THE
University of Vermont
HEALTH NETWORK

Central Vermont Medical Center

SENT VIA EMAIL

December 13, 2024

Green Mountain Care Board
c/o The Honorable Owen Foster, Chair
144 State Street
Montpelier, VT 05602

RE: Request for Information (November 26, 2024) - Planned Closure of CVMC Inpatient Psychiatry Unit

Dear Chair Foster:

Thank you for the opportunity to respond to your questions regarding our difficult decision to close the inpatient psychiatry (IPP) unit at Central Vermont Medical Center (CVMC). As you know, it has long been our goal to expand both the inpatient and outpatient psychiatric care delivered to Vermonters, either by delivering that care ourselves or by partnering with others to provide care in the most appropriate, cost-effective setting. Our implementation of the Primary Care Mental Health Integration (PCMHI) model at CVMC in September of this year is one example of that intent. Implementing innovative, evidence-based approaches to care delivery in lower-cost outpatient settings will be important to optimizing health outcomes and reducing the overall cost of the care provided to Vermonters. It is my hope that the information contained in this letter will form the basis for a constructive discussion regarding how Vermont can implement care delivery models that provide high value mental health care to its residents.

The GMCB budget order reduced approximately $16.2 million dollars in revenue from our original FY25 budget submission. That $16.2 million is the equivalent of more than 5% of CVMC's budgeted revenue.

CVMC takes the Board's budget order, and its commitment to controlling the revenue CVMC receives, very seriously, and we are committed to abiding by the order. It is nonetheless extraordinarily difficult to eliminate more than 5% of a hospital's budgeted revenue in less than one year without impacting patient services. I describe below the steps we took to meet the requirements of the budget order while causing the least hardship to the fewest patients.

First and most importantly, we reduced our budgeted commercial rate increase from 5.3% to 3.4%, which is what the Board's order requires of us. That commercial rate adjustment eliminated $3,872,000 in revenue from CVMC's budget, leaving a $12,326,000 gap in achieving the revenue order. As you are aware, we are unable to cut the set rates that Medicare and Medicaid pay for the care we provide to the 63.4% of our patients who are covered by those

programs, and doing so would increase the burden on commercial payers.

Second, in collaboration with our partners across the UVM Health Network, CVMC's reduction in administrative expenses was $2.9 million. While those cuts indirectly affect our ability to deliver the care Vermonters seek from CVMC, they were necessary in order to allow CVMC to avoid even more direct reductions in patient services and remain financially sustainable. These expense reductions by themselves would not decrease revenue in FY25, as the Board has required.

Third, we reduced FY25 budgeted volumes in order to reduce the associated revenue and expenses. This change will impact access to a number of services that CVMC will continue to provide, at a lower volume than Vermonters may need. We reduced growth estimates in our acute care, surgery, endoscopy and imaging services with an associated reduction of $7.48M in NPR. We determined, and continue to conclude, that CVMC cannot achieve the Board's revenue reduction target without moving one or more services outside of CVMC. As a result, we completed a service line review to evaluate which services we could eliminate or move out of the hospital setting while causing the least hardship to the fewest patients. On October 21, we provided you with a list of the services that were then under consideration for closure or significant curtailment, including the IPP service. On November 13, Dr. Eappen, Dr. Leffler and I met with you by phone to review the service reductions we would be announcing the following day, responding to the questions you had during that call.

As you know from our prior filings and as detailed below, CVMC's IPP unit capped its census at eight patients in December 2023. The census has been declining over the preceding three years. CVMC had difficulty recruiting psychiatrists following the departure of three psychiatrists. In FY24, the IPP unit had 343 patient discharges, brought in $3.4M in NPR, and had $6.2M in related direct expenses. As a result of all of these factors, and as described more fully below, we determined that moving this service to other locations, where possible, would support our compliance with the GMCB's budget order, while causing the least hardship to the fewest patients.

We met with leaders of IPP acute care and community-based services to explore their ability to provide both the inpatient and outpatient services that patients will need after we close our IPP unit. It is our goal to continue those collaborations to ensure that patients who require an acute psychiatric admission will have another care option in Vermont.

