# Fiscal Year 2025 Hospital Budget Submission to the Green Mountain Care Board

On behalf of Porter Hospital

July 8, 2024

**University of Vermont Health Network**

The people of our region deserve timely, high-quality care. This means health care that is equitable – both physically and financially accessible. At University of Vermont Health Network, we are united by a shared commitment to provide the best care to everyone who needs it, now and in the future.

We are proud of the progress we have made to become an integrated health system, but there is more work to do. Reaching this goal will allow us to fully realize the advantages of shared expertise, resources, clinical and administrative support and will better provide a consistent, high-quality patient experience across our hospitals, clinics and facilities in Vermont and northern New York.

Our commitment to our patients and community members is at the center of everything we do and drives all our requests to the Green Mountain Care Board. All that is included in our FY25 budget filing is what we need to best serve our communities and care for the people who trust us with their health and wellbeing every day.

The enclosed proposal outlines the FY25 budget submission for Porter Hospital. In this budget, you will see our health system making the necessary investments to provide more affordable and accessible health care, while implementing strategies to improve the health of all Vermonters. The work we are seeking to advance in FY25 stems from a common, system-wide strategy to achieve these goals. The nature of this work varies at each partner hospital in accordance with the unique health needs of the communities they serve, which guide local clinical and operational priorities.

About UVM Health Network

UVM Health Network is a nonprofit, rural academic health system serving more than one million people living in rural communities across Vermont and northern New York. Our system is comprised of six partner hospitals, a children's hospital, a home health and hospice agency, 154 outpatient care sites, three skilled nursing facilities, a multispecialty medical group with over 1,000 employed physicians, approximately 500 Advanced Practice Providers (APPs), and a population health services organization. Our 15,000 employees are driven to provide high-quality, cost-efficient care as close to home as possible. Each of our partner organizations remains committed and deeply connected to its local community by providing compassionate, personal care shaped by the latest medical advances and delivered by highly skilled experts. Meanwhile, our essential academic partnerships with local colleges and universities in Vermont help us train the next generation of caregivers and bring leading-edge research to the bedside. These partnerships include the University of Vermont Larner College of Medicine and College of Nursing and Health Sciences, Community College of Vermont, Norwich University and Vermont State University. Our three Vermont hospitals are subject to Green Mountain Care Board budget approval under 18 V.S.A. § 9375(b)(7).

As a nonprofit health system, every dollar that comes into UVM Health Network stays within our health system to support the care we provide. Across all our health care partner organizations, we are working hard each day to make the most of these resources and enhance the experience of our patients and caregivers: making it easier to access care physically and financially, strengthening our workforce and responsibly investing in the critical infrastructure we need to deliver the high-quality care our patients deserve, now and in the future.

Strengthening Access to Care

Across UVM Health Network, we are continuing to adopt new strategies and tools to break down barriers to access; reduce wait times for specialty care; strengthen collaboration between our primary care and

specialist health care teams; and reinforce the quality of in-person specialist referrals through thorough pre-visit work. Our FY25 budget requests reflect our ongoing investments to preserve and increase patient access to care through continued investment in specialty care and a significant focus on primary care, which we believe is essential to both keeping our communities healthy and to relieve bottlenecks in the care delivery system. The examples described below are available throughout our health system with equal access at each of our health care partner organizations.

Examples include:

- eConsults: We have grown our eConsults capability to include more than 20 specialties. Only 10% of eConsults require a separate, in-person visit with a specialist, which has opened much-needed capacity for those patients who do require in-person appointments. As one example, in rheumatology, eConsults have decreased average monthly referral volumes by 11%.
- Enhanced Referrals: When a specialist and primary care provider determine that a patient needs to be seen in-person quickly, we have developed "enhanced referrals" for many specialties to ensure those patients receive earlier appointments. Accessed through Epic, enhanced referrals direct providers to order eConsults when appropriate, while also offering further guidance on which tests, lab work, imaging or other information should be collected prior to a patient's visit, thereby strengthening the quality of the specialist visit and the patient's experience. We are working to broaden access to enhanced referrals to primary care providers outside UVM Health Network.
- "Refer Backs" to Primary Care: Once a patient has been treated by a specialist and their condition is well-managed, our providers are participating in another initiative to transition them back to primary care for ongoing maintenance. This program has created 965 slots for new patients or follow-up slots for existing patients in our specialists' schedules.
- Radiology Access: UVM Health Network radiology has worked to make it easier for patients to access CT, PET CT and MRI services in a timely fashion, increasing access by as much as 18%, 27% and 15% respectively through expanded service hours, the addition of new equipment and improving image quality.
- Patient Self-Scheduling: In the coming months, UVM Health Network will roll out new patient self-scheduling options for primary care appointments through MyChart, our patient portal.
- MyChart Fast Pass: On June 12, we launched Fast Pass, which allows for unused appointment slots to be offered via a MyChart message to a patient we have placed on our electronic wait list. Since then, we had nearly 190 "offers" accepted by patients, resulting in an average improvement of an appointment time by 49 days for family medicine and 43 days for general internal medicine.
- Surgical Access: Our perioperative services have expanded access to surgical care at each of our seven operating room (OR) locations across the region. Patient need for these services has increased significantly over the last several years and as a result, our Vermont ORs are operating at near-record volumes that surpass national benchmarks. We are able to achieve this significant progress thanks to expanded weekend operations, streamlined patient scheduling, the consolidation of equipment and instrumentation platforms, shared nursing best practices and surgical teams increasingly operating across sites.

Additionally, we are focused on reducing financial barriers and other roadblocks to care. As a nonprofit health system, we operate several health and financial assistance programs to ensure that cost does not prevent our patients from getting the care they need. For instance, through our health assistance program, 6,368 patients had access to $7.5M worth of free medications in FY23. Meanwhile, dedicated teams helped more than 3,500 patients connect with wrap-around care management services to help them better manage their health and overcome personal barriers to care. These initiatives are discussed in detail throughout our hospital partner budgets.

Bolstering our Workforce

Recognizing we cannot provide great care without great people, we have been continuing to reinforce our organization as an extraordinary place to work, both for our current employees and for the prospective employees we need.

For example:

- Center for Workforce Development: We continue to pioneer innovative solutions designed to train community members and members of our own workforce for in-demand positions. This includes internal training programs and partnerships with colleges, both here in Vermont and nationally. These initiatives are a key component of our ongoing effort to create scalable and sustainable workforce solutions across our health system. By doing so, we not only reduce our dependence on costly temporary labor but also benefit the broader health care systems of Vermont and northern New York.
- Opportunities for Historically Marginalized Groups: In 2025, the Center intends to grow its partnerships in the community, including schools, colleges, and community-based organizations. We will place a special focus on harnessing the talents of historically marginalized communities, including refugees, immigrants, asylees, opportunity youth and individuals with disabilities. This approach will support a diverse and inclusive workforce reflecting the communities our health system serves.

Responsibly Investing in Critical Infrastructure

Meanwhile, with our patient needs continuing to evolve with an aging and growing population, we remain focused on ensuring we have the right facilities and equipment to provide excellent care close to home. In addition to previously discussed initiatives such as our planned Outpatient Surgery Center, this work also includes local investments at each of our Vermont partner organizations reinforcing care options throughout our entire health system and across the region. These projects are designed to expand capacity for important health care services and give our patients more options for where and when they receive that care. Such investments include, among others:

- An ongoing partnership to develop a mental health urgent care clinic in the Burlington area.
- A planned renovation of our neonatal intensive care unit at UVM Medical Center.
- An expansion of the midwifery program at Central Vermont Medical Center.
- The recently filed Certificate of Need to replace and upgrade a linear accelerator at Central Vermont Medical Center.
- Strengthening our sports medicine surgery capabilities at Porter Hospital.

While these initiatives are located at a specific partner organization, we see them as serving our patients regionally and enhancing the services we provide everywhere within our system.

Building a Strong and Sustainable Health System for Vermonters

We have been transparent about the operational and financial difficulties we have faced over the last several years, from workforce shortages, changing care needs and the lingering effects of the pandemic to hyperinflation and inadequate availability of long-term care and mental health beds. While we are making progress responding to these unprecedented challenges – and slowly returning to a stronger financial footing – the fact remains there is more work to be done.

UVM Health Network's Vermont hospitals have seen a shift to a more sound financial footing based on a

number of factors, including administrative cost control through our system and partner-specific position control processes and delayed capital investments; access improvement efforts, thanks in large part to administrative and clinical integration; systemwide management in utilization of and reduced rates for contract labor; and one-time funding sources, among other drivers.

This budget request before the Board reflects what is needed to provide the health care all of us envision and strive for in our communities.

## Porter Hospital

### A. Executive Summary

**Provide a high-level overview of key considerations for the proposed budget. Include discussion of variations from the current year approved budget, including any assumptions about current year projections relative to the approved budget. Indicate areas where the proposed budget deviates from parameters specified in this Guidance, providing justifications for such deviations, including credible and substantive evidence to support those justifications. For hospitals that are part of a network, affiliation, or have a financial arrangement with another legal entity (e.g. nursing home), explain any differences in what is happening at the hospital versus the network level, and quantify any financial impact on the hospital budget as a result of the relationship with any non-hospital entities.**

The operating budget submitted by Porter Hospital contains no significant changes in volumes or scope of services from FY24. Our FY25 budget reflects refinements driven by increased collaboration and efficiencies within UVM Health Network.

The primary operational budget miss in 2024 is in operating room (OR) cases as detailed below. For 2025, a complete matrix of expected OR volumes was generated across UVM Health Network with insight from our UVM Health Network Medical Group providers and Case Management team.

Porter Hospital's budget conforms with the Board's benchmark of a commercial rate growth of no more than the PCE price index plus 1% as of January 2024, or 3.4%.

Despite flat volumes and a modest revenue increase assumption, our budget does include continued investment in staff recruitment and retention to remain competitive in the local labor market.

Recently, our support staff and technical professionals organized two additional bargaining units. When included with our existing nurses bargaining unit, approximately two thirds of our workforce is now unionized. Negotiations for the support staff and technical bargaining units are ongoing and will continue in the coming months, and at the time of submitting this budget, the union has not yet provided us a proposal on economics. As in any union negotiation, it is difficult to precisely estimate the value of an economic package that bargaining unit employees will accept. The wages reflected in our FY25 budget considers the wages provided employees in similar roles at other UVM Health Network partner hospitals.

Porter Hospital's administrative costs have decreased by over $750K from 2025 due to shared leadership with Elizabethtown Community Hospital (President/CFO/CMO/Laboratory/Compliance/Quality).

The Porter Hospital FY25 budget contains an operating margin of 4.7%, down from the FY24 submitted margin of 7.8%, but in line with current FY24 forecasted performance. The FY25 budget also includes continued support of Helen Porter Nursing Home operations with a combined budgeted operating margin of 1.2%.

Maintaining the organization's current level of financial performance is imperative, as long overdue infrastructure investments are being prioritized. With continued financial success, we hope to present these projects to the Board for review and approval.

## B. Background

**a) Explain any changes that occurred to your corporate structure within the last year.**

There have been no changes to Porter Hospital's corporate structure within the last year.

**b) Explain your approach to considering and participating in any corporate affiliations in which you or the other organization may have a financial stake.**

Porter Hospital is not currently considering any corporate affiliations. When we do consider participating in corporate affiliations, the primary consideration is whether the affiliation will allow us to better serve our patients' health care needs.

