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

On behalf of University of Vermont Medical Center

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 University of Vermont Medical Center. 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.

University of Vermont Medical Center

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 FY25 budget for the University of Vermont Medical Center presents a landscape marked by both longstanding challenges and opportunities.

We continue to see extraordinary expenses rising from pharmaceuticals and labor. We saw variances to the FY24 budget driven in part by nonacute, long stay patients who lack beds at the next level on their continuum of care. Additionally, we saw an alarming increase of treatment for infections and severe wounds due to Xylazine use in our service area.

We saw additional variances in FY24 driven by strategic expansions meant to address critical access issues for our patients. Some of these service expansions resulted in increased costs and direct revenue. Others resulted in reduction or avoidance of future costs. Significant initiatives included:

- Surgical services sprints to improve patient access, which drove a significant increase in the number of surgeries performed in our ORs.
- Inpatient services – The demand for inpatient services has significantly exceeded budgeted expectations. YTD May budget average daily census was 430, but actual YTD through May was 441 with many days patients waiting for beds. Due to the high number of nonacute patients in acute inpatient beds, UVM Medical Center created a temporary cohorting unit for nonacute patients to reduce the cost to provide care and to provide additional beds for acute inpatient needs.
- Various radiology modalities with weekend hours to increase patient access to imaging. For example, mammography scans have increased over 3,100 YTD May 2024 as compared to the same period in the prior year.
- Access to primary care mental health services, which cut in half ED visits by patients using the service.

These challenges and our work to strengthen patient access to care will continue to drive variances from guidance in FY25. Looking ahead, it is crucial to note that FY24 benefited from one-time funding sources, such as FY23 payment from Medicare for the 340B remedy ruling for CY18 through CY22, FEMA reimbursement related to COVID qualified expenses from 2021 through 2023, and the Employee Retention Credit related to 2020. These are not available in FY25 and will result in the loss of over $45M in funding when compared to FY24.

One-time revenue in FY24:

$19M	Medicare 340B (CY18-CY22)
$7.2M	FEMA reimbursement (COVID reimbursement 2021-2023)
$19.5M	Employee Retention Credit (COVID)
$45.7M	Non-recurring revenue total

It is also important to note the $19M lump sum from Medicare will be recouped over 16 years and will decrease our add-on payment from the 7.1% we received in FY24 to approximately 6.6%.

In terms of UVM Medical Center's relationship with UVM Health Network, we continue to transition departments into Network departments, which reduces redundancy and increases overall efficiency for the system. This is evidenced by our ability to hold shared service expenses as a percentage of total expense essentially flat. The largest example of this from FY24 was the transition of our academic department leadership to Network clinical leaders with the role of harmonizing medical departments across the system. Additionally, as we will discuss in more detail in this narrative, the Network's regional care coordination service continues to be an essential component ensuring that patients with the right level of acuity remain at UVM Medical Center, and that those with lower acuity transfer back to a local care setting where appropriate.

B. Background

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

There have been no changes to UVM Medical Center'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.

UVM Medical Center 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.

First and foremost, as our region's level 1 trauma center and tertiary care facility, UVM Medical Center partners with all area hospitals, rehabilitation therapy facilities and skilled nursing facilities (SNFs) to treat patients in need of our services and to find appropriate step-down care once acute care is no longer necessary. Often, we are the only hospital in our region that provides the services other hospitals' patients need, and last year, we accepted more than 4,100 transfers into UVM Medical Center for higher levels of care. While the majority of those transfers were received from other UVM Health Network partner hospitals, over 1,000 transfers were from Vermont hospitals outside our health system.

Increasingly, this partnership is also one in which area hospitals inside and outside our health system receive training and expertise from UVM Medical Center's academic faculty to improve outcomes prior to transfer and reduce unnecessary transfers. Examples of this include ongoing training of hospital EDs and local EMT services. We also provide tele-ICU and neonatal consults prior to transfer, where appropriate.

In addition to our work with hospitals, health systems and long-term care facilities, we also work with community service organizations like Community Health Centers, the Janet S. Munt Family Room, Howard Center, Pride Center of Vermont, AALV and Cathedral Square to meet health needs in the community rather than in our hospital.

Finally, while not necessarily a service organization or provider, our partnership with the University of Vermont – specifically the Larner College of Medicine and the College of Nursing and Health Sciences – is critical to training the next generation of doctors, nurses and APPs as well as providing Vermonters with access to clinical trials – such as the recent Lyme Disease vaccine – and creating new innovations and educational opportunities advancing Vermont's overall health care ecosystem.

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

- At UVM Medical Center, we increased our inpatient wound care service by two FTEs to address increasing need, driven by infections and complex wounds caused by Xylazine.
- We temporarily opened an area for nonacute patients. This area improves overall throughput within the hospital and reduces skilled FTE resources required to care for nonacute patients by cohorting them in a single location. Our hope is that as more nursing home and rehabilitation beds become available, we can stand down this temporary service.
- We continued to increase our perioperative service by 491 cases versus Q1 through Q3 of FY23 and services in CT, increasing access by 16% in the past two years, or over 4,600 studies per year.
- We constructed a new pediatric ED waiting room. Based on recent Press Ganey scores since launch, we believe this is driving higher satisfaction scores for our ED – especially when paired with our new virtual triage service that decreases the wait time to be seen by a physician.
- We added a pediatric exercise physiology program.

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.

Total FTEs	FY24 YTD May		
	Actual	Budget	Variance
Nursing	1,836.20	1,790.80	(45.40)
Perioperative Services	363.80	357.10	(6.80)

UVM Medical Center's FY24 current and continued FTE variance is related to volume increases based on inpatient demands that have exceeded our budgeted average daily census, along with work to improve access, training of new staff and an increase in observation needs of patients. We have also expanded our

inpatient wound care team in an attempt to manage chronic wounds of our patients.

There are no major service line changes, physician transfers or accounting adjustments. Below you will see the volumes for FY25 and the expected staffing needs as compared to FY24 budget. These volume and FTE additions align with our continued focus on access to care. Note for the table below: Physician wRVU volume and FTE line includes the addition of 8.6 APPs in the 14.67 total.

Volume Related Adds FY25	Volume Bud to Bud	FTEs Bud to Bud
IP Days	1.4%	2.00
OR Cases	1.5%	11.00
Physician wRVUs	3.5%	14.67
Total Radiology Procedures	4.2%	11.00
Lab Tests	3.8%	6.40
Cardiology Procedures	2.2%	5.50
OP Pharmacy	10.5%	20.60

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 Over the Section I Benchmark of 3.4%

As we shared last year and again in our feedback on this year's budget guidance, the 3.4% rate increase is an appropriate benchmark to set for total rate increase because it aligns with expected cost inflation for

the total number of patients served, but not as a target for an individual patient population (or individual payer). We believe doing so ignores the existence of the cost shift.

Last year the Board hosted speakers, some of whom articulated that the cost shift does not exist. There are several reasons cited by those who hold this view, many of which are based on retrospective studies. The most prominent argues that large networks are using their market power to negotiate higher commercial rates. This may be happening in some parts of the country, but that dynamic is not happening in Vermont. It is not happening because of the Board's insurance rate setting authority.

For many years, we have been transparent about the impact the cost shift is having on our finances, which has served as the basis for our commercial rate request. We suspect this level of transparency is also unique to Vermont. In the charts below, we are again transparently highlighting the cost shift, which serves as the basis for our commercial rate increase request. To highlight that we are not alone in our recognition of the cost shift, in Appendix A is a Health Affairs study that also recognizes its existence.

