THE University of Vermont HEALTH NETWORK

To: The Honorable Kevin Mullin, Chair, Green Mountain Care Board

From: Rick Vincent, Chief Financial Officer, University of Vermont Medical Center
Kimberly Patnaude, Chief Financial Officer, Central Vermont Medical Center
Scott Comeau, Chief Financial Officer, Porter Medical Center

Date: July 1, 2021

Subject: The University of Vermont Health Network Fiscal Year 2022 Budget Narrative

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A. Executive Summary

The University of Vermont Health Network is an integrated academic and community health system that serves more than one million residents across Vermont and Northern New York. We are working to preserve access to care for the communities we serve while simultaneously changing the way health care is delivered through innovation. Our mission is to create a financially sustainable network that focuses on wellness as much as illness, provides the highest quality care, and manages costs so that our communities can thrive. As we carry out that mission, we are committed to promoting a diverse, equitable, and inclusive health care environment for our patients, employees, and communities, and are actively addressing racial inequities in access to care and in health outcomes.

We are a system of six hospitals, a home health and hospice agency, and a medical group. The Network includes three hospitals subject to Green Mountain Care Board (Board) budget approval under 18 V.S.A. § 9375(b)(7) – the University of Vermont Medical Center, Central Vermont Medical Center, and Porter Hospital. This document describes the Network's budget submissions on behalf of these hospitals for Fiscal Year 2022 (FY 2022), as well as how these budgets comport with our mission to improve the affordability and quality of health care for Vermonters.

The past year was unprecedented in the history of our Network and its affiliates. We experienced a pandemic and a cyberattack, and had to take an "all hands on deck" approach to both. The combined effect of these emergencies was:

- We became skilled in all aspects of pandemic management. The Network had to ramp up a full-scale response to COVID-19. This included statewide triaging of all COVID-19 tests; becoming a primary statewide purchaser of personal protective equipment (PPE) and establishing resource distribution protocols; collaborating with other partners to develop a Patient Transfer Center (PTC) and develop the statewide surge plan; and launching mass vaccination clinics in each of our three Hospital Service Areas (HSAs).

- We halted much of our normal business. In alignment with declared states of emergency and to control virus spread, the UVM Health Network suspended all elective, non-urgent procedures and appointments starting on March 17, 2020. This led to a dramatic reduction in our normal revenues and to pent-up demand for our services when restrictions were eased.
- We became experts in cyberattack response and recovery. Upon becoming aware of the cyberattack that struck our Network on October 28, 2020, our Information Technology team brought down the Epic electronic health record system, which includes the MyChart patient portal, and also took down employee email and Internet connections, to protect patient and employee data. As a result of this action, the malware did not reach Epic, and patient data was not compromised. However, these necessary steps to protect our electronic health record system created significant operational interruptions for all personnel throughout our Network.
- We rebuilt large portions of our information systems. It took a significant amount of time for us to rebuild computer infrastructure systems where data had been encrypted as a result of the cyberattack. IT staff had to reconstruct the entire infrastructure before re-populating it with backed-up files and data, which took several weeks. In addition, IT staff had to scan and clean over 5,000 computers and endpoints that had been infected by the malware.

We made it through these crises, but are now witnessing, and coping with, their after-effects. As our vaccination levels approached 80% in Vermont and 70% in New York, we have been experiencing a surge in high acuity Emergency Department (ED) visits and inpatient stays. This surge includes both delayed care and a high volume of patients presenting with a primary diagnosis of mental illness. The historical lack of adequate mental health services combined with the pandemic exacerbated what was already deemed a health care crisis.

This aftershock comes at a time when many of our frontline providers and staff have lived through many months of extreme stress and are fatigued. To preserve their health, well-being and effectiveness, we are making major investments in temporary personnel. However, this comes at a time when there are workforce shortages at all our affiliate hospitals and across the entire country. In addition, like all businesses, we are seeing hyperinflation in all types of expenses.

The twin crises we have experienced in FY 2021 understandably diverted us from some of our priorities for the year. We paused planning for and implementation of some very important initiatives, including:

- Strategic investments in improving the state's mental health system, including planned submission of a Certificate of Need (CON) to build an inpatient psychiatric facility at CVMC, in coordination with the State of Vermont;
- Implementation of Epic at Porter and CVMC, which will allow for better coordination and efficiency of care across our Vermont affiliates;
- Planning for expansion and improvement of the UVM Medical Center ED and NICU, critical steps to establishing UVM Medical Center as the Network's tertiary care hub serving the people of our region;

- Consolidation of administrative services and systems aimed at reducing costs and improving efficiency, such as the expansion of our Robotic Process Automation (RPA) technology; and
- Planning for replacement of our Fanny Allen ambulatory outpatient care site.

The UVM Health Network has already restarted the planning and implementation of these critical initiatives, which will continue in FY 2022. We look forward to working with the Board as we emerge from this unusual year, and we recognize that it is incumbent upon us to justify each expense dollar and the corresponding revenue request.

For FY 2022, we are requesting net patient revenue (NPR) increases as follows:

- UVM Medical Center 6.34%
- Central Vermont Medical Center 4.54%
- Porter Hospital 4.85%

The assumptions in the FY 2022 budget include a 0.0% increase in Medicaid payment rates and an increase in Medicare payment rates between 2.0% to 2.5%. Because those public payer increases do not cover the inflationary pressures affecting our operations, our budget requests, if approved, necessitate aggregate commercial insurance rate increases of:

- UVM Medical Center 7.05%
- Central Vermont Medical Center 7.41%
- Porter Hospital 5.86%

These commercial rate requests are a reflection of the fact that our budget continues to be built on a fee-for-service foundation and a cost shift from public to private payers. This is not our desired state. We want to be paid, evaluated, and regulated based on how well we serve our community, in terms of both cost and quality of care. We respectfully request that the Board work with us during FY 2022 to transform the budgeting process to population-based metrics that hold us accountable for increases in per-capita costs and outcomes for the people we serve, while holding payers accountable for a reasonable rate of increase in per-capita expenditures for the people they cover, with a greater reliance on provider-driven management of health care delivery. This was the intent of the All-Payer Model (APM), and we remain committed to it.

Finally, we remain similarly dedicated, as a Network, to advancing health care reform in Vermont. COVID-19 has shown us again that a reliable and resilient health care system is essential to our State's health, and that changing how we pay for, organize, and evaluate our health care system is a pressing need. The APM continues to be our most promising path for achieving this vision, and we want to work with you toward that aim. We look forward to discussing this in further detail with the Board in the coming weeks.

Introduction

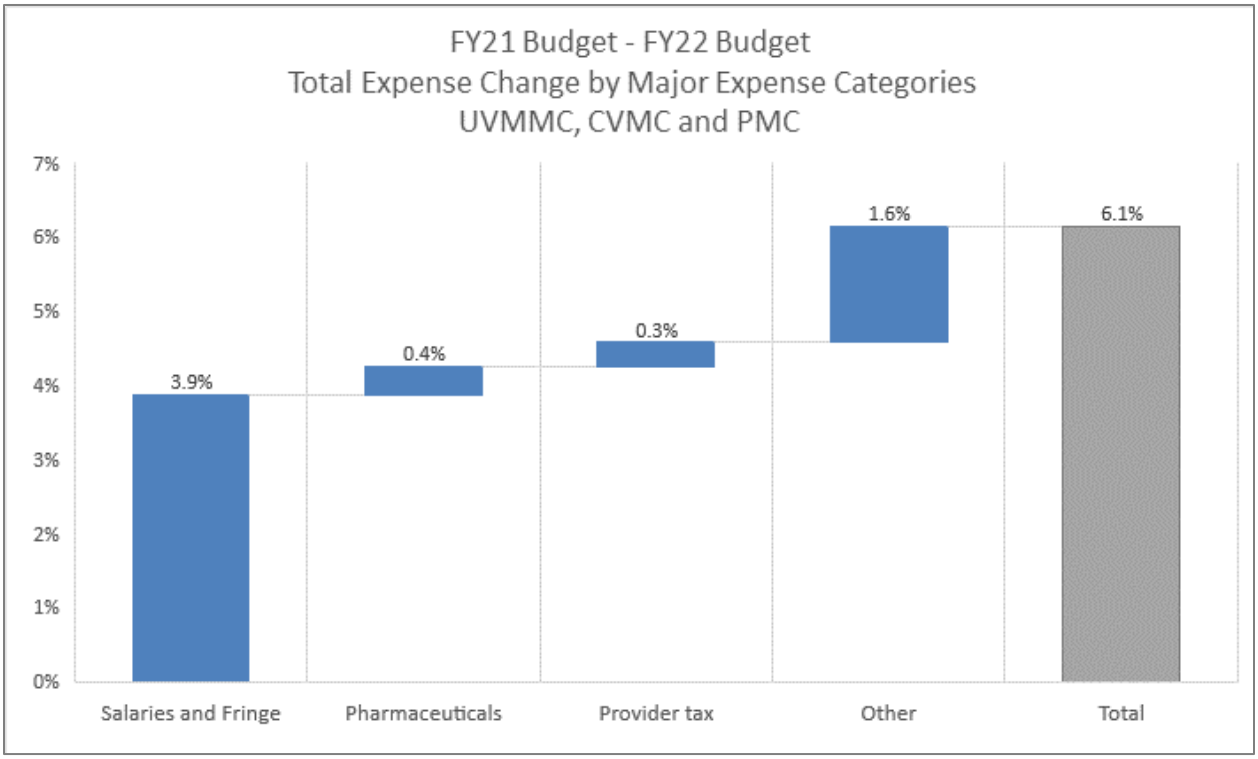
We have built our budgets to serve all of the principles governing this Board's hospital budget review process: (a) improving the health of the population; (b) reducing the per-capita rate of growth in health expenditures; (c) while ensuring that access to quality care is not compromised, both now and in the future; (d) enhancing the patient and health care professional experience; (e) supporting the recruitment and retention of high-quality health care professionals; and (f) achieving administrative simplification in health care financing and delivery. (18 V.S.A. § 9372; GMCB Rule 3.101.) We now ask the Board to examine our budgets through reference to these same statutory principles, utilizing objective metrics to determine whether our proposed revenues, expenses, and resulting margins are appropriate. When our budgets are judged against those standards and metrics, we are confident they should be approved as submitted.

At its core, any hospital budget is a combination of the expenses necessary to care for a population combined with the revenues necessary to both cover those expenses and to generate a margin sufficient to invest in the future of health care delivery. As set forth below, the UVM Health Network is working to control its expenses, and we believe we compare favorably with other delivery systems in the country – particularly when our expenses are examined on a population adjusted, per-capita basis. With respect to revenue, our budgets would produce the minimum operating margin and other measures of financial stability necessary to continue to reinvest in our patients, our providers, and the facilities in which care is received and delivered.

According to objective metrics, the UVM Health Network is controlling expenses as well or better than the vast majority of American health systems

Each of our budgets begins with the expenses necessary to care for our patients. Those include the inflationary pressures that are beyond the control of any Vermont business, such as labor and supplies. As discussed below, those pressures have been high and unusually unpredictable in recent months. Nonetheless, according to virtually all available measures, the UVM Health Network is providing some of the most cost-effective care in the state and in the nation.

