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

On behalf of Central 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 filings 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 Central 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.

Central 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 Central Vermont Medical Center addresses the complex interplay of financial constraints and strategic investments, highlighting Central Vermont Medical Center's commitment to navigating social drivers of health and economic pressures while pursuing stability and innovation. It reflects our primary goal of providing our staff with a safe and supportive working environment and our patients, residents and community with exceptional care.

We continue to incur significant expenses for pharmaceuticals and labor. We successfully negotiated a contract for our first two collective bargaining units, one for Registered Nurses (RNs) and the other for Technical Professionals. The election for representation occurred in August 2023. Negotiations for the first three-year contract began in December of 2023 and were completed April 19, 2024. Under the contract, nurses and Technical Professionals receive:

- Immediate wage increases, averaging over 7%, with no employee receiving less than 3%.
- Further wage increases of an additional 13.5% over the 3-year contract, with 4.5% increases in October 2024, 2025 and 2026.

Central Vermont Medical Center experienced additional variances in FY24 driven by our overarching strategy to expand access to care for our patients, a longstanding priority for our organization and the Board. For example, we continue to partner with UVM Medical Center to expand our surgical capacity to reduce wait times for surgical procedures. Our efforts to strengthen access to care, discussed in more detail throughout this submission, will continue to drive variances from the Board's FY25 guidance.

Looking ahead, it is important to note our FY24 budget benefited from one-time funding sources, such as the Employee Retention Credit, which we do not expect to be available in FY25. Our Woodridge Rehabilitation and Nursing facility qualified for the extraordinary financial relief funds for Medicaid residents, which was not budgeted in FY24. Central Vermont Medical Center will again apply for this relief in FY25, and this amount is reflected in our FY25 budget.

In terms of Central Vermont Medical Center's relationship with UVM Health Network, we continue to transition many 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 UVM Medical Center's academic department leadership to Network clinical leaders with the role of harmonizing medical departments across the system.

In anticipation of additional funding gaps, Central Vermont Medical Center is reviewing and updating all workforce benchmarks using the Syntellis system as well as reviewing provider benchmarks for

productivity. This strategic initiative aims to enhance efficiency throughout Central Vermont Medical Center, ensuring sustainable operations amidst a challenging financial environment.

B. Background

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

There have been no changes to Central Vermont 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.

Central Vermont 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.

Care Coordination and Regional Transfer

Central Vermont Medical Center is growing beyond a small community hospital to become a referral site for the entire central Vermont region and population. We serve as a referral resource for Critical Access Hospitals and patients who need acute inpatient medical, surgical and critical care.

Through UVM Health Network's care coordination system and regional transfer center, we help to provide patients with the right care, at the right time and as close to home as possible. We achieve this by using the resources of each of our partner hospitals to provide excellent regionalized rural health care. For our part, Central Vermont Medical Center has 20 medical and surgical specialties available to patients in the region.

ICU Referrals: Patients requiring critical care from Critical Access Hospitals in central Vermont are referred to the Central Vermont Medical Center ICU team. In FY23 and YTD FY24, over 30 patients have been referred and transferred to our ICU. Patients transferred into our ICU originated from Copley Hospital, Gifford Medical Center, Porter Medical Center and Northeastern Vermont Regional Hospital.

Inpatient Hospitalist and Specialty Consultative Care*:* Central Vermont Medical Center has a robust inpatient hospitalist program, a combined medical/surgical ICU and over 20 specialty services providing the specialty consultative care required for complex medical patients that are beyond the scope of other community hospitals in our region. In FY23 and FY24 YTD, our acute inpatient teams have treated 42 patients in our medical-surgical unit that have been transferred from community hospitals outside of our health system so they can receive a higher level of care.

Patient Transfers: In FY23 and YTD FY24, Central Vermont Medical Center has transferred 87 patients back into acute inpatient beds at our hospital following tertiary or quaternary evaluation and treatment at UVM Medical Center. This process allows for additional inpatient capacity in the state's only tertiary care center and promotes patient-centered care by bringing central Vermont patients closer to their family and support.

Specialty Services: Central Vermont Medical Center offers a range of specialties and serves as a referral point for the region for patients requiring these services:

Specialty Services	
Anesthesia	Ophthalmology
Cardiology	Orthopedics
Dermatology	Podiatry
Endocrinology	Psychiatry
ENT	Pulmonary
Gastroenterology	Rheumatology
General Surgery	SUD
GI	Urology
GYN	Internal Medicine
Infectious Disease	Emergency Medicine
Obstetrics	Pathology
Oncology	Geriatrics

Community Partnerships at Central Vermont Medical Center

Central Vermont Medical Center is the convener and fiscal agent for THRIVE, our Accountable Community for Health (ACH) serving Washington and Orange counties. Formed in 2018, THRIVE is a community collaborative promoting the cohesive integration of health and social services. Its mission is to optimize the health and wellbeing of those we serve through informed, collaborative and innovative solutions. Leadership partners include Washington County Mental Health Services, Central Vermont Home Health and Hospice, Green Mountain United Way, Vermont Department of Health, Vermont Foodbank and ten other not-for-profit organizations and agencies.

Together with our THRIVE partners, we support the integration of high-quality health care by leveraging and coordinating THRIVE's collective resources, expertise and data to identify and address gaps that exist in our health service area, with a specific focus on addressing social determinants of health.

Central Vermont Medical Center has leveraged our ACH to complete our last two Community Health Needs Assessments (CHNA) and our Community Health Improvement Plans (CHIP). The results include the following:

- Community Rides Vermont: In collaboration with Community Rides Vermont, Central Vermont Medical Center has launched an on-demand transportation service, designed to facilitate medical appointments, hospital discharges and pharmacy visits. This initiative directly addresses barriers to health care access, enabling patients to conveniently reach essential services, while reducing reliance on emergency department (ED) visits and inpatient stays.
- Central Vermont Prevention Coalition: As the convener of the Central Vermont Prevention Coalition, we continue to promote our innovative, community-wide approach to addressing substance use. Using a hub-and-spoke model, this coalition develops collaborative and innovative approaches to enhance care and support to individuals grappling with substance use disorders.
- Health Equity: We are advancing health equity through the VT Community Health Equity Partnership (VTCHEP) grant from the CDC. The grant focuses on understanding health equities in our post-pandemic environment. The grant supported the following: community based active

listening and learning sessions with diverse stakeholders, around diversity, health equity, and experiences within the system of care; the Washington County Mental health crisis intervention team and the allocation of $25,000 of grant funds to nine organizations and projects that support diverse and underserved populations within our community.

- Person-Centered Care: Central Vermont Medical Center and Woodridge rehabilitation and Nursing are patient- and resident-centered organizations. Patient and family advisors are a key component of this model and support us in improving health care services, offering insights from their own experiences to optimize our operations and clinical services. We value their input; it promotes collaboration, enhances participation, information sharing and ensures services are comprehensive and person-centered.