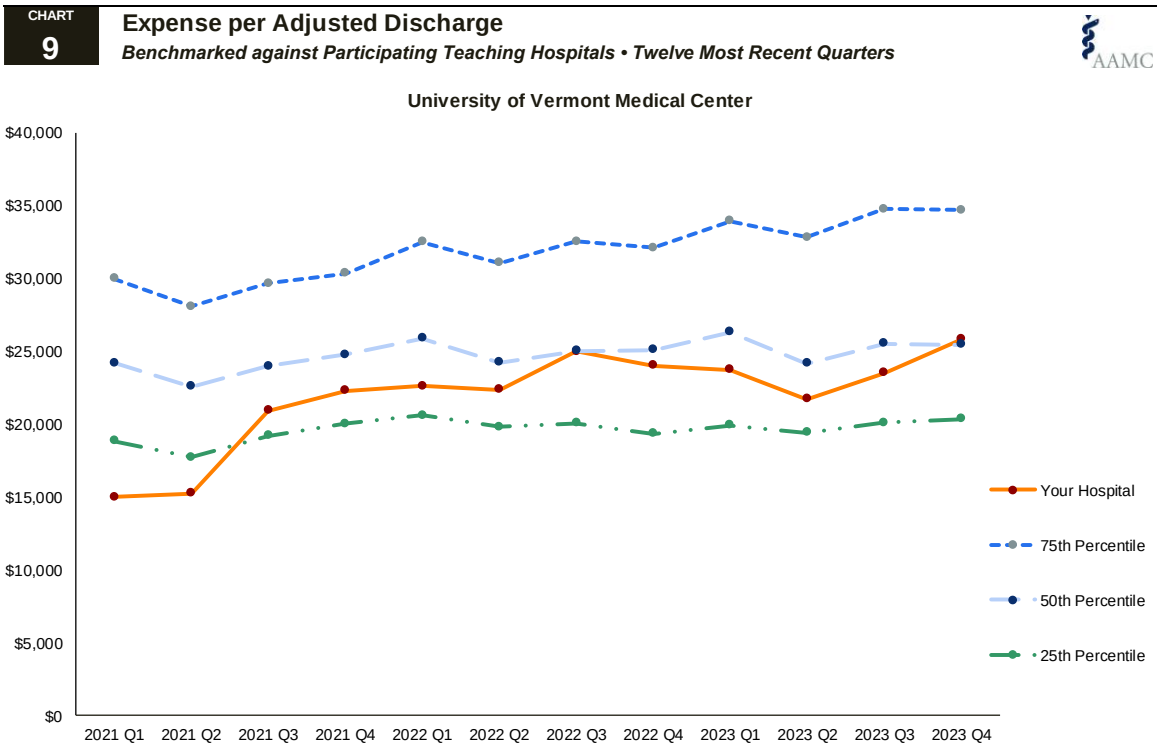
UVMMC	**FY2025 Cost Inflation**
Total Cost Inflation	$85,434,400
Less Retail Pharmacy	($7,783,141)
Net Cost Inflation for Commercial Rate Calc	**$77,651,258**
Less:	
FY2025 - Medicare Rate Increase	$7,277,283
FY2025 - Medicare ACO Rate Increase	$0
FY2025 - Medicaid Rate Increase	$8,508
FY2025 - Other Payer Changes	$2,016,053
APM Shared Savings	$5,975,837
LOS Reduction & Placement Impacts	$14,250,827
GME/IGT Change	$4,000,000
UM/UR Change	$2,217,597
PHSO	$1,089,673
Legislative Changes - Bad Debt/Charity/Denials	$2,706,261
Rate Impact on Bad Debt/Charity/Denials Calculation	($8,142,746)
Sub-Total	**$31,399,293**
Required Funding from Commercial Rate	**$46,251,965**
Per 1 % Impact of Commercial Rate:	
Budget Year (9 months: Jan-Sept)	$7,104,757
Commercial Rate Increase in FY2025 Budget	**6.51%**

CMS, the American Hospital Association and the Healthcare Association of New York State (Appendix B, C and D) also highlight how Medicare rate increases have not even covered the actual cost inflation for care delivered to Medicare patients. Focusing on the market basket increases, it is important to note that they are a projection with no adjustment going back in time to recognize the actual inflation incurred. In FY22, the market basket increase was 2.7%, but the actual inflation that year was 5.7%. In FY23, the market basket was 4.1%, but actual inflation was 0.7% higher.

UVM Health Network has added its voice to the need for Medicare to provide a one-time adjustment for the last three years of increases not keeping pace with the actual cost inflation and for increasing the FY25 proposed rate (Appendix E). If we are successful in getting a retroactive adjustment, depending on the timing, we would reflect it in this year's or next year's commercial rate request.

We understand in order to accept that cost inflation needs to be covered by rate inflation, the Board has to be comfortable that the base to which the cost inflation is being applied is reasonable. To that end, we have compiled benchmark comparisons for clinical and administrative efficiency showing our base expenses are at a very reasonable level.

For clinical efficiency we have the Association of American Medical Colleges – Council of Teaching Hospitals and Health Systems (AAMC-COTH) and National Academy for State Health Policy (NASHP) benchmark data. The AAMC-COTH data show that UVM Medical Center continues to be between the bottom quartile and the median for expense per adjusted discharge and expense per adjusted inpatient day. The NASHP data show that compared to academic medical centers (AMCs) in our region, UVM Medical Center is below the median and average for operating costs per adjusted discharge. Central Vermont Medical Center is slightly above when compared to community hospitals in our region.



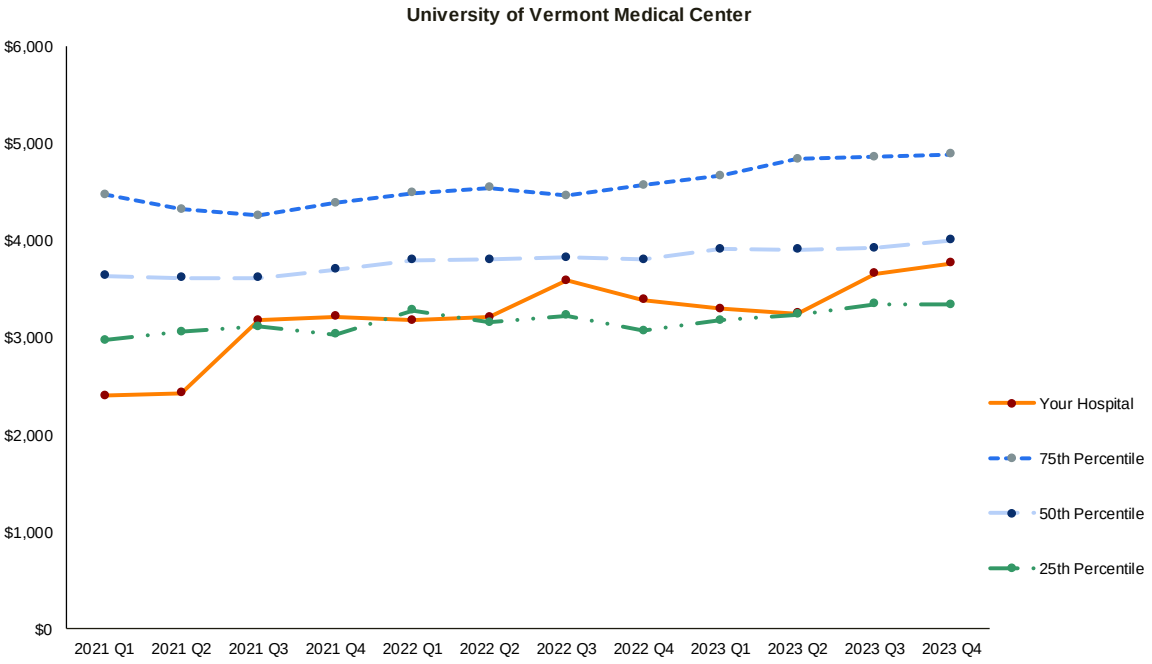
Source: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance

CHART 13

Expense per Adjusted Inpatient Day

Benchmarked against Participating Teaching Hospitals • Twelve Most Recent Quarters

AAMC



Source: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance

Hospital Operating Costs per Adjusted Discharge

ACADEMIC MEDICAL CENTERS	
ALBANY MEDICAL CENTER HOSPITAL	$19,375
BOSTON MEDICAL CENTER	$21,830
STRONG MEMORIAL HOSPITAL	$23,094
UNIVERSITY OF VERMONT MEDICAL CENTER	**$24,054**
UMASS MEMORIAL MEDICAL CENTER	$24,382
MARY HITCHCOCK MEMORIAL HOSP	$24,833
UNIVERSITY HOSPITAL AT SYRACUSE	$27,084
TUFTS MEDICAL CENTER	$27,737
MAINE MEDICAL CENTER	$29,301
MASSACHUSETTS GENERAL HOSPITAL	$30,806
BRIGHAM AND WOMENS HOSPITAL	$32,599
AVERAGE	$25,918
MEDIAN	$24,833

SOURCE: National Academy for State Health Policy 2022 Data

For administrative efficiency we have the Syntellis benchmark and the administrative cost per clinical ratio data that we address in greater detail in Section c) below. The Syntellis data show that our administrative shared services are below the median. Adjusting salaries to reflect Column 7 of cost reports for New England AMCs and mid-sized community hospitals, we were able to capture publicly available cost report data. UVM Medical Center is below the median and average.

