UVM Health Network
GMCB budget hearing – follow-up questions
September 5, 2023

Public meeting:

1. What is the payer mix in terms of proportion of gross patient revenue for patients from Vermont and those not from Vermont?

UVMMC

Share of Business Based on:

	Gross Patient Service Revenue	
State:	FY22	FY23: Oct-Jun
Other	2.8%	2.2%
NY	13.8%	13.1%
VT	83.4%	84.6%
Total	100.0%	100.0%

2. What is the estimated impact of the 7.5% Medicaid rate increase in NY State for each UVMHN hospital for inpatient, outpatient, and professional services?

The only hospital in the Network which NY Medicaid rate increases could marginally impact is UVMMC. The actual NY Medicaid increases were 7.5% on inpatient and 6.5% on outpatient services. These increases were factored into all Network New York hospitals' FY24 budgets. For NY Medicaid patients in UVMMC's FY24 budget, none of these increases were finalized at the time of budget development. We also did not know if they would be applied to out-of-state providers the same as NY hospitals. We are currently seeking confirmation from the NY Department of Health if those same rate increases will apply to out-of-state providers for NY Medicaid patients. If it is determined those same rate increases would apply to NY Medicaid patients seeking services at UVMMC, the estimated impact would be $2.2M of additional net patient revenue.

3. What are the inpatient, outpatient, and professional service rate assumptions for Medicare for each UVMHN hospital? How does the final IPPS rate affect these assumptions for CVMC and UVMMC?

FY2024 Budget Medicare Rate Assumptions

	IP	OP	PRO	SNF
UVMMC	5.14%	-1.54%	1.50%	n/a
CVMC	3.09%	-4.82%	1.50%	1.00%

FY2024 Budget Impact

	Medicare Rate Assumptions	ACO Shared Savings	Total Medicare
UVMMC	$9,081,815	$5,692,377	$14,774,192
CVMC	($65,513)	$2,300,014	$2,234,502

Medicare Final Rule Difference from FY2024 Budget

UVMMC	($133,965)
CVMC	$1,481,341

4. What were the 340B rebates received in FY21 and FY22? What is projected for FY23 and budgeted for FY24?

Please note hospitals do not receive rebates on 340B qualifying pharmaceuticals; they receive cost discounts – which is more appropriately referred to as cost avoidance. The cost avoidance can only be calculated after the fact based on actual drug utilization. While CVMC and PMC did realize cost avoidance in FY21 and FY22, the common systems were not in place to easily calculate.

$ in millions	FY21 Actual				FY22 Actual				FY23 Jul YTD Annualized			
	UVMMC	CVMC	PMC	UVMHN VT Total	UVMMC	CVMC	PMC	UVMHN VT Total	UVMMC	CVMC	PMC	UVMHN VT Total
Cost Avoidance Estimated 340B Cost Avoidance on pharmaceuticals provided through hospital outpatient & physician office patient encounters	$47.8			$47.8	$54.5			$54.5	$59.1	$1.9	$0.8	$61.8

5. What measures of provider productivity are you able to share per clinical ambulatory FTE? What are their affiliated benchmarks and how are those benchmarks derived?

We budget for and track total clinical FTE, which includes effort spent in multiple clinical settings, including ambulatory, eConsults, procedures, inpatient, and call coverage, among others. We do not separately track clinical effort spent solely in the ambulatory setting. We track productivity as measured by work RVUs, a unit of measure determined by CMS, and use specialty benchmark data per FTE for

comparison. Those benchmarks are generated from data submitted by health care organizations across the country.

6. What is the most up-to-date estimate for expected gains in FY23?

Based on YTD July actual, assuming no market deterioration by the end of the fiscal year, we estimated market returns would be approximately $86M. Approximately $11M of the $86M is realized, and the remaining $75M is unrealized.

7. What is the most up-to-date estimate for expected net operating income in FY23?

FY2023 YRE Margin Projections	At Budget Submission	Revised Projections	Change
UVMMC	$66,173,920	$63,619,112	($2,554,808)
CVMC	($7,159,623)	($12,944,276)	($5,784,653)
Porter Hospital	$10,598,497	$10,598,497	($0)

Please note there were $28M of one-time revenue/funding items included in UVMMC FY23 projections which were not anticipated in the FY23 budget. The primary sources of these one-time items were FEMA and retroactive IGT revenues.

