Response to the Green Mountain Care Board's FY 2018 Budget Analysis

August 18, 2017

UVM Medical Center Questions

1) INCOME STATEMENT: The NPR is budgeted to increase 3.5%. The total NPR increase is over the combined target of 3.4%. The hospital needs to explain the major pieces of the 3.5% increase. Please also describe how much of this increase is related to new health care reform investments.

The table below categorizes the pieces of the 3.5% NPR or $41 million change from FY 2017 budget to FY 2018 budget. Health reform investments in the FY 2018 budget are $6.4 million. This $6.4 million is part of the FY 2018 total expense budget.

The University of Vermont Medical Center									
2017 Approved	$ 1,172,785,845								
2018 Submitted	$ 1,213,835,692								
B17-B18 Change	$ 41,049,847	3.5%							
	Total		Medicare	Medicaid-VT	Medicaid Out-of-State	Commercial (Vermont Major - BCBS, MVP CIG)	Commercial (Self Pay/Other Smaller Payers)	Workers Comp	
Commercial Rate Request	$ 5,031,193	0.72%	$ -	$ -	$ -	$ 5,031,193	$ -	$ -	
Rate request (non-commercial payers)	$ 4,224,530		$ 3,257,218	$ (135,315)	$ (63,442)	$ -	$ 1,182,191	$ (16,121)	
Utilization	$ 59,669,582		$ 16,540,752	$ 5,048,136	$ 652,958	$ 28,981,406	$ 7,620,148	$ 826,181	
Payer mix shift	$ 9,212,215		$ 5,882,684	$ (10,934,174)	$ (721,080)	$ 9,634,178	$ 4,658,796	$ 691,810	
Rate difference: FY17 Act to Bud experience	$ (26,196,723)		$ (9,164,393)	$ 4,057,560	$ 6,968,797	$ (4,830,694)	$ (24,539,806)	$ 1,311,812	
Physician Acquisition or reduction	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
Free care	$ (4,946,430)								
Bad debt	$ (2,808,505)								
Disproportionate Share Change	$ (3,136,014)		$ -	$ (3,136,014)	$ -	$ -	$ -	$ -	
Other NPR changes	$ -			$ -		$ -	$ -	$ -	
	$ -								
Total NPR changes	$ 41,049,847		$ 16,516,262	$ (5,099,806)	$ 6,837,233	$ 38,816,083	$ (11,078,670)	$ 2,813,682	

2) NARRATIVE: The hospital states they have made investments in OneCare ACO and is taking risk in the All-Payer ACO model. What is the hospital's reporting structure regarding reserves/risk and fee for service versus premium revenue for each payer? How does this affect Net Patient Revenue?

We have not built any reserves into our NPR for moving to risk-based contracts. Based on guidance provided by our auditors (PwC), internally we record per-member per-month (PMPM) payments as other revenue, but for our budget submission, as requested, we have included it as NPR.

3) EXPLANATION OF VARIANCES:

a) The rate effect of the actual 2017 experience is shown as -$26.2 million. Discuss and provide a schedule that shows this information and how this was calculated.

b) **Provide a schedule supporting these reimbursement estimates. Medicare shows a decrease in reimbursement and an increase in utilization. Commercial shows a**

decrease in reimbursement and an increase in utilization. Medicaid shows an increase in reimbursement and a decrease in utilization.

Please see the attached detailed schedules, which reconcile to the summary table shared in response to Question 1 (Attachment A).

While the detailed schedules provide all the calculations, it may also be helpful to understand the process used to determine the collection percentage assumed for each payer category in the FY 2018 budget. First we use actual collection rates for the four-month period from October 2016 through January 2017. Then we make adjustments for known payment changes that will impact reimbursements or payments from February 2017 through September 2017. This is what we refer to as our base collection rates. Any difference between the base collections rates and the FY2017 budget rates is viewed as a rate variance, FY 2017 actual to FY 2017 budget.

We use a similar approach to understand changes in payer mix. We use actual payer mix from October 2016 through January 2017. We do make adjustments to payer mix if we believe there is going to be a significant change from February 2017 through September 2017. We then take those payer mix percentages and apply them to the FY 2017 gross revenue budget to determine what the payer mix shift change is. All of this is done at the gross revenue/charge level. To equate the impact to NPR or payments, we take the change at the gross revenue level by payer category and multiply it by the base collection rate discussed in the previous paragraph.