Shared Service Area	FY25 Budgeted UVMHN Administrative Shared Service Costs	FY25 Budgeted UVMHN Non-Patient Revenue Generated by Admin Shared Services	Net FY25 Budgeted UVMHN Admin Shared Service Costs	% of Total UVMHN Expense	Syntellis Benchmark Category	% of Total Expense Median	Difference from Benchmark
Finance Administration	$ 25,533,500	$ 794,725	$ 24,738,775	0.71%	Fiscal Services	0.67%	0.04%
HN External Relations	$ 9,681,302	$ -	$ 9,681,302	0.28%	Marketing	0.29%	-0.01%
HR Operations & Employee Health	$ 32,788,853	$ 892,464	$ 31,896,389	0.91%	Human Resources	0.45%	0.46%
Legal and Compliance	$ 6,993,965	$ -	$ 6,993,965	0.20%	Legal	0.15%	0.05%
Quality	$ 15,155,504	$ 18,700	$ 15,136,804	0.43%	Quality	0.57%	-0.14%
Revenue Cycle	$ 89,894,576	$ 265,789	$ 89,628,787	2.57%	Admit & Sched, HIM & Rev Cycle	1.56%	1.01%
Supply Chain	$ 19,728,170	$ 24,954	$ 19,703,216	0.56%	Supply Chain	0.49%	0.07%
IT Epic & Operations	$ 152,279,915	$ 112,274	$ 152,167,641	4.36%	Information Tech	2.72%	1.64%
UVMHN Administration, DEI, Development, Medical Group Admin, Medical Staff Admin	$ 46,735,129	$ 6,002,284	$ 40,732,845	1.17%	General Admin, Education & Strategy	4.50%	-3.34%
Physician Health Service Organization & Data Management Office	$ 36,634,705	$ 19,563,040	$ 17,071,665	0.49%	Care Coordination & Virtual Care	0.88%	-0.39%
Total Administrative Shared Services	$ 435,425,619	$ 27,674,230	$ 407,751,389	11.68%	Total	12.28%	-0.60%

Notes

- Total UVMHN Expenses = $3,490,667,008
- Syntellis General Admin benchmark reduced by 25% to account for executive teams not in Network shared services
- $2.7M was transferred from partner budgets into administrative shared services in FY25 and $7.3M after the FY24 budget was finalized, which are not incremental increases, without those transfers administrative shared services would be at 11.39%

	GMCB	Adjustments	Column 7 Adjusted Salaries
UVMMC			
Admin	147,339,642	(48,734,716)	98,604,926
Clinical	475,952,254	(71,878,882)	404,073,372
Admin %	**30.96%**		**24.40%**
Yale New Haven			
Admin	46,683,020	188,560,900	235,243,920
Clinical	952,606,829	22,061,884	974,668,713
Admin %	**4.90%**		**24.14%**
U Conn John Dempsey			
Admin	45,058,964	449,125	45,508,089
Clinical	138,780,786	7,013,199	145,793,985
Admin %	**32.47%**		**31.21%**
Maine Medical Center			
Admin	77,629,194	131,105,511	208,734,705
Clinical	590,533,547	(95,050,605)	495,482,942
Admin %	**13.15%**		**42.13%**
Boston Medical			
Admin	41,847,383	54,960,550	96,807,933
Clinical	350,707,089	76,558,828	427,265,917
Admin %	**11.93%**		**22.66%**
Mass General			
Admin	77,576,135	193,587,822	271,163,957
Clinical	939,230,992	(31,922,760)	907,308,232
Admin %	**8.26%**		**29.89%**
Baystate Medical			
Admin	73,103,493	63,138,261	136,241,754
Clinical	387,304,626	85,035,422	472,340,048
Admin %	**18.87%**		**28.84%**
Beth Israel Deaconess			
Admin	39,945,275	75,061,676	115,006,951
Clinical	522,635,422	79,526,721	602,162,143
Admin %	**7.64%**		**19.10%**
Tufts Medical Center			
Admin	81,315,488	(2,627,048)	78,688,440
Clinical	254,815,767	32,785,147	287,600,914
Admin %	**31.91%**		**27.36%**
UMass Medical			
Admin	125,718,617	3,316,671	129,035,288
Clinical	471,092,069	140,466,783	611,558,852
Admin %	**26.69%**		**21.10%**
Mary Hitchcock			
Admin	72,205,491	44,280,428	116,485,919
Clinical	193,284,630	73,162,451	266,447,081
Admin %	**37.36%**		**43.72%**
Rhode Island Hospital			
Admin	19,640,560	76,709,923	96,350,483
Clinical	323,538,440	44,721,868	368,260,308
Admin %	**6.07%**		**26.16%**

Median	**26.76%**
Average	**28.39%**

The last area we would like to provide evidence in support of our commercial rate request is how our current rates, and our current TCOC, compares to others. As stated in the NPR justification above, cost for payers and patients is the product of price multiplied by utilization. As an example to speak to price first, as we highlighted in our OSC CON response, our new Clarify price transparency subscription indicates commercial rates for knee replacements at UVM Medical Center compared to other AMCs in our region were generally lower, with only Beth Israel in Boston appearing to be lower.

The primary tool the Board has used for commercial rate comparisons is the RAND study. Based on our review and analysis, we believe this study is flawed, and others also hold this view (Appendix F). Appendix G has our detailed analysis, but to summarize, the Medicare basis for the study is not the same for all organizations across the country, and the unique outpatient market in Vermont has a higher volume of higher reimbursed services being provided by hospitals versus non-hospital providers than in other parts of the country. The issue with the inpatient component of the study can also be clearly seen when reviewing the VHCURES data for UVM Medical Center and Dartmouth Hitchcock Medical Center from last year's Board budget tool. The RAND study shows that Dartmouth Hitchcock receives higher reimbursement from Medicare than UVM Medical Center, as does the VHCURES data, although the difference is larger in the VHCURES data. For commercial rate, the RAND study has Dartmouth being lower than UVM Medical Center, and in the VHCURES data Dartmouth's is higher.

	Hospital Type	Medicare Payment Type	IP Relative Commercial Price	IP Standard Commercial Price	Calculated IP Medicare Standardized Price
Rand Study					
UVMMC	AMC	IPPS	2.43	$31,753	$13,067
DHMC	AMC	SCH/RRC	1.62	$28,485	$17,583
DHMC % of UVMMC				90%	135%

	UVMMC	DHMC	DHMC % of UVMMC
GMCB Budget Tool - VHCURES Data			
IP Commercial Payment per Encounter	$25,757	$31,339	122%
IP Medicare Payment per Encounter	$17,216	$26,001	151%

Moving on to TCOC (price multiplied by utilization, divided by population served), which is the true measure of health care costs, we have over the years highlighted the Burlington, Berlin and Middlebury health service areas (HSAs) through the Dartmouth Atlas as being the lowest cost HSAs in the country for Medicare spend per beneficiary. We have also stated that this low cost extends to our other payers and patient populations, as our clinical protocols are the same for all patients. In Appendix G are highlights from the Cooper analysis, which supports this view. Professor Cooper presented to the Board on April 5, 2023. The analysis shows a similar result to the Dartmouth Atlas for Medicare spend per beneficiary, with Vermont and the Burlington hospital referral region (HRR) being in the lowest quartile. For commercial and Medicaid, Vermont and the Burlington HRR are between the 2nd lowest quartile and the median.

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.