**c) Describe and quantify the impact of any participation in regional collaborations with other service organizations or providers.**

Porter Hospital has a rich history of partnering with key community organizations. As noted below, we are in the early stages of developing a partnership with Middlebury College and Addison County Home Health and Hospice.

Additionally, Porter Hospital provides free, on-site clinical space to the Open Door Clinic, a free health clinic for uninsured and under-insured adults in Addison County. As part of the collaboration, Porter has established a voucher system by which Open Door patients can receive certain diagnostic lab and imaging tests free of charge.

**d) Explain and quantify any service-line closures, transfers, or additions since the prior year budget review, please explain.**

There has been no change in the service lines at Porter Hospital.

## C. Budget Questions

**a) Concisely describe substantive variations from current year approved budget to current year projected, and to the proposed budget, in terms of service line changes (differentiate between new or divested services, and volume changes that necessitate changes in staffing), physician transfers, accounting adjustments etc.**

FY24 budget to FY24 actual:

The substantive variance from the FY24 current year approved budget to the FY24 current year projected:

- FY24 actual reflects a reduction in the orthopedic cases in the OR due to the retirement of an orthopedic surgeon in late FY23 that Porter Hospital was unable to replace. This resulted in a decrease in the OR cases as well as a shift in the case mix from complex joint replacements to ENT and ophthalmic cases. This revised case mix resulted in unfavorable GPSR, NPSR as well as a reduction on the related supplies, resulting in a negative variance to the net income.

FY25 proposed budget:

- Our FY25 proposed budget includes the replacement of the orthopedic surgeon resulting in the GPSR, NPSR, supplies and net income reflecting the results of the increased cases and a higher revenue per case mix.
- OR case volumes budgeted down to the provider level in collaboration with UVM Health Network Medical Group leadership and planned resource availability.
- Case management has improved during FY24 resulting in timely patient placement resulting in the ability to reduce swing and observation patients and increased acute patients.

**b) For each of the Section I benchmarks not met in the budget submission, explain and justify the deviation using credible and sufficient evidence.**

NPR Growth Over the Section I Benchmark of 3.5%

UVM Medical Center's NPR is growing by 8.6%, Central Vermont Medical Center's by 11.9% and Porter Hospital by 4.2%. The Section I benchmark is tying the 3.5% growth target to the 3.5% TCOC growth target in the Vermont All-Payer Model, but that is not how the individual hospital NPR growth is being measured. Utilization growth can be generated by taking care of more patients or providing more services to existing patients. The only way to create an accurate comparison to the 3.5% TCOC growth being used as a target for individual hospital growth is to measure NPR growth in the same manner, which is per capita or per covered life.

As we have provided in previous budget submissions, below is an update to our model that establishes a per capita growth figure. While it would be ideal if this could be measured centrally by the Board, we will continue to generate this model, as we believe it is critically important to factor in dynamics like the growth or decline of populations served, our state's aging population and the population served into the review of individual hospital NPR growth.

The chart below shows the TCOC for UVM Medical Center, Central Vermont Medical Center and Porter Hospital combined (all payers combined), which grew by 3.3% from FY23 actual to FY24 projected, below the 3.5% APM growth target. The FY24 budget to FY25 budget is growing by 3.7%, slightly above the 3.5% APM growth target. This is based on population estimates from the US Census Bureau, age cohort utilization differences from the CMS National Health Expenditure Data and market share estimates from SG2.

| | 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 | $ 2,428,953,922 |
| Less: NY NPR | | $ (297,031,399) | $ (334,245,928) | $ (319,641,871) | $ (364,343,088) |
| UVMHN VT NPR | | $ 1,809,574,268 | $ 1,924,172,506 | $ 1,914,053,943 | $ 2,064,610,834 |
| VT NPR per UVMHN VT Population (Age Adj) | | $ 2,116 | $ 2,185 | $ 2,218 | $ 2,301 |
| Percent Change | | | 3.3% | | 3.7% |

**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

In addition to looking at per capita NPR growth, we would also like to highlight that the Board, on multiple occasions over the last several years, has asked us to address obstacles to improve access to timely appointments and care.

Section 5 below has more detail on our access efforts, which are contributing to higher NPR, but to highlight some:

- CT scan capacity has been increased by 16% at UVM Medical Center, 18% at Central Vermont Medical Center and 8% at Porter Hospital in the last two years.
- PET CT scan capacity has been increased by 27%.
- MRI capacity has been increased by 15% at UVM Medical Center, 14% at Central Vermont Medical Center and 4% at Porter Hospital.

- eConsults, which increase capacity in specialty clinics, has expanded to include 20 specialties, and we are on target to order more than 3,600 in FY24.
- "Refer Backs" to primary care has so far added 965 appointment slots in specialty clinics in FY24.
- Near the start of FY25 we will be initiating a sprint to decrease the backlog in gastroenterology, endoscopy and mammography. The impact of these access initiatives in NPR is illustrated in key volume metrics below.

| Volume Metric | FY24 Budget | FY25 Budget | % Change |
|---|---|---|---|
| **UVMMC** | | | |
| Professional Work RVUs | 3,561,574 | 3,686,830 | 4% |
| OR Cases | 21,804 | 22,130 | 1% |
| OR Hours | 44,728 | 46,851 | 5% |
| GI / Endoscopy | 11,730 | 16,593 | 41% |
| Cath Lab | 5,107 | 5,502 | 8% |
| CT Scan | 71,065 | 74,763 | 5% |
| MRI | 24,260 | 25,761 | 6% |
| Mammography | 64,554 | 69,891 | 8% |
| **CVMC** | | | |
| Professional Work RVUs | 575,114 | 645,757 | 12% |
| GI / Endoscopy | 5,817 | 7,018 | 21% |
| CT Scan | 17,943 | 20,336 | 13% |
| MRI | 3,906 | 4,617 | 18% |
| **PH** | | | |
| Professional Work RVUs | 285,029 | 319,382 | 12% |

Pharmaceuticals also impact our NPR growth. We do not routinely itemize this component, but we should, as we have little control over that growth. As the cost of pharmaceuticals continues to rise, so will the NPR. Below is a chart showing how much of the FY24 to FY25 budgeted NPR increase is due to an increase in pharmaceuticals specifically.

| FY24 Budget to FY25 Pre-Rate Increase / Inflated Budget | | | |
|---|---|---|---|
| Partner | Pharmacy NPR Increase | Total NPR Increase | Pharmacy % of Total |
| UVMMC | $25,558,299 | $80,732,263 | 32% |
| CVMC | $2,968,087 | $23,010,753 | 13% |
| PH | $2,782,252 | $1,637,217 | 170% |

Commercial Rate Increase Under the Section I Benchmark of 3.4%

Porter Hospital's FY25 commercial rate increase meets the Section I benchmark of 3.4%. We can meet that benchmark because the impact of the cost shift is much less for a Critical Access Hospital, due to

Medicare reimbursing Critical Access Hospitals at their actual cost plus 1%. With Medicare covering annual cost inflation, less needs to be covered by (shifted to) commercial insurance.

| **Porter Hospital** | **FY2025 Cost Inflation** |
|---|---|
| Total Cost Inflation | $3,798,359 |
| Less Retail Pharmacy | $0 |
| **Net Cost Inflation for Commercial Rate Calc** | **$3,798,359** |
| | |
| **Less:** | |
| FY2024 - Medicare Rate Increase | $1,347,284 |
| FY2024 - Medicare ACO Rate Increase | $0 |
| FY2024 - Medicaid Rate Increase | $1,472 |
| FY2024 - Other Payer Changes | ($280) |
| APM Shared Savings | $1,108,633 |
| LOS Reduction & Placement Impacts | $0 |
| GME/IGT Change | $0 |
| UM/UR Change | $0 |
| PHSO | $141,352 |
| Legislative Changes - Bad Debt/Charity/Denials | $296,306 |
| Rate Impact on Bad Debt/Charity/Denials Calculation | ($313,071) |
| **Sub-Total** | **$2,581,697** |
| | |
| **Required Funding from Commercial Rate** | **$1,216,663** |
| | |
| Per 1 % Impact of Commercial Rate: | |
| Budget Year ( 9 months: Jan-Sept) | $406,911 |
| | |
| **Commercial Rate Increase in FY2024 Budget** | **2.99%** |

**c) Explain the assumptions embedded in your proposed budget for the following, providing evidence to support your assumption(s), as well as any substantive variations from FY24 (budget & projected). Please list any other factors not included below that may be material to your budget along with supporting material. This includes any assumptions that are uncertain but could have a potential budgetary impact. For such assumptions that are not reflected in your budget, please quantify the range of potential impact.**

**a. Labor expenses. Differentiate between the use of employed versus contracted labor, separating nursing from other clinical, and non-clinical staff. Please highlight any trends that are specific to particular clinical domains.**

| Entity | Division Smry | TRAVELERS AS % of TOTAL SALARIES 2024 Budget | 2024 YTD Apr Act | 2025 Infl Budget | TRAVELERS AS % of TOTAL FTEs 2024 Budget | 2024 YTD Apr Act | 2025 Infl Budget |
|---|---|---|---|---|---|---|---|
| **PORTER HOSPITAL** | | | | | | | |
| PORTER HOSPITAL | 2500 Clinical Services | 24.67% | 29.25% | 26.18% | 9.14% | 14.15% | 12.90% |
| PORTER HOSPITAL | 2500 Nursing Services | 35.04% | 43.49% | 30.14% | 14.95% | 25.51% | 16.82% |
| PORTER HOSPITAL | 2500 Other Clinical | 0.00% | 29.07% | 22.96% | 0.00% | 11.68% | 7.19% |
| PORTER HOSPITAL | 2500 PH Hospital Services | 9.58% | 13.40% | 8.58% | 2.96% | 4.15% | 2.59% |

**b. Utilization. Explain and quantify any anticipated changes in utilization across care settings (e.g. inpatient/outpatient), or any other expected deviations from historical trends. Indicate the method(s) used to derive utilization changes in proposed budgets. If utilization assumptions include increases associated with hiring additional staff or other capacity changes, provide evidence to support estimated impact on utilization.**

There is no common utilization measurement across all volume types (inpatient, outpatient and professional). The best one can reference is changes in gross revenue trends. Below is a table for how gross revenues are trending by area from FY24 budget to FY25 base budget. The FY25 base budget is based on the same gross charge price as FY24. The difference between FY25 base and FY25 inflated budget is the gross charge price increase included in the FY25 budget submission.

