**HSF QUESTIONS FOR HOSPITALS**

VERMONT
GREEN MOUNTAIN CARE BOARD

HOSPITAL 2: CENTRAL VERMONT MEDICAL CENTER (CVMC)

**Follow-Up Questions and Requests Related to Your Budget Submission**

**On your executive summary you write:**

1. **"We continue to partner with UVM Medical Center to expand our surgical capacity to reduce wait times for surgical procedures." To the best of your ability, please provide an estimate of how much surgical wait times have decreased as a result of this partnership**.

In FY24, CVMC partnered with UVMMC to optimize surgical capacity across our system. As a Network we have engaged in joint recruitment for surgeons who will operate both at CVMC and UVMMC. In FY24, the UVMHN goal was to move 100 surgical cases from UVMMC to CVMC to take advantage of available Operating Room time at CVMC. As of mid-August FY24, 86 cases were relocated from UVMMC and successfully completed at CVMC. This work will continue in FY25.

UVMMC:

| | Sep 8 2023 | Nov 3 2023 | May 16 2024 | August 13 2024 |
|---|---|---|---|---|
| Patients Waiting 90+ Days | 180 | 341 | 304 | 218 |
| Patients Waiting 60-90 Days | 441 | 375 | 220 | 314 |
| Patients Waiting 60+ Days (sum) | 621 | 716 | 524 | 532 |

CVMC:

| | Sep 8 2023 | Nov 3 2023 | May 16 2024 | August 13 2024 |
|---|---|---|---|---|
| Patients Waiting 90+ Days | 63 | 45 | 124 | 105 |
| Patients Waiting 60-90 Days | 61 | 68 | 57 | 73 |
| Patients Waiting 60+ Days (sum) | 124 | 113 | 181 | 178 |

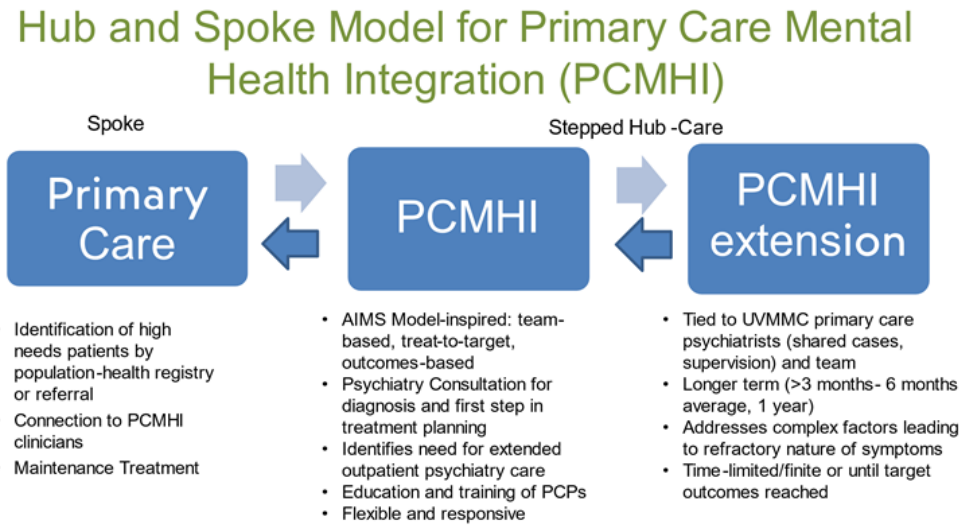
The principal source of patient backlog at CVMC has been Ophthalmology, specifically a private practice community surgeon. CVMC has offered additional Operating Room time to this provider, who has not been able to take advantage of the time offered. CVMC currently is recruiting an Orthopedic Surgeon, a replacement for a retirement, which is contributing to a backlog in Orthopedics in FY24.

**On service-line changes:**

2. **What evidence is there that the closure of the mental health practice site and utilizing a collaborative care model will better serve your patients? What is the financial impact of this shift?**

Primary Care Mental Health Integration (PCMHI) is based on research conducted by the University of Washington's AIMS Center. Resources previously located in our stand-alone psychiatric practice will be imbedded into CVMC's primary care practices. The co-location of these resources in patients' medical home has demonstrated improvements in destigmatizing mental health care, expanding the capacity of the care provided by using mental health clinicians as the entry point (the AIMS model), and significant improvement in diagnoses, such as depression and anxiety outcomes, as compared with usual care pathways.