		TRAVELERS AS % of TOTAL SALARIES			TRAVELERS AS % of TOTAL FTEs		
		2024	2024 YTD	2025	2024	2024 YTD	2025
Entity	Division Smry	Budget	Apr Act	Infl Budget	Budget	Apr Act	Infl Budget
UVMMC							
UVMMC	1300 Nursing Services	21.60%	24.46%	19.50%	9.69%	13.17%	11.00%
UVMMC	1404 Pathology & Laboratory Medicine	2.63%	5.57%	2.66%	1.37%	2.80%	1.34%
UVMMC	1502 Perioperative Services	21.19%	31.37%	25.70%	11.48%	17.02%	14.67%
UVMMC	1504 Radiology Services	6.62%	11.97%	7.94%	3.70%	5.77%	4.16%
UVMMC	1505 Rehab Renal & Respiratory Services	12.35%	17.97%	11.28%	6.19%	9.75%	6.47%
UVMMC	1600 Medical Group	0.00%	0.89%	0.08%	0.00%	0.43%	0.04%

The first step in developing our labor expense budget at UVM Medical Center is to project FTEs (staff and physicians). We use the FTEs we have at the end of January of the current year as the starting point (October to January period serves as the base for entire budget). From there, we adjust the FTEs for vacant positions that must be filled, known volume changes, planned recruitments, changes in service offerings, department consolidations, cost reduction targets and position eliminations. Current salary rates, shift differentials and on call payments are then applied to the FTEs (mid-point of the salary range is used for vacant positions) to generate a total salary cost. That salary cost is then adjusted for known or planned salary increases to occur in the current year that are not reflected in the October to January base period. The majority of the FTE additions is for volume increase tied to our access improvement efforts.

The benefits budget is developed line by line (health, dental, life, vacation, retirement, etc.) based on the number of FTEs in the budget, plus projected household members who will also be covered by UVM Health Network benefits. The last step in the process in developing the labor expense budget is to apply inflation factors.

The inflation factors consist of known position specific increases, such as negotiated union contract increases and market surveys that require salary adjustments, and a general merit/cost of living increase for all other positions. For the FY25 budget, the labor expense inflation factor for UVM Medical Center is 4.6% (driving the higher than benchmark increases at UVM Medical Center are existing and expected union contracts).

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.

The University of Vermont Medical Center

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			1,477,548,836	1,504,882,732	1,504,280,186	1,509,235,449	1,607,498,584
Outpatient Revenue Total			2,198,113,787	2,289,509,550	2,304,803,853	2,357,567,536	2,511,063,783
Professional Revenue Total			792,357,006	786,551,274	793,937,267	840,360,654	895,039,275
TOTAL GROSS REVENUE			**4,468,019,628**	**4,580,943,556**	**4,603,021,306**	**4,707,163,638**	**5,013,601,642**
INPATIENT REVENUE							
	1300	Nursing Services	826,272,528	844,108,355	841,317,202	834,761,960	889,111,549
	1403	Pharmacy	94,380,892	91,340,574	89,303,190	90,773,463	96,683,532
	1404	Pathology & Laboratory Medicine	70,827,852	71,951,473	70,582,865	70,635,936	75,234,893
	1502	Perioperative Services	219,962,384	231,198,114	231,810,285	246,311,103	262,347,900
	1504	Radiology Services	198,476,589	198,619,372	203,752,660	199,570,865	212,564,502
	1505	Rehab Renal & Respiratory Services	52,305,381	51,778,160	51,848,870	54,597,486	58,152,213
	1605	MG Provider Based Billing	14,083,419	14,650,907	13,872,207	11,350,166	12,089,151
	2000	Chief Executive Officer	1,239,790	1,235,778	1,792,906	1,234,470	1,314,843
	2400	Finance	0	-	-	-	-
	2900	Miscellaneous	0	-	-	-	-
	TOTAL INPATIENT GROSS REVENUE		**1,477,548,836**	**1,504,882,732**	**1,504,280,186**	**1,509,235,449**	**1,607,498,584**
OUTPATIENT REVENUE							
	1300	Nursing Services	290,831,677	323,283,700	322,937,550	322,321,223	343,306,877
	1403	Pharmacy	473,371,157	527,376,250	528,162,099	529,479,693	563,952,999
	1404	Pathology & Laboratory Medicine	123,647,502	134,220,576	134,920,272	132,853,195	141,502,987
	1502	Perioperative Services	266,565,954	263,039,088	263,879,649	267,573,637	284,994,792
	1504	Radiology Services	675,791,801	683,279,143	698,823,699	707,562,582	753,630,489
	1505	Rehab Renal & Respiratory Services	133,033,214	128,066,797	125,859,388	160,857,834	171,330,948
	1605	MG Provider Based Billing	222,882,985	216,986,132	216,949,533	223,772,047	238,341,372
	2000	Chief Executive Officer	11,820,256	13,207,343	13,106,175	13,096,403	13,949,082
	2400	Finance	0	-	-	-	-
	2500	Hospital Services	6,154	288	165	290	309
	2800	Human Resources	163,088	50,232	165,324	50,631	53,927
	2900	Miscellaneous	(0)	-	-	-	-
	TOTAL OUTPATIENT GROSS REVENUE		**2,198,113,787**	**2,289,509,550**	**2,304,803,853**	**2,357,567,536**	**2,511,063,783**
PROFESSIONAL REVENUE							
	1403	Pharmacy	7,411,268	13,802,974	15,306,193	14,262,521	15,191,124
	1505	Rehab Renal & Respiratory Services	1,843,345	2,463,578	2,483,702	2,483,130	2,644,801
	1600	Medical Group	781,942,571	768,444,426	774,197,082	820,010,399	873,399,546
	2000	Chief Executive Officer	494,029	1,185,712	1,219,420	1,195,122	1,272,934
	2500	Hospital Services	665,794	654,585	730,870	659,780	702,737
	2900	Miscellaneous	0	-	-	1,749,701	1,828,133
		1610 Emergency Medicine	33,507,734	30,318,199	31,423,170	34,458,038	36,701,528
		1611 Anesthesia	63,533,718	64,658,320	65,808,647	71,469,522	76,122,751
		1612 Pathology	23,982,113	26,055,948	26,144,435	27,053,540	28,814,938
		1613 Radiology	95,950,307	93,311,404	96,425,518	95,906,400	102,150,663
		1614 Medicine	167,495,916	165,850,327	165,474,256	178,055,775	189,648,611
		1615 Neurology	34,890,692	32,119,682	33,124,795	35,504,562	37,816,189
		1616 Psychiatry	24,438,119	20,353,200	21,064,151	24,908,190	26,529,909
		1617 Family Medicine	40,404,009	44,318,043	43,030,276	45,320,154	48,270,854
		1618 Childrens	32,966,213	27,700,952	26,892,336	31,493,295	33,543,757
		1620 Womens	44,085,871	39,750,615	40,520,569	45,148,033	48,087,526
		1621 Ortho Rehab	60,168,752	60,056,137	61,407,972	62,391,197	66,453,357
		1622 Surgery	145,775,425	149,197,136	148,046,229	154,287,930	164,333,291
		1624 MG Radiation Oncology	14,743,704	14,754,462	14,834,729	14,013,764	14,926,170
	TOTAL PROFESSIONAL GROSS REVENUE		**792,357,006**	**786,551,274**	**793,937,267**	**840,360,654**	**895,039,275**

As we do for all components of the budget, for utilization (i.e. volume), we start with volume levels from the October to January period, and from there we add or subtract volume for new recruits, departures, new equipment, access initiatives, and seasonal factors that we know are not present in the October to January base. The key volume metrics we budget for individually that drive the gross revenue budget (revenue before deductions are applied) are inpatient admissions and discharges, inpatient days, OR cases, ED visits, professional work RVUs, radiology exams (MRI, CT, nuclear medicine, mammography, ultrasound, diagnostic), catheterization lab procedures, electrophysiology lab procedures, endoscopy procedures, radiation oncology procedures, lab tests and pharmaceuticals.

Vermont is the lowest cost state in the nation per Medicare beneficiary, according to the Dartmouth Atlas. The Burlington HRR, which reflects the service territory of the UVM Health Network, is one of the lowest cost HRRs in the country.

We have also examined research showing actual commercial spending per person. The primary source that the Board has looked to for this information is research by Professor Cooper. Cooper presents data at the HRR level and notably adjusts per capita spending by age, addressing the fact that Vermont's population skews older than much of the rest of the country. Cooper's 2015 paper shows that the Burlington HRR is in the second spending quintile nationally (2nd least expensive). So, while the Burlington HRR is one of the least expensive Medicare regions, it is also among the lower cost commercial areas.

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.

