Fiscal Year 2023 Hospital Budget Submissions to the Green Mountain Care Board

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

July 1, 2022

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OVERALL SUMMARY OF THIS SUBMISSION

This submission includes Fiscal Year 2023 (FY23) budgets for three Vermont hospitals that are part of the University of Vermont Health Network: the University of Vermont Medical Center (UVMMC), Central Vermont Medical Center (CVMC) and Porter Hospital, which is part of Porter Medical Center (PMC). Through these budgets, we aim to stabilize our finances and support our hospitals, outpatient clinics and other facilities, our health care workforce and our patients amid the lasting impacts of the COVID-19 pandemic. These impacts include extreme burnout of our nurses, physicians and staff; unprecedented national cost inflation; a severe labor shortage; lack of adequate post-acute, mental health and substance use treatment capacity, as well as other access to care challenges; and the increasing need and intensity of need for health care services in our communities. We have more patients, with more acute needs, and less capacity to care for them, than at any point in our history.

We are at a critical juncture. Vermont's health care system is in a fragile state, and the decisions the Green Mountain Care Board (Board) makes this summer on FY23 hospital budgets will have a profound impact on the strength and resiliency of the health care system for years to come. We are not alone in this regard – hospitals and health systems across the country are struggling. In the June 2022 National Hospital Flash Report[1] published by Kaufmann Hall, a national consulting company that follows hospital financial health, it was noted: "Nearly halfway through 2022, margins are cumulatively negative. While some metrics have normalized, hospitals continue to perform below pre-pandemic levels, and there is an uncertain outlook for the rest of

[1] National Hospital Flash Report. Kaufman Hall, June 2022. Visited June 29, 2022.

the year… Elevated labor costs remain a significant challenge. Hospitals are still seeing higher labor costs and fewer hours worked, a sign of inflation and an indicator that long-standing labor shortages are likely worsened by increased turnover." Kaufman Hall noted that hospitals in the Northeast region of the United States are seeing the greatest financial challenges.

The difference in Vermont is that we entered the pandemic on a shakier foundation than many of our national peers due to several years of depressed margins, and extreme cost inflation is further eroding that foundation.

On March 18, we took the unprecedented action of submitting to the Board a mid-year budget adjustment request for two of our hospitals, UVMMC and CVMC. At that time, we projected our cost inflation for the year would be almost $123M above the budgets approved by the Board for FY22, related mostly to increased costs of labor. The requested budget adjustments would cover approximately half of that amount, in the hope that we could reduce the amount of cost growth and realize some additional revenue from Medicare, Medicaid or State workforce funds before the end of the fiscal year. We have been able to reduce the impact of the additional FY22 cost inflation by about $50M, reducing the carry-forward impact on FY23 to about $73M. The focused actions we are taking to reduce the impacts of cost inflation on both FY22 and FY23 are detailed in the body of this submission.

Despite our efforts to reduce expenses, our three Vermont hospitals will need a sizeable infusion of new patient revenue to have a positive operating margin in FY23. This revenue could come from Medicare, Medicaid or commercial health insurers. In the budgets we are submitting, we are assuming an average Medicare rate increase of 3.5% across our Vermont hospitals for FY23, largely driven by assumed ACO shared savings, but we are not assuming any change in hospital Medicaid rates.[2] We have had productive conversations with the Vermont Agency of Human Services about potential rate increases, but nothing is certain at this time.

The budgets submitted today would allow the Network to cover the remaining need, including both uncovered amounts from FY22 cost inflation of $52.7M and projected new cost inflation for FY23 of $111.9M. The total cost inflation in the FY23 budget is $164.6M. Of the $164.6M, $22.3M is offset by payment increases from governmental payers and retail pharmacy (see figure below). The remainder of $142.3M, if approved, and without additional Medicare or Medicaid funding, will necessitate commercial rate increases of 19.90% for UVMMC, 14.52% for CVMC and 11.45% for Porter Hospital.

[2] The Network continues to advocate for fair reimbursement from government payers, to more equitably cover cost inflation across all payers and to partially offset the commercial rate increases necessary to provide the same level of care Vermonters deserve and are accustomed to. The federal government recently released its proposed inpatient rate increase for 2023, which does not keep pace with current extraordinary cost increases; the Network submitted a comment letter to the Centers for Medicare and Medicaid Services (CMS) on June 16, 2022, in response to this proposed rule.

Figure 1:

FY22 + FY23 Cost Inflation in UVM Health Network FY23 Budgets

$123M	FY22 cost inflation as presented in March 2022
- $50M	Reduced FY22 cost inflation carry-forward to FY23
= $72.9M	Net FY22 cost inflation in FY23
+ $111.9M	FY23 new cost inflation
= $184.8M	Total FY22 + FY23 cost inflation
- $20.2M	Impact of FY22 mid-year commercial rate increase
= $164.6M	Cost inflation prior to FY23 rate changes
- $20.3M	FY23 offsets by payment increases from governmental payers and retail pharmacy
= $142.3M	Remaining cost inflation in commercial rate calculation

We do not make this request lightly. We fully understand that we are asking for significant rate increases, and we know this is a burden on the individuals and employers who purchase health insurance in this state who bear a disproportionate burden of the increases in health care costs. We hope that we can more equitably spread the costs of health care in the future, particularly through the All-Payer Model. It is our sincere hope that Medicaid will come forward with some sort of payment increase. The newly-negotiated Medicaid demonstration waiver gives us reason to think state funds could be brought to bear to reduce the need for commercial rate hikes. We also hope that commercial health insurers will release some of their reserves to address the current crisis. Insurers have incurred reduced claims for health care services in the past two years, relative to their budgets. Using their reserves to address the impacts of a once-in-a-lifetime pandemic seems appropriate.

We also urge the Board to examine whether there is more Medicare revenue to be realized through the All-Payer Model, and to fully exhaust that potential. We believe that the Board could bring more Medicare funding into the state without any negative impact, thereby reducing the need for commercial rate increases and lessening the effect of the cost shift.

The UVM Health Network's Vermont hospital budgets contain only the revenue necessary to cover operating expenses and produce a modest financial margin necessary to reinvest in the health care delivery system. In recent years, we have not been afforded rate increases that keep up with cost inflation. This has eroded our already-slim margins, forced us to tap into reserves to meet expense needs, and jeopardizes the sustainability of the health care services we provide.

The charts below illustrate just how precarious our finances have become, based on standard industry and regulatory metrics. Our operating EBIDA margin, the best measure of our financial health, has descended well below recommended thresholds. It bumped up slightly in FY21 due to an influx of state and federal COVID-19-related relief funding, but continued to slide in FY22.

