Fiscal Year 2024 Hospital Budget Submissions to the Green Mountain Care Board

On behalf of the University of Vermont Medical Center,
Central Vermont Medical Center and Porter Hospital

June 30, 2023

SECTION II: ADDITIONAL FILINGS

A. NARRATIVE

The budget narrative provides an opportunity to provide context for proposed budgets and highlight areas of interest and/or concern. The GMCB asks hospitals to answer each question succinctly and to strictly follow the format below by responding in sequence to every question.

I. EXECUTIVE SUMMARY

Provide a high-level overview about key considerations for the proposed budget, highlighting any adjustments required to the budget reference year (FY22 actuals). Indicate areas where the proposed budget deviates from parameters specified in this Guidance.

For hospitals whose budget interacts with or includes other entities, explain any differences in what is happening at the hospital versus consolidated level.

Executive Summary

The University of Vermont Health Network (UVMHN) is an integrated, non-profit academic health system that serves more than one million people living in rural communities across Vermont and northern New York. We are working to preserve access to care for the people we serve, while innovating the way health care is delivered. Our mission is to create a sustainable health care system that focuses on wellness while treating illness, provides the highest quality care, and manages costs – all in service to the health and well-being of our communities.

The UVM Health Network is comprised of an academic medical center, five community hospitals, a children's hospital, a cancer center, a home health and hospice agency, 154 outpatient patient care sites, three skilled nursing facilities, a multispecialty medical group with approximately 1,060 employed physicians, and a population health services organization.

Our three Vermont hospitals are subject to Green Mountain Care Board budget approval under 18 V.S.A. § 9375(b)(7) – the University of Vermont Medical Center (UVMMC), Central Vermont Medical Center (CVMC), and Porter Hospital, which is part of Porter Medical Center (PMC). This document describes the Network's budget submissions on behalf of these hospitals for Fiscal Year 2024 (FY24), as well as how these budgets comport with our mission to improve access to affordable and high quality health care for the people of this region.

This is a pivotal year for Vermont's hospitals, and discussions of budgeted net patient revenue (NPR) and commercial rate must go hand in hand with consideration of Vermonters' access to health care services, as well as the overall financial health of the statewide hospital system. This is a fine balance, and we stand ready to work in partnership with the Board and the State of Vermont to ensure the continued stability of our health care landscape in Vermont. Together, we can be proud of Vermont's continued high performance in the Commonwealth Fund's Scorecard on State Health System Performance. Vermont ranked fifth among all states on overall

performance in the 2023 Scorecard[1] across 58 measures of health care access, quality, outcomes, costs, health disparities and reproductive care.

Ongoing financial pressures and a changing population

As we file our FY24 hospital budgets, we do so amidst the stark financial realities our hospitals are still confronting, years after the COVID-19 pandemic. The cost and wage pressures that began during the pandemic – and have continued in its precarious aftermath – are not over. According to Kaufman Hall's April 2023 National Hospitals Flash Report, "[i]ncreased material costs associated with drugs and supplies as a result of inflationary pressures continue to negatively affect hospital margins. Additionally, workforce shortages persist, driving up the cost of labor, albeit at a slower pace than material costs."[2] Additionally, PwC's Health Research Institute states: "HRI is projecting a 7.0% year-on-year medical cost trend in 2024 for both Individual and Group markets. This trend is higher than the projected medical cost trend in 2022 and 2023, which was 5.5% and 6.0%, respectively. The higher medical cost trend in 2024 reflects health plans' modeling for inflationary unit cost impacts with their contracted health care providers, as well as persistent double-digit pharmacy trends driven by specialty drugs and the increasing use of certain medications used to treat Type 2 Diabetes or weight loss."[3] As a consequence, ensuring the financial sustainability of our system in order to meet the needs of people seeking lifesaving care is our paramount concern. The budget we submit to you for FY24 is responsible and reasonable, particularly when taking into account the continued record-setting inflation and expense challenges hospitals and health systems face, both here in Vermont and nationally.

The UVM Health Network is the safety net provider for many communities in our region, where we care for the most vulnerable and critically ill patients. Vermonters expect and deserve to receive the highest quality care at our state's only academic medical center – and we aim to continue to deliver those essential health care services, some of which can only be found in the state at UVMMC, long into the future. The budget we submit to the Board contains the financial support necessary to continue these needed tertiary and quaternary services to the region, while recognizing that UVMMC also serves as the local community hospital in Chittenden and Grand Isle Counties. It is also important to note that as a non-profit organization, dollars in our health care system stay invested in our community – in our patients, staff and facilities. The margin we have included in our FY24 budget is the *minimum necessary* to make these critical investments, which are detailed in this submission.

Expected population growth and utilization

We serve a population that is growing, aging, and whose needs are changing – and this has clear implications for our operating and capital budgets. Population growth in our region is occurring faster than Claritas' five year population forecasts in 2020 had projected. The Burlington Hospital Service Area (HSA) experienced 1.8% growth from 2020-2023, according to Claritas. In terms of numbers of new patients seeking health care in Chittenden County, the population

[1] Commonwealth Fund 2023 Scorecard State Health System Performance | Commonwealth Fund
[2] https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf
[3] pwc-behind-the-numbers-2024.pdf

growth from 2020-2023 added nearly 3,000 more people who need everything from routine primary care to highly specialized treatment. At this pace of growth, our 2025 population would show a 3% increase over 2020, in comparison to Claritas' 2020 projected growth of 2.4% for the same five year period. In terms of incremental patients from 2020-2025, these growth rates indicate that another 1,000-2,000 additional people will depend on UVMMC for their care.

Population forecasts indicate 4.6% population growth over the next 10 years in Chittenden County, with a 35% increase of those 65+. As the regional provider of tertiary and quaternary care, population changes in surrounding counties, particularly the growth of the 65+ segment of the population, factors into the increased number of patients from outside our HSA who may need care at UVMMC. Claritas forecasts indicate Franklin County's 65+ population growth at 32%, 25% in Washington County, and 23% in Addison County. In Chittenden County alone, the impact of this 35% growth rate is 10,000 additional people in the 65+ age cohort. For these counties combined, the result is over 18,000 additional seniors who will likely need more and higher acuity care – more than twice the population of Grand Isle County today. The CMS National Health Expenditure fact sheet states that "[p]er person personal health care spending for the 65 and older population was … almost 3 times the spending per working-age person."[4] As we have discussed in previous budget submissions, the health care utilization rate increases as people transition into older population cohorts.

Continuing our journey to stabilize our operations and increase patient access

Across our health system, an urgent body of work is underway to accelerate our path to operational improvement and financial stability in the face of extraordinary pressures. This effort emphasizes system-wide collaboration to enable our Network to better respond to the needs of our patients, our people and our communities. Our teams are focused on cost savings and increased efficiency, especially as our financial performance eroded over the last several years due to the pandemic and resulting global hyperinflation for goods and salaries.

We want to highlight some of the ways we are increasing access for patients, strengthening our workforce, reducing costs and increasing efficiency – all of which positively impact our Network's financial sustainability. We view this work as necessary to support our maturation as an integrated health system and to support major initiatives, such as the outpatient surgery center.

Reducing wait times for radiology

We decreased wait times for radiology studies, such as MRIs and PET scans, which are essential diagnostic tools and provide vital insights and inform diagnosis and subsequent treatment plans. The growing use of these services, combined with staffing shortages and increased demand from people who delayed care during the pandemic, had added to already unacceptably long wait times.

One year ago, a Network team came together to create a schedule dashboard to easily view appointment availability across our Network so that patients can be seen sooner. Radiologists and technologists team up to volunteer for extra shifts, and schedulers reach out to patients

[4] NHE Fact Sheet | CMS

waiting for scans to fill the schedule. The addition of a new MRI machine has also been helpful in this effort. The team has been able to serve nearly 2,000 patients from across the region since the effort began, reducing backlogs – wait times for MRIs dropped from two months to three weeks, and wait times for PET scans dropped from six weeks to two. While we are excited about the progress related to increased access in this area, it has come as a result of bringing in 19 travelers.

The UVM Health Network is investing in a single Radiology PACS (Picture Archiving and Communication System), replacing the 12 disparate systems currently in use across our Network. This project enables our radiologists to read and compare images from anywhere in our health system, giving them access to a patient's complete image record. This improves the quality and efficiency of patient care, ensuring that imaging studies do not need to be repeated if a patient transfers from one hospital to another in our Network. It also allows for radiologists to easily consult with each other in subspecialized areas, which also increases the quality of care.

Expanding access to surgical procedures

In FY23, our hospitals increased access to much-needed surgical procedures through new efficiencies in our perioperative services and by dynamically adjusting our operating room (OR) schedule to accommodate services with the most significant patient backlogs. As part of this new approach, we developed a revised model to communicate patient readiness for surgery among clinical teams, including developing a surgical readiness queue in Epic that identifies patients who could be moved up as OR capacity is made available.

On November 20, 2022, UVMMC opened its "sprint room," an incremental OR on the hospital's main campus. It is staffed and operated above and beyond our current block schedule and designed specifically to accommodate patients waiting in surgical queues longer than 90 days. At CVMC and PMC, teams follow a similar sprint process to prioritize access to available OR time, dynamically filling schedule availability with surgically-ready patients.

Patients awaiting surgery in the following fields have all benefited since November 2022: Cardiac Surgery, General Surgery, Gynecology, Orthopedics, Otolaryngology, Plastic Surgery, Neurosurgery, Thoracic Surgery, and Urology, among others. Specifically in Orthopedics, the UVMMC team has decreased backlogs by increasing the number of total joint procedures completed per day. Since the sprint process was initiated at CVMC in March 2023, CVMC has increased OR volume by an average of 15% per month compared to earlier in the fiscal year (October 2022 through February 2023). Orthopedic cases are also being performed by UVMMC surgeons at Porter Hospital to enhance access and utilize available block time.

More recently, we have used the UVMMC sprint room to accelerate access to the second daVinci surgical robot, helping reduce wait times for robot-supported surgery in General Surgery, Gynecology, Otolaryngology, Thoracic Surgery, and Urology.

In 2023, UVMMC also extended Fanny Allen OR hours, to temporarily accommodate additional cases in the outpatient setting. Resulting from these efforts, March 2023 and May 2023 have been the two highest volume months at UVMMC since October 2015, significantly taxing both

staff and UVMMC's physical plant. Like with increased MRI access, the cost of increasing this capacity has been approximately 60 traveler FTEs. The FY24 budget and outpatient surgery center Certificate of Need application before the Board provide necessary resources – both financial and physical – to ensure this level of access can be maintained.

We plan to continue this sprint process through September 2023 and incorporate sprint concepts into normal operations across our other sites beginning in FY24. Meanwhile, the team is investigating opportunities to further extend the Fanny Allen hours of operation and open its fifth OR. Despite being a small room and therefore limited in clinical scope, this OR could further increase timely access to select outpatient surgical care in the near term.

However, it is important to note that the gains we have achieved leveraging Fanny Allen's facilities are only temporary. It is not feasible to permanently increase our surgical capacity by expanding or renovating the Fanny Allen ORs or those on our main UVMMC campus. The size and design of many of the current ORs make them unsuitable for some of the complex procedures that are now common in the outpatient setting, and extending their hours of operation would not remedy the projected shortfall in surgical capacity that we anticipate in the coming years. In addition, failing physical structural issues within this facility have slowed our progress and decreased our confidence of opening additional rooms in this facility.

Innovating to optimize our capacity

Patient throughput remains a serious challenge throughout Vermont and the region, driven by staff shortages, robust demand for inpatient and outpatient care and a shortage of beds in a variety of care settings, including skilled nursing, residential care facilities and inpatient psychiatric facilities. In the past year, we have had days with zero ICU beds or zero med surg beds available to patients, due to workforce challenges and sub-acute patients waiting for appropriate placement. As UVMMC is Vermont's only trauma center, this creates a challenge for the entire state. In December 2022, on every day of the month an average of five patients who would normally be appropriate for transfer to UVMMC were declined due to capacity. As a consequence – and in addition to our recruitment and retention efforts discussed later in this filing – we continue to explore new ways to make the most of our capacity to provide care through improved operational efficiencies and the application of new tools and technologies. Helpfully, this capacity trend has recently shifted, thanks to an incredible amount of work, both within our organization and with provider partners outside of the Network. It remains, however, dynamic and at risk.

For example, we are improving our patient bed management so that patients are able to return home or to another point of care more quickly, thus freeing up inpatient beds for new patients. We are standardizing when we complete patient rounding as well as the timing of patient discharges. At times, there are patients who are medically ready to be discharged, but have social needs that require extra time in the hospital, such as the care team working through where the patient will be discharged to or what social services also need to be arranged before discharge. We are working toward establishing a patient discharge lounge at UVMMC for patients who are medically able to be discharged but still need more support before they leave our care sites, which frees up the inpatient bed for a new patient and positively impacts our patient access

efforts.