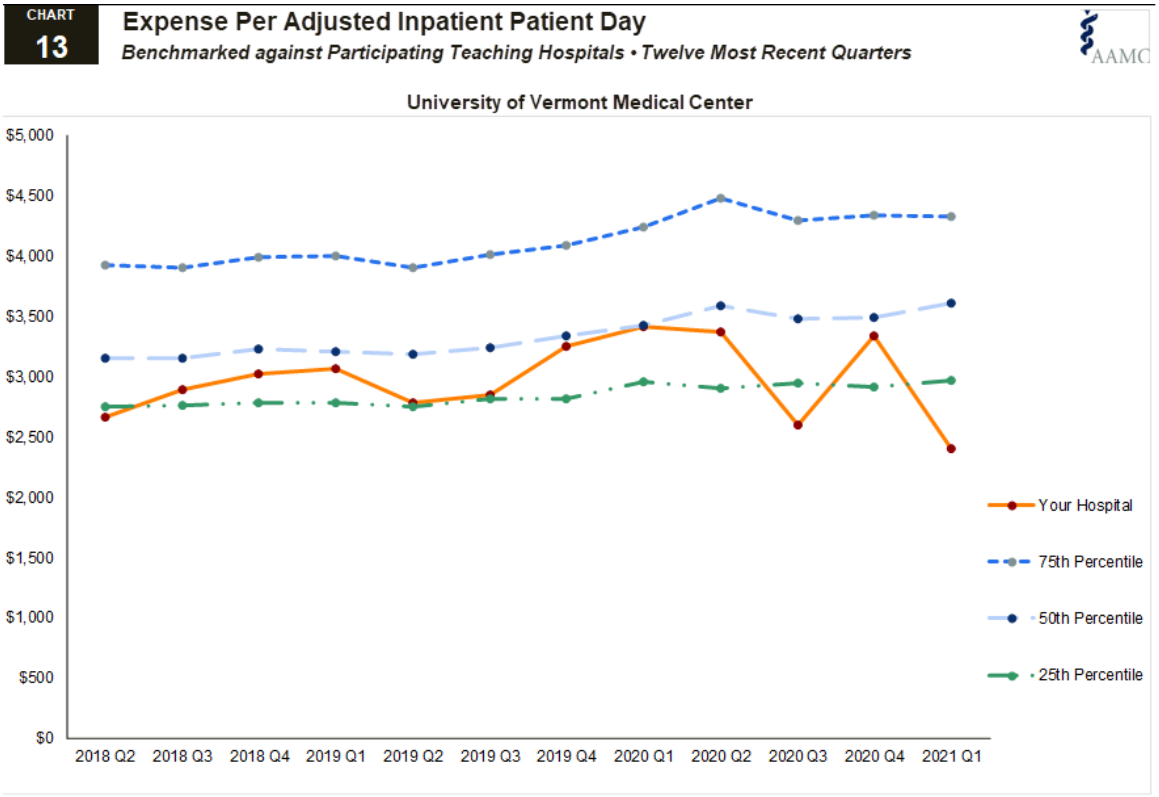
The growth of our expenses is primarily driven by the rising cost of labor. Salaries and fringe represents 64% of our Network's forecasted expense growth in FY 2022. The tightly constrained labor market is impacting all facets of our nonprofit integrated delivery system, from the cafeteria to central sterile to nursing and physicians. Like hospitals nationally, our leaders are struggling to maintain adequate staff to achieve our mission. To overcome these factors, we pay per diem to travelers and locum tenens and premium pay to our staff. Similar to last year, our labor and pharmaceutical expenses are not factors unique to Vermont – these are regional and national challenges, and are largely beyond the UVM Health Network's or the Board's control. Together, the growth of labor costs, pharmaceuticals, and the provider tax make up nearly 75% of our expense growth in FY 2022, as shown in the graph below.



Even with these externally-imposed inflationary pressures, reports commissioned by this Board consistently show that the UVM Health Network's Vermont hospitals provide high quality care at a lower cost than other hospitals and regions. By way of example, the following reports reflect that UVM Health Network provides high quality health care services at lower costs:

- All-Payer Total Cost of Care (TCOC) and Per Member Per Month (PMPM) TCOC interactive visualization tools, Green Mountain Care Board, 2021
- Price-Adjusted Total Medicare Reimbursements per Enrollee by HSA, Dartmouth Atlas Project, 2018

There is abundant evidence that our academic medical center is providing cost-effective care. Below is an example of a provider-level cost comparison from the Association of American Medical Colleges (AAMC) Council of Teaching Hospitals (COTH) survey. It shows that UVM Medical Center's Expense per Adjusted Patient Day over the last three years has consistently been between the median and the 25th percentile (lower cost) of other teaching hospitals.



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

Another comparison is the compensation ratio, which measures personnel costs as a percent of total operating revenue. With personnel cost being the single largest component of any hospital's expense structure, this is a key measure. Since FY 2016, UVM Medical Center's ratio has fluctuated from 55% to 58%, with the FY 2022 budgeted ratio at 55%. The Fitch A rating benchmark for this ratio is 56%.

Importantly, we have maintained high quality care while effectively working to control costs. More recently, the Board-commissioned report produced by Berkeley Research Group (BRG) shows that UVM Health Network hospitals compare favorably on many quality metrics. In particular, the Network hospitals are significantly below the Prevention Quality Indicator Overall Composite benchmark of 13.06, with Barre HSA at 8.01, Middlebury at 7.73, and Burlington at 5.96. We use this example to be illustrative – we are still in the process of reviewing the BRG report, along with all of the reports commissioned to support the Board's sustainability effort, and will comment accordingly.

In addition to these benchmark comparisons, another area where we are making progress is relative to Network administrative expenses. One of the goals in bringing the Network together was to take advantage of economies of scale to reduce administrative costs, and to also generate value by providing those services at a higher level of quality and performance. Measured as a percent of total revenue, UVM Health Network administrative services (HR, revenue cycle, IT, accounting, Network leadership, etc.) was 13.7% in the FY 2021 budget and is 13.4% in the FY 2022 budget. This reduction is being achieved even before we are on the same systems across the Network, such as Workday for HR/payroll, Epic for revenue cycle, and Premier Connect for

accounting, accounts payable, and purchasing. By the beginning of FY 2023, we expect to complete the implementation of these systems at each Network affiliate, at which point we will be able to accelerate the reduction in administrative costs as a percent of total revenue. In addition to this decrease in cost, we are starting to see improvements in the quality and performance of these services. Our payroll processing is much more efficient and reliable, recruiting staff and overall personnel management is more consistent across the Network, and we are identifying opportunities within our revenue cycle operations to increase collections on the revenue we are owed from insurance companies and government payers.

In light of these increased efficiencies, further significant cuts to expenses can now only reasonably come from one place: a reduction in the scope of services we provide to our patients, with a resulting movement of those services to out-of-state providers or reduced access for Vermonters. The financial ramifications of that movement could reverberate throughout the Vermont health care system: higher insurance costs necessary to reimburse out-of-state providers, lost provider tax revenue, lost employment opportunities for Vermonters, and lost opportunity to manage Vermont patients in a population health model. Of course, each of those results would run directly counter to the principles by which this Board is obligated to judge our budgets: improving the health of the population we serve; increasing, not reducing access, to high quality care; allowing us to retain and recruit providers, rather than struggle to maintain an adequate workforce; and supporting, rather than eroding, our ability to continue to invest in health care payment and delivery reforms.

The UVM Health Network budgets contain the revenue to cover today's operational expenses and to invest in tomorrow's health care delivery

The UVM Health Network's Vermont hospital budgets contain only the revenue necessary to cover operational expenses and to produce a margin necessary to reinvest in a health care delivery system that will continue to serve Vermonters in the future. Indeed, the revenue and rate increases reflected in our budget are just sufficient to continue to facilitate our return to financial stability – interrupted and delayed by COVID-19 and the cyberattack – after years of deteriorating margins.

Here too, we ask that the Board evaluate our revenue and margin requests through reference to objective measures. Our financial health is evaluated each year by objective third parties (such as the bond rating agencies), using consistent and objective metrics. In order for the UVM Health Network to have the financial stability to continue offering all the services our patients need and to reinvest in the communities we serve, we must meet key financial targets. Those targets, which should similarly guide this Board's assessment of our financial health, include:

- Earnings Before Interest Depreciation and Amortization (Operating EBIDA Margin): Indicates the cash profit or loss an organization is generating from its core operations. This is measured by operating margin with non-cash expenses removed. This metric is among the most important to our rating agencies and therefore has a profound effect on our costs of capital.
- Operating Margin: Indicates the profit or loss an organization is generating from its core operations. Hospitals need to generate a positive operating margin to survive; they cannot

rely on investment income or other non-operating revenue streams to meet the needs of their communities.

- Days Cash on Hand: Measure of liquidity. Higher levels, within reason, are better, as it means an organization has the funds to reinvest in the community, and has the reserves to weather unexpected negative impacts to its operating EBIDA margin.
- Long Term Debt to Capitalization Ratio: Indicates how much debt an organization has compared to its overall equity. Lower is generally better, as an organization with a higher ratio means they are carrying too much debt.
- Average Age of Plant: Indicates the average age of facilities, equipment, and other capital assets. Lower is better, as a higher number indicates a need to reinvest in the organization before assets become obsolete. This number fluctuates more from year to year than the metrics above based on the timing of large facilities projects.

	FY16 Actual	FY17 Actual	FY18 Actual	FY19 Actual	FY20 Actual	FY21 Projected	FY22 Budget	A Rated Benchmark Range
Operating EBIDA Margin								
UVMMC	11.5%	10.5%	8.0%	6.9%	5.4%	8.4%	8.1%	7.3% - 9.0%
CVMC	6.4%	4.3%	1.2%	2.2%	4.0%	2.1%	4.2%	7.3% - 9.0%
PMC	6.8%	7.8%	6.7%	6.0%	8.0%	2.9%	5.9%	7.3% - 9.0%
Operating Margin								
UVMMC	6.3%	5.5%	3.4%	2.2%	-0.3%	3.4%	3.0%	1.5% - 2.8%
CVMC	1.1%	-1.0%	-3.8%	-2.1%	-0.6%	-1.3%	1.0%	1.5% - 2.8%
PMC	2.4%	3.6%	3.0%	2.5%	3.2%	-0.3%	2.5%	1.5% - 2.8%
Days Cash on Hand								
UVMMC	208	222	205	172	174	209	186	213 - 246
CVMC	104	122	106	91	116	112	110	213 - 246
PMC	80	93	123	126	155	134	139	213 - 246
LT Debt to Capitalization Ratio								
UVMMC	37.8%	36.6%	34.6%	32.0%	31.8%	30.9%	29.7%	27.4% - 33.2%
CVMC	18.5%	16.7%	13.5%	11.4%	18.9%	15.3%	12.1%	27.4% - 33.2%
PMC	37.9%	32.3%	27.3%	25.3%	21.4%	19.4%	18.3%	27.4% - 33.2%
Average Age of Plant								
UVMMC	12.0	12.9	13.6	13.7	11.9	12.7	13.1	11.3 - 11.5
CVMC	9.4	10.2	10.8	13.0	15.7	15.3	16.1	11.3 - 11.5
PMC	11.5	12.0	13.3	14.4	14.9	15.6	13.5	11.3 - 11.5

The rating agencies (Moody's Investors Service, Fitch Ratings, and S&P) each have benchmarks they use for these metrics in assigning their credit ratings. Our performance since FY 2016 and the A rating benchmark for each agency (listed as a range) are highlighted above. These metrics must be viewed in relation to each other, as a whole; one cannot focus on just a single metric or a single year in isolation to determine if an organization is financially stable. The UVM Health Network was solidly within benchmark ranges in FY 2016, but in FY 2017 we began experiencing below expense inflation rate increases, which negatively impacted our operating EBIDA margin, which in turn negatively impacted our days cash on hand and average age of

plant. This continued through FY 2020. Thankfully our FY 2021 approved rate increase was closer to what was needed to cover expense inflation, and we hope that progress continues in FY 2022. The rating agencies this year made it clear that they are expecting the Network to be back in the 7% to 9% operating EBIDA margin range or risk a downgrade. Getting back to this level, not just one year, but every year, is key to our ability to return the other metrics to necessary levels that put us back on solid financial footing.