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

Collaborative Care Model for Mental Health
We will be closing a mental health practice site and shifting these resources to a collaborative care model where psychiatrists, psychologists and behavioral health care managers are integrated and embedded into our primary care practices to provide timely mental health services. The model includes routine mental health screenings during annual wellness visits and a team approach to develop personalized mental health treatment plans. This integrated mental health model will facilitate the delivery of high-quality mental health services to patients seen in our primary care practices.

Endoscopy Upgrades
To improve access to endoscopy services, we invested $320K for endoscopes and AV equipment to operationalize our third endoscopy room. This summer, we plan to invest an additional $170K to fully equip all three endoscopy rooms. By fall of 2024, we expect to increase our patient capacity by more than 2,000 cases annually from FY23 to FY25, representing a 60% increase in access over two years. Concurrently, we have expanded our endoscopy team by about 30% to support this growth. In total we increased our staffing complement from 14.5 FTE to 17.5 FTE in FY25.

STERIS Reprocessing System
Central Vermont Medical Center implemented an advanced STERIS reprocessing system in our endoscopy suite to enhance our infection control capabilities. The deteriorating condition of previous equipment and the need to meet federal safety and quality standards necessitated this change. The new system allows for separate cleaning/decontamination and high-level disinfection spaces in line with the Joint Commission's current requirements.

Primary Care
We are investing in primary care to improve patient access and enhance the quality of care. Our primary care practices are located in Berlin, Barre, Montpelier, Waterbury, Waitsfield and Northfield. A summary includes the following:

- Scheduling Simplification Project: To streamline the scheduling process, we have overhauled all scheduling templates and visit types for all adult primary care sites with the support of external vendors. This project aims to make scheduling more efficient and user-friendly for both our patients and our health care providers.
- Fast Pass, Ticket Scheduling and Direct Scheduling: With implementations on June 12, July 31 and September 4 respectively, these initiatives will make it easier for patients to book appointments they need across the entire UVM Health Network. Fast Pass offers open appointments to patients, allowing them to choose appointments that work for their

schedules. Ticket scheduling, also known as order-based scheduling, creates a trackable plan for follow-up patients as determined by the patient's provider. Direct scheduling allows patients to book appointments directly through an online portal or other self-service channels.

- Risk-Adjusted Panel Sizes: Implemented on July 1, 2024, this initiative adjusts the number of patients assigned to each provider based on patient risk factors. This approach improves access for patients and ties to provider compensation, ensuring that providers are adequately compensated for the complexity of their patient panels.
- Primary Care Mental Health Initiative: Central Vermont Medical Center has invested in a collaborative care model that integrates mental health clinicians and psychiatric consultants into primary care practices. This initiative supports primary care providers (PCPs) in managing the mental health needs of their patients, improving patient outcomes and enhancing the quality of care.
- eConsult Expansion: eConsults enable PCPs to obtain specialists' inputs into a patient's care treatment without requiring the patient to go to a face-to-face visit. The expansion of eConsults at Central Vermont Medical Center enhances care coordination and accelerates consultation response time. Our providers utilized 616 eConsults through June 2024, compared to 287 in FY23.
- Provider Recruitment: Our investments in provider recruitment are essential for amplifying the impact of all of the above.

Collectively, these initiatives are a significant investment in primary care. They demonstrate our commitment to advancing health, wellness and improving patient access for those we serve.

Mako SmartRobotics™ System

Central Vermont Medical Center recently acquired the Mako SmartRobotics system, which allows our orthopedic surgeons to create customized surgical plans based on each patient's unique anatomy. The robotic arm is guided by the surgeon with increased precision and accuracy, resulting in less post-operative pain, quicker recovery times and improved knee flexion.

As our population ages and the demand for total knee replacements increases, Central Vermont Medical Center is committed to staying at the forefront of orthopedic surgery to meet the needs of our patients. With this new technology, we join the growing list of UVM Health Network partner hospitals offering robotic surgery, giving our patients access to the most advanced treatments available in modern medicine.

Linear Accelerator Upgrades

Together with our UVM Health Network partners, we are embarking on a multi-year strategy to replace and upgrade six state-of-the-art linear accelerators across our health system. These machines are an important resource for individuals requiring radiation therapy for cancer treatment, targeting their tumors with pinpoint accuracy while preventing harm to nearby healthy tissue. The upgraded machines will allow for more efficient and precise treatments, potentially reducing treatment times and offering high-quality imaging during treatment. The first installation of this advanced technology in our health system will occur later this year at our hospital.

In addition to the new linear accelerators, a shared oncology care planning system will be installed. This will allow cancer experts across our health system to review patient treatment plans, regardless of where a patient receives care.

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.

Central Vermont Medical Center has no new service lines, physician transfers or accounting changes to report from our FY24 budget.

The favorable and unfavorable impact to FY24 projection versus FY24 approved budget are noted below:

- Gross Revenue: Increased volumes (access) to Medical Group services, imaging, lab services and pharmaceutical services.
- NPSR: Extraordinary financial relief funds for Woodridge Rehabilitation and Nursing for approximately $1.3M for Medicaid residents that was not budgeted for in FY24. As noted in *Section A, Executive Summary*, we will again apply for this relief in FY25, and this amount is reflected in the FY25 budget submission.
- Other Revenue: We received an Employee Retention Credit for CY22 for $1.9M recorded in other revenues. This is offset by lower than the budgeted client revenues.
- Expenses:
    - Fringe benefits are $2.0M higher than budget related to higher workers' compensation claims and higher employee pharmaceutical benefits.
    - Traveler use is $2.3M higher than budget; FTE use to cover essential patient care areas are 19 over budget.
    - Medical staff salaries are higher than budget by $1.4M; FTEs are over budget by 3.3 FTEs.
    - Pharmaceutical costs are higher than budget by $1M tied to high-cost oncology drugs.

Projections to FY25 budget changes from FY24:

- Gross Revenue: Central Vermont Medical Center starts with projected volumes, which includes volumes from trending and any increases to services to provide access to patients. For example, there is an increase in endoscopy services due to a new community gastroenterologist, which will improve access to care for this service and reduce backlogs for routine colonoscopies.
- NPSR: We are anticipating a 0.5% reduction in payer denials due to active management to reduce write offs for timely filing, lack of pre-authorization and provider enrollment issues. We use all available information at the time of budget to update reimbursement rates.
- FPP: No material changes.
- NPSR + FPP + OCV Revenue Collection % including FPP + OCV 44.1% to 42.6%.
- Other Revenue increase of $1.8M related to additional 340B contract revenue
- Expenses: The budget is $19.9M higher than projection.
    - $10M is due to inflationary increases, more than half of which is for salaries.
    - $4.3M is due to volume increases for drugs and supplies.
    - $2M is due to increases in medical staff salaries.
    - $3.6M is due to other expenses. We are budgeting more staff FTEs in place of traveler FTEs. The rate of pay for a traveler is more than twice that of a staff FTE, so we are able to increase our staff FTEs by 34, decrease our Traveler FTE by 16 and maintain the same salary expense.

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.

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%**

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 NASHP data which shows that Central Vermont Medical Center is slightly above the median and average for operating costs per adjusted discharge when compared to community hospitals in our region.

