Green Mountain Care Board – staff analysis questions
August 1, 2023

University of Vermont Medical Center

1) Specify how many of the 165 open physicians positions are UVMMC's and which department/specialty.

Right now, there are over 165 open physician positions across the UVM Health Network. There are 132 open positions at our Vermont hospitals and 35 at our New York hospitals. Please see the breakdown of Vermont open physician positions below. It is important to note that increasingly our providers are working across organizational boundaries (and state lines), including through the provision of eHealth services.

Location	Department	Open Positions	Location Total
CVMC	Anesthesia	2	
CVMC	Childrens	1	
CVMC	Family Med	2	
CVMC	Medicine/GIM	4	
CVMC	Neurology	1	
CVMC	Ortho	1	
CVMC	Surgery	1	12
Porter	Family Med	5	
Porter	Medicine/GIM	1	
Porter	Ortho	1	
Porter	Radiology	2	9
UVMMC	Anesthesia	11	
UVMMC	Childrens	8	
UVMMC	Emergency Me	10	
UVMMC	Family Med	2	
UVMMC	Medicine/GIM	30	
UVMMC	Neurology	8	
UVMMC	Ortho	3	
UVMMC	Pathology	11	
UVMMC	Psychiatry	8	
UVMMC	Radiology	8	
UVMMC	Surgery	8	
UVMMC	Womens	4	111

2) Your narrative indicates that UVMMC Ortho surgeons are working at Porter, how are these financials reported on each of the facilities' statements?

In this circumstance, the professional revenue and expense are reflected on UVMMC's financial statements. The outpatient facilities revenue and expense are reflected on Porter's financial statements.

3) If you provide the 13 comparators UVMHN believes are appropriate for UVMMC, we can add them to our comparator list. Include the rationale used for selecting these comparators.

We considered hospitals potentially part of the comparison group if they met the following criteria:

1. Hospital is an Academic Medical Center*;* and 2. Hospital is either the sole acute care hospital in its Hospital Service Area (HSA) or County. We found sole hospitals in the HSA by examining Dartmouth Atlas data showing hospitals by HSA (using the Dartmouth Atlas HSA definitions), which included a classification of the hospital type. We received the list of teaching hospitals that are also the sole acute care hospital in their counties from the Association of American Medical Colleges (AAMC).

For HSA-level analysis, we also considered hospitals that had another disproportionately small acute care hospital in the HSA (Dartmouth shares an HSA with a Critical Access Hospital; the Mayo Clinic, with over 1,000 beds and an average daily census of 777, shares an HSA with a 61 bed hospital).

We did eliminate four hospitals from the AAMC's list for the following reasons:

- One was a Veterans Affairs hospital and would not produce commercial claims costs.
- One was not listed as a teaching hospital in the Dartmouth Atlas data, and CMS payment formula data showed that it had no residents at the time of the FY 2021 Final Rule Impact File release.
- Two were not listed as teaching hospitals in the Dartmouth Atlas data, and CMS payment formula data showed that each had fewer than 25 residents at the time of the FY 2021 Final Rule Impact File release (with the next smallest having 123 residents and the average and median number of residents at the other hospitals at 348 and 352, respectively).

Note that when an Academic Medical Center (AMC) is the sole acute care hospital in either its HSA or County but not both, there are likely other acute care hospitals relatively nearby. UVMMC is one of only three AMCs in the country that is also the sole acute care hospital in both its HSA and its County.

Hospital	State	Inclusion Criteria
Geisinger Medical Center	PA	Sole Acute Care Hospital in County
Mayo Clinic Hospital Rochester	MN	Dominant Acute Care Hospital in HSA (Other hospital has 61 beds)
Carilion Medical Center	VA	Sole Acute Care Hospital in County
Stanford Health Care	CA	Sole Acute Care Hospital in HSA
Lehigh Valley	PA	Sole Acute Care Hospital in County
ECU Health Medical Center	NC	Sole Acute Care Hospital in HSA and County
University Of Virginia Medical Center	VA	Sole Acute Care Hospital in County
University Of Vermont Medical Center	VT	Sole Acute Care Hospital in HSA and County
University Of North Carolina Hospital	NC	Sole Acute Care Hospital in HSA and County
Dartmouth-Hitchcock Medical Center	NH	Dominant Acute Care Hospital in HSA (Other hospital is a CAH)
Yale-New Haven Hospital	CT	Sole Acute Care Hospital in HSA
Scott And White Memorial Hospital	TX	Sole Acute Care Hospital in HSA
Stony Brook University Hospital	NY	Sole Acute Care Hospital in HSA

4) What is the estimated underpayment by commercial plans for the past 3 FYs (i.e., FY21, FY22, and FY23 projected) for UVMMC?

Due to a number of factors (contract cycle v. budget cycle, nature of collecting data related to line of business reimbursement/denials/write offs/charity care/bad debt), reporting commercial plan underpayment is difficult. Payer performance, underpayments or overpayments, utilized in budget preparation is based on the payer mix and collection rate found in our base period. The base period, which is only a four month representation of experience, may not capture all payer policy impacts and a full year of patient revenue experience, and therefore is a best estimate based on limited data. Thus comparing budgeted expected rates includes a number of assumptions, making this comparison difficult. With that said, now that we have Epic fully deployed, we are investigating reporting opportunities to better track year over year comparison of payer profiles and performance.

While comparing actual to expected payer performance is complicated, what we can identify is the impact of payer policies released post contract negotiations and unilaterally enforced by payers. This is not a new issue but is getting worse. At the highest level, these policies result in:

- We estimate the range of these impacts to be between $8M and $16M annually
- Weekly distribution of payer policies and updates (over 175 since March) where each update can include multiple policy changes within one document and can be 100 pages long. [For example, UHC has a document each month for each line of business and each type of policy (medical, reimbursement, etc.) that are usually about 20-200 pages long (usually about six pdfs) and contain anywhere from 2-30+ policy updates (per line of business). Other payers usually have about 20-30 policies listed as reviewed/changed each month.]
- In addition to these policy changes reducing payment levels, it takes thousands of administrative staff hours annually

An example of a dispute with a payer resulting in significant administrative burden and financial losses, which were not contemplated or disclosed during contract negotiations, is the 2023 BCBSVT claims edit policy. In January, 2023 BCBSVT provided a generalized notice, followed by a 50 page policy, identifying new claims edits. Due to claims timing, the impact was not realized until March. The impact has been felt across the state and significantly impacting our entire Network. Once financial impact was identified we could not identify the cause. BCBSVT's claims edits denials were not clearly identified and despite the involvement of three departments and communication with BCBSVT, months have gone by without the ability to understand the reason for a claim edit and resolution process. BCBSVT's process did not provide any ability to dispute the edits. After two months of lack of clarity we formally disputed BCBSVT's actions, noting potential impact of the policy financially amounting to over $7M in professional claims alone. In addition, the administrative burden was thousands of hours and potentially thousands of medical records to potentially dispute an edit or refile a claim. Since May, BCBSVT has had to fix several issues with failed implementation. Our professional impact is now estimated to be $1M and we are still estimating the hospital service impact. This is still an estimate, however, as we are now in July without clear understanding of this process and reasons for denials. To date we have submitted over 800 medical records, with one email per record. We have staff in billing, contracting, reimbursement and analytics working on this one payer issue – including legal, as this is now escalated to DFR. This is one example of many contract disputes.

Payers across the board are unilaterally implementing policy changes, which effectively reduce our negotiated rates with policy impacts, allowing us little room to dispute. The concerning impact is not only financial but potentially access to care for patients. Some policies limit where services can be rendered and could result in increased patient liability, some policies cause such an impact that providers may terminate the relationship with a payer, and some policies unnecessarily delay care through prior approval processes that often include lack of responses from payers.