At CVMC we have revised our Patient Progression Rounds program. This daily huddle brings an interdisciplinary team together to proactively plan for discharge out of our acute care facility and into the next appropriate level of care or to their homes. This effort has resulted in an 8.2% reduction in CVMC's average length of stay FY23 year-to-date.

Meanwhile, we continue to invest in Network-wide eHealth technologies, a variety of health care services provided through video, phone calls and other digital connections, to help us expand patient access to specialists and emergency care when they need it most. These innovations also support new collaboration among providers across Vermont and northern New York, both within our Network and across the region's wider health care system.

One example is our growing use of eConsults. After a phased launch in 2021, eConsults have quickly become an essential tool for helping our patients access timely specialty care with the help of their primary care provider. Our clinicians initiated more than 1,000 eConsults during FY23 across 20 specialties, including Cardiology, Endocrinology, Gastroenterology, Gynecology, Infectious Disease, Neurology, Psychiatry, Pulmonology, Rheumatology, Sleep Medicine, and Urology. The last three months have seen our highest volumes of eConsults across the Network, a trend we expect to continue and accelerate.

Meanwhile, our use of mobile telemedicine technologies is helping us to continuously improve how we provide emergent care in rural communities. These applications help our providers to consult with each other via video on difficult cases or in emergency situations like a suspected stroke, but we are also increasingly using these tele-consultations to ensure the safe transport of critically ill patients. Because the system is linked to our shared electronic health record (EHR) system, it also supports our providers to share information and view and analyze in real time a patient's blood work, tests or scans. During the past 12 months, our teams in NICU, ICU, ED, stroke neurology, and EMS used emergency tele-consultations on 250 cases.

Population health initiatives

In fall of 2021, the UVM Health Network established its Population Health Services Organization (PHSO) with the goals of improving patient outcomes and quality, supporting care teams and optimizing value-based contract (VBC) performance. The PHSO is designed to support our Network's ability to influence the cost of care and make data-driven decisions on performance improvement initiatives related to high value care.

The PHSO, a Network shared services department, launched Care Management in the summer of 2022. The PHSO implements evidence-based, equitable, payer-agnostic population health solutions driving the Network's high value care performance in quality, cost of care, utilization optimization, and value-based contract performance improvement.

The PHSO has grown significantly over the last year and a half, thanks largely to the reallocation of existing resources from across the UVM Health Network into the PHSO. This has enabled significant operational efficiency and further aligned VBC with our Network's high value care

goals and programs. Recent PHSO highlights include: the addition of 26 patient-facing care management roles across Network primary care; the completion of a network-wide patient satisfaction survey; and the development of a dashboard to monitor program performance across a set of industry-standard key performance indicators. We are also seeking National Committee for Quality Assurance (NCQA) case management accreditation.

There are many population health initiatives across our Network, including significant continued investment in Chittenden County in housing for people experiencing homelessness in partnership with community organizations. We continue to publicize information about our Network-wide Health Assistance Program, which helps eligible low- and middle-income families get prescription medications at no cost and provides advocacy and support with obtaining other health care resources.

Boosting physician recruitment

The national marketplace for providers is highly competitive, and our Network must continually innovate our practices and strategies to secure the best candidates for our open positions. We have invested in provider recruitment positions to help us reach out to potential candidates and uncover opportunities for recruitment that might have previously been overlooked. Right now, there are over 165 open physician positions across the UVM Health Network. We are making strides to bring down our number of open positions, and the focus on finding and attracting top physician talent will remain an important focus for the foreseeable future. As we are now recruiting on a much more national scale in a highly competitive labor market with dwindling or poor housing opportunities, our Network must offer more competitive wages to ensure access.

We have also improved our retention of residents – physicians who are completing their medical training at the UVM Health Network. From 2018 to 2022, approximately 25% of our graduates remained at the UVM Health Network, either as fellows or as attending physicians. In primary care, Family Medicine has retained 14 out of 38 graduates over the past six years (inclusive of the current class graduating in June), which is a 37% recruitment rate. In Urology, a program that graduates only one resident per year, we have retained three graduates over the past five years (not including the upcoming class).

Our Network continues to recruit for many specialties, including Anesthesiology, Gastroenterology, Orthopedics, Urology and Oncology. While physician recruitment overall is an ongoing challenge, there are also bright spots. One area with particularly impressive results is in our Emergency Departments, which have been under serious pressure for several years. Of the six Emergency Medicine (EM) residency graduates from 2022, we recruited three to the UVM Health Network, and one remained in Vermont at another organization. For the upcoming June 2023 graduation, two of the six graduates are remaining in the department as hybrid faculty members and fellows in EM-sponsored non-Accreditation Council for Graduate Medical Education (ACGME) fellowships with the goal to retain both in 2024. Due to the relative success of residents and fellows graduating and remaining local for long-term employment, we will evaluate additional opportunities to expand these programs.

Strengthening our workforce

Similar to recent years, a recurring major theme of this year's budget is extreme wage pressure in a very tight labor market. We are making every effort to invest in developing a sustainable, permanent workforce. However, these workforce initiatives require time and resources before they can supplant the temporary labor costs we are currently paying. Our Network's focus to pay competitive wages to attract permanent team members continues to be a major area of focus at every level of our organization.

Our workforce optimization strategy has been a critical priority over the past year. In November 2022, we launched a centralized process for hiring travelers across all UVM Health Network locations. This new process standardizes the criteria for approval and sourcing of traveling workers.

This centralized process includes an auditing system, so that we can accurately track all payments to all contracted companies. This also includes centralized traveler approvals, so that staff requests and negotiated rates with all travel companies are handled centrally and consistently. Standardized traveler contracts has meant that we have been able to use our purchasing power as a network to leverage decreased rates. Since October, our full-time traveler numbers are down by nearly 100 Network-wide, and traveler expenses have declined by $2.9M per month. The rate we pay for travelers – an all-inclusive fee paid to staffing agencies – has declined by 35% since the beginning of FY22, from an average of $201 per hour to $130 per hour.

The Network now recruits candidates across our system as a single team, instead of by location or by organization. This allows recruiters to specialize in job types to help find the best candidates. To support this approach, our new Network careers website lets candidates view openings across the organization and select the role best suited for them. Our dedicated Talent Acquisition staff are focused on finding candidates for hard-to-fill positions, working with hiring managers to understand who the ideal applicant is and then proactively searching for candidates.

Facilitating professional development and advancement

In response to the persistent national workforce shortage, the UVM Health Network continues to pioneer innovative solutions designed to offer affordable and accessible career advancement opportunities for current employees and jobseekers. These workforce development programs enable employees within the UVM Health Network to earn wages and benefits while pursuing advanced studies to further their career – often with full tuition support or at no out-of-pocket cost. This approach provides much-needed flexibility for non-traditional learners, effectively removing the common barriers individuals often face when trying to balance life, work and continuing education. A complete listing of available programs can be found online.

CVMC leadership have a long history of thinking "outside-the-box" to fill the gap in the growing shortage of nurses, the effects of which were felt both in the local community and at the broader state and national levels. In fact, since 2018, CVMC has led our state – and our region – in developing new pathways for career advancement, which allow current employees the ability to

maintain work schedules while maintaining full-time salary and benefits, inclusive of paid study hours, in order to attend school. Students participating in the program would commit to working at CVMC full-time for three years as a Licensed Practical Nurse (LPN) following graduation and, thus, be eligible for all out-of-pocket tuition, fees, and book expenses to be reimbursed in thirds over the three-year period. Additionally, classes and clinicals would be held onsite at CVMC in order to reduce potential transportation barriers. This unique model quickly gained momentum as CVMC partnered with Community College of Vermont (CCV) and Vermont Technical College (VTC) – now named Vermont State University (VTSU) – to develop a program to graduate employees as LPNs, supporting our own community members to be employed locally and support their economic mobility.

A group of 18 students launched the inaugural LPN Pathway program cohort in August 2019. They completed their four prerequisite courses for nursing school at CCV and applied for their LPN year at VTC to begin in August 2020. Rather than pausing the program for COVID-19, the partners and students pivoted to virtual classes. Through creative thinking, while maintaining strict adherence to COVID-19 regulations, the students were able to complete not only their prerequisite year but also their LPN classes and clinical experience at CVMC. In June 2021, 13 CVMC employees graduated as LPNs. Each of the 13 took their NCLEX Board exams following graduation and passed with a 100% pass rate on each of their first attempts. This is a rare accomplishment for a whole class and speaks volumes of the dedication of the partnership from CVMC and the schools to support students to succeed. CVMC employees taught the LPN program, strongly supporting the students as they navigated their courses. This initial effort was very successful and resulted in savings of approximately $1M in traveler expenses.

CVMC also began a Registered Nurse (RN) pathway program, which allows recent LPN graduates to advance again and complete one additional year to become an RN. As of June 2023, 27 LPNs and 8 RNs have graduated through these pathway programs.

In addition to the success of the LPN and RN programs, CVMC is also offering Licensed Nursing Assistant (LNA) programs – which has graduated 30 participants so far – a newly launched Medical Assistant program to assist with patient flow through our medical practices, a phlebotomy program, a respiratory therapy program and a surgical scrub tech program. All of these programs are through partnership with local colleges and the UVM Health Network. These efforts support local community members with an interest in the medical field, as well as efforts to reduce the reliance on travelers to fill these key roles at CVMC. These programs are now being replicated across the Network. We are taking the best practices we have learned at CVMC and elsewhere within our Network to inform our planning and creation of sustainable Network-wide workforce development programs.

PMC has also established pipeline training programs for LNAs with Middlebury's Hannaford Career Center. Porter has provided both paid work and study/class time for participants and maintains employment of nearly all graduates. Additionally, Porter is formalizing relationships with Vermont State University (VTSU) for LNA to LPN and LPN to RN training programs to begin in 2024.

CVMC will soon be expanding educational space following approval of a $735,000 federal

grant. Vermont Senator Peter Welch helped secure the funding last year as a then-member of the U.S. House of Representatives through Congressionally Directed Spending. The funding will address a significant barrier to growth of existing workforce development programs at CVMC – the ability to provide dedicated space and resources. The funding will allow for the construction of a second classroom and simulation lab, all of which will help expand current nursing-specific programming into the areas of laboratory science and radiology. The new classroom will offer functional space with technology, and the simulation lab will enable students to practice their skills in a controlled environment. Both will provide space to grow for training in laboratory science and radiology. Additional space will allow CVMC to increase programming to meet staffing needs and deliver high-quality patient care for our community.

Last month, our Network and VTSU partnered to maintain and expand the state's only respiratory therapist training program. Respiratory therapists are highly-trained medical specialists whose focus is caring for patients with breathing or cardiopulmonary disorders that can stem from a wide variety of conditions and events, including acute respiratory distress syndrome – a serious condition that can occur following injuries or an illness like COVID-19. Respiratory therapists work in a variety of clinical settings, from EDs and ICUs to outpatient clinics, and with a variety of patients, from newborns to senior citizens. Given the challenges of recruiting in such a limited labor pool, UVMMC has been significantly relying on travelers to fill staffing shortfalls. Recognizing the critical need for respiratory therapists in Vermont, UVMHN and VTSU worked together to forge a public-private partnership that will sustain the program for as many as 25 individuals, starting in the fall of 2023. The partnership's goal is to preserve and expand Vermont's only pipeline for these crucial health care team members. In addition to providing financial support for the program, the Network will also focus on supporting employees who wish to pursue this career by offering flexible work arrangements, paid study time and tuition support for enrollees. As part of those efforts, the Network is working in partnership with VTSU and CCV to offer prerequisite courses like anatomy and physiology for interested employees, prior to their enrollment in the respiratory therapy program.

Investing in housing and childcare

As we work to hire permanent staff across all job types and service lines, many applicants cite the high cost of living and lack of available housing as major deterrents to move to or stay in Vermont. In turn, we are investing in housing and childcare for employees and new hires, beginning in South Burlington and expanding to other areas across our Network.

Building financial sustainability into the future

Our Network's FY24 budget helps us continue to emerge from the lasting impacts of the pandemic, including: extreme burnout of our nurses, physicians and staff; a severe labor shortage; well-documented, unprecedented national hyperinflation; lack of capacity throughout our state for adequate post-acute, mental health and substance use treatment, as well as other access to care challenges; and the ever-growing need for health care services in our communities. These factors were at a breaking point last summer when we submitted our FY23 budget. While we are seeing signs that our health care system's work over the past year has put us on a more positive path, we must not lose sight of the myriad challenges we still face, and the ground we

still have to make up after the last three years of financial deterioration.