October to January is used as the base, and from there adjustments are made for known volume changes and planned introduction of new drugs. Adjustments for new drugs that typically have a material impact on the budget are for chemotherapy treatments. From this FY25 base amount, inflation factors are then applied. In the FY25 budget, the inflation factor for pharmaceuticals is 4%.

As shown in the charts below, drug costs continue to increase at a faster pace than volumes, driven by drug mix and unit costs.

UVMMC	FY23 Actual	FY24 Budget	FY24 Projected	FY25 Budget
Retail Pharmacy Expense				
Non 340B COGS	$ 68,766,412	$ 66,199,318	$ 85,146,441	$ 88,518,336
340B COGS	$ 89,903,140	$ 103,868,352	$ 107,321,377	$ 113,843,342
Total	**$ 158,669,552**	**$ 170,067,669**	**$ 192,467,818**	**$ 202,361,678**
Pharmaceuticals				
IP Non Chemo Pharmaceuticals	$ 75,732,399	$ 74,460,763	$ 84,190,970	$ 86,896,001
IP Chemo Drugs	$ 46,686,095	$ 46,960,833	$ 54,456,969	$ 55,306,919
Total	**$ 122,418,494**	**$ 121,421,596**	**$ 138,647,940**	**$ 142,202,920**

UVMMC	FY23 Actual	FY24 Budget	FY24 YTD May Annlzd	FY25 Budget
Pharmacy Volumes				
Total Pharmacy Doses	3,178,390	3,267,021	3,276,338	3,257,824
Total Prescriptions	424,653	428,915	487,914	473,929

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	
UVMMC	% Increase	$ Increase
Wages/Compensation - Physicians	3.6%	$ 9,285,170
Wages/Compensation - Staff	6.2%	$ 42,339,445
Fringe	1.9%	$ 4,207,973
Drugs - All Other	4.0%	$ 5,520,151
Drugs - Retail Pharmacy	4.0%	$ 7,783,141
Supplies	3.1%	$ 4,586,603
Non-Medical Supplies	0.0%	$ -
Travelers (nurses)	0.0%	$ -
Equipment / Software / Other Maintenanc	3.0%	$ 2,956,099
Provider Tax	3.9%	$ 4,232,566
Purchased Services	3.1%	$ 2,874,379
All Other	0.7%	$ 1,648,874
Total	3.8%	$ 85,434,400

In addition to labor and pharmaceuticals, addressed above, the other areas that have inflation factors applied are medical and surgical supplies, purchased services, software and maintenance contracts, leases, utilities and insurance.

For medical and surgical supplies, the inflation factor we are using in the FY25 budget is 3.1%.

The inflation factors applied to purchased services – software and maintenance contracts, leases, utilities

and insurance – are a combination of known contractual increases and general expected inflationary increases. The inflation factors for these categories are all in the 3.0% range.

The expense inflation for retail pharmaceuticals is 4%. This category and associated expense inflation does not factor into the required patient rate increase calculation, as retail pharmacy revenue is what covers the cost of this expense.

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				
UVMMC	1.88	1.89	1.89	1.89

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).

UVMMC NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY24 GMCB Approved Budget	$ 1,833,658,419	$ 543,193,634	$ 196,313,202	$ 892,694,145	$ 186,306,526	$ 15,150,911
Cost Inflation (FY25)						
FY25 Net Revenue Rates - All Payers	$ 55,553,807	$ 7,277,283	$ 8,508	$ 46,251,965	$ 2,016,050	$ -
Utilization Management And Review	$ 2,217,597	$ 950,397	$ 214,071	$ 772,934	$ 280,195	
Inpatient Length of Stay Reduction	$ 3,720,000	$ 1,594,282	$ 359,102	$ 1,296,591	$ 470,025	
Placement of Long Stay patients	$ 10,530,827	$ 4,513,202	$ 1,016,570	$ 3,670,477	$ 1,330,578	
APM Shared Savings	$ 5,975,837	$ 5,975,837	$ -	$ -	$ -	
Denial Improvement	$ 2,706,261	$ -	$ -	$ -	$ 2,706,261	
GME/IGT Change	$ 4,000,000	$ -	$ 4,000,000	$ -	$ -	
Denials	$ (2,553,186)	$ -	$ -	$ -	$ (2,553,186)	
Bad Debt	$ (3,148,061)	$ (274,906)	$ (51,006)	$ (1,125,844)	$ (1,696,306)	
Charity	$ (2,441,499)	$ (497,561)	$ (11,653)	$ (413,661)	$ (1,518,625)	
FY24 Budget to Actual Collection Rate difference prior to rate impact						
All Payers	$ 14,575,795	$ 9,946,504	$ (18,235,464)	$ (5,209,426)	$ 28,074,180	
Value Base Contract (VBC) Incentives	$ 834,168	$ 152,831	$ 142,953	$ 381,799	$ 156,585	
GME Change	$ 7,364,710	$ -	$ 7,364,710	$ -	$ -	
Disproportionate Share Payments (DSH)	$ (3,868,600)	$ -	$ -	$ -	$ -	$ (3,868,600)
Denials	$ 3,373,644	$ -	$ -	$ -	$ 3,373,644	$ -
Bad Debt	$ (9,704,071)	$ 990,409	$ (41,430)	$ (384,481)	$ (10,268,569)	
Charity	$ (18,592,260)	$ (3,095,647)	$ 1,301,994	$ (2,428,309)	$ (14,370,298)	
Utilization (not factoring in change in charge request)						
All Payers	$ 98,778,467	$ 26,818,475	$ 6,633,712	$ 51,717,051	$ 13,609,228	$ -
Denials	$ (2,004,450)				$ (2,004,450)	
Bad Debt	$ (2,110,934)	$ (237,260)	$ (31,631)	$ (952,836)	$ (889,206)	
Charity	$ (953,417)	$ (191,640)	$ (38,159)	$ (214,622)	$ (508,996)	
Payer Mix						
All Payers	$ (1,958,808)	$ (3,929,523)	$ (1,717,804)	$ (9,935,650)	$ 13,624,169	$ -
Bad Debt	$ (4,155,018)	$ 453,125	$ 81,812	$ (131,497)	$ (4,558,458)	
Charity	$ (846,963)	$ 426,160	$ 71,097	$ (47,314)	$ (1,296,906)	
FY25 Proposed Budget	$ 1,990,952,266	$ 594,065,604	$ 197,380,585	$ 975,941,323	$ 212,282,443	$ 11,282,311

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.

UVM Medical Center:

	FY24 Projection	FY25 Budget
Margin	3.0%	2.9%
Days Cash on Hand	115.4	120.4
Debt Service Coverage Ratio	5.0	5.2

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.

UVMMC	FY23 Actual	FY24 Anlzd YTD Jan	FY24 Anlzd YTD May	FY24 Projected	FY25 Budget
Bad Debt as a % to Gross Revenue	0.42%	1.15%	1.07%	1.13%	1.03%
Free Care as a % to Gross Revenue	0.43%	0.63%	0.68%	0.70%	0.80%
Total Bad Debt + Free Care as a % to Gross Revenue	0.85%	1.78%	1.75%	1.83%	1.82%