5) Exhibit 10 does not indicate gross charges increases for previous years. Either update the exhibit or provide the percent change in charge implemented by payer and service type.

File provided to GMCB staff on 7/25/23.

6) What is the payer mix for revenues from 340B by for the Vermont Network hospitals (UVMMC, Porter, CVMC)? What proportion of formulae offered by UVMHN facilities is eligible for a 340B subsidy?

On the Health Resources & Services Administration (HRSA) webpage for the 340B drug pricing program, it states the intent of the program: "The 340B program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[1]

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

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;
- 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; and
- Help keep our hospitals solvent to ensure patients in our region have access to comprehensive, high-quality care.

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. For retail pharmacy, which includes Rx, mail order and specialty pharmacy combined, based on inventory supply order units, approximately 50% of our scripts run through our 340B program, and the other 50% run through other (non-340B eligible) wholesale acquisition cost (WAC).

7) Is your part C plan with MVP profitable? Provide a summary of profit and loss.

UVMHN does not currently have ownership interest(s) in a Part C plan with MVP. UVMHN has a contractual relationship with MVP as it relates to the co-branded Medicare Advantage product, UVM Health Advantage. As part of this, UVMHN and MVP collaborate in several ways, but UVMHN does not currently assume the financial performance of the Part C plan.

[1] https://www.hrsa.gov/opa

8) Explain line items on the balance sheet where variances between FY23B to FY24B exceed 100% (last column), with particular attention to "Other Designated Assets" (134% variance) and "Other" within "Board Designated Assets" (174%). (Balance Sheet)

ACO Risk Reserve/Settlement Receivable increased slightly from FY 2023 budget but is consistent with prior year actuals.

Other Current Assets change is related to a change in investment policy to move $100M previously recognized in Funded Depreciation to a short-term investment category. Other Current Assets was a category those funds were reported in the Adaptive B/S structure.

Under Board Designated Assets-Other there is a noticeable increase as we are anticipating a $150M plus/minus public bond issuance in FY 2024 to fund multiple capital projections, with the primary one being the OSC currently in GMCB CON review. This probably should have been reported under Escrowed Bond Funds instead of Other. The remaining dollar amount in this category will depend on where the actual capital spend is compared to the funds borrowed at the end of FY 2024.

The University of Vermont Medical Center
Report 2
Balance Sheet

	FY2019A	FY2020A	FY2021A	FY2022A	FY2023B	FY2023P	FY2024B	22A to 23P %	23B to 24B %
Assets									
Current Assets									
ACO Risk Reserve/Settlement Receivable	-	6,442,700	7,824,341	5,387,997	2,633,283	6,685,783	6,380,978	24%	142%
Other Current Assets	76,489,741	109,419,193	91,947,303	100,384,287	87,008,141	197,613,511	203,755,585	97%	134%
Board Designated Assets									
Escrowed Bond Funds	65,203,843	72,243,481	-	-	-	-	-		
Other	-	-	89,851,171	80,117,430	86,163,239	86,438,483	236,438,483	8%	174%

9) Explain line items on your profit and loss statement where variances between FY23-FY24 B % exceed 100%. (Profit and Loss Statement)

Below are the major variances. We believe they are related to alignment issues between the Adaptive reporting system and the hospital financial statements through the Axiom system. We will need more time to look into this issue and will circle back with staff, as this may require an update to Adaptive. In total, the numbers are appropriate but they may not be populated in Adaptive in the most appropriate line category currently. Our initial thinking is that Specialty Pharmacy and Outpatient Pharmacy Revenue should be combined into one category.

The University of Vermont Medical Center
Report 1
Profit & Loss Statement

	FY2022A	FY2023B	FY2023P	FY2024S	FY23 FY24 B $	FY23 FY24 B %
Other Operating Revenue	-	-	-	-	-	
340B Retail Pharmacy Programs	13,867,852	11,718,957	33,224,571	34,783,802	23,064,845	196.8%
Specialty Pharmacy	170,554,773	218,654,918	217,670,667	251,453,156	32,798,238	15.0%
Outpatient Pharmacy Revenue	14,347,535	10,384,176	(8,312,842)	(11,734,159)	(22,118,336)	-213.0%

10) How are physician FTEs captured in Exhibit 11?

Physician FTEs were not captured in Exhibit 11 as submitted. Below is the physician data for Exhibit 11.

Exhibit 11. Physician Summary

	FTES				SALARIES			
	FY21	FY22	FY23	FY24	FY21	FY22	FY23	FY24
UVMMC	Actual	Actual	FY23 YTD Mar	Budget	Actual	Actual	FY23 YTD Mar	Budget
TOTAL PHYSICIAN	628.2	641.3	659.3	712.0	170,317,775	191,324,666	101,009,129	228,039,112

Exhibit 11. Physician Summary

	FTES				SALARIES			
	FY21	FY22	FY23	FY24	FY21	FY22	FY23	FY24
CVMC	Actual	Actual	FY23 YTD Mar	Budget	Actual	Actual	FY23 YTD Mar	Budget
TOTAL PHYSICIAN	93.1	93.9	98.0	93.0	27,961,603	30,366,298	16,279,213	30,343,887

Exhibit 11. Physician Summary

	FTES				SALARIES			
	FY21	FY22	FY23	FY24	FY21	FY22	FY23	FY24
Porter Hospital	Actual	Actual	FY23 YTD Mar	Budget	Actual	Actual	FY23 YTD Mar	Budget
TOTAL PHYSICIAN	39.9	39.6	40.2	40.7	13,774,563	14,651,731	7,331,597	13,837,154

11) "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." - If there are more customer friendly payment mechanisms to make it easier for patients to pay their balance, then why is bad debt higher in FY22 than in previous years? (Narrative, 28)

The bad debt rates for CVMC and PMC were higher in FY22 due to needing to write off older self-pay balances from our legacy systems. This is a very common occurrence when converting to a new revenue cycle system. Had we not had these legacy write-offs, the rates would have been lower from the more customer friendly payment mechanisms. That is why in FY23 and the FY24 budget, without those legacy write-offs, you are seeing a decline in the rate.

12) "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." What about patients that are not self-pay? If a patient is contacted by a debt collection agency, and they do pay some or the full bill, who receives that money? (Narrative, 28)

Self-pay refers to balances due from a patient's guarantor. A self-pay balance would be due from the patient after insurance left a balance, the patient was uninsured, or the patient chose to not use insurance. After internal efforts to collect a self-pay balance are exhausted, the balance is sent to a collection agency and removed from our active A/R. If a patient pays a balance in collections, the amount of the payment is reversed from bad debt back to active A/R and credited to the account. The collection agency would then invoice us – a percentage of the amount collected – for the recovery.

13) Explain what is contained in the accounts "Other nonsalary expense, other purchased services – consulting, other purchased services – misc., and other services." (Profit and Loss Statement)

Below is a listing of the account lines which are included in the "Other nonsalary expense" total.