A key component of financial sustainability is the recognition by policymakers that public payers need to increase their reimbursement rates to providers, limiting the staggering impact of the cost shift onto private payers. The Network is particularly appreciative of our lawmakers in Montpelier and Albany who recognized the continued pressure of government underfunding and invested significantly in rate increases for the coming year. Notably, Vermont's FY24 Medicaid budget includes reimbursing primary care providers at 110% of Medicare rates, increasing specialty provider rates by 3.8%, and an increase for UVMMC's Graduate Medical Education payment by $21M annually. While largely not directly impacting the reimbursement rates for hospitals, the Vermont Legislature also provided increased support for the post-acute system of care, which will have beneficial impacts on patient flow through the system. Finally, New York's Legislature approved a 7.5% Medicaid rate increase for the fiscal year.

As we have detailed in previous budget submissions, our commercial rate increases derive from the budgeted cost inflation, less the impact of government payment changes and the remainder assessed to commercial payers. Inflation is felt in every industry and has been acknowledged by our payers. BlueCross BlueShield of Vermont (BCBSVT) acknowledges their administrative trend increase is due to "continued inflationary pressures" within their recent 2024 Vermont ACA Market Rate Filing.[5] The payer experience in our current environment further validates our continued need for increased hospital rates as reflected in BCBSVT's Large Group Filing submitted February 10, 2023, expecting 2024 unit costs to mirror 2023 rates for GMCB regulated providers.[6] The expectation of BCBSVT reflects the fact that hospitals continue to communicate concern regarding financial stability and continued pressures from inflation and increased expenses.

Unfortunately, more recent payer rate filings fail to include the acknowledgement of hospital financial circumstances found in BCBSVT's original Large Group Filing. Recent payer filings base unit cost assumptions on arbitrary prior experience. In BCBSVT's[7] and MVP's[8] ACA Market Rate Filings, both payers based unit cost trend on FY22 approved GMCB rates. The payers did not provide reasoning as to the use of the FY22 rates except for a brief reference by MVP that "due to the unusually large increases in budgets last year, we are using approved 2022 increases as the best estimate for future budget changes for 2024."[9] Basing unit cost trend on FY22 approved rates is an arbitrary selection at best, and lacks basis in expenses and related

[5] "The base administrative charges are projected to 2024 using a 4.0 percent annual trend. This projection factor is intended to make reasonable but modest provision for increases in overall operating costs PMPM. In light of continued inflationary pressures, BCBSVT believes that an overall administrative expenses annual trend of 4.0 percent better reflects the expected growth in costs." BCBSVT 2024 VT ACA Market Rate Filing, Actuarial Memorandum Section 3.7.6.1 Page 45.

[6] "For hospitals under the jurisdiction of GMCB review, we start with the assumption that the GMCB will approve hospital budgets for October 1, 2023, and October 1, 2024, that support identical commercial increases as those approved for October 1, 2022." BCBSVT 2024 Large Group Rate Filing, Actuarial Memorandum Section 4.1.1 Page 8.

[7] BCBSVT 2024 VT ACA Market Rate Filings, Actuarial Memorandum Section 3.4.7.2 Page 24.
[8] MVP Actuarial Memorandum 2024 Vermont Small Group Exchange Filing, Page 5.
[9] Id.

revenue needs.

BCBSVT's recently refiled Large Group Filing again demonstrates rate setting based on an arbitrary time period instead of relying upon hospitals' and providers' actual budget experience. In BCBSVT's filing, their submitted revised trend uses a five-year average of 2018-2022 rates.[10] The basis of BCBSVT's updated medical trend is due to the GMCB's Order to revise BCBSVT's originally filed unit cost using a five-year look back.[11] The modification is not due to actuarial or contracting experience nor due to a recommendation by the GMCB's actuaries.[12] The GMCB modified BCBSVT's expected trend while acknowledging "…many Vermont hospitals continue to experience significant financial difficulties…"[13]

Within the current environment, reliance on historical look back periods fails to acknowledge the transparent and highly critical budget presented to the Board today. Using an arbitrary prior rate or a historical period which ignores today's financial realities fails to acknowledge the statewide hospital systems' financial need.

Certificate of Need for Outpatient Surgery Center

UVMMC submitted a Certificate of Need to the Board in February 2023 for a multispecialty outpatient surgery center to be located at its current Tilley Drive campus in South Burlington. The new facility will help meet the need for surgical services for the aging and growing population in UVMMC's HSA and also will allow us to better recruit and retain physicians. Once built and fully operational, the outpatient surgery center is expected to contribute to the financial health of UVMMC, as well as offset the many services that incur financial losses for the organization. In time, the outpatient surgery center will improve UVMMC's operating margin.

For more information about the Network's strategic initiatives and stories of transformation, please click here.

Guidance on Net Patient Revenue

As we wrote in our letter to the Board on March 27 and again in our letter on May 23, the 8.6% NPR cap for FY23 and FY24 combined is not representative of the reality we experience delivering health care. It also does not address the record-setting cost inflation and expense challenges hospitals are facing. We appreciate the Board stating that they will consider access and revenue implications in this year's hospital budget process.

Over the last several years, we have urged the Board to establish externally-derived benchmarks and objective criteria drawn from credible national and regional health care data sources by which hospital budgets would be judged, and to publish those benchmarks and criteria in the

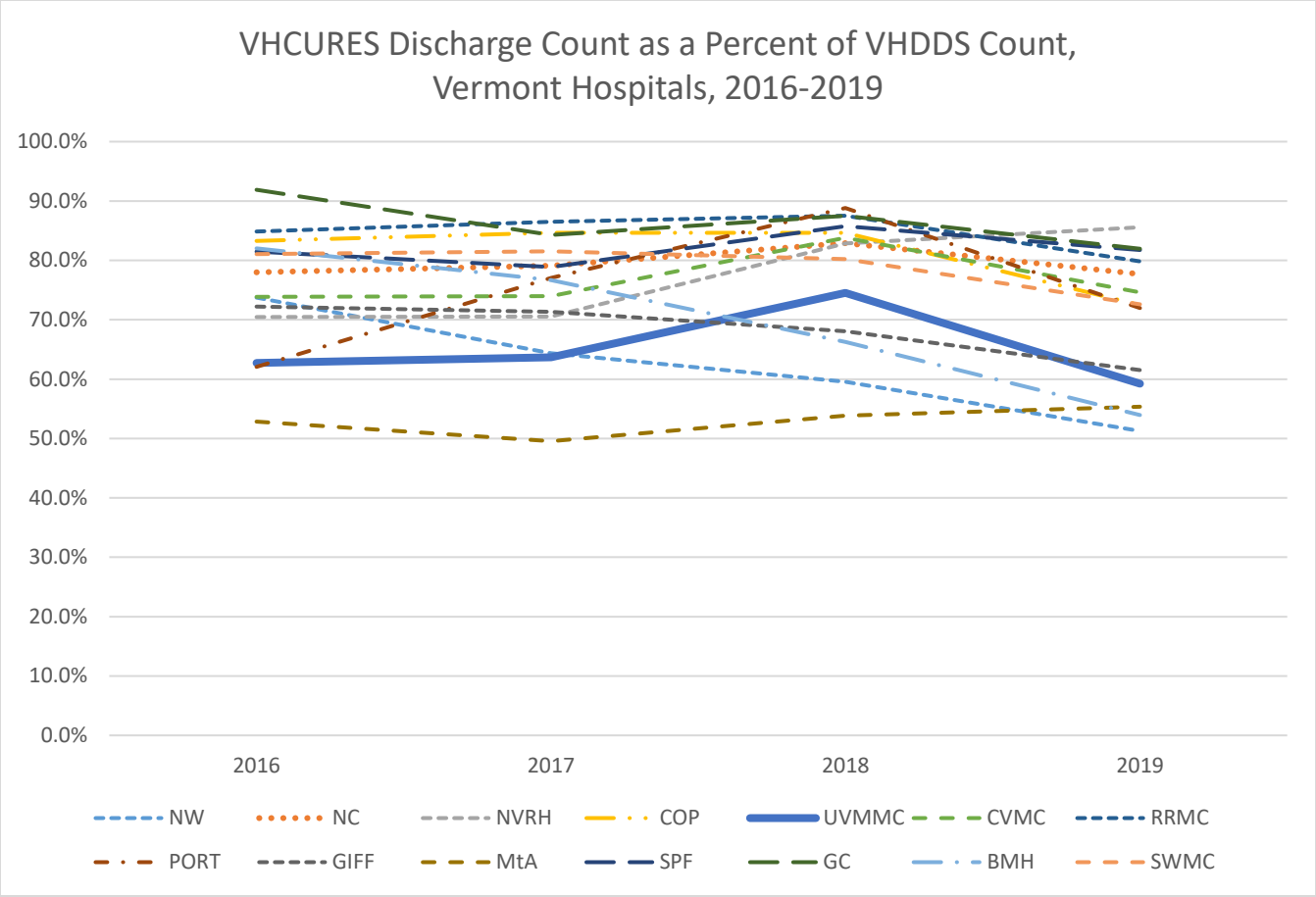
[10] BCBSVT 2024 Large Group Unit Cost Trend Filing, Actuarial Memorandum Section 3 Page 24.
[11] BCBSVT 2024 Large Group Rate Filing Decision and Order GMCB-001-23rr; Conclusions of Law II, Page 9 (2023).
[12] Id. at Findings of Fact 18, Page 4.
[13] Id. at Conclusions of Law II, Page 9.

hospital budget guidance.

We appreciate the Board's use of external benchmarks in this year's budget review process. Many of the benchmark sources you list in the budget guidance are relevant and legitimate. However, we feel compelled to comment on the limitations of some.

First, we would note that it is very difficult to find a valid comparison group for UVMMC. There are very few hospitals in the country that function as both general hospital in their immediate geographic area and tertiary care provider for a region. In fact, the Association of Academic Medical Colleges (AAMC) and our own work examining data from the Dartmouth Atlas identify at most 13 hospitals of this type (both sole academic medical center and sole community hospital in their service territory) nationally. The combination means that we tend to have a lower case-mix index than "pure" academic medical centers (AMC) and a higher case-mix index than community hospitals. We would be happy to work with you to identify the most appropriate peer group possible.

Moreover, some data sources, such as VHCURES, do not capture services provided to out-of-staters. Since we provide tertiary care services to many New Yorkers, this is a shortcoming, and VHCURES is missing claims for many Vermonters with self-insured employer coverage and those with no insurance. A comparison of VHCURES and the hospital discharge dataset, for example, reveals that claims related to a significant numbers of discharges are missing from VHCURES.



Source: Analysis by Policy Integrity, LLC

The Burns & Associates study relies on VHCURES data, and therefore suffers from the limitations cited above.

Another source cited in your guidance is the RAND pricing study. The RAND study is based on the assumption that Medicare prices are a good benchmark for comparing hospitals' commercial prices, and that any differences in Medicare should be mirrored in the commercial market.

The RAND study reports two types of hospital prices:

1. Standardized prices: the average allowed amount per standardized unit of service, where services are standardized using Medicare's relative weights; and
2. Relative prices: the ratio of the actual private insurer–allowed amount divided by the Medicare-allowed amount for the same services provided by the same hospital.

RAND's emphasis on relative pricing has limitations when assessing differences in hospital pricing in Vermont, especially if relative price calculations are not accompanied by a thorough illustration of the myriad factors that influence differences in Medicare reimbursement – such as

hospital type, case mix, inflation, and geographic factors like cost of living.

Inpatient Pricing

The RAND methodology can skew comparisons between hospitals that are otherwise considered peers, such as UVMMC and Dartmouth Hitchcock Medical Center (DHMC). In the example outlined below we see that UVMMC and Dartmouth have similar standardized prices for inpatient (IP) care, but Dartmouth is paid significantly more by Medicare for the same services.

As a consequence, their relative prices for IP care are substantially different, making Dartmouth appear – in the eyes of the RAND study – to be significantly cheaper than UVMMC for IP care. Specifically, the RAND study makes Dartmouth IP appear to be 42% cheaper than UVMMC, while in actual dollars to be paid by commercial insurance, Dartmouth is only 7% cheaper.

	Standard IP Price	Medicare IP Price	Commercial as a % of Medicare	Apparent Price Difference from UVMMC	Actual Price Difference from UVMMC
UVMMC	$ 28,896	$ 11,288	256%	0%	0%
Dartmouth	$ 26,804	$ 17,989	149%	-42%	-7%
Albany	$ 36,358	$ 10,662	341%	33%	26%

Source: Analysis by UVMHN Data Management Office

RAND's methodology would attribute the differing Medicare reimbursements to the differing costs associated with running the two hospitals, particularly the cost of living. This implies that the cost of living in the greater Hanover area is 60% higher than it is in the greater Burlington area; it does nothing to illuminate the diversity of factors that produce vastly different Medicare reimbursements at two otherwise similar hospitals, including the fact that DHMC has long held sole and rural referral center designations from Medicare, while UVMMC has only recently obtained those designations.