Ninety percent of all S&P rated hospital systems have an A rating or greater, and Vermont's only academic health system should not be an exception to that rule. An A rating is a powerful external validation that a health system is financially strong, has the capacity to care for its community, and is positioned well to embrace the scientific advancements of modern medicine. A downgrade is also a powerful external message that the finances of the organization will not support the investments necessary to make critical capital investments in facilities, technological advancements, or our people. We cannot build organizational resiliency or deliver on our mission to serve our community if we are in a state of decline.

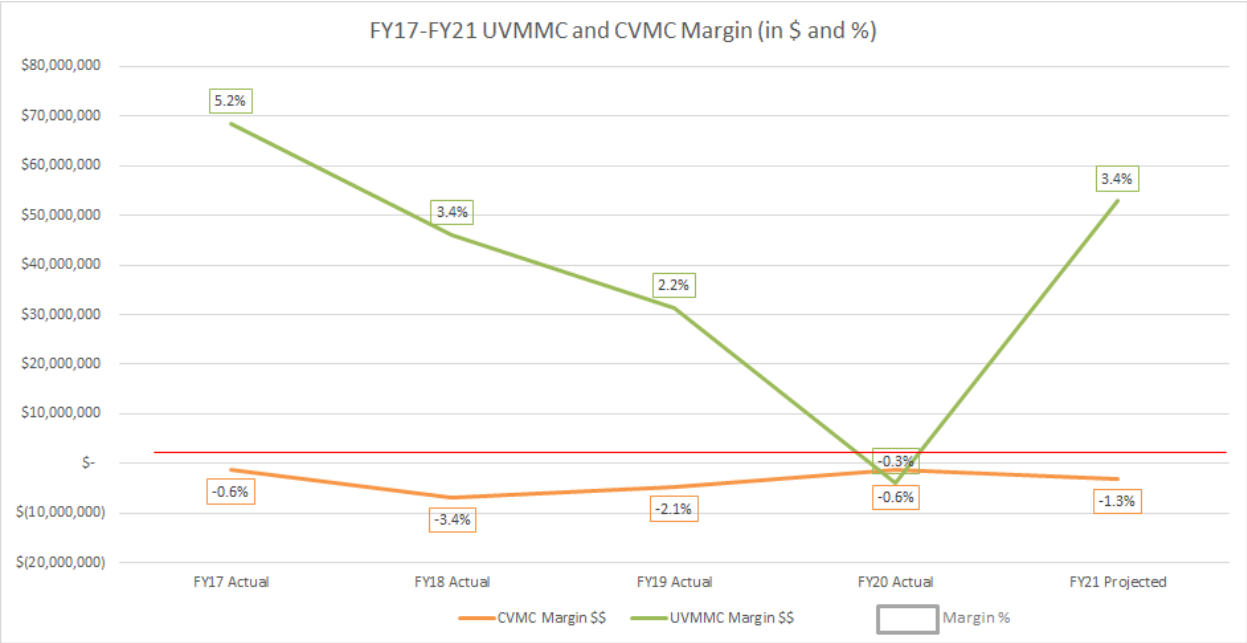
As noted above, the UVM Health Network as a whole needs to maintain an operating margin in the mid-2% range in order to fall squarely within the A rated range. This system-wide margin range can only be achieved if the academic medical center can attain a higher margin to balance the remainder of its health system. The complex nature of an academic medical center requires a higher margin than the median of the broader health system, shown in the table above, to properly fund critical capital investments and liquidity. The COTH survey, which contains only academic medical centers in its dataset, supports this construct – the median operating margin for academic medical centers nationwide is 5%. The operating margin targets contained in our budgets align with all of these benchmarks. As we begin a rebuilding process that will return us to financial health over the next three years, the target this year for our six-hospital network is 2.2%, while UVM Medical Center's is 3.0%.

Testing our budget assumptions

Although our budgets reflect NPR growth in excess of the 3.5% guidance published by the Board, they would produce financial results that still fall near the low end of the ranges expected of academic medical systems and A rated hospitals and health systems. Those revenues are, therefore, necessary to meet Vermont's stated statutory goals of maintaining access to high quality health care services for Vermonters, both now and into the future, while supporting our health care workforce.

Conversely, any cuts to the patient revenue we have proposed would jeopardize our shared responsibility to meet those goals and would undo the important progress that we made during last year's budget process. The margin graph below displaying our Vermont actual margins over a five year timeline, with FY 2021 projected for year end, gives us great pause. Our system, and each hospital, cannot operate without a sufficient margin to invest in our facilities, technology, and innovation. Notably, the FY 2020 negative actual margin results for UVM Medical Center and CVMC would have been even lower without the $100M of federal and state COVID-19 relief funds these two affiliates received and without austere cost-cutting efforts while the pandemic limited our ability to provide aspects of patient care.

Similarly, the positive margin projected in FY 2021 for UVM Medical Center is solely related to the arrival of approximately $84M additional COVID-19 relief dollars. Although the FY 2021 projected margin is 3.4%, or roughly $53M, this result is completely based upon these relief dollars, without which we would have anticipated an actual margin loss of almost ($31M). We are grateful for the federal and state support, but we must rely upon margin from operations; it is this margin, directly from the business we manage that we – and our bondholders – value most.



Evaluating affordability through TCOC analysis

Of course, every hospital budget must also meet Vermont's goal of "reducing the ***per-capita*** rate of growth in expenditures for health services in Vermont across all payers." (18 V.S.A. § 9372(2) (emphasis added)). Simply put, hospitals need to do their part to make health care more affordable. Here, too, the UVM Health Network's Vermont hospital budgets serve this goal when measured by a per-capita basis as required by law.

In prior submissions we have highlighted that a key missing component in the 3.5% revenue cap that the Board uses as its primary regulatory mechanism is that it is not anchored to a denominator, such as covered lives or per-capita. This would be the only true way to measure revenue growth, or cost growth from the patient/payer perspective. In prior submissions the denominator we used was what we called "unique patients," the number of patients we cared for in a given year. We made clear that this was not a perfect measure, as it did not represent the total population we serve, which we strive to keep healthy so that they do not need to access our services and add to our unique patient count. As a result, this year we have attempted to improve this analysis by using age stratified population data to create a per capita revenue figure. This is still not a perfect measure, but we believe it is an improvement over what we have presented in the past, and we again invite the Board to work with us to further refine it as a tool for consistent, year-over-year measure of health care costs.

In the analysis below we have used available Vermont population data and created a projection for FY 2022 using the population change projection in the recently commissioned capacity and quality Board report from BRG. This data has been adjusted to reflect the UVM Health Network (combined UVM Medical Center, Central Vermont Medical Center, and Porter Hospital) county market share, and broken out the data into three age categories – under 45, 45 to 64, and over 65. These categories reflect the difference in utilization of health care services between those age groups and is benchmarked using the average health care spending in those categories from the U.S. Department of Health and Human Services (HHS). Those aged 45 to 64 utilize health care services at 2.52 times the rate as those under 45, and those over 65 at 4.45 times the rate. We have used these utilization factors to adjust the population figures to reflect these differences in health care utilization. Our model, built on BRG's estimates, does not contain the 2020 Census data that was released in April 2021 at the state level. This new Census data, of 643,000 Vermonters, or a 3.2% one-year increase over the 2019 Census estimate, renders the BRG 2026 estimates stale. We chose to use the BRG data until the county data is released later this year. In light of this new information, the model we have built is directionally accurate.

	Average US Health Care Spending	Utilization Factor
Under 45	$ 2,544	1.00
45 - 64	$ 6,406	2.52
65 +	$ 11,316	4.45

In this model, after removing the New York-based NPR generated by UVM Medical Center, CVMC, and Porter (so that we are only comparing Vermont-based NPR with Vermont population), you can see that the UVM Health Network hospitals from FY 2016 through FY 2021 have been below the 3.5% growth guidance used by the Board. From FY 2016 though our projected FY 2021, the average rate of increase was 0.2%. Part of the reason for this low number is the impact of the COVID-19 pandemic in FY 2020 and the cyberattack in FY 2021. The projected $2,047 figure for FY 2021 is actually below what it was in FY 2017.

From the FY 2021 to FY 2022 budget we are also below the 3.5% growth guidance, sitting at a 2.6% increase that would be the envy of most states seeking to reduce the growth of the per-capita rate of health care costs. FY 2021 represented the first year since FY 2016 that UVM Health Network hospitals received a revenue rate increase that was close to covering expense inflation. If our FY 2022 budget is approved as submitted, which again includes a revenue rate increase that is meant to solely cover our expense inflation and the growing cost shift, we will continue to get back to more solid financial footing and still remain within the 3.5% growth guidance, when properly adjusted for the population we serve.

	FY16	FY17	FY18	FY19	FY20	FY21	FY21 Budget	FY22 Budget
Primary Market Population								
Chittenden	161,531	162,372	164,572	163,774	162,646	164,180	163,413	166,737
Franklin	48,915	49,025	49,421	49,402	49,116	49,690	49,403	50,271
Grand Isle	6,919	6,998	7,090	7,235	7,022	7,485	7,254	7,979
Lamoille	25,333	25,337	25,300	25,362	25,318	25,496	25,407	25,675
Washington	58,504	58,290	58,140	58,409	58,350	59,069	58,710	59,797
Addison	36,959	36,776	36,973	36,777	36,882	36,585	36,734	36,290
Subtotal	338,161	338,798	341,496	340,959	339,334	342,505	340,920	346,749
Rest of Vermont	286,433	284,859	284,803	283,030	284,979	280,746	282,863	276,576
Total Vermont	624,594	623,657	626,299	623,989	624,313	623,251	623,782	623,325
UVMHN Population (market share adj)								
Under 45	173,641	173,776	176,855	177,026	174,951	172,519	173,735	173,874
45 - 64	88,963	88,167	87,683	86,704	88,038	91,213	89,625	92,606
65 +	50,573	53,038	55,701	58,033	60,228	62,028	61,128	64,255
Total	313,177	314,981	320,239	321,763	323,217	325,760	324,488	330,734
Utilization Adjusted UVMHN Population								
Under 45	173,641	173,776	176,855	177,026	174,951	172,519	173,735	173,874
45 - 64	224,045	222,041	220,821	218,357	221,716	229,711	225,714	233,219
65 +	224,982	235,949	247,799	258,173	267,938	275,942	271,940	285,851
Total	622,668	631,766	645,474	653,556	664,604	678,173	671,389	692,944
UVMHN NPR	$ 1,432,524,332	$ 1,494,225,412	$ 1,538,581,738	$ 1,587,997,998	$ 1,481,191,345	$ 1,588,364,113	$ 1,752,443,841	$ 1,856,448,264
Less: NY NPR	$ 171,168,905	$ 181,667,846	$ 194,375,659	$ 195,355,597	$ 178,900,659	$ 199,977,545	$ 220,842,404	$ 234,092,653
UVMHN VT NPR	$ 1,261,355,427	$ 1,312,557,566	$ 1,344,206,079	$ 1,392,642,401	$ 1,302,290,686	$ 1,388,386,568	$ 1,531,601,437	$ 1,622,355,611
VT NPR per UVMHN VT Population	$ 2,026	$ 2,078	$ 2,083	$ 2,131	$ 1,959	$ 2,047	$ 2,281	$ 2,341
Percent Change		2.6%	0.2%	2.3%	-8.0%	4.5%		**2.6%**
FY16 to FY21 per Year Average						**0.2%**		

FY 2022 budget request: NPR, commercial rate, and cost shift analysis

With all of these factors in mind, the UVM Health Network respectfully submits our three affiliate budgets after the completion of a thoughtful and deliberate process that is further described below. For FY 2022, we are requesting NPR increases as follows:

- UVM Medical Center 6.34%
- Central Vermont Medical Center 4.54%
- Porter Hospital 4.85%

The assumptions in the FY 2022 budget include a 0.0% increase in Medicaid payment rates and an increase in Medicare payment rates between 2.0% to 2.5%. This means that our budget requests, if approved, would necessitate aggregate commercial insurance rate increases of:

- UVM Medical Center 7.05%
- Central Vermont Medical Center 7.41%
- Porter Hospital 5.86%

As we begin to emerge from the pandemic, a massive cyberattack, and the financial consequences of both unprecedented events, the UVM Health Network must focus on returning to a place of financial stability and strength. Our FY 2022 budget is intended to do just that: begin a rebuilding process that will return us to financial health over the next three years for the sole purpose of allowing us to continue to provide high quality care at the lowest cost possible that Vermonters deserve to receive close to home, both now and into the future.