	FY22 Actual	FY23 Budget	FY23 Projected	FY24 Budget
Medical & Surgical Supplies	121,621,374	123,759,980	135,646,580	132,585,256
Retail Pharmacy Expense	114,058,752	139,643,143	146,505,459	170,067,669
Pharmaceuticals	108,095,687	111,514,163	114,653,511	120,314,488
Nutrition Supplies	5,422,368	5,051,520	5,575,930	6,201,913
Other Supplies	3,307,270	3,304,937	3,560,433	3,407,771
Purchased Services	85,755,950	67,828,899	81,403,492	74,150,382
Facility and Equip Maintenance and Repairs	30,261,880	33,145,521	31,775,155	36,826,435
Software and IT Maintenance Fees	27,010,419	47,288,924	49,048,789	60,478,480
Lease and Rental	14,240,464	15,421,938	15,794,602	18,594,063
Utilities	13,780,501	14,752,068	14,225,922	14,975,989
Other Expenses	85,699,910	64,341,168	78,027,267	91,444,222
Insurance	9,634,705	17,537,682	14,711,947	14,969,680
Adaptive Other Operating Expense	**618,889,279**	**643,589,944**	**690,929,087**	**744,016,347**

14) Page #7; para #5 et al: While we laud your PHI program, we are concerned that its efforts may well be duplicative of other statewide initiatives such as OneCare Vermont, Vermont Blueprint for Health, and SASH. How are you planning to leverage these existing resources and better manage costs in your plans for the future?

Since its inception 20 months ago, the PHSO has worked collaboratively with the Blueprint for Health, OneCare Vermont, the UVMHN Medical Group and our UVMHN health care partner organizations to ensure that there is not duplication, but rather alignment and efficiency with statewide initiatives including OneCare and Vermont Blueprint for Health.

These statewide initiatives create a value-based ecosystem and necessary funds flow to support key population health services for patients and care teams. It is the responsibility of the Network to ensure these initiatives and any associated funding are used efficiently and effectively to further our collective goals of improved patient outcomes and quality, care coordination, and reduced cost of care.

The PHSO is the Network's mechanism for delivering on these statewide initiatives for our patients and care teams. The PHSO will continue to foster collaboration and leverage all appropriate funding and existing resources to build out its services and avoid duplication within the Network.

As an example, the Network has leveraged all Blueprint Community Health Team grants and OneCare Care Coordination funds to support a single Care Management model within the PHSO. As a result, the PHSO has been able to significantly increase the number of patient and care team facing Care Management resources (see response to question 16), reduce the number of duplicative administrative roles, and lower the upfront investment by the Network to build necessary infrastructure required to achieve sustainable performance under all types of risk-based arrangements. Furthermore, this single Care Management model has enabled standardization of program design including:

- Team structure and caseloads
- Oversight and management
- Patient eligibility and proactive identification
- Workflows and documentation
- Monitoring and evaluation

This approach also enables the Network to explore NCQA accreditation for its services and pursue additional funding mechanisms for PHSO services, such as delegated arrangements with commercial payers to further avoid duplication and ensure financial sustainability of the programs.

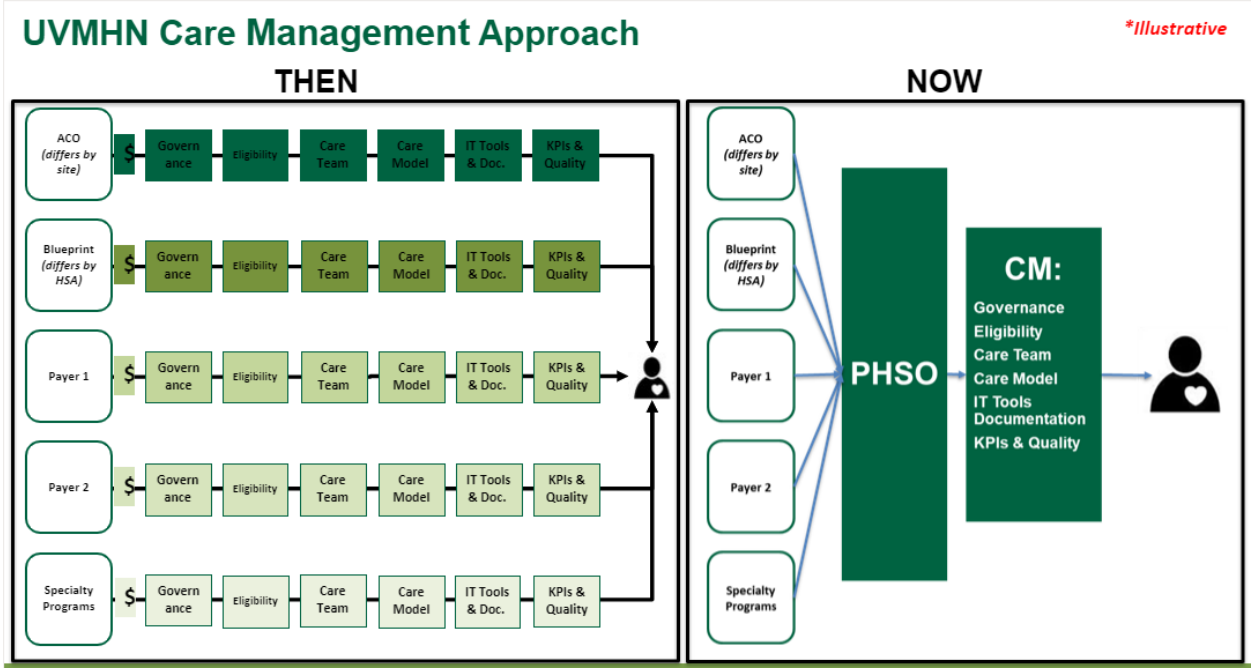
Beyond Care Management, several other key functions of the PHSO have been established with the goal of administrative and operational efficiency and intentional alignment with various statewide initiatives:

- Network-wide Primary Care Medical Home (PCMH) recognition and recertification project management
- Quality Improvement facilitation
- Blueprint for Health grant administration and reporting
- OneCare Care Coordination reporting
- Quality measure alignment, performance monitoring and reporting
- Care gap closure support, reporting and performance (all payers)

Additionally, the PHSO is in close collaboration with both the Blueprint for Health and OneCare on other key topics in an effort to offer the Network's perspective on key strategic discussions and ensure alignment when appropriate. Two examples of these collaborative discussions include Social Determinant of Health (SDOH) screening and reporting and evaluation of Care Management/Care Coordination activities and outcomes.

Finally, it is important to acknowledge the efficiency of the Population Health analytics functions between the Network and OneCare. While OneCare makes up a significant portion of the Network's attributed lives, the Network has many other value-based contracts that require industry standard performance analytics to help inform population health initiatives at both a strategic and operational level. By aligning with OneCare, both entities have avoided potential duplication of people, process, and technology and can instead focus on aligned performance monitoring and population health analytics that best serve both OneCare and the Network.

If the Board is interested in learning more about the Network's PHSO activities, we would welcome the opportunity to present in greater detail through a dedicated session.



15) Are OCV employees a part of the PHSO or a separate? If separate, where do they fall on this chart? (Narrative, Page 45)

During FY 2023, 9 FTEs who used to work for OneCare Vermont have transferred to work for the PHSO. As the Board is aware, OneCare purchases some analytics services from the PHSO. Those 9 transferred employees are included as part of the PHSO on this chart. The employees who continue to work for OneCare are not included on this chart as part of the PHSO or any other UVM Health Network shared service.

16) PHSO – 154 FTEs – this is substantial – 5th highest group / 19 admin groups in terms of total FTEs – what are the short and long-term goals of this organization and how do they relate to the goals and vision for OCV? Detail the employee titles of this PHSO. (Narrative, Page 45)

The PHSO has grown substantially since inception in fall of 2021. The majority FTE growth (55%) is due to transferring existing roles into the PHSO to ensure strategic alignment, consistent delivery, and operational efficiency of Population Health services for the Network. Additionally, 81% of the net new PHSO FTEs are either patient facing or in direct support of our care team's patient facing work and support the PHSO's position as the delivery mechanism for statewide initiatives such as the Blueprint for Health and OneCare's PHM and Care Coordination

programs.