Hospital Operating Costs per Adjusted Discharge

COMMUNITY HOSPITALS	
PARKLAND MEDICAL CENTER	$7,247
SOUTHWESTERN VERMONT MEDICAL CENTER	$9,478
CANTON-POTSDAM HOSPITAL	$9,625
FRISBIE MEMORIAL HOSPITAL	$10,089
CHESHIRE MEDICAL CENTER	$10,481
NORTHWESTERN MEDICAL CENTER	$11,022
WENTWORTH DOUGLASS HOSPITAL	$11,209
SOUTHERN NH MEDICAL CENTER	$11,543
PORTSMOUTH REGIONAL HOSPITAL	$12,256
ELLIOT HOSPITAL	$12,513
ST. JOSEPH HOSPITAL	$13,077
GLENS FALLS HOSPITAL	$13,353
EXETER HOSPITAL INC.	$13,372
BRATTLEBORO MEMORIAL HOSPITAL	$13,643
CENTRAL VERMONT HOSPITAL	**$13,679**
RUTLAND REGIONAL MEDICAL CENTER	$14,415
CONCORD HOSPITAL - LACONIA	$14,679
CONCORD HOSPITAL INC.	$18,318
ALICE HYDE MEDICAL CENTER	$18,427
CHAMPLAIN VALLEY PHYSICIANS HOSPITAL	$18,634
CATHOLIC MEDICAL CENTER	$19,471
AVERAGE	$13,168
MEDIAN	$13,077

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 mid-sized community hospitals, we were able to capture publicly available cost report data. Central Vermont Medical Center is above the median, at the 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
CVMC			
Admin	16,459,151	2,969,061	19,428,212
Clinical	79,243,767	(15,618,465)	63,625,302
Admin %	**20.77%**		**30.54%**
Central Maine Medical Center			
Admin	4,853,338	29,979,147	34,832,485
Clinical	145,002,204	(28,189,758)	116,812,446
Admin %	**3.35%**		**29.82%**
Southern Maine Health Care			
Admin	7,646,715	29,933,202	37,579,917
Clinical	129,705,776	(24,413,711)	105,292,065
Admin %	**5.90%**		**35.69%**
Mid Coast Hospital			
Admin	3,838,220	16,469,184	20,307,404
Clinical	86,101,962	(25,934,755)	60,167,207
Admin %	**4.46%**		**33.75%**
Canton-Potsdam Hospital			
Admin	7,649,690	(797,689)	6,852,001
Clinical	95,693,944	(32,346,011)	63,347,933
Admin %	**7.99%**		**10.82%**
Charlotte Hungerford			
Admin	5,023,102	12,238,087	17,261,189
Clinical	72,263,173	(21,381,109)	50,882,064
Admin %	**6.95%**		**33.92%**
Portsmouth Regional			
Admin	5,206,820	21,928,457	27,135,277
Clinical	58,816,122	(200,038)	58,616,084
Admin %	**8.85%**		**46.29%**
Geisinger Lewiston Hospital			
Admin	4,260,278	6,956,941	11,217,219
Clinical	36,925,947	8,112,140	45,038,087
Admin %	**11.54%**		**24.91%**
Anna Jacques Hospital			
Admin	5,959,407	3,230,924	9,190,331
Clinical	43,016,185	2,594,034	45,610,219
Admin %	**13.85%**		**20.15%**
Chesire Medical Center			
Admin	5,806,554	3,779,070	9,585,624
Clinical	39,306,178	6,089,883	45,396,061
Admin %	**14.77%**		**21.12%**
Niagara Falls Medical Center			
Admin	5,268,068	(105,421)	5,162,647
Clinical	41,213,862	(4,613,057)	36,600,805
Admin %	**12.78%**		**14.11%**
Landmark Medical Center			
Admin	6,024,596	2,713,647	8,738,243
Clinical	33,014,652	1,212,956	34,227,608
Admin %	**18.25%**		**25.53%**
Saint Joseph Hospital (NH)			
Admin	3,385,842	11,481,067	14,866,909
Clinical	77,120,694	(9,985,488)	67,135,206
Admin %	**4.39%**		**22.14%**
Rutland Regional Med Ctr			
Admin	21,774,786	6,970,093	28,744,879
Clinical	107,644,670	(20,500,489)	87,144,181
Admin %	**20.23%**		**32.99%**
Evangelical Community Hospital			
Admin	9,476,269	8,755,592	18,231,861
Clinical	46,358,587	18,828,668	65,187,255
Admin %	**20.44%**		**27.97%**
Auburn Memorial Hospital			
Admin	8,481,288	1,882,711	10,363,999
Clinical	36,857,361	16,282,175	53,139,536
Admin %	**23.01%**		**19.50%**
The Griffin Hospital			
Admin	15,952,893	163,444	16,116,337
Clinical	68,460,946	1,399,841	69,860,787
Admin %	**23.30%**		**23.07%**
Cooley Dickinson			
Admin	16,797,344	4,449,898	21,247,242
Clinical	53,988,589	(316,635)	53,671,954
Admin %	**31.11%**		**39.59%**
Bristol Hospital			
Admin	14,720,145	(682,984)	14,037,161
Clinical	41,993,411	(2,086,652)	39,906,759
Admin %	**35.05%**		**35.17%**
Saint Joseph Hospital (ME)			
Admin	10,099,562	7,406,260	17,505,822
Clinical	61,108,394	(8,896,333)	52,212,061
Admin %	**16.53%**		**33.53%**

Median	**28.89%**
Average	**30.54%**

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. To speak to price first, our new Clarify price transparency subscription indicates commercial rates for Central Vermont Medical Center are lower compared to other community hospitals for radiology and surgical services in Massachusetts, New Hampshire, and New York. We are in aggregate lower cost than our community hospital colleagues based on payer reported data for the BlueCross plans (Anthem, Empire, BlueCross BlueShield of Vermont) and Aetna. At two New Hampshire hospitals and one New York hospital, Aetna is paying in aggregate 1000% more than they pay at Central Vermont Medical Center. The BlueCross plans vary but are generally reimbursing the same for similar radiology and lab services. We do identify services such as MRI of the chest and spine where the BlueCross plans in aggregate reimburse Central Vermont Medical Center higher than other community hospitals. While the data is limited and nascent, we see in aggregate payer costs at Central Vermont Medical Center are at par or better than at regional community hospitals.

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 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
CVMC							
CVMC	21300 Nursing Services	24.52%	21.65%	18.22%	11.58%	10.19%	9.50%
CVMC	21402 Cardiology	0.00%	21.84%	28.21%	0.00%	10.12%	13.86%
CVMC	21403 Pharmacy	0.00%	2.15%	0.00%	0.00%	1.56%	0.00%
CVMC	21404 Pathology & Laboratory Medicine	16.84%	25.77%	16.39%	6.95%	13.80%	7.49%
CVMC	21500 Clinical Services	0.00%	0.11%	0.00%	0.00%	0.06%	0.00%
CVMC	21504 Radiology Services	31.66%	32.48%	25.27%	14.93%	15.88%	11.95%
CVMC	21505 Respiratory Therapy	49.80%	51.64%	52.95%	26.39%	34.60%	37.05%
CVMC	22900 Nursing Home	28.55%	35.96%	23.99%	14.49%	21.65%	15.36%

The first step in developing our labor expense budget at Central Vermont 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 our 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
- 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. Most 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 Central Vermont Medical Center is 4.8% (driving the higher than benchmark increases at Central Vermont 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.