The addition of collaborative care mental health clinicians (CCMHC) to the psychiatric consultant model helps to engage the patients in treatment earlier in their disease progression, reducing use of ED and Inpatient Psychiatry. The reduction in ED and Inpatient Psychiatric utilization will have an impact on the cost of care.




3. **How much money have you devoted to the primary care investments you describe in response to narrative response B.d (pages 9 –10)?**

Provider and staff investment in FY25 are as follows:

| | FY25 Provider FTEs | FY25 Staff FTEs |
|---|---|---|
| *FM Barre* | 8.42 | 19.38 |
| *FM Berlin* | 6.30 | 19.12 |
| *FM Montpelier Integrative Health* | 7.59 | 17.62 |
| *FM Waterbury* | 6.53 | 12.79 |
| *FM Green Mountain* | 4.54 | 11.24 |
| *FM Mad River* | 3.75 | 7.57 |
| *CVMC Family Medicine – Main Campus* | 6.83 | 17.52 |
| **Total** | **55.03** | **120.23** |

**On labor expenses:**

4. **How many new staff and clinical positions have you created since last year's budget submission? What are the labor expenses associated with these new positions? Please differentiate by the type of position.**

   The summary table below identifies the new positions for CVMC:

| | | FTE | | Estimated Labor |
|---|---|---|---|---|
| **Hospital Services - Direct Patient Care:** | | | | |
| Critical Care | RN | 1.0 | $ | 100,200 |
| Med-Surg Unit | RN | 4.1 | $ | 367,100 |
| Ambulatory Care | RN | 3.3 | $ | 336,900 |
| Surgical Services | RN | 3.1 | $ | 325,100 |
| Central Sterile Reprocessing | CSR Tech | 2.6 | $ | 128,700 |
| Pharmacy | staff pharmacist | 2.3 | $ | 317,100 |
| Respiratory Therapy | Resp therapist | 1.8 | $ | 136,900 |
| MRI SERVICES | Tech apprentice | 1.0 | $ | 56,000 |
| **Hospital Services - Support Services:** | | | | |
| Plant Facilities | supervisor prop mgmt & tech | 1.8 | $ | 139,800 |
| Environmental Services | Tech | 1.0 | $ | 50,700 |
| Nursing Education | Educator | 1.0 | $ | 108,700 |
| **Total Increase to Hospital** | | 23.0 | $ | 2,067,200 |
| **Woodridge Nursing & Rehabilitation - Direct Patient Care:** | | | | |
| Spruce Commons Nursing Unit | LNA | 1.2 | $ | 56,400 |
| **Woodridge Nursing & Rehabilitation - Support Services:** | | | | |
| Nutrition & Food Services | cook | 1.0 | $ | 47,900 |
| **Total Increase to Woodridge Nursing & Rehabilitation** | | 2.2 | $ | 104,300 |
| **Total Increase to CVMC** | | 25.3 | $ | 2,171,500 |

Please note new providers (MDs and APPs) are not budgeted for until a contract has been signed. This is a standard budgeting practice for the UVMHN Medical Group.

5. **The table in response to narrative question c.c.a is somewhat unclear. Where have you reduced spending and staffing of travelers? Where have you increased such spending and staffing? And do you foresee that the new union agreement (or any other developments) will reduce your total dollar reliance on travelers in the future?**