Critical Access Hospitals

We see a similar pattern in outpatient (OP) pricing with respect to Critical Access Hospitals (CAH). Vermont has a high density of CAHs, which are paid significantly more by Medicare. Using RAND's relative pricing makes CAH commercial prices look significantly cheaper than non-CAH hospitals in the region, such as UVMMC.

For example, the third most expensive CAH in Vermont in actual dollar terms receives $202.94 from Medicare for a standardized OP service, while UVMMC receives $98.60 and CVMC receives $108.46. This same CAH would receive $418.06 from commercial insurance for the same standardized service (206% of their Medicare rate), UVMMC would receive $351.02 (356% of Medicare), and CVMC would receive $302.30 (279% of Medicare). This means that, while this CAH appears to be 42% less expensive than UVMMC in the RAND study for OP care, it is actually 19% *more* expensive in actual dollars.

	Standardized OP Price	Medicare OP Price	Commercial as a % of Medicare	Apparent Price Difference from UVMMC	Actual Price Difference from UVMMC
UVMMC	$ 351.02	$ 98.60	356%	0%	0%
CVMC	$ 302.60	$ 108.46	279%	-22%	-14%
CAH1	$ 418.06	$ 202.94	206%	-42%	19%
CAH2	$ 277.33	$ 142.22	195%	-45%	-21%
IPPS1	$ 329.68	$ 102.70	321%	-10%	-6%

Source: Analysis by UVMHN Data Management Office

The two CAHs are the third most and third least expensive OP hospitals in Vermont in this data. The IPPS hospital is the 7th least expensive hospital overall, and is the median IPPS hospital.

Summary of each hospital's FY24 budget submission

We are requesting NPR increases from FY22 actual to FY24 budget as follows:

- UVM Medical Center 23.8%
- Central Vermont Medical Center 21.4%
- Porter Hospital 28.4%

As in past years, the rate of increase from Medicare and Medicaid does not cover the total cost inflation facing our Vermont hospitals, as demonstrated in the chart below.

	FY24 Total Cost Inflation	FY24 Avg Rate Increase	
		Medicare	Medicaid
UVMMC	5.2%	2.9%	0.7%
CVMC	3.9%	2.1%	1.9%
Porter Hospital	3.2%	3.5%	2.2%

This shortfall necessitates commercial insurance rate increases of:

- UVM Medical Center 13.45%
- Central Vermont Medical Center 10.95%
- Porter Hospital 6.86%

These rate requests would have been higher if not for investments made by the State of Vermont to increase Medicaid reimbursement rates, which offsets some of the increases we would need from commercial payers.

The breakdown of that FY22 actual to FY24 budget in NPR is:

	Volume	Rates to Cover Cost Inflation	All Other	Total
	Access Improvement, Population Growth & Aging	Medicare, Medicaid & Commercial	Payer Mix, Bad Debt & Charity	
UVMMC	8.1%	15.6%	0.1%	23.8%
CVMC	8.1%	12.6%	0.7%	21.4%
PMC	6.0%	13.8%	8.6%	28.4%

To validate from another perspective the volume related increases experienced from FY22 to FY24, below is the population, aging and market data we have included in prior budget submissions, updated with FY23 data. It shows that since 2017, the age-adjusted population served by the Network has grown on average by 2.5% per year. Based on the Claritas population and aging projections shared above, we expect that growth to continue in FY24. With that assumption, the data indicates that our volume and/or utilization[14] should be growing by 5.0% from FY22 to FY24 (2.5% multiplied by 2). Adding the impact of our access improvement efforts to this 5.0% growth shows how the 6.0% to 8.1% volume related increases, derived from our financial statements, for UVMMC, CVMC and PMC have materialized.

[14] NHE Fact Sheet | CMS

Utilization Adjustment		FY17	FY18	FY19	FY20	FY21	FY22	FY23
Primary Market Population								
Chittenden		162,372	164,572	163,774	168,323	168,865	169,409	169,954
Franklin		49,025	49,421	49,402	49,946	50,325	50,707	51,092
Grand Isle		6,998	7,090	7,235	7,293	7,421	7,551	7,684
Lamoille		25,337	25,300	25,362	25,945	26,126	26,308	26,492
Washington		58,290	58,140	58,409	59,807	59,969	60,131	60,294
Addison		36,776	36,973	36,777	37,363	37,260	37,157	37,055
Subtotal		338,798	341,496	340,959	348,677	349,966	351,264	352,571
Rest of Vermont		284,859	284,803	283,030	294,400	295,604	296,114	296,167
Total Vermont		623,657	626,299	623,989	643,077	645,570	647,378	648,737
UVMHN Population (market share adj)								
Under 45		173,776	176,855	177,026	181,750	178,348	174,231	171,066
45 - 64		88,167	87,683	86,704	90,608	94,068	97,520	102,003
65 +		53,038	55,701	58,033	60,283	62,117	64,524	66,941
Total		314,981	320,239	321,763	332,642	334,533	336,275	340,009
Utilization Adjusted UVMHN Population								
Under 45	X 1.00	173,776	176,855	177,026	181,750	178,348	174,231	171,066
45 - 64	X 2.44	215,089	213,908	211,521	221,045	229,486	237,906	248,843
65 +	X 4.56	241,977	254,130	264,770	275,033	283,399	294,384	305,407
Total		630,843	644,892	653,316	677,828	691,233	706,520	725,316
Yearly % Increase			**2.2%**	**1.3%**	**3.8%**	**2.0%**	**2.2%**	**2.7%**

	Average US Health Care Spending	Utilization Factor
Under 45	$ 4,186	1.00
45-64	$ 10,212	2.44
65+	$ 19,098	4.56

SOURCE: CMS National Health Expenditure Data [15]

II. QUESTIONS

a. Concisely describe necessary adjustments to your FY22 actuals or other considerations required for the proposed budget. Examples may include physician transfers, accounting adjustments, or changes to service offerings, staffing, or infrastructure.

There are no material items which warrant adjustments.

[15] NHE Fact Sheet | CMS

b. Clearly and succinctly explain the factors used in your proposed budget and how they compare with those outlined in Section I of the FY24 GMCB Hospital Budget Guidance, providing evidence to support your assumption(s). Each factor should be addressed. Hospitals should include other factors material to the proposed budget along with supporting material.

i. Labor expenses

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

The benefits budget is developed line by line (health, dental, life, vacation, retirement, etc.) based on the number of FTEs in the budget, plus projected household members who will also be covered by UVMHN 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 FY24 budget, the labor expense inflation factor for UVMMC is 6.4% (driving the higher than benchmark increases at UVMMC are an 11% increase for the new resident union contract and a 14% increase for the new tech union contract), CVMC 4.7% and PMC 3.9%.

Total compensation inflation for Civilian Workers in Hospitals from the Bureau of Labor Statistics (BLS) from October 2021 to October 2022 was 5.4%. From October 2022 to March 2023, it was 2.5%. Annualizing that six month figure generates an October 2022 to October 2023 rate of 5.0%. For general compensation inflation, the BLS is projecting 5.2% for 2024.

ii. Utilization

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

The best source of utilization data of which we are aware is the Dartmouth Atlas. The Atlas is considered the gold standard for assessing differences in population-based use of health care services, as the data are adjusted for price, age, sex and race.

As the Dartmouth Atlas states, "Medicare spending varies more than twofold among hospital referral regions. Spending also varies from state to state, and from one hospital to another, even among hospitals within the same region. Most of this variation is not due to differences in the price of care in different parts of the country, but rather to differences in the volume, or the amount of inpatient care delivered per patient."[16] While the Atlas only includes Medicare data, it is widely assumed that the differences revealed in the data reflect overall differences in practice patterns from region to region across all patient populations. Additionally, the Medicare population has an out-sized impact on overall utilization patterns, given their higher health care needs relative to Medicaid and commercially-insured populations. The most recently available Dartmouth Atlas data are from 2019.

Vermont is the lowest cost state in the nation per Medicare beneficiary, according to the Atlas. The Burlington hospital referral region (HRR), which reflects the service territory of the UVM Health Network, likewise is the lowest-cost HRR in the country. The three HSAs that are served by our three Vermont community hospitals rank first (Middlebury), third (Burlington) and fifth (Berlin) lowest in the country for Medicare reimbursements per beneficiary.

Another measure of utilization included in the Dartmouth Atlas is hospital utilization per Medicare beneficiary. Our HRR ranks among the lowest nationally for surgical discharges and also relatively low for medical discharges.

iii. Pharmaceutical expenses

October to January is used as the base, and from there adjustments are made for known volume changes and planned introduction of new drugs. Adjustments for new drugs that typically have a material impact on the budget are for chemotherapy treatments. From this FY24 base amount, inflation factors are then applied.

In the FY24 budget, the inflation factor for pharmaceuticals is 4%. Pharmaceutical inflation from the BLS Producer Price Index from October 2021 to October 2022 was 2.2%. From October 2022 to April 2023, it was 2.5%. Annualizing that six month figure generates an October 2022 to October 2023 rate of 5.0%. The BLS does not provide projections, but Vizient is projecting 3.8% for July 2022 to July 2023. We have added 0.2% to this projection to account for the expected continued inflation through the end of FY24 (July to September).

iv. Cost inflation

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

[16] https://www.dartmouthatlas.org

contracts, leases, utilities and insurance.

For medical/surgical supplies, the inflation factor we are using in the FY24 budget is 3.5%. Medical/surgical inflation from the BLS Producer Price Index from October 2021 to October 2022 was 3.0%. From October 2022 to April 2023, it was 1.6%. Annualizing that six month figure generates an October 2022 to October 2023 rate of 3.2%. The BLS does not provide projections, but Vizient is projecting 3.3% for July 20222 to July 2023. We have added 0.2% to this projection to account for the expected continued inflation through the end of FY24 (July to September).

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. This is the 2024 general inflation rate projected by several sources.[17]

The expense inflation for retail pharmaceuticals is 7%. 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.

It is important to recognize the FY22 and year-to-date FY23 cost inflation is currently exceeding the FY23 approved rate increases. The health care industry has continued to bear the burden of the lingering effects of unprecedented cost inflation in FY22 and year-to-date FY23. In the FY22 and FY23 budget process, requests were made to adjust commercial rates to address the extraordinary negative financial impacts of cost inflation and workforce challenges that affected hospital cost structures.

In the FY23 budget rate request, there was a component of the FY23 rates which were attributed to FY22 cost inflation that was above the approved mid-year rate request. In preforming a year-end reconciliation of actual FY22 cost inflation and FY23 rate changes, there is still $47.6M of unfunded FY22 cost inflation for UVMMC and $10.7M for CVMC. When comparing FY23 year-to-date May actual to FY23 budgeted cost inflation, FY23 year-to-date annualized actual cost inflation is exceeding budget for UVMMC by $23.3M and $8.0M for CVMC. When combining FY22 year-end and FY23 year-to-date unfunded cost inflation, the aggregate impact on UVMMC is $70.9M and $18.7M on CVMC.

These are very large amounts that are having a significant impact on financial performance and cash reserves. It is essential to understand that none of these amounts were factored into the FY24 budget rates, and that any changes to those requested rates would further add to the unfunded cost inflation hospitals are already burdened with, and will further negatively impact financial performance and cash reserves.

[17] Inflation Rate Forecast 2023/2024 (tradingeconomics.com)

	FY22 Budget	FY22 Actual	FY22 Add'l Cost Inflation Above Budget	FY23 Budget	FY23 YTD May Actual	FY23 Add'l Cost Inflation Above Budget	Total FY22 & FY23 Uncovered Cost Inflation
UVMMC							
Avg Sal per FTE	$ 98,560	$ 111,395	$ 90,200,501	$ 111,870	$ 115,445	$ 25,530,163	
Med/Surg as % of In/Out Rev	4.12%	4.20%	$ 2,191,044	3.90%	3.91%	$ 272,779	
Pharm as % of In/Out Rev	3.40%	3.73%	$ 9,564,491	3.52%	3.44%	$ (2,472,583)	
Total			**$ 101,956,035**			**$ 23,330,358**	
FY22 Cost Inflation in FY23 Rates							
FY23 Budget Process			$66,109,926				
Payer Change			($11,800,000)				
FY22 Add'l Cost inflation in FY23 Rates			**$ 54,309,926**				
Total Uncovered Cost Inflation			**$ 47,646,109**			**$ 23,330,358**	**$ 70,976,467**
CVMC							
Avg Sal per FTE	$ 93,507	$ 105,265	$ 15,405,738	$ 100,519	$ 107,765	$ 9,353,878	
Med/Surg as % of In/Out Rev	2.97%	3.31%	$ 1,393,258	3.10%	3.29%	$ 901,818	
Pharm as % of In/Out Rev	6.00%	5.78%	$ (874,981)	5.57%	5.08%	$ (2,288,115)	
Total			**$ 15,924,014**			**$ 7,967,581**	
FY22 Cost Inflation in FY23 Rates							
FY23 Budget Process			$6,809,332				
Payer Change			($1,600,000)				
FY22 Add'l Cost inflation in FY23 Rates			**$ 5,209,332**				
Total Uncovered Cost Inflation			**$ 10,714,682**			**$ 7,967,581**	**$ 18,682,263**

v. Commercial price changes

Below are the detailed calculations for our commercial price increases that were highlighted above. We have included this detailed calculation in our budget submission for several years. The calculation clearly shows the link between annual expense inflation and the required patient revenue rate increase to keep pace with that cost inflation. It clearly shows that the cost shift is real. If you have a payer that does not increase their rates to keep pace with cost inflation, then others have to make up the difference.