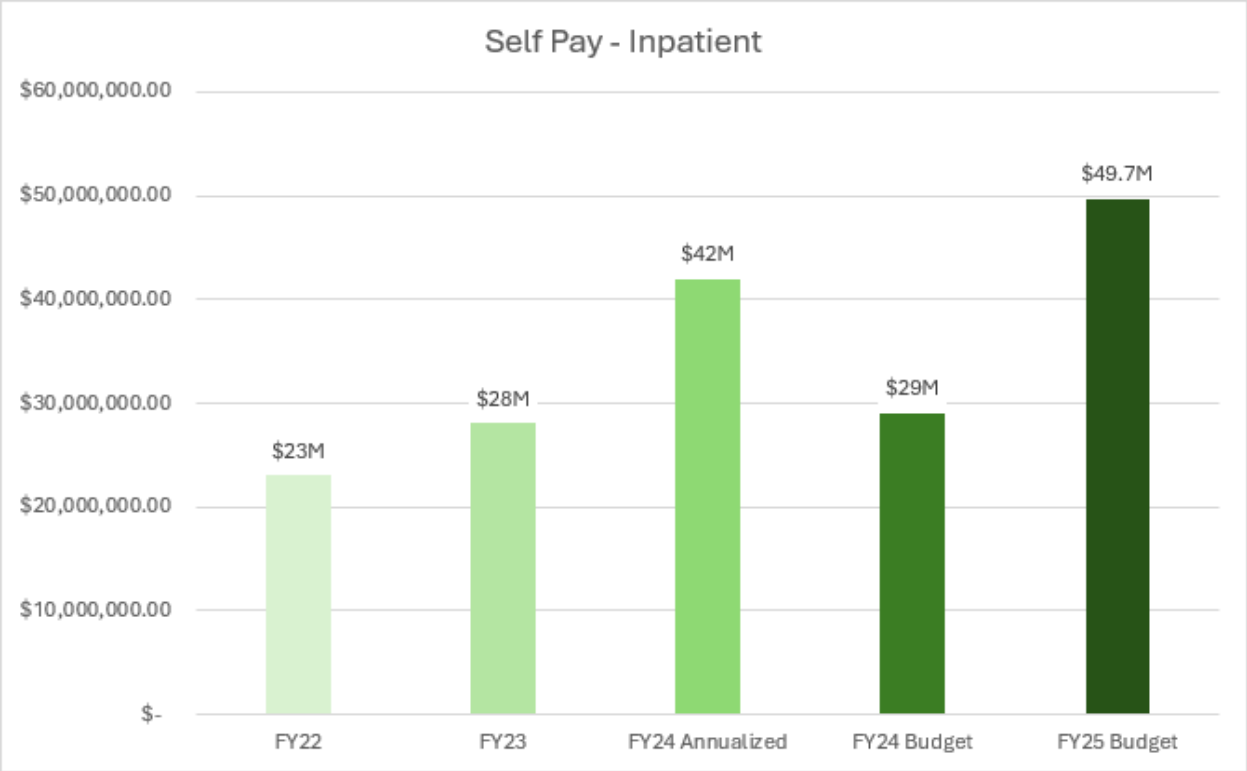
j. Community Benefit. Differentiate between the various drivers of community benefit.

Please refer to UVM Medical Center'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.

- As noted in detail by Dr. Bruce Hamory through his work under Act 167, the lack of suitable housing and childcare has impacted permanent workforce availability and if this remains a top issue, it will continue to drive reliance on contracted labor. UVM Medical Center and UVM Health Network are investing in housing and childcare, but we cannot resolve the issue without broader local and state efforts.

- Receiving lower than requested commercial rate increase would have negative effects on:
    - Ability to fund increased costs associated with expanding access to care
    - Meeting wage pressures for retaining and recruiting skilled staff
    - Managing facility needs to avoid system breakdowns of critical equipment and plant, impacting patient care
- The chart below demonstrates the increase of uninsured patients in our inpatient setting; our experience through May FY24 has already exceeded our FY24 budget. Our FY25 budget is based on the current uptick shown in our FY24 projection, and if growth continues at the current pace, it will exceed our FY25 budget and create increased financial strain.



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 standalone. 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 used 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 used 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 are 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 UVM Medical Center, 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 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, UVM Medical Center billed Medicare for $114M in provider-based facility billing. Were we not approved by CMS for provider-based billing, the total amount of $114M 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 UVM Medical Center's price transparency file located at the link below:
https://www.uvmhealth.org/medcenter/patients-and-visitors/billing-insurance-and-registration/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 63% of UVM Medical Center's NPR increase is tied to utilization and access improvement, 77% of Central Vermont Medical Center's and 134% of Porter Hospital's, there would be no option but to reduce the amount of clinical services we provide to stay within a lower number. If any of the 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 the margin.
- We would look at open staff positions and eliminate the ones that do not have a positive impact on the 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 be focused 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.

UVMMC FY23 Lobbying Expense		
Vermont Association of Hospitals & Health Systems (VAHHS)	$ 54,578	These amounts represent the portion of dues paid to associations and trade groups and is directly connected to lobbying by those groups on behalf of their members.
American Hospital Association (AHA)	$ 18,383	
National Association of Children's Hospitals (NACH)	$ 8,490	
Association of American Medical Colleges (AAMC)	$ 695	
Healthcare Association of NY State (HANYS)	$ 5,373	
Lake Champlain Regional Chamber of Commerce	$ 650	
VT Chamber of Commerce	$ 391	
Necrason Group, PLLC	$ 60,773	
UVMHN Government Relations Staff Time	$ 40,319	
	$ 189,653	

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 UVM Medical Center, we estimate that in FY25 we will receive donations totaling $4,000,000. Priority areas include workforce development, patient and family support funds, programs within the UVM Children's Hospital and the UVM Cancer Center and enhancements to our aging facilities and equipment. Should the Outpatient Surgery Center be approved, it will also be a priority fundraising effort for FY25 and FY26, significantly increasing our estimated donations.

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 and 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 hit 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 and 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 get 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.

In the last two years the reductions in revenue due to quality performance are found in UVM Medical Center's Medicare reimbursement. There is only one year of impact as the Medicare programs were paused due to the COVID-19 Public Health Emergency. In FY24 Medicare revenue was reduced due to the following: (1) Hospital Acquired Conditions (HAC) Penalty = Impact (-$1.4M); and (2) Value Based Purchasing (VBP) and Readmissions Penalty = (-$425K).

Efforts to address these issues include, but are not limited to:

- Throughout our Collaborative Leadership structure, we have prioritized several areas of work focused on HACs:
    - Increase communication of expectations for performance in staff meetings, huddles, quality boards and debriefs with Unit Champions
    - Prioritize staff protected time to do this work with detailed improvement plans for each HAC
    - Prioritize trainings (wound care and vendor)
    - Perform leadership sweeps
    - Perform unit-based audits and real time recovery
    - Reward and recognize high performers
- Similarly, reducing readmissions:
    - The Working to Reduce Admissions Program (WRAP) at UVM Medical Center is a significant initiative aimed at improving patient care and reducing readmissions. Initially serving inpatient and ED high utilizers, WRAP began its services for ED patients in August 2023. The program's success has led to its expansion to the Porter Hospital and Central Vermont Medical Center EDs. A multidisciplinary team, including social workers, case managers, leaders and physicians conducts quarterly reviews of readmissions. This collaborative approach focuses on transitions of care and systematic improvements to reduce the rate of readmissions at UVM Medical Center. The program's innovative application of evidence-based models and best practices is crucial for enhancing patient outcomes and care continuity.
- Across UVM Health Network, we have instituted additional initiatives, including:
    - A Transition of Care (TOC) workflow will be deployed in July where an outpatient care manager will attend discharge planning discussions and use a standardized tool to identify those patients who are at high risk of readmission. Two RN FTEs have been

hired to focus on TOC coordination. They will conduct the follow up TOC calls and ensure that necessary appointments are scheduled before the patient leaves the hospital.
    - To ensure these patients receive timely follow-up care, we created both capacity and appointment holds on PCP schedules to accommodate the follow-up appointment. We created a workflow for warm handoffs from the inpatient team to the outpatient team for those high-risk patients.

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 UVM Medical Center include:

- Through our partnership with Community College of Vermont and Vermont State University, UVM Medical Center's LNA to RN Pathway Program allows hospital employees to continue earning a salary while taking classes toward an advanced health care degree. In FY24, we had 26 enrolled in the program.
- Our Phlebotomy Training Program is a partnership between our Pathology Department and Vermont HITEC. In FY24, we enrolled 21 trainees with 20 graduating so far (summer 2024 program is still in progress).
- As one of the sole providers of renal services in Vermont, our Dialysis Technician Training Program provides a critical pipeline of dialysis technicians. Our Dialysis Technician Training

Program is a 12-week, paid training program that includes a blend of classroom instruction, online education and hands-on experience to prepare trainees to become a Hemodialysis Technician at UVM Medical Center and adjacent dialysis clinics in Vermont.

- Project SEARCH is a collaboration between Howard Center and UVM Medical Center. It provides internships for high school-age adults with developmental disabilities. The program focuses on workplace training, career exploration and transferable skills. The goal of the program is for participants to graduate with marketable skills and receive job offers for competitively paid employment. In FY24, we had 7 interns graduate from the program.
- UVM Health Network is an academic health system anchored by our academic medical center, UVM Medical Center, through its longstanding affiliations with the University of Vermont Larner College of Medicine and the College of Nursing and Health Sciences. In the most recent class of 2024, 121 medical students graduated, with 14 of them matching within UVM Health Network. Meanwhile, 113 undergraduates and 141 graduate students received nursing degrees in this latest class, many of whom are destined for UVM Medical Center.