The same pandemic has also created unprecedented budgetary uncertainty. It is difficult to reliably predict whether patient volumes will return or to what level – it is hard to predict patient behavior with certainty, including the levels of in-person and virtual health care visits they will seek. Other uncertainties include what sort of post-COVID-19 inflationary pressures will prevail in health care, whether we will be asked to mount a mass booster vaccination effort, or whether there may be a variant-driven COVID-19 resurgence in the fall.

The commercial rates identified are, first and foremost, the product of a mathematical equation designed to cover cost inflation on the commercial business and to cover the cost shift related to expense inflation. To be clear, our margin, costs incurred from the cyberattack, and rebuilding our balance sheet are not considered in our commercial rate request. A table outlining this request for each hospital is below.

University of Vermont Medical Center:

Expense Category	Expense Inflation
Salary & Fringe	$ 27,381,482
Med/Surg Expense	$ 3,589,777
Pharmacy	$ 2,568,598
All Other	$ 2,896,267
Provider Tax	$ 2,175,921
Total Expense Inflation	**$ 38,612,045**

	Revenue Required to Cover Expense Inflation		
Payer Category	Rate **without** Costshift	Rate **with** Costshift	Difference
Medicare	$ 11,276,822	$ 4,221,551	$ (7,055,271)
Medicaid	$ 4,488,607	$ (321)	$ (4,488,928)
Other Payers/Bad Debt/Free Care	$ 878,139	$ (5,129,090)	$ (6,007,228)
Commercial	$ 21,968,477	$ 39,519,904	$ 17,551,427
Total	**$ 38,612,045**	**$ 38,612,045**	**$ 0**

Budgeted Commercial Rate Increase	**$ 39,519,904**
Value of 1% of Commercial Rate Increase	**$ 5,605,660**
Budgeted Commercial % Rate Increase	**7.05%**

Central Vermont Medical Center:

Expense Category	Expense Inflation
Salary & Fringe	$ 3,962,006
Med/Surg Expense	$ 360,606
Pharmacy	$ 961,338
All Other	$ 469,792
Provider Tax	$ 339,212
Total Expense Inflation	**$ 6,092,954**

	Revenue Required to Cover Expense Inflation		
Payer Category	Rate **without** Costshift	Rate **with** Costshift	Difference
Medicare	$ 2,216,337	$ 1,232,823	$ (983,514)
Medicaid	$ 773,607	$ (178,653)	$ (952,260)
Other Payers/Bad Debt/Free Care	$ 249,726	$ (825,379)	$ (1,075,105)
Commercial	$ 2,853,285	$ 5,864,163	$ 3,010,879
Total	**$ 6,092,954**	**$ 6,092,954**	**$ 0**

Budgeted Commercial Rate Increase	**$ 5,864,163**
Value of 1% of Commercial Rate Increase	**$ 791,385**
Budgeted Commercial % Rate Increase	**7.41%**

Porter Hospital:

Expense Category	Expense Inflation
Salary & Fringe	$ 1,724,583
Med/Surg Expense	$ 142,343
Pharmacy	$ 121,338
All Other	$ 111,064
Provider Tax	$ 91,631
Total Expense Inflation	**$ 2,190,959**

	Revenue Required to Cover Expense Inflation		
Payer Category	Rate **without** Costshift	Rate **with** Costshift	Difference
Medicare	$ 875,907	$ 711,756	$ (164,151)
Medicaid	$ 230,763	$ (0)	$ (230,763)
Other Payers/Bad Debt/Free Care	$ (71,599)	$ (404,850)	$ (333,250)
Commercial	$ 1,155,889	$ 1,884,054	$ 728,165
Total	**$ 2,190,959**	**$ 2,190,960**	**$ 0**

Budgeted Commercial Rate Increase	**$ 1,884,054**
Value of 1% of Commercial Rate Increa	**$ 321,511**
Budgeted Commercial % Rate Increase	**5.86%**

The idea that our expense growth would be evenly distributed amongst our payers, to limit the burden that any one payer may bear, remains elusive. Our budgets reflect this troubling reality, and in the case of UVM Medical Center, places a $17.5M dollar burden on the commercial insurers to cover costs not covered by other payers. This implicit tax makes our rate increases, dollars needed to cover the expense inflation we experience, almost twice as expensive.

Investing margin dollars to secure our health care future

Maintaining the necessary level of care to our patients requires continuous reinvestment in our people, our facilities, and our equipment. Our ability to make these investments has eroded over time, and we have fallen behind on the capital reinvestment that is necessary to remain a modern, well-functioning health system over the long haul, again according to objective externally validated metrics. Our FY 2022 budget begins the process of putting us on a path to making sustainable investments in the people and infrastructure that deliver the care our patients need and expect to continue to receive locally.

As we have shared in previous budget narratives, our financial framework is a five year projection that 1) establishes the minimum operating EBIDA margin target for each year (the number we budget), 2) allows us to project the impacts on the financial metrics above to ensure they are either within or headed towards the rating agency benchmark range, and 3) informs how much capital we can spend in that five year period. The assumptions built into our financial framework are tested and relied upon in determining our rating by the rating agencies. This framework is updated every year in January. The most recent version projects annual operating EBIDA margins to return to the 7% to 9% range, and that the other financial metrics will also return to being within the rating agency benchmarks.

If we are not able to achieve our financial targets, the amount of investment we are planning to make will have to be reduced, and/or we will need to evaluate the services we provide to determine if by eliminating some we can still meet these targets and still make needed investments, or run the risk of a downgrade in our rating, which would not serve anyone's interests.

The value of an integrated health system during COVID-19

Our budget is built on the realization, made evident to all of us over the last year-and-a-half, that Vermont relies on its nonprofit health care system to step up in times of crisis. The COVID-19 pandemic provided a vivid illustration of the need to allow for Vermont's nonprofit hospital system to have the financial resiliency to not only weather the COVID-19 crisis, but also have the ability to work with the State of Vermont to keep Vermonters, patients, and providers healthy and well, vaccinate them to help end the pandemic, and reopen the State's economy.

The COVID-19 pandemic presented new challenges, almost daily. Mastering PPE procurement, staff safety protocols, offsite testing, new laboratory procedures and equipment, and vaccination protocols presented us with these challenges, which impacted every aspect of our operations and consumed our collective focus. These challenges continue, as we look to ensure we maintain everything from ongoing vaccination and testing capacity to the clinical capacity to treat acutely ill COVID-19 patients.

Hospitals of all sizes experienced steep declines in patient volume and revenue, while incurring extraordinary costs to expand capacity and keep staff and patients safe. The UVM Health Network instituted a number of initiatives to reduce the spread of the virus, protect and support our patients and staff, and safeguard our supplies and protective equipment. In alignment with

declared states of emergency and to control the spread of the virus among patients and our staff, the UVM Health Network announced on March 17, 2020 the suspension of all elective, non-urgent procedures and appointments. Across the UVM Health Network, affiliates undertook extraordinary measures to stand up COVID-19 units, temporary testing facilities, and create additional capacity in anticipation of a surge in COVID-19 patients.

The UVM Health Network has, in partnership with the State, led Vermont through the COVID-19 pandemic. We partnered with providers across the region, as well as local and state governments, to respond to the health care crisis and meet the needs of our communities. Examples include:

- The Network, in collaboration with the Vermont Department of Health, was asked by the Governor to take on the statewide triaging of all COVID-19 tests. Our Department of Pathology and Laboratory Medicine worked tirelessly to meet the ever-expanding testing needs of our state's COVID-19 response.
- The Network became one of the primary purchasers for the State of Vermont for PPE and established resource distribution protocols for scarce statewide resources.
- The Network, in collaboration with all Vermont hospitals and Dartmouth-Hitchcock, developed and instituted a Patient Transfer Center (PTC) to allow for the swift and timely movement of COVID-19 patients. This action, under the authority of the State of Vermont, was instrumental in developing the statewide surge plan.

The swift and bold actions of local and state government leaders, coupled with an incredibly coordinated response by Vermont's entire health care delivery system, resulted in COVID-19 case surges that did not exceed our delivery system's capacity. Continued vigilance will be necessary as we re-emerge from the pandemic and work to prevent or address any further waves of COVID-19 activity in our region. We are incredibly proud of the leadership role the UVM Health Network's dedicated and talented people played in every facet of Vermont's response to this crisis.

Vermont's strong emergence from COVID-19 is due in large part to our State's dedication to vaccinating as many Vermonters as possible and as quickly as possible. The UVM Health Network's vaccine program, launched across all three HSAs, was an incredible personnel and logistical feat. With the goal of vaccinating up to 2,000 Vermonters a day, we created mass vaccination clinics offsite in Berlin, Middlebury, and at the fairgrounds in Essex Junction. This mobilization required hundreds of our staff to organize, train, and execute this complicated public health response in partnership with the State of Vermont. To date, the UVM Health Network has administered more than 139,000 doses of the COVID-19 vaccine.

The three UVM Health Network vaccination sites have contributed to Vermont's No. 1 ranking in the country for percentage of vaccinated residents. Hundreds of dedicated staff members across the UVM Health Network have worked tirelessly since December to administer shots to as many Vermonters as possible. In recent weeks, the vaccination effort has proven to be successful – with the number of new COVID-19 cases declining steeply.

We remain committed to health care reform

In light of a pandemic, a cyberattack, and the incredible strain of our current employment situation, the UVM Health Network remains absolutely committed to health care reform, rooted in our unwavering dedication to improving the health of our patients. We believe that only by changing how we are paid to deliver care, coupled with meaningful changes in care delivery, can we begin to see the health outcome improvements we seek. We are expecting an approximately 7.5% increase in value-based payments over year-to-date actual experience. Changing how we are paid without changing how care is delivered will not improve TCOC growth or deliver the quality improvements our patients need. To this end, we have worked hard to create new care models that will deliver on the promise of integrated care.

B. Year-Over-Year Changes

NPR/FPP: Overview

Referencing the data submitted in Appendix 1, explain each component of the budgeted FY 2022 NPR/FPP change over the approved FY 2021 budget, referencing relevant FY 2022 budget-to-projection variances:

Please note FY 2021 projected NPR/FPP was determined at the total for each affiliate, and there was not an in-depth analysis completed at the payer level. Thus, the responses below for change from FY 2021 projected to FY 2022 budget will be based in total, and change from FY 2021 budget to FY 2022 budget will be based at the payer level, when possible.

Discuss changes in NPR/FPP expected from Medicare, Medicaid, and Commercial; and other reimbursements from government payers:
Significant changes to revenue assumptions from FY 2021 budget to FY 2022 budget:

University of Vermont Medical Center: Please refer to Appendix 1, Tables 1 and 3 on pages 3 and 4 in the appendices.

