REDACTED

University of Vermont Medical Center
Follow-up questions from FY25 budget hearing
Responses submitted to Green Mountain Care Board 9/6/24

1. Case Mix Index (CMI). Explain any substantive changes in CMI by Payer, providing evidence to justify anticipated changes. Quantify any impacts on your budget by payer.

Below is the data that was submitted in our response on 8/30/24. Documentation is about the patient condition and not payor. It is also about ensuring a complete medical record. Continuous education is provided as new information becomes available.

	FY23 Actual	FY23 Budget	FY24 Projected	FY24 Budget	FY25 Budget
CMI Documentation Improvement					
Medicaid	146,164	423,719	444,041	385,387	0
Medicare	212,512	1,104,625	3,520,323	1,232,843	0
Commercial	74,181	1,372,782	3,110,465	1,174,546	0
All Other	136,070	98,875	689,239	183,224	0
Total	568,926	3,000,001	7,764,067	2,976,000	0

2. How much of $8.9M (of $18M reserved funds for mental health) for 2024 is on track to be spent? How much will be expended in the first year?

The UVM Health Network, in cooperation with the Vermont Department of Mental Health, has been working towards compliance with the Green Mountain Care Board's order dated March 22, 2023, which mandates the investment of the remaining funds ($18 million) set aside in accordance with the Board's order dated April 18, 2018. As noted in our May 31, 2023, letter, we anticipated the possibility of delays to the three-year plan for the expenditure of these funds due to emerging priorities limiting staff resources or implementation postponements as the proposals moved from original ideation towards implementation. The planning phases have extended as the projects received further vetting and minor modification, but all are still on track for execution, just not in the original timelines. While spending may not fall exactly into the proposed fiscal year, we fully expect to spend the entire $18 million. The following is an accounting of our projected spending as of October 1, 2024.

UVMMC Fiscal Year 2024 Proposed Investments	Proposed Spending	Actual Spending	Remaining Funds
Primary care mental health integration	$640,000.00	$0.00	$640,000.00
Develop and implement protocols for suicide risk assessment and prevention	$320,000.00	$7,938.76	$312,061.24
Establish Esketamine Program	$550,000.00	$0.00	$550,000.00
Establish Transcranial Magnetic Stimulation (TMS) Program	$90,000.00	$0.00	$90,000.00
Establish Mental Health Urgent Care Clinic	$2,850,000.00	$2,312,500.00	$537,500.00
Reconfigure psychiatric unit at Central VT Medical Center	$4,500,000.00	*$340,000.00*	$4,160,000.00
Pilot program: Transport patients after hours to Brattleboro Retreat (year 2 projected spend that began in year 1)	$0.00	$62,499.99	$0.00
UVMMC Fiscal Year 2024 Total	**$8,900,000.00**	**$2,722,938.75**	**$6,227,061.25**

3. How have you incorporated savings from the care management program into the budget? Quantify the amount of savings and explain the drivers.

The NCQA Accredited (received NCQA Accreditation in December 2023) PHSO Care Management program will have been live in all UVM Health Network Vermont Primary Care sites in support of our attributed patients as of October 2023. Evidence-based Care Management Models have shown that building a longitudinal relationship, with the right patients, decreases TCOC and shifts utilization to more cost-effective settings over time. (Hsu J, Price M, Vogeli C, Brand R, Chernew ME, Chaguturu SK, Weil E, Ferris TG. Bending The Spending Curve By Altering Care Delivery Patterns: The Role Of Care Management Within A Pioneer ACO. Health Aff (Millwood). 2017 May 1;36(5):876-884. doi: 10.1377/hlthaff.2016.0922. PMID: 28461355.)

To date we have 5,500 enrolled for six months with about 600 new referrals per month. We have not had patients enrolled in Care Management long enough to budget for outcomes.

Of note, the majority of ED utilization at our facilities is driven by non-UVMHN attributed patients. Given the continued increase in ED utilization network-wide, a sizeable reduction in ED utilization among our Primary Care attributed population is unlikely to bend the overall ED utilization curve for our facilities.

Due to these factors, we did not budget the impact of Care Management in the FY25 budget.

4. Please identify all one-time expenses in FY23 or FY24, and show where they were excluded in the FY25 budget. Identify any one-time expenses from FY23 or FY24 that were *not* excluded.

No known one-time expenses were carried into FY24 or FY25.
Example – we track all one-time revenues and one-time expenses each month. During budget preparation, we conduct an additional review of all expenses for non-recurring expenses such as a sign-on bonus for a new employee, contract ratification bonuses, retention bonuses, any one-time small equipment purchases, etc.
We then rebase without these, use metrics and meet with department leaders to understand any upcoming one-time or unusual expenses to be added to the budget such as contract price increases, volume related small equipment, etc.

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Exhibit reflecting removal of one-time large and small expense items in addition to known cost savings:

One-time large expense items not budgeted in FY25

Miller Respite House funding catchup	$	3,300,000
Retention Bonus for Nurses from previous contract - Apr'24	$	2,100,000
COVID-19 Inventory write-offs (N95 masks, test kits, lab supplies)	$	1,500,000
Exam gloves (forced to use high cost COVID gloves before expired)	$	700,000
Traveler premium	$	5,400,000
Stike planning fees (admin and lodging)	$	790,000
Total	**$**	**13,790,000**

Items in FY24 taken out of FY25 Budget		
Purchased Srvcs - Professional Srvcs - CT Mobile Rental CLARITY MOBILE IMAGING LLC	$	97,971
purchased services - MM Hayes Data Migration services (WD related)	$	145,207
purchased services - Avantas SmartSquare conversion (WD related)	$	90,000
purchased services - RK Payroll Solutions FTE backfill (WD related)	$	170,085
purchased services - EndoSoft data migration / upgrade / training	$	60,855
purchased services - Philips data center move	$	16,501
purchased services - Nihon Kohden Polysmith upgrade	$	30,211
purchased services - Hyland OnBase upgrade	$	162,000
contract maintenance - EchoStor legacy contracts running out as we change our technology / refresh on other hardware	$	418,044
purchased services - Integration Partners implementation services	$	66,660
purchased services - ConvergeOne staff aug / project help	$	14,400
purchased services - Spok implementation services	$	38,520
temp help - Enhanced Communications Solutions telecom support / project help	$	70,720
small equipment - Central VT Communications pagers	$	67,600
SaaS - Microsoft license true-up	$	280,109
purchased services - Knowledgewave Learning site	$	38,400
licenses - EchoStor VMWare licenses (one-time)	$	190,629
licenses - Competitive Computing Active Directory migration licenses / services	$	28,444
software maintenance - EchoStor VMWare ELA (stop-gap licenses needed only thru transition of hardware)	$	714,860
purchased services - Clinisys Atlas upgrade	$	25,445
staff aug - Health System Informatics staff aug / project help	$	52,600
small equipment - Insight Direct computer refresh (large year-end purchase)	$	851,170
small equipment - Insight Direct language carts / iPad project	$	385,748
purchased services - Merge Healthcare data center move	$	180,567
purchased services - Knowledgewave HN PACS implementation analyst	$	108,332
purchased services - Alku Technologies staff aug / project help	$	61,600
purchased services - Health System Informatics staff aug / project help	$	35,200
licenses - Epic one-time Epic licenses	$	239,492

purchased services - Various one-time Epic implementation expenses	$	402,409
Medical Surgical - Suction Wall Regulators	$	28,304
Small Equipment - Suction Wall Splitters	$	16,899
Medical Surgical - Shield EP Left Subclavian	$	20,000
Med Surg Specialty Items - Related to lower use of SPACEOAR VUE	$	18,349
Gyn/Uro Implants - Based on lower use	$	100,000
Bare Metal Stents - Based on lower use	$	30,000
Cochlear Implants and Hearing Aids - Based on lower use	$	100,000
Called-In - Lowered due to change in how it's used (YTD Jan compared to FY25 Budget)	$	200,120
Purchased Services - Reduction based on permanent hire; no longer use consultant	$	314,859
Rent - Building - Reduction of rent in satellite properties by consolidating offices and work from home initiatives	$	155,315
Groceries - Net food savings expected from Leanpath software to reduce food waste.	$	120,000
Recruitment - Recruitment- RECRUITIFI INC Pos 1	$	27,186
Recruitment - Recruitment- RECRUITIFI INC Pos 2	$	28,500
Rent - Building - Reduction of Fanny Allen rent via purchase (Colchester PILOT remains)	$	1,260,000
Small Equipment - Small Equipment needs for clinical room and waiting room furniture replacement, cleaning equipment, etc.	$	123,866
Total	**$**	**7,587,175**

5. FY23 Actuals – Bridges (Revenue & Expense)

a. For each line item (revenue and expenses) on your Bridges document, (a) break down when you applied for or learned of the potential variance/change, (b) when it occurred, and (c) UVMMC's budget vs. actual variance for each line item for FY21-24.

The bridges document is updated twice a year, in January when reporting prior budget to actual results, and in July when submitting the budget.

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.

b. Explain utilization variance by payer for FY2023, including breakouts by core service and specialty.

Please refer to the responses we submitted on 8/16/24 for the departments driving the change.
Below is the utilization by payer.

NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other
Utilization	$ 121,231,384	$ 35,910,847	$ 10,220,678	$ 59,413,576	$ 15,686,283

c. Break out reimbursement & payer mix numbers and explain key drivers of variations.

The below table provides the impacts by payer.

NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other
Rate	$ (15,511,292)	$ 10,586,135	$ (14,890,742)	$ (21,104,424)	$ 9,897,738
Payer Mix	$ (59,705,167)	$ 18,206,432	$ 3,796,437	$ (85,688,009)	$ 3,979,972

Variations occur based solely on actual patient visits and the patient's individual care plan from their health care provider. We do not target or solicit by payor.

The chart above shows this variation. Higher utilization by patients using commercial insurance will yield higher net patient revenue – but reimbursement rate is unchanged. Patients moving from Medicaid to Commercial Insurance will increase utilization in that payor bucket but not rate. More patients seeking services with Medicare as the payor will yield more NPR in Medicare category but not necessarily a higher rate. Depending on the situation, a patient's care may qualify for Medicare outlier payments and therefore the rate of payment is higher; but we cannot predict that in advance. We budget based upon what we have seen historically and any known changes. We have seen an increase in patients opting to self-pay as well.

d. Provide a breakout of administrative write-offs for FY23, and when each of those write offs occurred.

Amounts in thousands

FY23 Sep	FY23 Aug	FY23 Jul	FY23 Jun	FY23 May	FY23 Apr	FY23 Mar	FY23 Feb	FY23 Jan	FY23 Dec	FY23 Nov	FY23 Oct
3,934	2,970	3,203	4,132	1,879	4,850	7,787	4,487	3,464	2,250	2,680	2,601

e. ACO shared loss – how much was it where does that show up in FY23 bridges?

The total shared savings for FY23 Actuals was $265,331. This is unfavorable to budget causing a -$8.2M variance. The

unfavorable variance was captured in the "Rate" category of the Bridges.

	Shared Savings (+) / Loss (-)		
	2023 Budget	2023 Actual	Variance
TOTAL	**8,459,749**	**265,331**	**-8,194,418**
			Unfavorable

Total FY23 Actual Shared Savings / Loss by Plan Year	
2021	335,748
2022	1,494,797
2023	(1,565,214)
	265,331

f. Break out contracted labor and locums costs by each service area for FY23, and provide a month by month breakout for those expenses.