## Porter Hospital

**GROSS PATIENT SERVICE REVENUE (GPSR)**

| Division | CC# | Cost Center Description | TOTAL FY24 Budget | TOTAL FY24 Anlzd YTD Jan | TOTAL FY24 Anlzd YTD Apr | TOTAL FY25 Base Budget | TOTAL FY25 Inflated Budget |
|---|---|---|---|---|---|---|---|
| Inpatient Revenue Total | | | 18,481,504 | 22,473,061 | 22,473,836 | 23,209,048 | 23,903,840 |
| Outpatient Revenue Total | | | 162,610,165 | 155,607,496 | 156,413,448 | 164,018,872 | 168,928,984 |
| Professional Revenue Total | | | 35,097,547 | 37,206,347 | 36,679,234 | 42,129,689 | 43,391,152 |
| Swing Revenue Total | | | 5,699,703 | 5,054,065 | 3,849,491 | 5,092,005 | 5,244,440 |
| **TOTAL GROSS REVENUE** | | | **221,888,918** | **220,340,970** | **219,416,009** | **234,449,613** | **241,468,416** |
| **INPATIENT REVENUE** | | | | | | | |
| | 2500 | Clinical Services | 2,803,193 | 3,695,263 | 3,641,042 | 3,677,731 | 3,787,829 |
| | 2500 | Hospital Operations | 812,765 | 403,710 | 511,377 | 760,325 | 783,087 |
| | 2500 | MG PART A | 1,106 | 783 | 962 | 917 | 944 |
| | 2500 | Nursing Services | 12,700,895 | 15,718,042 | 15,599,382 | 16,118,904 | 16,601,443 |
| | 2500 | Other Clinical | 242,883 | 407,385 | 422,542 | 402,969 | 415,032 |
| | 2500 | PH Hospital Services | 1,920,661 | 2,249,007 | 2,303,090 | 2,249,062 | 2,316,391 |
| | 2500 | PMG Facility Providers | - | 4,875 | 777 | 4,552 | 4,689 |
| | 2500 | PMG PRACTICES | - | (6,003) | (5,335) | (5,413) | (5,575) |
| | **TOTAL INPATIENT GROSS REVENUE** | | **18,481,504** | **22,473,061** | **22,473,836** | **23,209,048** | **23,903,840** |
| **OUTPATIENT REVENUE** | | | | | | | |
| | 2500 | Clinical Services | 54,248,577 | 58,740,740 | 60,963,988 | 58,736,907 | 60,495,271 |
| | 2500 | Hospital Operations | 7,028,634 | 2,701,637 | 2,731,356 | 5,072,598 | 5,224,453 |
| | 2500 | MG PART A | 4,734,484 | 4,373,226 | 4,018,227 | 4,777,425 | 4,920,443 |
| | 2500 | Nursing Services | 55,676,542 | 50,498,214 | 48,408,478 | 56,961,333 | 58,666,543 |
| | 2500 | Other Clinical | 6,635,028 | 6,796,001 | 7,288,234 | 6,769,350 | 6,971,999 |
| | 2500 | PH Hospital Services | 25,964,972 | 25,421,235 | 26,089,053 | 25,421,047 | 26,182,058 |
| | 2500 | PMG Facility Providers | 3,820,122 | 3,242,100 | 3,141,437 | 2,641,199 | 2,720,266 |
| | 2500 | PMG PRACTICES | 4,501,804 | 3,834,342 | 3,772,675 | 3,639,014 | 3,747,952 |
| | **TOTAL OUTPATIENT GROSS REVENUE** | | **162,610,165** | **155,607,496** | **156,413,448** | **164,018,872** | **168,928,984** |
| **PROFESSIONAL REVENUE** | | | | | | | |
| | 2500 | Hospital Operations | (0) | - | - | 583,559 | 601,286 |
| | 2500 | PMG Facility Providers | 9,259,305 | 11,335,140 | 11,371,792 | 12,144,713 | 12,508,280 |
| | 2500 | PMG PRACTICES | 25,838,241 | 25,871,207 | 25,307,442 | 29,401,417 | 30,281,586 |
| | **TOTAL PROFESSIONAL GROSS REVENUE** | | **35,097,547** | **37,206,347** | **36,679,234** | **42,129,689** | **43,391,152** |
| **SWING REVENUE** | | | | | | | |
| | 2500 | Clinical Services | 499,327 | 446,968 | 367,437 | 445,003 | 458,325 |
| | 2500 | Hospital Operations | 73,277 | 28,050 | 22,735 | 116,020 | 119,493 |
| | 2500 | Nursing Services | 4,885,630 | 4,434,306 | 3,347,035 | 4,386,238 | 4,517,545 |
| | 2500 | Other Clinical | 591 | - | - | - | - |
| | 2500 | PH Hospital Services | 240,878 | 144,741 | 112,284 | 144,745 | 149,078 |
| | **TOTAL SNF GROSS REVENUE** | | **5,699,703** | **5,054,065** | **3,849,491** | **5,092,005** | **5,244,440** |

**c. Pharmaceutical expenses. Differentiate assumptions regarding growth due to price from volume, or product mix. Please estimate reimbursements received in excess of the cost of pharmaceuticals (FY23 actuals, FY24 budget, projection, & proposed budget) noting how you arrived at those estimates? Include estimates for rebates associated with the 340B program.**

YTD January FY24 is used as a base, to which adjustments are made for known volume changes and planned introduction of new drugs, some of which require adjustment to current procurement/pricing strategy. In the FY25 budget, the inflation factor for pharmaceuticals is 4%.

**d. Cost inflation. Please explain any substantive changes and break out by medical and non-medical supplies and isolate the price effect separately from the utilization effect.**

| Expense Category | FY2025 Budget - Cost Inflation | |
|---|---|---|
| **Porter Hospital** | % Increase | $ Increase |
| Wages/Compensation - Physicians | 3.8% | $ 612,768 |
| Wages/Compensation - Staff | 4.1% | $ 1,630,903 |
| Fringe | 3.6% | $ 465,985 |
| Drugs - All Other | 4.0% | $ 219,098 |
| Drugs - Retail Pharmacy | 0.0% | $ - |
| Supplies | 3.0% | $ 234,226 |
| Non-Medical Supplies | 0.0% | $ - |
| Travelers (nurses) | 0.0% | $ - |
| Equipment / Software / Other Maintenanc | 3.0% | $ 30,868 |
| Provider Tax | 2.9% | $ 218,567 |
| Purchased Services | 2.9% | $ 292,610 |
| All Other | 0.5% | $ 93,334 |
| Total | 3.0% | $ 3,798,359 |

**e. 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.**

| | FY24 Budget | FY24 Anlzd YTD Jan | FY24 Anlzd YTD May | FY25 Budget |
|---|---|---|---|---|
| **CMI - All Payers** | | | | |
| **Porter Hospital** | 1.20 | 1.16 | 1.17 | 1.16 |

**f. Rate Changes by Payer. Explain any assumptions related to rate changes for Medicare, Medicaid (e.g. In State/Out of State), and Commercial Payers overall and by setting of care (inpatient, outpatient, professional services).**

| Porter Hospital NPR | Total | Total Medicare | Total Medicaid | Total Major Comm | Total Self-Pay/Other | DSH |
|---|---|---|---|---|---|---|
| FY24 GMCB Approved Budget | $ 125,035,102 | $ 50,369,350 | $ 14,648,653 | $ 48,093,402 | $ 11,476,431 | $ 447,265 |
| **Cost Inflation (FY25)** | | | | | | |
| FY25 Net Revenue Rates - All Payers | $ 2,565,138 | $ 1,347,284 | $ 1,472 | $ 1,216,662 | $ (280) | $ - |
| Utilization Management And Review | $ - | $ - | $ - | $ - | $ - | |
| Inpatient Length of Stay Reduction | $ - | $ - | $ - | $ - | $ - | |
| Placement of Long Stay patients | $ - | $ - | $ - | $ - | $ - | |
| APM Shared Savings | $ 1,108,633 | $ 1,108,633 | $ - | $ - | $ - | |
| Denial Improvement | $ 296,306 | $ - | $ - | $ - | $ 296,306 | |
| GME/IGT Change | $ - | $ - | $ - | $ - | $ - | |
| Denials | $ (138,054) | $ - | $ - | $ - | $ (138,054) | |
| Bad Debt | $ (134,425) | $ (7,048) | $ (987) | $ (26,825) | $ (99,565) | |
| Charity | $ (40,591) | $ (19,320) | $ (66) | $ (9,679) | $ (11,527) | |
| **FY24 Budget to Actual Collection Rate difference prior to rate impact** | | | | | | |
| All Payers | $ (4,498,970) | $ (461,941) | $ (4,100,625) | $ 2,823,408 | $ (2,759,812) | |
| Value Base Contract (VBC) Incentives | $ 246,374 | $ 42,622 | $ 45,047 | $ 109,024 | $ 49,682 | |
| GME Change | $ - | $ - | $ - | $ - | $ - | |
| Disproportionate Share Payments (DSH) | $ (33,170) | $ - | $ - | $ - | $ - | $ (33,170) |
| Denials | $ 394,491 | $ - | $ - | $ - | $ 394,491 | $ - |
| Bad Debt | $ (2,862,760) | $ (32,413) | $ (32,684) | $ (809,385) | $ (1,988,278) | |
| Charity | $ (178,408) | $ (254,391) | $ (390) | $ (187,657) | $ 264,030 | |
| **Utilization (not factoring in change in charge request)** | | | | | | |
| All Payers | $ 8,103,765 | $ 3,229,957 | $ 1,031,412 | $ 2,840,301 | $ 1,002,095 | $ - |
| Denials | $ (301,859) | | | | $ (301,859) | |
| Bad Debt | $ (116,381) | $ (31,037) | $ - | $ (10,399) | $ (74,945) | |
| Charity | $ (75,557) | $ (13,440) | $ (269) | $ (9,621) | $ (52,227) | |
| **Payer Mix** | | | | | | |
| All Payers | $ 667,269 | $ 33,461 | $ 231,481 | $ 695,617 | $ (293,290) | $ - |
| Bad Debt | $ 119,037 | $ (13,320) | $ - | $ 27,918 | $ 104,440 | |
| Charity | $ 173,386 | $ 62,429 | $ 926 | $ 44,247 | $ 65,785 | |
| **Provider Acquisitions/Transfers** | $ - | $ - | $ - | $ - | $ - | $ - |
| FY25 Proposed Budget | $ 130,329,326 | $ 55,360,825 | $ 11,823,971 | $ 54,797,013 | $ 7,933,423 | $ 414,095 |

**g. Capital Expenses. Explain any anticipated capital expenditures in the proposed budget, including a description of funding sources.**

To be submitted with the capital expense detail by August 1.

**h. Financial indicators. Explain any changes (key drivers) to your Operating Margin, Days Cash on Hand, and Debt Service Coverage Ratio relative to your FY24 projections, as well as any other key financial indicators that are important to consider in relation to your budget request.**

While these represent the calculated financial indicators for the respective hospital, it is important to note that for bond agency rating assessments and annual bank and debt covenant testing thresholds, these financial indicators are calculated at the UVM Health Network level, rather than individual hospitals.

Porter Hospital:

| | FY24 Projection | FY25 Budget |
|---|---|---|
| Margin | 4.0% | 4.7% |
| Days Cash on Hand | 112.0 | 93.2 |
| Debt Service Coverage Ratio | 9.0 | 9.6 |

**i. Uncompensated care. Differentiate any assumptions/changes as they relate to exogenous trends (e.g. patient needs) or internal practices (e.g. changes in accounting or business processes) related to bad debt and free care. Please include a description of collection processes. Report your budgeted bad debt to free care ratio and how you derived your estimates for bad debt and free care.**

There are no significant changes to report regarding internal practices related to the accounting practices for bad debt and free care. Any changes in trends are related to previous actual experiences. Previous actual experiences are used to model future impacts for current services provided. As actual experiences fluctuate, the model is updated to reflect changes in previous actual experiences to estimate future impacts.