8. Provide all assessments associated with UVMHN case mix index (CMI) results, including benchmarks (e.g., assessment completed by 3M mentioned in testimony).

The outside entities that perform our assessments do so on the basis that they remain confidential, for internal use only, and cannot be disclosed. In the calculations below, we have nonetheless summarized those findings and the potential financial impacts in an effort to demonstrate how we derived our projections.

9. How were the alternative CMI projections derived, including any work papers or other supporting documentation of the calculations.

Below is the calculation for how the projected CMI was derived.

UVMMC CMI Projection Calculation

Estimated Iodine System Implementation Revenue Opportunity	$	12,300,000
Additional CDI Process Enhancements Estimated Revenue Opportunity	$	7,700,000
Total Estimated Revenue Opportunity	$	20,000,000
Medicare % of Inpatient Revenue		52%
Total Estimated Medicare Inpatient Revenue Opportunity	$	10,400,000
Each 0.01 Change in CMI Medicare Revenue Value	$	534,380
Medicare CMI Increase Opportunity		0.19
Projected FY23 Medicare CMI		2.11
Projected Future Medicare CMI		2.30

10. What revenue is estimated to be associated with the $4.6 million cost inflation in the FY24 budget expense associated with pharmaceuticals for UVMMC?

The $4.6M pharmaceutical expense referenced in this question directly relates to 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 and flows through net patient service revenues. As such, $4.6M of revenue is factored into the rate calculation to cover this cost inflation.

11. When administrative and general shared services appearing on line 5 of the FY22 cost reports are appropriately reallocated to each hospital, what is the resulting ratio of admin and general salaries to clinical salaries for each UVMHN hospital? If possible, include hospitals operating in NY.

As we researched the calculation and the results reported from the FY24 budget reporting tool published by GMCB, it became evident the results were not like-for-like comparisons between the reported peer group hospitals in the reporting tool.

While there is agreement the numbers came from the Medicare Cost Report, with the calculation only focusing on column 1 it does not take into consideration significant reporting differences and varying organizational shared services support structures of the hospitals. Medicare itself acknowledges these and provides guidance on how to maneuver such differences when submitting the Medicare Cost Report. Column 1 is just the initial starting point for the calculations in a cost report. Medicare provides columns 2-6 with definitional guidance of how to populate based on each hospital's reporting and organizational support structures. In those columns expenses are reported, re-classed, and reconciled with the intent to get to a common reporting structure. Medicare Cost Report comparable and common reporting between hospitals is best recognized in column 7, which is the total of columns 1-6.

The below table of the UVMHN Vermont hospitals and a couple compare group hospitals incorporates the salary related adjustments which occur in columns 2-6 of the FY22 Medicare Cost Reports and calculates the ratio of administrative and general salaries to clinical salaries.

There was only time to provide numbers for three other compare group hospitals from the FY24 budget reporting tool, but one could expect similar variation of results for other hospital organizations between column 1 and column 7 due to the significant differences in reporting and shared service organizational structures. If the Medicare Cost Report is being used as a hospital comparative or benchmark reporting tool, column 7 should be utilized to avoid misinformed conclusions, incomplete data comparisons, and/or possibly even false assertions to inform decision-making.

	GMCB FY24 Budget Reporting Tool	Entries, Reconciliations & Reclass Adjustments	Total Salaries
	Medicare Cost Report Column 1	Medicare Cost Report Columns 2-6	Medicare Cost Report Column 7
UVMMC			
Admin	147,339,642	(48,734,716)	98,604,926
Clinical	475,952,254	(71,199,966)	404,752,288
Admin as % of Clinical	**30.96%**		**24.36%**
CVMC			
Admin	16,459,151	3,207,288	19,666,439
Clinical	79,243,767	(15,618,465)	63,625,302
Admin as % of Clinical	**20.77%**		**30.91%**
Porter			
Admin	4,665,096	2,878,899	7,543,995
Clinical	34,357,029	(8,565,434)	25,791,595
Admin as % of Clinical	**13.58%**		**29.25%**
Compare Group Hospitals			
Southern Maine Healthcare			
Admin	7,646,715	28,166,450	35,813,165
Clinical	129,705,774	(24,413,706)	105,292,068
Admin as % of Clinical	**5.90%**		**34.01%**
Mid-Coast Hospital			
Admin	3,838,220	15,710,208	19,548,428
Clinical	86,101,962	(16,860,584)	69,241,378
Admin as % of Clinical	**4.46%**		**28.23%**
Maine Medical Center			
Admin	77,629,196	136,344,657	213,973,853
Clinical	590,533,549	(150,478,213)	440,055,336
Admin %	**13.15%**		**48.62%**