To understand the impact of volume or change in utilization we take all the submitted gross revenue budgets at the department level and roll them up by payer. We then take any increase or decrease in gross revenue and back out any impact from the payer mix shift calculation above. Any remaining gross revenues are viewed as a change in volume or utilization. We then take the base collection and multiply it by the gross revenue by payer to determine the NPR or payment impact.

The final step is to determine new rate request(s) and what the impact will be in the new budget year FY 2018 (October 2017 – September 2018). Once determined we take the impact of the change and multiply it by the total base NPR by payer group to calculate the dollar amount of the change. This change amount then gets added to the total base net revenue by payer group, which then becomes the FY 2018 net patient service revenue budget.

c) Bad Debt/Free Care are both starting to increase. UVMMC states that this is due to changes in health care coverage. Is there evidence to support this? Explain these increases.

The primary increase in bad debt is coming from balances after insurance, not pure self-pay (individuals who do not have insurance). This probably indicates a higher number of people in high-deductible plans who cannot afford to pay. Many of those probably also qualify for our financial assistance program, which in turn increases our level of free care.

4) INCOME STATEMENT: Other operating revenue is increasing $14.9 million due to specialty pharmacy and the 340B program. Explain these increases.

These are not new revenues to the system. We have started a prescription home delivery program and extended the hours of our retail pharmacies to try and get patients to use our pharmacies instead of the for-profit pharmacies in our community. We have also increased the number of pharmacists embedded in our outpatient clinics to help providers manage their patients' medications, with the goal of reducing potentially more-costly services down the road (population health). At the same time we are making sure patients are aware that they can use our pharmacies for their specialty and routine drug needs. This keeps more of that revenue within our system – where it can be used to maintain access to critical services, to invest in population health initiatives, to offset below-inflation rate increases from commercial insurers, and to offset the "cost shift" we are absorbing from commercial insurers no longer covering this shift – instead of going to for-profit pharmacies. In addition, when patients use our pharmacies, we can more effectively manage their medications since the orders from our pharmacies go directly into our electronic health record (EHR). These are the primary drivers behind the $14.9 million increase.

5) INCOME STATEMENT: Other operating expense is increasing $21.1 million due [to] "other services." Explain these increases.

The major drivers for this increase include outpatient pharmacy drug costs from the expansion described in Question 4 ($2 million); higher pharmaceutical costs due to higher volume (number of patients) and a 4% inflation rate ($10 million); IT purchased services and systems (including a clinical trials system, Microsoft upgrade, new security software, and an Epic 2018 update ($10 million); and lower professional liability insurance costs resulting from improved claims experience (-$1 million).

6) NPR PAYER: Specifically describe the utilization activities – more patients, types of services, complexity, etc. Also, why do you expect to see less or more reimbursement?

The number of patients we serve has steadily increased over the years. We have added providers to meet this need, which shows up in the growth of worked RVUs. As we explained in our narrative, we have also seen a surge in our inpatient volume. There were many days this past year when we were at 85%+ capacity. You can see this growth in our inpatient days. This growth is predominantly Medicare patients living in Chittenden County. Our length of stay and

our CMI has also been increasing. One of the drivers is a higher number of patients on our inpatient units with mental health needs.

	FY15 Actual	FY16 Actual	FY17 Budget	FY17 Anlzd YTD Jan	FY17 Anlzd YTD Jul	Rolling 12 Mths (Aug - Jul)	FY18 Budget
HOSPITAL							
Inpatient Discharges	21,240	22,211	21,500	21,912	22,177	22,271	22,300
Inpatient Patient Days	119,902	120,562	115,240	128,769	123,965	124,689	125,549
Outpatient Patient Days	32,624	33,514	33,268	34,269	34,560	34,398	33,494
ALOS - Discharge Days	*5.80*	*5.47*	*5.36*	*5.90*	*5.76*	*5.75*	*5.63*
CMI - Case Mix Index	*1.66*	*1.69*	*1.71*	*1.71*	*1.71*		*1.71*
PROFESSIONAL							
MG Professional Worked RVUs	2,605,665	2,663,050	2,698,178	2,715,468	2,782,535	2,799,442	2,828,981
ANCILLARY							
Operating / Minor Rooms							
Total OR Cases	16,464	17,029	17,010	17,397	17,280	17,242	17,267
Total Minor Cases	3,215	3,212	3,064	2,973	3,011	3,004	2,826
Procedures							
Total Cath Lab	4,648	4,683	4,461	5,244	5,076	5,070	4,940
Total EP	1,366	1,511	1,511	1,596	1,580	1,575	1,546
Total GI/Endoscopy	13,016	13,160	13,113	13,524	13,090	13,269	13,405
Total Interventional Radiology	11,485	11,411	12,576	12,216	13,448	13,104	12,576
Total Radiation Oncology	38,255	37,193	37,412	29,469	33,775	34,590	34,573
Major Imaging							
Total MRI	18,785	19,279	19,766	18,987	19,218	19,266	19,766
Total CT Scan	46,004	47,065	45,577	46,254	47,459	47,779	47,265
Total Nuc Med + PET	6,497	6,340	6,330	5,919	6,194	6,239	6,245