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).

UVM Medical Center's investments in workforce retention include:

- In conjunction with UVM Health Network, we have made investments in two apartment buildings in South Burlington to aid in employee housing needs.
- We have also invested in subsidized childcare at the YMCA, as well as an additional subsidized childcare facility expected to open in the fall of 2024.
- We also provide tuition reimbursement for all eligible staff and offer several wellness programs for physical and mental wellbeing.
- These expenses are reflected in the UVM Medical Center areas of fringe expenses, leases and rental expenses, and utilities. Any revenue will be seen in other revenue.

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 UVM Medical Center'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: Increased costs associated with compliance and implementation.
- Post-Acute Stays: Direct costs for care associated with non-acute patients due to lack of non-hospital placement options in the community/state.
- Pharmaceuticals – Inpatient: Our negotiation power is limited to reduce expenses related to medications and pharmaceuticals used specifically for inpatient care, including specialized drugs or treatments.

- 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. These directly relate to Vermont's housing and childcare crises and represent an exigent circumstance that requires our action to continue recruiting and retaining staff. In addition, UVM Medical Center is not passing on to employees the new Vermont childcare tax, estimated at $3.6M in our benefits expense line for FY25.
- 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 UVM Medical Center should be held harmless for the associated expenses.
    - Safety Equipment: Investments in personal protective gear, panic buttons or other safety alert systems to safeguard staff from workplace violence.
    - Security: Costs associated with hiring additional security personnel.
    - 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.
- Expenses for Mental Health Technicians: Costs associated with staffing of Mental Health Technicians to manage ED beds occupied by patients awaiting care or placement.
- Expenses to Open After-Hour Care for Access in Radiology: Additional costs incurred to extend hours in radiology departments to accommodate after-hour patient care needs and address persistent backlogs.

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.

Implementation of a High Value Care Staffing Model in Primary Care: The implementation of a High Value Care staffing model represents a strategic approach to optimize health care delivery by emphasizing quality, efficiency and cost-effectiveness. This innovative staffing model focuses on aligning staffing levels and skill mix with patient needs, utilizing evidence-based practices to enhance clinical outcomes while controlling costs. By fostering interdisciplinary collaboration, promoting care coordination and leveraging technology, the model aims to improve patient satisfaction, reduce health care-associated complications and ensure the delivery of personalized, high-quality care across all service lines.

Mental Health Urgent Care: Developed in partnership with Community Health Centers and Pathways Vermont, this program is slated to launch in August. It is difficult to yet quantify the impact of this partnership. Mental Health Urgent Care has a specific focus on mental health and wellbeing. Care is provided in a trauma-informed, person-centered environment, and staff can provide a number of different

types of support and services based on need. This initiative will provide a therapeutic alternative to the ED for those who believe they may be in the early stages of experiencing a mental health crisis. We do anticipate that it will reduce the number of patients waiting for an inpatient bed in the ED and result in better outcomes for many of our patients currently seeking mental health care in the ED. We are eager to learn from this program, measuring impact in partnership with the Department of Mental Health.

Dementia Caregiver Center: Provided in partnership with the University of Vermont Larner College of Medicine, the Dementia Caregiver Center is a statewide resource for caregivers of individuals living with dementia. We offer educational programs, caregiver support groups, respite care options and personalized guidance to assist caregivers in navigating the challenges of caring for loved ones with dementia. Our center aims to empower caregivers with knowledge and resources to enhance quality of life for both the caregiver and the person with dementia.

Mental Health Primary Care: Mental Health Primary Care integrates mental health services into routine primary care settings, ensuring holistic health care that addresses both physical and psychological well-being. Our approach includes mental health screenings, therapy sessions, psychiatric consultations and coordination with primary care physicians to provide comprehensive and accessible mental health care for patients of all ages. The pilot of this program cut ED, inpatient psychiatry and primary care provider appointments in half for participants.

Medicare Expansion of Comprehensive Pain Program: Operated in partnership with the University of Vermont, the Osher Center for Integrative Health develops clinically rigorous programs focused on holistic health practices. The Center's director, Dr. Jon Porter, operates the award-winning Comprehensive Pain Program at UVM Medical Center. The program reduces reliance on the ED and reduces health care costs. Most recently, funding for the program has expanded to include Medicare patients.

Expanding Testing to Improve Primary Care – Focus on Radiology Access: UVM Medical Center Radiology has expanded services in CT, increasing access by 16% in the past two years or over 4,600 studies per year. For PET CT, we have expanded services by adding equipment and weekend clinics, increasing access by 27%. Our plan for PET CT is to continue opening additional hours of operation as needed to keep backlogs down as much as possible. MRI has expanded services by 15% over the past two years; we expect our MRI access to improve further over the next year, as our staffing situation is stabilizing.

Surgical Access: UVM Medical Center is operating at 81.3% room utilization across the main and Fanny Allen campuses during the weekday, which far exceeds the national benchmark of 75%, and UVM Medical Center has expanded weekend operations to accommodate urgent surgical needs of patients in our region. In FY23, UVM Medical Center achieved the highest OR volume over the past 10 years and will be exceeding FY23 records in FY24.

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. As of June, providers at UVM Medical Center used 1,357 eConsults in FY24.

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, in rheumatology, 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 EHRs 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 UVM Health Network and independent practices. 11% of these patients were referred back to UVM Medical Center primary care providers, and 28% were referred back to community-based primary care providers outside of our health system.

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.

Many of the access initiatives described above offer opportunities to bolster our already strong collaboration with other providers and FQHCs in our community. At the request of colleagues outside of our health system, our providers regularly consult with these external colleagues on routine and emergent care needs, from pediatrics and radiology to neonatal intensive care and stroke neurology. This type of collaboration is vital to a strong health care system for our state and region.

At the request of some these community providers and FQHCs, we have evaluated the feasibility of streamlining our medical consultations, sharing our electronic health records or enhancing the interoperability of our services and systems. While we continue to explore ways to elevate collaborative care with providers outside of our health system by making our electronic health records more available and expediting our consultation process, we have found that these endeavors are expensive simply to evaluate and significantly more expensive to execute – in some cases, prohibitively so.

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 the 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.

UVM Medical Center
Total paid for collection efforts: $521,571
Revenue generated from collection efforts: $3,825,858

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. This is in addition to financial screening that occurs pre-service when uninsured patients are advised of the financial assistance program and hardship is identified as noted below.

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 benefit advisors, financial advocates 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 advocates 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 and 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.

For inpatient "boarders" – patients requiring further treatment but who lack an available, appropriate bed in our inpatient setting – we have taken our actual Length of Stay (LOS) and compared it to the Vizient expected LOS to calculate our expected average daily census, which we then compare to our actual average daily census. The difference between our actual average daily census and expected average daily census, multiplied by 365 days represents the number of uncompensated days. The assumption is that once a patient has extended beyond the Vizient expected LOS, we are no longer receiving payment for that patient. We make an adjustment to that assumption to reflect the percent of patients that we still collect payment on beyond that Vizient expected LOS (for example – outlier payments), to get down to an adjusted annual uncompensated days total. That total days figure is then multiplied by our average cost per day. The trend is that the LOS, and the gap between it and the Vizient expected LOS, has been going down the last few years, which is resulting in a lower amount of uncompensated care.

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

4. **<u>FY2025 Budget Request (Adaptive)</u>**
   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).

<u>5. Hospital Operations</u> (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.

UVMMC	**1792.4**
Mid-Level Provider	176.7
Physician	0.0
Registered Nurse	1615.7
UVMMG	**726.9**
Physician	726.9
UVMMG NA	**217.1**
Physician	217.1

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.

UVMMC	**113.3**
Mid-Level Provider	7.6
Physician	0.0
Registered Nurse	105.8
UVMMG	**18.6**
Physician	18.6
UVMMG NA	**26.4**
Physician	26.4

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.

UVMMC	**225.3**
Mid-Level Provider	9.2
Physicians	2.4
Registered Nurses	213.8
UVMMG	**41.7**
Physicians	41.7

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).