		2023 Actual												
Entity	GMCB	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	TOTAL
Expenses - 6640855 Traveler/Agency Fees														
UVMMC	Administration	0	0	0	0	0	0	0	0	13,716	0	0	0	13,716
UVMMC	Blood Bank	0	0	0	0	0	0	0	0	5,700	17,505	18,780	34,291	76,276
UVMMC	Cardiac Catheterization	45,332	31,093	44,655	19,624	16,162	39,060	39,259	43,021	39,642	22,614	23,299	28,081	391,844
UVMMC	Cat Scan	195,215	173,683	152,146	101,760	145,438	161,501	140,310	150,665	151,503	130,686	146,988	184,710	1,834,606
UVMMC	Central Services & Supplies	227,386	267,444	289,732	279,637	287,274	276,894	278,500	294,551	273,755	264,412	385,624	281,029	3,406,238
UVMMC	Chronic & Rehabilitation	6,324	11,733	7,806	10,653	6,154	17,193	27,681	34,280	42,448	21,583	45,518	23,010	254,534
UVMMC	COVID	3,939,844	3,934,825	3,028,155	3,340,300	2,747,248	2,820,435	2,440,020	2,280,417	(1,999,750)	5,911,890	1,604,503	1,205,152	31,859,245
UVMMC	Critical Care	521,951	551,055	568,340	2,275,108	680,668	653,503	630,410	575,843	544,540	484,180	582,168	351,025	8,430,207
UVMMC	Emergency Room	850,989	845,432	804,668	3,207,900	1,204,680	1,257,381	1,161,746	1,121,687	1,056,205	1,037,626	821,768	976,008	14,436,140
UVMMC	Fiscal Services	(11,368)	(21,278)	(66,976)	(14,575,979)	(2,725,208)	(2,806,560)	(2,440,876)	(2,280,417)	1,980,534	(5,911,890)	(1,604,503)	(1,205,152)	(31,669,674)
UVMMC	Inhalation Therapy	123,699	243,199	245,228	244,266	203,989	204,290	219,552	194,456	181,138	238,946	221,621	219,324	2,534,707
UVMMC	IV Therapy	72,749	53,858	48,800	237,579	73,159	123,897	130,726	124,380	99,466	130,250	161,623	115,591	1,372,077
UVMMC	Labor & Delivery	140,734	163,782	133,815	639,870	127,437	99,926	107,717	87,938	75,170	71,986	75,206	5,334	1,728,913
UVMMC	Laboratory	19,247	47,559	41,608	39,389	73,648	126,658	90,514	100,851	83,509	104,987	91,175	69,883	889,027
UVMMC	Magnetic Resonance Image	40,700	30,000	64,789	76,321	58,435	84,918	76,336	112,784	112,740	82,779	69,224	53,873	862,899
UVMMC	Medical/Surgical	2,145,197	2,083,977	1,810,632	7,666,477	2,471,880	2,552,482	2,724,725	2,666,234	2,351,147	2,427,810	2,093,855	2,285,313	33,873,040
UVMMC	Neonatal ICU	110,279	94,070	40,662	312,571	59,444	125,522	94,579	117,221	124,414	152,791	87,717	76,766	1,396,056
UVMMC	Nuclear Medicine	45,772	36,255	35,052	23,040	22,400	24,800	18,400	12,143	7,375	22,571	23,270	24,613	295,691
UVMMC	Nursing Administration	0	0	0	0	0	0	0	0	0	22,013	24,589	13,943	60,545
UVMMC	OB/GYN	34,844	35,390	65,086	235,612	74,364	105,750	104,045	183,130	191,206	211,656	136,392	132,140	1,509,613
UVMMC	Operating Room	568,414	491,740	540,716	1,926,209	927,629	928,867	734,198	773,162	757,047	786,170	812,527	585,245	9,831,924
UVMMC	Pediatric	32,038	69,919	73,495	312,262	76,092	96,248	64,611	60,272	25,333	22,662	21,713	3,980	858,626
UVMMC	PHYSICIAN: Family Medicine	(4,890)	12,404	19,930	10,562	11,928	(2,313)	11,554	18,837	4,888	4,465	0	0	87,365
UVMMC	PHYSICIAN: Medicine	62,715	54,985	36,945	175,187	46,425	45,856	40,820	24,717	39,106	61,727	79,279	44,939	712,701
UVMMC	PHYSICIAN: Neurology	15,261	6,179	22,788	19,149	11,543	15,612	56,512	49,224	49,316	29,612	46,443	64,975	386,614
UVMMC	PHYSICIAN: Surgery	0	918	(162)	8,943	21,586	26,889	23,008	5,319	0	0	0	0	86,600
UVMMC	PHYSICIAN: Womens	0	0	0	0	0	0	0	0	16,020	17,722	19,502	(3,299)	49,945
UVMMC	Psychiatry	353,902	277,847	316,700	882,225	320,292	347,003	374,138	375,420	315,854	309,182	266,813	324,779	4,464,163
UVMMC	Radiology, Diagnostic	100,513	109,632	167,795	279,437	157,710	121,468	92,983	53,813	45,767	77,003	50,883	44,195	1,301,200
UVMMC	Recovery Room	79,547	93,056	65,522	237,257	90,035	94,514	103,450	87,171	102,126	104,082	106,783	46,280	1,209,821
UVMMC	Rehabilitative Services	(6,654)	0	0	14,457	35,588	37,599	23,614	17,675	19,716	23,923	34,936	27,697	228,551
UVMMC	Renal Dialysis	288,724	286,735	295,859	604,026	363,235	372,459	383,439	415,268	380,431	328,011	331,163	333,623	4,382,975
UVMMC	Surgical Day Care	41,668	33,677	27,487	78,115	59,828	88,494	79,735	86,567	70,128	88,066	88,970	81,789	824,525
UVMMC	Ultrasound	24,884	32,190	58,117	115,992	94,255	97,808	69,118	76,267	36,616	18,407	34,980	19,907	678,540
TOTAL UVMMC Travelers		10,064,925	10,052,258	9,538,776	8,888,731	7,743,417	8,138,245	7,915,988	7,856,903	7,196,815	7,310,437	7,532,789	6,449,964	98,689,249

		2023 Actual												
Entity	GMCB	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	TOTAL
Expenses - 6640095 Physician Locum Tenens														
UVMMC	PHYSICIAN: Anesthesia	220,693	143,388	108,105	142,343	157,850	259,538	155,163	129,880	205,549	187,186	205,503	165,720	2,072,916
UVMMC	PHYSICIAN: Childrens	0	0	1,852	3,704	(5,556)	0	1,852	5,556	9,000	0	7,408	(1,454)	22,362
UVMMC	PHYSICIAN: Medicine	69,480	82,372	105,772	86,913	126,866	150,966	191,069	226,311	263,686	177,205	558,530	251,772	2,271,941
UVMMC	PHYSICIAN: MG Radiaton Oncology	71,021	69,416	26,949	30,028	717	0	(40,638)	0	0	0	0	0	157,493
UVMMC	PHYSICIAN: Pathology	62,600	22,812	34,915	2,022	13,000	27,625	15,276	1,444	53,111	30,889	88,444	70,800	422,939
UVMMC	PHYSICIAN: Psychiatry	205,901	197,799	297,025	216,826	310,267	167,557	184,748	213,927	416,379	(227,813)	(43,912)	(33,361)	1,905,343
UVMMC	PHYSICIAN: Surgery	0	0	0	0	0	0	0	0	0	0	0	360,950	360,950
UVMMC	PHYSICIAN: Womens	0	0	0	0	0	0	0	0	0	0	0	30,000	30,000
TOTAL UVMMC Physician Locum Tenens		629,694	515,786	574,619	481,836	603,144	599,686	507,469	577,118	947,725	167,467	816,973	822,427	7,243,948

g. Break out pharmaceutical spending by service area (inpatient, outpatient, retail pharmacy etc.), noting key drivers for each; quantify the drug mark ups/margins associated with the expense overage in FY23.

Drug markups are not a part of IP expense overages. Expenses on IP are due to patient utilization at higher level or the use of higher cost drugs.

Retail pharmacy expense rises in accordance with demand and yields offsetting revenue.

Account	FY23 Budget	FY23 Actual	Amount Change
Retail Pharmacy Revenue	208,578,245	223,134,710	(14,556,465)
Retail Pharmacy Expense	139,643,143	158,669,552	(19,026,409)

h. What are the three largest contributors to the "other" bucket in the FY23 bridges expenses?

Largest categories include: Interest Expense, Shared Services, and expenses related to Supplemental Academic Support payments to University of Vermont Larner College of Medicine.

6. Medicare Designation & Reimbursement Impact

a. What, if any, is the financial impact of your rural hospital designation?

Rural hospital reclassification/designation, on its own, has a negative Medicare reimbursement impact for UVMMC. In FY23 our rural reclassification and Rural Referral Center status had a negative financial impact, but it was offset by the positive financial impact of rural Sole Community Hospital designation.

b. What month and year did you begin reviewing whether you may qualify as a sole community hospital?

Please see letter sent to the Board on 8/30/24.

c. Was Northwestern Medical Center considered a like-hospital in prior periods?

Please see letter sent to the Board on 8/30/24.

d. Who was responsible to ensure that UVMMC pursued all potential enhanced payment designations from Medicare?

Working with the reimbursement and government relations teams, the CFO is ultimately responsible for pursuing enhanced payment designations.

e. Was anyone held accountable by your leadership or Board for failing to review and ensure UVMMC qualified for all enhanced Medicare payment designations? Why/why not?

Please see letter sent to the Board on 8/30/24. UVMMC applied for Sole Community Hospital designation when we were confident the designation criteria had been met and would continue to be met, given a demonstrated trend over time.

f. What is the total amount of money that UVMMC could have received from Medicare had it applied for Sole Community Hospital status when UVMMC was first eligible?

Please see letter sent to the Board on 8/30/24. UVMMC applied for Sole Community Hospital designation when we were confident the designation criteria had been met and would continue to be met, given a demonstrated trend over time. If UVMMC had applied for rural reclassification, RRC status and SCH designation based on the first period they could potentially be considered eligible, the approximate amount of additional reimbursement UVMMC would have received from Medicare in the first full fiscal year (FY20) would have been $1.7M.

g. What is the total amount of executive bonuses paid during periods in which UVMMC could have qualified as a sole community hospital? Explain whether your Board was aware of, and considered, UVMMC's failure to review and apply for sole community hospital status in awarding such bonuses.

Please see letter sent to the Board on 8/30/24. UVMMC applied for Sole Community Hospital designation when we were confident the designation criteria had been met and would continue to be met, given a demonstrated trend over time.

No failure to review for eligibility exists.

h. After learning of UVMMC's application for SCH status in FY23, did your Board ever inquire about whether UVMMC could have qualified for SCH status earlier? If not, why not?

Please see letter sent to the Board on 8/30/24. UVMMC applied for Sole Community Hospital designation when we were confident the designation criteria had been met and would continue to be met, given a demonstrated trend over time.

i. Additional question received via email Monday, 9/2/24: Could you please complete the below chart for FYs 2016-2018?

	UVMMC	CVPH	NWMC
FFY2018 Cost Reporting Period	9/30/2018	9/30/2018	9/30/2018
S3 Pt 1 Line 14	115,274	52,128	7,761
Less: Swing Beds Line 5&6	0	0	0
Add: L&D Days	1,422	1,926	840
	116,696	54,054	8,601
8% Compare	9,336		
Like Hospital (>8% for Compare)		**YES**	**NO**
FFY2017 Cost Reporting Period	9/30/2017	9/30/2017	9/30/2017
S3 Pt 1 Line 14	114,188	49,524	8,915
Less: Swing Beds Line 5&6	0	0	0
Add: L&D Days	1,457	212	920
	115,645	49,736	9,835
	9,252		
8% Compare		**YES**	**YES**
Like Hospital (>8% for Compare)			
FFY2016 Cost Reporting Period	9/30/2016	9/30/2016	9/30/2016
S3 Pt 1 Line 14	108,023	52,128	8,930
Less: Swing Beds Line 5&6	0	0	0
Add: L&D Days	1,502	1,926	0
8% Compare	109,525	54,054	8,930
Like Hospital (>8% for Compare)	8,762		
		YES	**YES**

7. NPR by payer Actuals vs. Budget

a. For FY21 through FY23, why have you consistently and significantly underbudgeted Medicare/Medicaid budgets consistently over budgeted commercial?

We do not target under- or overbudgeting for any payer. Our budgets are built on the best available information, and we cannot predict patient changes in utilization by payer. As an example, a change from Medicaid to self-pay can be budgeted, but until the change occurs, the true change is unknown. Assumptions may include a shift from Medicaid to commercial insurance, but actual enrollment can be higher or lower than budget. Monthly reporting is provided, which provides for awareness as soon as possible. In addition, any changes are incorporated into the budget base for the next fiscal year. Since the pandemic, health care has seen behavior changes in patients seeking services. We are still experiencing the long-term impacts of those behavior changes and there is not a predictive model that is in use to provide unwavering foresight into this trend.

Post COVID, UVMMC has focused on meeting the unmet needs of patients, which has been widely discussed in public in various forums. As a nonprofit hospital, our efforts did and do not focus on any particular payer – but rather service

areas that needed additional access, such as CT, MRI, Mammography, sleep center, etc. To improve availability for patients' needs, additional expenses were incurred to secure staffing, and the impact of cost inflation is not fully covered by NPR. Removing NPR increases does not eliminate the expenses related to providing additional access for patients. The NPR is required to support these costs that were already incurred and to facilitate our ability to provide the amounts and levels of care Vermonters require.

In the table below you can see that after factoring Bad Debt, Free Care, and any other adjustments which may affect total NPR; Medicare & Medicaid reimbursements were over budget & Commercial reimbursements were *lower than budget for all three years.* For the periods FY21-FY23 in total, Medicare & Medicaid reimbursements combined were $143M higher than budget where Commercial was $133M lower than budget with Total NPR within -0.8 % of Budget.