Figure 2:

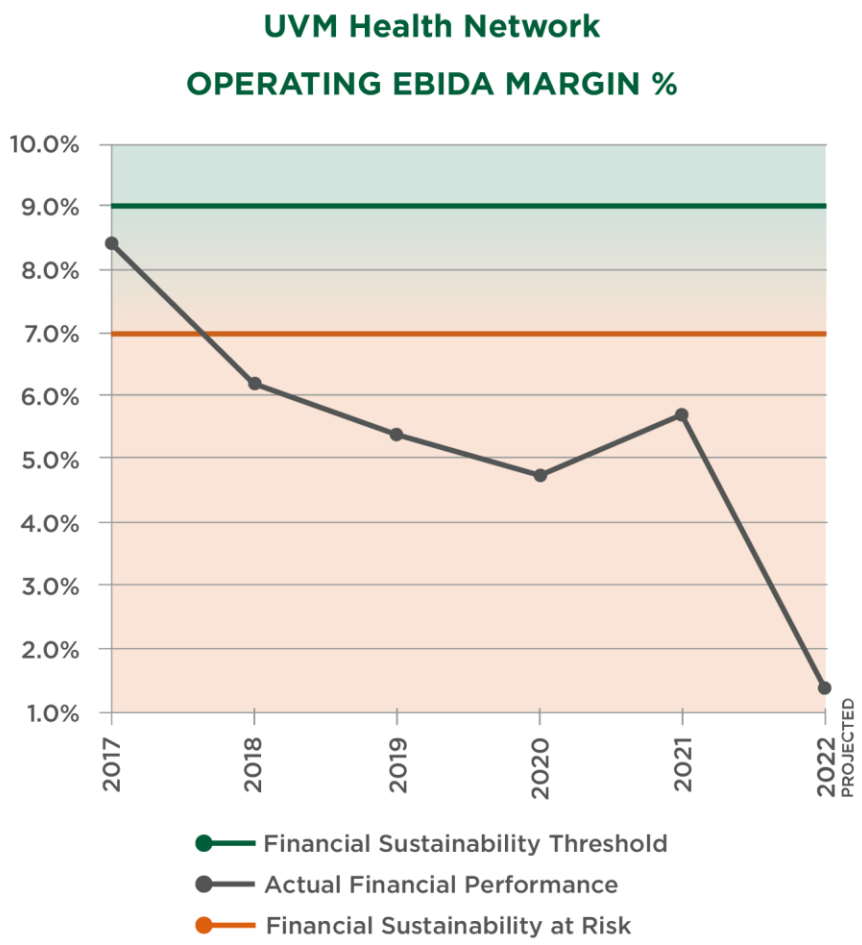
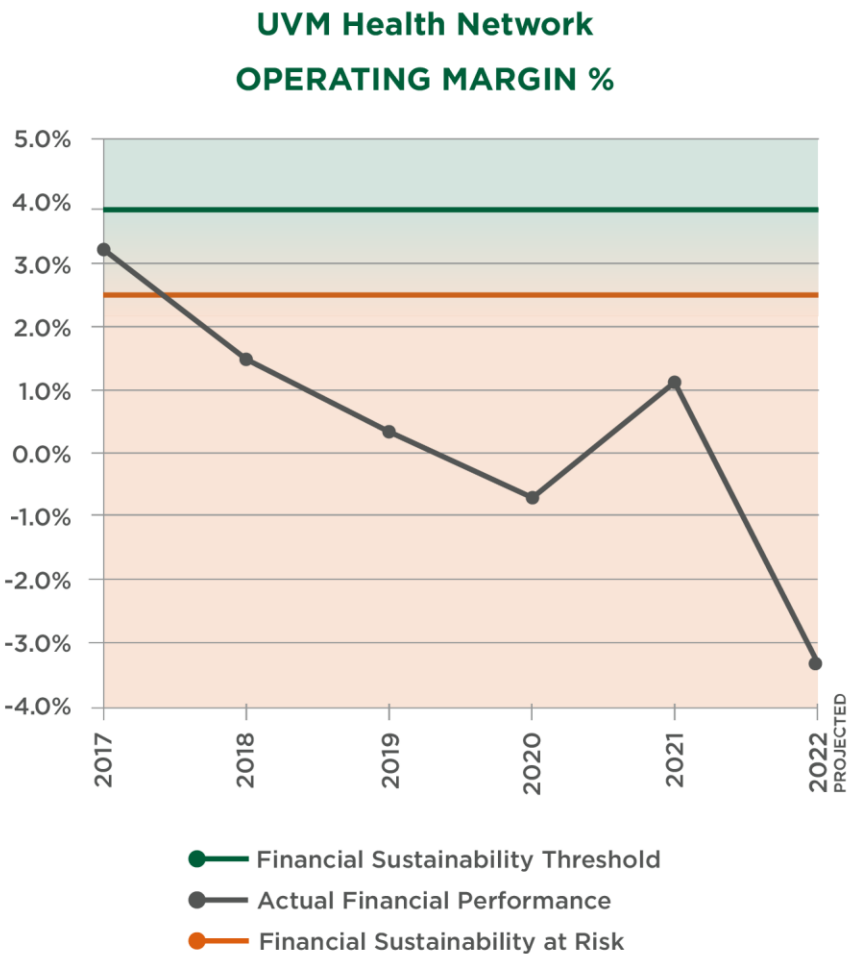
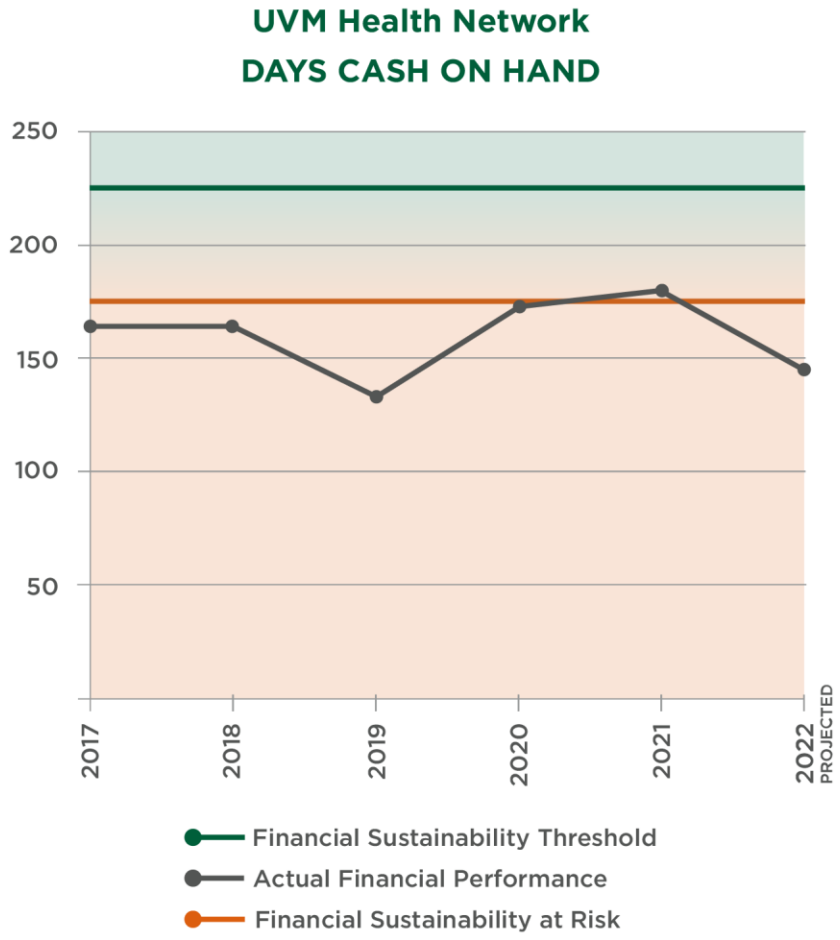