As stated previously, the PHSO took on the expense of these FTEs and the responsibility of delivering resources across the Network. Revenue associated with these efforts was also redirected to the PHSO (i.e., Blueprint for Health Community Health Team grant). Additionally, the PHSO has been successful in securing additional funding mechanisms to further offset the costs of these services. In the FY 2024 budget, any additional expense above the expense transfers, revenue offsets were added into the budget to cover the new expenses.

The financial vision for the PHSO is to develop evidence-based services that demonstrate impact on key indicators of High Value Care and enable the Network to align value-based contracts to sustainably fund these services.

The short-term goals of the PHSO are the following:

- Build evidence-based population health services for the Network inclusive of monitoring and evaluation for each PHSO service.
- Establish the internal infrastructure necessary to align PHSO services with and perform on risk-based contracts. Supporting Network practices and care teams with the resources and data necessary to improve patient outcomes and value-based performance.
- Provide equitable access to care management for patients and care teams across the Network.

The long-term goals of the PHSO are the following:

- Design contacts and payment strategies in partnership with payers allowing for change in the care delivery system to reduce health disparities, address health-related social needs, improve health care quality, and reduce costs.
- Monitor and report on performance in key High Value Care indicators across the Network, including:
    - Utilization, Cost of Care, Quality Performance
- Leverage data to proactively engage patients and care teams ensuring appropriate resource utilization

PHSO Service Category	Job Title/Category	Transfer to PHSO (FTEs)	Net New (FTEs)	Total FY24 FTEs	% Transfer	% Net New	
PHSO Admin	Network AVP, Population Health Services	0	1	1	0%	100%	NOTE: Includes Blueprint QI Facilitator resources; Medical Director FTE will be re-aligned existing Physician admin effort
PHSO Admin	PHSO Project Coordinator	1	3	4	25%	75%	
PHSO Admin	Medical Director	2.5	0	2.5	100%	0%	
PHSO Admin	Quality Measurement Program Coordinator	1	0	1	100%	0%	
	Admin Subtotal	4.5	4	8.5	53%	47%	

PHSO Analytics	Director, Population Health Analytics	1	0	1	100%	0%	NOTES: Analytics team provides Population Health analytics for UVMHN and for OCV via Analytics Service Order
PHSO Analytics	Manager, Population Health Analytics	0	1	1	0%	100%	
PHSO Analytics	Business Intelligence Analyst	8	0	8	100%	0%	
PHSO Analytics	Data Warehousing Architect	2	0	2	100%	0%	
	Analytics Subtotal	11	1	12	92%	8%	
PHSO Care Management	Director, PHSO Care Management	1	0	1	100%	0%	NOTES: Includes all Blueprint CHT resources; Blueprint Grant Administration Resources; Self-Management Resource; As noted in Question 14 response: funding from Blueprint for Health and OneCare VT offsets cost of patient facing CM resources
PHSO Care Management	PHSO Manager, Care Management	3	3	6	50%	50%	
PHSO Care Management	PHSO Care Manager	31.8	16	47.8	67%	33%	
PHSO Care Management	PHSO CM Implementation Specialist	1	2	3	33%	67%	
PHSO Care Management	PHSO, Resource Coordinator	8.8	12.3	21.1	42%	58%	
PHSO Care Management	PHSO, Clinical Diabetes Educator	3	0	3	100%	0%	
PHSO Care Management	PHSO, Community Health Worker	0	4.5	4.5	0%	100%	
PHSO Care Management	PHSO Health & Wellness Coach	2.9	4	6.9	42%	58%	
PHSO Care Management	Community Health Improvement Assistant	1	0	1	100%	0%	
PHSO Care Management	Community Health Improvement Administrator	1	0	1	100%	0%	
PHSO Care Management	Care Management Department Assistant	1	0	1	100%	0%	
PHSO Care Management	PHSO Care Management Quality RN	0	1	1	0%	100%	
PHSO Care Management	Blueprint Program Manager	1	0	1	100%	0%	
PHSO Care Management	Self-Management Program Coordinator	1	0	1	100%	0%	
PHSO Care Management	Community Health Improvement Supervisor	1	0	1	100%	0%	
	Care Management Subtotal	57.5	42.8	100.3	57%	43%	
PHSO Risk Adjustment	Manager, PHSO Risk Adjustment & Quality Programs	0	1	1	0%	100%	
PHSO Risk Adjustment	Network CDIS Educator, Ambulatory	1	0	1	100%	0%	
PHSO Risk Adjustment	Coding Educator	1	0	1	100%	0%	
PHSO Risk Adjustment	Clinical Doc. Integrity Specialists - Outpatient	0	10	10	0%	100%	
PHSO Risk Adjustment	Professional Coder	3	4	7	43%	57%	
	Risk Adjustment Subtotal	5	15	20	25%	75%	

MAT	Community Health Care Coordinator - LADC	2.6	0	2.6	100%	0%
MAT	Community Health Care Coordinator - RN	3.4	0	3.4	100%	0%
	MAT Subtotal	6	0	6	100%	0%
HVC Contracting & Quality Performance	Healthcare Contract Specialist - HVC	0.5	0	0.5	100%	0%
	PHSO Contracting Program Manager	0.8	0	0.8	100%	0%
	PHSO Resource Partner	0	6	6	0%	100%
	Contracting & Quality Subtotal	1.3	6	7.3	18%	82%
	PHSO Total	85	69	154	55%	45%

17) Page #2; para# 2; line #4: Of the 1,061 employed physicians how many are based in Vermont and how many are practicing primary care? What actions are you taking with the UVM Medical School to definitively increase the number of primary care physicians training and to retain those trained?

Of the 1,061 employed physicians, 859 are practicing in Vermont. We have 150 primary care physicians in Vermont, not including pediatrics. The 150 figure is a headcount, not FTE or clinical FTE count.

We are currently in the process of ramping up our data analytics to more comprehensively target physician recruitment and retention needs and to focus on clinical areas in primary and specialty care where patients are experiencing access issues and where we anticipate future needs—e.g., physician retirements, population growth and shifting patient care needs. We are also continuing to invest in doctor training through residency programs in primary and specialty care, and to offer competitive opportunities to practice and develop careers in our region after residency graduation. In FY23 we expanded loan repayment to all physicians joining our Medical Group, and are continuing this investment in FY24. Our Family Medicine residency program offers training in the full scope of primary care practice, including rural rotations which have contributed to graduates staying in Vermont; five of the six Family Medicine resident doctors who will graduate in June 2024 have expressed an interest to stay in Vermont. We continue our strong affiliation with the Larner College of Medicine (LCOM) at the University of Vermont. In 2019 LCOM increased the incoming class from 120 to 124 medical students, expanding positions for two additional Vermont students with a goal of increasing the number of graduates who stay in Vermont for residency training or return in the future to practice in Vermont. The LCOM Office of Primary Care offers programs for third and fourth year medical students to pursue primary care in Vermont, including scholarships, loan forgiveness, and educational series such as the Area Health Education Centers (AHEC) Scholars. For the past five years 38-42% of the LCOM graduating class entered primary care residency programs in Family Medicine, Internal Medicine, and Pediatrics. Across Vermont, 41% of primary care physicians trained at either LCOM or a UVM Medical Center residency.

18) Page #2: para #5; line #6: You reference the Commonwealth score card and the Board appreciates the work of all Vermont hospitals. However, we are concerned that Vermont has experienced worsening numbers in 30-day mortality, women ages 18-44 receiving routine care, and diabetic adults without recent A1C tests. In addition, Vermont is the lowest ranked New England state in Reproductive Health. How are these issues specifically addressed through your proposed budget?

