HOSPITAL 10: PORTER HOSPITAL

Follow-up questions and requests related to your budget submission:

On your executive summary:

1. You write in your narrative that "maintaining the organization's current level of financial performance is imperative, as long overdue infrastructure investments are being prioritized" (page 6). Can you detail these infrastructure investments and why you believe they are necessary?

Contingent on approval of Porter Hospital's operating budget are approximately $3.5M of planned capital expenditures; the majority is earmarked for facility improvements, such as repaving and security system installation or clinical equipment replacement.

There are two large projects in the planning phase. The first is the consolidation of three clinical spaces in Middlebury. Existing spaces are out of compliance with current clinical standards, and in one case, the building has been sold and the new owner does not desire to rent to Porter.

The second project is an investment in Porter's Emergency Department. The existing space is inadequate for proper care of current patient volumes and staff security.

2. You write that Porter's "administrative costs have decreased by over $750K from 2025 due to shared leadership with Elizabethtown Community Hospital" (page 6). How have your administrative costs changed overall in the past fiscal year (what were the key drivers and costs associated with each)? How are they projected to change in FY2025?

Administrative cost reductions were driven by the elimination of leadership positions, made possible by efficiencies of operating within our Network. There is now only one President, Chief Financial Officer, Chief Medical Officer, Lab Director and Compliance Director for both Porter Hospital and Elizabethtown Community Hospital. These five positions have been removed from the Network cost structure, and the savings accrue to Porter and Elizabethtown Community Hospital equally.

Continued savings opportunities are being identified and will likely extend beyond administrative costs and into areas of patient care, as well.

On substantive variations from last budget:

3. You've been unable to fill the orthopedics OR vacancy since late FY23. What convinces you that you'll be able to refill that position in the coming year?

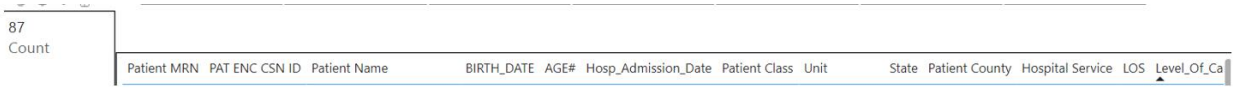
We have a signed contract with an orthopedic surgeon who will begin seeing patients in September 2024.

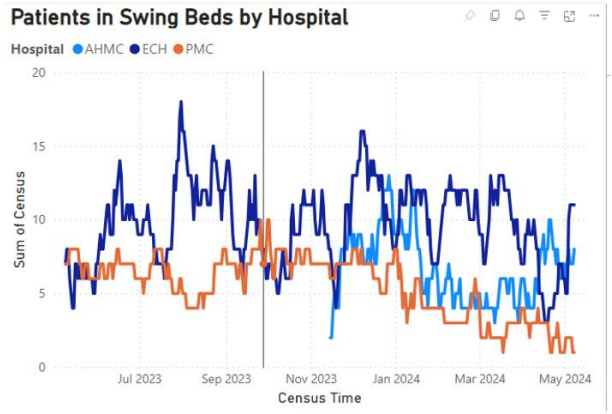
4. You've written "case management has improved during FY24 resulting in timely patient placement resulting in the ability to reduce swing and observation patients and increased acute patients." How have you been able to improve case management? To your knowledge, has this reduced ED length of stay?

In FY24 you can see from the graph below (Porter is orange) we have steadily lowered our swing bed admissions – we keep accepting patients from partner hospitals, and we are successful in placing these patients. We are doing a couple things we have not done before – like transferring patients out to a geri-psych facility for medication management and stabilization with a return to Porter then a placement in long term care (LTC). Additionally, we have hired a dedicated utilization management resource for Porter which has brought our observation use into focus. We are embarking, with UVM Health Network, on an "outpatient in a bed" program on October 1, 2024, to try and increase placement and resources for admissions without a safe discharge plan who do not have a medical need for admission.

We have reached out to the community, and we are building relationships with facilities and care homes in the area. We are working on a pathway to hospice – inpatient and outpatient with Addison County Home Health and Hospice (ACHHH). We are also collaborating with ACHHH to help keep patients at home – they are piloting a program with our primary care offices that allows an ACHHH nurse to be at the home when the patient has a follow-up appointment via telehealth. They provide the objective data – vital signs and assessment, while helping the clients navigate the telehealth technology – often for the first time.

While this has not lowered our length of stay (LOS) for the ED, it has all but eliminated patients awaiting placement in the ED. This is important as we increase our ED visits (July 2024 = >13,000).





On core justifications:

5. You've requested a higher operating margin than any other hospital this year. Why do you believe a 4.6% margin is necessary, particularly when you're also requesting the board for a substantial rate increase?

While the Porter Hospital operating budget for FY25 reflects a 4.6% margin, Porter Medical Center in total reflects a budgeted operating margin of 1.2%. The difference is the subsidy of Helen Porter Rehabilitation & Nursing, which has a budgeted margin of (32%).