7) NARRATIVE: Discuss the professional work Relative Value Units (RVUs) that are expected to increase by 4.3%. This is mostly related to the anticipated increase in the number of providers.

Yes, as noted in our narrative, this increase is coming from 20 new physicians and 8 advanced practice providers in areas such as Dermatology, Endocrinology, Cardiology, Neurology, Psychiatry, Pediatrics and Family Medicine.

8) NARRATIVE: UVMMC states that the average patient age increased 3 years in the past year. Explain.

According to our data, the average age of our in-house patients from 2016 to 2017 increased by 3 years. We do not have an explanation for this other than that it likely reflects the aging of Vermont's population as a whole.

9) UTILIZATION & STAFF: Adjusted admissions [are] increasing 1.1% from the 2017 budget to the 2018 budget, acute admissions [are] increasing 3.9%. There was also a 7% increase in patient days. Explain what is happening with patients and utilization. Also, explain the increase in FTEs and the related salary increases that are budgeted.

The 7% increase in patient days is consistent with the volumes we have been experiencing over the last 12 – 18 months. Discharges and length of stay have also increased, combined with a slight increase in case-mix index (CMI).

As we explained in our narrative, we experienced a significant surge in inpatient volume from July 2016 to February 2017. There were many days during that time period that we were at 85%+ capacity. We had to hire many new nurses and other support staff to handle the volume, which put great stress on our people and our systems. The unexpected surge was driven by a significant 12% increase in length of stay. This was predominantly Medicare patients living in Chittenden County. Adding to the length of stay issue was the high number of patients with mental health needs on our inpatient floors. This made our population more complex to care for, but it did not have a one-to-one impact on our CMI measure due to mental health diagnosis codes not having a large impact on this metric.

The main drivers of the large FTE increase budget-to-budget are volume increases relating to Nursing and Medical Group, as well as expansion of our Specialty Pharmacy and Quality programs. The majority of the salary increases are directly related to the increase in FTEs with only a slight increase in average hourly rate due to our merit/market adjustments.

10) Discuss your long-term capital spending plans for the UVMHN.

UVM Health Network's capital plans include both routine spending and periodic major investments in large-scale projects necessary to our mission and vision.

Routine capital spending includes equipment replacement (fully-depreciated equipment, both large and small, such as scopes, ultrasounds, and patient monitoring systems), facility maintenance (such as replacement elevators, windows, boilers, and paving), and information technology expenses (including server replacements, upgrading clinical and business software, and replacing obsolete computer hardware). Major projects include upgrades to major facilities, such as the current replacement of aged inpatient units with the Miller building, and the proposed replacement of EHRs in four of our Network hospitals with the Epic platform for both clinical and other uses.

As noted in our narrative, the UVM Health Network has a Network-wide business planning process to ensure that major capital investments are planned on a system-wide basis that takes into account regional needs, not simply the needs of individual hospitals or service areas. As we also described, consistent with our drive towards population health, greater affordability, and the expectation that revenues will continue to decrease over time, any capital investments we make must be tightly managed and prioritized. That has led us, as a Network, to reduce our planned long-term capital spending considerably, from five-year projected capital spending of $773.2 million (FY 2015 budget) to $583.1 million (FY 2018 budget).

Looking forward, we will continue to prioritize which programs and projects are included in our long-term capital plans using similar parameters and processes.

CVMC Questions

11) INCOME STATEMENT: The NPR is budgeted to increase 3.6%, and includes health care reform investments of $1.3 million. The investments are higher than the 0.4% cap and the total NPR increase is over the combined NPR target of 3.4%. The hospital needs to explain the major pieces for the 3.6% increase.