Our proposed budget invests resources in objectives to deliver safe, effective, and equitable care. Our Data Management Office and Population Health Services Organization are working to make quality data more timely, attuned to patient risk factors, visible, and actionable. For example, the Commonwealth Scorecard for 2023 is based on data from 2018-2021, depending on the measure. We are investing in care delivery programs that can improve a range of measures, such as physician and advanced practice provider recruitment, call coverage coordination across our Vermont locations, primary care and mental health integration, eConsults, and community outreach. We also are investing in ways to improve specific quality measures. For example, we are working to improve hospital 30-day mortality through sepsis care pathways, expanded intensivist staffing at CVMC, and improved coordination of inter-facility transfer for those patients requiring a higher level of care; routine care for women ages 18-44 through primary care recruitment and digital scheduling; and diabetes monitoring and management through a dedicated physician

Network Director of Diabetes, hemoglobin A1c test result importation in the Epic EHR, automated identification and testing of diabetic inpatients who are due for hemoglobin A1c testing, point-of-care A1c testing, extensive clinical support measures built into the primary care EHR to promote care meeting current ADA standards, and hiring a team of dedicated ambulatory pharmacists who are focusing on optimizing the pharmacologic management of diabetic patients. We play an important role in Vermont's commitment to reproductive health, and are investing in outreach to underserved populations, imaging access, prenatal care, and teams of obstetrical providers working together across Central Vermont Medical Center, UVM Medical Center, and Porter Hospital.

19) Page#3; para #2; line #8: How do you reconcile your rate increases at both UVMMC and CVMC, which far exceed the cost of 7% trend increase in the HRI projection?

The 7% trend increase projection from the PWC Health Research Institute is a nationwide projection, which includes differing degrees of commercial cost shift across the country. The purpose of highlighting that number in our narrative was to put into context the cost inflation we are budgeting in FY24, which is 5.0% for UVMMC, 3.9% for CVMC, and 3.3% for PMC. Those cost inflation figures then dictate the revenue inflation we need in rates (exhibits on pages 24 through 26 in our budget narrative). If Medicare and Medicaid funded their share of cost inflation, our commercial rate increases would be 5.0%, 3.9% and 3.3%. Instead they are 13.45%, 10.95% and 6.86%. As we highlighted in the budget narrative, the reason for the smaller delta between cost inflation and the required commercial rate increase for PMC is because as a Critical Access Hospital, Medicare does pay their share of cost inflation.

20) Page #8 et al: What were the total physician recruitment expenses in each of the past 5 years and the amount budgeted in the 2024 budget?

Please see below for recruitment costs by Vermont hospital for FY18 – FY23 year-to-date June and the FY24 budget. Please note that these costs include recruitment related to physicians, APPs, and a small number of administrative leadership positions. For actual UVMMC expenses prior to FY21, resident and fellow recruitment expenses are also reflected in the figures below. Since FY21, those expenses have been separately tracked. Unfortunately it is not possible to isolate physician recruitment expenses from the other recruitment expenses. Additionally, there are some physician recruitment expenses that are recorded on the University of Vermont's financial statements and are therefore not included in the figures below. Lastly, in FY24 we budgeted $522,000 for physician recruitment in a Network shared service cost center, which is not included in the figures below. The $522,000 will support physician recruitment at all of our Network health care partner organizations.

FY19	
UVMMC	$1,048,918
CVMC	$ 622,395
PMC	$ 133,880
	$1,805,193
FY20	
UVMMC	$ 842,417
CVMC	$ 361,243
PMC	$ 74,408
	$1,278,068
FY21	
UVMMC	$ 539,294
CVMC	$ 183,620
PMC	$ 149,074
	$ 871,988
FY22	
UVMMC	$ 750,411
CVMC	$ 146,417
PMC	$ 180,497
	$1,077,325
FY23 YTD June	
UVMMC	$ 593,765
CVMC	$ 62,792
PMC	$ 41,402
	$ 697,959
FY24 Budget	
UVMMC	$1,464,455
CVMC	$ 342,090
PMC	$ 32,873
	$1,839,418

21) Page #11: para #2: et al: What amount is budgeted in 2024 to support the development of the Respiratory Therapy Program with VTSU?

$834,302 is budgeted in FY 2024. Absent our financial support for this program – the only program in Vermont producing respiratory therapists – the pipeline for this critical health care provider group would be eliminated. The annualized cost of traveler respiratory therapists is $6M across the UVM Health Network. Without a program producing respiratory therapist graduates in our region, supply will decrease, demand will increase and those agency costs will only increase each year. The cost for one full time traveler respiratory therapist is $344,000.

22) Page #12; para #1; line #2: You reference "the staggering impact of the cost shift onto private payers." There are many hospitals/hospital systems that now "manage to Medicare," targeting those cases for break-even performance. Has UVMHN leadership considered adopting that operating approach and, if so, how will it be accomplished?

We are constantly seeking efficiencies in our operations, and reductions in measures such as length of stay and cost per case. Since our overall prices are capped by the Green Mountain Care Board, we focus less on Medicare reimbursements as a benchmark and more on total costs. In markets that are less regulated and highly competitive, providers might seek to increase their margin on Medicare services specifically so that they can live within a lower margin for commercial business (though it is not entirely clear that is the case among hospitals expressing a commitment to "managing to Medicare," such as the system highlighted in a recent discussion of the concept among the Board). In our market, those limits are externally enforced. Medicaid rates are set by the State, Medicare rates are set by the federal government, and commercial rate increases are set by the GMCB. The mix of those determine how we cover annual cost inflation.

We manage within this patient mix not only by cutting costs per case, but also by reducing administrative costs, de-duplicating services, reducing unnecessary or low-value care and by limiting capital investments. Even with all of this, it is difficult to cover cost – that difference is made up primarily by our 340B pharmacy program. Managing cost per case has been particularly challenging in the past two years. Lack of capacity in both the mental health and long term care systems statewide, coupled with our nonprofit mission to care for everyone who comes through our doors regardless of their insurance coverage, have resulted in us housing a significant number of patients per day in acute care beds who do not need that level of care. At UVMMC, 13.5% of medical/surgical bed capacity in CY 2021 was occupied by sub-acute patients (patients no longer needing inpatient hospital-level care), and has increased to 20.5% for the first six months of CY 2023. Likewise, most days we have between 12 and 15 patients in-house awaiting a psychiatric inpatient bed or other type of safe discharge. If these patients were removed from calculations of length of stay and cost per case, our LOS and costs are quite low compared with national benchmarks.

23) Page #20; Labor Expenses; para #1; line #10: Provide details on the additional FTEs to be devoted to "access improvement efforts." Of specific interest are the numbers, qualifications and cost of the additional FTEs and how long you anticipate they will be employed.

- Specialists at the UVM Health Network are utilizing more time to do eConsults. The specialists and subspecialists are employed, and we anticipate utilizing more of their time as eConsults expand. This may result in the need to recruit more specialists to improve access using multiple modalities.
- We are investing in specialists to expand access to eConsults, with over 70 different specialty providers currently fulfilling eConsults for over 52 different medical conditions in 18 specialties. Our eConsult volume continues to grow, from a start of 31 in 2021, to 534 in 2022, to our projection of 1,630 in 2023.

24) Page #25; para #1; line #5: Provide the Board with any recent (past three years) evaluation of the appropriateness of employee staffing levels at Vermont UVMHN hospitals.

The key evaluation, which we have included in the last several budget narratives, is how we compare on a total cost basis to other Academic Medical Centers. With staffing being 60% to 70% of a health organization's costs, if you compare favorably on total cost, it is because your staffing is at an appropriate level. Below is the most recent data for UVMMC, which shows they are still around the 25th percentile compared to other Academic Medical Centers.