Bad debt and free care are tracked, monitored and estimated as a percentage of gross revenue. Below are the trends used to inform the FY25 budget.

| **Porter Hospital** | FY23 Actual | FY24 Anlzd YTD Jan | FY24 Anlzd YTD May | FY24 Projected | FY25 Budget |
|---|---|---|---|---|---|
| Bad Debt as a % to Gross Revenue | 1.10% | 2.21% | 2.00% | 2.06% | 1.91% |
| Free Care as a % to Gross Revenue | 0.74% | 0.57% | 0.76% | 0.73% | 0.58% |
| Total Bad Debt + Free Care as a % to Gross Revenue | 1.84% | 2.79% | 2.76% | 2.79% | 2.49% |

**j. Community Benefit. Differentiate between the various drivers of community benefit.**

Please refer to Porter's most recent 990.

**d) Briefly summarize known risks in the budget as submitted, including the potential impact of and any known timelines associated with the risk, as well as any risk mitigation efforts, and their cost or potential benefit.**

Volumes: Porter Hospital's FY25 budget is based on annual volumes across all service lines. As demonstrated in FY24 projected, the absence of a single provider has a significant impact on our ability to meet our financial results. In the FY25 budget, the volumes are based on historical rates as well as growth that has been estimated as reasonable to achieve. As with any assumption, there are risks that the expected volumes may not materialize.

Payer Mix: Our FY25 budget has the allocation of the payer mix consistent with FY24 actual data. However, there is a risk that the payer mix may continue to migrate to Medicare Advantage plans that have higher denial rates, resulting in lower collection rates as compared to Medicare (which is cost plus 1% as a Critical Access Hospital) resulting in a lower NPSR and net income.

Cost Increases: As described in the assumption section of this document, we have included reasonable inflation costs in our FY25 budget. However, there is always a risk that these assumptions understate the actual levels that may be incurred in FY25 and that the cost will exceed the budgeted amounts.

Wage Pressures: Recently, our support staff and technical professionals organized two additional bargaining units. When included with our existing nurses bargaining unit, approximately two thirds of our workforce is now unionized. Negotiations for the support staff and technical bargaining units are ongoing and will continue in the coming months, and at the time of submitting this budget, the union has not yet provided us a proposal on economics. As in any union negotiation, it is difficult to precisely estimate the value of an economic package that bargaining unit employees will accept. The wages reflected in our

FY25 budget considers the wages provided employees in similar roles at other UVM Health Network partners hospitals.

Contract Labor/Travelers: Porter Hospital's FY25 budget continues to rely on contract labor to fill registered nurse (RN), radiology technologist and licensed nursing assistant (LNAs) positions across our various cost centers. The total number of positions filled by contract labor has declined in our FY25 budget, but the FTEs continue to be significantly above pre-COVID levels. Porter has been working to recruit and retain staff in these areas, and we believe that the culture and work environment will continue to reduce our reliance on contract labor. However, our ability to identify and retain these positions also depends on certain factors outside of our control, including housing, new nurse graduates and available childcare. As such, the levels included in our FY25 budget may not be met.

**e) Administrative vs. Clinical Expenses: using the Medicare Cost Report definition of administrative clinical, and mixed expenses in Wang & Bai (2023)2, also defined in the Uniform Reporting Manual, please comment on the relative trends in each of these expense categories over time. If you believe the Medicare Cost Report definition does not accurately reflect your organization, please articulate how you would adjust the calculation and why, and provide an alternative estimate with sufficient detail that it can be cross-walked to the standard definition. Further, to the extent you make modifications specific to your hospital, indicate which of your peers require such modification and the impact of such modification on each such hospital.**

At UVM Health Network, the annual Medicare cost report is completed in accordance with Medicare cost report-specific regulations, definitions and instructions published in CMS Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Hospital & Hospital Health Care (Form CMS 2552-10). Each Medicare cost report filed with CMS is subsequently audited or reviewed by a CMS-contracted entity to ensure full compliance with all Medicare rules, instructions and guidelines. That said, some amount of variation in approach is both common and acceptable.

The use of the Medicare cost report to compare one hospital to another can be misleading because of the differences in how each hospital and system is structured. Some hospitals are part of systems, while others are stand-alone. Some systems have separate home office organizations, while others allocate shared costs through accounting entries. How the shared costs are allocated to each member hospital varies greatly from one system to another, which leads to variations in how cost report data is presented.

Another consideration is that costs considered "non-reimbursable" based on the Medicare cost report instructions and definitions cited above are clearly patient-care related and legitimate costs incurred by the hospital. For example, physician patient service costs and charges are excluded on the Medicare cost report, but those costs are included in the budget presented to the Board. In addition, there may be patient care related cost centers that are considered non-reimbursable under the Medicare cost report regulations because it is reimbursed under a different reimbursement methodology. These "non-reimbursable" costs are either entirely removed from the cost report (as in physician costs) or they are reported in the non-reimbursable area of the cost report which would not be captured in the Board's administrative versus clinical expenses calculations. It is difficult to include these lines because they are non-standard lines on the cost report and therefore vary from one provider to another.

To mitigate some of these deficiencies when using Medicare cost report data to calculate financial metrics, it is important to pull the data for the calculation from the correct location. The Medicare cost report regulations require hospitals to make specific adjustments to the data to attempt to equalize the reporting among providers. In last year's budget process, the data utilized by the Board to calculate an administrative to clinical percentage was pulled from Worksheet A Column 1 of each hospital's Medicare

cost report. This column is before any of these adjustments. If the Medicare cost report is going to be utilized in this manner, then the data should be pulled from Worksheet A Column 7 (not Column 1) for all hospitals in the peer group, as Column 7 includes all the relevant cost report-specific adjustments and improves the comparability from one provider to another. Although this recommendation does not mitigate the exclusion of physician costs, it ensures that regardless of hospital structure the costs are more likely to be reported in the same manner across providers.

On December 23, 2023, we sent the Board staff an Excel file with detailed calculations that created an adjusted Column 7 for salaries, consistent with what we presented during last year's budget deliberations and offered to meet to go over the information in greater detail. We are still open to meeting with Board staff to do a deeper dive into what we have described above, which could be an easier way for the Board staff to calculate a more accurate administrative to clinical ratio comparison for all Vermont hospitals.

**f) Facility Fees: Please describe the methodology your hospital uses to establish any facility fees and how much they totaled in FY24 and are expected to total in FY25.**

Medicare provider-based billing of facility fees in hospital-owned, physician outpatient clinics is driven by Medicare payment policy under 42 CFR § 413.65 - Requirements for a determination that a facility or an organization has provider-based status. "Provider-based" is a Medicare payment designation established by the Social Security Act allowing facilities owned by and integrated with a health care provider (usually a hospital) to bill Medicare as a department of that health care provider. Through these regulations, Medicare recognizes that clinical integration enhances coordinated care, allowing doctors and hospitals to work together to provide patients with the best possible care and services, as well as manage more complex patients with multiple chronic conditions. Hospital-owned, provider-based clinics are subject to stricter government rules, quality standards and are subject to the same regulatory requirements as the main hospital.

At Porter Hospital, the total gross charge for a specific service rendered in a physician outpatient clinic is the same regardless of whether it is billed to Medicare under provider-based regulations, or to any other insurer. When billing to a commercial insurance or Medicaid, the total gross charge is billed solely on a professional bill. When billing to Medicare under provider-based regulations, the total gross charge is "split" into two components – a smaller professional component and a corresponding facility component. The total of those two components billed to Medicare equal the same dollar amount that would have been billed to commercial or Medicaid on the professional bill for the same service.

In FY23, the last year for which we have complete data, Porter Hospital billed Medicare for $3M in provider-based facility billing. Were we not approved by CMS for provider-based billing, the total amount of $3M in charges would be combined with the professional component on one professional bill, consistent with the total billing for all other payers.

Per federal regulations, all gross charge information is publicly available on our price transparency file located at the link below:
https://www.portermedical.org/patients-visitors/patient-financial-services/price-transparency/

To be clear, UVM Health Network does not charge facility fees for any payer besides Medicare.

**g) Does your budget increase request consider consumer affordability, and if so, how?**

Yes. Across UVM Health Network, we are dedicated to providing high-quality care that our patients can

afford.

Reducing the rate of growth in the costs of our services reduces barriers to access, which is, in itself, one of our main affordability strategies. We know that by increasing access to care – especially primary, preventive and wraparound care – the health of our patients improves and thus reduces total long-term care costs. We are making progress in improving access to care, and our budget submissions support many strategies and initiatives to continue this work, while balancing investments in those services with overall affordability.

We have major initiatives underway across the entire system to reduce wait times for care, which helps improve efficiencies within our system and control overall costs. New self-scheduling options will help our patients see their primary care providers more quickly; our growing use of eConsults, enhanced referrals and refer backs are expanding access to specialist care, while cutting down on clinically unnecessary in-person visits; expanded clinic hours are helping patients receive mammograms and medically-necessary CT and MRI scans sooner; and our proposed Outpatient Surgery Center will increase access to surgical care and help control overall costs by keeping patients local and out of more expensive inpatient settings.

By investing in lower-cost care services like our care management program, we can help address more of our patients' barriers to care and social determinants of health, shifting more health care away from comparatively high-cost settings like the ED or inpatient care. Early data from one of our initiatives show that patients enrolled in care management require less acute care, with a 42% reduction in ED visits and a 41% reduction in inpatient admissions. Our investments in primary care, long-term care, mental health and substance use disorder programs and partnerships are helping to steer more individuals away from more costly hospital settings.

All these initiatives impact consumer affordability and are supported by our FY25 budget submissions.

Continuing our work to improve access to care is critical, especially when we consider that health care costs are not evenly distributed in Vermont and that the burden of cost increases falls disproportionately on Vermonters who are commercially insured. For this population, a lack of access may force patients to seek health care farther from home and at higher prices, which widens disparities and worsens the cost shift by having our commercial payments benefit out-of-state providers.

Cutting Costs

Last year we successfully reduced our expenses by $70 million by reducing 130 open administrative positions across our system; we also deferred planned investments meant to improve access and maintain our infrastructure. This focus on prudence and efficiency has resulted in lowering the rate of growth in costs.

In this year's submission, to keep the overall rate of growth as low as possible, we tightened administrative and certain clinical spending, as highlighted in section C. b).

Building a High-Quality, Low-Cost Health System for Vermonters

Looking at affordability in the national context, according to data sources utilized by the Board, we are one of the lowest cost health systems in the country for Medicare beneficiaries. For example, data enclosed in the RAND price transparency study and economist Professor Cooper's research (as discussed previously) shows UVM Health Network inpatient prices are moderate to low when compared to similar hospitals. Overall, the Burlington area has low per capita health care costs across the board once we

account for the age of the population.

However, being comparatively low cost does not mean everyone can afford to access care, and none of that matters to someone who is struggling to pay their health insurance premiums or to employers shouldering high expenses to provide their employees with insurance. As we submit our FY25 budget, we remain focused on balancing the need to keep our expenses in check while addressing the very real issues with access to care discussed throughout this proposal. The budget we have submitted outlines our efforts to provide the high-quality care our patients deserve, and transparently reflects what it costs to provide that care.

Our NPR requests represent the needs of our community's growing and aging population, as well as our health system's focus on increasing patient access to care. Our commercial rates reflect the cost of providing these needed health care services. That means the commercial rate requests before the Board are solely what we need to cover cost inflation; this burden is mostly borne by commercial ratepayers, as Medicare and Medicaid do not keep up with increases in cost inflation. An exception is Critical Access Hospitals, which receive cost-based funding from Medicare and therefore do not need to request the magnitude of commercial rate increases that PPS hospitals need. This is a long-standing structural problem that has a real impact on Vermonters and the hospitals that serve them. We work hard on this and still, we recognize that health care is still too expensive for too many. We stand ready to continue our work with the Board and our partners to address this challenge without compromising the quality or accessibility of health care available to the people of our state.