UVMHN has centralized traveler contracting and recruitment. This service has negotiated lower rates for traveler contracts. This centralized approach, along with a national reduction in agency staffing rates, has reduced our projected traveler spend. See table below for reduction in total spend for both Woodridge Nursing and Rehabilitation and the Central Vermont Hospital:

| WDR | FY2022 | FY2023 | FY24 Annualized | FY2025 | FY25-Proj24 |
|---|---|---|---|---|---|
| Traveler Exp | $ 6,516,074 | $ 6,785,106 | $ 5,515,959 | $ 3,802,850 | $ (1,713,108) |
| Traveler FTE | 26.9 | 39.0 | 37.6 | 27.4 | -10.2 |
| Rate of Pay | $ 116.50 | $ 83.75 | $ 70.53 | $ 66.73 | $ (3.80) |
| | | | | | |
| CVH | | | | | |
| Traveler Exp | $ 17,314,648 | $ 14,863,607 | $ 11,632,063 | $ 9,737,314 | $ (1,894,748) |
| Traveler FTE | 48.9 | 53.2 | 56.8 | 48.4 | -8.4 |
| Rate of Pay | $ 170.30 | $ 134.32 | $ 98.42 | $ 96.72 | $ (1.70) |
| | | | | | |
| Total | | | | | |
| Traveler Exp | $ 23,830,722.00 | $ 21,648,713.00 | $ 17,148,021.33 | $ 13,540,164.60 | $ (3,607,856.73) |
| Traveler FTE | 75.8 | 92.2 | 94.4 | 75.8 | -18.6 |
| Rate of Pay | $ 151.21 | $ 112.95 | $ 87.31 | $ 85.88 | $ (1.43) |

In 2018 CVMC launched innovative "earn while you learn" workforce development programs. CVMC continues to invest in workforce development programs reducing our reliance on Travelers for the following clinical roles: RNs, LPNs, LNAs, MAs, Surgical Scrub Techs, and Respiratory Therapists. The FY25 budget is reflective of an 18.6 FTE decrease in travelers use from the current FY24 projection, with a corresponding $3.6M expense reduction. These workforce development programs have been replicated as part of UVMHN's Center for Workforce Development.

At this time, the newly formed RN and Technical Professional Bargaining Units are not anticipated to reduce the reliance on travelers.

**On utilization:**

6. **Your projected NPR for FY2024 is 4.8% above budgeted NPR. In the narrative you attribute this to increased volume:**

   **"The favorable and unfavorable impact to FY24 projection versus FY24 approved budget are noted below...increased volumes (access) to Medical Group services, imaging, lab services and pharmaceutical services." (page 11)**

   **Can you provide a more specific assessment of where volume has increased above FY2024 budgeted expectations. How have you recalibrated your expectations as to not underpredict your NPR for FY2025?**

Budgeted volumes are based on a twelve-month rolling trend using actual performance. Adjustments to the projection and to the budget are then made based on information gathered (i.e. new providers, retiring providers, etc.).

| | FY23 Actual | FY24 Budget | FY24 Projection | FY25 Budget |
|---|---|---|---|---|
| Discharges | 4,206 | 4,501 | 4,426 | 4,813 |
| Patient Days | 22,685 | 22,810 | 21,001 | 21,984 |
| ED Visits | 27,666 | 27,000 | 27,673 | 28,258 |
| OR Cases | 4,154 | 4,617 | 5,189 | 5,339 |
| GI Procedures | 4,686 | 5,817 | 5,809 | 7,018 |
| MRI | 4,295 | 3,906 | 4,797 | 4,617 |
| CT | 19,492 | 17,943 | 21,569 | 20,336 |
| Minor Imaging | | | | |
| Total Rad Diagnostic | 37,894 | 34,755 | 37,987 | 37,987 |
| Total Ultrasound | 9,391 | 8,672 | 9,391 | 9,391 |
| Total Mammography | 9,347 | 8,592 | 9,177 | 9,177 |
| Lab Total Billed Tests | 492,966 | 483,729 | 513,533 | 491,375 |
| Pharmacy Doses | 492,966 | 550,633 | 512,907 | 527,670 |
| Medical Group | | | | |
| RVU's | 583,822 | 574,114 | 593,877 | 645,757 |

**On pharmaceuticals:**

7. **Could you provide more detail on your planned pharmaceutical expenses? Why do you foresee that such expenses will increase by 23%?**

   With the continued fluctuations with manufacturing restrictions on 340B eligible cost savings, the offset will be higher drug costs than current trending. CVMC continues to provide outpatient chemotherapy services. These drugs over the course of a treatment can be quite costly.