UVMMC	FY2024 Cost Inflation
Total Cost Inflation	$105,184,805
Less Retail Pharmacy	($11,125,922)
Net Cost Inflation for Commercial Rate Calc	**$94,058,883**
Less:	
FY2024 - Medicare Rate Increase	$9,081,815
FY2024 - Medicare ACO Rate Increase	$5,692,377
FY2024 - Medicaid Rate Increase	($121,437)
FY2024 - Other Payer Changes	($4,097,796)
Impact on Bad Debt/Charity/Denials Calculation	($5,483,592)
Sub-Total	**$5,071,367**
Required Funding from Commercial Rate	**$88,987,516**
Per 1 % Impact of Commercial Rate:	
Budget Year (9 months: Jan-Sept)	$6,503,624
Commercial Rate Increase in FY2024 Budget	**13.68%**
Additional Adjustments not yet in FY2024 Budget	
Medicaid Professional Rate Increases for Specialty & Primary Care	$1,512,995
Adjusted Funding from Commercial Rate	$87,474,521
Adjusted Commercial Rate after Add'l Medicaid changes	**13.45%**

CVMC	FY2024 Cost Inflation
Total Cost Inflation	$11,399,391
Less Retail Pharmacy	$0
Net Cost Inflation for Commercial Rate Calc	**$11,399,391**
Less:	
FY2024 - Medicare Rate Increase	($65,513)
FY2024 - Medicare ACO Rate Increase	$2,300,014
FY2024 - Medicaid Rate Increase	$240,819
FY2024 - Other Payer Changes	($207,522)
Impact on Bad Debt/Charity/Denials Calculation	($917,051)
Sub-Total	**$1,350,747**
Required Funding from Commercial Rate	**$10,048,644**
Per 1 % Impact of Commercial Rate:	
Budget Year (9 months: Jan-Sept)	$886,191
Commercial Rate Increase in FY2024 Budget	**11.34%**
Additional Adjustments not yet in FY2024 Budget	
Medicaid Professional Rate Increases for Specialty & Primary Care	$346,166
Adjusted Funding from Commercial Rate	$9,702,478
Adjusted Commercial Rate after Add'l Medicaid changes	**10.95%**

PMC	FY2024 Cost Inflation
Total Cost Inflation	$4,079,059
Less Retail Pharmacy	$0
Net Cost Inflation for Commercial Rate Calc	**$4,079,059**
Less:	
FY2024 - Medicare Rate Increase	$647,310
FY2024 - Medicare ACO Rate Increase	$1,106,745
FY2024 - Medicaid Rate Increase	$7,747
FY2024 - Other Payer Changes	($288,633)
Impact on Bad Debt/Charity/Denials Calculation	($142,738)
Sub-Total	**$1,330,432**
Required Funding from Commercial Rate	**$2,748,627**
Per 1 % Impact of Commercial Rate:	
Budget Year (9 months: Jan-Sept)	$357,687
Commercial Rate Increase in FY2024 Budget	**7.68%**
Additional Adjustments not yet in FY2024 Budget	
Medicaid Professional Rate Increases for Specialty & Primary Care	$295,637
Adjusted Funding from Commercial Rate	$2,452,990
Adjusted Commercial Rate after Add'l Medicaid changes	**6.86%**

vi. Financial indicators

As we have shared in the last several budget submissions, our five year financial framework uses rating agency A medians (S&P, Fitch and Moody's) to establish financial metric targets that represent a financially stable health care organization. We have laid out the rationale for why that is the case, and how each financial metric works in concert with one another to create that stability.

The Kaufman Hall National Flash Reports were cited in the Board's budget guidance as a source to measure financial metrics against, but the Flash Reports are a reflection of the current state of the health care industry. The Flash Reports do not indicate where metrics *should* be to be considered a financially stable organization (A rating or above). The January 2023 Kaufman Hall Flash Report highlighted that national health care margins were slightly below break-even between October 2022 to December 2022, that revenues were up by 2%, but that expenses were over by 7% during that same time period. We did not find financial metric benchmarks on the sites of the other two sources, Cecil G. Sheps Center at the University of North Carolina and

Flex Monitoring Team.

Using the rating agency A medians to establish our targets, below is how our FY24 budgeted metrics (UVMHN in total) compare. The comparisons indicate that we are budgeting to be at the floor or below all metric targets in FY24. It is not until FY26 to FY27 that we project to be at target operating margin levels. Days cash on hand is not projected to be at target until after FY27, and average age of plant is projected to grow from FY24 through FY27, demonstrating a need to increase our investments in those years in order to maintain modern systems, equipment and facilities. Our projections indicate we will have some debt capacity in FY27, which could potentially be available to increase our investments and decrease our average age of plant.

The major takeaway we hope this framework highlights is that our FY24 budget is only a small first step at rebuilding our finances to be on the solid financial footing needed to support our communities and region.

	Actual		Projections					Performance Targets		
	FY21	FY22	FY23	FY24	FY25	FY26	FY27	Floor	Mid	Upper
Profitability Ratios										
Operating Margin	1.1%	(3.3%)	1.4%	2.6%	3.3%	3.5%	4.1%	2.5%	3.3%	4.0%
Operating EBIDA Margin	5.7%	1.1%	5.4%	6.8%	7.6%	7.9%	8.4%	7.0%	8.0%	9.0%
Capital Structure Ratio										
Long Term Debt to Capitalization	33.4%	35.9%	36.7%	38.0%	34.6%	36.4%	32.8%	40.0%	35.0%	30.0%
Liquidity Ratio										
Days Cash on Hand	179.5	115.4	122.9	132.7	132.7	160.0	169.1	150.0	175.0	200.0
Other Ratio										
Average Age of Plant	12.2	11.6	12.7	12.4	12.8	13.3	13.7	13.0	12.0	11.0

vii. Known pricing changes for Medicare and Medicaid

The known increases we have built into our FY24 budget are:

	UVMMC		CVMC		PMC	
	%	$	%	$	%	$
Medicare						
Inpatient Rates	5.1%	$ 10,808,467	3.1%	$ 1,301,463	5.0%	$ 416,970
Outpatient Rates	-1.5%	$ (2,529,321)	-4.8%	$ (1,599,841)	0.5%	$ 129,324
Professional Rates	1.5%	$ 802,670	1.5%	$ 170,743	1.5%	$ 32,359
SNF Rates	0.0%	$ -	1.0%	$ 62,122	0.0%	$ -
Swing Bed Rates	0.0%	$ -	0.0%	$ -	1.7%	$ 68,658
OCV Shared Savings		$ 5,692,377		$ 2,300,014		$ 1,106,745
Total		$ 14,774,193		$ 2,234,501		$ 1,754,056
Medicaid						
Inpatient Rates	-0.9%	$ (74,050)	0.0%	$ (653)	0.0%	$ (188)
Outpatient Rates	-0.9%	$ (47,475)	-0.4%	$ (3,743)	0.0%	$ (562)
Professional Rates	2.3%	$ 1,513,083	7.0%	$ 346,166	7.2%	$ 295,637
SNF Rates	0.0%	$ -	2.3%	$ 245,215	0.0%	$ -
Swing Bed Rates	0.0%	$ -	0.0%	$ -	3.0%	$ 8,498
Total		$ 1,391,558		$ 586,985		$ 303,385

viii. Uncompensated care

Below is a chart showing the bad debt and charity rates for the last six years. We did not project a material change in these rates for the FY24 budget related to the Medicaid redeterminations. Our assumption is that the majority of patients that no longer qualify for Medicaid will seek coverage on the health insurance exchange. As a result, we have budgeted a payer mix shift from Medicaid to commercial insurance that increases revenue at UVMMC by $11.4M, at CVMC $1.4M and PMC $400K.

Bad debt rates were higher in FY22 for CVMC and PMC due to the transition to the new Epic revenue cycle system, and the need to write-off older balances. Also affecting all three organizations are more customer service friendly payment mechanisms introduced in FY23 making it easier for patients to pay their balance.

	Bad Debt % of Gross Charge						Charity % of Gross Charge					
	FY19 Actual	FY20 Actual	FY21 Actual	FY22 Actual	FY23 YTD Jan Annualized	FY24 Budget	FY19 Actual	FY20 Actual	FY21 Actual	FY22 Actual	FY23 Jan Annualized	FY24 Budget
UVMMC	1.13%	1.04%	0.82%	1.02%	0.67%	0.74%	0.63%	0.67%	0.43%	0.51%	0.37%	0.39%
CVMC	1.34%	1.48%	1.34%	1.45%	0.95%	0.97%	1.08%	0.66%	0.51%	0.40%	0.36%	0.49%
PMC	2.49%	2.80%	2.10%	2.82%	0.96%	0.91%	0.83%	0.53%	0.54%	0.75%	0.53%	0.54%

c. Briefly summarize known risks in the budget as submitted and indicate how the risks are being addressed. Include the cost, any realized benefit, and descriptions of new or ongoing measures used to reduce or otherwise manage budgeted expenses. Understanding the dollars associated with efforts to decrease or slow the increase in specific categories of expenditures is most helpful in understanding implications for the proposed budget.

The primary budget risks for UVMMC, CVMC and PMC are commercial rate increase, 340B contract revenue, continued wage pressures, traveler FTEs and traveler payment rates. Below is detail on each risk, and potential opportunities we have not accounted for in our FY24 budget from the many initiatives we are currently and planning to pursue, in an effort to continue to improve our finances, access to the services we provide, and the quality of those services.

Commercial Rate Increase

Each year, the most consequential component of the GMCB budget process comes down to the commercial rate increase. It is the same this year. We have clearly laid out in full transparency for the last several years how our commercial rate request is calculated, and why it is so important to being able to continue providing the high quality care that our communities and region rely on. Even if the commercial rate is approved, and we successfully negotiate the increase with our payers, there is still a risk the increased revenue will not materialize. That is due to commercial payers having significantly increased their efforts in the past year to not pay us what we are owed. This takes the form of new policies, policy changes, and prior authorization changes. Even when we have done everything correctly according to the policy or prior authorization requirements, the volume of claims that payers have not paid us correctly has been rising. We are able to identify these discrepancies through our underpayment module in Epic. In addition to the rise in the number, incorrectly paid claims are taking longer to resolve.

340B Contract Pharmacy Revenue

The pharmaceutical industry has continued their attack on the 340B program. Their primary focus the last few years to pull dollars out of the health care system, back to their shareholders and others who benefit from the massive profits they generate, has been on contract pharmacy arrangements. These arrangements are where a health care provider's patient has their prescription filled at a local pharmacy that the provider has a contract with to supply the drug. For a growing list of drugs, manufacturers are refusing to sell those drugs to health care providers at the 340B program rate. Last year drug manufactures stated that if providers supplied them with de-identified script level transaction data, they would resume providing drugs at 340B rates for contract pharmacy arrangements. As a result, we began supplying that data, as many health systems did, and the drug manufacturers reinstated 340B rates, but only for a short period. This year the drug manufactures have gone back on that commitment, and our contract pharmacy revenue, which is a key resource we rely on to provide access to care, has continued to deteriorate.

Traveler FTEs and Rates

Below are charts showing where we currently stand on traveler FTEs and payment rates, what we are projecting for FY23 year-end, and what we are budgeting for FY24. We are feeling confident in our assumptions for traveler rates. As you can see in the chart, unless there is an

unexpected event that drives up demand, we do not have very far to go to get to the rates we have in our FY24 budget. Our traveler FTE assumptions, however, carry more risk. Our recruitment and retention efforts, which have included pipeline programs, salary increases, retention payments, housing support and engagement initiatives have definitely created a downward trend on our utilization of travelers. In addition, we have over 150 new graduate nurses who will be through their orientation period by the end of CY23. Even with these positive trends, if we lose more staff through retirement and job changes, or if volumes exceed expectations and ability to recruit, then the traveler FTE target will not materialize.