12. What are the regulations imposed on travel for employees of UVMHN and its affiliates?

Below is a summary of the UVMHN travel regulations:

- Reimbursement for employee travel is for legitimate business purposes only.
- Employee is expected to travel the day of, or if necessary, the day before the start of the conference, meeting or other business event.
- Employee must return on the last day of, or if necessary, the day following the conclusion of the event.
- All flights under 6 hours of continuous flight time must be purchased in the main cabin; flights over 6 hours of continuous flight time may be purchased in business or first class.
- Employees are required to book the lowest logical airfare that is determined using the following search criteria:
    - Routing requires no more than two additional interim stops each way.
    - Travelers may elect a non-stop flight (over a lower-priced, connecting flight) provided that the additional cost is less than $400 per round trip of domestic travel and $1,000 for international travel.
    - The connecting flight would have added more than a 2-hour extension of travel time each way.
- Travel upgrades and airline clubs are not reimbursable.
- Employees are required to reserve standard hotel rooms only.
- The cost of renting a vehicle is permitted if it is less expensive than other modes of transportation, taking safety and travel time into consideration.
- Rail travel may be used if it is less expensive than air travel and adds no more than one and a half hours to the total travel time, and the total elapsed time is less than driving.
- Personal vehicle usage is reimbursed at the standard IRS rate.
- Employees will be reimbursed up to a maximum of $140 per day for meals, with the recommended breakdown by meal being:
    - Breakfast – up to $20
    - Lunch – up to $30
    - Dinner – up to $90

13. What was Helen Porter's operating loss in FY22?

While Helen Porter operated at a $5.4M loss in FY22, we view the facility as an essential part of our delivery system that needs to be supported. As Vermont acute care settings become more populated with patients needing long-term care placement, having Helen Porter at near full capacity as a resource to Porter Hospital and other hospitals is essential for patient care in Addison County and beyond.

Despite recent financial challenges, Porter Hospital's FY24 budget as submitted allows for continued Helen Porter support and overall Porter Medical Center financial stability.

14. What information are you able to provide to indicate how Porter's consolidation with UVMHN has led to improved outcomes, including changes in price pre and post consolidation?

A variety of service integrations have been accomplished with revenue cycle, PACS, matrixed relationships, and shared services that have brought varied levels of depth of service, expertise, and best practice benefits. There are some functions (e.g., legal, risk, etc.) where Porter would have to purchase outside support were it not for Network integration. For some other services, particularly integrated

functions, Porter would be vulnerable (personnel and expertise) in several of these functions if not for Network integration.

Porter adopting the Epic system would not have been possible without the Network resources and vision; Epic makes possible great improvement opportunity – clinically, operationally and financially. By converting to Epic, Porter is saving $422K per year on system and staffing costs, and the PACS integration is saving Porter $117K per year. These are just two examples of benefits of affiliation with the Network.

Overall health outcomes in Addison County have benefited from Network integration, most notably in Porter's response to COVID-19. Network resources enabled Porter to deliver a stronger, quicker response for testing, vaccinations and providing up-to-date information. This preparation and integration is essential to mitigating future outbreaks in our region in the future.

15. Provide more detail about how the All other category listed in Exhibits 9 and 10 has changed over time for PMC. What changes are associated with changes to the billing system and/or the way products have been mapped over time?

The below table provides the major mapping category changes which occurred with the conversion from Meditech to Epic from FY21 to FY22. In FY22 Porter joined the UVMHN employee self-insurance plan; previously they purchased a commercial plan for their employees.