Fiscal Year	Approved Budget Total NPR	Actual to Budget Variance by Payer: Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH	Actual Total NPR	% Change Actual to
FY 2023	$ 1,658,725,627	$ 76,397,447	$ 34,080,715	$ (33,751,303)	$ 15,389,782	$ (11,826,485)	$ 1,739,015,783	4.8%
FY 2022	$ 1,508,506,476	$ 10,649,075	$ 20,376,377	$ (39,107,894)	$ (11,991,040)	$ 9,031,156	$ 1,497,464,148	-0.7%
FY 2021	$ 1,415,656,433	$ (16,246,363)	$ 18,094,922	$ (61,097,772)	$ (48,708,463)	$ 17,475	$ 1,307,716,232	-7.6%
Combined Totals: FY23+FY22+FY21	$ 4,582,888,536	$ 70,800,159	$ 72,552,014	$ (133,956,969)	$ (45,309,722)	$ (2,777,855)	$ 4,544,196,163	-0.8%

NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY 2023 Approved Budget	$ 1,658,725,627					
Utilization	$ 121,231,384	$ 35,910,847	$ 10,220,678	$ 59,413,576	$ 15,686,283	
Rate	$ (15,511,292)	$ 10,586,135	$ (14,890,742)	$ (21,104,424)	$ 9,897,738	
Payer Mix	$ (59,705,167)	$ 18,206,432	$ 3,796,437	$ (85,688,009)	$ 3,979,972	
Bad Debt	$ 26,478,210	$ 10,190,879	$ 1,439,339	$ 11,496,151	$ 3,351,842	
Free Care	$ 6,866,039	$ 1,503,154	$ 2,801,639	$ 2,131,402	$ 429,844	
Changes in DSH	$ (11,826,485)					$ (11,826,485)
GME Reimbursement Change	$ 30,713,364		$ 30,713,364			
Administrative Write-Offs	$ (17,955,898)				$ (17,955,898)	
FY 2023 Actual Results	$ 1,739,015,783	$ 76,397,447	$ 34,080,715	$ (33,751,303)	$ 15,389,782	$ (11,826,485)

NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY 2022 Approved Budget	$ 1,508,506,476					
Utilization	$ 38,391,201	11,691,709	4,456,666	16,024,609	6,218,217	
Rate	$ (37,715,980)	(20,028,900)	(19,072,583)	1,636,435	(250,932)	
Payer Mix	$ (37,518,560)	9,068,964	9,583,139	(63,001,959)	6,831,295	
Bad Debt	$ 1,894,241	7,340,124	67,968	5,720,112	(11,233,963)	
Free Care	$ 5,701,915	2,577,178	2,841,186	512,909	(229,358)	
Physician Acq/Trans	$ -					
Pharmacy	$ -					
Changes in Accounting	$ -					
Changes in DSH	$ 9,031,156					9,031,156
GME Reimbursement Change	$ 22,500,000		22,500,000			
Administrative Write-Offs	$ (13,326,300)				(13,326,300)	
Other (please label)						
FY 2022 Actual Results	$ 1,497,464,148	$ 10,649,075	$ 20,376,377	$ (39,107,894)	$ (11,991,040)	$ 9,031,156

NPR/FPP	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY 21 Approved Budget	$ 1,415,656,433					
Utilization	(78,398,518)	(23,834,991)	(6,339,073)	(38,159,965)	(10,064,489)	-
Rate	17,312,243	(4,425,438)	11,302,172	9,912,410	523,099	-
Payer Mix	(43,905,315)	12,014,066	13,131,824	(32,850,217)	(36,200,987)	
Bad Debt	10,548,481				10,548,481	
Free Care	10,097,051				10,097,051	
Changes in DSH	17,475					17,475
GME Reimbursement Change	-					-
Administrative Write-Offs	(23,611,617)				(23,611,617)	
FY 21 Actual Results	$ 1,307,716,232	(16,246,363)	18,094,922	(61,097,772)	(48,708,463)	17,475

Original submission called out separate category for Phys Transfer of -4.5M which is included in utilization in the above table.
For Bad Debt & Free Care Payer specific payer information was not available, in the above table it was reported in Self-Pay/Other.

8. UVM Med School

a. What is budgeted commitment payment for FY25?

The FY25 budgeted commitments to the University of Vermont Larner College of Medicine are $60,907,735.

b. How much of the commitment payment is directly related to compensating physicians for clinical time spent at UVMMC?

$20,243,674 of the UVM LCOM commitment is for physician salaries. A nominal amount of this total supports administrative leadership roles, and the remainder supports clinical efforts at UVMMC.

9. Health System Transfers/Funds Flows

a. For the $60M due from related party CVPH to UVM, provide a detailed breakdown of that balance, when it accrued, for what, and the status of repayment.

Outstanding at 9/30/23. As stated during the 8/28/24 GMCB UVMMC budget hearing, this balance fluctuates at any given time.

Approximate breakdown of $60M

- $10M for Shared Services and other integrated expense funding models
- $30M for Pharmacy expense
- $20M for Physician salary & fringe

10. Quality

a. Please send us (for FY21-FY24) historic and more up to date data on UVMMC performance on (1) hospital acquired conditions and (2) VBP and readmissions. And explain the timing between performance and financial impact.

b. Provide GMCB the tracking UVMMC uses for purposes of assessing quality, safety, and patient satisfaction for FY21-24.

Please refer to attachments submitted with these responses.

11. UVM Admin Shared Services

a. Please explain why admin is growing (29 employees to 47, and salaries from $20M to $27M)? How much of this is new positions vs. reallocations (and from where)?

35% of the increase is due to transfers/reallocations from hospital budgets, 10% is for partially budgeted FTEs in last year's budget (based on their projected start date) that are now full time in this year's budget, and 55% is due to incremental additions. The incremental additions are focused on increasing our RN clinical informatics resources to make Epic more efficient for our nurses, bolstering our information security resources, and adding resources to more effectively manage at the Network level nurse staffing and facilities planning with the ultimate goal of achieving greater efficiencies and better patient outcomes across the system.

b. Please explain PHSO FTE and salary growth. Why and how much of this is new vs. reallocation?

The PHSO increased by approximately 27 FTEs. 14 the 27 were reallocation FTEs.

The remaining 13 FTEs / $1.35M were related to incremental FTEs. Of the 13 incremental FTEs: 10 FTEs are allocated to Care Management, 3 FTEs are related to Quality Improvement.

12. In your presentation on August 28th (Slide 28) you stated that the calculation for UVM Network NPR growth adjusted for population served does not reflect your updated budget request. Please update the calculation.

	Utilization Adjustment	FY23 Actual	FY24 Projected	FY24 Budget	FY25 Budget
Primary Market Population					
Chittenden		169,481	169,845	169,590	170,210
Franklin		50,994	51,316	51,091	51,640
Grand Isle		7,467	7,532	7,487	7,598
Lamoille		26,060	26,106	26,074	26,151
Washington		60,142	60,271	60,181	60,401
Addison		37,720	37,843	37,757	37,966
Subtotal		351,864	352,913	352,179	353,967
Rest of Vermont		295,600	296,071	295,741	296,541
Total Vermont		647,464	648,984	647,920	650,507
UVMHN Population (market share adj)					
Under 18		57,966	56,169	57,430	55,504
19 - 64		208,948	208,313	208,760	208,872
65 & Over		64,827	70,204	66,434	73,268
Total		331,741	334,686	332,624	337,644
Utilization Adjusted UVMHN Population					
Under 18	X 1.00	57,966	56,169	57,430	55,504
19 - 64	X 2.17	453,571	452,193	453,163	453,406
65 & Over	X 5.30	343,676	372,179	352,192	388,421
Total		855,213	880,541	862,785	897,332
UVMHN NPR		$ 2,106,605,667	$ 2,258,418,434	$ 2,233,695,814	$ 2,442,176,446
Less: NY NPR		$ (297,031,399)	$ (334,245,928)	$ (319,641,871)	$ (366,326,467)
UVMHN VT NPR		$ 1,809,574,268	$ 1,924,172,506	$ 1,914,053,943	$ 2,075,849,979
VT NPR per UVMHN VT Population (Age Adj)		$ 2,116	$ 2,185	$ 2,218	$ 2,313
Percent Change			**3.3%**		**4.3%**

Utilization Adjustment Source: 2020 CMS National Health Expenditure Data
Population Source: 2000 - 2023 US Census Bureau Data Trended Forward for 2024 & 2025
Market Share Source: 2018 - 2021 SG2 Data Trended Forward for 2022, 2023, 2024 & 2025

13. On page 19 of your narrative you break out Gross Patient Service Revenue by core service area and cost center. What is included in the cost center line item "Chief Executive Officer"?

All gross revenue flowing through Chief Executive Officer rollup is related to the following services:

- Main Campus Infusion
- Tilley Drive Ambulatory Infusion
- Transplant Services

14. Please provide more detail and explain the drop in non-op revenue (from $55m in FY 23 $53M in FY24P to $20.6M in FY25B). Please tie back the "other revenue" worksheet data on non-operating revenue to the explanations of investment and donor revenue in the narrative (e.g., page 30: anticipated donations of $4m, $21M budgeted for "change in interest in investment pool for UVMMC). Now that the OSC is conditionally approved, how would UVM's expressed commitment to increase donations if the OSC is approved impact non-operating revenue (p 30)?

Non-operating revenue for FY23 and FY24 was virtually all from investment income. Actual investment income for FY23 and FY24 was much higher than the budgeted 4.0%. The $20.6 million budget for FY25 is a 4.0% return assumption for investment income, like it is budgeted every year.

Restricted donations for capital projects would not impact non-operating revenue. Any donations related to the OSC would go directly into a specific purpose restricted fund. The specific purposed fund would then be used to fund a portion of the capital expense for the project.

15. Efficiency

a. On page 13 of your narrative, and also in your presentation, you cite that expense per adjusted discharge benchmarked against teaching hospitals for UVMMC has grown from the 25th to just above the 50th percentile. Provide evidence to support your explanation made during the hearing for this (e.g. higher use of contracted labor, higher wage growth, lower ability to discharge to appropriate settings compared to other teaching hospitals in the country etc.).

The purpose of including the AAMC COTH expense per adjusted discharge and expense per adjusted inpatient day was to provide evidence on clinical efficiency, as required by the Board's hospital budget guidance. The data showed that both measures are below the median of AMCs. A question was asked about the growth in those measures from 2021 to 2023. The answer we provided was that it was due to UVMMC needing to employ more contract labor compared to other AMCs to continue to meet patient demand, and that higher utilization of contract labor also caused us to increase salaries at a more rapid rate to replace that contract labor with permanent staff. As the AAMC COTH charts below show, in 2021, the beginning of the rise in UVMMC's utilization of contract labor, UVMMC's total spend of $45M on contract labor was between the median and 75th percentile of other AMCs. In 2023 UVMMC's $125M spend was above the 75th percentile. AAMC COTH has not yet published their 2023 comprehensive report that includes this contract labor detail, but we expect it will show similar results.

Although contract labor costs have come down in FY24, our reliance has not yet decreased to the level we would like due to continued needs in our communities while labor shortages persist. Additionally, somewhat offsetting the decrease in contract labor rates is the increased wage pressures of employed labor. We have had significantly higher increases during this time period for our collective bargaining units as well as greater numbers of employees unionizing, both of which will increase our overall costs. We await the results of the next COTH study to see the relative change overall compared to other hospitals in this comparative group.

TABLE 51 CONTRACTED AND OUTSOURCED STAFF

Survey Year 2021
Hospital Fiscal Years Ending January 1, 2021 to December 31, 2021

	Total Contracted FTE Nursing Staff	Total Contracted FTE Non-Nursing Staff	Total Contracted FTE Labor[1]	Total Outsourced Labor[2]	Total Contracted and Outsourced Labor Expenses
UVM MEDICAL CENTER	149	65	214	-	$45,200,312

[1]Contracted labor is defined as individuals contracted to work in a department.
[2]Outsourced labor is defined as an entire department or area that is contracted.
Note: Summary statistics (reported on the final page of this table) do not incorporate zero or null values.

TABLE 51 CONTRACTED AND OUTSOURCED STAFF

Survey Year 2021
Hospital Fiscal Years Ending January 1, 2021 to December 31, 2021

	Total Contracted FTE Nursing Staff	Total Contracted FTE Non-Nursing Staff	Total Contracted FTE Labor[1]	Total Outsourced Labor[2]	Total Contracted and Outsourced Labor Expenses
Total N	121	121	132	56	110
Mean	131	224	326	280	$49,490,920
Minimum	2	2	7	6	$56,944
25th	45	39	95	62	$16,519,071
Median	79	91	190	161	$35,649,950
75th	153	294	412	306	$64,815,420
Maximum	1,035	1,848	1,896	3,146	$259,906,926

[1]Contracted labor is defined as individuals contracted to work in a department.
[2]Outsourced labor is defined as an entire department or area that is contracted.
Note: Summary statistics (reported on the final page of this table) do not incorporate zero or null values.

TABLE 51 CONTRACTED AND OUTSOURCED STAFF

Survey Year 2022
Hospital Fiscal Years Ending January 1, 2022 to December 31, 2022

	Total Contracted FTE Nursing Staff	Total Contracted FTE Non-Nursing Staff	Total Contracted FTE Labor[1]	Total Outsourced Labor[2]	Total Contracted and Outsourced Labor Expenses
UVM MEDICAL CENTER	348	7	355	-	$125,506,236

[1]Contracted labor is defined as individuals contracted to work in a department.
[2]Outsourced labor is defined as an entire department or area that is contracted.
Note: Summary statistics (reported on the final page of this table) do not incorporate zero or null values.

TABLE 51 CONTRACTED AND OUTSOURCED STAFF

Survey Year 2022
Hospital Fiscal Years Ending January 1, 2022 to December 31, 2022

	Total Contracted FTE Nursing Staff	Total Contracted FTE Non-Nursing Staff	Total Contracted FTE Labor[1]	Total Outsourced Labor[2]	Total Contracted and Outsourced Labor Expenses
Total N	126	124	133	53	103
Mean	217	264	451	298	$84,790,561
Minimum	10	3	20	1	$3,355,328
25th	92	44	159	86	$38,504,616
Median	160	126	301	173	$67,301,205
75th	306	324	532	396	$112,654,600
Maximum	1,758	2,619	3,316	3,223	$378,430,153

[1]Contracted labor is defined as individuals contracted to work in a department.
[2]Outsourced labor is defined as an entire department or area that is contracted.
Note: Summary statistics (reported on the final page of this table) do not incorporate zero or null values.

b. UVMHN issued a press release on Aug 7th stating that UVMMC is in the lowest-cost 25 percent of academic medical centers nationwide. Please provide the specific source for this for this statement and help us understand how the evidence relates to other cost estimates and benchmarks you use in your budget materials.