The tables we reference show the changes in the funds we collect as we move from our FY 2021 budget to our build of the FY 2022 budget. This deep dive into the impacts of rate, payer mix, utilization, and other factors is a combination of the aggregate commercial rate request and the first quarter FY 2021 adjustments factored into an annual adjustment. Taken together, this analysis shows how we budget from year to year and adjust our estimates based on the most current data available. Our ability to rely on this base budget adjustment is challenged by the Epic installation in the first quarter of FY 2020 and the cyberattack in the first quarter of FY 2021. Because of these factors we believe the NPR change year to year is best viewed over time at the combined budget total and not by individual payer categories.

The justification for the commercial rate request is spoken to on page 13 in the budget narrative.

Central Vermont Medical Center: Please refer to Appendix 1, Tables 1 and 3 on pages 12 and 13 in the appendices.

The table fairly speaks to changes in NPR/FPP from period to period. The only item to note is the negative impact on FY 2021 rates of $2.5M when combining mix and rate impact.

The justification for the FY 2022 commercial rate request is spoken to on page 14 in the budget narrative.

Porter Hospital: Please refer to Appendix 1, Tables 1 and 3 on pages 21 and 22 in the appendices.

The table fairly speaks to changes in NPR/FPP from period to period. The item to note is the negative impact on FY 2021 rates of $1.4M when combining mix and rate impact.

The justification for the FY 2022 commercial rate request is spoken to on page 14 in the budget narrative.

Significant changes to revenue assumptions from FY 2021 projected:

University of Vermont Medical Center: Please refer to Appendix 1, Table 1 on page 3 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 1, Table 1 on page 12 in the appendices.
Porter Hospital: Please refer to Appendix 1, Table 1 on page 21 in the appendices.

The main area of change from FY 2021 projected to FY 2022 budget, beyond what was shared above, is the assumption of volumes returning to pre-COVID-19 levels for all three hospitals in the utilization category: UVM Medical Center $91.8M, CVMC $12.7M, and Porter Hospital of $4.6M. With those changes come corresponding increases to bad debt and free care.

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

The UVM Health Network does not budget based upon the number of insured individuals. Bad debt and free care are calculated on a percentage of total gross revenue from all payers. For the most part, the percentage of bad debt and free care is measured as a percentage of total revenue and is relatively the same from budget to budget.

Bad Debt & Free Care as % of Total Gross Revenue

	FY2021 Budget	FY2022 Budget
UVMMC	1.81%	1.79%
CVMC	2.27%	2.00%
Porter Hospital	3.84%	3.79%

In the Vaccine Clinics and Testing tab of Appendix 5, include the revenues and expenses incurred by the hospital for providing employee and public COVID-19 vaccine clinics and testing:

University of Vermont Medical Center: Please refer to Appendix 5 on page 8 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 5 on page 17 in the appendices.
Porter Hospital: Please refer to Appendix 5 on page 26 in the appendices.

Impact of COVID-19 vaccine clinics and testing on FY 2021 projection and FY 2022 budget:

At all three of our Vermont hospitals, our projection was based on continued vaccine clinics and testing through the summer months. At the time of submission, the FY 2022 budget only includes continued COVID-19 testing, with vaccines becoming part of the normal primary care clinic operations.

NPR/FPP: Utilization

Describe any significant variances from the FY 2021 budget and projection (including changes in reimbursement and utilization):

University of Vermont Medical Center: Please refer to Appendix 1, Table 3 on page 4 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 1, Table 3 on page 13 in the appendices.
Porter Hospital: Please refer to Appendix 1, Table 3 on page 22 in the appendices.

Change from FY 2021 budget to FY 2022 budget:

- After removing FY 2022 gross charge increase and physician transfers, while there are some individual areas of plus/minus, UVM Medical Center utilization in aggregate is relatively the same as FY 2021 budget.
- After removing FY 2022 gross charge increase and physician transfers, while there are some individual areas of plus/minus, CVMC had utilization increase of $13M in gross charge dollars compared to FY 2021 budget.
- After removing FY 2022 gross charge, while there are some individual areas of plus/minus, Porter Hospital had utilization increase of $6.7M in gross charge dollars compared to FY 2021 budget.

Change from FY 2021 projected to FY 2022 budget:

- The material change for all three hospitals was the assumption that volume would mostly return to pre-COVID-19 levels.

Referencing the data submitted in Appendix 3, explain changes in your utilization assumptions to support your NPR/FPP variances:

University of Vermont Medical Center: Please refer to Appendix 3 on page 6 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 3 on page 15 in the appendices.
Porter Hospital: Please refer to Appendix 3 on page 24 in the appendices.

Table 1 in Appendix 1 reflects the NPR/FPP change associated with any utilization assumptions.

Charge Request

Referencing the data submitted in Appendix 2, explain the hospital's overall charge request on the charge master in Table 1:

University of Vermont Medical Center: Please refer to Appendix 2 on page 5 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 2 on page 14 in the appendices.
Porter Hospital: Please refer to Appendix 2 on page 23 in the appendices.

For all three hospitals, the gross charge increase was mostly spread as the same percentage to inpatient, outpatient, and professional services.

Explain how the request impacts gross revenue, NPR and FPP by payer and what assumptions were used in quantifying the requested increase/decrease for each in Tables 2-3. Describe how the charge request affects the areas of service (for example, inpatient, outpatient, etc.) in gross revenues, NPR and FPP by payer. Explain the underlying assumptions and methodology used to make that allocation:

University of Vermont Medical Center: Please refer to Appendix 2, Tables 2 and 3 on page 5 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 2, Tables 2 and 3 on page 14 in the appendices.
Porter Hospital: Please refer to Appendix 2, Tables 2 and 3 on page 23 in the appendices.

As noted above, the gross charge increase was mostly spread as the same percentage to inpatient, outpatient, and professional services.

For changes to NPR/FPP, it varies by payer:

- Medicare – UVM Medical Center and CVMC assumed a 2.5% increase in inpatient payment rates and 2.0% increase in outpatient payments. Porter Hospital assumed a 2.4% increase in Medicare payment rates for both inpatient and outpatient services. All three hospitals assumed a 0.0% payment increase on professional services.
- Medicaid – all hospitals assumed 0.0% increase in payment rates for inpatient, outpatient, and professional services.

- Commercial – the same payment rate increase was assumed for inpatient, outpatient, and professional services for each hospital: UVM Medical Center 7.05%, CVMC 7.41%, and Porter Hospital 5.86%. Justification for how those percentages were determined is found on pages 13 and 14 in the budget narrative.

Please note there is very little FPP reported for commercial; the covered commercial lives participating in the APM are adjudicated through FFS process, and then a reconciliation process is completed at the end of the year to determine any shared savings or risk.

Please indicate the dollar value of 1% NPR/FPP FY 2022 in Table 3 of Appendix 2, overall change in charge:

University of Vermont Medical Center: Please refer to Appendix 2, Table 4 on page 5 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 2, Table 4 on page 14 in the appendices.
Porter Hospital: Please refer to Appendix 2, Table 4 on page 23 in the appendices.

Adjustments

University of Vermont Medical Center
Effective September 2020, the following three provider practices have been transferred to CVMC: Berlin Family Medicine, Berlin ENT, and Berlin General Surgery. This accounts for a budget to budget reduction of $4.5M in NPR + FPP for UVM Medical Center.

Central Vermont Medical Center
Effective September 2020, the following three provider practices have been transferred from UVM Medical Center: Berlin Family Medicine, Berlin ENT, and Berlin General Surgery. This accounts for a budget to budget increase of $4.5M in NPR + FPP for CVMC.

Porter Hospital
There have been no major operational or financial changes that have material impact on financial projections or budgeting.

Other Operating and Non-Operating Revenue

Explain the budgeted FY 2022 other operating revenue and non-operating revenue changes over the approved FY 2021 budget, as well as relevant FY 2021 budget-to-projection variances:

University of Vermont Medical Center
Other Operating Revenue: Increasing by $27.5M or 14.8% from FY 2021 budget to FY 2022 budget.

- $10.3M growth in outpatient pharmacy business (new contracts with local pharmacies, expanded mail to home, Specialty Pharmacy, and expanded Meds to Beds, offsetting certain pharmaceutical companies limiting our 340B drug distributions to local pharmacies)
- $8.7M higher external lab revenue and COVID-19 lab testing for external clients
- $1.4M additional grant revenue offset by expenses (zero impact to margin)
- $6.4M Non-Affiliate MD contract revenue that was budgeted in FY 2021 as a salary cost recovery and is now flowing through as contract revenue (zero impact to margin)

FY 2021 budget-to-projection is heavily impacted by the HHS, FEMA, and State of Vermont COVID-19 relief funds, as identified in Appendix 7.

Non-Operating Revenue: FY 2021 budget-to-projection variances within the investment categories represent actual market performance YTD versus what was originally budgeted.

Central Vermont Medical Center
FY 2022 budget excludes any operating income pertaining to stimulus monies compared to FY 2021 projection, as well as reduction to outpatient pharmacy revenues pursuant to changes with 340B manufacturers that limit the distribution of certain 340B drugs through community pharmacies. Non-operating revenues budgeted based on current market trends for investments.

Porter Hospital
Other Operating Revenue is decreasing by $698K or 10.1% from FY 2021 budget to FY 2022 budget. Loss of revenue from closure of local pharmacy Porter supplied.

Please denote the COVID-19 advances, relief funds, and other grants received in Appendix 7, and the respective treatment of each funding source as of September 30, 2020, projected as of September 30, 2021, and budgeted as of September 30, 2022:

University of Vermont Medical Center: Please refer to Appendix 7 on page 10 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 7 on page 19 in the appendices.
Porter Hospital: Please refer to Appendix 7 on page 28 in the appendices.

Please discuss to the best of the hospital's knowledge, any potential funds that could be received by the hospital (with an estimated timeframe) related to COVID-19 advances, relief funds, and other grants:

At the time of this budget submission, no additional federal or state COVID-19 relief funds have been identified for UVM Medical Center, Central Vermont Medical Center, or Porter Hospital. The UVM Health Network will continue to review all opportunities on an ongoing basis.

Explain the relative stability of significant sources of other operating revenue and non-operating revenue and discuss strategies to address revenue streams the hospital considers unpredictable or unstable:

University of Vermont Medical Center
Other Operating Revenue: Negative actions by pharmaceutical manufacturers have created decreases in 340B program revenue beginning in FY 2020, but these lower revenues have been offset by volume growth achieved through improved contract coverage and program optimization efforts. While these negative actions will likely continue through 2021 and well into 2022, the program is well positioned to meet its targets for FY 2021 and FY 2022 through continued performance management. Covered entities like UVM Medical Center have the support of regulators and the Biden Administration in relieving the effects of manufacturers refusing to fully honor the 340B statutes, but we anticipate that legal action around federal enforcement will take one to two years to resolve.

Non-Operating Revenue: The stability of investment income is unpredictable, except for the portion of investments that are in fixed income. About 40% to 50% of the investment balances are in fixed income, so that income is stable based on the dividends and interest generated from those investments. The remaining 50% to 60% of the investment balances are in equity and/or other growth strategies that are less predictable and potentially unstable, depending how the capital markets perform. The strategic long-term allocation of the investment portfolios supports the capital plan of the organization as well as the debt covenant requirements of our creditors and investors.

Central Vermont Medical Center
Other operating revenues are dependent on 340B program stability. CVMC is working with the UVM Health Network to launch a retail pharmacy program, which includes a Health Assistance Program housed at UVM Medical Center and a specialty pharmacy program designed to improve access to those who need this service. This program is being launched with two pharmacists to be shared in the Hematology-Oncology, Dermatology, and Rheumatology Clinics.