Figure 3:



The current financial crisis has forced us to expropriate cash from our reserves, known as days cash on hand, to try to stabilize our operating expenses. These actions have placed at risk our reserve obligations to creditors and our ability to invest in health care delivery system infrastructure and projects to benefit patients now and in the future.

Figure 4:



If the Board denies all or a portion of our budget request, we will be faced with a challenge unlike any we have seen before. We already are in an unprecedented financial crisis: Our projected FY22 year-end operating EBIDA margin has been reduced to 1.4% and our days cash on hand is projected at 148, well below minimum industry standards of 7.0% and 175 days. Now the aftermath of the pandemic and the cost of labor and other inputs is pushing us to reduce expenses and increase budget requests to a degree that we could not have imagined a few years ago.

We have provided the Board with what we believe is a fair and realistic approach to keeping our Network solvent. We have reduced expenses below projected levels by more than $70M for FY23. We are already a low-cost provider network – lowest in the country for Medicare costs. This is because our patients and providers use fewer services than *anywhere else in the nation*. This is largely due to years of focus on the development of clinical pathways and implementation of best practice, resulting in the appropriate utilization of care. If the Board

cuts our budget, we will need to assess the services we are currently providing. If we are forced to make reductions, we will look at service lines that are low volume or do not cover their costs, but we will not reduce or eliminate a service without a clear plan for where our patients can go to get the care they need.

A. EXECUTIVE SUMMARY

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

The UVM Health Network is comprised of an anchor academic medical center, five community hospitals, a children's hospital, a home health and hospice agency, 254 outpatient patient care sites, three skilled nursing facilities, a multispecialty medical group with approximately 940 employed physicians plus over 600 affiliated physicians, and a population health services organization (PHSO). Our three Vermont hospitals are subject to Green Mountain Care Board budget approval under 18 V.S.A. § 9375(b)(7) – the University of Vermont Medical Center (UVMMC), Central Vermont Medical Center (CVMC), and Porter Hospital. This document describes the Network's budget submissions on behalf of these hospitals for FY23, as well as how these budgets comport with our mission to improve the affordability and quality of health care for Vermonters.

Summary of each hospital's FY 2023 budget submission

For FY23, we are requesting net patient revenue (NPR) increases as follows:

- UVM Medical Center 10.0%
- Central Vermont Medical Center 7.3%
- Porter Hospital 10.9%

The assumptions in the FY23 budget include a 0.0% increase in hospital Medicaid payment rates and an average increase in Medicare payment rates of 3.5%. With overall FY22 and FY23 cost inflation at approximately 8.0%, this necessitates aggregate commercial insurance rate increases of:

- UVM Medical Center 19.90%
- Central Vermont Medical Center 14.52%
- Porter Hospital 11.45%

Figure 5:

UVMMC	FY2022 Cost Inflation (above FY2022 Budget)	FY2023 Cost Inflation	Total Cost Inflation
Cost Inflation	**$66,109,926**	**$84,661,860**	**$150,771,787**
Less:			
FY2022 Mid-Year Rate Increase	$17,500,000	$0	$17,500,000
FY2023 - Medicare Rate Increase	$0	$6,367,829	$6,367,829
FY2023 - Medicare ACO Rate Increase	$0	$8,500,000	$8,500,000
FY2023 - Medicaid Rate Increase	$0	$150,172	$150,172
FY2023 - Other Payer Changes	$0	$256,963	$256,963
Impact on Bad Debt/Charity/Denials Calculation	$0	($7,889,621)	($7,889,621)
Sub-Total	**$17,500,000**	**$7,385,343**	**$24,885,343**
Required Funding from Commercial Rate	**$48,609,926**	**$77,276,517**	**$125,886,444**
Per 1 % Impact of Commercial Rate:			
Calendar Year (12 months: Jan-Dec)	$7,620,366		
Budget Year (9 months: Jan-Sept)		$5,715,274	
Commercial Rate Increase in FY2023 Budget	**6.38%**	**13.52%**	**19.90%**

Figure 6:

CVMC	FY2022 Cost Inflation (above FY2022 Budget)	FY2023 Cost Inflation	Total Cost Inflation
Cost Inflation	**$6,809,332**	**$12,471,026**	**$19,280,358**
Less:			
FY2022 Mid-Year Rate Increase	$2,700,000	$0	$2,700,000
FY2023 - Medicare Rate Increase	$0	$1,507,518	$1,507,518
FY2023 - Medicare ACO Rate Increase	$0	$3,000,000	$3,000,000
FY2023 - Medicaid Rate Increase	$0	$712,668	$712,668
FY2023 - Other Payer Changes	$0	($119,565)	($119,565)
Impact on Bad Debt/Charity/Denials Calculation	$0	($917,605)	($917,605)
Sub-Total	**$2,700,000**	**$4,183,016**	**$6,883,016**
Required Funding from Commercial Rate	**$4,109,332**	**$8,288,010**	**$12,397,342**
Per 1 % Impact of Commercial Rate:			
Calendar Year (12 months: Jan-Dec)	$1,044,078		
Budget Year (9 months: Jan-Sept)		$783,059	
Commercial Rate Increase in FY2023 Budget	**3.94%**	**10.58%**	**14.52%**

Figure 7:

PMC	FY2022 Cost Inflation (above FY2022 Budget)	FY2023 Cost Inflation	Total Cost Inflation
Cost Inflation	**$6,773,617**	**$5,593,270**	**$5,593,270**
Less:			
FY2022 Mid-Year Rate Increase	$0	$0	$0
FY2023 - Medicare Rate Increase	$0	$3,278	$3,278
FY2023 - Medicare ACO Rate Increase	$0	$1,280,000	$1,280,000
FY2023 - Medicaid Rate Increase	$0	$560,438	$560,438
FY2023 - Other Payer Changes	$0	$62,566	$62,566
Impact on Bad Debt/Charity/Denials Calculation	$0	($291,024)	($291,024)
Sub-Total	**$0**	**$1,615,258**	**$1,615,258**
Required Funding from Commercial Rate		**$3,978,012**	**$3,978,012**
Per 1 % Impact of Commercial Rate:			
Calendar Year (12 months: Jan-Dec)	$463,233		
Budget Year (9 months: Jan-Sept)		$347,425	
Commercial Rate Increase in FY2023 Budget	**0.00%**	**11.45%**	**11.45%**

Greyed highlighted areas excluded from FY2023 Commercial Rate Calculation

Programmatic and service line changes

Both before and during the pandemic, and through the financial and operational challenges of FY22, the UVM Health Network has served as the essential safety net for patients in need of primary care, urgent care, emergency care and post-acute care. We have worked to sustain our portfolio of programs this year, while also expanding programs that help us improve access to care, such as a Regional Transport Center, a Patient Access & Service Center, Outpatient Pharmacy, telehealth and eConsult services. We are also aggressively working to find ways to expand services needed for high-value care delivery, such as colorectal cancer screening, customized primary care panels, mental health integration with primary care, genetic screening for appropriate pharmaceutical treatments, telestroke access and minimally invasive surgery. However, our ability to truly advance these efforts for our patients is limited by many factors we cannot control: We are impacted by the difficulty in recruiting either permanent or temporary (locum) physicians and advanced practice providers across multiple service lines, with many providers citing the cost of living and lack of available housing as deterrents to move to or stay in Vermont.

Below are a few selected examples that highlight how we are working to innovate amid our challenges to provide our patients with the high-quality care they need:

- **Lung cancer screening and treatment:** Lung cancer remains the leading cause of cancer deaths in Vermont and nationwide, and large randomized controlled trials have confirmed that screening offers the best chance for early detection and improved survival

for current and former smokers. To achieve these goals, a lung screening program must have access to accurate data to monitor uptake of screening and performance of the program; determine what needs must be addressed to improve patient access; and gain insight on how to enhance the program's quality. A nearly 12-month long project was undertaken in our Radiology Department to improve the quality of UVMMC's lung cancer screening program by harnessing the capabilities of the electronic medical record (Epic) to perform data extraction and analysis. In addition, UVMMC invested in a robotic bronchoscopy system that has resulted in dramatically decreased time to treatment for early-stage lung cancer, as well as reduced complications. Earlier treatment is associated with better overall survival for lung cancer and greater patient satisfaction. We have now performed more than 100 cases.

- **Stroke care:** Options for acute stroke care have evolved rapidly, with treatment efficacy and long-term prognosis highly dependent upon rapid diagnosis and time-sensitive interventions. The UVMHN Telestroke service provides all UVMHN Emergency Departments with immediate virtual access to a UVMMC stroke neurologist, combined with evidence-based processes for rapid patient evaluation, decision support, initiation of treatment and transport to UVMMC when appropriate. Through use of this innovative system, patients presenting to our rural EDs have immediate access to the same high level of care as those presenting directly to UVMMC, an AHA/ASA-designated Primary Stroke Center.

- **Emergency Department telemedicine:** Emergency physicians and nurses in rural Emergency Departments can benefit from access to the expertise and experience of a colleague, especially in high-risk, low-frequency events. Through the AUGMENT Tele-EM program, the UVMMC ED now provides immediate access to virtual support from emergency physicians, nurses and pharmacists to colleagues in the CVMC and Porter Medical Center EDs, giving patients access to the right expertise, when and where they need it.

- **eConsults:** An electronic consult, or "eConsult," is an asynchronous tool we can use to help patients gain quicker access to health information from medical specialists for non-urgent patient concerns. Currently, a primary care provider can order an eConsult for certain specialties and receive a response within a week. This means patients do not have to wait for another appointment, travel to the appointment or take time out of their day for the visit. This approach gets the patient to care faster and saves specialist time, while supporting our medical experts in making the best decisions as to when in-person referrals are needed. It also helps primary care providers gain knowledge that can help them better respond directly to patient concerns in the future, possibly avoiding the need for another eConsult or referral. We are piloting eConsults with eight UVMMC primary care clinics and are beginning to engage primary care clinicians across the Network. We currently have 10 active UVMMC specialties participating in the eConsult program with more planned.

- **Primary care mental health integration:** The goal of this program is to improve patient access in a fair and equitable way by integrating specialty and mental health care within

our 38 primary care sites across New York and Vermont. A primary care physician, nurse practitioner or physician's assistant; a psychiatric consultant; and a behavioral health care manager work as a team focused on whole-person health. Primary care providers are also supported by tele-psychiatry, eConsults, electronic or phone consultation, and education to improve immediate access to expert recommendations while the patient is in the office receiving care. In addition to improving patient access, studies show that we can also shift a pattern of costly service utilization (ED, admissions) by actively engaging patients for mental health treatment within the primary care setting. We have implemented this program in nine sites and will launch three additional sites later in 2022.

Changes in staffing

The major changes in staffing across the UVM Health Network in FY22 related to the use of temporary nursing staff (travelers) and physicians (locums) to meet patient demand during a severe workforce shortage, and during a second wave of COVID-19 that infected many of our staff. Temporary staff costs are detailed below. The bottom line is, in order to meet the needs of patients coming to us for care, we had to contract with four times the normal number of temporary nursing staff at more than double the rates we budgeted. Additionally, we implemented significant wage increases for our permanent frontline clinical staff to help retain them and avoid the use of even more travelers. Increased use of temporary staff also disrupted care team workflows, given turnover and variations in experience and skillsets. We expect our reliance on temporary staff, at higher costs, to be a long-term reality for our health system, even as we work hard to moderate the financial impact.

At the same time, we are making necessary investments in the integration and sustainability of our Network through the addition of key senior leadership positions, including a Chief Nursing Officer (CNO), Chief Medical Officer (CMO) and Chief Diversity and Inclusion Officer (CDIO). The CNO and CMO are central to our efforts to standardize and better coordinate care across the Network. The CDIO is charged with implementing our Network-wide DEI strategy, described below.