As Member Holmes inquired about the comment in the release, it became clear the external relations team was using an older chart from the COTH survey for the data reference. The line in the digital version of the release has been deleted and will be updated to reflect current data. The COTH survey shows that UVMMC is below the median on cost per adjusted discharge and cost per adjusted patient day, as does the other benchmark comparisons we included as evidence of our efficiency: NASHP cost per adjusted discharge, Syntellis admin cost as percent of total cost, home office cost report adjusted NASHP admin salary to clinical salary ratio, and Gallagher senior leader costs as a percent of net revenue and total payroll.

c. Please provide a more detailed crosswalk between the UVMHN admin expense categories and the Syntellis categories in your narrative on page 15.

Please refer to the chart in UVMMC budget narrative on page 15 and the 8/28/24 budget presentation slide 43.

d. Please explain the areas of largest growth and largest decline between FY24 and FY25 on the "staff FTE" worksheet with particular attention given to the growth in clinical and non-clinical staffing in Medical Group Administration.

	FY2024	FY2025	Change	Change %	Comments
Clinical FTEs					
Cardiac Catheterization	71	77	6	8.0%	Mostly clinical related to volume increases
Rehabilitative Services	99	106	7	7.4%	Mostly clinical related to volume increases
Central Services & Supplies	54	62	8	15.2%	Mostly clinical related to volume increases
Medical Care Evaluation	38	50	13	34.4%	Primarily driven by UM in PHSO. Please refer to response for question 11B for PHSO.
Pharmacy	125	147	22	18.0%	Mostly clinical primarily related to expansion of outpatient retail pharmacy efforts.
Medical Group Administration	88	122	33	37.6%	13 transfers and 16 relate to PHSO Care Management. Please refer to response for question 11B for PHSO.
Non Clinical FTEs					
Medical Group Administration	131	160	29	21.9%	10 transfers, 8 Provider Recruitment & Onboarding, 6 clinical operations admin, 1 DEI position, 4 clinical operations training & education positions

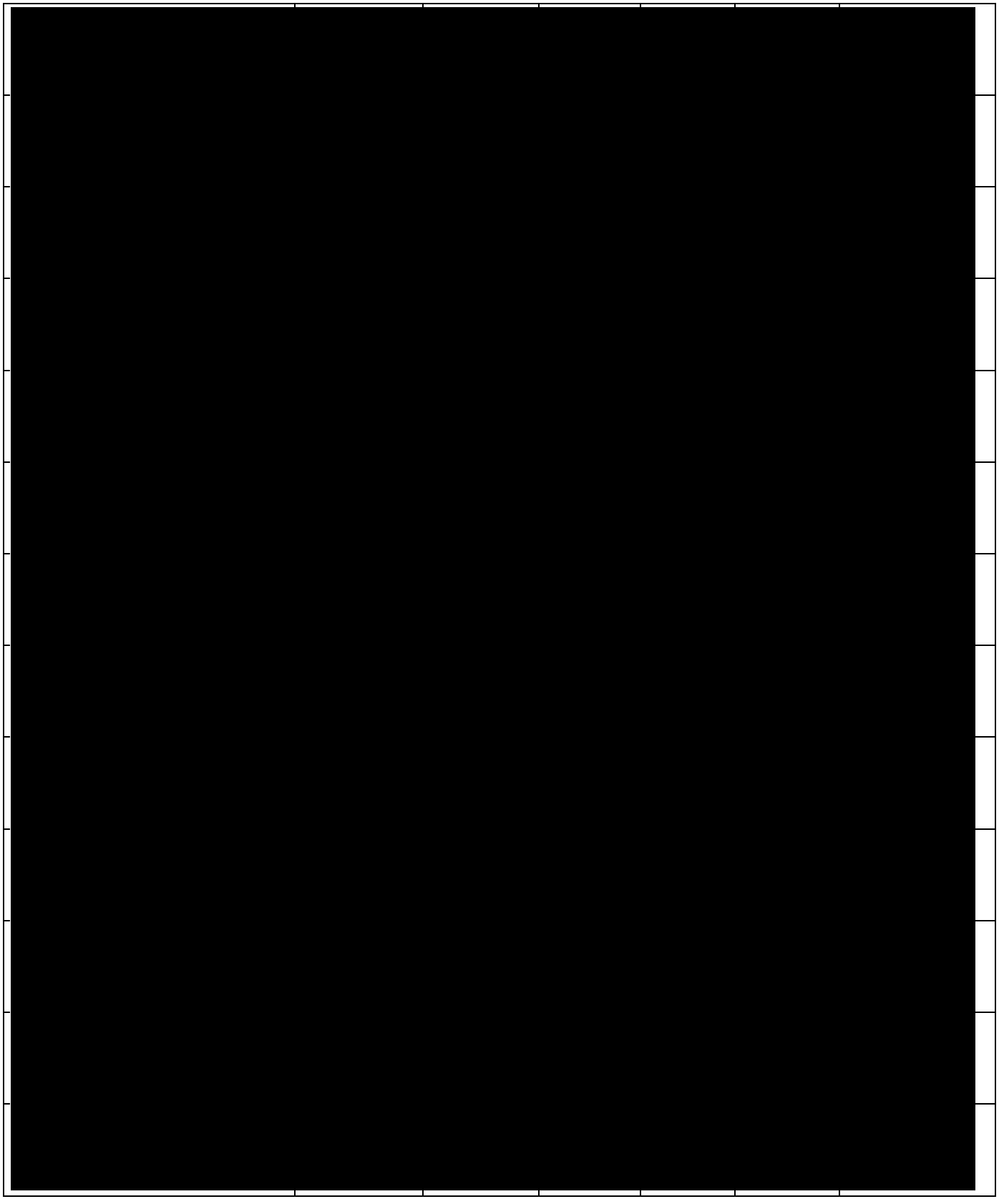
e. Quantify the portion of NPR due to utilization, if any, that is coming from expected increases in clinical productivity for primary care and specialty care separately; what are the targeted performance expectations (in percentiles) by specialty, assumed in the FY25 budget?

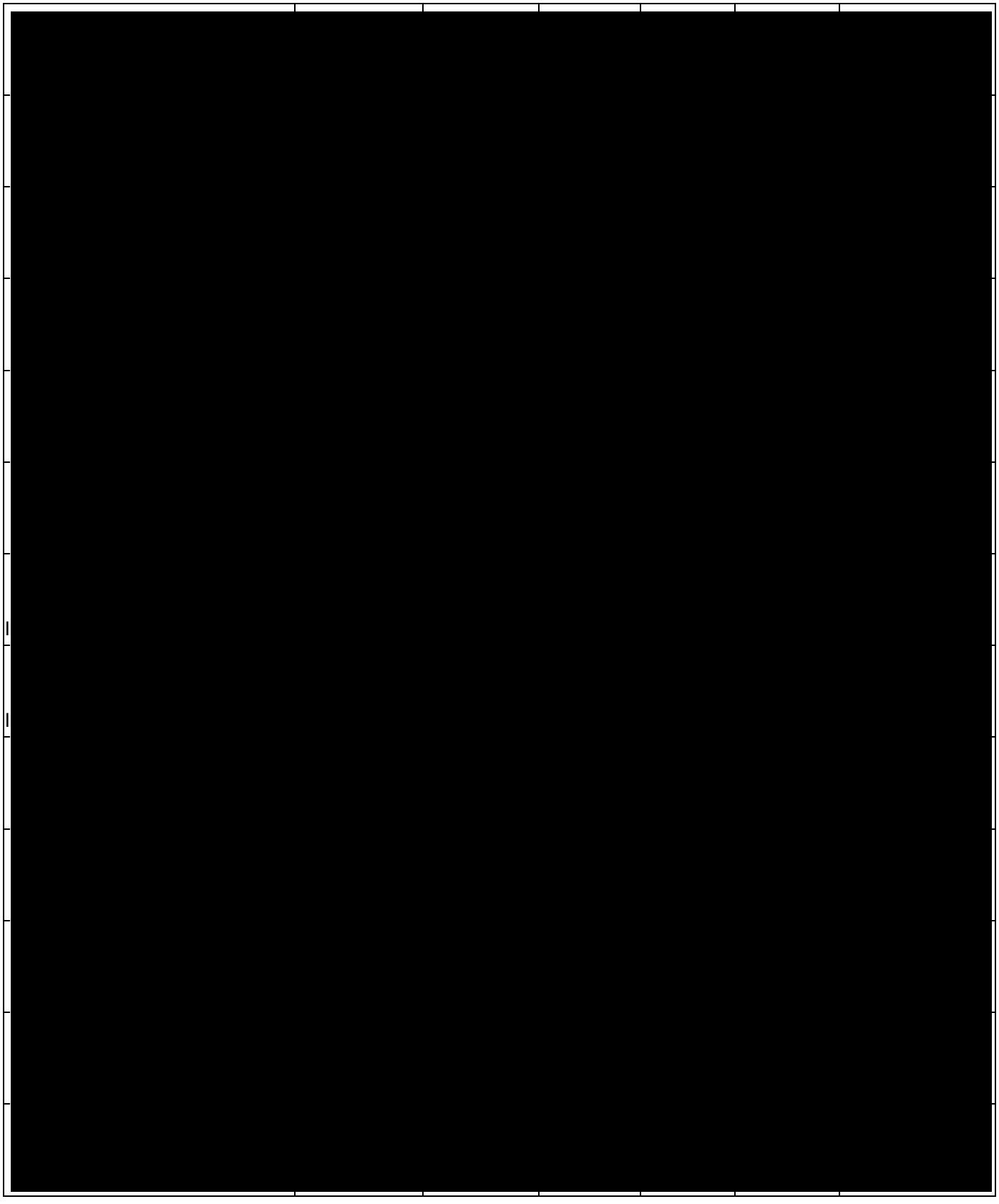
As discussed at the GMCB budget hearing, we budget productivity at what we think is possible. In some cases, this is a result of current restraints. For example, in some subspecialty areas, where patient volumes are low in our region, we may need to hire more than one physician to ensure call coverage.

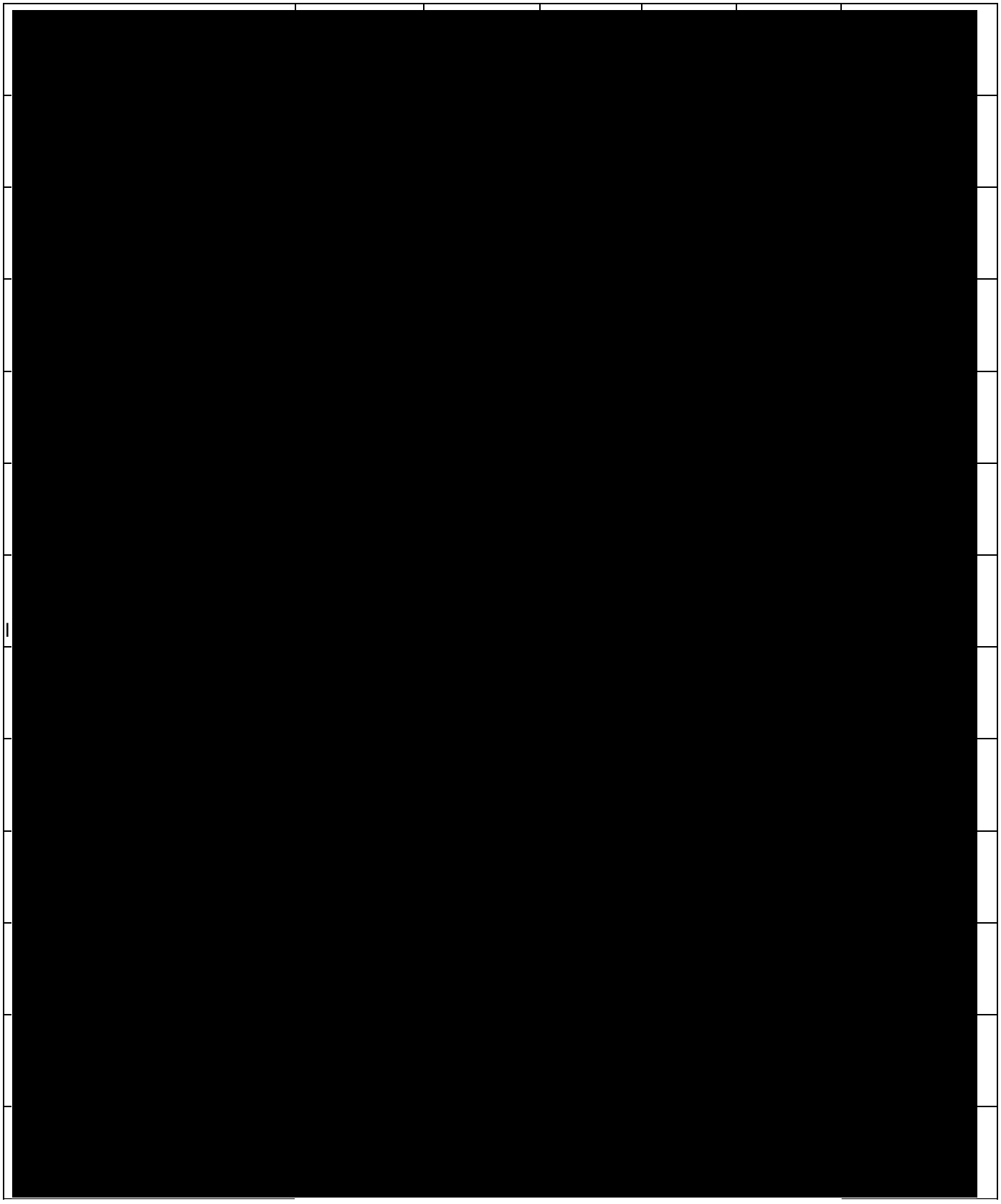
Professional NPSR	FY24 July YTD Annualized	FY25 Budget	Difference
Primary Care	25,704,976	30,337,208	4,632,232
			64% Rate
			36% Utilization (Volumes)
Specialty Care (includes hospital-based)	277,746,737	336,857,640	59,110,903
			79% Rate
			21% Utilization (Volumes)