It nonetheless remains the case that the closure of CVMC's IPP unit will cause hardship for patients and their families, and we acknowledge the significant impact that this decision will have on patients who would have received high quality care in CVMC's IPP unit. We are confident in the partnership of our colleagues who will continue providing acute inpatient psychiatric services. Through collaborations with Washington County Mental Health Services (WCMHS) and Vermont Department of Mental Health (DMH) and exploring opening a Mental Health Urgent Care service in central Vermont, we can continue to positively impact the outcomes of patients who seek mental health services.

Please review our responses below to your request for information dated November 26, 2024.

1. Explain how closing the inpatient psychiatric unit at CVMC complies with the FY25 budget established by the GMCB.

Response:

The difficult decision to close the IPP unit was influenced, in part, by the low census, and high costs associated with operating the unit. In December 2023, the inpatient psychiatry unit (IPP) census was capped at eight patients, following the transition of three employed psychiatrists to per diem status. Medical coverage for this reduced census was achieved with three locums and one employed psychiatrist. 0.85 FTE of advance practitioner time was allocated to provide medical consultation on our IPP unit. Recruitment for replacement of the psychiatrists was underway beginning December 2023. The IPP unit design is an open milieu, impacting the level of acuity of the patients who can be treated in the setting. In FY23, we had 398 discharges from the IPP unit with an average daily census (ADC) of 10 patients. In FY24, we had 343 patient discharges with an ADC of eight. The annual NPR reduction when fully implemented will be $3.3M and the annual expense reduction will be $6.9M. $1.3M of the $2.9M indirect administrative shared service expense reduction is attributed to this service reduction, bringing the total expense reduction to $8.2M.

NPR Budget Reduction for 9 Months	$2,450,976	12 Months	$3,267,986
Expense Budget Reduction for 9 Months	$5,172,401	12 Months	$6,896,534

2. Describe the actions CVMC and UVMHN took to identify other areas for expense mediation and/or revenue reduction before deciding to close the inpatient psychiatric unit.

Response:

To comply with the GMCB order to reduce net patient revenues by $16.2M, CVMC completed the following: 1) Commercial rates were reduced from 5.3% to 3.4%; 2) Administrative shared services expenses were reduced by $2.9M; and 3) FY24 service line actual performance was compared to FY25 budgeted volumes. Adjustments were made to the FY25 budgeted volumes, reducing growth estimates in our acute care, surgery, endoscopy and imaging services with an associated reduction of $7.48M in NPR. Additional adjustments will be achieved with the consolidation of primary care practice locations from our current footprint of seven to five locations and the consolidation of rehabilitation service sites in the communities we serve.

3. Describe why other courses of action were not pursued instead of closing the inpatient psychiatry unit.

Response:

As described, many other courses of action were considered, and they were not sufficient to reduce revenue to the extent necessary to comply with the GMCB's FY24 budget order within this fiscal year.

4. Describe potential collateral financial impacts closing inpatient psychiatry will have on CVMC's budget, including costs associated with increased length of stay, patients being treated in different care settings, and any impact on other providers.

Response:

We are not anticipating any increases in length of stay associated with the closure of this service.

The closure of the inpatient psych unit will impact CVMC's Emergency Department (ED) and potentially our ExpressCare setting. Individuals evaluated in our ED who require an acute psychiatric admission will be transferred to an appropriate inpatient psychiatric setting outside of CVMC. We are reviewing ED and ExpressCare staffing and assessing the need to provide additional staff coverage during historically peak census times. We are in the process of exploring the addition of psychiatric coverage in the ED. Given the relatively small number of patients treated in the IPP unit, and the fact that their continuing care will be dispersed among many providers both within and outside of CVMC (see below), we do not anticipate that closure of the unit will have a material financial impact on any other portions of CVMC's budget.

Before the November 14 service reduction announcements, we contacted Brattleboro Retreat, Windham Center in Springfield, Rutland Regional Medical Center and UVM Medical Center to discuss potential impacts on their facilities due to the closure of our IPP unit. All have stated support for placement of patients who require acute care admissions in their facilities. Additionally, we began discussions with Washington County Mental Health Services and the Department of Mental Health regarding the impacts of this closure. Exploratory discussions have begun regarding the potential of offering Mental Health Urgent Care (MHUC) services in central Vermont, adapting the model recently opened in Chittenden County. We would like to explore the ability to repurpose $4.5M of the FY17 enforcement action dollars to fund the launch of this service in Washington County.