8. **Does the 340B program reduce pharmaceutical prices for patients as well as the hospital? Can you please provide a sense of how much of the 340B discounts you're passing onto patients?**
   - On the Health Resources & Services Administration (HRSA) webpage for the 340B drug pricing program, it states the intent of the program: "The 340B program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." [1]
   - HRSA's 340B prescription drug discount program is critically important to our rural providers, as it is a vital lifeline for safety net health care organizations providing a high level of services to low-income individuals or serving isolated rural communities. Significantly more 340B hospitals provide vital, but money-

losing, health services than non-340B hospitals – services like mental health and substance use disorder treatment, trauma centers, and neonatal intensive care units.

- Not every non-profit hospital qualifies for the 340B program. University of Vermont Medical Center qualifies as a disproportionate share hospital (DSH > 11.75%), Central Vermont Medical Center qualifies as a sole community hospital (DSH > 8%), and Porter Medical Center qualifies through their status as a critical access hospital. Unlike University of Vermont Medical Center, Central Vermont Medical Center and Porter Medical Center are excluded from 340B pricing for orphan status medications. [2]
- At the UVM Health Network, we use our 340B savings to:
  - Fund patient assistance programs that provide access to medications to thousands of patients with financial need.
    - In FY23, 8.3% of patients served by the UVMHN pharmacy qualified for the health assistance program (under- and un-insured) and received co-pay assistance. This encompassed 18.4% of all prescriptions filled.
  - Provide necessary care to all patients regardless of ability to pay.
  - Support the health and wellness of our communities in Vermont and northern New York.
  - Lessen the gap between the cost of care and reimbursement from government payers.
  - Help keep our hospitals solvent to ensure patients in our region have access to comprehensive, high-quality care.
- The 340B program is a cost-avoidance program that is funded by participating pharmaceutical manufacturers and not by taxpayers.

Reference:

1. Health Resources and Services Administration. https://www.hrsa.gov/ops Accessed August 12, 2024.
2. Health Resources and Services Administration. https://www.hrsa.gov/opa/program-requirements/orphan-drug-exclusion Accessed August 12, 2024.

9. **Do you make a profit off your pharmaceutical operations? If so, can you please specify how much. Please specify any profits made from the 340B program specifically.**

   Yes, however, we cannot provide a payer mix for revenues from 340B. We estimate approximately 80% to 90% drug supply replenishment cost for hospital outpatient provided pharmaceuticals for qualifying sites of service are eligible for the 340B drug pricing program.

- Regardless of access to the UVMHN outpatient pharmacy, prescriptions likely would have been filled and dispensed to eligible patients. The UVMHN outpatient pharmacy allows those health care dollars to stay in our system and be reinvested into the care of patients throughout the UVMHN.
- UVMHN participates in contract pharmacy arrangements, which allows 340B cost-avoidance/cost-savings to be captured through prescription fills and refills at contracted non-UVMHN pharmacies. In FY23, UVMHN received $34.8M in margin from the contract pharmacy arrangements [UVMMC $24.6M, CVMC $9.0M, and PMC $1.2M].

**On investments in mental health, SUD, LTC, and primary care:**

10. **What is the patient capacity at Woodridge and what is the average number of beds available on any given day?**

**Woodridge**

| | 2023 Actual | 2024 Projected | 2025 Budgeted |
|---|---|---|---|
| Budgeted Average Daily Census | 103 | 125 | 125 |
| Actual Average Daily Census | 119 | 121 | 125 |

**On your network:**

11. **To what extent does your organization share physicians and other clinical staff with other hospitals in your network? Have you taken these partnerships into account in your budget?**

There are 34 physicians with budgeted effort at CVMC that are shared with at least one other hospital in UVMHN. These shared providers are accounted for within the CVMC FY25 budget. Volumes, professional revenue, and personnel costs are reflected in the respective hospital budget based on the planned effort at each partner hospital.

**On your workbook submission:**

12. **In Table 1 of the workbook, it suggests referral wait times are often longer than 3 days. Do you have any indication or estimate of how much longer it takes to process a referral?**

Average referral lags vary between clinics with an average lag of 8 business days. Clinically urgent referrals are prioritized. Our new “enhanced” referral process will transition the triage process to an Epic referral order. This shift will reduce provider time related to this task, improve efficiency and decrease the referral lag.