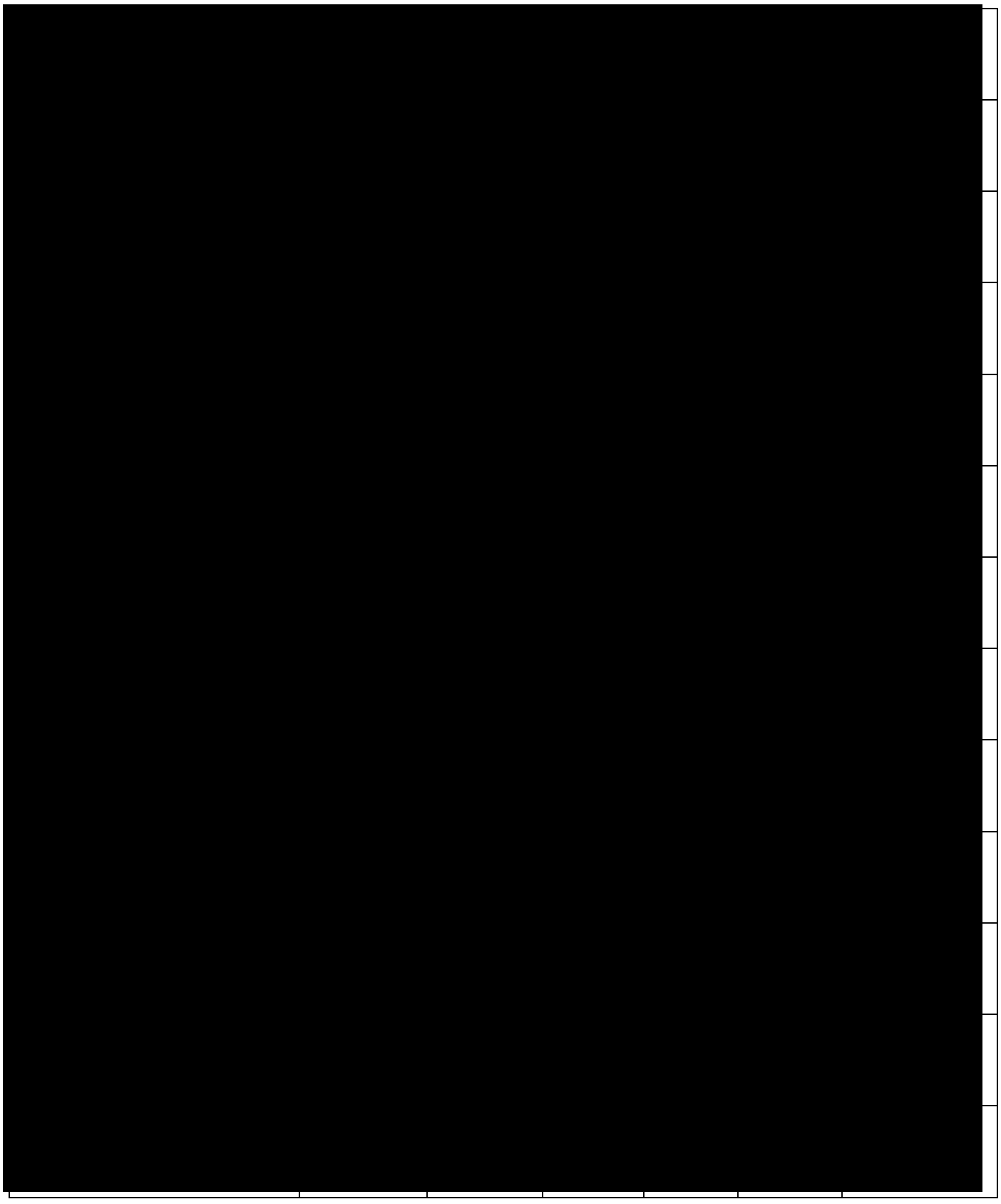
Clinical Productivity

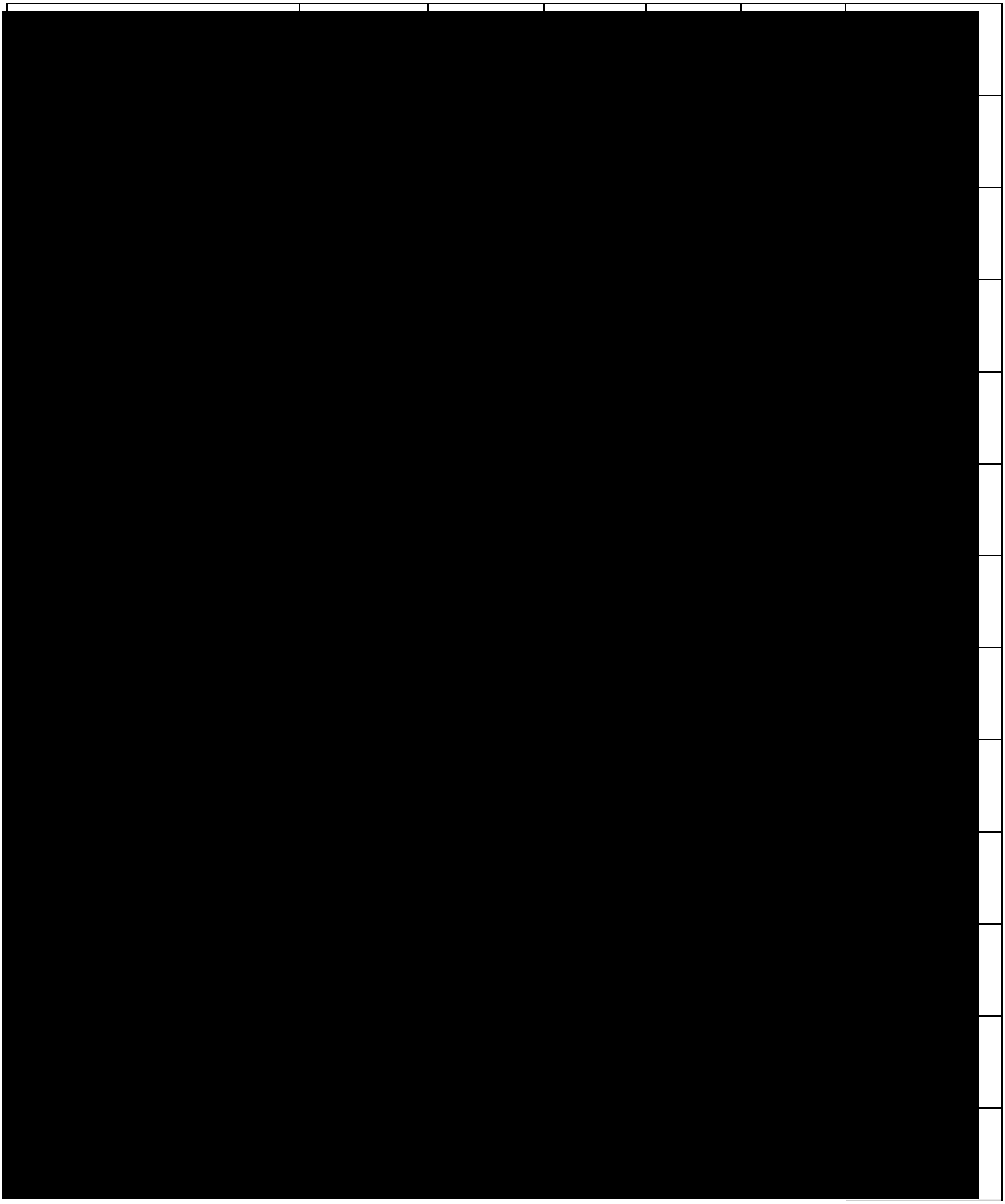
Question 15.e. What are the targeted performance expectations (in percentiles) by specialty, assumed in the FY25 budget?