**h) If your proposed rate and/or NPR increase request were to be reduced, provide a high-level description of your hospital's contingency plan for maintaining access to essential services and generating a positive margin.**

At UVM Health Network, we will not be able to commit to either maintaining or, more importantly, improving access to services if our NPR increase request is reduced. By default, given that 134% of Porter Hospital's NPR increase is tied to utilization and access improvement, 63% of UVM Medical Center's and 77% of Central Vermont Medical Center's, there would be no option but to reduce the amount of clinical services we provide. If any of our UVM Health Network partner hospital's NPR increase was reduced:

- We would go through our list of open provider recruitments and pause recruitment for positions that have a negative impact on margin.
- We would look at open staff positions and eliminate those that do not have a positive impact on margin, many of which would be tied to the provider recruitments we would pause.
- We would continue to pursue and advocate for government rate increases, like the retroactive Medicare rate increase for market basket increases that have not kept pace with inflation.
- We would scale back planned salary increases, negatively impacting overall recruitment and retention.

This work would not be focused on just generating a positive margin, as that is not enough. It would focus on generating the margins we have budgeted, which are driven by our 5-year financial framework that is essential to caring for the needs of our patients.

Our framework lays a path back to financial stability and generates the resources we need to reinvest in our communities, which enables us to continue providing high quality care. The last three years have significantly eroded the liquidity that nonprofit health care organizations require for reinvestment. Our

three Vermont hospitals are no different. Liquidity has been significantly eroded, and millions of dollars in capital investment have been delayed.

- The chart below shows that combined, our three Vermont hospitals will still be down $370M in liquidity at the end of FY24.
- Delayed capital investment, using the S&P median of 125%, will be $141M.
- For days cash on hand, the preliminary 2023 A rated S&P median benchmark is 178.
- These delayed investments have created a significant backlog that we need to begin addressing now before significant damage is done to the availability and quality of the health care we provide.
- To provide additional context for the size of the issue, UVM Health Network recently engaged with Global Commercial Real Estate Services (CBRE) to conduct a facilities condition assessment for all partner sites. They are 80% complete on their assessment of the UVM Medical Center campus and are estimating we have $620M of deferred maintenance costs that will need to be addressed over the next 10 years.

| | FY21 Actual | FY22 Actual | FY23 Actual | FY24 Projected |
|---|---|---|---|---|
| **UVMMC** | | | | |
| Days Cash on Hand | 201 | 113 | 113 | 121 |
| Increase / (Decrease in Cash) | | $ (378,400,000) | $ - | $ 47,200,000 |
| Cumulative | | $ (378,400,000) | $ (378,400,000) | **$ (331,200,000)** |
| | | | | |
| Capital Spend | $ 42,331,000 | $ 53,798,000 | $ 51,251,000 | $ 70,000,000 |
| Depreciation | $ 62,290,000 | $ 68,233,000 | $ 69,412,000 | $ 69,441,000 |
| Capital Spend as % of Depreciation | 68% | 79% | 74% | 101% |
| Capital Spend at 125% of Depreciation | $ 77,862,500 | $ 85,291,250 | $ 86,765,000 | $ 86,801,250 |
| Capital Spend Deficit | $ (35,531,500) | $ (31,493,250) | $ (35,514,000) | $ (16,801,250) |
| Cumulative | $ (35,531,500) | $ (67,024,750) | $ (102,538,750) | **$ (119,340,000)** |
| | | | | |
| **CVMC** | | | | |
| Days Cash on Hand | 99 | 64 | 73 | 70 |
| Increase / (Decrease in Cash) | | $ (26,880,000) | $ 7,182,000 | $ (2,499,000) |
| Cumulative | | $ (26,880,000) | $ (19,698,000) | **$ (22,197,000)** |
| | | | | |
| Capital Spend | $ 3,480,000 | $ 4,602,000 | $ 2,543,000 | $ 8,200,000 |
| Depreciation | $ 7,789,208 | $ 7,344,200 | $ 6,844,619 | $ 6,575,728 |
| Capital Spend as % of Depreciation | 45% | 63% | 37% | 125% |
| Capital Spend at 125% of Depreciation | $ 9,736,510 | $ 9,180,250 | $ 8,555,774 | $ 8,219,660 |
| Capital Spend Deficit | $ (6,256,510) | $ (4,578,250) | $ (6,012,774) | $ (19,660) |
| Cumulative | $ (6,256,510) | $ (10,834,760) | $ (16,847,534) | **$ (16,867,194)** |
| | | | | |
| **PORTER HOSPITAL** | | | | |
| Days Cash on Hand | 163 | 119 | 103 | 113 |
| Increase / (Decrease in Cash) | | $ (14,300,000) | $ (5,680,000) | $ 3,810,000 |
| Cumulative | | $ (14,300,000) | $ (19,980,000) | **$ (16,170,000)** |
| | | | | |
| Capital Spend | $ 2,060,000 | $ 1,731,000 | $ 1,972,000 | $ 2,576,000 |
| Depreciation | $ 2,882,000 | $ 2,953,000 | $ 2,627,000 | $ 2,457,000 |
| Capital Spend as % of Depreciation | 71% | 59% | 75% | 105% |
| Capital Spend at 125% of Depreciation | $ 3,602,500 | $ 3,691,250 | $ 3,283,750 | $ 3,071,250 |
| Capital Spend Deficit | $ (1,542,500) | $ (1,960,250) | $ (1,311,750) | $ (495,250) |
| Cumulative | $ (1,542,500) | $ (3,502,750) | $ (4,814,500) | **$ (5,309,750)** |

**i) Provide all costs associated with (i) lobbying and (ii) marketing, advertising, and branding, and identify the amount paid to each entity that performed such services on your behalf.**

The lobbying data is FY23 and is consistent with both our historic and current lobbying expenses.

| Porter FY23 Lobbying Expense | | |
|---|---|---|
| Vermont Association of Hospitals & Health Systems (VAHHS) | $ 11,242 | These amounts represent the portion of dues paid to associations and trade groups |
| American Hospital Association (AHA) | $ 4,715 | and is directly connected to lobbying by those groups on behalf of their members. |
| Necrason Group, PLLC | $ 3,920 | |
| UVMHN Government Relations Staff Time | $ 2,601 | |
| | **$ 22,478** | |

The marketing, advertising and branding functions are part of a Shared Service that serves all UVM Health Network health care partners across Vermont and northern New York. As a Shared Service, costs are shared by all health care partners based on total revenue. We do not budget specifically for health care partners. Rather, the overall budget is zero-based and built to reflect the systems that enable our work, the people who do the work, with dollars set aside for anticipated and unanticipated priorities. Based on our FY25 budget for marketing, advertising and branding for the health system and the shared cost allocations, the budget for these functions is as follows:

| FY25 | Marketing/Advertising/Brand Budget |
|---|---|
| UVMMC | $585,816 |
| CVMC | $60,515 |
| PH | $35,573 |
| **Total** | **$681,904** |

**j) Describe planned fundraising efforts and anticipated donations for FY25.**

At Porter Hospital, we estimate that in FY25 we will receive donations totaling $250,000. Priority areas will be unrestricted dollars, workforce development and investments in our facilities and equipment.

**k) Describe projected investment income and, if projected to be zero, please provide a 3-year summary of annual investment income.**

For UVM Health Network, there are two lines related to investment income: “Change in Interest in Investment Pool” and “Investment Income & Losses on Investment.” “Change in Interest in Investment Pool” is where the interest/dividends and gains/losses (both realized and unrealized) of the short-term investments and long-term reserves hits and represents virtually all investment income and/or losses for each organization. This line is budgeted at a 4% return based on current investment balances at the time of budgeting. The FY25 budget for this line is a little over $23M, $21.2M for UVM Medical Center, $0.7M for Central Vermont Medical Center, and $1.2M for Porter Hospital.

The “Investment Income & Losses on Investment” line is where interest/dividends on operating bank account balances and gains/losses on any investments held outside the broader investment program gets posted. This line is generally budgeted at or near zero. Actual income on this line for FY21, FY22 and FY23, was:

| Partner | FY21 | FY22 | FY23 |
|---|---|---|---|
| UVMMC | $0.7M | $0.6M | $4.2M |
| CVMC | $2.6M | $3.1M | $28k |
| PH | $0 | $ 0 | $0 |

**l) Has your hospital experienced a reduction in payment from any payer based on quality performance in the last two years? If so, please explain the nature of the penalty, the revenue impact, and steps taken to remediate the situation.**

Porter Hospital did not experience negative adjustments in the last two years.

**m) Describe the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors, residency programs, and any other workforce development initiatives in which you are participating. Include a description of the program and where the accounting entries show up in your proposed budget (income statement and balance sheet).**

Workforce Development Across our Health System

The UVM Health Network's Center for Workforce Development continues to pioneer innovative solutions designed to train community members and members of our own workforce for in-demand positions across our system. This includes internal training programs and partnerships with colleges, both here in Vermont and nationally. These initiatives are a key component of our ongoing effort to create scalable and sustainable workforce solutions across the health system. By doing so, we not only reduce our dependence on costly temporary labor but also benefit the broader health care systems of Vermont and northern New York.

In 2025, the Center for Workforce Development plans to harmonize and scale its efforts across Vermont and New York, ensuring that its initiatives reach as many individuals as possible. A focus will be on preparing more frontline employees for advanced educational programs, such as pre-requisite courses at community colleges.

The Center also plans to diversify its pathway programs to continue creating innovative solutions that meet the growing talent needs across the health system. This includes expanding existing programs and introducing new ones to cater to a wider range of health care roles. In certain areas, apprenticeships will be leveraged as a method for meeting talent needs.

In 2025, the Center intends to grow its partnerships in the community, including schools, colleges, and community-based organizations. A special focus will be placed on harnessing the talents of historically marginalized communities, refugees/immigrants/asylees, opportunity youth, and individuals with disabilities. This approach will support a diverse and inclusive workforce that reflects the communities served by our health system.

Specific workforce development initiatives at Porter Hospital include:

- Collectively, the initiatives outlined below highlight our comprehensive approach to workforce development, education and recruitment within the nursing program. They focus on supporting

staff growth, enhancing skill sets and expanding educational opportunities for current and future health care professionals. The costs associated with these programs run through Porter Hospital's operating expense base and are included in the FY25 budget as submitted.

- LNA Trainees: We have hired four LNAs, with an additional four set to start in July. This influx of trainees shows a commitment to growing the workforce and providing opportunities for entry-level health care professionals. LNA trainee costs are captured in the FY25 salary and benefit line on the income statement.
- State Workforce Grant: A team within the nursing program has successfully applied for a State Workforce Grant, demonstrating dedication to securing funding and resources that support the growth and development of the nursing team.
- Licensed Practical Nurse (LPN) Student Progression: LPN students who have completed prerequisites will be embarking on a 1:1 program at Vermont State University (VTSU) starting in August. These students are not only gaining academic qualifications, but also practical experience as techs in hospital areas, with a service commitment following their training.
- Pipeline Programs: We participate in various pipeline programs, including recruiting for respiratory therapist, medical technician and surgical technician candidates. This initiative showcases our holistic approach to workforce development and recruitment.
- Preceptor Differential: Offering a preceptor differential for core staff members emphasizes the value we place on training and mentorship within the nursing program, encouraging experienced staff to support the growth of their peers.
- Recruitment for MSN Program: Actively recruiting for the VTSU Master of Science in Nursing (MSN) program through the workforce grant signifies our focus on continuous education and professional advancement within the nursing team.
- Simulation Lab Updates: We are renovating a space to realize the grant monies from the Northern Border Regional Commission and building out our clinical simulation lab. We are partnering with VTSU to allow students to use the space.