We continue to make strides in reducing the amount of the Helen Porter operating loss, which will continue to improve the combined Porter Hospital/Helen Porter financial performance.

On labor expenses:

6. You expect significant drops in travelers as percentage of total FTEs from 2024 YTD to FY25 Budget (including a drop from about 25.5% of total FTEs to about 16.8% in your nursing staff and about 11.7% to about 7.2% in your 'other clinical' staff). You also predict similar drops in travelers as a percentage of total salaries. What makes you expect these drops?

For travelers, we have focused on recruiting new nurses and retaining nurses. We have hired 17 of our target of 18 inpatient nurses (10 + 7 new grads in July). We have also added 12 of the 11 target LNAs at Helen Porter and 8 additional LNA trainees.

Across UVM Health Network, the CNOs worked with CFOs to accurately forecast traveler use in 2025 – we cross-walked openings with expected orientation/training time to capture the above FTE needs. Additionally, we have been focused more specifically on matching traveler FTE to open recruiting FTE, except where needed overage to allow for training.

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

Job Category	Sum of FTEs 2024 Budget	Sum of FTEs 2025 Budget	FTE Additions	Incremental $ Impact
APP	29.06	30.27	1.21	$ 149,208.02
MD	40.68	44.92	4.25	$ 1,668,612.37
Staff	454.27	465.31	11.04	$ 809,789.94
Traveler	27.42	34.06	6.64	$ 1,557,895.10
Grand Total	**551.42**	**574.56**	**23.13**	**$ 4,185,505.43**

On pharmaceuticals:

8. Could you provide more detail on your planned pharmaceutical expenses? Why do you foresee that such expenses will increase by nearly 25%?

Pharmaceutical costs are increasing not only because of the cost of drugs but also expansion of the types of drugs utilized, especially within our infusion service. For example, in September 2023, after approval of the FY24 budget, an infusion center patient was added with a drug cost of ~ $360,000 annually. This is an extreme example, but is representative of how infusion volume (even the addition of one patient) impacts the expense budget.

9. Does the 340B program reduce pharmaceutical prices for patients as well as the hospital? Can you please provide a sense of how much of the 340B discounts you're passing onto patients?

On the Health Resources & Services Administration (HRSA) webpage for the 340B drug pricing program, it states the intent of the program: "The 340B program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."

HRSA's 340B prescription drug discount program is critically important to our rural providers, as it is a vital lifeline for safety net health care organizations providing a high level of services to low-income individuals or serving isolated rural communities. Significantly more 340B hospitals provide vital, but money-losing, health services than non-340B hospitals – services like mental health and substance use disorder treatment, trauma centers, and neonatal intensive care units.

At the UVM Health Network, we use our 340B savings to:
- Fund patient assistance programs that provide access to medications to thousands of patients with financial need; upwards of 20% of patients who qualify for the health assistance program (under- and un-insured) are eligible for co-pay assistance.
- Provide necessary care to all patients regardless of ability to pay.
- Support the health and wellness of our communities in Vermont and northern New York.
- Lessen the gap between the cost of care and reimbursement from government payers.
- Help keep our hospitals solvent to ensure patients in our region have access to comprehensive, high-quality care.

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

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

On rate changes:

11. Why is the majority of your commercial price increase allocated to inpatient?

Our intention is a budgeted flat price increase across service lines in FY25. Instead of measuring budget to budget, our internal process calculates FY25 price increases after current year utilization and payer mix adjustments have been factored in. Instead of 3.7% inpatient, 2.4% outpatient and 2.4% professional increases, we are budgeting a flat 2.99% annual increase. As we work with payers implementing our approved rate increase, we mutually agree at times to variable service line rates to achieve the approved aggregate.

On risk:

12. On your rate decomposition sheet, you predict a large increase in volumes for Medicare and commercial: 3.9% Medicare FFS, 6.1% Medicare MA, and 5.9% Commercial. Why do you predict these levels? This somewhat contradicts FY24 Actuals data that shows your volumes have generally dipped -- particularly OR volumes. Do you have a mitigation strategy should these volumes not materialize?

We expect increase in Medicare and commercial volumes to be largely offset by decreases in Vermont Medicaid volumes, as redetermination activity continues. Having secured a replacement orthopedic surgeon, we are confident OR volume will return to previous levels.

On your income statement:

13. You're budgeting for a large jump in swing beds PT care revenue, (~36%), even though you write in your narrative that you've improved case management and reduced swing bed patients. How do you reconcile these two statements?

Thank you for the opportunity to clarify. We expect improved case management efforts to decrease swing bed length of stay, but we do expect to increase swing bed admissions in service to Network patient placement efforts thus continuing the upward revenue trend. Concurrently, we also expect a slight increase in acute admissions in FY25, as well.