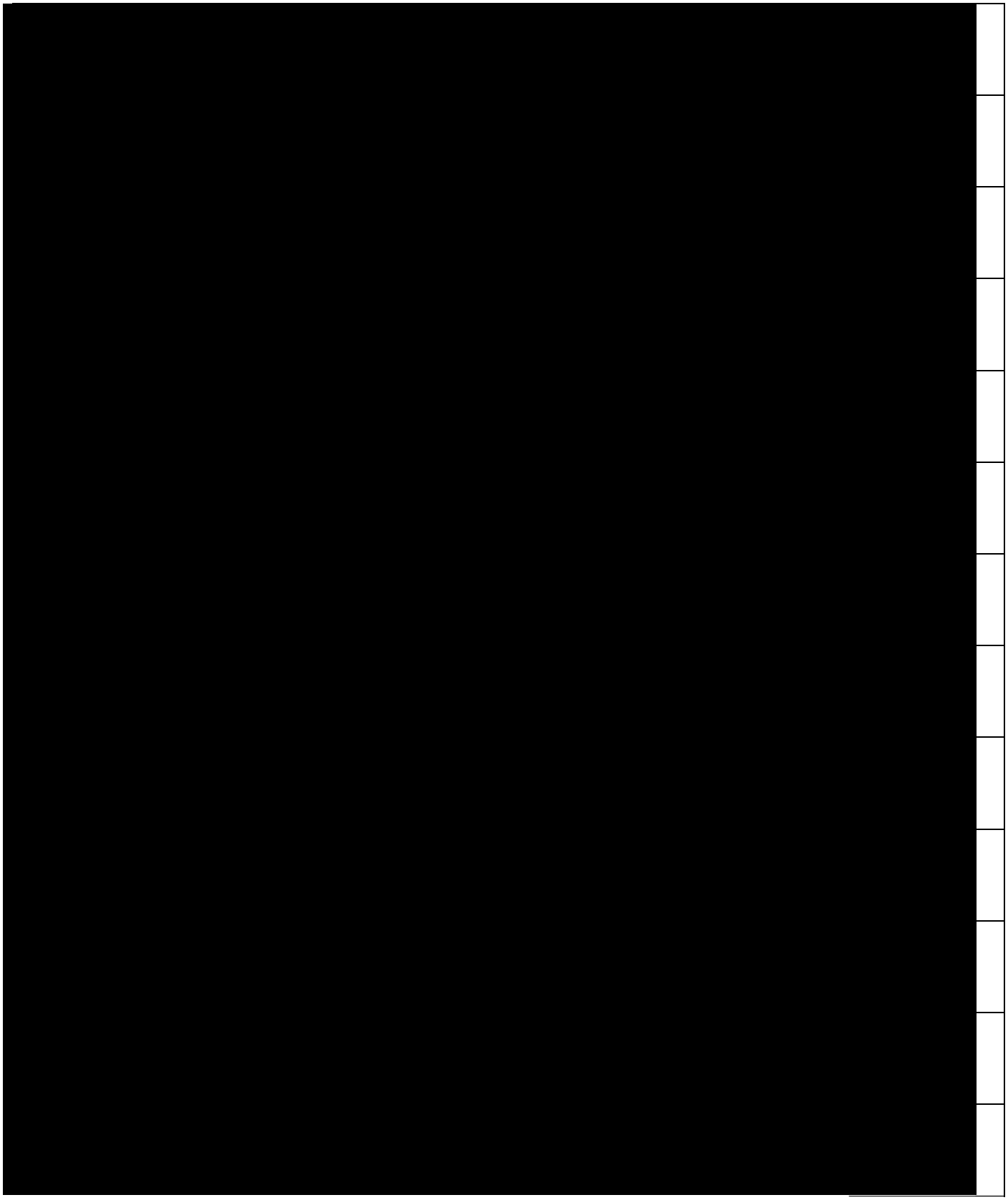


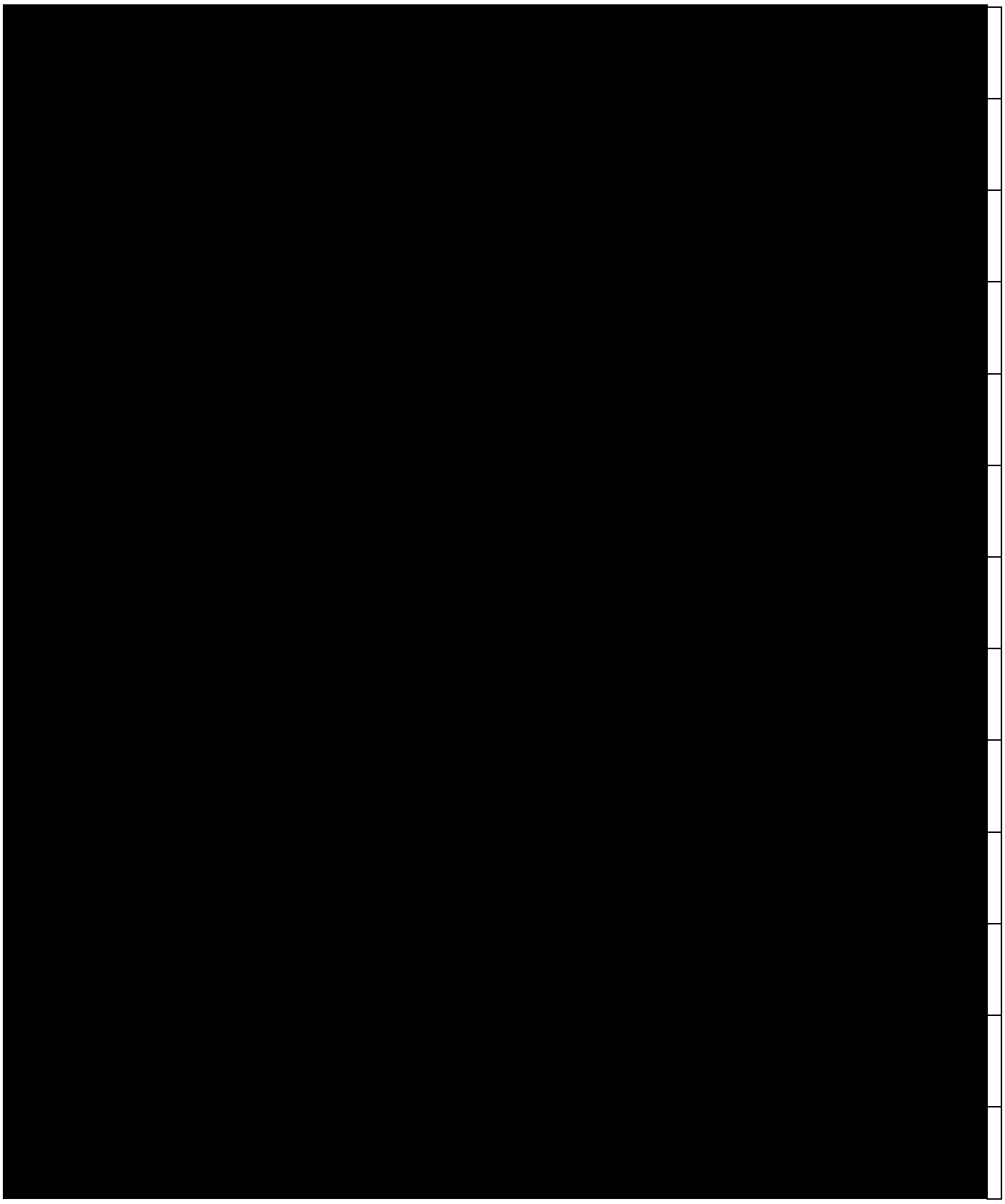


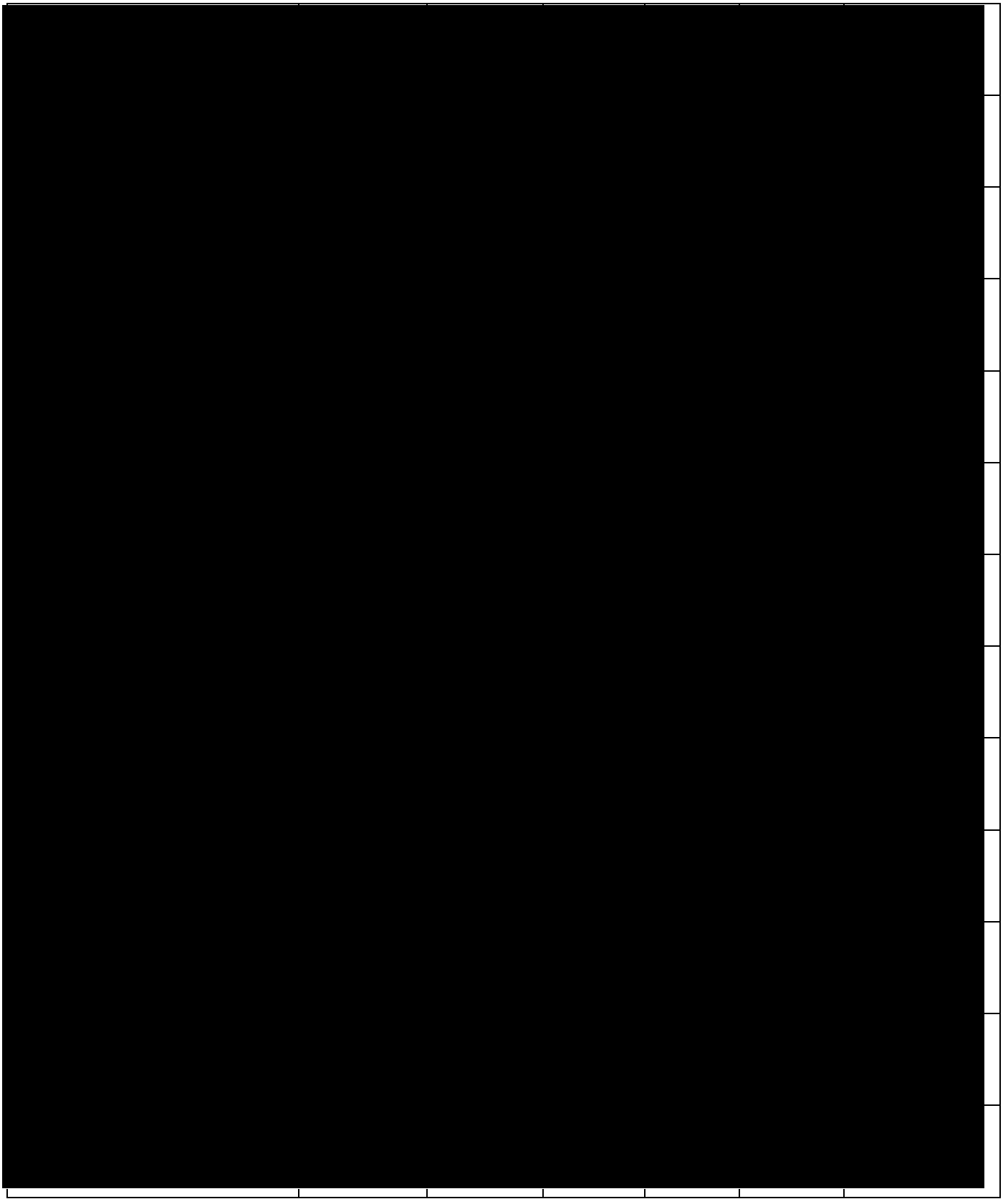


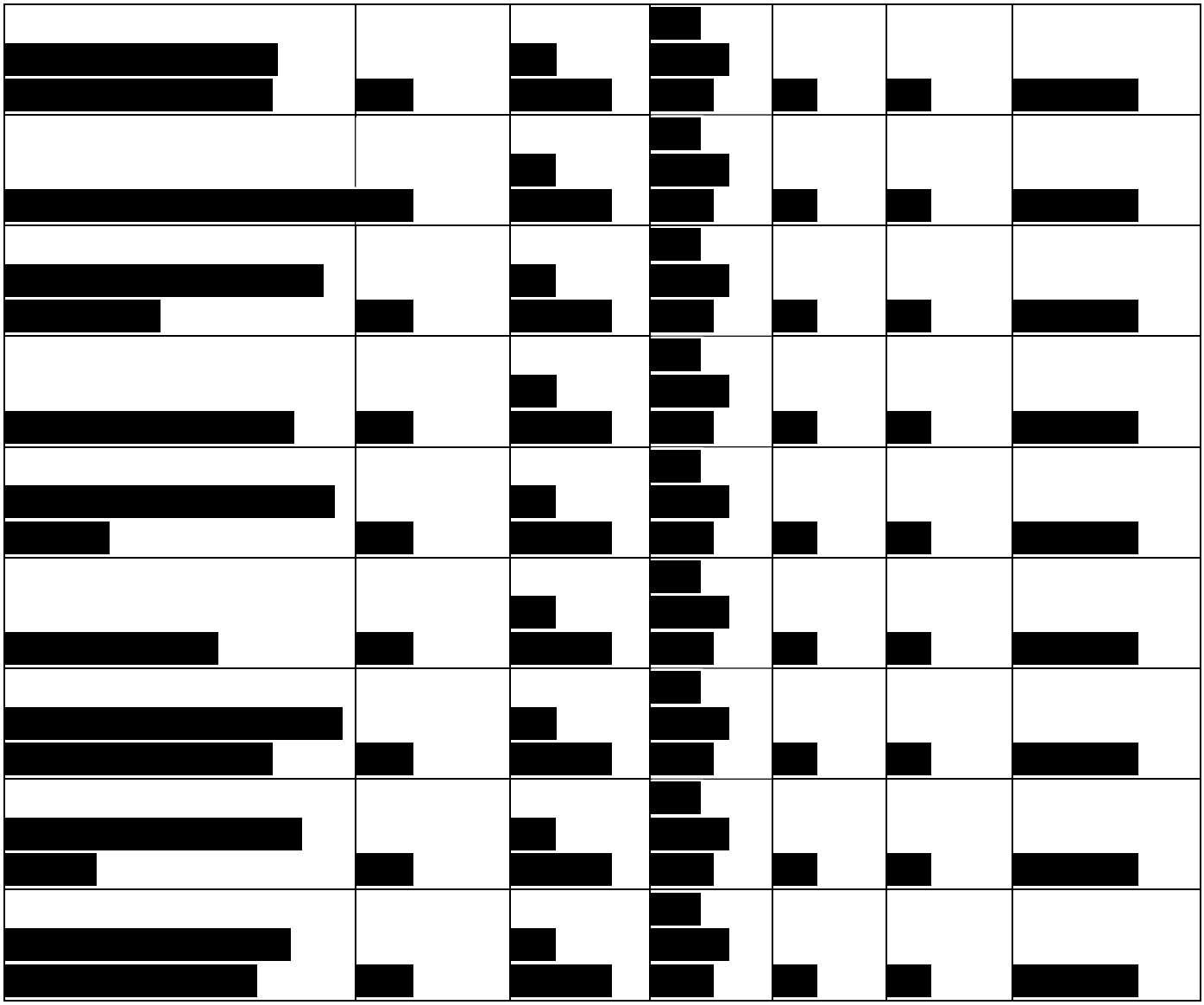












16. Medicare & Medicaid Cost Coverage

a. Please reconcile your internal Medicare cost coverage estimates with the NASHP cost tool estimates, noting differences between what was submitted in the OSC submission. Please explain your internal calculation, outlining the methodology in a way that it can be replicated. How do you expect these estimates to change in FY25?

	A	B	C	D	E=B-C-D	F	H	I=E-F-H	J = E / (F+H)
			Allocations			Cost of Services			
FY 2023 Actual (in $millions)	Gross Patient Service Revenue (GPSR)	Net Patient Service Revenue (NPSR)	Denials/Other Admin (% of GPSR)	Bad Debt / Charity (VT_Caid-0, Sellpay - 60%, Remainder % GPSR)	Net Revenue After Allocations	RCC 42.66% ((TotExp-Provider Tax-OtherRev) /GPSR)	Provider Tax	Net Income / (Loss)	Cost Coverage %
Medicare	$ 1,995.7	$ 526.6	$ (20.2)	$ (8.2)	$ 498.2	$ 741.5	$ 25.35	$ (268.6)	65.0%
Medicaid_VT	$ 583.1	$ 182.3	$ (5.9)	$ -	$ 176.4	$ 216.7	$ 8.78	$ (49.0)	78.3%
Medicaid_NY & Other	$ 112.8	$ 33.3	$ (1.1)	$ -	$ 32.1	$ 41.9	$ 1.60	$ (11.4)	73.8%
Major Commercial	$ 876.1	$ 665.4	$ (8.9)	$ (3.6)	$ 652.9	$ 325.5	$ 32.03	$ 295.4	182.6%
All Other	$ 703.4	$ 411.0	$ (7.1)	$ (24.5)	$ 379.3	$ 261.4	$ 19.8	$ 98.2	134.9%
Denials/ Other Admin		$ (43.2)	$ 43.2	$ -	$ -				
Bad Debt Deductions		$ (18.1)	$ -	$ 18.1	$ -				
Charity		$ (18.2)	$ -	$ 18.2	$ -				
Total	$ 4,271.0	$ 1,739.0	$ -	$ -	$ 1,739.0	$ 1,586.9	$ 87.5	$ 64.6	103.9%

The table above is our internal cost coverage file.

While we did not perform a detail review comparing the NASHP cost estimate tool and our internal calculation, they are two different approaches which is why there could be variations in the cost coverage percentages. The NASHP tool relies solely on Medicare Care Cost Report and other payer available data sets to gather the information for their calculations which excludes certain costs based on Medicare cost report regulations and may not reconcile to the P&L performance for the respective year. Our internal calculation is based on the actual P&L performance for the respective year.