Attachment A of the narrative summarizes these changes. CVMC had additional off-cycle physician acquisitions in the amount of $368,061 for two separate services.

The first transfer of $223,421 in NPR was due to the retirement of a community physician, Dr. Vassar, whose patients were absorbed into Dr. Cynthia Smith's practice.

The second transfer relates to the retirement of an oncologist from Copley Hospital. Copley and CVMC have partnered to care for Copley's oncology patients, who now come to CVMC to receive their initial infusions, and then return to Copley for continued treatment. The revenues associated with those infusion services amount to $144,640.

A Physician Transfer form was completed and sent to the GMCB on May 31 of this year. Adjusting for these services, CVMC is at the NPR target of 3.4%.

While CVMC reported more health care reform investments than the cap, this is not factored into NPR.

12) Gross revenue is up 3.2%, and includes increased utilization and a 0.72% commercial rate/price increase. However, adjusted admissions utilization does not show an increase in utilization though many categories of utilization show increases. Explain what is happening in utilization. Why are adjusted admissions showing a reduction?

Inpatient revenue is growing at a faster rate than outpatient revenue, which causes the reduction in adjusted admissions.

Much of the growth in the outpatient area has been for the physician practice revenue services. As CVMC makes the shift from fee-for-service into the ACO environment, more emphasis is being placed on wellness and primary care. The physician practice revenue is typically a lower-priced service than an inpatient or an ancillary outpatient service such as Radiology.

The budget-to-budget adjusted admissions are decreasing by 40, while acute admissions are increasing 23.

13) Discuss the rate increase described as 0.72% commercial increase and a 0.2% overall increase. Describe what this means and why the hospital characterizes the rates this way.

The overall increase takes into consideration our list prices for all payers.

CVMC is only applying a price increase to our skilled nursing home rates, which has a separate rate setting process administered by the Division of Rate Setting, part of the Agency of Human Services. The skilled nursing facility payer mix is largely governmental payers or self-pay, and does not impact commercial rates. CVMC is not increasing list prices for hospital or physician services.

The 0.72% commercial increase is the increase in reimbursement that CVMC is budgeting to receive through contractual negotiations with our commercial payers.

14) NPR PAYER: Specifically describe the utilization activities – more patients, types of services, complexity, etc. Also, why do you expect to see less or more reimbursement? Provide more explanation schedule supporting these reimbursement estimates.

For all payers CVMC starts with current payer mix and reimbursement terms and then adjusts based upon information that we have at the time the budget is built, which was generally limited to the CMS inpatient prospective proposed rules issued on April 4. The CMS outpatient proposed rules were not issued until July 13, two weeks after our budget submission. The detailed NPR payer information was provided in the rate schedule as part of the GMCB budget submission.

	FY15 Actual	FY16 Actual	FY17 Budget	FY17 Anlzd YTD Jan	FY17 Anlzd YTD Jul	Rolling 12 Mths (Aug - Jul)	FY18 Budget
HOSPITAL							
Inpatient Discharges	4,193	4,553	4,483	4,641	4,481	4,550	4,469
Inpatient Patient Days	19,216	19,541	19,759	21,141	19,742	19,920	20,227
Outpatient Patient Days	1,261	1,430	1,356	1,267	1,475	1,485	1,273
ALOS - Discharge Days	*4.58*	*4.29*	*4.41*	*4.56*	*4.41*	*4.38*	*4.53*
CMI - Case Mix Index	*1.17*	*1.22*	*1.24*	*1.17*	*1.18*		*1.18*
PROFESSIONAL							
MG Professional Worked RVUs	263,832	310,740	329,954	319,841	319,239	317,819	328,769
ANCILLARY							
Operating / Minor Rooms							
Total OR Cases	3,305	3,778	3,796	3,567	3,480	3,544	3,473
Total Minor Cases	2,923	3,303	2,988	3,153	3,136	3,085	3,355
Hours Per Minor Case	-	-	-	-	-	-	-
Procedures							
Total GI/Endoscopy	2,921	2,938	3,070	2,883	2,903	2,820	2,940
Total Radiation Oncology	4,838	4,236	4,737	3,720	4,002	4,084	3,735
Major Imaging							
Total MRI	3,956	4,095	4,244	3,627	3,672	3,714	3,635
Total CT Scan	11,070	12,321	11,399	13,248	12,854	12,981	13,258
Total Nuc Med + PET	1,812	2,129	1,948	1,941	2,089	2,102	1,946

a) Medicare shows less favorable reimbursement and much higher utilization.