13. **In Table 7, for those departments operating at a very low productivity compared to peers, is your organization evaluating or undertaking any initiatives to increase productivity? If so, please explain.**

There are a variety of initiatives underway related to productivity.

- Scheduling simplification ensures a standardization of both visit types and visit lengths across all our primary care providers. This reduction in variation allows us to move to standard visit lengths of 15, 30 and 45 minutes. Prior to this work, we had providers who had 60 minute visits built into their templates. All template editing is held within the responsibility of the practice's administrative leader and one other staff member as backup. This ensures we are matching our expected provider capacity with our actual available appointments for each provider on the team.
- Implementation of Fast Pass ensures appointments that become available are filled with a patient who is on our wait list, moving patients forward and thereby creating future capacity on the schedule for another patient who needs access.

14. **Please review the rate decomposition details you submitted as well as the "summary" tab and explain the following (where available, show supporting calculations):**
    a. **How did you arrive at the assumed rates of growth for price, volume, and payer mix shifts by payer?**
    b. **For non-zero values in the "other" column, how did you derive these estimates?**

NPR Crosswalk from FY24 Budget to FY25 Budget

| | A | B | C | D | E=A+B+C+D | F | H=E+F |
|---|---|---|---|---|---|---|---|
| | FY24 Budget | FY24 Actual to Budget Rate Experience | Payer Mix Shift Impacts | Utilization Changes | FY25 Base NPR Prior to FY25 Rates | FY25 Rate Assumptions | FY25 NPR Budget |
| CVMC | | | | | | | |
| **Total NPR** | **275,002,293** | **(3,023,640)** | **2,874,582** | **23,159,811** | **298,013,046** | **9,659,283** | **307,672,329** |
| Medicaid | 30,164,521 | 4,110,977 | (1,542,185) | 1,657,853 | **34,391,165** | 323,262 | 34,714,428 |
| Medicare | 105,762,815 | (2,781,186) | 2,399,088 | 8,735,634 | **114,116,351** | 3,151,838 | 117,268,190 |
| Major Commercial | 116,759,374 | (3,392,784) | 3,692,195 | 11,213,075 | **128,271,861** | 6,472,076 | 134,743,937 |
| All Other | 30,598,907 | (1,537,493) | (870,376) | 2,470,186 | **30,661,225** | 416,316 | 31,077,541 |
| Bad Debt | (6,370,585) | (1,156,212) | (598,310) | (616,547) | **(8,741,654)** | (571,815) | (9,313,469) |
| Free Care | (3,212,007) | 1,695,585 | (205,830) | (300,390) | **(2,022,642)** | (132,395) | (2,155,037) |
| DSH | 1,299,268 | 37,472 | - | - | **1,336,740** | - | 1,336,740 |

| Total NPR % Change | B/A | C/A | D/A | (E-A)/A | F/A | (H-A)/A |
|---|---|---|---|---|---|---|
| From FY24 Budget | -1.1% | 1.0% | 8.4% | 8.4% | 3.5% | 11.9% |

| | F/E |
|---|---|
| FY25 Rate/Price on FY25 Base | 3.2% |

| GMCB Rate Decomp File: Data Column Reference | | | | | | |
|---|---|---|---|---|---|---|
| | C | R | Q | M | | K+O | E |

Column B reflect what is represented in the "other" column in the Rate Decomposition file. This represents the difference in FY24 Budget to Actual collection experience.

The calculation is based upon the GPSR change from FY24 budget to FY25 Base (prior to any rate changes) multiplied by the collection rate difference from the FY24 Budget to FY24 Actual experience.

Column C reflects payer mix difference from FY24 Budget to FY24 actual experience.

The calculation is based on taking the difference in FY24 Budgeted payer mix to current actual experience. Then restating what FY24 Budget GPSR would have been by payer if based on current actual payer. Then take the difference in GPSR by payer and multiply by FY24 Budgeted collection rate for that payer.