Central 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			126,156,821	137,729,390	135,810,912	134,319,240	143,103,133
Outpatient Revenue Total			358,455,819	389,926,330	385,658,305	391,329,864	416,921,132
Professional Revenue Total			112,058,083	116,177,813	114,999,542	127,131,352	135,411,043
SNF Revenue Total			24,919,159	24,559,910	24,129,193	24,771,374	26,391,314
Swing Revenue Total			-	-	-	-	-
TOTAL GROSS REVENUE			**621,589,882**	**668,393,443**	**660,597,953**	**677,551,830**	**721,826,622**
INPATIENT REVENUE							
	21300	Nursing Services	85,649,667	89,595,351	87,648,171	90,301,888	96,207,239
	21402	Cardiology	3,423,485	4,138,215	4,177,255	3,813,094	4,062,454
	21403	Pharmacy	8,256,914	6,867,304	6,520,546	6,792,862	7,237,085
	21404	Pathology & Laboratory Medicine	12,055,663	14,419,397	14,349,298	12,858,702	13,699,605
	21500	Clinical Services	115,389	309,366	356,520	153,006	163,012
	21504	Radiology Services	13,041,749	15,978,551	16,354,448	14,275,956	15,209,542
	21505	Respiratory Therapy	3,735,282	4,430,828	4,418,515	4,164,206	4,436,527
	21506	Rehabilitation Therapies	1,668,194	1,833,131	1,830,053	1,803,580	1,921,527
	21600	Medical Group	17,701	21,400	21,630	21,570	22,981
	21650	MG Provider Based Billing	214,405	135,847	134,476	134,375	143,162
	22400	Finance	0	-	-	-	-
	22600	Hospital - Physician	-	-	-	-	-
	22900	Miscellaneous	(2,021,629)	-	-	-	-
	TOTAL INPATIENT GROSS REVENUE		**126,156,821**	**137,729,390**	**135,810,912**	**134,319,240**	**143,103,133**
OUTPATIENT REVENUE							
	21300	Nursing Services	115,409,366	114,982,679	114,156,735	122,918,404	130,956,733
	21402	Cardiology	10,715,889	10,256,227	10,915,538	10,319,501	10,994,352
	21403	Pharmacy	48,051,053	55,489,683	53,511,167	55,930,078	59,587,661
	21404	Pathology & Laboratory Medicine	48,494,933	52,210,087	51,249,992	50,786,831	54,108,068
	21500	Clinical Services	11,453,714	14,847,693	13,296,619	7,849,034	8,362,326
	21504	Radiology Services	86,094,234	96,406,708	97,330,439	94,743,574	100,939,391
	21505	Respiratory Therapy	1,629,274	2,084,975	2,076,894	2,101,523	2,238,953
	21506	Rehabilitation Therapies	17,244,752	17,928,846	17,948,731	18,081,562	19,264,018
	21600	Medical Group	2,868,847	3,044,038	3,132,550	3,068,197	3,268,843
	21650	MG Provider Based Billing	20,481,703	22,609,181	21,967,711	25,465,666	27,131,010
	22400	Finance	(0)	-	-	-	-
	22500	Hospital Services	116,635	66,212	71,932	65,494	69,777
	22600	Hospital - Physician	-	-	-	-	-
	22900	Miscellaneous	(4,104,581)	-	-	-	-
	TOTAL OUTPATIENT GROSS REVENUE		**358,455,819**	**389,926,330**	**385,658,305**	**391,329,864**	**416,921,132**
PROFESSIONAL REVENUE							
	21600	Medical Group	91,222,121	94,965,453	94,124,141	105,320,778	112,174,152
	22400	Finance	0	-	-	-	-
	22600	Hospital - Physician	20,835,962	21,212,360	20,875,401	21,810,575	23,236,891
	TOTAL PROFESSIONAL GROSS REVENUE		**112,058,083**	**116,177,813**	**114,999,542**	**127,131,352**	**135,411,043**
SNF REVENUE							
	22900	Nursing Home	24,919,159	24,559,910	24,129,193	24,771,374	26,391,314
	TOTAL SNF GROSS REVENUE		**24,919,159**	**24,559,910**	**24,129,193**	**24,771,374**	**26,391,314**

As with all components of the budget, for utilization (i.e. volume), we start with volume levels from the October to January period.

From there, we add or subtract volume for:

- New recruits
- Departures

- New equipment
- Access initiatives
- 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
- 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.

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.

We use October to January 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%.

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	
CVMC	% Increase	$ Increase
Wages/Compensation - Physicians	3.9%	$ 1,328,373
Wages/Compensation - Staff	4.5%	$ 4,875,369
Fringe	2.0%	$ 725,032
Drugs - All Other	4.0%	$ 1,211,085
Drugs - Retail Pharmacy	0.0%	$ -
Supplies	3.0%	$ 568,270
Non-Medical Supplies	0.0%	$ -
Travelers (nurses)	0.0%	$ -
Equipment / Software / Other Maintenanc	3.0%	$ 127,474
Provider Tax	3.3%	$ 564,829
Purchased Services	3.0%	$ 314,047
All Other	0.6%	$ 259,417
Total	3.2%	$ 9,973,896

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

For medical/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				
CVMC	1.42	1.49	1.49	1.49

There are no material changes in CMI from FY24 to FY25.

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).