CVMC's inpatient services are primarily Medicare, which is where utilization is increasing. An outside consulting company performed an analysis that showed that CVMC has a higher-than-average population of aging patients. This is a continuation of the trends CVMC experienced in FY 2015 and FY 2016. For outpatient services we assumed an increase of 1.82% in our reimbursement terms.

b) Commercial shows more favorable reimbursement and higher utilization.

CVMC is budgeting for a 0.72% reimbursement increase as allowed by the GMCB. As noted below, CVMC is seeing a shift of patients from Medicaid onto commercial insurance, which is why we have budgeted higher utilization there.

c) Medicaid shows less favorable reimbursement and much less utilization.

For all services we used current reimbursement assumptions with no change. For state FY 2017, after CVMC filed our budget, there were several cuts from Medicaid that are impacting FY 2017 reimbursement.

In terms of utilization, CVMC is seeing a shift into Medicare from Medicaid as part of the aging of the population. This will need to be carefully evaluated from the risk contracting perspective since historically Medicare and Medicaid patients had different utilization patterns. This was noted when CVMC filed our 2016 Medicare cost report, which showed a decline in our DSH percentage. As noted above, CVMC is also seeing a shift of Medicaid patients onto commercial insurance.

15) DASHBOARD: Bad debt and free care as a % of gross revenue is increasing unfavorably from 2% to 2.2%. While bad debt is trending favorably, free care shows a large unfavorable increase. Discuss the changes occurring with free care.

During FY 2017 a significant number of Medicaid patients lost Medicaid eligibility and became eligible for Vermont Health Connect plans. Many of these patients cannot afford those plan rates, even with subsidies. In addition, we have also experienced patients who were formerly insured through VHC opting out of insurance altogether. We have seen a significant (20%) increase in self- pay accounts as a result.

These patients are eligible for CVMC's health assistance program, which is why free care is increasing and bad debt is remaining flat. We expect this trend to continue.

16) INCOME STATEMENT: Other operating revenue increasing $2.5 million:

a) 340B pharmacy program ($1.6 million). Describe the risks associated with this program.

The total benefit of the 340B program to CVMC is $7 million, which is a combination of expense savings and the retail pharmacy program. The 340B program is essential for CVMC's financial health as well as our ability to keep our rate increases to a minimum.

In Medicare's proposed outpatient payment system (OPPS) rules issued on July 13, CMS proposed a major reduction in reimbursement for 340B drugs. CVMC calculated this impact to be approximately $415,000 should that proposal be implemented.

Another risk that CVMC is facing is the decline in our disproportionate share hospital (DSH) percentage as patients move from Medicaid to commercial plans or to Medicare. If CVMC's DSH percentage falls below 8%, we would no longer qualify to participate in the 340B program.

b) Premium revenue and payer incentives ($1.1 million). Please explain.

This is Blueprint and Community Health Team funding that will in the future be reimbursed through the ACO.

17) INCOME STATEMENT: Operating expenses are increasing 4.6%:

a) Salary expenses are increasing 5.8%, even though there are FTE reductions. Explain this level of increase.

There was a technical correction that was made for the FY2018 budget as to where vacation/CTO expense was being reported. This was the first year this was reported in the staff salary expense line, so the true increase is overstated. If you adjust for this amount, the actual increase is only 3.2%.

CVMC budgeted for a 2% cost-of-living adjustment on salaries. The remaining 1.2% is due to market adjustments needed in order to retain and recruit more nurses for both the hospital and the nursing home. While there are FTE reductions in the budget the mix of employees has changed to include more clinical staff at higher rates of pay than administrative or support staff. The market adjustments are less expensive than having to hire traveling nurses.

b) "Other operating expenses" are increasing 9.1%. Explain the major increases.

The FY 2017 budget included $3 million in performance improvement initiatives that were targeted to hit the other operating expense line. These plans were not fully realized. As a

result, during FY 2017, additional plans were developed and our FY 2018 budget reflects multiple, specific financial improvement plans either already implemented or scheduled to be implemented during the first half of FY 2018.

18) DASHBOARD: Cost per adjusted admission is higher than the state median. Explain the drivers of this statistic.