**n) Please describe the hospital's investments in workforce retention such as housing, day care, and other employee benefits. Include a description of the program and where the associated accounting entries show up in your proposed budget (income statement and balance sheet).**

Porter Hospital is making specific financial investments in the training and recruitment of nurses. A current program sponsors up to five nurses with $2,500 per year towards the cost of a BSN or MSN. We are also actively working with VTSU on an MOU to subsidize the cost of completing a BSN for any nurse.

Both of these programs come with service commitments on behalf of the recipients. The costs of these programs are budgeted within Porter Hospital's salary/fringe expense.

The housing and childcare initiatives in Chittenden County, supported by UVM Health Network, are available to all system employees.

**o) For what drivers of expense growth do you feel hospitals should be "held harmless" and why?**

The following items drive expense growth and are largely outside Porter Hospital's control or are required to address patient access, and therefore we request these not be counted against growth limits.

- Provider Tax: As we provide more services and increase access, this tax increases in a corresponding capacity. We have no control over this expense.

- Vermont Act 119: Compliance and the increased costs associated with implementation.
- Pharmaceutical Expense: Our negotiation power is limited to reduce expenses related to medications and pharmaceuticals.
- Direct Staff Labor Cost: Additional expenses due to multi-year contractual obligations for wage increases, along with increased costs for recruitment and retention to provide a workforce to deliver high-quality patient care.
- Volume: We have seen a steady increase in patient volume since the pandemic, which is driving corresponding increases in operational costs, staffing requirements and resource allocation, and we are limited in terms of ability to reduce these increases without negatively impacting access.
- Housing and Childcare: Support services provided to staff such as housing allowances, childcare benefits or other programs that support employee wellbeing and increase the effectiveness of recruitment and retention efforts.
- Workplace Violence Initiatives for Prevention and Safety: To address rising incidents of violence in our health system, we will continue to invest in equipment, staff and training. We believe Porter Hospital should be held harmless for the associated expenses.
    - Safety Equipment: Investments in personal protective gear, panic buttons or other safety tools to safeguard staff from workplace violence.
    - Security: Costs associated with hiring additional security personnel or contracting with security firms.
    - Training: Expenses for specialized training programs aimed at violence prevention and conflict de-escalation.
    - Cameras: Installation and maintenance of surveillance equipment to monitor and enhance security.
    - New Locks and Doors: Upgrading physical infrastructure to improve security measures and protect staff.

**D. Hospital & Health System Improvement**

**a) Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, please share any investments you are making and/or the steps you are taking to improve access in each of those areas, with specific ties to your budget, where appropriate.**

Porter Hospital continues to invest in the Helen Porter Nursing Home to ensure that the facility can operate close to full capacity. The investment is not only financial, but also in the form of Porter Hospital staff, such as security, human resources, patient financial services and finance and accounting, to name a few. These services ensure the safety of the staff and residents and improve the financial processes – coding, billing and colleting funds as well as proper review for transparency and financial accuracy.

Radiology Access: Porter Radiology has expanded services in CT, increasing access by 8% in the past two years and MRI services by 4%. We are upgrading the CT scanner by the end of FY24, which will increase image quality as well as reliability for uptime.

System-Wide Access Initiatives: As described in more detail below, certain access initiatives are intentionally designed to improve access to care irrespective of where patients seek care in our health system. eConsults, enhanced referrals and our refer back initiative are three such examples, which improve access by:

- Strengthening care collaboration between primary care and specialist providers,
- Allowing more care to remain in primary care, as appropriate,

- Reducing clinically unnecessary in-person specialist visits, and
- Expediting in-person specialist care for those who require it, while boosting the productivity of these visits.

eConsults: Since 2021 we have grown our eConsults capability across our system to include more than 20 specialties, including endocrinology, cardiology, pulmonology, and rheumatology, with others continuing to join. In FY24, providers are on track to order more than 3,600 eConsults, with an internal goal of 4,000. Last month (May 2024) saw the single highest usage of eConsults since the program kicked off, with 381 eConsults ordered by clinicians across the health system. Providers at Porter Hospital used 305 eConsults through June 2024, compared to 152 in FY23.

Early data show that in about 75% of eConsult cases, primary care physicians and APPs say that the eConsult likely prevented a patient from needing a separate visit with the specialist. Only about 13% of cases result in a specialist referral in the nine months following the initial eConsult. In other words, close to 90% of eConsults do not end up as an in-person visit, which opens much-needed capacity for those patients who do require in-person appointments. As one example, rheumatology at UVM Medical Center and Central Vermont Medical Center, one of our health system's busiest specialties, eConsults have decreased average monthly referral volumes by 11%.

Enhanced Referrals: At the same time, when a specialist and primary care provider determine that a patient needs to be seen in person quickly, we have developed 'enhanced referrals' for many specialties to ensure that appropriate patients receive earlier appointments. Accessed through our unified electronic health record system, enhanced referrals direct providers to order eConsults when appropriate, while also offering further guidance on which tests, lab work, imaging or other information should be collected prior to a person's visit, thereby strengthening the quality of the specialist visit and the patient's experience. At their core, enhanced referrals mean that when people arrive for their specialist visit, they have everything in hand to make their appointment as productive as possible. Enhanced referrals are focusing on specialty areas with high referral volumes such as rheumatology, cardiology, endocrinology, hematology, certain types of surgical subspecialties (ENT, vascular, ortho), with additional plans in process for other high demand specialties.

To broaden access to primary care providers outside UVM Health Network, we are working on a pilot program with Hudson Headwaters Health Network that will allow their providers to access eConsults and enhanced referrals for rheumatology. Once the IT interface between Epic and other electronic health records is streamlined, this work will include additional specialties and primary care practices.

"Refer Backs" to Primary Care: Once a patient has been treated by a specialist and their condition is well-managed, our providers are participating in another initiative to transition them back to primary care for ongoing maintenance. This 'refer back' initiative aims to address the fact that historically, many people continue to routinely see specialists even when they no longer require specialty care, which in turn impacts access for new and existing patients who require it. Since the initiative launched in October 2023, 536 patients receiving care from specialists have been 'referred back' to their primary care providers for ongoing care, encompassing primary care practice patients both inside the UVMHN and independent practices. This has created 965 slots for new patients or follow-up slots for existing patients in the specialists' schedules (for this population of patients with chronic care needs, patients see their specialist about 1.8 visits on average per year per patient).

**b) Describe how you work with other providers in your community, including the FQHC, designated agencies, other community-based services etc., being sure to include opportunities and obstacles to ensuring smooth transitions of care along the care continuum.**

Partnerships with other organizations are key to cohesive patient care, especially in rural Addison County. With that in mind, Porter Hospital has started discussions with Middlebury College and Addison County Home Health and Hospice to identify opportunities for collaboration and coordination for patient care. This partner group understands the mutual benefit of working together for improved patient care. In FY25, integration of services will be the main focus of our discussions.

As mentioned previously, Porter Hospital provides free, on-site clinical space to the Open Door Clinic. As part of the collaboration, Porter has established a voucher system by which Open Door patients can receive certain diagnostic lab and imaging tests free of charge. These vouchered tests totaled $212K in FY23.

**c) If your hospital was asked to submit a Performance Improvement Plan, please provide an update on progress or challenges relative to that plan.**

The performance improvement plan we were asked to provide was related to reducing our administrative shared service costs. On December 22, 2023, we submitted that plan, which targeted a $17.4M reduction in administrative shared services, which decreased the cost as a percent of total cost from 12.6% to 11.6% for our Vermont hospitals. Through March FY24 we are at 11.5% of total cost, on track with the target. We expect to be on target at the end of the fiscal year, as well.

**d) Hospital Networks: Explain your shared services strategy, any additional revenues associated with such investments and methodologies for allocating associated costs. Quantify any efficiencies to date, and when you expect to achieve any future efficiencies**.

At UVM Health Network, our strategy for administrative shared services is to become as efficient as possible in order to have more resources to care for patients. As highlighted in section C. b) above, the current Syntellis median for administrative shared services is 12.3%. For FY24 we are at 11.5%, and the FY25 budget is at 11.7%.

Looking forward, we do see additional efficiencies that should continue to reduce our proportion of administrative costs. As we have shared, standardizing our systems – which creates standardized processes, allows for leadership centralization and staff cross coverage – is a key component that enables us to become more efficient. Most of our core systems, such as Epic (revenue cycle and clinical systems), Workday (HR and payroll), Premier Connect (general ledger) and Syntellis (financial reporting), have all been standardized across our health system. The last core system to be standardized for scheduling and timekeeping, Qgenda, will go live on January 1, 2026. Beyond system standardization, where we see additional efficiency opportunities is through the use of artificial intelligence (AI) and robotic process automation (RPA).

The revenues associated with shared services are highlighted in section C. b) above. UVM Health Network uses total revenue to allocate administrative shared service costs.

**F. Other**

**a) Is this a zero-based budget? If not, when was the last time your organization developed a true**

**zero-based budget (creating a budget from scratch and then justifying every expense rather than basing the budget on prior spending)?**

At UVM Health Network, our budgets are not developed using the "zero-based" methodology, as that would be an enormous undertaking and, if we were to truly conform, would require the removal of the staffing guidelines that have been agreed to in labor contracts. While we do not use that methodology, it does not mean expense budgets are not scrutinized and department leaders are not tasked with justifying their budgets every year. For clinical areas, expense budgets are tied to a volume metric. The ratio of expense to volume metric is based on current run rate, then analyzed for any one-time or abnormal increases or decreases and then compared to inflation expectations or contracted increases for items such as staff wages or maintenance agreements. For expenses, when adjusted for changes in volume, we incorporate scale and efficiencies where possible. In addition, where we have data, that ratio is compared to a benchmark. For example, for most nursing units, expense budgets are set at the 50th percentile for Nursing Hours per Patient Day (NHPPD) from the National Database for Nursing Quality Indicators (NDNQI) survey, and the Labor Management Institute (LMI) survey for others. For administrative shared services, each area is provided a total targeted budget amount that keeps the aggregate budget at no more than the current cost as a percent of total Network costs, which is below the Syntellis median.

Lastly, budget development work is only a moment in time. Things are constantly changing in health care and within our facilities. What is more important is how we manage expenses throughout the year. We monitor each month how we are performing not only compared to budget but to run rate and associated benchmarks like average length of stay. This allows us to adjust operations in a timely manner, while focusing on ways to become more efficient.

**b) Patient Financial Assistance**

**a. If a contract with a third party exists to collect payments from patients, please provide this contract and disclose the amount paid for such collection efforts and the revenue generated therefrom.**

Porter Hospital
Total paid for collection efforts: $53,991
Revenue generated from collection efforts: $394,819

Please see Appendix H through J for these three contracts. These three agreements cover all three of our Vermont hospitals.