Operational changes

In FY22, we continued our implementation of centralized IT platform services and applications across the UVM Health Network. Applications include the electronic health record (Epic), supply chain (Premier Connect), human resources (Workday), Cardiology imaging (Merge), Radiology (Visage) and many more clinical, infrastructure and business systems. This work is an investment in driving efficiency, reducing costs, improving staff satisfaction and, more importantly, standardizing and improving patient care.

Continued impacts of COVID-19

The impact of the pandemic will continue for some time, especially for a generation of health care providers. Experts have predicted the health care industry will go through three stages.[3] The first was the crisis stage. Next comes the stabilization stage, and finally the normalization stage. As an industry we are now entering the stabilization stage, and current financial pressures are just as great as they were during the crisis stage. In the initial stage, financial pressures were primarily caused by lower revenues from patients not receiving care, which was at least partially offset by an infusion of one-time federal and state funds. In the stabilization stage, the primary driver of financial stress is higher costs – but there has been nowhere near the same amount of federal and state support to help offset these pressures. The UVM Health Network, like many other health care systems across the country, has seen its balance sheet dramatically eroded, and is on the verge of violating debt covenants.

The duration of the stabilization stage is unknown. Until we are able to achieve contract labor utilization and cost inflation back to pre-pandemic levels, our hospitals will continue to struggle. We have made assumptions for these pressures to decrease in our FY23 budget, but stabilization will need to continue well beyond FY23.

The pandemic continues to impact our operations and our ability to provide all the care our communities need. Workforce challenges continue to create access issues across multiple service lines. Our ability to discharge patients and create the bed capacity needed for more acute patients has been limited due to a lack of staffing in non-acute settings, such as long-term care and skilled nursing facilities. The same capacity issues exist for mental health inpatient beds. New supply chain issues are constantly emerging – national shortages that impact our ability to get the materials we need to take care of our patients are creating backlogs in treatment, such as the severe reduction in iodinated contrast media available for CT scans and other radiological imaging. The mental health crisis, exacerbated by the pandemic, has continued to put tremendous pressure on our staff and providers, especially in our Emergency Departments. Additionally, we have seen an increase in workplace violence, placing even more stress on our staff.

Engagement in sustainability planning

Rural health care is in peril: It simply is not sustainable in its current form due to financial, demographic and workforce pressures. In many parts of this country, people living in rural areas do not have adequate access to essential health services, from primary care to the complex and specialized services provided at an academic medical center. Since 2010, 138 rural hospitals have closed nationwide, and today many more are on the brink of financial collapse.[4] We launched the UVM Health Network in 2012 as part of our strategy to preserve access for our communities to avoid this outcome.

Building a sustainable health care system has been the focus of the UVM Health Network for

[3] Covenant Challenges Signal Need to Chart a Path to Sustainability. Kaufman Hall, June 15, 2022. Visited June 29, 2022.
[4] Rural Hospital Closures. The Cecil G. Sheps Center for Health Services Research. Visited June 29, 2022.

more than a decade. We welcome active engagement in the health care sustainability discussions currently underway in Vermont. We have important lessons to share – examples of how achieving sustainability leads to better health care for the future and for right now.

Sustainability, for us, has two major facets:

1. Making sure that services are available locally or regionally for the communities we serve, to the greatest extent possible, while maintaining high standards of care.
2. Working to ensure that we have the financial wherewithal to meet patient needs; to hire high quality providers and staff; to maintain and improve our equipment and facilities; and to create the best possible working environment for our workforce.

We are engaging in sustainability planning for our integrated health system in Vermont and northern New York. Without some degree of planning, we will not have a viable academic medical center to serve the region, nor the quaternary, tertiary, secondary and primary care services our communities need. We have concrete examples of how we are making this work through Network-wide patient navigation in both Vermont and New York, such as a Regional Transport System, which manages patient transport between care settings and care coordination, and regional allocation of health care providers to make care accessible even if it is not located in a specific community. We hope we can bring these experiences to bear in informing the State's sustainability planning process.

In addition, Network leaders have completed a comprehensive review of services, expenses, facilities and programs to develop the most effective and comprehensive plan for financial stabilization and sustainability, while minimizing the impact on our patients and communities. We have chosen to focus on solutions that will make the best use of the talent, skill and capabilities of our people to improve access to care while increasing revenue in FY23. Some initiatives that will help ensure our sustainability include:

- **Innovation in managing the use of acute care patient beds and post-acute beds and expansion of surgical capacity** to maximize the number of beds and operating rooms available. This new management system ensures that beds at one Network hospital are not underutilized while another is over capacity, and enables certain surgeries to be scheduled across Network hospitals that have the expertise and the operating rooms available for use. These efforts will harness the benefits of connected care now that Network hospitals share a common electronic health record, Epic. This shared electronic platform provides a more effective way to manage patient needs by fully utilizing available care and treatment options across the Network.

- **Further improving talent pipeline programs, employee recruitment and retention efforts** to reduce reliance on expensive temporary personnel. This includes ongoing investments in programs to educate staff and other members of the care team within the Network, expanding and enhancing health care career opportunities, recruiting efforts, and managing the use of temporary personnel on a Network-wide basis. While we have made significant progress in recruitment this year, much work remains.

- **Organizing and expanding pharmacy services under a common structure** to better achieve economies of scale in one of the fastest-growing areas of patient and provider health care expense. Demand for the Network's local outpatient pharmacy services is increasing from both the Network's own employees and their families and patients receiving medication through our Health Assistance Program and mail order pharmacy initiative. The Network is responding with an innovative approach to centralization and expansion of retail pharmacy space.

- **Moving toward a contemporary workforce with hybrid and remote work.** At the beginning of the pandemic, the Network moved some staff into remote and hybrid roles. We will continue with workforce innovations for the long term, which will provide opportunities to consolidate space, reduce real estate costs and, ultimately, improve staff satisfaction. This approach also expands the health system's recruitment reach beyond the region to attract people who are interested in remote roles.

- **Addressing the backlog in delayed care by reducing the wait times** caused by the pandemic and made worse by the workforce crisis. Many have deferred care since the start of the pandemic, and the population of our region will need more care as they age. We will continue to make progress on the efforts outlined in our Access Action Plan to shorten wait times and increase access for patients in need of routine preventive screenings and primary care, as well as complex surgeries, such as hip and joint replacements.

These measures, and more, represent a significant amount of work by leaders across the Network, all with the singular goal of avoiding major service cuts, at least in the near term, or truly unaffordable commercial rate hikes. Taken together, these and other initiatives have the potential to improve our Network margin by $159M to $232M, getting us to our budgeted operating margin of 1.7%. However, as the last two years have demonstrated, achieving these savings will require continued evaluation and adaptation to an unpredictable health care landscape.

Objective financial metrics

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 bond rating agencies) using consistent and objective metrics. In order to have the financial stability necessary 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 the Board's assessment of our financial health, include:

- **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.