Porter Hospital
Other Operating Revenue: The stability of investment income is unpredictable, except for the portion of investments that are in fixed income. The strategic long-term allocation of the investment portfolios supports the capital plan of the organization as well as the debt covenant requirements of our creditors and investors. Additionally, philanthropic contributions are budgeted as Other Revenue and are not fully within Porter's control.

Operating Expenses

Explain changes in budgeted FY 2022 operating expenses over the approved FY 2021 budget:

University of Vermont Medical Center: Please refer to Appendix 1, Table 2 on page 3 in the appendices.
Central Vermont Medical Center: Please refer to Appendix 1, Table 2 on page 12 in the appendices.

Porter Hospital: Please refer to Appendix 1, Table 2 on page 21 in the appendices.

Describe any significant variances between your FY 2022 budget and FY 2021 projections (e.g., variances in costs of labor, supplies, utilization, capital projects) and how those variances affected the hospital's FY 2022 budget:

University of Vermont Medical Center
The variances between the FY 2021 budget and FY 2021 projections were heavily impacted by COVID-19 and the cyberattack. Since we do not anticipate either item having a large impact in FY 2022, the FY 2022 budget was minimally impacted by the FY 2021 budget-to-projection variances.

Operating expenses are increasing by $101M or 6.5% from the FY 2021 budget to the FY 2022 budget.

- $41.2M expense inflation
- $32.9M increase in staff FTEs and provider salary increases. Staff FTE increases driven by Unit Staffing Collaborative agreement between UVM Medical Center and the nursing union (AFT) to create appropriate staffing levels, IT and Epic, and reduced assumption of budgeted vacancies. Provider salary increases are related to bringing the salaries up to the median benchmark.
- $7.3M increase in purchased services driven by Epic wave 2 go-live, along with slightly higher legal and consulting expenses
- $6.1M increase to depreciation directly related to the Epic wave 2 go-live
- $4.6M increase in med/surg supplies for COVID-19 testing supplies
- $3.7M increase in other expenses spread across multiple categories
- $2.8M increase in provider tax tied to increase in NPR

Central Vermont Medical Center
FY 2022 budget includes reductions in CVMC's COVID-19 pandemic response costs that began in March 2020. The continued prevalence of COVID-19 resulted in continued costs related to the care and treatment of COVID-19 patients and our vaccination efforts for Washington County and surrounding counties during FY 2021. We anticipate those costs will be reduced significantly as we move to vaccinations imbedded in our primary care practices versus operating a vaccination hub model.

Increased costs of traveler/agency premium staff are factored into the FY 2022 budget. Our costs for agency/traveler resources have increased significantly due to the increased demand nationally in health care systems.

Porter Hospital
Labor costs budgeted in FY 2022 above the FY 2021 projection include additional staff to support a team based model in select outpatient clinics as well as three additional physicians. Merit adjustments for staff and contractually obligated rate increase to RNs are also budgeted.

Supplies and pharmacy costs are increasing 3% and 2% respectively, driven by volume and market prices.

Referencing the information and data submitted in Appendices 1 and 4 and relevant portions of the FY 2022 budget submission, please discuss the categories of inflation and their relevance to the hospital's budget and operations:

University of Vermont Medical Center: Please refer to Appendices 1 and 4 on pages 3 and 7 in the appendices.
Central Vermont Medical Center: Please refer to Appendices 1 and 4 on pages 12 and 16 in the appendices.
Porter Hospital: Please refer to Appendices 1 and 4 on pages 21 and 25 in the appendices.

Please refer to pages 13 and 14 in the budget narrative.

Describe any cost saving initiatives proposed in FY 2022 and their impact on the budget:

University of Vermont Medical Center
As part of their everyday work, the supply chain team uses several benchmark sources to identify opportunities to reduce supply, drug, and purchased services costs, and works toward capturing those opportunities. We continue to expand our use of Robotic Process Automation (RPA) to reduce staffing costs, and look forward to an expansion in this area in FY 2022. We are assuming in our FY 2022 budget that we will be able to increase recruitment of staff, through planned HR initiatives to decrease our traveler usage. As we complete the implementation of systems at each of our Network hospitals, such as Premier Connect (GL, AP, and purchasing), Workday (HR and payroll), and Epic (EMR and billing), we are reducing costs, or avoiding adding costs in the same proportion as our growing volumes. From the FY 2021 budget to the FY 2022 budget, the total amount spent on all administrative services (HR, IT, revenue cycle, Network leadership, etc.) as a percentage of NPR is decreasing from 13.7% to 13.4%.

Central Vermont Medical Center
Talent Pipeline: CVMC has committed to developing talent pipelines to close the gap in direct care providers in nursing services with the goal of decreasing our reliance on costly agency and traveler staff. The pre-pandemic workforce shortages were exacerbated during the pandemic. Our talent pipeline programs will reduce the need for LPN travelers in our skilled nursing facility. A subset of the 13 LPNs completing the program will be advancing to a RN degree program that is being supported by CVMC. In FY 2021, we launched a second LPN cohort. Those individuals will complete the program and graduate in FY 2022. In addition to these programs, CVMC has been developing a partnership to educate Medical Assistants and Licensed Nurse Aides. These "grow our own" programs provide a unique opportunity for staff from our organization to enter professional health care careers.

Porter Hospital
Versatile and sustainable staffing is a key Porter organizational objective, with staffing costs

representing over 60% of the organization's budget. Decreasing reliance on agency – or traveler – staffing and overtime and creating a pipeline of direct care providers is a specific FY 2022 focus. FY 2021 premium staffing costs are expected to exceed FY 2020 record levels by over 25%. Strategies to reduce premium staffing costs will be offset by increased salary and recruitment costs near term, but these costs are necessary to gain market competitiveness and will result in longer term cost avoidance. A related FY 2022 project will be to reassess staffing models and strengthen staffing productivity systems to optimize staffing management. Porter is enacting numerous proactive measures to support stable staffing and avoid premium labor costs, including an LNA training program in collaboration with Hannaford Career Center that was implemented in FY 2021 and will be expanded in future years.

Describe the impact operating expenses have on requested NPR/FPP:

The inflationary expense increases have a direct relationship on NPR/FPP, as shared in pages 13 and 14 in the budget narrative.

Other expenses are factors of changes in patient volumes, increased cost of supplies, and/or pharmaceuticals administered to patients. Any other remaining expense increases are offset by other revenues.

Operating Margin and Total Margin

Discuss the hospital's assumptions in establishing its FY 2022 operating and total margins. Explain how the hospital's FY 2022 margins affect its overall strategic plan. If the hospital relied on third party benchmarks or targets, please identify those benchmarks and sources (e.g., lending institutions, credit rating agencies, industry standards, parent company/affiliate policy). Please also discuss any relevant FY 2021 budget-to-projection variances:

Please refer to the section regarding key financial metrics on page 7 in the budget narrative.

Does the hospital's budget request include support or a need to support any other entities outside of the physical hospital? An example includes a higher operating margin to transfer surplus to a subsidiary:

All of our Vermont hospitals support activities and entities outside the physical hospital. We understand this question to be seeking information regarding whether hospital budgets are constructed to produce a margin sufficient to provide regular, material financial support to a sibling organization that, due solely to its separate corporate status, is not incorporated within the hospital budget. For instance, Porter Hospital supports the operation of the associated skilled nursing facility, Helen Porter Rehabilitation and Nursing. Our other Vermont hospitals do not have corporate relationships with skilled nursing or other facilities operated by similarly affiliated entities, rather than by the hospital itself. For instance, Woodridge Rehabilitation and Nursing is an integral part of CVMC's budget, rather than a separate corporate entity.

C. Risks and Opportunities

Please discuss the hospital's risks and opportunities in FY 2022. Recognizing the risks and opportunities in the current environment, please explain how the FY 2022 budget proposal supports strategies for addressing these issues:

We have addressed the major risks and opportunities previously in the budget narrative (specifically pages 1 through 17). We would be happy to answer any additional questions the Board has on this topic.

Please describe the impact of COVID-19 on access to care/wait times at your organization, including the use of telehealth and telemedicine, COVID-19 related safety protocols, and other relevant factors:

University of Vermont Medical Center

- Telehealth was fundamental for outpatient care.
- From a hospital (not outpatient) standpoint, COVID-19's largest impact was when telehealth was not appropriate for patient care, including the OR, endoscopy, and radiology. COVID-19 caused significant inefficiency in these places due to numerous factors (testing, prolonged OR turnover times per COVID-19 protocols, delaying non-urgent/emergent OR cases, procedures, and radiology studies last spring).
- COVID-19 resulted in backlogs for radiology and the OR (in addition to the Fanny Allen closure), which has dramatically affected our people now that we are trying to work through those backlogs and provide the care people need. People in these care areas are exhausted and burnt out; we are losing staff, especially in the OR.
- The impact on access from an ambulatory perspective was significant. We essentially stopped providing all non-essential care for the early part of the pandemic. As we restored access, it was largely through telehealth and a greatly reduced in-person visit volume to support social distancing and increased exam room turnover time.
- The cleaning/room turnover requirements we put into place also decreased efficiency in our clinic settings and notably in the OR. Pre-procedural testing impacted all areas where aerosolizing procedures occurred. The workflow involved numerous areas and added a level of complexity and follow-up that exceeds anything we have previously experienced. This impacted the number of patients we could accommodate on any given day.
- Telehealth was the silver lining of COVID-19 – we implemented a system that would have otherwise taken us five years in about four weeks. While not always perfect, it worked. We are now going back to re-implement in a manner where it is more fully integrated with Epic, which will make telehealth viable long-term.

Central Vermont Medical Center

- During FY 2021 all medical group practices, skilled nursing facilities, rehab and acute care operations followed the guidelines from the State of Vermont, the CDC, and OSHA.

- Telehealth services, including audio-only and audio/video services, were adopted across specialty and primary care practices and urgent care. Our Community Health Teams were able to offer patient outreach remotely, as well. Currently, remote care averages 18% to 20% of all visit volume.
- Access to care and wait times were initially negatively impacted in the early days of COVID-19. However, once telehealth capability was established, these wait times decreased back to baseline rates.
- During our pandemic response, we also launched an Acute Respiratory Clinic (ARC) and a COVID-19 call center. Both of these new services were set up to reduce patient wait times for access to care. At of the time of this submission, since volume demand has been reduced, both of these services have been transitioned and are now imbedded in our primary care and specialty care clinic operations.

Porter Hospital

- The biggest impact of COVID-19 was when we could not use telehealth. These instances included the OR, endoscopy, and radiology. COVID-19 caused significant inefficiency in these places due to numerous factors (testing, prolonged OR turnover times per COVID-19 protocols, delaying non-urgent/emergent OR cases, procedures, and radiology studies last spring). This resulted in backlogs for radiology and the OR.
- The impact on access from an ambulatory perspective was significant. We essentially stopped providing all non-essential care for the early part of the pandemic.
- The cleaning/room turnover requirements we put into place also decreased efficiency in our clinic settings and notably in the OR. Pre-procedural testing impacted all areas where aerosolizing procedures occurred from the ORs and procedure room.

Please discuss any lessons learned from the COVID-19 pandemic thus far, and any positive changes the hospital has adopted or plans to adopt for the future:

University of Vermont Medical Center

- Telehealth is a key strategy going forward – it improves flexibility and decreases our dependency on physical space, while saving patients travel time and, in the case of audio-only services, helps our patients overcome the digital divide, which can cause delayed care.
- Telehealth can be a component of patient care, but many patients still prefer in-person visits; and some health care needs do not align well with telehealth modalities. We made great progress, but telehealth will not replace in-person for all health care needs or for all patients.
- Supply chain redundancy is critically important, even if it costs a bit more.
- Collaboration between the State of Vermont (especially the Department of Health), Vermont's hospitals, and residents of Vermont is the reason our state did so well in fighting COVID-19.
- Financial stability is important to weather unforeseen challenges.
- Staffing is becoming more difficult as our employees deal with the fatigue of the pandemic.