5. CVMC writes that earlier this year, it implemented a Primary Care Mental Health Integration model, which places mental health clinicians in all primary care clinics. It also writes that it will support mental health needs through innovative staffing in the Emergency Department and through community partnerships like the recently opened Mental Health Urgent Care in Burlington. To what extent does CVMC believe that these programs will reduce the number of patients projected to need services in an inpatient psychiatric unit in FY25.

Response:

The Primary Care Mental Health Integration (PCMHI) model at CVMC is based on the AIMS model from the University of Washington and the model implemented at UVM Medical Center in 2020. In FY24, the UVMMC PCMHI program participants experienced a 40% reduction in ED utilization from pre- to post-PCMHI program enrollment. The UVMMC PCMHI program participants experienced a 30% reduction in inpatient psychiatric utilization from pre- to post-PCMHI program enrollment. Clinically, these patients experienced a 39% reduction in treatment-resistant severe and moderate symptoms with most patients leaving the PCMHI program with only mild to minimal symptoms, which is considered a robust treatment response, outperforming

medication treatment alone or care as usual. We anticipate comparable results at CVMC. The PCMHI model was fully implemented at the end of September 2024. Program evaluation includes analysis of pre- and post- implementation metrics to measure its impact.

The closure of the inpatient psychiatric unit provides an opportunity to leverage CVMC's strong partnership with Washington County Mental Health Services to explore a Mental Health Urgent Care (MHUC) modeled after the service recently opened in collaboration with the Howard Center, Pathways Vermont, and Community Health Centers. While many things can contribute to changes in the ED census, early findings of the Chittenden County program have demonstrated shifts in patients presenting at the MHUC who would have previously presented in the UVMMC ED. Of note, a number of patients have returned on subsequent days to receive more peer support (provided by Pathways) outside of an acute care setting. Outcome measures for this program will continue to be tracked to better understand the impact of this new service. The impact of a similar program in central Vermont in FY25 will be dependent on a number of factors, one of which would be the launch date for the program.

6. For the inpatient psychiatric unit, provide actual NPR for FY22 and FY23 and projected NPR for FY24. Include a breakout by payer type (e.g. Medicaid, traditional Medicare, Medicare Advantage, commercial, other).

Response:

	FY24 NPR	FY23 NPR	FY22 NPR
Medicaid	311,451	465,387	437,667
Medicare - Traditional	399,771	497,528	833,267
Medicare - Advantage	441,657	300,718	207,766
Fixed Prospective Payments			
FPP - Medicare	1,068,953	1,925,984	1,233,965
FPP - Medicaid	366,982	298,535	548,511
FPP - Other	190,829	77,053	410,120
Other Public Agencies	11,634	52,140	16,234
Commerical			
Blue Cross	501,400	364,908	460,704
Cigna	2,498	49,845	57,216
All other Commercial	77,359	46,991	79,109
	3,372,534	4,079,089	4,284,559

7. For the inpatient psychiatric unit, provide the NPR as calculated in CVMC's proposed FY25 budget (14 beds). Provide what would have been budgeted FY25 NPR had CVMC budgeted for cap of 8 beds. Include a breakout by payer type.

Response:

Although we described our efforts to expand the census in CVMC's IPP unit, CVMC's FY25 budget submission in July 2024 was for an average daily census of eight. Our revised budget

submission on November 27, 2024, was for an IPP unit at a census of eight, with a projected closure date of January 1, 2025. As of this response submission, the program is scheduled to close on January 31, 2025. The table below is the budget for the inpatient psych unit and professional direct costs. There are estimated additional savings of indirect costs of $1.3M that are not in this table.