On your workbook submission:

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

Assumptions for growth in volume are based on current experience layered with known service provider additions that would add volume to current levels.

Assumptions for payer mix changes are based on current YTD experience layered with market analysis and interpretation. For example, budgeting the continued shift of volume away from Medicaid.

Price assumptions are last to be factored in once all other service line/mix changes are accounted for and governed by the balance between covering costs/earning a proper margin and responding to pressures of affordability.

The non-zero values in the Other column represent the difference between FY24 budget and FY24 actual collection rate experience.

Other:

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

All physicians for UVM Health Network hospitals are provided by the UVM Health Network Medical Group. The cost for those physicians is charged to the hospital they provide services. If a physician provides services at more than one hospital, the amount charged is based on the amount of time the physician spends at each hospital. The services provided by the physicians are billed by the hospital where the service was provided. Thus, all physician costs and revenue are reflected in the individual hospital budgets.

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

We feel Vermont Medicaid is underfunding the cost of delivering care and we, as a Critical Access Hospital, use Medicare as our benchmark in the analysis. In the FY25 budget submitted, if inpatient, outpatient and professional services provided to the Vermont Medicaid patients were reimbursed at corresponding Medicare rates, the difference would be approximately $4M for Porter Hospital.

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

We feel that as a designated Critical Access Hospital, Medicare is not underfunding the cost of care to our patients. The reimbursement process ensures we are managing costs appropriately and then provides adequate cost coverage.

18. In the attached spreadsheet, please review the measures of financial health that we have calculated for your hospital. We have included the measure definitions. Confirm that these calculated values reflect your understanding. If your financial measures differ from our calculations, please review our formulas, provide your calculation, and explain why you believe your calculation is a better measure for your organization.

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

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

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

	FY23 Actual	FY24 Projected	FY25 Budget	
Cost Per Day	$ 594.00	$ 632.09	$ 652.97	
Occupancy Rate	88.8%	89.0%	89.7%	
Operating Margin	-53.1%	-27.0%	-32.2%	
Average Reimbursement per Day				**Percent of Patient Population**
Medicaid**	$ 309.04	$ 456.12	$ 462.79	**67.4%**
Medicare	$ 610.69	$ 440.82	$ 509.88	**19.1%**
Commercial	$ 628.45	$ 205.30	$ 367.20	**0.7%**
Self-Pay	$ 420.40	$ 429.61	$ 575.88	**12.9%**
Subsidy Amount	$ (6,545,680)	$ (6,794,018)	$ (5,103,850)	

**FY24 Medicaid Rate includes an EFR (Extraordinary Financial Relief) of $100 per patient day. The EFR amount is included in the FY25 budget but is not guaranteed.

Narrative questions that still need to be answered:

Question C.f (facility fees): Please describe the methodology your hospital uses to establish any facility fees and how much they totaled in FY24 and are expected to total in FY25.

This response was originally included on page 18 of the submitted Porter Hospital narrative document: https://gmcboard.vermont.gov/sites/gmcb/files/documents/Porter%20Narrative%20FY25.pdf

Medicare provider-based billing of facility fees in hospital-owned, physician outpatient clinics is driven by Medicare payment policy under 42 CFR § 413.65 - Requirements for a determination that a facility or an organization has provider-based status. “Provider-based” is a Medicare payment designation established by the Social Security Act allowing facilities owned by and integrated with a health care provider (usually a hospital) to bill Medicare as a department of that health care provider. Through these regulations, Medicare recognizes that clinical integration enhances coordinated care, allowing doctors and hospitals to work together to provide patients with the best possible care and services, as well as manage more

complex patients with multiple chronic conditions. Hospital-owned, provider-based clinics are subject to stricter government rules, quality standards and are subject to the same regulatory requirements as the main hospital. At Porter Hospital, the total gross charge for a specific service rendered in a physician outpatient clinic is the same regardless of whether it is billed to Medicare under provider-based regulations, or to any other insurer. When billing to a commercial insurance or Medicaid, the total gross charge is billed solely on a professional bill. When billing to Medicare under provider-based regulations, the total gross charge is "split" into two components – a smaller professional component and a corresponding facility component. The total of those two components billed to Medicare equal the same dollar amount that would have been billed to commercial or Medicaid on the professional bill for the same service. In FY23, the last year for which we have complete data, Porter Hospital billed Medicare for $3M in provider-based facility billing. Were we not approved by CMS for provider-based billing, the total amount of $3M in charges would be combined with the professional component on one professional bill, consistent with the total billing for all other payers. Per federal regulations, all gross charge information is publicly available on our price transparency file located at the link below:
https://www.portermedical.org/patients-visitors/patient-financial-services/price-transparency/

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

Question F. b. (collections ROI): If you have a contract with a third party [for your collection efforts], please describe the return on investment for this decision compared to managing these activities internally as a part of Patient Financial Assistance Programs?

All Porter Hospital self-pay collection activities are done within UVM Health Network and are not subcontracted.