CVMC NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY24 GMCB Approved Budget	$ 275,002,293	$ 103,979,164	$ 30,100,086	$ 113,433,177	$ 26,190,598	$ 1,299,268
Cost Inflation (FY25)						
FY25 Net Revenue Rates - All Payers	$ 6,947,101	$ 90,212	$ 205,435	$ 6,279,253	$ 372,201	$ -
Utilization Management And Review	$ 260,855	$ 168,614	$ 30,266	$ 49,418	$ 12,557	
Inpatient Length of Stay Reduction	$ 754,666	$ 487,809	$ 87,561	$ 142,968	$ 36,328	
APM Shared Savings	$ 2,405,203	$ 2,405,203	$ -	$ -	$ -	
Denial Improvement	$ 264,108	$ -	$ -	$ -	$ 264,108	
Denials	$ (268,440)	$ -	$ -	$ -	$ (268,440)	
Bad Debt	$ (571,815)	$ (146,129)	$ (21,355)	$ (288,757)	$ (115,575)	
Charity	$ (132,395)	$ (43,755)	$ (5,078)	$ (33,484)	$ (50,078)	
FY24 Budget to Actual Collection Rate difference prior to rate impact						
All Payers	$ (3,396,000)	$ (2,967,890)	$ 4,048,926	$ (3,700,515)	$ (776,521)	
Value Base Contract (VBC) Incentives	$ 567,845	$ 186,704	$ 62,051	$ 225,342	$ 93,748	
Disproportionate Share Payments (DSH)	$ 37,472	$ -	$ -	$ -	$ -	$ 37,472
Denials	$ (772,331)	$ -	$ -	$ -	$ (772,331)	$ -
Bad Debt	$ (1,156,212)	$ (1,641,499)	$ (278,793)	$ (945,005)	$ 1,709,085	
Charity	$ 1,695,585	$ 526,643	$ (65,507)	$ 373,261	$ 861,188	
Utilization (not factoring in change in charge request)						
All Payers	$ 24,356,231	$ 8,735,634	$ 1,657,853	$ 11,213,075	$ 2,749,669	$ -
Denials	$ (279,483)				$ (279,483)	
Bad Debt	$ (616,547)	$ (44,598)	$ (4,336)	$ (289,665)	$ (277,948)	
Charity	$ (300,390)	$ (93,684)	$ (1,090)	$ (73,277)	$ (132,339)	
Payer Mix						
All Payers	$ 3,678,722	$ 2,399,088	$ (1,542,185)	$ 3,692,195	$ (870,376)	$ -
Bad Debt	$ (598,310)	$ 37,105	$ 9,274	$ (465,422)	$ (179,267)	
Charity	$ (205,830)	$ 97,319	$ 1,139	$ (117,475)	$ (186,813)	
FY25 Proposed Budget	$ 307,672,329	$ 114,175,941	$ 34,284,247	$ 129,495,090	$ 28,380,312	$ 1,336,740

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.

Central Vermont Medical Center:

	FY24 Projection	FY25 Budget
Margin	0.7%	0.0%
Days Cash on Hand	72.8	69.4
Debt Service Coverage Ratio	4.0	4.4

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.

CVMC	FY23 Actual	FY24 Anlzd YTD Jan	FY24 Anlzd YTD May	FY24 Projected	FY25 Budget
Bad Debt as a % to Gross Revenue	1.39%	1.28%	1.07%	1.37%	1.29%
Free Care as a % to Gross Revenue	0.50%	0.30%	0.37%	0.38%	0.30%
Total Bad Debt + Free Care as a % to Gross Revenue	1.89%	1.58%	1.44%	1.75%	1.59%

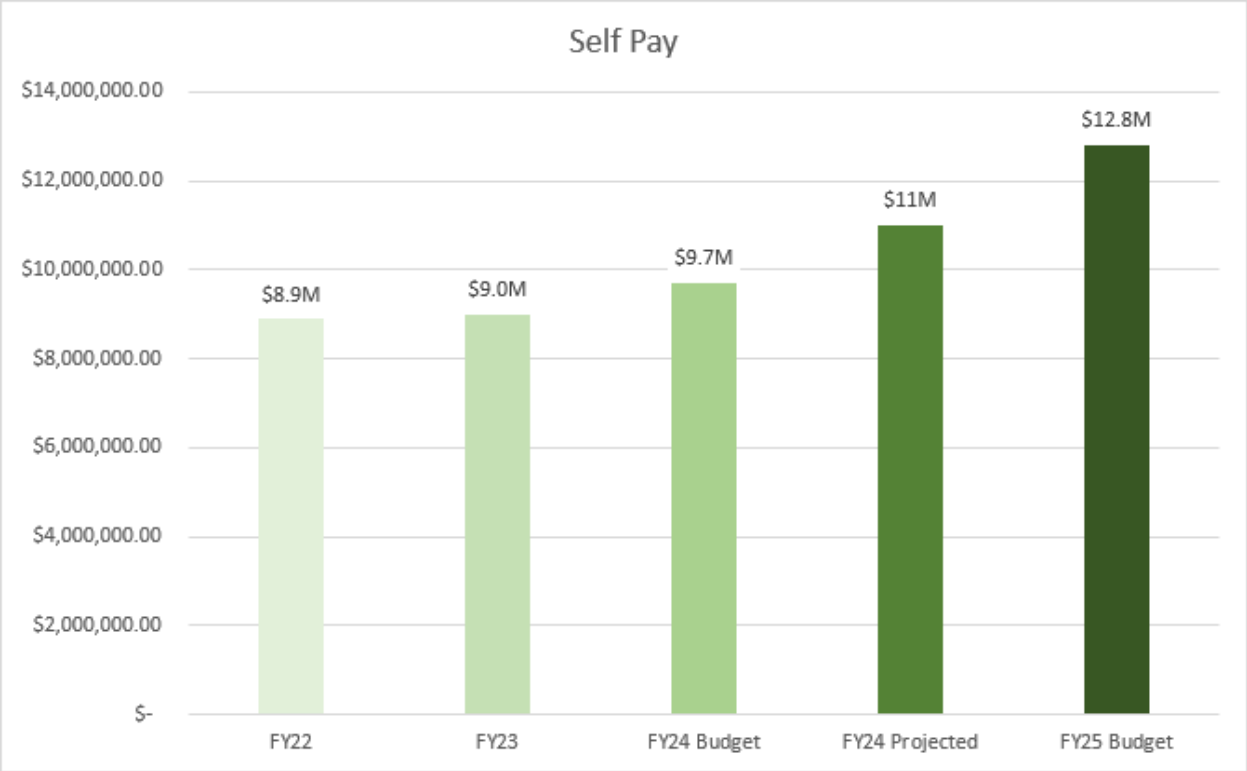
j. Community Benefit. Differentiate between the various drivers of community benefit.

Please refer to Central Vermont 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.

We note the following budget risks in the Central Vermont Medical Center budget:

- Increased volumes for endoscopy cases for FY25, as projected, from expanding patient capacity by more than 2,000 cases annually from FY23 to FY25, representing a 60% increase in access over two years. Concurrently, we have also expanded our team of endoscopy caregivers by about 30% to support this growth. This projection is based on patient demand and the goal of improving patient access to this service.
- Within NPR, there is an assumption that Woodridge Rehabilitation and Nursing, as part of Central Vermont Medical Center, will submit a request for a continuation for an increase in its Medicaid rate as per Section 10 – Extraordinary Financial Relief as contained in the State of Vermont, Agency of Human Services, Division of Rate Setting manual – Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities. The estimated impact to NPR is approximately $1.5M for the fiscal year.
- The chart below reflects our growing uninsured population. Our experience through May FY24 has already exceeded our FY24 budget. Our FY25 budget is based on the current increase shown in our FY24 projection, and if growth continues at the current pace, the uninsured population will exceed our FY25 budget and create increased financial strain.



- The lack of available and affordable housing and childcare has impacted our ability to recruit permanent staff. We have relationships with local housing developers and have been exploring the potential for a daycare partnership with an established provider. If these constraints persist, we believe Central Vermont Medical Center will need to continue utilizing contracted labor.
- Receiving a lower than requested reimbursement rate increase would negatively affect our ability to:
    - Fund costs associated with opening access
    - Respond to market wage pressures
    - Address deferred maintenance to address an aging facility plant
    - Further invest in programing to meet the needs of our aging community

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

At UVM Health Network, the annual Medicare cost report is completed in accordance with Medicare cost report-specific regulations, definitions and instructions published in CMS Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Hospital & Hospital Health Care (Form CMS 2552-10). Each Medicare cost report filed with CMS is subsequently audited or

reviewed by a CMS-contracted entity to ensure full compliance with all Medicare rules, instructions and guidelines. That said, some amount of variation in approach is both common and acceptable.