- True capitation could have been a stabilizing factor during the early stages of the pandemic. This promise of the APM has not been fully delivered as of yet.
- Many of our staff and providers are able to work remotely – this was not something we believed possible prior to the pandemic.
- Centralizing our responses was highly effective (staffing models for who would cover inpatient COVID-19 units, ED, ICUs and how we would essentially close down ambulatory offices if we were in full blown crisis).

Central Vermont Medical Center

- Facility/infrastructure: Prior to the pandemic, CVMC had nine negative pressure rooms. During the height of the pandemic, we converted 27 additional patient care rooms across all acute care service sites to negative pressure rooms to enable us to effectively manage the COVID-19 patient volumes. We have also constructed permanent negative pressure spaces in our ED and ExpressCare. We are in the process of completing a permanent conversion for negative pressure spaces at our Pediatric Care Clinic.
- Availability of PPE: As supply chains became restricted internally and across the United States, PPE availability was constrained. CVMC was able to source PPE to adequately meet the needs of our patients, residents, and staff. We also adopted the approved practice of sterilizing N95 masks, and purchased HALO masks and additional equipment to support care delivery.
- Technology investments: Automated temperature check stations were installed in entry areas of our main facility, practice locations, and Woodridge Rehabilitation and Nursing. Technology to support telehealth and technology to support virtual family visitation all contributed to increased cost for our system. One notable challenge to our community is access to stable internet services, hence the necessity of ongoing audio-only services and reimbursement.
- Working remotely: Staff employed in non-direct care or business functions have been working remotely. We are currently assessing which of these roles can continue to effectively meet their job accountabilities while working from home.

Porter Hospital

- Supply chain redundancy is critically important.
- Collaboration between the State of Vermont (especially the Department of Health), Vermont's hospitals, and residents of Vermont is the reason our state did so well in fighting COVID-19.
- Financial stability is important to deal with unforeseen challenges.
- Staffing is becoming more difficult as our employees deal with the fatigue of the pandemic.
- Many of our staff and providers are able to work remotely – this was not something we believed possible prior to the pandemic.

D. Value-Based Care Participation

UVM Medical Center, Central Vermont Medical Center, and Porter Hospital are planning to participate in OneCare Vermont's Medicaid, Medicare, Commercial, and Self-Insured programs in CY 2022.

ACO dues:

Hospital	FY 2021 Projected	FY 2022 Budget
UVM Medical Center	$6,680,288	$6,654,373
Central Vermont Medical Center	$2,040,021	$1,918,789
Porter Hospital	$659,203	$659,203

Our UVM Health Network hospitals have been changing the way we deliver care to improve the health of the population we serve for some time. Participation in OneCare Vermont programs has accelerated these changes in two key areas: 1) lowering TCOC; and 2) improving quality for certain metrics. Several TCOC studies over the years have highlighted that we have been successful in our endeavors. We consistently monitor how we are doing against TCOC targets to help inform our clinical improvement efforts. In terms of quality, we have relied upon the quality measures identified as part of the quality incentive funds to help us focus on specific measures. By way of example, we have identified and focused on the metric for lowering HbA1C levels. Consequently, our Network Committee on Quality and Performance Improvement (NCQPI) has implemented several performance improvement processes aimed at improving outcomes, and this began with the fundamental work of conducting interviews with patients to identify the primary needs they have or obstacles they face in attempting to control their levels. In addition, we began conducting a gap analysis based on the American Diabetes Association's Standard of Medical Care, and we are in the process of addressing with each hospital for purposes of making progress towards lowering HbA1C in a meaningful way.

There are several improvements that need to be made to how the APM is administered and with OneCare Vermont programs to unlock even more delivery system reforms. Below are several examples of critical areas that require change:

- The Board needs to allow the full rate increase allowed under the APM. This would also help ease the burden on commercial insurers needing to cover a larger proportion of provider expense inflation.
- The Medicare program needs to move to an unreconciled fixed payment like the Medicaid program.
- Medicare must change the way the Blueprint money is accounted for in the APM, as it is currently creating asymmetric risk in the Medicare program (much larger downside risk than upside potential).
- Quality incentives need to be additive rather than a penalty, and need a new funding source to remove the burden on OneCare Vermont participating hospitals funding the majority of these incentives.
- With risk shifting from payers to providers, providers need to be able to build risk reserves, like the payers do.

- Need to move away from establishing spend targets based on prior year FFS equivalents and create a fixed starting point to which annual trend and other factors would then be applied. With spending targets being based on prior year FFS, the good work providers do to decrease utilization works into future spend targets, so that providers never generate the funds necessary to invest further upstream in the health care continuum to improve the overall health of the population.

Regarding the "tipping point," or threshold, defined as the percentage that true FPP comprises of total NPR/FPP, necessary to support the successful transformation of the delivery system to a system substantially based on value-based care, the tipping point is less about the percentage of true FPP versus FFS and more about addressing the APM and OneCare Vermont issues identified above. When those topics are addressed, a significant amount of population health potential would be unlocked within the delivery system and create the path where 100% of care is FPP for the UVM Health Network's hospitals.

UVM Medical Center, Central Vermont Medical Center, and Porter Hospital already participate in Medicare FPP. For commercial, the payment would have to be a true FPP, not reconciled to FFS, and the target not based on prior year FFS revenue.

Risk liability for CY 2022:

All OCV Programs Combined	**UVM Medical Center**	**Central Vermont Medical Center**	**Porter Hospital**
Maximum Upside	$15,772,397	$5,623,944	$2,292,520
Maximum Downside	($22,178,321)	($8,500,009)	($3,437,112)

E. Capital Investment Cycle

As noted in the FY 2021 budget narrative, the UVM Health Network has developed an enterprise-level approach to capital budgeting, and our FY 2022 – FY 2026 capital budget process and submission reflects a continued commitment to this approach. This budgeting methodology allows for routine capital expenses to be managed at a hospital-level, while reserving larger, strategic investments to be prioritized at a Network-level, ensuring that capital expenditures and organizational commitments are:

- Adequately supporting our ability to provide high quality patient care;
- Consistent with the UVM Health Network's long-term strategic plan;
- Meet identified community needs;
- Have the necessary components for success; and
- Comply with state and federal regulations.

Additionally, and perhaps most importantly, this method allows for a consistent and systematic approach to managing capital expenses in relation to financial performance (i.e. pulling back on capital swiftly when financial performance necessitates it). This fiscal policy also mandates a conservative quarterly capital spend cadence that ensures adequately timed cash flows, providing

further budgetary control. This approach will continue into FY 2022 as we emphasize our ability to restrict capital as needed and where clinically safe, while allowing our budget to be enhanced if and when financial targets are met. Our current five year capital framework has been updated and revised to reflect a reduction in projected margin as we continue to recover from financial challenges we faced from the COVID-19 pandemic and the cyberattack, decreasing the amount of available capital over the next five years. Revisions to this five year capital allocation, based on the Network's overall financial framework, are typically done annually.

Over the past 18 months, in response to the financial pressures imposed by the pandemic, the Network's internal capital request process moved from an annual approval of routine capital expenditures to a quarterly review and approval process. Ad hoc, break-fix capital requests were approved individually by executive leadership regardless of the project size. Many strategic-level projects, and the planning associated with those projects, were postponed, re-prioritized, or cancelled.

Two notable projects were placed on hold during the pandemic: the planning for the inpatient psychiatric investment at CVMC, which leveraged numerous Network employees and external consultants, was placed on hold to allow for key personnel to focus on COVID-19-related, emergency projects necessary for continued hospital operations during the height of the pandemic. Additionally, a completed facilities plan related to the renovation and expansion of the ED at UVM Medical Center was placed on hold. This initiative has become a priority once again, as our ED continues to be stressed by the lack of available inpatient beds and surging patient volumes, including patients presenting with a primary diagnosis of mental illness.

The capital budget cycle for the five year (FY 2022 – FY 2026) refresh was substantially delayed due to the COVID-19 pandemic and the cyberattack. A process that typically starts in early December was delayed until February. With this delay, additional work is still necessary to close budget gaps between internal capital requests and available capital allocation. The budget detail presented in August will likely include "Required Savings" lines, indicating where work is still necessary to prioritize capital requests.

For FY 2022, the UVM Health Network's Vermont hospitals are proposing a capital budget not to exceed $89.5M with an additional $20.9M projected to be carried forward from FY 2021. A more accurate carry forward (CF) total will be available as the fiscal year comes to a close. The below table represents additional detail regarding the forecasted capital allocation by expense type.

	49.1	*64.6*	*(24.1)*	89.5

Entity	Routine	Major	Share of Required Major Reduction	TOTAL
UVMMC	40.7	48.7	(17.6)	71.8
CVMC	6.0	11.8	(5.0)	12.8
PMC	2.5	4.0	(1.6)	4.9
			Subtotal FY22 Capital	**89.5**
Estimated CF as of 6.17.2021	5.3	15.6		20.9
Epic CF				-
			Subtotal FY21 CF	**20.9**
Total UVMHN-VT FY22 Capital Budget + CF				**110.4**

There are several CON applications potentially slated for FY 2022 submission. Not all FY 2022 CON submissions have capital commitments planned for FY 2022 and therefore may only be partially included in the numbers above. Full details on the timing and capital estimates of these projects will be included in the five year capital budget submission in August. These projects include:

- Outpatient surgical center
- ED renovation and expansion at UVM Medical Center
- NICU relocation and expansion at UVM Medical Center
- Relocation of Dermatology and Ophthalmology to 350 Tilley Drive
- Consolidation of Network Outpatient Pharmacy dispensing services to Holly Court
- Linear Accelerator replacement at UVM Medical Center (1 of 3 total)
- Implementation of Epic Home Health applications to UVM Health Network Home Health and Hospice

Questions from the Office of the Health Care Advocate

Reimbursement ratio relative to standardized Medicare reimbursement:

The information is not available to answer this question in the manner it was asked. We would be happy to work with the Health Care Advocate's office on this topic.

Hospital financial assistance and bad debt during COVID-19:

University of Vermont Medical Center
No formal changes have occurred with financial assistance. We are in the process of updating our policy for FY 2022, however, no substantive changes are anticipated. There has been no material change with how patient collections are handled.

UVM Medical Center works with collection agencies, but does not sell patient debt to these

agencies. We refer accounts that have met our policy for outside collection: patient has received at least four statements on the account/invoice and has not made payment, established a payment plan, or met the agreed upon payment plan arrangement.

If a patient is overcharged, UVM Medical Center has dedicated staff in the Customer Service/Self Pay department who serve as liaison to our collection agencies. These staff review and take steps to correct any balances that are disputed by the patient via the collection agency.

How many patients had bills that you sent to collection agencies during the following timespans: (1) Q4 FY 2019 and Q1-Q3 FY 2020 and (2) Q4 FY 2020 and Q1-Q3 FY 2021?

Quarter	**Patients**
Q4 2019	15,802
Q1 2020	14,241
Q2 2020	15,390
Q3 2020	379
Q4 2020	6,279
Q1 2021	8,064
Q2 2021	16,565
Q3 2021	8,967

What is the total dollar amount of bills sent to collection agencies during the following timespans: (1) Q4 FY 2019 and Q1-Q3 FY 2020 and (2) Q4 FY 2020 and Q1-Q3 FY 2021?