	FY25 Revised Budget	FY25 Original Budget	FY25 Budget Net Savings
Total Gross Patient Service Revenue	**2,048,158**	**8,432,112**	**(6,383,954)**
TOTAL NPSR + FPP + OCV REVENUE	**786,964**	**3,237,940**	**(2,450,976)**
Collection % including FPP + OCV	*38.4%*	*38.4%*	
TOTAL UNRESTRICTED REVENUE & OTHER	**786,964**	**3,237,940**	**(2,450,976)**
Salaries, Payroll Taxes, and Fringe Benefits	**1,542,759**	**6,593,383**	**(5,050,625)**
Total Non-Salary Expense	**38,634**	**160,410**	**(121,776)**
TOTAL DIRECT EXPENSES	**1,581,392**	**6,753,793**	**(5,172,401)**

	FY25 Revised Estimated Net Payor Collections	FY25 Original Estimated Net Payor Collections
Medicaid	133,752	548,496
Medicare - Traditional	129,006	530,728
Medicare - Advantage	76,121	309,721
Fixed Prospective Payments		
FPP - Medicare	74,393	306,987
FPP - Medicaid	142,550	588,324
FPP - Other	24,645	209,948
Other Public Agencies/Workers' Comp	7,597	31,398
Self Pay	10,708	43,850
Commerical		
Blue Cross	154,963	528,820
Cigna	1,919	7,891
All other Commercial	31,309	131,776
Total Estimated Net Payor Collections	786,964	3,237,940

8. For the inpatient psychiatric unit, provide actual expenses for FY22 and FY23 and projected expenses for FY24. Provide a breakout that at minimum separates labor expenses from all other expenses.

Response:

	FY24 Actual	2023 Actual	2022 Actual
Salaries, Payroll Taxes, and Fringe Benefits	**5,289,099**	**6,564,005**	**7,264,578**
Total Non-Salary Expense	**866,931**	**915,428**	**959,840**
TOTAL EXPENSES	**6,156,030**	**7,479,433**	**8,224,418**

Please note: The reduction in Salaries, Payroll Taxes and Fringe Benefits for FY24 was a change in expense tracking for Mental Health Technicians (MHTs) that were historically

budgeted and reported in the IPP cost center, but were utilized in the ED to cover psychiatric patient needs in that location. Starting in October 2023, the MHT time was transferred to the ED cost center to better align this expense to the location of utilization. In FY25, these resources are budgeted in the ED cost center.

9. For the inpatient psychiatric unit, provide the expenses as calculated for CVMC's proposed FY25 budget (14 beds). Provide what would have been budgeted FY25 expenses had CVMC budgeted for a cap of 8 beds. For each, provide a breakout that at minimum separates labor expenses from all other expenses.

Response:

The July FY25 budget submission reflected a census of eight patients in IPP. The revised budget submitted on November 27, 2024, kept the unit at a census of eight patients, with an estimated service closure date of January 1, 2025. The revised date of closure is now January 31, 2025.

10. Provide the following for FY22 and FY23 (actuals) and FY24 (projected):

Response:

a. Percent of CVMC's total NPR generated by its inpatient psychiatric unit

	FY24 Actual	2023 Actual	2022 Actual
IP Psych Unit Net Patient Revenue	3,362,123	4,079,089	4,284,559
Total CVMC Net Patient Revenue (A)	298,706,266	252,125,510	240,386,620
	1.13%	1.62%	1.78%

(A) Total CVMC Net patient revenue & expenses includes Woodridge Nursing & Rehabilitation Skilled Nursing Facility

b. Percent of CVMC's total expenses driven by its inpatient psychiatric unit

	FY24 Actual	2023 Actual	2022 Actual
IP Psych Unit Total Operating Expenses	6,156,030	7,479,433	8,224,418
Total CVMC Total Operating Expenses (A)	311,192,657	291,318,581	280,204,325
	1.98%	2.57%	2.94%

(A) Total CVMC Net patient revenue & expenses includes Woodridge Nursing & Rehabilitation Skilled Nursing Facility

c. Average daily census & FTE staffing (by month)