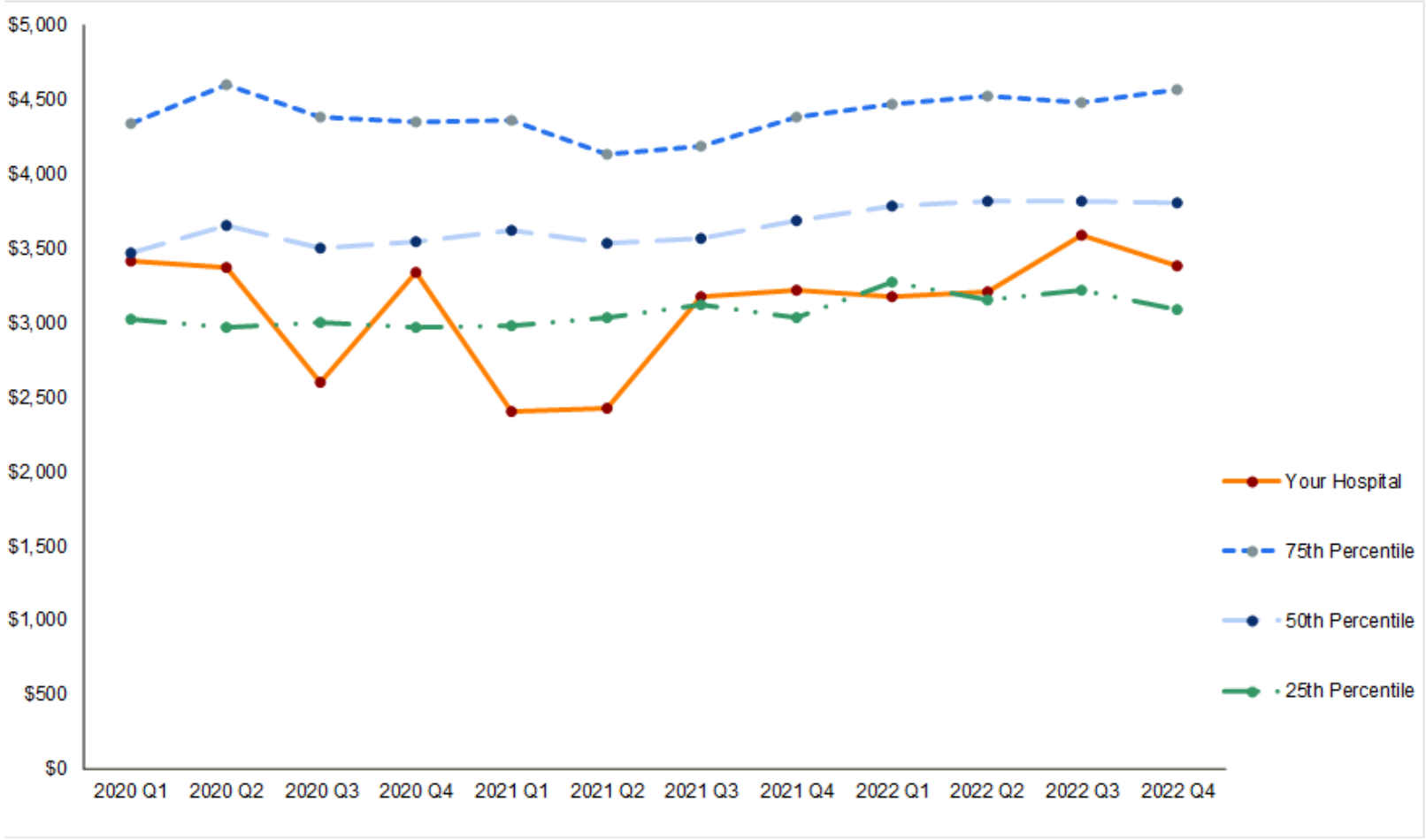
CHART 13

Expense per Adjusted Inpatient Day

Benchmarked against Participating Teaching Hospitals • Twelve Most Recent Quarters

AAMC

University of Vermont Medical Center



Source: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance

Another evaluation is how we compare on shared service total costs. Below is a chart from our Syntellis system showing the median expense per total organizational expense for select shared service areas. While we are still working on creating a more accurate apples to apples comparison, the areas listed below align closely with what we include as a shared service at the UVM Health Network. The total of the medians for these areas is 12.7%, which is approximately the same percentage as our FY24 shared service budgeted costs ($416M figure in chart on page 45 of the budget narrative).

Syntellis Functional Area Metric Comparisons

Description	Standard Classification	Measure	50th Percentile
Health System - CompAn Only	ADMIT AND SCHED	Admit and Centralized Sched Expense as % of Total Expense	0.46%
Health System - CompAn Only	CARE COORDINATION	Care Coordination Expense as % of Total Expense	0.72%
Health System - CompAn Only	EDUCATION	Education Expense as % of Total Expense	0.30%
Health System - CompAn Only	FISCAL SERVICES	Fiscal Services Expense as % of Total Expense	0.68%
Health System - CompAn Only	GENERAL ADMIN	General Admin Expense as % of Total Expense	4.38%
Health System - CompAn Only	HIM	HIM Expense as % of Total Expense	0.32%
Health System - CompAn Only	HUMAN RESOURCES	HR Expense as % of Total Expense	0.47%
Health System - CompAn Only	INFORMATION TECH	Information Technology Expense as % of Total Expense	2.77%
Health System - CompAn Only	LEGAL	Legal Expense as % of Total Expense	0.22%
Health System - CompAn Only	MARKETING	Marketing Expense as % of Total Expense	0.46%
Health System - CompAn Only	QUALITY	Quality Expense as % of Total Expense	0.49%
Health System - CompAn Only	REVENUE CYCLE	Revenue Cycle Expense as % of Total Expense	0.63%
Health System - CompAn Only	STRATEGY	Strategy Expense as % of Total Expense	0.17%
Health System - CompAn Only	SUPPLY CHAIN	Supply Chain Expense as % of Total Expense	0.59%
Health System - CompAn Only	VIRTUAL CARE	Virtual Care Expense as % of Total Expense	0.03%
		Total	**12.7%**

In terms of the more detailed process and decision making that goes into how we develop the staffing budgets that lead to the results above, it is performed differently based on area. For example, for nursing units, the union contracts dictate what we budget for staffing. The metric used is Nursing Hour per Patient Day (NHPPD). We centrally budget how many patient days we are projecting, which is factored into the union negotiated metric (20.29 NHPPD for SICU, 11.10 NHPPD for Miller 4 Cardiology, 9.71 NHPPD for Baird 4 General Medicine, etc.), which then determines the number of FTEs we budget. For other clinical areas such as radiology, lab and periop, we use the historical Worked Hours per Unit of Service (WHPUOS), make adjustments to that figure if necessary, then multiply by the number of units (radiology exams, lab tests, OR cases,

etc.) that we are budgeting to determine the FTEs. For shared services we use the total cost comparison to help decide FTEs levels.

25) Page #26: Financial Indicators. Based on current market rates, please inform the Board of the borrowing cost of $100,000,000 at institutional grade A, A-, BBB+, BBB, and BBB-.

Please see below a table of the current borrowing costs for a health system at different rating categories, provided by our financial advisor.

	A	A-	BBB+	BBB	BBB-
Tax Exempt	4.51%	4.61%	4.76%	4.91%	5.06%
Taxable	5.60%	5.75%	5.90%	6.15%	6.45%

It is important to note that if the rating were to fall into the BBB category, it would not just increase the cost of new borrowing, but could also impact some existing borrowing, as well. In addition, a downward trajectory would indicate an organization that had not reached long-term sustainable operations. Legal requirements would likely increase, and access to certain products and capital access at all could also be significantly limited at the lower rating categories.