When responding to the OSC question the information came from our cost accounting and decision support system which allocates the provided tax and Medicaid supplement payments differently. When the cost accounting system was setup many years ago the provider tax was not booked as an expense on the P&L as it is now, it was recorded as a reduction to revenue which is how the cost accounting system was setup. Medicaid supplemental payments are allocated in the cost accounting system as an expense reduction which gets allocated across all payers not just Medicaid. In the cost coverage table above, any Medicaid supplemental payments are allocated only to Vermont Medicaid.

The calculation has not been prepared for FY25 at this time.

b. What costs are included in your internal cost coverage calculation versus what is included in other publicly available calculations?

It is difficult to speak to what is publicly available at a broad level given the variability in formulas. We would need to have a specific identified cost calculation to compare data and calculation definitions.

For our internal calculation, all expenses which are reflected in the P&L for the respective year are included as costs.

c. Please show and explain quantitatively how you consider additional Medicaid payments when calculating Medicaid cost coverage?

Any additional Medicaid payments are assigned to Medicaid as a revenue source.

d. Please explain how your cost coverage calculations relate to your payer revenue sheet. You've reported a significant difference between the cost coverage of Medicare vs. Medicaid. However, you've also stated that Medicare and Medicaid receive a similar discount from gross charges (about 74% reduction from gross charges). How do you reconcile these two statements?

Total revenue in our cost coverage calculation reconciles to the payer revenue sheet. Any difference at the payer level is most likely related to the allocation methodology related to column C & D in the table included in 16a.

We would need to see the data related to the reference of reduction from charges to respond with more specifics. From a general perspective they should reconcile if they both should tie to the P&L for the respective year. Any differences are most likely related to differences in allocations at the payer level but in total they should reconcile.

17. Could you provide more clarification why you expect such a significant Medicare shortfall? The expectation seems out of proportion to your cost coverage calculations.

We do not understand the basis or the reference for this question or statement. We believe, based on the table provided in the response for question 16, the Medicare shortfall is in line with the cost coverage.

18. Pricing

a. What evidence supports your assertion that you are a low-cost commercial provider?

We have demonstrated using GMCB's own research that we are a low-cost provider of inpatient services. Also, the Cooper study, while dated and included limited payers, tells the correct story that within our hospital service areas the cost to commercial payers is among the lowest. The payers referenced did not include the larger payers in Vermont but based on historical reimbursement the payers included in the study reimbursed higher than our larger in state payers. Thus, the study would show them even lower, and such continues to be the case today.

There are areas where we are reimbursed at a higher rate as compared to hospitals in our region, particularly in outpatient services. We have discussed several factors that influence the cost of services, some of which we can address and some that are systematic issues. For example, having a small population to spread costs across results in higher cost per service. Additionally, providing services that lose margin, such as dialysis, that no other provider provides requires subsidization from other services. Reimbursement factors we can impact include a review of long-standing reimbursement arrangements with payers collaborating on right sizing terms, such as in radiology and lab.

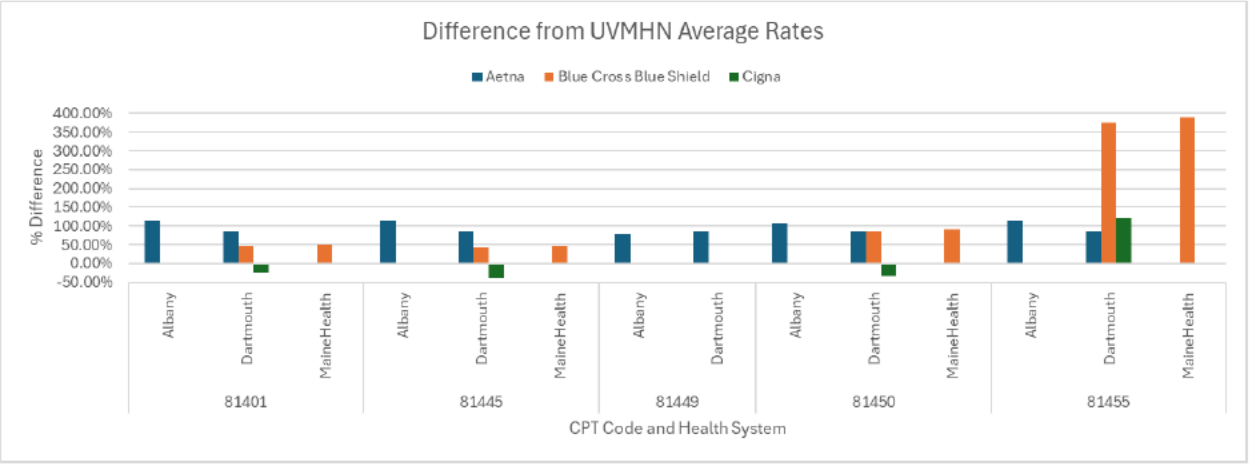
In totality, the term low-cost takes into consideration the cost of services provided to patients and the cost to the patient or value to the patient to be able to access those services locally rather than leave the state impacting their home and work lives. UVMMC is committed to balancing the cost to provide services in our rural region with the impact patients and employers experience when purchasing health care services.

b. Please submit the Clarify report used by UVM to compare its negotiated outpatient prices to national, regional, and VT hospitals.

The University of Vermont Health Network (UVMHN) has recently adopted the Clarify Health price transparency platform. This tool is designed to access the immense amount of price transparency data released by hospitals and payers allowing for a comprehensive analysis of hospital reimbursements across various regions and benchmark hospitals. Unlike a static report, Clarify Health offers a dynamic, interactive database that enables detailed, code-level comparisons of reimbursement rates from different payers to hospitals.

The data compiled by Clarify Health is sourced from transparency reports mandated by law, submitted by both payers and hospitals. However, it is crucial to recognize that this data's completeness and accuracy depend on the quality of the submissions. For instance, there was an occasion where a payer inadvertently omitted reporting prices for our hospital and neighboring institutions due to a submission error. While there is a trend towards improved reporting standards, the inherent limitations of the data provided must be considered.

Below, we have included a sample analysis our analyst put together from a massive data output from the Clarify Health tool to illustrate its capabilities and the type of information it can yield.



c. what are the types of services being considered for adjustment down for affordability? And are you increasing other areas to account for adjustment down in others?

Our data-driven approach has identified radiology and select high-volume outpatient services as initial targets for price and reimbursement modifications. Our long-term strategy includes a perpetual review of our reimbursement framework, incorporating market analysis and patient cost considerations, to further refine our service pricing. Collaboratively, we are negotiating with payers to offset reductions in certain service reimbursements with increases in others, particularly where our rates are below industry benchmarks and peer institutions. This balanced approach has been previously implemented with success, aligning overall reimbursement terms with those ordered by the GMCB. As we proceed with these adjustments, it is imperative to evaluate their implications on future value-based budgeting models. These models, utilized by both government and commercial payers, must account for patient out-of-pocket expenses while ensuring the establishment of an adequately funded budget.

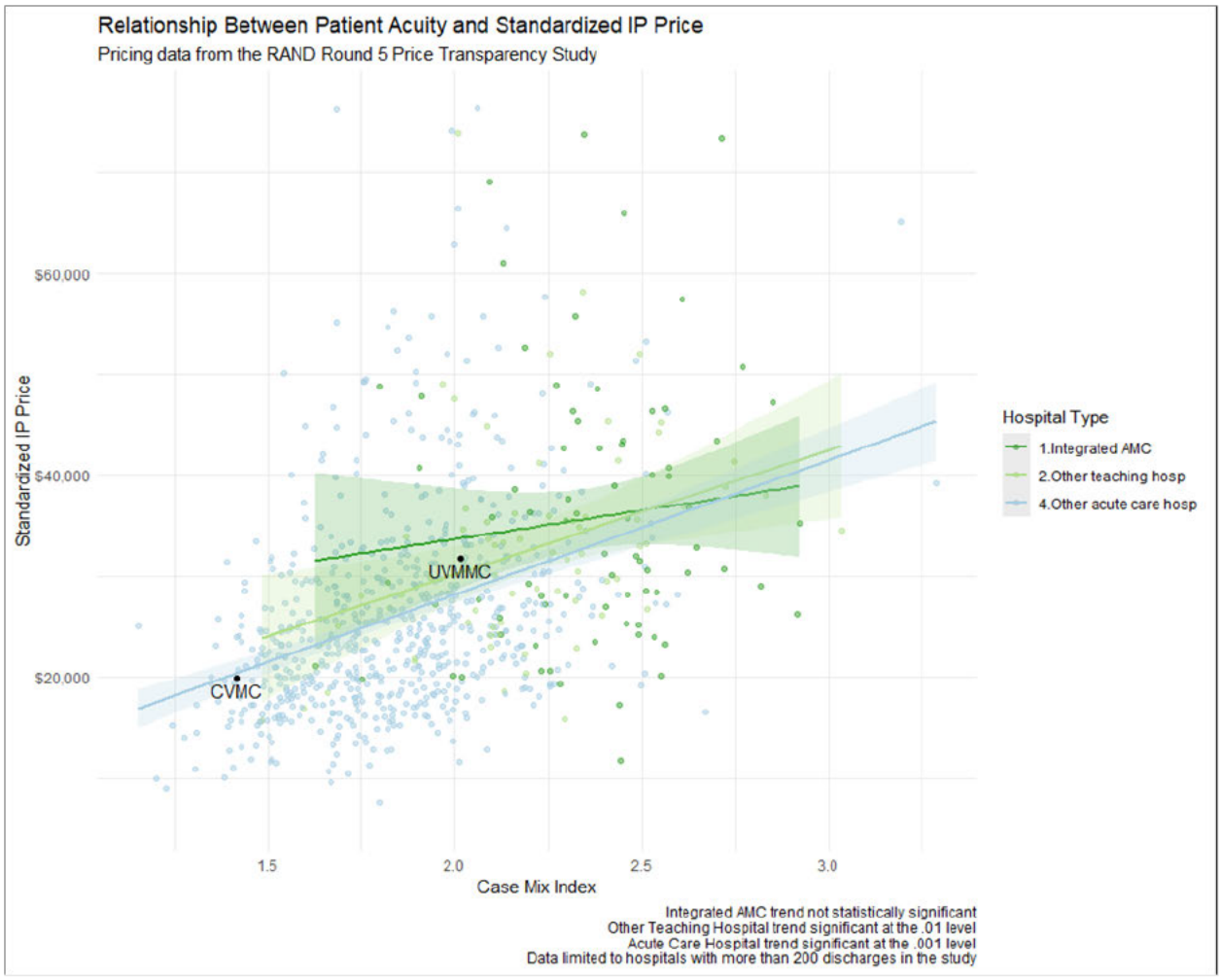
d. How are you factoring in available comparative price data (and high relative outpatient prices) to future pricing?

In formulating our future pricing strategies, we are incorporating available comparative price data, with a particular focus on high relative outpatient prices. This data is informative when establishing fair pricing and payer reimbursement terms that reflect market dynamics. With recent access to more comprehensive pricing information, we are integrating market analysis to ensure our pricing structure is balanced with our budgeted needs. As the data and affordability conversations continue, we can also consider areas where patients may face higher out-of-pocket expenses. Moreover, our reimbursement rates are influenced by payer mandates, alongside a careful evaluation of how these rates affect Medicare and Medicaid reimbursements. This multifaceted approach ensures that our pricing is not only data-driven but also aligned with industry standards and patient affordability.

e. Please provide evidence that the Rand standardized pricing tool is significantly impacted by a hospital's service mix or site of care mix.

<u>Inpatient Care</u>

For inpatient care, we have access to Medicare CMI data that we can use to estimate the acuity of patients treated at a given hospital. Based on this, we see a clear relationship between patient acuity and standardized reimbursements. This implies that the acuities being used in the RAND analysis are failing to capture all of the effect of acuity on payments.



It is possible that this pattern is partly explained if hospitals serving higher acuity patients have greater bargaining power, but this pattern appears more strongly in the general acute care hospitals than in the AMCs (where the result is not statistically significant) where we would expect more expansive capabilities to translate into greater bargaining power more strongly. Bargaining power also cannot explain the discrepancies that we see in the RAND report when we look at outpatient care.