	FY23 Year-End Projected								FY24 Assumptions			
	Actual	Projected					Apr to Sept		FY24	Sept FY24	Sept 23 to Sept	
	April	May	June	July	Aug	Sept	Change		Budget	Target	24 Change	
UVMMC	377	365	345	325	305	**283**	-94	-25%	**256**	**229**	-54	-19%
CVMC	120	120	115	115	110	**108**	-12	-10%	**75**	**42**	-66	-61%
PMC	75	75	72	72	70	**67**	-7	-10%	**43**	**20**	-48	-71%

	FY23 Year-End Projected								FY24 Assumptions		
	Actual	Projected					Apr to Sept		FY2024	Sept 23 to Sept	
	April	May	June	July	Aug	Sept	Change		Budget	24 Change	
UVMMC	$121	$129	$125	$120	$115	**$105**	($16)	-13%	**$105**	$0	0%
CVMC	$125	$121	$115	$115	$110	**$105**	($20)	-16%	**$105**	$0	0%
PMC	$109	$114	$114	$114	$114	**$114**	$5	5%	**$114**	$0	0%

Opportunities to Offset Risk

As we shared in last year's budget narrative, in May 2022 we launched our 12 workstreams, a number of which were aimed at offsetting a large variance in our traveler FTE assumption. In FY23, we have made significant progress at working through surgical, radiology and office visit patient backlogs, we are significantly under what we budgeted for administrative shared services, and we have made strides at improving our revenue cycle operation. Looking ahead to FY24, the work continues for some of our workstreams, which combined with other pursuits, present an opportunity to do better than what we have budgeted in FY24. Those opportunities include:

- It is possible we could exceed the LOS target at UVMMC. We have put a tremendous amount of focus on this area, including having a consultant (ECG) support our efforts. Recent data shows we are starting to have an impact at discharging patients sooner. If post-acute capacity in our region increases, that combined with our continued efforts would produce better than budgeted results.

- Even though we have had success at reducing administrative costs as a percentage of our total revenue, there is more opportunity. As a Network, we are now close to all being on the same systems (EHR – Epic, Human Resources/Payroll – Workday, and General Ledger – Premier Connect). That standardization of systems creates economies of scale. In addition, these systems are constantly being optimized to improve workflows and efficiency. Beyond our core systems, other technologies creating opportunities for more

efficient delivery of administrative services are robotic process automation (RPA) and artificial intelligence (AI). We purchased an RPA system called BluePrism three years ago, and created an internal team of bot builders to automate processes. This year we are planning to expand into AI, and have begun evaluating a company that specializes in health care. These technologies should continue to reduce our administrative costs.

- We will continue to work with our payers and legislators to reduce the administrative burden of being paid appropriately for the services we provide. There is a tremendous amount of non-value added cost in the health care system – for both providers and payers – tied up in these processes.

- We will continue pursuing one-time funds to help replenish our depleted reserves, such as additional FEMA grants and an employee retention credit.

d. Provide an up-to-date chart or graphic outlining the corporate structure associated with the hospital.

For ease of readability, please click here for our organizational chart.

e. For any referrals or appointments requested in the first two weeks of May 2023, report the following metrics separately for each hospital-owned primary and specialty care practice as well as the top five most frequent imaging procedures:

1. Referral lag, the percentage of appointments scheduled within 3 business days of referral (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), and

2. Visit lag, the percentage of new patient appointments scheduled for the patient to be seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received or the date the patient will be seen.)

If you are unable to report these metrics, explain what is preventing the calculation and when you will be able to report them. In their place, provide the third next available appointment for practices and imaging procedures identified above along with those for comparable hospitals or other industry benchmarks.

For ease of readability, please click here for referral lag data for UVMMC, CVMC and PMC. Please click here for visit lag data for UVMMC, CVMC and PMC.

Radiology

The process of protocolling and preauthorization of exams prior to scheduling ensures that the studies are appropriate and are properly scheduled. Once confirmed, schedulers reach out to

patients to find the best time. This contributes to longer lead times in the scheduling process, but ultimately shorter wait times for appointments by eliminating the need for rescheduling or obtaining new authorizations for studies that were incorrectly ordered. These data sets represent outpatients scheduled for routine studies. Stat and urgent studies are accommodated same day.

UVM Medical Center

Service Area	Imaging Procedure	%Scheduled within 3 days	%Appts within 14 days of scheduled	%Appts within 30 days of scheduled	%Appts within 60 days of scheduled	%Appts within 90 days of scheduled	%Appts within 180 days of scheduled
UVM MEDICAL CENTER SERVICE AREA	CT ABDOMEN PELVIS WITH CONTRAST	58.28%	57.06%	73.01%	100%	100.00%	100.00%
UVM MEDICAL CENTER SERVICE AREA	CT CHEST WITH CONTRAST	61.27%	52.82%	69.72%	100.00%	100.00%	100.00%
UVM MEDICAL CENTER SERVICE AREA	CT HEAD WO CONTRAST	56.25%	52.08%	79.17%	100.00%	100.00%	100.00%
UVM MEDICAL CENTER SERVICE AREA	MR HEAD WITH AND WITHOUT CONTRAST	55.41%	31.76%	86.49%	98.65%	98.65%	100.00%
UVM MEDICAL CENTER SERVICE AREA	US ABDOMEN LIMITED	53.74%	93.39%	98.24%	100.00%	100.00%	100.00%

Inpatients and ED patients are not included in this data set which are performed as ordered – same day. Of note, for the first two weeks of May, ED and inpatient CT scans accounted for 62% of the total volume for CT, with 38% accounted for outpatient scans.

Central Vermont Medical Center

Service Area	Imaging Procedure	% Scheduled within 3 days	% Appts within 14 days of scheduled	% Appts within 30 days of scheduled	% Appts within 60 days of scheduled	% Appts within 90 days of scheduled	% Appts within 180 days of scheduled
CENTRAL VERMONT MEDICAL CENTER	CT ABDOMEN PELVIS WITH CONTRAST	47.83%	47.83%	100.00%	100.00%	100.00%	100.00%
CENTRAL VERMONT MEDICAL CENTER	CT CHEST WITH CONTRAST	45.83%	41.67%	89.83%	100.00%	100.00%	100.00%
CENTRAL VERMONT MEDICAL CENTER	CT HEAD WO CONTRAST	22.22%	51.85%	100.00%	100.00%	100.00%	100.00%
CENTRAL VERMONT MEDICAL CENTER S	MR HEAD WO AND WITH CONTRAST	50%	40%	50.00%	100.00%	100.00%	100.00%
CENTRAL VERMONT MEDICAL CENTER	US ABDOMEN LIMITED	75%	73.61%	24.00%	100.00%	100.00%	100.00%

Inpatients and ED patients are not included in this data set which are performed as ordered – same day. Of note, for the first two weeks of May, ED and inpatient CT scans accounted for 55% of the total volume for CT, with 45% accounted for outpatient scans.

Porter Medical Center

Service Area	Imaging Procedure	%Scheduled within 3 days	%Appts within 14 days of scheduled	%Appts within 30 days of scheduled	%Appts within 60 days of scheduled	%Appts within 90 days of scheduled	%Appts within 180 days of scheduled
PORTER MEDICAL CENTER SERVICE AREA	CT ABDOMEN PELVIS WITH CONTRAST	38.30%	78.72%	100.00%	100.00%	100.00%	100.00%
PORTER MEDICAL CENTER SERVICE AREA	CT CHEST WITH CONTRAST	24.00%	68.00%	100.00%	100.00%	100.00%	100.00%
PORTER MEDICAL CENTER SERVICE AREA	CT HEAD WO CONTRAST	75.00%	50.00%	100.00%	100.00%	100.00%	100.00%
PORTER MEDICAL CENTER SERVICE AREA	MR HEAD WITHOUT AND WITH CONTRAST	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%
PORTER MEDICAL CENTER SERVICE AREA	US ABDOMEN LIMITED	76.32%	36.84%	94.74%	100.00%	100.00%	100.00%

Inpatients and ED patients are not included in this data set which are performed as ordered – same day. Of note, for the first two weeks of May, ED and inpatient CT scans accounted for 70% of the total volume for CT, with 30% accounted for outpatient scans.

f. Provide a summary of planned capital expenditures for FY24, including a description of their funding source(s). If relevant, indicate how the pandemic relates to these expenditures, such as deferred projects or new associated needs.

The UVMHN annual and five year capital budget allocation is calculated in conjunction with the development of the larger Network financial framework, and is broken down into two major areas of focus – routine capital and major capital. These budgets are primarily developed using a five year outlook, with annual totals varying from year to year based on the timing of strategic investments and infrastructure/equipment needs. The Network's current five year capital framework target is approximately $666M for FY23-FY27. This includes capital investment for all organizations of the Network. The projected capital amount for FY24 is estimated at $135M for the Vermont hospitals. It is anticipated we will be going to the public market for debt issuance in the range of $150M in FY24 to fund a couple major projects. The majority of the financing would be used to fund a new outpatient surgery center which is currently in the CON review process.

Available capital spend is directly tied to meeting financial objectives set through the financial framework. The Network instituted a rigorous capital approval oversight process to preserve cash, which limited capital spend to break/fix items only, as well as projects that provide a high return on investment and projects of significant strategic value.

The consequence of the Network not meeting necessary financial targets is that planned capital spend had to be significantly reduced. Over the last 36 months, approximately $120M of planned capital spend has had to be eliminated. This is clearly evident when looking at our capital spend as a percentage of depreciation: FY21 68%, FY22 78%, and FY23 projected at 78%. Hospital benchmarks for capital spend as a percentage of deprecation usually average around 125%. This capital reduction has caused the partner hospitals of the UVM Health Network to delay many necessary equipment replacement and infrastructure projects. Given this, as we navigate this fiscal year, we will be placed in the very difficult position of choosing between and prioritizing necessary and overdue equipment and infrastructure replacements. As we maneuver through this prioritization process, the equipment and project list could change.

We continue to work on key long range facility planning, including both ambulatory and inpatient bed planning. Concurrently, UVMHN remains committed to improving both inpatient and outpatient access to mental health services by fulfilling our commitment to invest in mental health priorities. These projects have recently been outlined in our proposal to the Board dated May 31.

The list below provides an overview of potential major equipment and major strategic investments planned for FY24. Additional detail on capital projects exceeding $500K during the next five fiscal years will be available by August 1. Please note that the below table represents our FY24 framework, which guides our budget development. Actual capital spend for FY24 may differ from this framework for various reasons, such as financial performance, changes in project priorities, projects which bridge multiple fiscal years, and timing of CON approvals. However, in sum, the expectation is to manage within the financial framework totals. The financial framework is updated annually to keep projections as current as possible.

Major Replacement Projects with Expected FY24 Capital	Major Strategic Projects with Expected FY24 Capital
UVMMC	**UVMMC**
IT Infrastructure	350 Tilley Drive Purchase/Fit-up
Microbiology System	Regional Mental Health Investments
Radiology (CT, Mammo, Interventional X-ray)	Outpatient Surgery Center (Pending CON Approval)
Hybrid OR	UVM Cancer Center Investments
Cath Lab	Fanny Allen Purchase
CVMC	**CVMC**
Mammography	Regional Mental Health Investments
Stormwater Upgrades	Primary Care Investments
PMC	**PMC**
Mammography	Helen Porter Nursing Upgrades
	Musculoskeletal Clinic

g. Describe planned expenditures related to cybersecurity.

While the Green Mountain Care Board's focus is Vermont, the UVM Health Network now operates many of its departments, including IT, as a shared service for the full Network spanning Vermont and New York. The Network's total IT spend in the FY24 budget is $155.6M.

For FY24, the Network is budgeting approximately $6.8M for direct cybersecurity expenditures. This budget represents the people, technologies and services with a core value of identifying, detecting, preventing and responding to cyber threats to the Network. These investments, both new and ongoing, cover a broad range of threats, including: social engineering, ransomware, attacks against medical devices and accidental or malicious data loss. The control areas covered by the cybersecurity budget include endpoint security, email security, internet security, identity and access management, threat and vulnerability management, risk and compliance management and incident response capabilities.

Beyond the direct cybersecurity budget, the UVM Health Network IT infrastructure budget represents investments in people, technologies and services that provide the underlying technology architecture that supports the Network's digital services. The cybersecurity architecture is inseparable from the infrastructure architecture, as networking investments provide security segmentation capabilities, availability and recovery investments provide incident response capabilities, and systems investments provide security configuration and vulnerability management capabilities. As such, the approximately $54M budgeted in FY24 for the UVM Health Network IT infrastructure should also be considered directly related to cybersecurity.