There is a wide variation in cost per adjusted discharge as shown on Report 7, from a low of $7,667 to a high of $19,605. The comparison by hospital does not take into consideration the services the hospital may or may not have that impact this metric. For example, hospitals that employ a large medical group (like CVMC) would have a higher cost structure, but this employment would not necessarily impact the adjusted admission statistic. What is more meaningful is the comparison over time of each hospital.

CVMC's cost per adjusted admission has grown by 1.54% from FY 2016 to FY 2018. The statewide median cost per adjusted admission, according to Report 7, grew by 10.5% in this same time frame.

19) BALANCE SHEET: Describe the large increase in "other non-current liabilities."

There are two factors impacting other non-current liabilities on CVMC's balance sheet. The first is that CVMC recorded a $10 million increase to our pension liabilities on September 30, 2016, due to a decline in discount rates from 4.72% to 3.72%.

The second factor is a function of Health Network fund flows between CVMC and UVM Medical Center. CVMC and UVM Medical Center's balance sheets should be viewed as a single, combined balance sheet given the amount of shared services and initiatives between the two organizations. The funds flow is largely due to services UVM Medical Center provides to CVMC, such as employing the physicians in CVMC's inpatient psychiatry unit. Any balance is driven by a timing difference between when the expenses or revenues are recorded and actual cash is transferred across the entities.

Joint Questions

20) INCOME STATEMENT: Are the 2017 projections still valid? If not, please describe material changes.

UVM Medical Center's projections are still valid, although we are experiencing a very high census this month (August, with many days over 400 patients), which may drive NPR higher.

For CVMC, the FY 2017 income statement projections are still valid. The major changes would be how the ACO PMPM is recorded on its financials (in other revenue, versus as NPR on the GMCB's financials). The FY 2017 capital projections are over-stated. CVMC is projecting to spend closer to the $10.3 million on capital rather than the budgeted $14.1 million.

21) Refer to the Act 53 price and quality data schedules that were included in the presentation of FY 2018 Hospital Budget Submissions-Preliminary Review on July 27, 2017 and be prepared to address questions the Board may have concerning that information.

We are prepared to respond to questions from the Board on those schedules.

22) Please be prepared to address the following issues during your GMCB budget presentation. Given the uncertainty of the federal actions, what are the potential implications of actions that the federal government may take to include: a) 340B pricing (if applicable) and its effect on your hospital, b) potential risks for your hospital to include economic viability, c) effects on bad debt/free care.

Per the instructions in Janeen Morrison's email of August 10, the UVM Health Network will address these questions during our budget presentation on August 22.

23) In the March 31 GMCB hospital guidance, the Board allowed up to 0.4% for *new* health care reform. The Board directed each hospital to provide a detailed description of each new health care reform activity, investment or initiative included within the designated 0.4%, provide any available data or evidence-based support for the activity's effectiveness or value, and identify the benchmark or measure by which the hospital can determine that the activity reduces costs, improves health, and/or increases Vermonters' access to health care. With this in mind, please describe how you are investing for new health care reform activities in the four approved areas:

a) Support for Accountable Care Organization (ACO) infrastructure or ACO programs;

b) Support of community infrastructure related to ACO programs;

c) Building capacity for, or implementation of, population health improvement activities identified in the Community Health Needs Assessment, with a preference for those activities connected with the population health measures outlined in the All-payer Model Agreement;

d) Support for programs designed to achieve the population health measures outlined in the All-payer Model Agreement.

As we discussed in our narrative, we are shifting our thinking from "making health reform investments" to what needs to be accomplished to transition from today's volume-driven world

to one in which the majority of our revenues come from value-based payments, including capitated payments under the APM. To that end, both CVMC and UVM Medical Center have been investing in a variety of areas, well over and above the 0.4% NPR "allowance," because we understand them to be necessary to our ability to effectively manage the health of the populations attributed to us.

Specific investments that were identified in our budget filing for FY 2018 include initiatives intended to increase capacity in primary care and psychiatry at CVMC, increasing the ability of Woodridge Nursing Home to accept higher-acuity patients, enhancing care coordination for the CVMC medical group, and at UVM Medical Center, additional staffing for our Community Health Teams and Medication-Assisted Treatment programs, a new complex pain management program, and additional investments in psychiatry and mental health services. All of these are part and parcel of building our population health capacity and supporting our ability to support the state's goals as set out in the APM.