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	FY Total
FY24	Average Daily Census	11	9	10	8	8	7	7	7	7	8	8	7	8
	IP unit FTE's	29.86	30.91	29.38	26.59	29.23	27.01	29.53	26.26	29.95	28.99	31.29	38.05	29.73
	APP FTE's	2.20	2.20	2.20	2.20	2.20	2.20	2.20	2.20	2.20	2.20	2.20	2.20	2.20
	Provider FTE's	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6
	Total FTE Support	36.66	37.71	36.18	33.39	36.03	33.81	36.33	33.06	36.75	35.79	38.09	44.85	36.53
FY23	Average Daily Census	9	12	10	11	11	10	9	8	9	11	10	10	10
	IP unit FTE's	33.79	35.18	35.52	34.62	36.73	35.72	36.66	37.73	36.39	36.80	35.35	38.22	36.05
	APP FTE's	3.70	3.64	3.71	3.70	3.70	3.70	3.75	3.70	3.75	3.70	3.57	3.60	3.70
	Provider FTE's	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8
	Total FTE Support	44.29	45.62	46.03	45.12	47.23	46.22	47.20	48.23	46.93	47.31	45.72	48.62	46.55
FY22	Average Daily Census	13	12	10	11	11	13	12	11	11	12	11	12	12
	IP unit FTE's	41.90	32.42	34.06	39.71	35.84	36.00	36.60	37.51	34.26	37.22	38.23	37.50	36.80
	APP FTE's	2.12	2.12	2.12	2.12	2.12	2.12	2.12	2.12	2.12	2.12	2.12	2.12	2.12
	Provider FTE's	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61	6.61
	Total FTE Support	50.63	41.15	42.79	48.44	44.57	44.73	45.33	46.24	42.99	45.95	46.96	46.23	45.53

NOTE: IP Unit includes Care Mgt coverage of 2.4 for FY24, 2.9 for FY23 and 2.75 for FY22

11. Provide the following regarding CVMC's proposed FY25 proposed budget:

Response:

a. Percent of CVMC's total NPR generated by its inpatient psychiatric unit

	FY25 Revised Budget	FY25 Original Budget
IP Psych Net Patient Revenue	786,631	3,237,940
Total CVMC Net Patient Revenue (A)	291,502,431	307,672,329
	0.27%	1.05%

(A) Total CVMC Net patient revenue & expenses includes Woodridge Nursing & Rehabilitation Skilled Nursing Facility

b. Percent of CVMC's total expenses driven by its inpatient psychiatric unit

	FY25 Revised Budget	FY25 Original Budget
IP Psych Total Direct Operating Expenses	1,581,392	6,753,793
Total CVMC Total Operating Expenses (A)	309,321,046	325,490,944
	0.51%	2.07%

(A) Total CVMC Net patient revenue & expenses includes Woodridge Nursing & Rehabilitation Skilled Nursing Facility

c. Projected average daily census (14 beds)

The projected average daily census was capped at eight in the FY25 original budget submission and remains projected at eight until the unit is closed.

d. Updated projected cost to increase inpatient psychiatric unit from 8 beds to 14 beds

The inpatient psychiatric unit currently has two single bed patient rooms and six rooms which are double occupancy, for a total of 14 beds. The project goal was to convert six beds from double occupancy rooms to private rooms. Bringing the total count from two private rooms to eight and retaining three double occupancy rooms. The capital cost for this conversion was estimated at the time to be $4.5M. The increase in staffing to cover the 14 patients would be an additional RN, and Care Manager/Social Worker as noted in the model in Q16 below.

12. With the closure of the inpatient psychiatric unit, provide the projected FY25 NPR increase for all other CVMC departments and primary care practices, with a breakout by department. Provide the projected FY25 expense increase for all other departments and primary care practices, with a breakout by department.

Response:

Please see the answer to Q4, above. We are not anticipating any material increase in NPR or expenses in other CVMC departments or primary care practices due to this service closure and will monitor any potential impact over time to confirm this assumption.

13. With the closure of the inpatient psychiatric unit, provide the projected FY25 NPR increase for all other UVMHN departments and primary care practices, with a breakout by department. Provide the projected FY25 expense increase for all other departments and primary care practices, with a breakout by department.

Response:

Please see the answer to Question 4, above. We are not anticipating any material increase in expenses or NPR related to this closure in UVMHN departments.