**b. If you have a contract with a third party, please describe the return on investment for this decision compared to managing these activities internally as a part of Patient Financial Assistance Programs?**

If a patient does not make an effort to resolve their balance, either by paying in full, setting up a payment plan, applying for financial assistance or making other arrangements with our Patient Financial Services Department and has received four statements over a 120-day time period, the account is referred to a third-party collection agency. Our collection agencies have the depth to reach out on large volumes of accounts with high levels of efficiency. They use a series of letters and make telephonic, text and voice mail attempts to reach the patient. Once contact is made, the agencies work with the patient on repayment terms that best fit their financial needs. Agencies also discuss financial assistance and advise how they can apply. Additionally, as part of our Medicare Bad Debt Reporting we can demonstrate that reasonable

collection efforts were made. While we use the services of an agency, UVM Health Network has never negatively reported bad debt – meaning, patient credit scores are not impacted by this practice.

**c. Please describe how patients are screened for Patient Financial Assistance at your hospital.**

While laws in Vermont and New York require certain unique specifications, our approach to patient financial assistance is consistent across our hospitals within our system.

Registrars throughout UVM Health Network are educated on our financial assistance programs. Depending upon the role or location, a soft initial screening may occur, followed by a referral to our advocates and counselors where a full screening occurs. Within registration, the plain language summary followed by applications and referrals serve as a conduit to aid our patients, beginning with the pre-registration process.

Our approach is to educate and ensure patients are aware of program guidelines, with referrals to dedicated staff in our system to aid with the application process.

We notify our patients of our financial assistance program through multiple means, including prior to their visit, at the time of their visit and concurrent with the care they receive. After discharge, a written notification – with contact information – is visible on our patient statements. Policies, summaries and applications are also on our public website and available for download. Signage is in our waiting areas and our registration staff provide copies of our plain language policy summary.

In addition to the above methods of communication, we employ financial counselors and patient advocates who provide initial screenings and subsequently assist patients in the application process for health exchange coverage, Vermont or New York Medicaid and the UVM Health Network financial assistance program. The counselors work with patients via the phone, in person and at the bedside with our team members completing the applications, advising on necessary documentation and subsequently submitting all materials for review and approval by the appropriate teams or agencies.

With patients in our ED, our financial counselors meet with the uninsured and/or underinsured patient during care (upon request), or with the uninsured patient after care to help them obtain financial sponsorship.

We educate all patients on financial assistance in our customer service calls. When one of our patients wishes to establish a budget plan or expresses hardship, our representatives educate them on the assistance program and initiate a financial screening by asking questions about household size, income, etc. If the patient qualifies, the team offers to help the patient complete the application or mail them the application based upon their preference. Subsequently, an application (or the partially completed application) is mailed to the patient or sent via MyChart. The patient is then responsible for verifying their data, signing the application, attaching necessary supporting documentation and returning it to the UVM Health Network financial assistance office.

Staff advise patients that they will receive a written decision within 30 days and, if approved, the adjustments will be taken at the time of letter generation. Like our point of service processes, this screening leads immediately to assistance in the application process. For those who prefer an in-person meeting, we refer them to our financial advocates located within the hospital or billing offices.

**d. When patients receive a bill – either paper or electronic – are they made aware of the hospital's patient financial assistance policy and how to apply?**

Each statement, whether paper or electronic, has reference to financial assistance and a phone number for contact inquiries. Additionally, this information is on our websites along with the application form, current FPLs, financial assistance policy, contact phone numbers, mailing address. Patients can check the status of their financial assistance application electronically (via MyChart or email) or contact us via telephone.

**c) For reporting on boarding as required in Section VI, please explain how you derived your estimates and explain key drivers and trends over time.**

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

For patients boarding in our EDs, we have calculated the average number of patients per day who stay in the ED past 24 hours with a mental health diagnosis, multiplied that number by 24 hours and divided by 365 days to generate a total annual number of ED mental health boarder days. That number of annual days is then multiplied by the average cost per day to generate the cost of these patients awaiting treatment, as we do not receive reimbursement for those who stay beyond 24 hours. The trend has been that the number of patients awaiting mental health treatment boarding in our EDs is going down, which is lowering the uncompensated care.

## SECTION VI: HOSPITAL REPORTING REQUIREMENTS

1. **FY2023 Medicare Cost Report (upload)**
   **Submit a pdf of your full FY23 Medicare Cost Report as submitted to the Centers for Medicare and Medicaid Services (CMS).**

2. **Verification under Oath (upload)**
   **Attestation to truth of filing on which the hospital Board, CEO and CFO, swears and affirms that the information provided is true and accurate to the best of their knowledge. The hospital should submit an individual document for each of these Executives.**

3. **Budget Narrative (upload)**
   **For each hospital, submit a budget narrative (see Section V for specific requirements and questions to be answered).**

4. **FY2025 Budget Request (Adaptive)**
   **Each hospital must submit details of its budget request in the Adaptive database using the following Sheets. Projections for FY24 should also be provided in those same sheets. These Adaptive sheets are listed below in the most efficient order of completion since some accounts populate accounts in other sheets. More detailed definitions and requirements can be found in the Uniform Reporting Manual and Adaptive User Guide.**

***Hospital and Physician Revenue***
**The Hospital and Physician Revenue Sheet collects units of service and Net Patient Revenues and**

**Fixed Prospective Payments, Reserves and Other Payments at the Department level.**

***Payer Revenue***
**The Payer Revenue sheet records Gross Patient Revenues and Deductions by Payer, where payer is broken by Medicaid, Traditional Medicare, and Commercial; and Commercial is broken out by, Traditional Commercial, Medicare Advantage, Workers Comp, Self-Pay, Commercial FPP, and Other. The Net Patient Revenue by Payer calculated from these submitted values should tie to the totals reflected in the Rate Increase Decomposition sheet.**

***Other Revenue***
**The Other Revenue sheet includes both Other Operating Revenues (for example, grant income, 340B pharmacy, etc.) and Non-Operating Revenues.**

***Staff/FTE***
**The Staff/FTE (Full Time Equivalent) sheet collects all budgeted FTEs for each Hospital by department and service area by clinical and non-clinical FTEs per the uniform reporting manual.**

***CON Sheets (Non-CON Detail, CON Detail, Capital Summary)***
**The CON sheets provide information on hospitals' planned capital expenses. The Non-CON detail sheet includes information on projects costing more than $500K but not triggering a Certificate of Need reviews, while the CON Detail sheet includes all CON projects. The Capital Summary sheets combines the Non-CON and CON detail sheet while also entry of the aggregated cost of non-CON projects less than $500K each.**

***Rate Decomposition***
**The Rate Decomposition sheet collects Net Patient Revenue due to rate (i.e. charges less discounts) versus Net Patient Revenue due to non-rate changes (i.e. utilization, payer mix, case mix, service etc.), by core service line (inpatient, outpatient, and professional services) and payer, where payer is broken out by payer category and major commercial payers as defined previously in this guidance. This sheet will be used to assess budget assumptions due to non-rate changes.**

As noted in the separate letter submitted herewith, this information is being submitted under seal, along with a request that it be treated as confidential and exempt from disclosure under the Vermont Access to Public Records Act.

***Balance Sheet***
**If your budget is entered in the order above, several accounts in the Adaptive balance sheet will be populated by entries made on other sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions.**

***Income Statement***
**Like the balance sheet, several accounts will be automatically populated if your entries are made in the order above. Where accounts are not linked, please ensure that all figures reported on your income statement tie to the relevant figures on the Other Revenue and Payer Revenue sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions. Income statement will be driven by entries on the payer revenue sheet and other revenue.**

***Network Shared Services Financials***
**Adaptive sheets will be used to collect financial details associated with network-level shared services, including Network Administration, Revenue Cycle, Other Fiscal Services, Human Resources, Information Technology, Supply Chain, Marketing & Advertising, Quality, Population**

**Health Services, and other.**

***Supplemental Exhibits***
**Adaptive sheets will be used to collect supplemental information including: Case Mix Index overall and by payer, the number of unique patients served overtime, separated by Vermont residents, and out of state residents, the number of repeat patients served overtime, separated by Vermont residents and out of state residents (for FY22 actuals, FY23 actuals, FY24 projections, FY25 budget).**

**5. Hospital Operations (Adaptive)**
**While the data requested below are not viewed as being wholly reflective of a hospital's operating performance, it will be considered in the broader context of administrative data and other types of data noted in other sections of this guidance.**

***Referral and Visit Lags***
**Each hospital must submit data on referral and visit lags (see definitions below) for all referrals or appointments requested from May 1, 2024 - May 14, 2024. Please report such lags for each hospital-owned primary care practice, each hospital-owned specialty care practice, and the same imaging procedures as the hospital reported in FY24. If the five most frequent imaging procedures have changed, please add the new imaging procedures as well.**

**Referral lags: the percentage of appointments scheduled within 3 business days of referral (that is, the percentage of all referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place).**

**Visit lags: the percentage of new patient appointments scheduled for the patient to be seen within 14 days, 30 days, 90 days, and 180 days of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received.) This metric only concerns appointments for new patients. Please include all holidays and weekends in your calculation.**

Please see submitted data.

***Staffing Turnover and Vacancies***
**Please report the following staffing data for FY2024.**
**1. The total number of FTE physicians, FTE mid-level providers and FTE nurses employed by the hospital as of May 31, 2024. Please note that positions do not include travelers.**

| **Porter** | **159.8** |
|---|---|
| Mid-Level Provider | 22.5 |
| Physician | 0.8 |
| Registered Nurse | 136.5 |

**2. The total number of FTE physicians, FTE mid-level providers and FTE nurses who terminated their employment between June 1, 2023, and May 31, 2024. Please note that FTE positions do not include travelers.**

| Porter | 11.7 |
|---|---|
| Physician | 0.0 |
| Registered Nurse | 11.7 |

**3. The total number of vacancies for FTE physicians, FTE mid-level providers and FTE nurses that exist at the hospital as of May 31, 2024 (that are included in the approved budget). Please note that FTE positions do not include travelers.**

| Porter | 28.9 |
|---|---|
| Mid-Level Provider | 4.5 |
| Physicians | 0.8 |
| Registered Nurses | 23.6 |

***Boarding***

**1. Please estimate total number of discharges, patient days, associated expenditures and reimbursements for FY22 (Actuals), FY23 (Actuals), FY24 (Projected) and FY25 (Budget):**

**a. Provision of care due to the inability to discharge patients home due to lack of services or transfer patients to post-acute or other more appropriate care settings. Examples might include hospital stays beyond what is clinically indicated due to difficulties discharging/transferring after patients are deemed safe and appropriate for discharge/transfer or stays for which patients received care that would not generally be provided in a hospital setting (i.e. admissions for social reasons).**

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

**2. Assuming the majority of patients who stay in emergency departments for greater than 24 hours without an admitted disposition are patients boarding for a mental health evaluation, please define the LOS in patient hours for patients who have a LOS greater 24 hours without an admitted disposition and the total number of episodes this represents. Please estimate the associated expenditures and reimbursements associated with these encounters.**

Our hospitals' EDs are increasingly challenged with "boarders," patients requiring further treatment, but who lack an available, appropriate bed. Previously, most boarding patients were people awaiting appropriate settings for mental health treatment. This growing group of patients is frequently bound for unavailable medical or surgical beds. Typically, these patients enter our EDs for diagnostics, treatment, and admission, board in the ED overnight and depart the ED the following day when beds become available. Although the volume of these patients and associated cost of caring for these patients has increased over the last several years, the question as written addresses patients that have a length of stay greater than 24 hours without an admission disposition. The overwhelming majority of the subset of ED patients waiting this long are being evaluated and treated for mental health care needs. To that end, below is the requested data for Porter Hospital, restricted only to those patients staying greater than 24 hours without an admission disposition. There is no reimbursement for these ED boarders.

| | FY24 | | | | |
|---|---|---|---|---|---|
| | Avg Daily ED MH Borders | Avg Annual ED MH Border Hours | Avg Annual ED MH Border Days | Avg Direct Cost per Day | Total ED MH Border Cost |
| PH | 0.3 | 2,628 | 110 | $ 979 | $ 107,201 |

*Clinical Productivity*
**Please report average work RVUs per clinical FTE by department – both the level and the associated percentile of national benchmarks, or similar, for the most recent year available. Report the number of clinical and budgeted FTEs (if different) that are included in the denominator. Hospitals only need to supply these data if their budget does not meet the Section I benchmarks for Commercial Rate growth or Operating Margin requirement.**

We have submitted our clinical productivity data from FY23, our most recent complete data set. The data submitted identifies the clinical FTEs, total FTEs, wRVUs and benchmark data for each specialty and subspecialty. APPs and physician data has been separated since the benchmarks are different. Please note the clinical FTE includes all clinical activities, not all of which are wRVU producing.