Outpatient Care

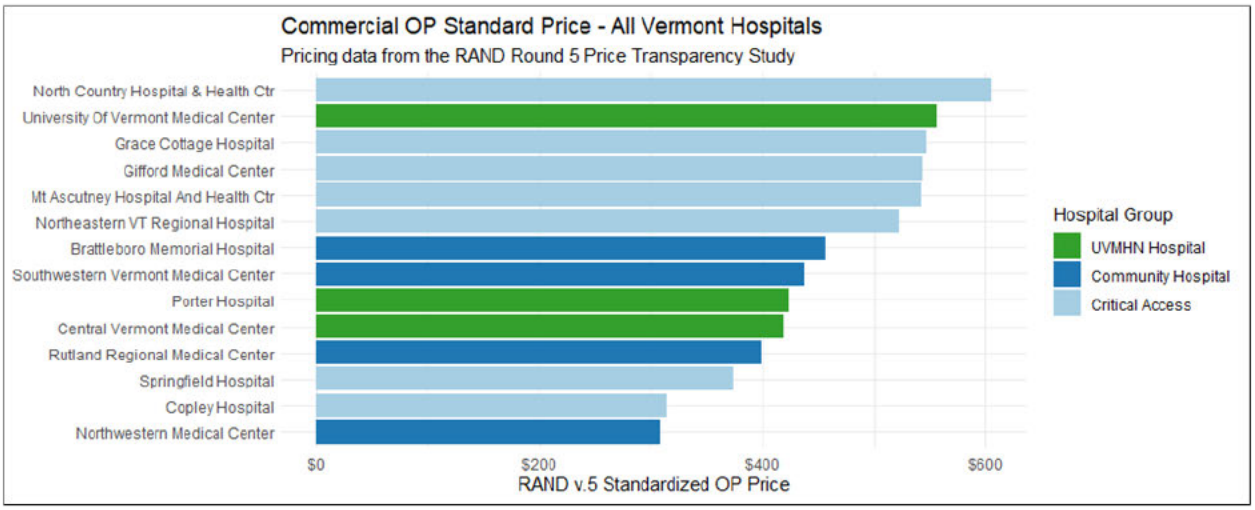
To show that case mix is impacting the data in the RAND outpatient data, we use a "proof by contradiction" – a form of argument commonly used in pure mathematics in which one lays out an assumption and then shows that that assumption will produce an impossible result as a means of disproving it. We show the following:

1. Using Critical Access Hospital data, we can calculate Commercial margin from the RAND study, Medicare margin from the Medicare payment methodology for CAHs, and the Medicaid margin from the Medicare cost reports to calculate the hospitals' total operating margins assuming that the RAND study's prices are correct.
2. We show that this produces a nonsensical result based on what we know about the actual financial performance of these hospitals (estimating profit margins of 33-59% in hospitals which are not breaking even).
3. We account for the other potential sources of variance in the data going into the RAND price transparency study.

Because the RAND study produces results which are clearly untrue and the fact that we can account for the variables other than service mix, service mix must be skewing reported hospital prices in Vermont.

Use of Critical Access Hospital Data to Estimate Margins

UVMMC's reported outpatient prices are grouped with a set of 5 critical access hospitals, 4 of which produce comprehensive price data for the RAND analysis[1]. They range from an OP Standardized price 6% lower to 9% higher than UVMMC's, and three are within 3% of UVMMC.



We can use the critical access hospitals to dig further into the commercial pricing for two reasons:

1. Medicare pays critical access hospitals 101% of the hospital's cost to treat them. Because of this, when RAND expresses commercial prices as a percent of what Medicare would have paid, we can use the Medicare payment formula to calculate how much of the hospital's cost to treat them is covered by the commercial payment.
2. The payer mix and distribution of costs attributed to those payers are both attributed based on charges. Cost coverage for Medicaid and Medicare are both calculated using a cost to charge ratio applied to the charges for those payers, so we can be confident that when we apply a commercial cost coverage ratio to the commercially insured patients, the costs associated with them are being calculated in the same way as the costs for the government payers.

We calculate Commercial insurance cost coverage as follows:

Medicare Price = 101% * Cost of delivering care
Commercial relative price = Price as % of Medicare (reported by RAND)
Commercial cost coverage = Price as % of Medicare * 101% * Cost of delivering care

We calculate the Medicaid cost coverage from the Medicare cost reports (schedule S-10) as follows:

Medicaid cost coverage = (Medicaid Net Patient Revenue + DSH payments) / Cost of delivering care.

Finally, we take the payer mix reported by the NASHP study, and calculate the total cost coverage, and consequently the operating margin, assuming that the input components are correct. All components of this calculation as well as the result are shown in the table below:

Hospital	Commercial Cost Coverage	Medicare Cost Coverage	Medicaid Cost Coverage	Commercial Payer Mix	Medicare Payer Mix	Medicaid Payer Mix	Charity Care, Bad Debt, and Uninsured	Calculated Margin with RAND Prices	Margin in Audited Financials
North Country	268%	101%	79%	38%	38%	22%	2%	59%	-9%
Grace Cottage	207%	101%	40%	50%	36%	12%	2%	44%	-6%
Gifford	194%	101%	19%	39%	41%	18%	2%	20%	-4%
Mt. Ascutney	207%	101%	81%	38%	44%	15%	3%	36%	2%
NVRH	189%	101%	94%	41%	35%	21%	2%	33%	0%

Gifford's Medicaid Cost Coverage number conflicts with the audited financials for FY22. Medicare Cost Reports show 2.5% of NPR from Medicaid, notes to financial statements state approximately 12% of NPR is Medicaid. Calculated Margin increases to 33% with Medicaid at 12% of NPR

Cost Coverage for Charity Care, Bad Debt, and Uninsured is 0%

Margin in Audited Financials taken from financial statements posted on the GMCB FY2022 Actuals Data site. (Statement of operations, Operating Income / Total Expenses), except Grace Cottage which was taken from the FY Actuals page, FY2023 Financial Audit (FY2022 Comparison)

The prices reported by RAND at these hospitals show significant disparities between the calculated margins for these hospitals and the margins reported to the GMCB through the hospital budget process. They range from 32% to 68% (One hospital appears to have an anomaly in its Medicaid data[2]), with the most profitable hospital by this analysis also showing the highest RAND standardized OP price and the highest relative price of the critical access hospitals. Even if these hospitals were not paid *anything* by Medicaid (while still incurring the costs), the prices reported in the RAND study imply that they would still all have margins of greater than 10%.

This matches what we see from the NASHP data, which calculated the commercial break-even price as a percent of Medicaid. NASHP shows break-even prices in the 105-138% percent of Medicare range, so we would expect to see actual commercial prices in that range given that these hospitals are operating at close to break-even or below.

We can see the scale of this problem by comparing the calculated Commercial operating profits provided in the NASHP data to the profits reported by RAND. RAND reports commercial prices that are 44% to 142% higher than NASHP shows (excluding a likely reporting error at one hospital).

Hospital	NASHP Commercial Price % of Medicare	NASHP Commercial Break-Even Price as % of Medicare	RAND Price as % of Medicare	RAND Price higher than NASHP price by
North Country	110%	105%	265%	142%
Grace Cottage	112%	116%	205%	83%
Gifford	147%	138%	192%	31%
Mt. Ascutney	142%	127%	205%	44%
NVRH	121%	114%	187%	54%

NASHP Commercial Price is calculated as the NASHP Commercial Margin + 100% divided by 101%. This converts the NASHP margin to a cost coverage ratio, and then dividing by 101% converts that to a percent of Medicare spending.

The likely error in Gifford's Medicaid reimbursement impacts the NASHP Commercial spending number as well. Because NASHP does not have a direct source for Commercial insurance costs and revenues, they instead work from the totals and subtract government payers. This means that when revenue from a government payer is under-reported, revenue (but not cost) for commercial payers will be overstated by an equivalent amount.

This is why we conclude that the reported prices for the Vermont hospitals surrounding UVMMC are incorrect. We find it to be implausible that UVMMC's pricing data is correct while the prices of all the other Vermont hospitals in the same price range are not.

Conclusion that this is due to service mix

We conclude that this discrepancy must be due to service mix because we know that Vermont has a different pattern of care delivery than much of the rest of the country which has the potential to produce different results, and because we can rule the other potential factors out.

The RAND analysis calculates standardized prices by taking the actual prices paid for services and dividing by the weights assigned to those services (CMI for inpatient, APC weights for outpatient). No weighting system is perfect, and if the errors occur in high-volume, low-acuity services, the errors that they produce can be significant. We could also see significant swings if a hospital or a region has higher than average prices in very low acuity services. Considering the factors included in the study, we can say the following:

- **Commercial Prices** are based on real data, and because Vermont provided VHCURES data for recent versions of the study, they are based on a lot of data (UVMMC has the 6th highest number of total outpatient services of all hospitals included in the study).
- **Medicare Prices** can be cleanly calculated based on Medicare's payment rules. This is particularly true for Critical Access Hospitals, which are paid based on a cost to charge ratio, and the commercial claims include charges.
- **Acuity Weights** are based on a standard formula used for all hospitals in the study.

Because the Medicare pricing algorithm and the acuity weights drive the simulated Medicare prices, and the commercial prices are taken directly from claims, the only remaining factor is the mix of the actual claims that were included.

Potential reasons for differences in service mix

Without access to the underlying data used in the RAND study, we cannot pinpoint the exact source of the disparities that we are seeing here, and given that we have definitively shown that the standardized prices reported in this study do not match reality in our state and that we can rule out other factors we do not believe that we need to.

We provide the following possibilities to make the results that we see here more understandable. The United States is a predominantly urban and suburban country, by population. Because of this, studies such as this one primarily examine data from suburban and urban areas.

In more populated parts of the country, much of the low-acuity care that is provided by hospitals in Vermont is offered in non-hospital settings instead. We see this for ambulatory surgery and screenings such as colonoscopies, and particularly for basic imaging and lab work. This is the case both for patients who primarily use a critical access hospital for these kinds of services and for patients in Burlington for whom UVMMC is their community hospital.

We know that no weighting system is perfect. Studies such as this one carry an often-unstated assumption that the errors in the weights are distributed evenly across subjects, so that the subjects can still be fairly compared. These differences in service mix have the ability to impact reported pricing when they distribute errors in the service weights in problematic ways. This is the distribution of services that we are talking about when we point to service mix as a cause for the differences that we see in Vermont.

Small errors in weighting can be magnified when they occur in low-acuity services. A weight decrease from 20 to 19.5 is only a change of 2.5%, while a decrease from 1 to 0.5 is a 50% decrease. Because hospitals in most parts of the country are not doing a lot of low acuity care, this is likely an area that has not garnered significant focus.

Given that we know that the kinds of errors that we are looking for occur across the state, and that the use patterns for low-acuity care are the same across the state (neither Newport nor Burlington have robust independent imaging or lab options), we believe that this is the most likely source of this discrepancy.

[1] Grace Cottage does not show Inpatient relative or standardized prices and the downloadable data file omits the total relative price, but the interactive price transparency tool which RAND links to does provide a total of 205% of Medicare. This number is credible in light of the reported relative price of 215% of Medicare for Grace Cottage's outpatient services which is provided in the RAND downloadable data.
[2] Gifford shows that Medicaid only pays it 19% of what it costs to care for Medicaid patients in its Medicare Cost Report. If this is correct, Gifford's total margin, assuming the RAND price, would be 20%. However, the Medicaid NPR reported in Gifford's cost report would only amount to 2.5% of total NPR, and the notes to Gifford's audited financial statement for 2022 (p. 13) state that Medicaid made up approximately 12% of NPR. If this is correct, it would add an additional 13 percentage points to margin, bringing the total to 33%.

19. What percent of clinical and non-clinical FTEs included in the staff/FTE submission are funded from outside sources (grants etc.)? Provide total dollars by clinical & non-clinical.

Funding is not reported at the FTE level and not tracked based on clinical or non-clinical splits. Funding is managed and tracked by actual funding dollar amounts. For FY23, grants fund approximately $5.3M of salary and fringe expense.

20. In an answer to a recent follow-up question (question #2 in your pre-hearings question list), you suggest that the amount of surgical operations has increased over time. However, your values exclude operations from the Fanny Allen Campus. Once you include these operations, it seems that you performed fewer operations (not more) in 2023 compared to 2019. Is this correct?

The data file currently in use has all surgeries and was used for comparison for all years; however, the file for 2019 did exclude Fanny Allen Campus. Submitter was not aware of this change at time of submission.

21. In your rate decomp sheet, can you provide a more detailed breakdown of the "all other" category under total NPR? Since it accounts for such a large amount of NPR ($203 million), we'd like to better understand its composite parts. We're particularly interested on the amount of revenues it captures from smaller commercial insurers.

The chart below details what makes up this category:

All Other Payer Category	FY24 Budget	FY25 Budget
Employee Self-Insurance Plan	$ 62,684,692	$ 58,362,734
Small & Non-Contracted Commercial	$ 112,039,004	$ 134,517,116
Public Agency	$ 24,370,748	$ 37,165,593
Workers Comp	$ 12,337,186	$ 17,816,143
Sefl-Pay	$ 20,542,124	$ 39,710,431
Other	$ 12,716,635	$ 16,349,731
Payer Denials (prior auth, timely filing, medical necessity, etc)	$ (40,899,614)	$ (39,047,693)
Total All Other Payer Category	**$ 203,790,775**	**$ 264,874,055**

22. Do you ever negotiate with Medicare Advantage plans to pay rates higher than 105% of Medicare?

[redacted]

[redacted]

[redacted]

[redacted]

23. What savings do you project for your consumer affordability program?

Can you please provide more specifics as to what you are referencing as we do not understand the question or what prompted it. At this time, we are not able to answer this question.

24. For which practice areas are appointment schedules only available for three months such that patients need to call back to schedule an appointment if there are no available times in the three-month window?

We were unable to identify any clinics that schedule appointments out for a maximum of three months. However, we do have clinics whereby the providers set their call schedules at six-month increments. If a patient were to call for an appointment after three months of a six-month schedule window has passed, it is possible the schedule for the following six months is not yet built and therefore at that point in time, the schedule would only be available for another six months. Additionally, as providers onboard and/or depart, schedules become available and unavailable. Therefore, it is possible that if a provider is leaving and it is not yet public knowledge, the communication may be around the fact that the schedule is not available for a specific number of months.