-than-expected volumes you experienced? If so, please provide detail of where you've assigned travelers and how these assignments correlate to high volumes.**

    Most of the cost centers that have staff overages (see traveler unfavorable variances in question #9) are due to higher volumes. For those cost centers that do not have higher volumes, the staff overage was due to the need to hire travelers due to staff shortage. The travelers were hired to ensure adequate staffing levels for safe patient care.

    Below is a chart that shows the variance in increased traveler costs and the corresponding volume increases.

PORTER HOSPITAL		TOTAL	*Statistics* Budget	Actual	Statistic Measure
Expenses - 6640855 Traveler/Agency Fees					
EKG	$	131,901	4,549	7,506	Cardiology Procedures
Emergency Room		1,813,268	12,237	13,349	ER visits
Inhalation Therapy		696,349	4,766	48,667	Minutes
Laboratory		100,785	186,695	240,415	Lab Tests
Medical/Surgical		2,959,826	5,040	5,807	Patient Days
OB/GYN		978,312	537	641	Inpatient Days
Radiology Diagnostic		510,255	26,007	28,883	Radiology Procedures
TOTAL Porter Hospital	**$**	**7,190,696**			
Note: Operating Room, Recovery Room and Anesthesiology cost centers had staff overages as compared to budget due to staff vacancies that were filled by travelers. These travelers were necessary to ensure adequate staffing levels to perform the medical services.					

12. **You've stated that you received residual covid-related one-time funds in 2023. When did you first know of the potential of these one-time funds and when did they materialize?**

    One-time funds received in FY23 related to the Premium Pay for Workforce Recruitment and Retention Grant Program. The grant was awarded April FY23 with remittance of funding subject to grant criteria being met.

13. **On page 32 of your narrative, you've budgeted your PCPs to a certain clinical productivity level (3723 RVUS / Clinical FTE). However, your FY23 Actuals data suggest that your PCPs and APPS have already been operating at a higher level of clinical productivity. How do you explain the difference? Why are you budgeting for PCPs to operate a lower productivity than FY23?**

    The difference between the PCP provider productivity levels from FY23 actuals to FY25 budget is a byproduct of timing. The budget was built at a time where we were in the middle of transitioning the practice from a historical wRVU production-based methodology to a risk-adjusted panel size model. The foundation for a lot of the work is to standardize the schedules, and there is a period of time when those changes were not yet realized. We therefore utilized the most recent data to

build the budget, which was during this transition. As we see wRVU improvements from the scheduling work and opening panel sizes, the wRVU production will increase.

14. **Like all Vermont hospitals, UVMHN hospitals have often struggled to transfer patients to more appropriate care settings. Dr. Eappen identified this a major problem for the network. How would you estimate the impact of this problem on both your total expenses and lost potential revenues? This is a general question and may be answered in whatever form you prefer.**

    Critical Access Hospitals can generate swing revenue on patients who stay beyond their acute care needs, thus we do not have any uncompensated care resulting from an inability to discharge patients.