Porter Hospital
Summary of Mapping Changes from Meditech to Epic

GMCB Reporting Categories:	FY2021	FY2022
Commercial	**24,993,795**	**39,805,738**
All Other Payer Category		
Employee Self-Insurance Plan	0	1,986,207
Small & Non-Contracted Commercial	20,348,121	6,092,514
Public Agency	0	1,678,004
Workers-Comp	913,246	1,855,622
Self-Pay	873,503	2,289,022
Other	1,681,313	72,273
Payer Denials (prior auth, timely filing, medical necessity, etc.)	(963,188)	(4,111,475)
Total All Other Payer Category	**22,852,995**	**9,862,166**

16. Health Ventures: Describe at a high level how much is currently invested and what the profit/losses have been in the last three years. If any profits have been realized, where have they flowed (days cash on hand, capital investment, etc.). If any losses have been incurred, where are they reflected on your P&L?

The current holdings and unrealized values are listed in the chart below. These investments represent 1.2% of our total investment portfolio.

Current Holdings		
Investment	**Book Value** (Cost)	**Current Unrealized Value** (409a Valuations, Trade Sales & IPOs)
DisCure	$ 1,000,000	$ 2,000,000
Betaliq	$ 750,000	$ 1,354,300
BioFactura	$ 2,500,000	$ 6,071,000
CoreMap	$ 1,500,000	$ 2,726,000
Veralox	$ 1,000,000	$ 1,106,000
Prolocor	$ 200,000	$ 324,000
Total	$ 6,950,000	$ 13,581,300

The realized gain or (losses) for FY23 YTD, FY22 and FY21 are listed below. The loss in FY21 was the write-off of Aspenti Health; the loss in FY22 was the beginning of the wind-down of Yankee Medical; and the FY23 loss was the closure and final write-off of Yankee Medical and the write-off of Theya Health.

FY23 YTD ($1.5M)
FY22 ($632K)
FY21 ($7.3M)

Health Ventures has its own P&L, just like all subsidiaries, so there is no activity flowing through the UVMMC, PMC and CVMC financial statements. The financial activity is part of the consolidated UVMHN financial statements.

The cash source for Health Ventures investments is from UVMHN, thus impacts the overall UVMHN days cash on hand, but not the individual cash balances at UVMMC, PMC and CVMC.

17. Regarding your collaboration with MVP for UVMHN Health Advantage plan, does MVP pay UVMHN or any of its affiliated entities any type of licensing (or similar) fee? If so, share this amount.

MVP does not pay UVMHN or any of its affiliated entities a licensing fee to use the name "UVM" in the product, UVM Health Advantage.

18. Describe all costs associated with your involvement with the UVMHN Health Advantage plan, including any marketing and FTE time, and any revenue or income generated from your association with it.

UVMHN does not receive any revenue or income from the long-term agreement that it has with MVP for the UVM Health Advantage product. In terms of expenses, MVP is responsible for the marketing and advertising of UVM Health Advantage. UVMHN does participate in the co-creation of materials to ensure

UVM brand adherence and alignment with our overarching UVMHN mission and goals as an organization.

19. Does MVP grant contractual benefits to UVMHN in exchange for working with them on UVM Health Advantage (in other words, more favorable terms in payment contracts or better reimbursement rates?

No.

20. If requested, could UVMHN obtain the case mix for patients enrolled in UVM Health Advantage?

UVMHN measures case mix index at the aggregate level (commercial, Medicare, Medicaid, etc.) and the total Medicare level (traditional Medicare, Medicare Advantage, etc.). The Network does not measure CMI at the product level for any payer, including the co-branded UVM Health Advantage product. The GMCB will need to request from MVP (or any other payer) product level information. As reflected in our budget hearing on August 23, 2023, UVMHN is focused on coding efforts to accurately reflect the acuity of patients we serve.

21. Describe all PHM PCP payments you've received and how they were utilized to support primary care, including any increased number of FTE's directly funded by those payments.

OneCare Vermont provides Population Health Model (PHM) payments to CVMC, PMC, and UVMMC. These payments include a blended base payment, which includes care coordination, and a bonus opportunity based on quality. The PHM payments offset a portion of the costs required to run the primary care practices. The primary care practices do not generate sufficient revenue to cover their full cost. The UVM Health Network has made strategic investments in primary care, in part due to these PHMs, related to provider recruitment, the addition of 26 patient-facing care management roles in the PHSO, development of a dashboard to monitor PHSO program performance, and care coordination support.