Indirectly related cybersecurity spending can also be found throughout the remainder of the approximately $148M total IT budget, in the form of maintenance contracts and application upgrade expenditures. A primary source of cyber risk for the organization comes from the presence of technical vulnerabilities in software used to the run the business. UVM Health Network's software vendors are responsible for delivering software "patches" and updates to address these vulnerabilities when discovered. Software vendors will only provide security updates when the Network has an active maintenance contract and is running a current version of the application. Software vendors will not invest the resources in correcting software vulnerabilities in older versions of their products. As a result, UVM Health Network must continue to invest in keeping all applications current to avoid increased threat exposure and cyber risk.

UVM Health Network is carrying a budget in FY24 for 19 FTEs working directly in Cybersecurity Engineering, Cybersecurity Operations, Cyber Risk Management and Identity Governance. These resources have the primary responsibility of understanding the cyber threats and risks to the organization, designing and implementing the controls to combat those risks, operating and monitoring those controls and responding to threats when they materialize. Additionally, every member of the approximately 450 total budgeted IT FTEs for the UVM Health Network plays a role in the cybersecurity of the organization. Implementing cybersecurity controls requires broad cross-functional initiatives consuming resource capacity across the IT

application and infrastructure departments, and all members of IT are active participants in the identification of and response to threats and risks to the organization.

	UVMHN Information Security
FTEs	19.0
Salaries, Payroll Taxes, and Fringe Benefits	$ 2,785,252
Medical and Surgical Supplies	$ -
Nutrition Supplies	$ -
Other Supplies	$ -
Purchased Services	$ 62,071
Software and IT Maintenance Fees	$ 3,861,807
Facility and Equip Maintenance and Repairs	$ -
Lease and Rental	$ -
Utilities	$ 14,832
Other Expenses	$ 29,544
Depreciation and Amortization	$ -
Interest Expense	$ -
Internal Expense Allocation	$ -
Total Expenses	**$ 6,753,506**

h. Indicate the estimated annual expenditures associated with providing care that cannot be reimbursed due to the inability to transfer patients to post-acute or other more appropriate care settings. Examples include stays that exceed length of stay requirements for reimbursement or other care that would not generally be provided in a hospital setting. Provide these estimates for as many fiscal years as possible, including the estimates for FYs 23 and 24. Indicate how the values are derived or otherwise estimated. How are these unreimbursed expenses captured in the proposed budget? Include an estimate of how many boarding episodes occurred in your Emergency Department for that period, the associated total patient days and charges, and the proportion of each associated with a primary diagnosis related to mental health.

Below is a chart with the estimated amount of uncompensated inpatient care that has been provided at UVMMC and CVMC in FY22, FY23 and in the FY24 budget, due to the inability to transfer patients to post-acute or other more appropriate care settings. The calculation is based on the expected LOS from our Vizient database, adjusted for payer mix. The calculation then assumes we are not receiving reimbursement for the portion of the patient stay that extends beyond the expected LOS, for insurance plans that reimburse on a DRG basis. PMC is not included because their cost plus 1% reimbursement mechanism as a Critical Access Hospital does not generate a large amount of uncompensated inpatient care due to this factor. The lack of compensation is compounded by the fact that so much of our reliance on travelers is driven by the increased number of hard-to-discharge patients.

	FY22 Actual								
	Actual ALOS	Vizient Expected ALOS	Actual Avg Daily Census	Expected Avg Daily Census	Uncomped Annual Days	Adjustment for Non-DRG Payment	Adjusted Uncomped Annual Days	Avg Direct Cost per Day	Uncomped Care $$
UVMMC	6.42	5.20	399	323	27,661	15%	23,512	$ 2,222	$ 52,243,566
CVMC	5.16	4.13	59	48	4,331	15%	3,681	$ 1,962	$ 7,222,127
								Total	**$ 59,465,693**

	FY23 YTD May Annualized								
	Actual ALOS	Vizient Expected ALOS	Actual Avg Daily Census	Expected Avg Daily Census	Uncomped Annual Days	Adjustment for Non-DRG Payment	Adjusted Uncomped Annual Days	Avg Direct Cost per Day	Uncomped Care $$
UVMMC	6.59	5.20	409	323	31,471	15%	26,750	$ 2,222	$ 59,439,581
CVMC	4.89	4.13	56	48	3,198	15%	2,718	$ 1,962	$ 5,333,407
								Total	**$ 64,772,988**

	FY24 Budget								
	Actual ALOS	Vizient Expected ALOS	Actual Avg Daily Census	Expected Avg Daily Census	Uncomped Annual Days	Adjustment for Non-DRG Payment	Adjusted Uncomped Annual Days	Avg Direct Cost per Day	Uncomped Care $$
UVMMC	6.35	5.20	400	328	26,470	15%	22,499	$ 2,222	$ 49,993,398
CVMC	5.05	4.13	62	51	4,141	15%	3,520	$ 1,962	$ 6,906,405
								Total	**$ 56,899,803**

Also below is a chart showing the cost of ED boarders at UVMMC, CVMC and PMC for FY23. We do not specifically budget for ED boarders, but since we use the current year run rate (October to January) as the starting point for building our budget, the FY24 budget assumes our FY23 experience will continue.

	FY23 Actual			
	Avg Daily ED MH Borders	Avg Annual ED MH Border Days	Avg Direct Cost per Day	Total ED MH Border Cost
UVMMC	12	4,380	$ 761	$ 3,333,180
CVMC	2	730	$ 540	$ 394,200
PMC	1	365	$ 979	$ 357,335
				$ 4,084,715

Vermont Medicaid has adopted a per diem reimbursement rate intended to help offset the cost of ED boarders. Combined, our three Vermont hospitals expects to receive a total of $11,028 in FY23. Since the impact is measuring actual expense, Vermont ACO Medicaid reimbursement is not included in this projected offset.

i. How much revenue did the hospital net for reimbursements above cost for pharmaceuticals in FY22 actuals, FY23 projections, and in estimates used for the proposed budget? Include estimates for rebates associated with the 340B program. How does the hospital spend or otherwise account for the net revenue?

The vast majority of medical claims (Part A and Part B) are reimbursed on a per encounter basis, meaning the payment we receive is for all the services a patient received for that encounter. As a result, there is no way to specifically attribute the revenue that was received for a pharmaceutical billed on a medical claim. We are, however, able to specifically attribute pharmaceutical revenue billed on non-medical claims (Part D), which is reflected in the charts below.

	FY22 Actual	FY23 Budget	FY23 YTD April Annualized	FY24 Budget
UVMMC				
Net Revenue (In house Pharmacies)	$ 171,931,384	$ 208,578,245	$ 206,489,162	$ 239,718,997
Net Revenue (Contract Pharmacy)	$ 26,838,775	$ 32,179,806	$ 35,573,714	$ 34,783,802
Cost of Goods Sold (COGS)	$ (111,823,153)	$ (136,733,215)	$ (143,716,488)	$ (166,694,101)
Net Revenue less COGS	$ 86,947,006	$ 104,024,836	$ 98,346,387	$ 107,808,698
CVMC				
Net Revenue (In house Pharmacies)	$ -	$ -	$ -	$ -
Net Revenue (Contract Pharmacy)	$ 8,904,183	$ 10,453,677	$ 9,922,416	$ 9,448,975
COGS	$ -	$ -	$ -	$ -
Net Revenue less COGS	$ 8,904,183	$ 10,453,677	$ 9,922,416	$ 9,448,975
PMC				
Net Revenue (In house Pharmacies)	$ -	$ -	$ -	$ -
Net Revenue (Contract Pharmacy)	$ 1,510,708	$ 1,636,565	$ 1,371,369	$ 1,256,859
COGS	$ -	$ -	$ -	$ -
Net Revenue less COGS	$ 1,510,708	$ 1,636,565	$ 1,371,369	$ 1,256,859
Total				
Net Revenue (In house Pharmacies)	$ 171,931,384	$ 208,578,245	$ 206,489,162	$ 239,718,997
Net Revenue (Contract Pharmacy)	$ 37,253,666	$ 44,270,048	$ 46,867,498	$ 45,489,636
COGS	$ (111,823,153)	$ (136,733,215)	$ (143,716,488)	$ (166,694,101)
Net Revenue less COGS	$ 97,361,897	$ 116,115,078	$ 109,640,172	$ 118,514,532

Notes:
- Net revenue for in house pharmacies includes contra revenue accounts (340B revenue transferred to affiliates, DIR fees, Medicaid payback to State of Vermont, revenue from employee scripts transferred to HR for expense offset, and charity care).
- FY23 projection is only a calculation of YTD April results annualized.
- There are no 340B rebates included in these financials.

j. Facility Fees: Does your institution charge "facility fees" to patients who access your emergency department? Facility fees have been defined as "the cost of walking in the door" that are billed separately to cover overhead and other costs to provide care in addition to the charges for specific services received by the patient. If your institution charges facility fees, please provide an estimate of the total sum of facilities fees billed and collected in FY22.

When a patient receives clinical care in the Emergency Departments (ED) of UVMMC, CVMC or Porter, they are charged for the care provided, including clinical evaluation and any tests, procedures or treatments necessary. If a patient walks into the ED, is registered, but leaves before receiving clinical care, they are not charged.

Emergency Department Evaluation and Management (E&M) service procedure codes (CPT codes 99281-99285, definitions listed below) represent the overall services provided to the patient in the ED and do not include any additional tests or procedures the patient may require. E&M services are coded and billed at different complexity levels from 1 (least complex) to 5 (most complex) by professional coding staff based on clinical documentation, and represent the intensity of the hospital services and resources (nursing care, equipment, technology, etc.) required to appropriately stabilize and care for the patient while in the ED.

Hospitals must maintain the appropriate ED staffing levels and technical resources required to meet strict regulatory standards. Licensed EDs are required to remain open 24 hours a day, seven days a week, all year round. Compliance with the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to provide appropriate emergency triage, evaluation and stabilization to every patient arriving at the ED, regardless of their ability to pay.

Each Vermont hospital's charge for ED E&M care, CPT codes 99281-99285, is available on the Vermont Department of Health Act 53 report card, which can be found here: HSI-stats-HRC-2023-CPT-Table-ED.pdf (healthvermont.gov). This information is also available on each individual hospital's price transparency webpage.

The estimated total sum of hospital E&M codes 99281-99285 charges billed during FY22 for all patients, including those who were admitted as inpatient after evaluation and stabilization in the ED, was $122,581,672 (57,306 visits) at UVMMC, $18,841,290 (19,020 visits) at CVMC, and $8,228,066 (10,736 visits) at Porter Hospital. We are unable to provide the total sum of the payments collected on this subset of charges due to how we are reimbursed by our government and commercial payers. In the majority of cases, we are not reimbursed at an individual ED code level, but rather for the totality of the patient's clinical stay throughout the entirety of their episode of care (i.e. a case rate, an outpatient APC rate or an inpatient MS-DRG rate).

Please note that although we are unable to provide the total sum collected on this subset of FY22 charges for CPT codes 99281-99285, the amounts insurance companies are contracted to reimburse hospitals for these ED E&M codes can be found on each individual hospital's publically available price transparency file located on the hospital website. The full price transparency files for the UVM Health Network's Vermont hospitals can be accessed via the links below. A summary grid showing the FY23 charge and reimbursement for CPT codes 99281-99285 for UVMMC, CVMC, and Porter is pasted below the links.