14. For the inpatient psychiatric unit, provide the following for September 2022, September 2023, and September 2024:

a. The number of open positions
b. The type of each open position
c. The duration of time each position was (or has been) open

Response:

This grid represents staff positions only:

Open Requisitions	Number	Days Open
Sep-22		
CVMC_3040 - RN	4	1,855
CVMC_4099 - CVMC Mental Health Technician	7	2,062
CVMC_5065 - CVMC Administrative Assistant	1	133
Sep-23		
CVMC_3034 - Clinical Nurse Coordinator	1	516
CVMC_3040 - RN	5	1,425
CVMC_4099 - CVMC Mental Health Technician	3	252
CVMC_5065 - CVMC Administrative Assistant	1	478
Sep-24		
CVMC_3011 - Nurse Pract.	1	117
CVMC_3040 - RN	2	467
CVMC_4099 - CVMC Mental Health Technician	5	743
CVMC_5065 - CVMC Administrative Assistant	2	294
CVMC_6022 - LNA - MHT	1	108
CVMC_6022 - LNA - MHTCVMC_6024 - Nurse Assistant Trainee-CVH	1	221

In addition to staff positions, FY22 and FY23 had no departures or open positions posted for psychiatrists. In FY24, 3 psychiatrists transitioned from their committed hours to a per diem status, including the medical director of the program.

15. For the inpatient psychiatric unit, provide the following for FY22, FY23, and FY24

Response:

a. The number of employee departures

This grid represents staff positions only:

	FY22	FY23	FY24	Total
IPP Departures	**9**	**13**	**18**	**40**

b. The type of each position departure

This grid represents staff positions only:

Departures	FY22	FY23	FY24	Total
CVMC Administrative Assistant		2	1	3
CVMC Mental Health Technic	3	7	8	18
LPN		1	1	2
RN	6	3	8	17
Total	**9**	**13**	**18**	**40**

c. The duration of time each position was (or has been) open

Please refer to Q14 for duration of position vacancies.

16. For the inpatient psychiatric unit, provide the following for FY25:

Response:

a. Current staffing levels:

24/7 Coverage to support 8 beds

Nurse (RN)	4
Mental Health Technicians	4
Administrative Assistants	2
Psychiatrists	4
Advanced Practice RNs	2
Care Managers/Social Workers	2

b. Staffing levels required to support 14 beds:

24/7 Coverage to support 14 beds	
Nurse (RN)	5
Mental Health Technicians	4
Administrative Assistants	2
Psychiatrists	4
Advanced Practice RNs	2
Care Managers/Social Workers	3-4

c. Staffing levels required to support 8 beds:

24/7 Coverage to support 8 beds	
Nurse (RN)	4
Mental Health Technicians	4
Administrative Assistants	2
Psychiatrists	4
Advanced Practice RNs	2
Care Managers/Social Workers	2

17. For the inpatient psychiatric unit, provide the following for FY22, FY23, FY24 (projected), and FY25 (proposed budget):

Response:

a) Number of staff FTEs (excludes travelers)

	FY25 Original Budget Actual	FY 25 Revised Budget Actual	FY24 Actual	2023 Actual	2022 Actual
Staff FTE's	31.80	7.60	29.53	35.20	34.30

b) Number of traveler FTEs

	FY25 Original Budget Actual	FY 25 Revised Budget Actual	FY24 Actual	2023 Actual	2022 Actual
Traveler FTE's	0.00	0.00	0.20	1.30	2.50

c) Cost differential between FTE and traveler

For FY24 the estimated cost between a RN staff FTE and traveler FTE for the 0.2 FTE was approximately $13,800. Traveler staff have not been utilized in the inpatient psych unit since December 2023.

18. For FY25 CVMC initially budgeted for 1 new clinical FTE and 29 new non-clinical FTEs. Have these numbers been revised since the GMCB established the hospital's FY25 budget? For all new non-clinical FTEs currently budgeted for FY25, provide a breakout of position type.

Response:

For the resubmitted budget, all non-clinical FTE additions have been removed from the original FY25 budget. Total FTEs from FY25 resubmitted budget as compared to the projected FY24 FTEs is less by 16.4 FTEs.

	FY24 Projected	FY25 Original Budget Submission	FY25 Revised Budget Submission
Acute Care Services	**203.75**	**225.19**	**176.86**
Clinical FTEs	168.39	179.88	136.36
Non Clinical FTEs	21.05	26.06	22.95
Clinical FTEs	14.60	18.65	16.95
Non Clinical FTEs	(0.29)	0.61	0.61
Ancillary Services	**315.41**	**322.61**	**311.22**
Clinical FTEs	278.69	265.84	257.49
Non Clinical FTEs	36.72	56.77	53.73
General Services	**328.82**	**328.61**	**311.99**
Clinical FTEs	58.71	57.83	54.07
Non Clinical FTEs	270.11	270.78	257.92
Physician Office Practice Services	**400.61**	**396.68**	**407.35**
Clinical FTEs	304.65	303.48	297.65
Non Clinical FTEs	95.96	93.20	92.70
Clinical FTEs			17.01
SNF	**173.32**	**178.59**	**198.25**
Clinical FTEs	119.33	119.07	138.52
Non Clinical FTEs	53.99	59.53	59.73
Grand Total	1,421.91	1,451.69	1,405.67