Column D reflections utilization/Access improvements.
The calculation is based on GPSR change by payer from the FY24 budget to FY25 Base (prior to any rate changes) +/- any payer mix changes then multiply that difference by FY24 Budgeted collection rates by payer.

Column F reflects the rate changes necessary to cover cost inflation.
As spoken to in question 12, we take rate assumptions for the non-commercial payer first, then apply any initiatives and assumptions which were utilized to offset cost

inflation prior to the rate calculation; the remainder is then used to calculate the commercial rate increase necessary to fund cost inflation. The calculation is below.

| CVMC | FY2025 Cost Inflation |
|---|---|
| Total Cost Inflation | $9,973,896 |
| Less Retail Pharmacy | $0 |
| **Net Cost Inflation for Commercial Rate Calc** | **$9,973,896** |
| | |
| **Less:** | |
| FY2025 - Medicare Rate Increase | $90,212 |
| FY2025 - Medicare ACO Rate Increase | |
| FY2025 - Medicaid Rate Increase | $205,437 |
| FY2025 - Other Payer Changes | $372,201 |
| APM Shared Savings | $2,405,203 |
| LOS Reduction & Placement Impacts | $754,666 |
| GME/IGT Change | $0 |
| UM/UR Change | $260,855 |
| PHSO | $314,612 |
| Legislative Changes - Bad Debt/Charity/Denials | $264,108 |
| Rate Impact on Bad Debt/Charity/Denials Calculation | ($972,650) |
| **Sub-Total** | **$3,694,644** |
| | |
| **Required Funding from Commercial Rate** | **$6,279,253** |
| | |
| Per 1 % Impact of Commercial Rate: | |
| Budget Year ( 9 months: Jan-Sept) | $960,130 |
| | |
| **Commercial Rate Increase in FY2025 Budget** | **6.54%** |

**Other**

15. **Do you think Medicaid is underfunding the cost of delivering care to your Medicaid patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.**

    Based FY23 P&L and using a Ratio Cost to Charge allocation methodology, Medicaid covered about 66% of the total cost of care, with a funding shortfall estimated at $15M.

16. **Do you think Medicare is underfunding the cost of delivering care to your Medicare patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.**

    Based FY23 P&L and using a Ratio Cost to Charge allocation methodology, Medicare covered about 77% of total cost of care, with a funding shortfall estimated at $29M.

17. **In the attached spreadsheet, please review the measures of financial health that we have calculated for your hospital. We have included the measure definitions. Confirm that**

**these calculated values reflect your understanding. If your financial measures differ from our calculations, please review our formulas, provide your calculation, and explain why you believe your calculation is a better measure for your organization.**

Please refer to the attached file for the response to this question.

- GMCB Formulas - Added columns C, D, & E to the tab. Columns C & D are the respective formulas for the Annual & Mid-Year calculations. Column D represents comments speaking to differences in the formula approaches.
- Report Data - Added comparison columns to GMCB calculation compared to the methodology for the calculation as performed for bond covenant & Rating Agency reporting. Comparisons were done for FY23 Actual, FY24 Projection, & FY25 Budget.

18. **Related to your nursing home, please provide the following (2023 actuals, 2024 projected, and 2025 budgeted):**
    a. **Avg Cost per day**
    b. **Avg Reimbursement per day, by payer**
    c. **Avg Occupancy Rate**
    d. **Operating margin**
    e. **Hospital subsidy to nursing home (if any)**

| | 2023 Actual | 2024 Projected | 2025 Budgeted |
|---|---|---|---|
| Average cost per day | **554.66** | **543.24** | **543.82** |
| Avg Reimbursement per day | **456.62** | **522.61** | **479.42** |
| Medicare | 723.41 | 760.03 | 710.59 |
| Medicaid | 390.33 | 483.58 | 417.96 |
| Commercial | 976.61 | 617.21 | 528.97 |
| Other (SP & Public) | 457.50 | 474.53 | 470.51 |
| Avg Occupancy rate | **77.63%** | **78.94%** | **81.70%** |
| Operating margin | **$ (3,755,723)** | **$ (1,485,168)** | **$ (2,919,000)** |

The annual investment to support Woodridge is the negative operating margins.