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

Another consideration is that costs considered "non-reimbursable" based on the Medicare cost report instructions and definitions cited above are clearly patient care related and legitimate costs incurred by the hospital. For example, physician-patient service costs and charges are excluded on the Medicare cost report, but those costs are included in the budget presented to the Green Mountain Care 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 vs. 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.

In addition, administrative costs captured by the calculation often provide support to these Medicare cost report-specific non-reimbursable clinical cost centers that are not included in the clinical costs captured by the calculation. An example of this is Woodridge Rehabilitation and Nursing, which appears on the Central Vermont Medical Center cost report in the non-reimbursable section of the cost report, per the cost report regulatory guidance. Many of the shared administrative functions for Central Vermont Medical Center and Woodridge are captured in the reimbursable administrative lines (and included in the calculation), yet all of the clinical functions for Woodridge are captured on Line 07965 in the non-reimbursable section of the cost report and therefore not included in the calculation.

To mitigate some of these deficiencies when using Medicare cost report data to calculate financial metrics, it is important to pull the data for the calculation from the correct location. The Medicare cost report regulations require hospitals to make specific adjustments to the data to attempt to equalize the reporting among providers. In last year's budget process, the data utilized by the Board to calculate an administrative-to-clinical percentage was pulled from Worksheet A, Column 1 of each hospital's Medicare cost report. This column is before any of these adjustments. If the Medicare cost report is going to be utilized in this manner, then the data should be pulled from Worksheet A, Column 7 (not Column 1) for all hospitals in the peer group, as Column 7 includes all the relevant cost report-specific adjustments and improves the comparability from one provider to another. Although this recommendation does not mitigate the exclusion of physician costs, it ensures that regardless of hospital structure, the costs are more likely to be reported in the same manner across providers. For the unique structure of Woodridge within Central Vermont Medical Center, we respectfully request that Line 07965 be included with clinical expenses.

On December 23, 2023 we sent the Green Mountain Care 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've described above, which could be an easier way for 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 healthcare provider (usually a hospital) to bill Medicare as a department of that healthcare 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 Central Vermont 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 a commercial insurance or Medicaid, the total gross charge is billed solely on a professional bill. When billing to Medicare under provider-based regulations, the total gross charge is "split" into two components: a smaller professional component and a corresponding facility component. The total of those two components billed to Medicare equal the same dollar amount that would have been billed to commercial or Medicaid on the professional bill for the same service.

In FY23, the last year for which we have complete data, Central Vermont Medical Center billed Medicare for $16.7M in provider-based facility billing. Were we not approved by CMS for provider-based billing, the total amount of $16.7M in charges would be combined with the professional component on one professional bill, consistent with the total billing for all other payers.

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

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

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

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

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

We have major initiatives underway across the entire system to reduce wait times for care, which helps improve efficiencies within our system and control overall costs. New self-scheduling options will help our patients see their primary care providers more quickly; our growing use of eConsults, enhanced

referrals and refer backs are expanding access to specialist care, while cutting down on clinically unnecessary in-person visits; expanded clinic hours are helping patients receive mammograms and medically-necessary CT and MRI scans sooner; and our proposed Outpatient Surgery Center will increase access to surgical care and help control overall costs by keeping patients local and out of more expensive inpatient settings.

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

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

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

Cutting Costs

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

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

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

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

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

Our NPR requests represent the needs of our community's growing and aging population, as well as our health system's focus on increasing patient access to care. Our commercial rates reflect the cost of

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

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

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

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

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

Our framework lays a path back to financial stability and generates the resources we need to reinvest in our communities, which enables us to continue providing high quality care. The last three years have significantly eroded the liquidity that nonprofit health care organizations require for reinvestment. Our three Vermont hospitals are no different. Liquidity has been significantly eroded, and millions of dollars in capital investment have been delayed.

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

Center campus and are estimating we have $620M of deferred maintenance costs that will need to be addressed over the next 10 years.

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

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

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

CVMC FY23 Lobbying Expense			
Vermont Association of Hospitals & Health Systems (VAHHS)	$	18,713	These amounts represent the portion of dues paid to associations and trade groups
American Hospital Association (AHA)	$	7,813	and is directly connected to lobbying by those groups on behalf of their members.
Necrason Group, PLLC	$	7,307	
UVMHN Government Relations Staff Time	$	4,848	
	$	**38,680**	

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 Central Vermont Medical Center, we estimate that in FY25 we will receive donations totaling $400,000. Primary areas of focus will include workforce development, the Branches of Hope Cancer Patient Fund, Health Care Share Fund, wellness and respite, and annual fund to support our mission. We also anticipate seeking support for investments in our aging facilities and equipment, including strategic renovation to patient care units to better serve our community.

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

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

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

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

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

In the last two years the reductions in revenue due to quality performance are found in Central Vermont Medical Center's Medicare reimbursement. There is only one year of impact as the Medicare programs were paused due to the pandemic. In FY24, our Medicare revenue was reduced due to the following: 1) Hospital Acquired Conditions (HAC) Penalty = Impact (-$313K); and 2) Value Based Purchasing (VBP) and Readmissions Penalty = Aggregate + impact of $338K but readmissions did have a slightly negative impact on performance.

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:
    - Identification of readiness to practice (new graduates, new staff) and practice deficiencies (travelers).
        - We implemented lean methodology to advance our performance improvement efforts. Lean improvement boards located in areas across our organization have been implemented and are focused on the following:
            - Daily team huddles on key performance indicators with evaluation of action plans to enhance performance.
            - Weekly and biweekly performance improvement team reviews focused on implementing evidence-based practices.
        - We use a rapid cycle improvement model to address identified areas of improvement.
        - We conduct daily audits of patients identified as being at risk.
        - We purchased additional equipment to support targeted reductions in HACs, such as variable air mattress surfaces for Stryker beds.
- Similarly, reducing readmissions, we have instituted a weekly interdisciplinary review which includes community partners such as:
    - Central Vermont Hospice and Home Health and Washington County Mental Health: This team discusses patients who have a high risk of an unplanned readmission rate of >20% and/or a value-based score of 4-6. This review identifies proactive measures that can be implemented to reduce readmissions.
- 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 Central Vermont Medical Center include:

- In 2018, Central Vermont Medical Center pioneered a new approach to career progression, enabling employees to pursue further education while maintaining full-time salary and benefits. This initiative, in partnership with Community College of Vermont and Vermont State University, led to the creation of a program that allowed employees to graduate as Licensed Practical Nurses (LPNs). The first cohort of 13 LPNs graduated in June 2021, saving the institution approximately $1 million in traveler expenses.