- **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.

- **Annual debt service coverage ratio:** Indicates the organization's ability to make its annual payments to debt holders. The organization needs to be taking in more cash than the annual payments, or risk defaulting on their debt. Due to the $90M loss projected for FY22, this is the debt covenant metric that the UVM Health Network could violate this year.

- **Days cash on hand:** This is a 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.

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. The table below displays the A category medians for each agency (on the left, in blue), and the performance threshold ranges we have established for the UVM Health Network based on these benchmarks (on the right).

Figure 8:

	Rating Agency Medians Data				Short-Term Sustainability / Short & Long-Term Sustainability — Performance Thresholds		
	Moody's 'A' Median (A2)	Fitch 'A' Median	S&P 'A' Median (stand-alone)	S&P 'A' Median (system)	Financial Sustainability Lower Range *If Below - At Risk*	Financial Sustainability Middle Range	Financial Sustainability Upper Range
Operating Margin	1.70%	0.90%	0.60%	0.70%	2.50%	3.25%	4.00%
Operating EBIDA Margin	8.40%	8.20%	8.20%	6.60%	7.00%	8.00%	9.00%
Max Annual Debt Service Coverage	4.9	3.4	3.7	3.6	3.0	4.0	5.0
Days Cash on Hand	259	259	273	178	175	200	225
LT Debt to Capitalization Ratio	33%	33%	26%	40%	40%	35%	30%
Average Age of Plant	11.5	12.2	11.7	11.6	13.0	12.0	11.0

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. Starting in FY17, the Board began approving rate increases that did not cover the rate of cost inflation. In FY17 this lowered our operating EBIDA margin, which in turn negatively impacted our days cash on hand and average age of plant. These below-cost inflation rate increases continued in FY18, FY19 and FY20, further deteriorating our financial stability.

In FY20, our days cash on hand was bolstered by federal and state COVID-19 relief funds, and the Miller Building and Epic implementation at UVMMC, which lowered our average age of plant. In FY21 we received a rate increase that was closer to the rate of cost inflation, but the pandemic continued to impact our finances. Now in FY22, the rate increase we received has come nowhere close to covering the rate of cost inflation, which is why we submitted a mid-year budget adjustment request. That request was significantly reduced, which at year-end will have a dramatic impact on our days cash on hand and put us on the precipice of violating our debt service coverage ratio covenant. The budget we are submitting for FY23, and the associated rate increase, will only allow us to make an incremental step back towards financial stability. Our operating EBIDA margin will still be below our financial framework threshold, and we will slightly improve our days cash on hand.

In order to have the resources to reinvest in the organization and the community (lower average age of plant), and to have enough reserves to weather unexpected events (increase days cash on hand), future budgets will have to have operating EBIDA margins that get back to the 8%+ margins we were generating before FY17. The table below displays the UVM Health Network's actual performance relative to our performance thresholds (shown above in figure 8) for the years FY17 through FY21 and projections for FY22 through FY26.

Figure 9:

						Projection Years				
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Profitability Ratios										
Operating Margin	3.3%	1.4%	0.7%	(0.7%)	1.1%	(3.4%)	2.1%	2.7%	3.1%	3.2%
Operating EBIDA Margin	8.4%	6.2%	5.4%	4.7%	5.7%	1.4%	6.7%	7.3%	7.7%	7.7%
Capital Structure Ratios										
Long Term Debt to Capitalization	35.2%	33.3%	32.0%	36.9%	33.4%	33.3%	33.4%	33.4%	30.6%	27.8%
Annual Debt Service Coverage	4.3	3.3	3.1	2.5	1.9	1.3	3.9	3.9	3.9	4.4
Liquidity Ratios										
Days Cash on Hand	166	166	142	174	179	148	163	166	165	174
Other Ratios										
Average Age of Plant	15.7	16.6	16.9	10.5	12.2	12.3	13.4	14.3	14.6	15.0

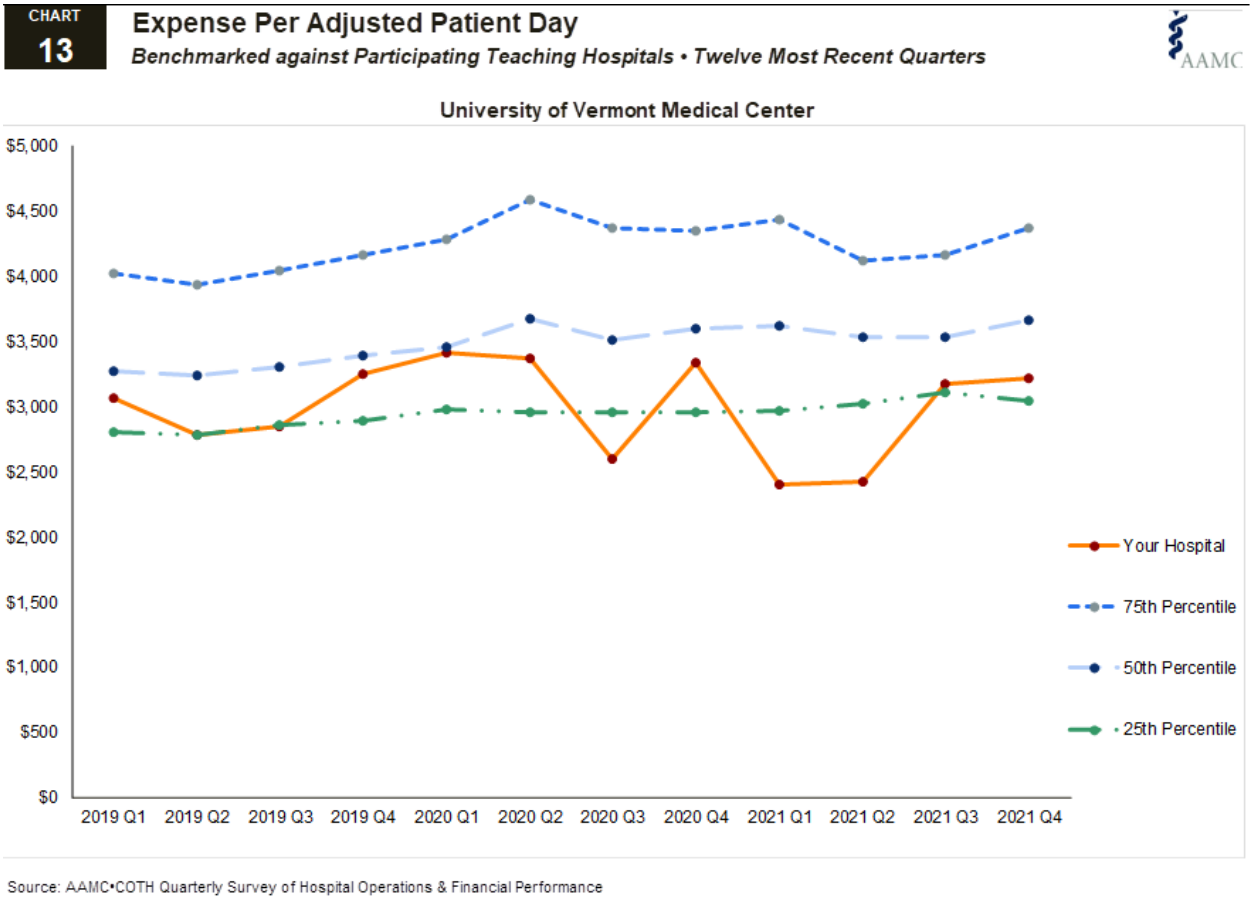
Ninety percent of all S&P-rated hospital systems have an A rating or greater, and Vermont's only academic health system should not be an exception to that rule. An A rating is a powerful external validation that a health system is financially strong, has the capacity to care for its community, and is 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 outlays necessary to make critical investments in facilities, technological