19. Since its FY25 budget was established, describe the actions CVMC has taken to reduce non-clinical costs.

Response:

Administrative shared services expenses were reduced by $2.9M. FTE requests are required to go through a position control process to fully evaluate whether the position should be filled. We have reviewed non-patient care-related expenses to evaluate whether the service is required and whether a lower cost can be negotiated. CVMC uses "lean" improvement methodology to optimize the efficiency of our administrative and clinical processes, where appropriate.

As part of the UVM Health Network, CVMC continues to review departments to reduce redundancy and increase overall efficiencies to the system, in administrative cost centers and in clinical support areas. For example, this coming January, the inpatient care management teams will transition to a single leader to reduce barriers to patient transfers to the most appropriate level of care. Additional examples of consolidating roles are in Revenue Cycle with the elimination of a leader position at CVMC, sharing resources in Emergency Preparedness and Facilities Planning and Engineering services. In addition, as noted in the FY25 budget narrative submission, CVMC is reviewing and updating workforce benchmarks using the Syntellis system. As part of UVMHN, CVMC is in the process of contracting with Logic Source to review purchased services and at-risk contracts to validate if there are additional non-clinical cost savings.

20. CVMC has a Medicare payment to cost ratio that is 12% lower than its peers. (See CVMC Hospital Budget Order, Findings, ¶ 15). Since the establishment of its FY25 budget, describe the actions the hospital has taken to improve its Medicare payment to cost ratio.

Response:

CVMC's Medicare payment to cost ratio was addressed in our budget presentation. In particular, Medicare-calculated wage index fluctuations play a significant role. Increased wage pressure following the pandemic, high contract labor needs and costs, and a multi-year delay before these higher costs are factored into the wage index used to calculate Medicare reimbursement directly impacts Medicare cost coverage. We anticipate a CVMC Medicare cost coverage closer to 87% for FY23 (based on the specific calculation methodology referenced in CVMC Hospital Budget Order, Findings, ¶ 15).

21. CVMC has recently underestimated its operating expenses. (See CVMC Hospital Budget Order, Findings, ¶ 10). The hospital's operating expenses were approximately $15.9 million higher than budgeted in FY22. Operating expenses were $6.3 million higher than budgeted in FY23. Operating expenses are projected to be approximately $11.5 million higher than budgeted in FY24. Describe measures that CVMC has taken for FY25 to ensure operating expenses are better controlled.

Response:

FY22 and FY23 actual operating expenses ended higher than budget as a result of the increased need and use of travelers. Traveler costs were above budget by $21M and $14M for FY22 and FY23 respectively. FY24 expenses were above budget as a result of higher volumes that resulted with higher labor, pharmaceuticals and provider taxes. One of the controlling levers that CVMC was able to pull to contain costs for labor in FY24 was tied to UVMHN centralized management of traveler contracts and more deliverable expectations with the number of travelers needed to care for the patients in our community. In FY22 and FY23 we were much more aggressive in our assumptions to reduce the number of travelers. For FY25, CVMC has budgeted for higher traveler use based on trended data as we did in FY24. We therefore expect our actual labor costs to better track with our budgeted expenses in FY25.

Thank you for the opportunity to respond to your questions regarding the closure of this service. I look forward to continued collaboration as we work toward implementing care delivery models that provide high value, cost-effective care to the Vermonters we serve.

Sincerely,

Anna T. Noonan, BSN, MS
President and Chief Operating Officer
Central Vermont Medical Center

cc: Sunil Eappen, MD, President and Chief Executive Officer, UVM Health Network
Eric Miller, Senior Vice President and General Counsel, UVM Health Network
Mark Hengstler, Staff Attorney, GMCB
Mike Barber, General Counsel, GMCB
GMCB Health Systems Finance
Health Care Advocate Policy Team