In FY25 our primary care providers are transitioning away from "provider productivity" being tracked by wRVUs and moving toward tracking via Observed to Expected Risk Adjusted Panel Size. This change creates a standard approach to panel sizes, further ensuring panels are opened to new patients when a provider's Observed to Expected panel size is below 100%. For example, with this shift we anticipate additional capacity for up to 7,000+ patients across UVM Health Network in Vermont. Of that total, up to 2,600+ new patients will be in the Porter Hospital catchment area. We anticipate beginning to open panels in late July 2024.

On June 12, 2024, we launched Epic's Fast Pass, which allows for unused appointment slots to be offered via a MyChart message to a patient we have placed on our electronic wait list. Since then, we had nearly 190 "offers" accepted by patients, resulting in an average improvement of an appointment time by 49 days for family medicine and 43 days for general internal medicine. On July 31 and September 4 respectively, we will launch "Ticket Scheduling" and "Direct Scheduling," giving our patients access to digital tools to self-schedule based on a computer-generated algorithm. The combination of these three new technologies will help to improve our patients' access experience as well as provider utilization.

For FY25, Porter PCPs are budgeted to generate 3,723 wRVUs/clinical FTE (14th percentile) and the primary care APPs are budgeted to generate 3,031 wRVUs/clinical FTE (31st percentile).

**6. Community Health Needs Assessment (CHNA) and Implementation Plan (upload)**
**Submit a complete copy of the hospital's most recent Community Health Needs Assessment (CHNA) and, if applicable, the most recent Implementation Strategy, as required by the Patient Protection and Affordable Care Act.**

To view the most recent Community Health Needs Assessment and associated materials, please visit:
https://www.uvmhealth.org/health-wellness/uvm-health-network-community-benefit
https://www.portermedical.org/about/community-health-needs-assessment/

**7. Financial Assistance Policy & Reporting (upload)**
**In accordance with Act 119 of 2022, hospitals are required to submit a plain language summary of their financial assistance policy (FAP). In addition, please report the following:**
- **Total number of applicants granted any amount of FAP**
- **Number of applicants granted 100% FAP**
- **Number of applicants granted less than 100% FAP**
- **Total applicants denied FAP**
- **Breakdown of reason for denial (% or #)**

| **FY 2023** | |
|---|---|
| **Porter Financial Assistance Program** | **Volumes** |
| Total Applications | 844 |
| Total Household Members | 888 |
| | |
| **Approved / Granted** | |
| <200 FPL (Free Care) | 437 |
| <201% FPLG - 400% FPLG (Discounted) | 256 |
| Total Approved | 693 |
| | |
| **Denied** | |
| Denied - Over Assets | 70 |
| Denied - Over Income | 21 |
| Denied - Over Income & Assets | 5 |
| Incomplete Application or Documentation | 55 |
| **Total Denied** | 151 |

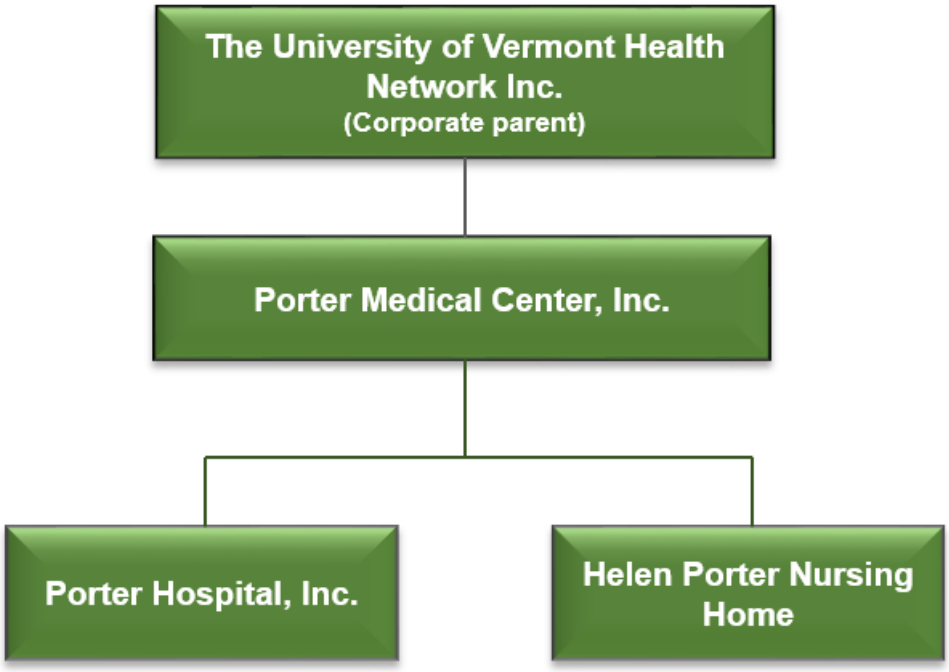
Please see Appendix M for Porter's plain language summary of the financial assistance policy.

**8. Affiliations & Third-party Contracts (upload)**
**Submit copies of contracts you have with any Medicare Advantage Plans or Management Companies.**

Porter Hospital does not have contracts with any Medicare Advantage management companies, and the only contracts we have with Medicare Advantage plans are those governing the reimbursement received from the plans for services we provide to plan participants. Porter Hospital is contracted with the following Medicare Advantage plans:

- Aetna Health Management, LLC
- Vermont Blue Advantage
- Capital District Physicians' Healthcare Network, Inc./Capital District Physicians' Health Plan
- MVP Health Plan, Inc./MVP Select Care, Inc./MVP Affiliates, Inc.
- UnitedHealthcare Insurance Company

**9. Corporate Structure (upload)**
**Provide an up-to-date chart or graphic outlining the corporate structure associated with the Hospital.**




**10. Salary (upload)**
**Provide the salaries for the hospital's executive and clinical leadership and the hospital's salary spread, so that the Board may consider that salary information, and including a comparison of median salaries to the medians of northern New England states in accordance with 18 V.S.A. § 9456(b)(12). Provide any benchmarks and/or bases on which such compensation was established.**

Please see the uploaded spreadsheets, which include for each hospital executive (President and all Vice-Presidents) and clinical leader (Chief Nursing Officer and Chief Medical Officer) the following information: (a) FY24 base salary; (b) base salary benchmark; (c) FY24 total cash compensation; (d) total cash compensation benchmark. The spreadsheets also include the same information for the senior executives of UVM Health Network. Please note that the salaries of UVM Health Network leaders, like all shared services, are supported by all UVM Health Network hospitals in both Vermont and New York. As a result, each Network hospital is only responsible for a fractional portion of those salaries. For each position, we also provide detailed information regarding the source(s) of the benchmarks used for each position.[1]

[1] Although we summarize the salary data and benchmarks below, we are filing the spreadsheets under seal and request that the benchmarking information contained within them be exempt from public disclosure under the Vermont Access to Public Records Act. The legal basis for that request is set forth in the letter filed separately herewith.

Compensation for hospital leaders is approved by a committee of people from the community who are members of the UVM Health Network Board of Trustees. They are all volunteers and work with our internal as well as external national experts to determine fair compensation. In approving the compensation of the hospital's senior leaders, our volunteer Board of Trustees utilize the following compensation philosophy, which is designed to ensure reasonable compensation while attracting skilled administrators:

| | |
|---|---|
| **Peer Group** | Nationwide peer group of similar size organizations, as UVMHN and its affiliates compete for talent with hospitals, health systems, and academic medical centers across the country |
| **Base Salary** | Salaries targeted at the 50th percentile (median) of the peer group |
| **Total Cash Compensation** | Performance-based variable pay sufficient to provide total cash compensation (TCC) opportunities at the 65th percentile when target incentive awards are earned by achieving strategic and operational Network objectives set by the Committee |

Peer Group: We recruit – and are therefore in competition for – skilled leaders from across the country. To ensure our compensation is appropriate, we benchmark our compensation through reference to a nationwide peer group of similarly sized organizations, rather than solely to organizations in New England. Generally, we have found that market rates from the New England region are higher than nationally. As a result, using a national peer group rather than a New England peer group does not result in higher benchmarks. We also understand that we do not solely recruit and lose talent to other New England hospitals.

Base Salary: We target base pay to be in the middle (50th percentile) for people in similar positions at similarly sized organizations nationally. Individual salaries are administered within ranges structured with midpoints set at median and a 50% range spread from minimum to maximum. Those individual salaries will vary above or below the 50% mark, depending on a number of criteria, including but not limited to performance and tenure. In our most recent market analysis, we found that for FY23, base salaries fell significantly below the targeted philosophy of the 50th percentile on average. Our positioning changed in FY24, but still falls well below the 50th percentile:

| Executive Level | FY23 Percentile Positioning | FY24 Percentile Positioning |
|---|---|---|
| UVMHN Senior Executives | 39.0 | 44.8 |
| Partner Presidents | 45.5 | 48.2 |
| Executive Average | 41.4 | 45.8 |

Total Cash Compensation: For total cash compensation – including base salary and variable pay – the target is the 65th percentile for similar positions at similarly sized organizations nationally. Our Board of Trustees has determined that this benchmark best balances fiscal responsibility with the need to attract and retain skilled leaders. Actual total cash compensation for an individual leader may be below, at, or above the 65th percentile of the market depending on: the positioning of the executive's base salary within the appropriate salary range; performance of the Network and its partners; the employee's job performance, among other criteria. In the last five plan years, actual total cash compensation has fallen well below the 65th percentile target, averaging just above the 40th percentile. Looking at FY23, in particular, we were just above the 33rd percentile on average:

| Executive Level | FY23 Actual TCC Percentile Positioning |
|---|---|
| UVMHN Senior Executives | 35.2 |
| Partner Presidents | 30.0 |
| Executive Average | 33.2 |

**11. Net Revenue & Public Payer Reimbursement (upload)**
**File an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals as specified in 18 V.S.A. § 9456(b)(8) and (b)(9).**

With the passage of Act 111, an act relating to prior authorization and step therapy requirements, we estimate a reduction in denials and possibly bad debt and charity care built into the FY25 budget:

| | |
|---|---|
| UVM Medical Center | $2,706,261 |
| Central Vermont Medical Center | $264,108 |
| Porter Hospital | $141,352 |