26) Page #31; para #2; line #2: In addition to working with payers and Legislators, what other approaches are you taking to address "non-value cost in the health care system."

UVMHN continues to maximize the value and efficiencies resulting from Network-wide standardization of processes and programs. Through consolidation of administrative services we have reduced vendors and vendor costs. We have moved PMC and CVMC from outsourced self-pay collection agreements to internal resources, reducing the cost to collect by more than half. We are moving from outsourcing workers compensation medical claims payments at CVMC to internal resources, at a savings of two-thirds the outsourced cost. Additionally, we continue to work on operational standardization so that we can share training materials and training resources. Sharing in resources and efficient onboarding allows us to move resources to fill employment gaps internally and reduce contract labor costs. Finally, the build out of self-service tools not only provides a better experience for our patients, but also reduces the number of phone operators required to staff our call center. We are utilizing a Robotic Process Automation (RPA) system to reduce the need for FTEs, and are in the final stages of exploring an AI system/vendor that will further reduce our workforce needs. All of these efforts maximize our limited resources, removing wasted costs out of the system.

While we will commit to continuous improvement on our internal processes, we are also working with our payers to limit the costs of administrative requirements which add significant costs to the system and create barriers to care. Some payers are willing to work with us using

technology to streamline processes and reduce processes where possible. The progress in this area is slow and unfortunately some payers continue to implement policies requiring significant staff and provider time in order to attain services for our patients. Until this area of health care is addressed, our ability to reduce non-value costs is limited.

27) Page #31; Patient Referral Lag Time: In a two-week period, there were 85 families seeking pediatric health care from UVMHN hospitals that were unable to do so. In addition, there were 112 women's seeking care that failed to get prompt access. In addition, there were 142 patients seeking primary medical care that could not be scheduled within 30 days. In addition, there were 315 women seeking women's health care, 196 of whom were seeking obstetrical care and were unable to get it within a full month. Provide an outline of your definitive plans for resolving the above systemic challenge. What is hindering your ability to address it?

We are aware of the access issue in Pediatrics, especially in higher referral divisions like Pediatric Gastroenterology and Endocrinology. We have an additional endocrinologist starting in October to help relieve the access in that program and an additional nephrologist and cardiologist joining us in the summer of 2024. We have a job posted for an additional gastroenterologist and geneticist with the hope that we will fill those positions in the months ahead. In the meantime, the physicians in the divisions named and others are triaging the patients on their waitlists to make sure those with acute needs are being scheduled as quickly as possible, and the providers are also adding in additional time and clinic sessions to see these patients who need to be seen despite all appointment schedules being fully booked. The providers also provide teleconsults to referring physicians to provide help to patients who are waiting to be seen. Adolescent services has a plan in place in FY24 to double its staff and space so as to increase access for its programs in adolescent health, eating disorders, and transgender youth. Our autism referral program is merging staff and space with the child psychiatry Center for Children Youth and Families with the purpose of expanding their ability to see more patients. The pediatricians in the state are also being trained via our Vermont Child Health Improvement Program to do their own autism screening which will reduce the waitlists for that program as well.

Bottom line—we are dealing with access issues, by adding providers and staff, adding sessions, offering immediate telemedicine access to providers making referrals to give them plans to help diagnose or treat their patients while they await their consultative visit, and making sure all clinical sessions are fully utilized. There is also a paucity of some pediatric subspecialists nationally which can hamper our ability to recruit in some specialties as quickly as we would like to do so.

For OB, we work hard to make sure that in vitro activations (IVA) are available in the appropriate timeframe. Our next available is 8/10 (telemedicine) and 8/14 (in-person). When we are booking too far out, we adjust or add clinics to accommodate. We do run into situations where individuals are calling in at four weeks, and we want to wait to see them for the ultrasound to be able to see appropriately. For GYN, we can be booking far out, depending on the provider. We get in urgent referrals, but if someone needs to see a specialist, there can be a significant wait.

28) Page #34; Last Para: line #6: Of the envisioned $666M in capital needs that have been identified for investment in UVMHN, what proportion are for Vermont versus New York expenditures?

Our FY 2023 – FY 2027 capital framework of $666M includes approximately 86.2% in capital attributable to the Vermont partner hospitals of the UVM Health Network (approximately $574M).

29) Page #34; et al: Identify by position employees within the capital budget planning process who represent patient needs, expectations, and experience.

The capital planning process includes input from numerous leaders (Directors and above) representing both clinical and non-clinical areas through an open budget request process. Representing patient needs, expectations and experience is a shared responsibility of all leaders during budget development. This process is all overseen by a Network Capital Committee comprised of Network and partner organization CFOs, and other key financial and administrative leaders who oversee clinical areas. Additionally, each Network partner organization undertakes an extensive capital prioritization process annually, and currently must obtain approval for all capital expenditures from the Network EVP/CFO, Network EVP/COO, and EVP/President of the UVMHN Medical Group.

30) Page #37; para #2; line #4: We believe that a more appropriate calculation on the impact of uncompensated excess inpatient care would be to utilize the actual 2020 UVMMC average length-of-stay which is at least one day longer than the expected Vizient number. Utilize this actual number and resubmit the three tables at the top of page #38.

We do not agree that a more appropriate calculation would be to use the 2020 average length of stay, as the question asked how much "uncompensated" care we are providing. The reason why we have used the Vizient expected ALOS is because that is the figure that aligns most closely with the ALOS connected to the DRG payment received for that care. By using the 2020 LOS, which is higher than the expected, which by proxy is beyond what we are getting reimbursed for, we are ignoring a large portion of the uncompensated care that we are providing. We have provided the chart below using the actual FY20 ALOS, but again, we do not feel this accurately reflects the uncompensated care we are providing.

	FY22 Actual								
	Actual ALOS	FY20 Actual 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	5.89	399	366	12,017	15%	10,214	$ 2,222	$ 22,695,975
CVMC	5.16	4.80	59	55	1,514	15%	1,287	$ 1,962	$ 2,524,238
								Total	**$ 25,220,214**

	FY23 YTD May Annualized								
	Actual ALOS	FY20 Actual 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	5.89	409	365	15,849	15%	13,471	$ 2,222	$ 29,933,602
CVMC	4.89	4.80	56	55	379	15%	322	$ 1,962	$ 631,588
								Total	**$ 30,565,190**

	FY24 Budget								
	Actual ALOS	FY20 Actual 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	5.89	400	371	10,588	15%	9,000	$ 2,222	$ 19,997,359
CVMC	5.05	4.80	62	59	1,125	15%	957	$ 1,962	$ 1,876,740
								Total	**$ 21,874,100**

31) Page #41; Emergency Department Charges: Please add a column to the charts reflecting the actual expense of providing these services.

The below table represents the average cost per CPT for FY 2022 actual volumes and expenses, computed from our cost accounting system.

University of Vermont Medical Center FY 2022	
CPT	Total Cost per CPT
C_99281	$119
C_99282	$222
C_99283	$322
C_99284	$506
C_99285	$911
Central Vermont Medical Center FY 2022	
CPT	Total Cost per CPT
C_99281	$78
C_99282	$136
C_99283	$202
C_99284	$350
C_99285	$452
Porter Medical Center FY 2022	
CPT	Total Cost per CPT
C_99281	$105
C_99282	$134
C_99283	$225
C_99284	$464
C_99285	$702

32) Page #44; para #1; line #1: How long has this shared service organization been in place?