24) Please identify which ACO(s) you will have a contractual relationship with in 2018. If your hospital plans (or already is) in a risk-bearing contract with OneCare, please explain the effect of the risk on your financial statements. Please explain specific strategies your hospital is developing to move toward population-based payment reform. Finally, what tools does your hospital employ to ensure appropriate, cost effective, quality care when working with providers outside the CHAC or OneCare network?

As described in our narrative, all three UVM Health Network hospitals in Vermont have committed to participating in OneCare Vermont's accountable care programs – Medicaid, Medicare and hopefully commercial – in 2018.

As noted in response to Question 2 to UVM Medical Center, we have not built any reserves into our NPR for moving to risk-based contracts. Based on guidance provided by our auditors (PwC), internally we record per-member per-month (PMPM) payments as other revenue, but for our budget submission, as requested, we have included it as NPR.

Our population health strategies have been described in detail in our budget narrative, as our budget is essentially an operating plan for continuing to meet our mission and vision while moving into a value-based payment system.

We work with providers outside the OneCare network to the extent that non-participating hospitals, FQHCs, designated agencies and others share patients with us, either because those patients seek care from different service providers at different times, or because patients are referred among us. Unless those providers are part of the UVM Health Network, however, neither UVM Medical Center nor CVMC has any tools to directly influence the care those providers offer. One of the key values of participating in OneCare Vermont, by contrast, is the

ability of disparate provider organizations and clinics to come together to accept accountability for just those things: appropriate, cost-effective, quality care for the individuals whose lives are attributed to them.

ATTACHMENT A

	A	B	C	D = B - A	E	F	G = F - E	H = G * (Total of A)	I	J = H * I
	FY17 Budget Gross Revenue	FY18 Base Gross Revenue	FY18 Budget Gross Revenue	Gross Revenue Change FY17B to FY18 Base	Payer Mix					
					FY17 Budget Payer Mix	FY18 Base Payer Mix	Change Bud - Bud	Impact on Gross Billings	FY17 Budget Collection %	Payer Mix Impact
Medicare	$ 1,026,212,456	$ 1,096,917,492	$ 1,103,157,956	$ 70,705,035	41.0%	41.7%	0.7%	$ 18,549,137.31	31.71%	$ 5,882,684
Medicaid_VT	$ 359,739,076	$ 340,842,828	$ 342,804,361	$ (18,896,249)	14.4%	13.0%	-1.4%	$ (35,102,539)	31.15%	$ (10,934,174)
Medicaid_Other	$ 63,220,360	$ 62,908,300	$ 62,772,335	$ (312,060)	2.5%	2.4%	-0.1%	$ (3,303,205)	21.83%	$ (721,080)
Major Commercial	$ 771,405,056	$ 823,582,106	$ 819,444,012	$ 52,177,051	30.8%	31.3%	0.5%	$ 13,017,620	74.01%	$ 9,634,178
Workers Comp	$ 25,471,186	$ 27,909,413	$ 27,913,874	$ 2,438,227	1.0%	1.1%	0.0%	$ 1,111,199	62.26%	$ 691,810
Sub -Total	**$ 2,246,048,134**	**$ 2,352,160,139**	**$ 2,356,092,538**	**$ 106,112,004**				**$ (5,727,788)**		**$ 4,553,419**
Other 1	$ 176,117,891	$ 171,866,423	$ 170,820,396	$ (4,251,468)	7.0%	6.5%	-0.5%	$ (12,423,320.44)	65.40%	$ (8,124,513)
Other 2	$ 19,907,194	$ 31,574,005	$ 31,127,456	$ 11,666,811	0.8%	1.2%	0.4%	$ 10,165,539.53	70.72%	$ 7,189,191
Other 3	$ 32,769,854	$ 35,990,836	$ 35,829,871	$ 3,220,982	1.3%	1.4%	0.1%	$ 1,509,700.68	23.02%	$ 347,565
Other 4	$ 30,868,768	$ 39,208,930	$ 36,930,072	$ 8,340,162	1.2%	1.5%	0.3%	$ 6,475,868.12	81.02%	$ 5,246,552
*Other 5**	$ -	$ -	$ -	$ -				$ -	*-0.55%*	$ -
Sub -Total	**$ 259,663,707**	**$ 278,640,194**	**$ 274,707,794**	**$ 18,976,487**				**$ 5,727,788**		**$ 4,658,796**
Total	**$ 2,505,711,841**	**$ 2,630,800,332**	**$ 2,630,800,332**	**$ 125,088,491**				**$ 0**		**$ 9,212,215**
Bad Debt Deductions	$ -	$ -	$ -	$ -				$ -	*-0.83%*	$ -
Charity	$ -	$ -	$ -	$ -				$ -	*-0.43%*	$ -