Quarter	**Dollars**
Q4 2019	$9,995,200
Q1 2020	$9,053,390
Q2 2020	$9,604,139
Q3 2020	$76,312
Q4 2020	$4,518,921
Q1 2021	$7,445,625
Q2 2021	$14,292,694
Q3 2021	$6,156,245

Central Vermont Medical Center

CVMC has not changed the Patient Financial Assistance Policy or procedures. Call collection efforts were resumed effective 07/01/20 and continue according to established procedures.

CVMC works with collection agencies; CVMC does not sell patient debt to these agencies. CVMC partners with the collection agencies for debt collection for which the agency does outreach to the patient by means of telephone calls and statements. If insurance is obtained, the account is referred back to Patient Financial Services to review for billing opportunity. Patients can also establish payment plans through the agency.

If a patient is overcharged, accounts are recalled from the agency for charges to be corrected and resubmitted to the insurance carrier, or for the patient to receive an updated statement.

How many patients had bills that you sent to collection agencies during the following timespans: (1) Q4 FY 2019 and Q1-Q3 FY 2020 and (2) Q4 FY 2020 and Q1-Q3 FY 2021?

Quarter	**Patients**
Q4 2019	6,191
Q1 2020	5,658
Q2 2020	6,333
Q3 2020	4,117
Q4 2020	2,925
Q1 2021	2,530
Q2 2021	10,064
Q3 2021	1,375
Total	39,193

What is the total dollar amount of bills sent to collection agencies during the following timespans: (1) Q4 FY 2019 and Q1-Q3 FY 2020 and (2) Q4 FY 2020 and Q1-Q3 FY 2021?

Quarter	**Dollars**
Q4 2019	$1,565,099
Q1 2020	$1,258,454
Q2 2020	$1,372,284
Q3 2020	$1,452,817
Q4 2020	$1,341,033
Q1 2021	$1,117,761
Q2 2021	$1,222,694
Q3 2021	$247,683
Total	$9,577,825

Porter Hospital

No formal changes have occurred with financial assistance, however we did temporarily freeze our patient collection efforts. There has been no material change in how patient collections are handled.

Porter Hospital works with collection agencies, but does not sell patient debt to these agencies. We refer accounts that have met our policy for outside collection: patient has received at least four statements on the account/invoice and has not made payment, established a payment plan, or met the agreed upon payment plan arrangement.

If a patient is overcharged, Porter has dedicated staff in the Customer Service/Self Pay department who serve as liaison to our collection agencies. These staff review and take steps to correct any balances that are disputed by the patient via the collection agency.

How many patients had bills that you sent to collection agencies during the following timespans: (1) Q4 FY 2019 and Q1-Q3 FY 2020 and (2) Q4 FY 2020 and Q1-Q3 FY 2021?

Quarter	Patients
Q4 2019	1,185
Q1-Q3 2020	2,031
Q4 2020	287
Q1-Q3 2021	8,214

*The patient count for the Q1-Q3 2021 period is likely overstated approximately 5%, due to a system conversion double counting of some patients from both the hospital side and the professional side.

What is the total dollar amount of bills sent to collection agencies during the following timespans: (1) Q4 FY 2019 and Q1-Q3 FY 2020 and (2) Q4 FY 2020 and Q1-Q3 FY 2021?

Quarter	Dollars
Q4 2019	$1,207,212
Q1-Q3 2020	$1,784,520
Q4 2020	$171,787
Q1-Q3 2021	$7,183,063

Medicaid screening processes

Emergency Medicaid

University of Vermont Medical Center
If your organization has written policies regarding screening for emergency Medicaid, please provide them:

No written policy or procedures around emergency Medicaid are in place. We use Epic work queues for uninsured patients to drive financial counseling workflows, particularly for emergency admissions, newborns, and Medicare inpatients where no supplemental or secondary insurance coverage exists. Each of these cases is managed by a financial advocate who will work with patients to assist in Medicaid, exchange enrollment, or financial assistance where no other funding source can be obtained.

For Q1-Q3 of FY 2021, please provide the number of facility patients screened for emergency Medicaid and the number of facility patients who received emergency Medicaid:

We do not track emergency Medicaid specifically, as noted above; it is blended in our counseling workflows.

Total cases opened: 704
Total cases approved: 467
Total cases denied: 191
Total cases pending: 46

For Q1-Q3 of FY 2021, please provide the number of labor and delivery patients screened for Medicaid and the number of labor and delivery patients who were covered by emergency Medicaid:

Volume included above. We do not track for pregnancy as a carve-out, and those are managed with traditional coverage pre-delivery.

If your organization has outreach materials on the application process and eligibility criteria Emergency Medicaid, please provide them. Please explain how your patients can access these materials and list the languages that the materials have been translated into:

No outreach materials exist or are managed by registration. We have a high touch financial counseling program (noted above), where scheduled services (pregnancy), uninsured, emergent and inpatient admissions have a dedicated counselor/advocate to work with to obtain coverage.

The Health Assistance Program, in addition to Registration, also screens (and will enroll as qualified) every patient who is referred to HAP for being uninsured for emergency Medicaid (called Presumptive Eligibility) or regular Medicaid/any health insurance. We advertise that we assist with this, but HAP does not have specific materials that spell out the process or criteria. We were the first program to pilot it back in 2018, and got only two patients during the whole first year. This past year, we suspect the numbers were equally low due to COVID-19 benefits of unemployment and additional open enrollment periods. While emergency Medicaid is not specifically spelled out in our outreach materials, it is captured in "insurance with the Vermont Health Connect Exchange" on the back of our new rack card. These new rack cards will be printed soon. Rack cards will be distributed in their current spaces: pharmacy, primary care offices, specialty, ED, and the Frymoyer Community Health Resource Center. Social workers and other community organizations are aware we offer this service and connect patients to us; data show that we do not receive many emergency Medicaid enrollments. Enrollment comes up at Registration more often, when patients need to set up an appointment. Our current version of the prescription assistance program rack card was submitted to be translated into Arabic, Bosnian, Cantonese, French, Mandarin, Nepali, Somali, Spanish, Swahili, and Vietnamese; these new rack cards should be ready in the next few months.

The UVM Medical Center public facing website has reference to obtaining insurance: https://www.uvmhealth.org/medcenter/patients-and-visitors/patients/assistance/health-assistance-program

Central Vermont Medical Center

If your organization has written policies regarding screening for emergency Medicaid, please provide them:

The CVMC public facing website has reference to obtaining insurance: https://www.cvmc.org/patients-visitors/patient-financial-services/financial-assistance

For Q1-Q3 of FY 2021, please provide the number of facility patients screened for emergency Medicaid and the number of facility patients who received emergency Medicaid:

Quarter	**Patients Screened**	**Patients Enrolled**
Q1 2021	808	86
Q2 2021	400	78
Q3 2021	157	32

For Q1-Q3 of FY 2021, please provide the number of labor and delivery patients screened for Medicaid and the number of labor and delivery patients who were covered by emergency Medicaid:

No statistics have been kept on this patient population.

If your organization has outreach materials on the application process and eligibility criteria Emergency Medicaid, please provide them. Please explain how your patients can access these materials and list the languages that the materials have been translated into:

The CVMC public facing website has reference to obtaining insurance: https://www.cvmc.org/patients-visitors/patient-financial-services/financial-assistance

Porter Hospital

If your organization has written policies regarding screening for emergency Medicaid, please provide them:

No written policy or procedures around emergency Medicaid are in place.

For Q1-Q3 of FY 2021, please provide the number of facility patients screened for emergency Medicaid and the number of facility patients who received emergency Medicaid:

We do not track emergency Medicaid specifically, as noted above.

For Q1-Q3 of FY 2021, please provide the number of labor and delivery patients screened for Medicaid and the number of labor and delivery patients who were covered by emergency Medicaid:

N/A per above

If your organization has outreach materials on the application process and eligibility criteria Emergency Medicaid, please provide them. Please explain how your patients can access these materials and list the languages that the materials have been translated into:

No outreach materials exist or are managed by registration.

Deemed newborns

University of Vermont Medical Center
If your organization has written policies regarding screening newborns for Medicaid, please provide them:

As noted above, there is no written policy regarding newborn enrollment, however, our work queues capture all newborn admissions for follow-up action. These actions occur for all insurance plans, where advocates and advisors work with new mothers to (1) counsel regarding the need to enroll newborns in the parent's commercial plans or (2) to apply newborns for Vermont or New York Medicaid. Our advocates continue to work with new mothers until the enrollment process is complete, and in the case of Medicaid, until the newborn's ID number has been assigned.

For Q1-Q3 of FY 2021, please provide the number of newborns screened for Medicaid without an application and the number of those newborns who received Medicaid:

Total newborn Medicaid cases: 402
Total approved: 341
Total denied: 31
Total pending: 30

Central Vermont Medical Center
If your organization has written policies regarding screening newborns for Medicaid, please provide them:

The CVMC public facing website has reference to obtaining insurance:
https://www.cvmc.org/patients-visitors/patient-financial-services/financial-assistance

For Q1-Q3 of FY 2021, please provide the number of newborns screened for Medicaid without an application and the number of those newborns who received Medicaid:

Quarter	Newborns Screened	Newborns Enrolled
Q1 2021	24	24
Q2 2021	20	20
Q3 2021	14	14

Porter Hospital

If your organization has written policies regarding screening newborns for Medicaid, please provide them:

As noted above, there is no written policy regarding newborn enrollment.

For Q1-Q3 of FY 2021, please provide the number of newborns screened for Medicaid without an application and the number of those newborns who received Medicaid:

No statistics have been kept on this patient population.

Please discuss any analyses or tracking your hospital conducts or is considering conducting regarding access to care, care efficacy, or satisfaction among vulnerable populations including, but not limited to:

a. patients whose primary language is not English,
b. BIPOC patients,
c. patients with no or intermittent broadband and/or cellular telephone service, and
d. patients who are not U.S. citizens.

University of Vermont Medical Center

Access to care: We have evaluated both primary care and telehealth visits by demographic. The percentage of primary care and telehealth visits closely resemble the percentages of different demographics within our catchment area. We have just requested data from the Data Management Office to evaluate both screening mammograms and colonoscopies by demographic.

Care efficacy: Mortality, length of stay, and readmissions have all been adjudicated by demographic (race/gender). There is some discrepancy in outcomes between demographics. However, some of the demographics have very small numbers of patients, making the drivers of discrepancies (in either a positive or negative direction) difficult to determine. We are trending this to understand with more certainty.

Patient experience: We have analyzed Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data by demographic. Again, there are some discrepancies by demographic, again with low numbers of responses. We have engaged with Press Ganey to better understand the drivers of overall satisfaction, and to understand if different demographics value aspects of the patient experience differently.

Patients whose primary language is not English: HR is working on improving language services, which came up as a broad theme around quality of care at UVM Medical Center. Language services are already improved, and we expect progress to continue. COVID-19 made this very difficult, due to the remote nature. However, we have a plan to support these patients in a better manner. The ED and Care Management teams are tracking, collaborating, and providing purposeful post-ED visits/phone calls to patients whose primary language is not English.

Central Vermont Medical Center

Care access, care efficacy, and patient satisfaction: CVMC is working with the UVM Health Network to capture relevant demographic data from the Epic platform for our practice sites. Our current acute care IT platform is not enabled to capture the relevant demographic data. We will be working with the UVM Health Network to capture the relevant demographic data using Epic when we transition to that platform in November 2021.

Porter Hospital

Care access, care efficacy, and patient satisfaction: Porter is working with the UVM Health Network to capture relevant demographic data from the Epic platform for our practice sites. Our current acute care IT platform is not enabled to capture the relevant demographic data. We will be working with the UVM Health Network to capture the relevant demographic data using Epic when we transition to that platform in November 2021.