There is no standalone shared service organization in place at this time. There is a shared service funding model. The shared service funding model is for common administrative service expenses which would typically be incurred as a standalone hospital. Having a shared administrative services structure allows for more efficiencies, economies of scale, and better value opportunities for Network partner organizations which may not otherwise be there as a standalone hospital.

The shared service funding structure was initiated around FY 2016 and has continued to evolve since to the current state, which includes the full continuum of services which we believe fairly represents shared administrative services for the Network.

33) Page #46: Et Al: What is UVMHN's expected management spans of control which, within this document range from 2 to 1 to 18 to 1?

The management span of control varies by area. The 2 to 1 and 18 to 1 figures highlighted on the chart on page 45 of the narrative is only for shared services. For certain areas, primarily shared service areas, it is not the number of employees that dictates the need for a management position, but the need to lead a "function" across the Network. As an example, we have a leader of our transformation office that leads the implementation of key initiatives across the Network. There is only one other staff person in this area, but the leader has the authority to call on resources from across the Network to implement those key initiatives. In clinical areas, the number of FTEs plays a larger part in the number of leaders needed. It is not an exact science, but in general the more standardized the work is in a given area, the larger the ratio; the more specialized, the lower the ratio. As an example, on a nursing unit the ratio can be as high as 50 to 1, and in Medical Physics it is 7 to 1.

34) Page #45: Et Al: How will you measure the success of the investment of $4M and 19 FTEs in the Diversity, Equity, and Inclusion effort?

The $4M DEI budget for our network is divided into approximately $2.3M for the Community Health Improvement team and separately into Diversity, Equity and Inclusion work ($1.7M) for our hospitals and Network.

Community Health Improvement (CHI) is a department with 9 staff and one Director ($1M in salary and fringe) who work on various initiatives internally and externally focused on building a thriving, equitable community throughout Vermont, as well as capture and increase Community Benefit. (There is also a nursing position that resides within this structure who serves as the Poison Outreach Educator for Vermont Poison Control Center.)

The CHI department shifted into the DEI department last year, as its main focus is on equity, increasing access to care for key populations and using an equity lens (state and national recognition) to conduct the CHNA in an inclusive, community driven way.

Below are the major areas of staff/budget allocation. Of note, over half of this budget goes directly into the community to support equity, access and CHNA needs, and the rest is to support the staff to do the related work.

Community Health Needs Assessments and Investments:

- Triennial consulting and publication fees as needed.
- Initial funding for each health care partner to establish a program to regularly invest in community partners ($150K). This is to leverage their work as partners and experts (on addressing SDOH, mental health, health equity, etc.) while fueling a systematic approach to meeting the communities' identified needs and implement key (community driven) strategies to build overall health in the community.
- UVMMC has a well-established (CHI) program that invests approximately $1M in the community from this budget. Key components include the following:
    - Key supporter of Community Health Centers (over $100K annually) for the sliding fee scale
    - Cover Medicaid patients' pharmacy co-pays ($10K)
    - United Way (over $100K annually) for program support
    - Other organizations and programs to support marginalized communities include Boys and Girls Club, Vermont Racial Justice Alliance, Turning Point Center (substance use), New American Girls on the Rise program, Pathways Vermont (housing), Dad Guild, The Dream Program and more ($800K+ annually via equitable application process)
- The Blueprint requirements for Accountable Communities for Health (steering committee of community leaders) play key roles in the CHNA and resulting strategies.
- Pediatric food initiative: $10K of food purchased for patients leaving the hospital who have no food at home.

The UVM Health Network participates in the Health Anchor Network; the goal is establishing internal capacity and baseline data for formalizing our commitment to being an anchor institution that centers equity and focus on buying, investing, hiring locally to increase wealth and health in our communities, and also working to create a sustainability (environmental justice and climate health) plan for our Network.

The CHNAs for each hospital is already included in the budget.

The detail of the work for the $1.7M is as follows: $880K for the Network staff who oversee the Network and also specifically cover Porter and CVMC; $700K for UVMMC; and $120K for UVM Health Network – Home Health & Hospice. This covers salary and benefits.

The specific goals that are planned for FY24 is to collect an accurate report of the race and equity of our workforce—currently approximately 12% of the data is missing due to staff not reporting ("blank" answer field) by creating a process of safely allowing for a voluntary submission of that data into Workday. The goal is to reduce missing data to less than 6%. The second goal is to provide DEI education for 80% of all of our staff and new employees across the Network with our unified "Everyday Inclusion Training."

We are also currently defining the specific question on the Gallup Employee Engagement survey to improve as part of our employee experience improvement.

For health care equity, we have targeted diabetes (A1C) and colorectal screening rates reporting for Medicaid patients and specific primary care offices in under-resourced locations to improve to overall averages. The specific measures that we are currently anticipating reporting for FY24 is included in our 2022 DEI impact report, but we have decided to focus on diabetes and colorectal screening for our Network. This was recommended by our Population Health and Quality Board subcommittees.

Central Vermont Medical Center

1) How many of the 165 open physician positions are CVMC's and which department/specialty.

Please see response to question 1 in UVMMC section above.

2) CVMC will soon be expanding educational space following approval of a $735,000 federal grant. Will this project be 100% grant funded?

At this time, we are unsure if the project will be 100% funded by the federal Congressionally Directed Spending from Senator Peter Welch, as there has not yet been a final decision regarding the project location.

3) Exhibit 10 does not indicate gross charges increases for previous years. Either update the exhibit or provide the percent change in charge implement by payer and service type.

File provided to GMCB staff on 7/25/23.

4) What is the estimated underpayment by commercial plans for the past 3 FYs (i.e., FY21, FY22, and FY23 projected) for CVMC?

Please see response to UVMMC question number 4, above.

5) Elaborate on the 207% increase from 23B to 24B% in other current liabilities (Balance Sheet)

The increase in current liabilities between FY23B and FY24B is tied to a FY23B misalignment of the due to/from related parties spread between budget and actual. For FY24B CVMC followed the current liability spread modeled by FY22A. This would be a 29% increase from FY22A and if compared to FY23P, 6.4% increase.

6) Explain why traveler FTEs are projected to remain at essentially the same level (75 vs 76) compared from FY24B to FY22A (Exhibit 11)

The need for travelers continues to be influenced by recruitment, retention and continuing to maintain a capacity to care for the Central Vermont community. During the fiscal year the need for travelers is adjusted based on capacity needs, and the average traveler need is approximately 76 for CVMC. It should be noted, approximately 30 FTEs of the 76 FTEs are to cover staffing at Woodridge.

Porter Hospital

1) Specify how many of the 165 open physicians positions are Porter's and which department/specialty.

Please see response to question 1 in UVMMC section above.

2) Exhibit 9 lists $34,614,243 for commercial GPR whereas $56,042,111 is reported in Adaptive for FY21. Which value is correct?

The $56M figure is more representative of what the commercial amount was in FY 2021. In FY 2021 Porter Hospital converted their general ledger reporting system from Meditech to Premier Connect. Then in FY 2022 they converted their electronic health record from Meditech to Epic. The Meditech system did not provide much general ledger detail, and manual adjustments were previously made for Adaptive report through FY 2021. Being on the same systems across the Network has allowed for system generated reporting, resulting in more consistent and detailed reporting directly from the general ledger system with no manual adjustments necessary for Adaptive.

For comparative trend analysis we would recommend only using FY 2022 data forward, as they were all reported from the same systems with consistent criteria.

3) Exhibit 10 does not indicate gross charges increases for previous years. Either update the exhibit or provide the percent change in charge implement by payer and service type.

File provided to GMCB staff on 7/25/23.

4) What is the estimated underpayment by commercial plans for the past 3 FYs (i.e., FY21, FY22, and FY23 projected) for Porter?

Please see response to UVMMC question number 4, above.