- Building on the success of the LPN program, we expanded our offerings to include the RN Pathway Program. By June 2023, these groundbreaking programs had produced 27 LPNs and eight RNs. In June 2024, our hospital celebrated the graduation of another six LPNs and six RNs. These programs resulted in overall savings of approximately $2.1 million in estimated traveler nursing costs.
- Central Vermont Medical Center continues to broaden our workforce development programs to include licensed nursing assistants (LNAs), medical assistants, phlebotomists and surgical technologists.
- We are proud our workforce development model has since been adopted throughout UVM Health Network, setting a precedent for workforce development across our partner organizations.

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).

Absorbing New Childcare Payroll Tax for Employees
The Vermont Legislature recently passed a new childcare payroll tax. Central Vermont Medical Center, along with the UVM Health Network, will cover both the employee and employer share of this tax.

Housing Partnerships
We are working with the towns in central Vermont to address the housing crisis. Here we engage with local leaders and housing development partnerships on an ongoing basis.

Prospect Heights Development, Inc. (PHDI): Our chief financial officer serves on the board of PHDI. As one of the region's largest employers, Central Vermont Medical Center lends public support to this project and we are considering ways to further support it as the plan progresses.

Habitat for Humanity: We have met with Habitat for Humanity on numerous occasions to discuss how it can support their mixed-use housing development project in Montpelier.

Fecteau Homes: We master-lease 16 units from Fecteau Homes in Montpelier to address transitional employee housing challenges.

Downstreet Housing and Community Development: Our vice president of support services at Central Vermont Medical Center serves on the board of this organization, which is dedicated to alleviating housing issues in central Vermont.

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 Central Vermont 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.

- 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 in order to continue recruiting and retaining staff.
- 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 Central Vermont 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.
    - A metal detector was added to the ED for screening patients and visitors.
- Expenses for Mental Health Technicans: Costs associated with staffing Mental Health Technicians to manage ED beds occupied by patients awaiting care or placement.

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.

Mental Health: Central Vermont Medical Center's Inpatient Psychiatry Unit is currently capped at a census of eight patients due to vacancies in our provider staff. Our financial loss at this census level is $3.2M. Provider recruitment efforts are underway to enable us to reach our census capacity of 14 psychiatric patients. Additionally, in accordance with the plan approved in April 2023, we will be seeking permission from the Board to make the necessary capital improvements to our unit to increase the number of single occupancy rooms, thereby increasing the flow and efficiency of our unit.

Substance Use Disorder: Central Vermont Medical Center serves as the convener of the Central Vermont Prevention Coalition (CVPC), promoting an innovative, community-wide approach to substance use through a hub-and-spoke model. This coalition is dedicated to developing collaborative strategies that provide enhanced care and support for individuals grappling with substance use disorders, thereby improving access and quality of care. With a dedicated full-time coordinator complementing its physician

lead and a membership roster of 30 community partners, CVPC launched new initiatives with the investment of Central Vermont Medical Center board-designated funds, including the Refocus on Alcohol Dependence program; expanded harm reduction supply access throughout our PCP practices, women's health, and ExpressCare; the Central Vermont NaloxBox Project; and our community post-overdose response pilot, Project BEACON, 2023. CVPC's innovative endeavors garnered local and national recognition, leading to presentations at conferences regionally and nationwide.

Long-Term Care: Woodridge Rehabilitation and Nursing is part of our medical center's care continuum, enabling us to serve an aging population who meet criteria for short-term rehabilitation, skilled or long-term care services, close to home. Woodridge provides rehabilitation, memory care and long-term care to those we serve and enables the transfer of appropriate patients from acute care settings, freeing up capacity at Central Vermont Medical Center and UVM Medical Center. In FY23, the average daily census was 118 residents. FY24 YTD the census average is 121.

Despite our innovative workforce development programs and consistent market adjustments to salaries, staffing has continued to be a challenge. As of May 2024, Woodridge has 37.4 FTE travelers, with the majority being in the nursing department, primarily LNAs. Over the past 20 months, the number of traveler FTEs has varied, reaching a peak of 41.7 and a low of 32.4. We secured a request for an increase in our Medicaid rate as per Section 10 – Extraordinary Financial Relief (EFR) as contained in the State of Vermont, Agency of Human Services, Division of Rate Setting manual – Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities. The estimated impact to NPR is approximately $1.5M for the State fiscal year. As noted previously, we will be re-submitting a request for EFR again this summer.

Radiology Access: Central Vermont Medical Center radiology has expanded services in CT, increasing access by 18% in the past two years or over 1,300 studies per year. For PETCT, we have worked with our mobile vendor to upgrade the PETCT unit in order to increase image quality and are working to increase access over the coming year. MRI has expanded services by 14% over the past two years, as we have continued to work to stabilize our technologist staffing.

Surgical Access: Central Vermont Medical Center is achieving near-record volumes as we serve patients from the central Vermont region, as well as from the Burlington area. We anticipate that in FY24 more than 100 patients originally planning their surgery at UVM Medical Center will receive surgical care earlier at Central Vermont Medical Center and Porter Hospital, as surgeons and surgical teams increasingly operate across our sites.

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

- Strengthening care collaboration between primary care and specialist providers,
- Allowing more care to remain in primary care, as appropriate,
- Reducing clinically unnecessary in-person specialist visits, and
- Expediting in-person specialist care for those who require it, while boosting the productivity of these visits.

eConsults: Since 2021 we have grown our eConsults capability across our system to include more than 20 specialties, including endocrinology, cardiology, pulmonology, and rheumatology, with others continuing to join. In FY24, providers are on track to order more than 3,600 eConsults, with an internal goal of 4,000. Last month (May 2024) saw the single highest usage of eConsults since the program kicked off, with 381 eConsults ordered by clinicians across the health system. Providers at Central Vermont Medical Center utilized 616 eConsults through June 2024, compared to 287 in FY23.

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

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

"Refer Backs" to Primary Care: Once a patient has been treated by a specialist and their condition is well-managed, our providers are participating in another initiative to transition them back to primary care for ongoing maintenance. This 'refer back' initiative aims to address the fact that historically, many people continue to routinely see specialists even when they no longer require specialty care, which in turn impacts access for new and existing patients who require it. Since the initiative launched in October 2023, 536 patients receiving care from specialists have been 'referred back' to their primary care providers for ongoing care, encompassing primary care practice patients both inside the UVM Health Network and independent practices. 56% of these patients were referred back to Central Vermont 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.

Emergency Department Partnership with Washington County Mental Health Services
Our partnership with Washington County Mental Health Services (WCMHS) includes a team of "screeners" employed by WCMHS who conduct mental health screenings in our ED and the community, particularly during mental health crises.

Available 24/7, these screeners work with our providers, nurses and care management teams to provide patients and their families with necessary resources and guidance. They assist with safety planning, risk mitigation and safe discharge plans. As integral members of our health care team, they participate in daily interdisciplinary meetings, contributing to care coordination and planning.