Across our health system, patients with severe cognitive impairment make up the largest proportion of patients who experience obstacles to being discharged or transferred to the next appropriate level of care. These are individuals who are not able to live independently or without supervision to ensure safety – such as people with dementia or Alzheimer's – and who require around the clock care or where the caregiver burden has exceeded their ability to care for the patient. This, coupled with the lack of capacity within our state's skilled nursing facility (SNF) partners – specifically for long term dementia/memory care/secured units – has strained our health system, with hospitals responsible for keeping such patients in inpatient care, lacking an alternate safe discharge plan. This significantly impacts patient flow throughout our system of care, from our EDs to the acute care system.

We work diligently through our care management teams, health system and state and regional resources to try to secure a more appropriate level of care setting for patients. We also engage with families and support persons to look for ways to increase support at home or previous place of residence in the hope some can return while awaiting long term care. Case management of this population often entails a court petition for guardianship or durable power of attorney for those who are determined to lack decisional capacity and have no appointed health care agent. This process can take months while the individual resides in our acute care setting.

Upon guardianship appointment, we facilitate the patient's application for Vermont Choices for Care/LTC Medicaid, which can take up to six months due to difficulty obtaining the patient's financial assets/liabilities/bank statement information. Once all information is obtained, submitted and a decision is reached regarding approval, there are often complexities, such as "spend-downs" patients/families are ordered to put in place before LTC coverage is secured. This is tremendously challenging work and taxing for the patient and their family.

We refer statewide all patients for whom SNF placement is recommended, and we also work to expand referrals out of state as appropriate. There are some out of state facilities that are contracted with the State to bill CFC due to lack of this level of care in our state. The lack of post-acute care settings in the state of Vermont has a negative impact most significantly on the individual and their families, adds cost, and impacts flow into the acute care setting for those who require that level of care.

As we provided last year, in the chart below is our model for calculating uncompensated inpatient care. We are assuming that once a patient encounter has extended beyond the Vizient expected LOS for that encounter, that we have also extended beyond the DRG payment for that encounter. At UVM Medical Center, we are assuming 14% of our inpatient encounters are not paid by DRG, thus the extended stay is covered by revenue.

	FY22 Actual								
	Actual ALOS	Vizient Expected ALOS	Actual Avg Daily Census	Expected Avg Daily Census	Uncomped Annual Days	Adjustment for Non-DRG Payment	Adjusted Uncomped Annual Days	Avg Direct Cost per Day	Uncomped Care $$
UVMMC	6.42	5.47	399	340	21,539	14%	18,524	$ 2,222	$ 41,160,071

	FY23 Actual								
	Actual ALOS	Vizient Expected ALOS	Actual Avg Daily Census	Expected Avg Daily Census	Uncomped Annual Days	Adjustment for Non-DRG Payment	Adjusted Uncomped Annual Days	Avg Direct Cost per Day	Uncomped Care $$
UVMMC	6.40	5.63	402	354	17,671	14%	15,197	$ 2,222	$ 33,768,363

	FY24 YTD April Annualized								
	Actual ALOS	Vizient Expected ALOS	Actual Avg Daily Census	Expected Avg Daily Census	Uncomped Annual Days	Adjustment for Non-DRG Payment	Adjusted Uncomped Annual Days	Avg Direct Cost per Day	Uncomped Care $$
UVMMC	6.17	5.64	409	374	12,831	14%	11,035	$ 2,222	$ 24,519,918

	FY25 Budget								
	Budgeted ALOS	Estimated Vizient Expected ALOS	Budgeted Avg Daily Census	Expected Avg Daily Census	Uncomped Annual Days	Adjustment for Non-DRG Payment	Adjusted Uncomped Annual Days	Avg Direct Cost per Day	Uncomped Care $$
UVMMC	6.10	5.52	406	367	14,088	14%	12,116	$ 2,222	$ 26,921,605

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 UVM Medical Center, 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
UVMMC	4.8	42,048	1,752	$ 761	$ 1,333,272

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 4,400+ new patients will be in the UVM Medical Center 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, UVM Medical Center primary care physicians are budgeted to generate 5,318 wRVUs/clinical FTE (41st percentile) and the primary care APPs are budgeted to generate 3,940 wRVUs/clinical FTE (51st 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.uvmhealth.org/medcenter/about-uvm-medical-center/the-community/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 #)

FY23	
UVM Medical Center Financial Assistance Program	**Volumes**
Total Applications	5,735
Total Household Members	6,089
Approved / Granted	
<200 FPL (Free Care)	2,682
<201% FPLG - 400% FPLG (Discounted)	2,216
Total Approved	4,898
Denied	
Denied - No Eligible Charges	15
Denied - No Current/Scheduled Charges	8
Denied - Other Reason	28
Denied - Out of Service Area	1
Denied - Over Assets	82
Denied - Over Income	180
Denied - Over Income & Assets	10
Incomplete Application or Documentation	425
Medicaid Denied - Non-Compliant	2
No Response from Patient	25
Qualified for Medicaid	60
Qualified for Other Assistance Programs	1
Total Denied	837

Please see Appendix K for the UVM Medical Center plain language summary of the financial assistance policy.

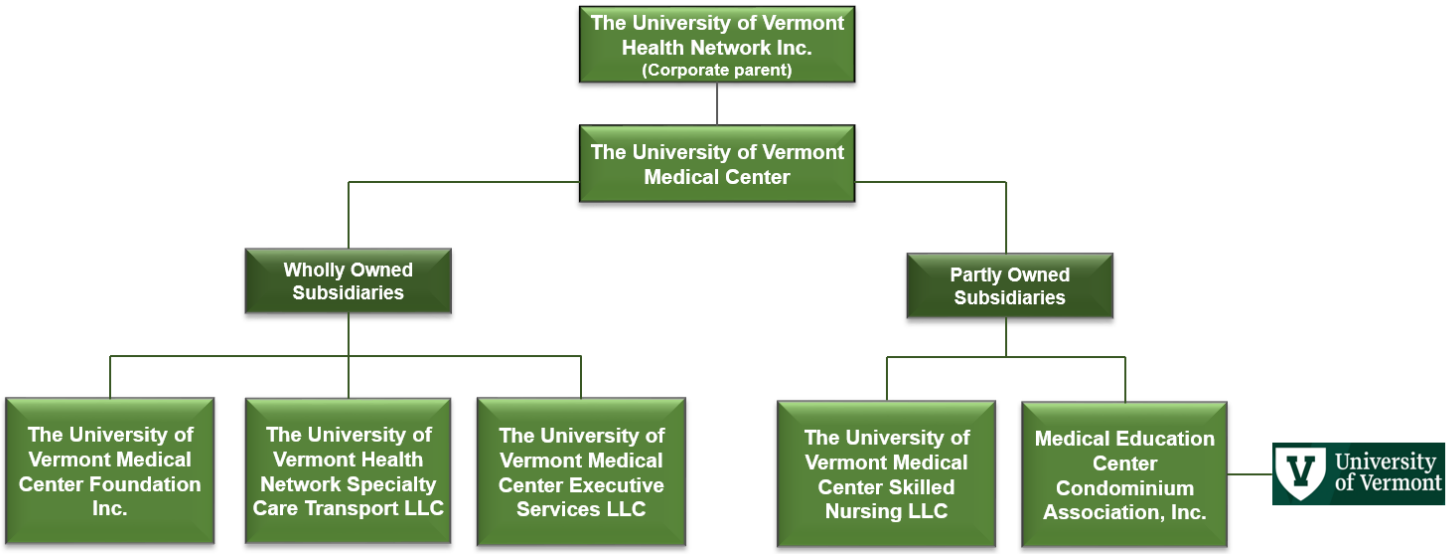
8. Affiliations & Third-party Contracts (upload)
Submit copies of contracts you have with any Medicare Advantage Plans or Management Companies.

UVM Medical Center 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 we receive from the plans for services we provide to plan participants. Currently, UVM Medical Center is contracted with the following MA plans:

- Aetna Health Management, LLC
- Vermont Blue Advantage

- Capital District Physicians' Healthcare Network, Inc./Capital District Physicians' Health Plan
- Excellus Health Plan, Inc.
- New York State Catholic Health Plan, Inc. d/b/a Fidelis Care New York
- 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 the UVM Health Network leaders, like all shared services, are supported by all of the UVM Health Network's 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

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 the national data cut. 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:

Vermont Access to Public Records Act. The legal basis for that request is set forth in the letter filed separately herewith.

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