Note: Items in blue are calculated on Total Gross Revenue

	K = D - H	I	L = I * K
	Utilization/Volume		
	Volume after Payer Mix Shift	FY18 Base Budget Collection %	Volume Impact
Medicare	$ 52,155,898.09	31.71%	$ 16,540,752
Medicaid_VT	$ 16,206,291	31.15%	$ 5,048,136
Medicaid_Other	$ 2,991,145	21.83%	$ 652,958
Major Commercial	$ 39,159,431	74.01%	$ 28,981,406
Workers Comp	$ 1,327,028	62.26%	$ 826,181
Sub -Total	**$ 111,839,792**		**$ 52,049,433**
Other 1	$ 8,171,852.22	65.40%	$ 5,344,169
Other 2	$ 1,501,271.15	70.72%	$ 1,061,717
Other 3	$ 1,711,281.27	23.02%	$ 393,974
Other 4	$ 1,864,294.23	81.02%	$ 1,510,395
*Other 5**	$ -	*-0.55%*	$ (690,105)
Sub -Total	**$ 13,248,699**		**$ 7,620,148**
Total	**$ 125,088,491**		**$ 59,669,582**

Bad Debt Deductions	$ -	$ (1,033,997)
Charity	$ -	$ (533,010)

Note: Items in blue are calculated on Total Gross Revenue

	M	N = M - I	B	O = B * N	P	Q	R	S = J+L+O+Q+R
	Rate							
	FY18 Budget Collection %	Bud to Base Bud Coll% Change	FY18 Base Gross Revenue	Base Rate from FY17	Rate Change Assumption for FY2018	Payer Rate Request / Change in FY18	DSH	Total NPR Change FY17 Budget to FY18 Budget
Medicare	30.9%	-0.8%	$ 1,096,917,492	$ (9,164,393.04)	In: 1.4% / Out: 1.3% / Pro: 0%	$ 3,257,218		$ 16,516,262
Medicaid_VT	32.3%	1.2%	$ 340,842,828	$ 4,057,560	0%	$ (135,315)	$ (3,136,014)	$ (5,099,806)
Medicaid_Other	32.9%	11.1%	$ 62,908,300	$ 6,968,797	0%	$ (63,442)		$ 6,837,233
Major Commercial	73.4%	-0.6%	$ 823,582,106	$ (4,830,694)	0.72%	$ 5,031,193		$ 38,816,083
Workers Comp	67.0%	4.7%	$ 27,909,413	$ 1,311,812	0%	$ (16,121)		$ 2,813,682
Sub -Total			**$ 2,352,160,139**	**$ (1,656,918)**		**$ 8,073,532**		**$ 59,883,453**
Other 1	58.5%	-6.9%	$ 171,866,423	$ (11,893,360)	Mulitple Assumptions: need to break down at lower level to explain	$ 544,055		
Other 2	79.7%	9.0%	$ 31,574,005	$ 2,847,981		$ (386,655)		
Other 3	20.2%	-2.9%	$ 35,990,836	$ (1,032,360)		$ (13,183)		
Other 4	57.1%	-23.9%	$ 39,208,930	$ (9,385,712)		$ (573,920)		
*Other 5**	*-0.74%*	*-0.19%*	$ -	$ (5,076,353.98)		$ 1,611,894		Total of Other
Sub -Total			**$ 278,640,194**	**$ (24,539,806)**		**$ 1,182,191**		**$ (11,078,670)**
Total			**$ 2,630,800,332**	**$ (26,196,723)**		**$ 9,255,723**	**$ (3,136,014)**	**$ 48,804,783**
Bad Debt Deductions	*-0.90%*	*-0.07%*		$ (1,869,079)	*-0.89%*	94,571		**$ (2,808,505)**
Charity	*-0.60%*	*-0.18%*		$ (4,614,912)	*-0.59%*	201,491		**$ (4,946,430)**

Note: Items in blue are calculated on Total Gross Revenue

Grand Total **41,049,847**