Partnership with Turning Point of Central Vermont Embeds Peer Recovery Coaches in ED
We continue to partner with the Turning Point Center of Central Vermont to integrate peer recovery coaches into the ED. These coaches, who are individuals in long-term recovery themselves, work alongside clinicians to offer immediate support to patients struggling with substance use disorder. The immediate proximity of recovery coaches allows for a seamless transition from clinical assessment to the transformative impact of peer support and additional resources for patients.

Inpatient Care for Admissions from Community Providers
Our hospitalist team provides coverage for acute care admissions for patients of community providers, including Plainfield Health Center, our local FQHC. Our medical director and provider staff at Woodridge Rehabilitation and Nursing cover admissions, care and treatment of all residents admitted into this facility.

THRIVE
As noted and described in more detail in section B. c), Central Vermont Medical Center is the convener and fiscal agent for THRIVE, our Accountable Community for Health serving Washington and Orange Counties.

Central Vermont Medical Center has leveraged our ACH to complete our last two Community Health Needs Assessments (CHNA) and our Community Health Improvement Plans (CHIP).

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 to have more resources to care for patients. As highlighted in section C. b) above, the current Syntellis median for administrative shared services is 12.3%. For FY24 we are at 11.5%, and the FY25 budget is at 11.7%.

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

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

F. Other

a) Is this a zero-based budget? If not, when was the last time your organization developed a true zero-based budget (creating a budget from scratch and then justifying every expense rather than basing the budget on prior spending)?

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

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

b) Patient Financial Assistance

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

Central Vermont Medical Center
Total paid for collection efforts: $114,013

Revenue generated from collection efforts: $855,114

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 PFS Department and has received four statements over a 120-day time period, the account is referred to a third-party collection agency. Our collection agencies have the depth to reach out on large volumes of accounts with high levels of efficiency. They use a series of letters and make telephonic, text and voice mail attempts to reach the patient. Once contact is made, the agencies work with the patient on repayment terms that best fit their financial needs. Agencies also discuss financial assistance and advise how they can apply. Additionally, as part of our Medicare Bad Debt Reporting we can demonstrate that reasonable collection efforts were made. While we use the services of an agency, UVM Health Network has never negatively reported bad debt – meaning, patient credit scores are not impacted by this practice.

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

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

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

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

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

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

With patients in our ED, our financial counselors meet with the uninsured and/or underinsured patient

during care (upon request), or with the uninsured patient after care to help them obtain financial sponsorship.

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

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

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

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

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

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

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

Hospital and Physician Revenue
The Hospital and Physician Revenue Sheet collects units of service and Net Patient Revenues and Fixed Prospective Payments, Reserves and Other Payments at the Department level.

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

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

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

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

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

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

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

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

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

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

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

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

Referral lags: the percentage of appointments scheduled within 3 business days of referral (that is, the percentage of all referrals where the clinic or hospital has completed scheduling an appointment

within 3 business days of receiving the referral, regardless of the date on which the appointment will take place).

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

Please see submitted data.

Staffing Turnover and Vacancies

Please report the following staffing data for FY2024.

1. The total number of FTE physicians, FTE mid-level providers and FTE nurses employed by the hospital as of May 31, 2024. Please note that positions do not include travelers.

CVMC	**333.7**
Mid-Level Provider	53.3
Physician	1.0
Registered Nurse	279.4

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.

CVMC	**33.6**
Mid-Level Provider	3.6
Physician	2.5
Registered Nurse	27.5

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.

CVMC	**66.5**
Mid-Level Provider	6.8
Registered Nurses	59.8

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 Central Vermont Medical Center, we are assuming 3% 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 $$
CVMC	5.16	4.15	59	48	4,247	3%	4,120	$ 1,962	$ 8,083,550

	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 $$
CVMC	4.89	4.56	56	52	1,375	3%	1,334	$ 1,962	$ 2,616,818

	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 $$
CVMC	4.76	4.76	58	58	-	3%	-	$ 1,962	$ -

	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 $$
CVMC	4.57	4.57	60	60	-	3%	-	$ 1,962	$ -

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 Central Vermont 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
CVMC	1.0	8,760	365	$ 540	$ 197,100

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. Central Vermont Medical Center primary care providers currently have panel sizes larger than our standard by 1,023 patients. This will be addressed when our two new providers join in September and October.

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, Central Vermont Medical Center primary care providers are budgeted to generate 4,247 wRVUs/clinical FTE (21st percentile) and the primary care APPs are budgeted to generate 3,692 wRVUs/clinical FTE (45th 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.cvmc.org/about-cvmc/community/community-health-needs-assessment

7. Financial Assistance Policy & Reporting (upload)

In accordance with Act 119 of 2022, hospitals are required to submit a plain language summary of their financial assistance policy (FAP). In addition, please report the following:

- **Total number of applicants granted any amount of FAP**
- **Number of applicants granted 100% FAP**
- **Number of applicants granted less than 100% FAP**

• Total applicants denied FAP
• Breakdown of reason for denial (% or #)

FY 2023	
CVMC Financial Assistance Program	**Volumes**
Total Applications	1,240
Total Household Members	1,338
Approved / Granted	
<200 FPL (Free Care)	565
<201% FPLG - 400% FPLG (Discounted)	498
Total Approved	1,063
Denied	
Denied - Other Reason	2
Denied - Out of Service Area	1
Denied - Over Assets	10
Denied - Over Income	51
Denied - Over Income & Assets	5
Incomplete Application or Documentation	108
Total Denied	177

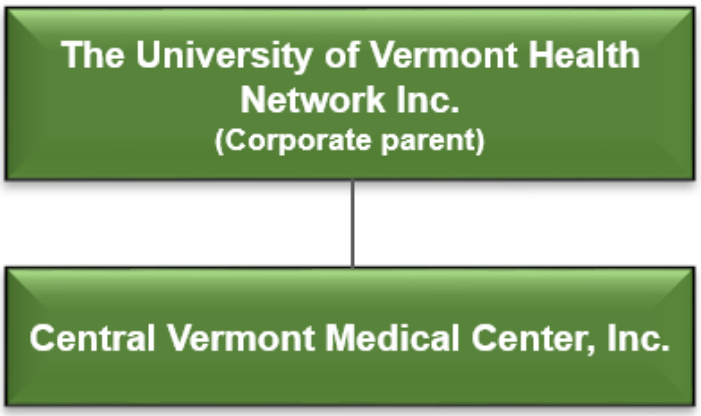
Please see Appendix L for the Central Vermont Medical Center plain language summary of the financial assistance policy.

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

Central Vermont 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 provided to plan participants. Currently, Central Vermont Medical Center is contracted with the following Medicare Advantage plans:

- Aetna Health Management, LLC
- Vermont Blue Advantage
- 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 UVM Health Network hospitals in both Vermont and New York. As a result, each Network hospital is only responsible for a fractional portion of those salaries. For each position, we also provide detailed information regarding the source(s) of the benchmarks used for each position.[1]

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

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

compensation philosophy, which is designed to ensure reasonable compensation while attracting skilled administrators:

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

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

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

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

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

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

11. Net Revenue & Public Payer Reimbursement (upload)

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

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

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