Price Transparency | The University of Vermont Health Network (uvmhealth.org)

Price Transparency | Central Vermont Medical Center (cvmc.org)

Price Transparency - Porter Medical Center

American Medical Association CPT (Current Procedural Terminology) ED E&M codes and descriptions:

CPT Code	CPT/Charge Code Description
99281	HC - EMERGENCY DEPARTMENT VISIT LIMITED/MINOR PROB
99282	HC - EMERGENCY DEPARTMENT VISIT LOW/MODER SEVERITY
99283	HC - EMERGENCY DEPARTMENT VISIT MODERATE SEVERITY
99284	HC - EMERGENCY DEPARTMENT VISIT HIGH/URGENT SEVERITY
99285	HC - EMERGENCY DEPT VISIT HIGH SEVERITY&THREAT FUNCJ

University of Vermont Medical Center

CPT Code	FY23 Gross Charge	Minimum Commercial Payment Rate	Maximum Commercial Payment Rate	Medicare Payment Rate	Vermont Medicaid Payment Rate
99281	$ 437.44	$ 209.97	$ 393.70	$76.38	$ 61.57
99282	$ 813.92	$ 390.68	$ 999.42	$142.09	$ 114.55
99283	$ 1,178.24	$ 565.56	$ 1,406.38	$249.23	$ 200.92
99284	$ 1,854.03	$ 889.93	$ 3,401.47	$388.16	$ 312.92
99285	$ 3,339.68	$ 1,603.05	$ 5,494.96	$557.51	$ 449.45

Central Vermont Medical Center

CPT Code	FY23 Gross Charge	Minimum Commercial Payment Rate	Maximum Commercial Payment Rate	Medicare Payment Rate	Vermont Medicaid Payment Rate
99281	$269.39	$71.12	$475.00	$80.32	$61.57
99282	$473.77	$128.78	$1,025.00	$149.41	$114.55
99283	$705.14	$226.90	$3,153.00	$262.08	$200.92
99284	$1,220.12	$356.66	$3,515.00	$408.17	$312.92
99285	$1,576.65	$511.94	$3,515.00	$586.27	$449.45

Porter Hospital

CPT Code	FY23 Gross Charge	Minimum Commercial Payment Rate	Maximum Commercial Payment Rate	Medicare Payment Rate	Vermont Medicaid Payment Rate
99281	$190.00	$ 76.67	$ 183.86	$ 94.96	$ 61.57
99282	$243.00	$ 98.42	$ 235.15	$ 121.45	$ 114.55
99283	$407.00	$ 164.84	$ 393.85	$ 203.42	$ 200.92
99284	$841.00	$ 340.61	$ 813.84	$ 420.33	$ 312.92
99285	$1,271.00	$ 514.76	$ 1,229.95	$ 635.25	$ 449.45

k. Patient Financial Assistance:

i. Are patients given a financial assistance plan or policy with the first attempt to collect a debt?

Patients are offered a copy of our financial assistance policy (FAP) summary at time of arrival in all registration and check-in locations. Copies of the full policy are available upon request, and patients are counseled regarding financial assistance during pre-service financial clearance calls.

Our patient assistance policies and phone numbers are listed in multiple places online and in print, including our patient statements. We do not routinely discuss our patient financial assistance policies with the patient at the first attempt in the office setting for routine co-pay collection.

ii. 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.

We do not use a third party for self-pay collections. We do list patients with bad debt agencies after we have exhausted our internal self-pay efforts.

iii. At what point of non-collection does the hospital write off the money owed as bad debt?

Accounts are written-off as bad debt at the point that they are moved to the collection agency. Accounts are moved to the collection agency after there is no payment activity after four billing cycles, according to our credit and collections policy:

When billing statements, follow-up phone calls and mailed financial assistance applications fail to result in payment (and a minimum of 120 days have been exhausted), the aged account shall be sent to a third party collection agency for follow-up.

iv. What happens if a debt is collected outside of the allowed payment window? Does it show up as revision of the FY in which the services were provided or does it show up in some revenue line in the FY it was collected?

We would never go back and revise financial statements from a prior year, so it shows up as a reduction of bad debt or charity care in the year it was collected.

v. What, if any, effort does the hospital undertake to evaluate whether a patient can pay money owed to the hospital?

Financial screening for hardship assistance may begin prior to service as part of the financial clearance process. When identified, assistance with Medicaid and FAP is embedded in our pre-service calls.

We have several avenues for the patient to contact us and request financial aid.

vi. What, if any, effort does the hospital undertake to proactively evaluate whether a patient, prospective, current, or past, is eligible for the hospital's free care program?

The State of Vermont does not allow soft hits on credit scores. This limits our ability to proactively evaluate a patient's ability to qualify for programs, which includes presumptive eligibility.

Potential debt awareness begins prior to and concurrent with admissions. Patients may receive financial counseling as estimates and out-of-pocket expenses are calculated and/or a self-pay or underinsured patient is admitted to the hospital. Financial discussions include hardship identification, awareness of budget plans, alternate coverage such as Medicaid, and UVM Health Network financial assistance. Subsequently, our benefit advisors and advocates aid patients in the application process for programs where they would qualify.

We do attempt to contact patients without insurance prior to elective services to review our financial assistance programs.

vii. Please provide the quantitative and/or qualitative evidence the hospital used to determine the appropriate Federal Poverty Limit ranges used for free care eligibility.

A periodic review of regional academic medical centers/teaching hospitals is completed to assess Federal Poverty Level (FPL) levels and discounting. The most recent review from January 2023 is reflected below. Note: CVMC, PMC and UVMMC are currently finalizing policy changes and will be moving our 100% charitable grant from 200 to 250% FPL. Additionally, we review cases exceeding 400% FPL to identify patterns indicating we should consider increasing this level, and have yet to find volume or a need to proactively increase beyond 400% FPL. Our policy, however, supports an appeals process for all cases exceeding 400% FPL where a multi-disciplinary team assesses these cases along with supporting hardship documentation and may choose to grant varying levels of assistance based upon the circumstances presented.

FAP Program Parameter Assessment - updated 2023		Grant	
	Maximum FPLG	FPLG for 100% Grant	Sliding Scale FPLG > Full Charity
Albany Medical Center	400%	250%	
Bassett Health System	300% 200%	300% 200%	Uninsured Underinsured
Dartmouth Hitchcock	300%	225%	capped @ AGB >300% - reviewed case by case
Duke	300%	200%	
Eastern Maine Medical	250%	150%	>250% - reviewed case by case
Geisinger Health System	300%	300%	
Hartford Hospital	400%	250%	
Lehigh Valley	400%	200%	Uninsured: 80/90% Insured: 50%
New York Presbyterian	600%	100%	
Stanford Health System	400%		
University of Connecticut	400%	250%	
University of Rochester	400%	200%	
Virginia Medical Center	400%	200%	
Yale Medical Center	550%	250%	

Our Network team looks forward to working with the Office of the Health Care Advocate in the implementation process of Act 119, an important effort to standardize hospital financial assistance and billing and collections policies and procedures.

l. Administrative Costs:

i. Please provide a breakdown of administrative costs by activity type and title (billing and insurance, non-billing and insurance, Executive, VP, Director, etc). If no such disaggregation can be provided or a different breakdown more accurately reflects the specific structure of your hospital, please explain.

The UVM Health Network has a shared administrative services management structure. While these FTEs and expenses are imbedded in all of the affiliated organizations across the Network, there is one Network management structure and a shared funding model. The manner in which the funding model works is any affiliate organization which initiates the expense gets reimbursed 100% for the expense they funded, then through the shared funding model they are charged a percentage of the total shared administrative services expense, less any offsetting revenues which flow through shared administrative services. The charge back percentage is determined by each affiliated organization's percentage of total revenues.

We believe this model provides an efficient structure for management of shared administrative services for cost savings and service opportunities that individual organizations would not be able to achieve on their own. As the Network continues the journey of implementing single software solutions and integrated management structures, more opportunities will come. We believe this single management approach to Network shared administrative services has already created a more efficient cost structure, as the total shared administrative expense of $416M in the Network's FY24 budget represents less than 13% of the total expense for the Network in the FY24 budget.

	FY24 Budget		FY24 Budget FTES			FY24 Budget Salaries		
UVM Health Network	**Total Expense**	**Total Other Rev**	**Total**	**Management**	**Staff Other**	**Total**	**Management**	**Staff Other**
Shared Administrative Services								
Employee Health	4,077,210	-	26	6	20	2,275,954	586,718	1,689,236
Finance Administration	24,055,548	420,487	161	39	122	15,745,344	6,462,588	9,282,756
HN DEI	4,184,383	22,844	16	6	10	1,853,207	1,055,830	797,377
HN Development	4,620,069	606,457	30	13	18	2,896,109	1,630,047	1,266,063
HN External Relations	9,729,032	-	44	14	30	5,250,630	2,388,221	2,862,410
HN Medical Group Admin	14,248,504	-	37	15	22	5,083,748	3,380,578	1,703,170
HN Medical Staff Admin	3,894,819	26,000	10	5	5	754,638	448,270	306,368
HR Operations	26,547,665	267,700	168	42	126	15,430,566	6,071,038	9,359,527
Legal and Compliance	7,020,774	0	22	6	16	3,085,181	1,256,150	1,829,031
Network Transformation	713,465	-	2	1	1	348,427	222,946	125,481
Quality	14,350,845	12,517	94	21	73	9,986,985	2,703,074	7,283,911
Revenue Cycle	82,398,878	309,020	973	84	889	59,584,765	8,803,695	50,781,070
Shared Services Budget Assumptions	(1,333,288)	-	(98)	-	(98)	(7,911,456)	-	(7,911,456)
Supply Chain	21,372,125	200,425	146	19	127	9,439,040	2,257,134	7,181,906
UVMHN Administration	21,540,831	3,094,995	36	17	19	8,942,211	7,440,653	1,501,558
IT EPIC	28,740,841	10,481	123	7	116	13,207,184	983,465	12,223,719
IT Operations	119,787,382	48,838	331	45	286	34,800,211	7,092,288	27,707,923
IT Other	7,108,241	-	45	8	37	5,637,996	1,427,032	4,210,964
PHSO	23,158,451	16,163,856	154	16	138	13,695,341	1,996,812	11,698,529
Total Shared Administrative Services	**416,215,773**	**21,183,618**	**2,320**	**363**	**1,957**	**200,106,082**	**56,206,539**	**143,899,542**

ii. Please provide the number of FTEs by type by average and median salary and total compensation (i.e. total cost of FTE to the organization) by clinical (physicians, PAs, NPs, nurses, etc.) and non-clinical (C-suite, managerial, other).

	FTEs	SALARIES	Avg FTE Cost with Fringe
	FY24 Budget	FY24 Budget	FY24 Budget
UVMMC			
TOTAL STAFF	**7,521**	**714,028,011**	**116,847**
Resident	366	29,247,265	98,464
APP	308	46,836,383	187,093
Traveler	256	55,847,695	218,155
Management	583	87,602,039	184,838
LPN	58	4,331,369	91,275
RN	1,538	171,075,069	136,861
Tech	557	49,636,627	109,676
Staff Other	3,854	269,451,564	86,046
CVMC			
TOTAL STAFF	**1,344**	**117,694,559**	**108,150**
Resident	-	-	n/a
APP	65	9,468,404	178,924
Traveler	75	15,243,186	202,379
Management	138	16,059,027	143,399
LPN	41	3,161,833	95,804
RN	251	26,489,001	130,555
Tech	56	3,636,045	80,509
Staff Other	718	43,637,062	75,065
PORTER HOSPITAL			
TOTAL STAFF	**511**	**46,049,004**	**107,455**
Resident	-	-	n/a
APP	29	4,023,848	165,033
Traveler	27	7,574,208	276,278
Management	50	5,738,496	137,236
LPN	5	335,829	88,356
RN	96	9,598,767	119,717
Tech	46	2,680,201	68,912
Staff Other	258	16,097,655	74,365

B. FORM 990 (TAX YEAR 2022) No later than June 30, 2023, file a complete copy of hospital's most recent Form 990 (for FY22), including the most current version of Schedule H that has been submitted to the Internal Revenue Service as part of the hospital organization's Form 990 reporting obligations under Section 501(c)(3) of the Internal Revenue Code.

The 990s for tax year 2022 for UVMMC, CVMC and PMC will be available on August 15, at which time we will submit them to the Board.

C. COMMUNITY HEALTH NEEDS ASSESSMENT No later than June 30, 2023, file a complete copy of hospital's most recent Community Health Needs Assessment (CHNA) and/or most recent Implementation Strategy, as required by the Patient Protection and Affordable Care Act.

To view the most recent Community Health Needs Assessment (CHNA) and/or most recent Implementation Strategy for UVMMC, CVMC and PMC, please visit:
UVM Health Network Community Benefit

The UVM Health Network is working toward creating a systems' approach to the hospital CHNA processes and related Community Health Improvement Plans (CHIP). Often, the priorities that arise in each HSA are the same and identify barriers to care or access issues, as well as social determinants of health needs. Sharing resources as a Network is not only fiscally responsible, but it leverages the work and creates a more systems' approach. In the last two years, CHNA leaders were trained in best practices and Community Benefit to better establish standards for this work, increase the engagement of diverse and structurally marginalized communities within the process to better capture their voices, and work to align related identified priorities with a Network strategy. UVMMC has received state and national recognition for the inclusive way the CHNA was conducted. UVMMC partnered with community-based non-profits serving BIPOC, LGBTQIA2S+, Abenaki and members of the community with disabilities to inform the questions of the survey and support a broad range of participation. The CHNA was translated into 11 languages and through that and other supports, the responses to the survey more than doubled from the previous 2019 CHNA. The CHNA will now be used as a business decision making tool for leaders and a guide for investment of resources. Because engaging with community partners throughout this process is also key, those partners are able to use the CHNAs as well for their strategic decision making, so we all work to address the same priority areas for greater impact.