advancements and human resources. We cannot build organizational resiliency, retain and recruit physicians and nurses, or deliver on our mission to serve our community if we are in a state of decline.

Cost metrics

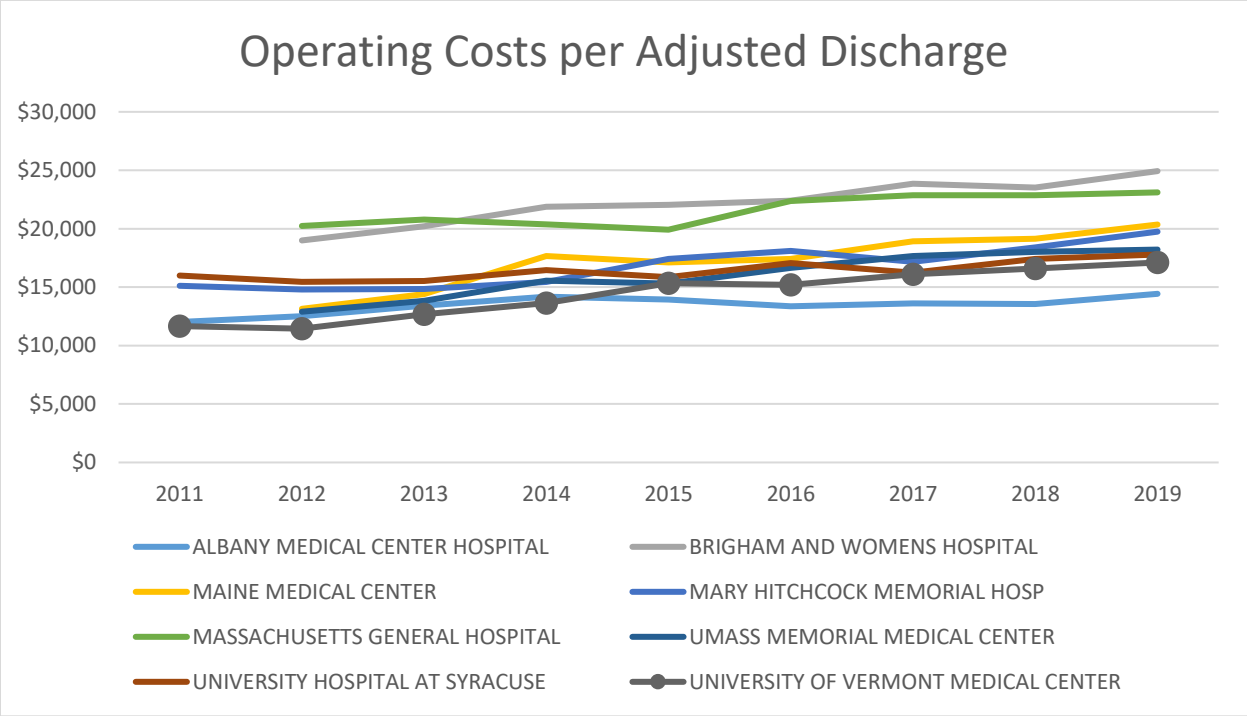
In addition to the financial metrics described above, we regularly compare our costs to outside benchmarks. The UVM Health Network tends to compare favorably regarding cost management from a provider perspective, as well as from a patient and payer perspective. Our hospitals have always controlled their expenses more effectively than most of our national peers. For example, the chart below from the Association of American Medical Colleges (AAMC) shows that the UVM Medical Center is consistently around the 25th percentile in expense per adjusted patient day, when compared to other U.S. academic medical centers.

Figure 10:



UVMMC also compares favorably to regional peers in terms of operating costs per adjusted discharge, as shown below.

Figure 11:

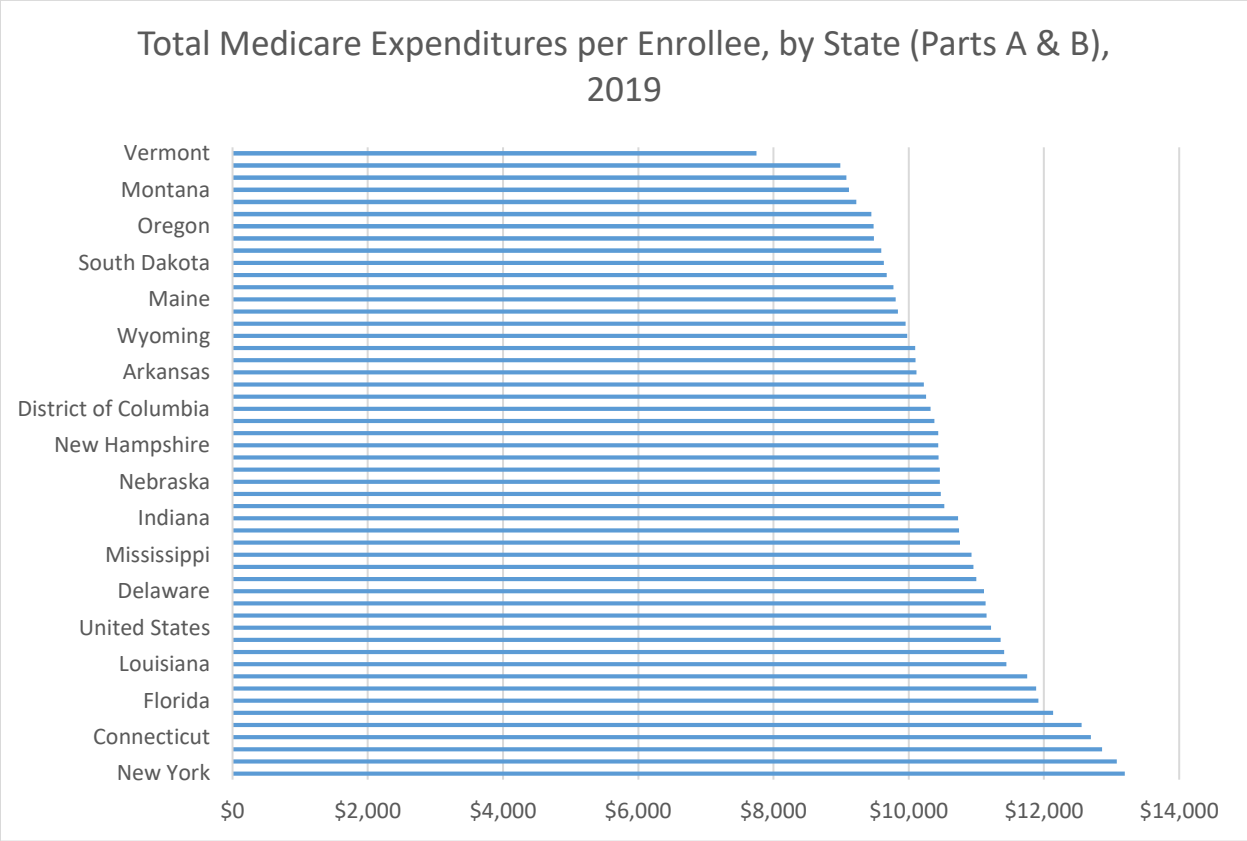


Source: National Academy for State Health Policy. Hospital Cost Tool. Visited June 30, 2022.

In terms of per capita costs, Vermont has the lowest Medicare per capita reimbursements in the country, while the Health Service Areas (HSAs) where our Network hospitals are located are among the lowest-cost within Vermont for the Medicare program. In fact, the Middlebury HSA, where Porter Hospital is located, has the absolute lowest per-capita Medicare reimbursements in the country, and our three core service territories are the three lowest-cost HSAs in the country.[5]

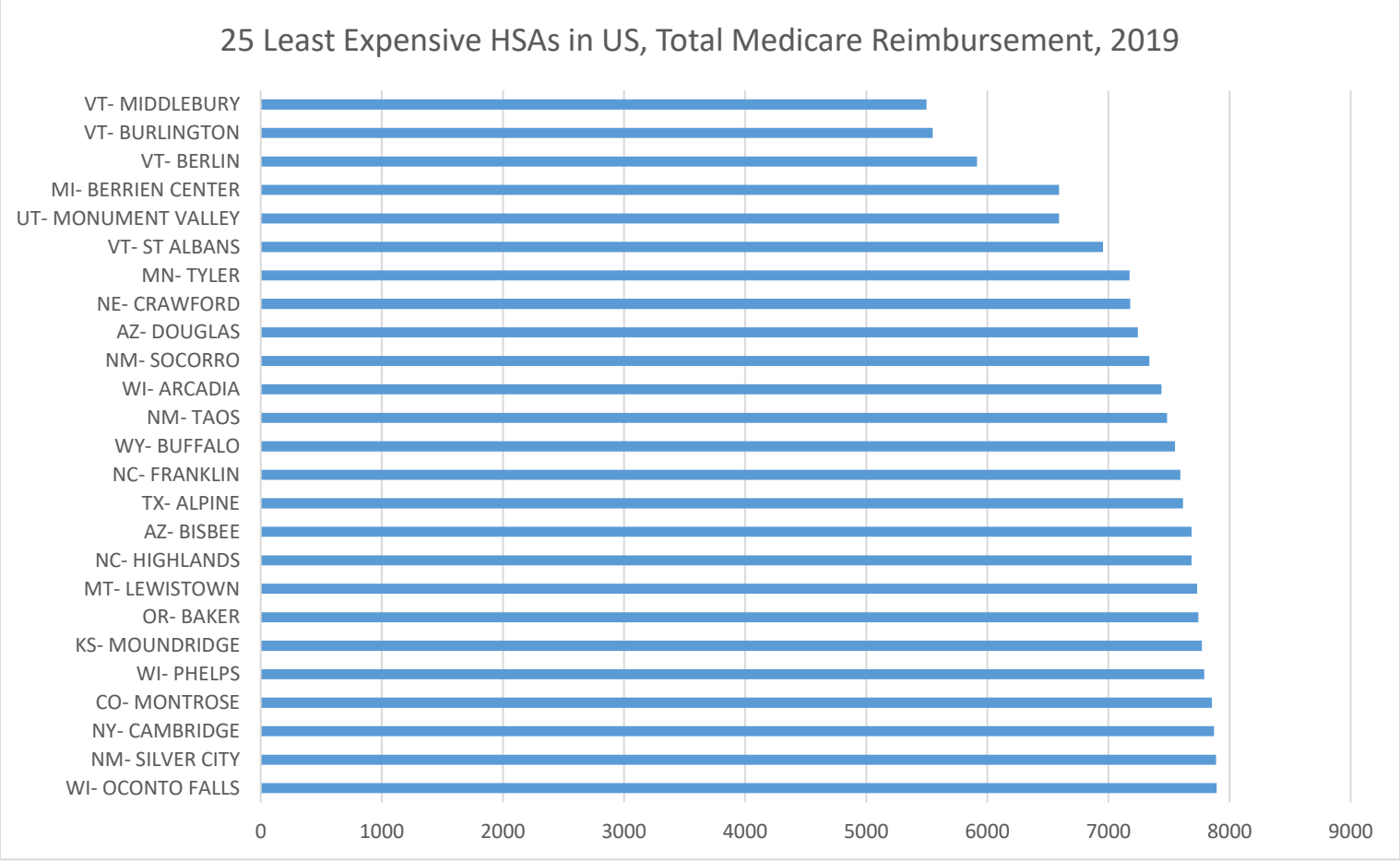
[5] Maps: Price-Adjusted Total Medicare Reimbursements per Enrollee (Parts A and B), by State and by HSA (2019). Medicare Reimbursements - Dartmouth Atlas of Health Care (visited March 17, 2022). The data set forth at Price-Adjusted Total Medicare Reimbursements per Enrollee (Parts A and B), by State and by HSA (2019) of publication/press release was obtained from Dartmouth Atlas Data website, which was funded by the Robert Wood Johnson Foundation, The Dartmouth Clinical and Translational Science Institute, under award number UL1TR001086 from the National Center for Advancing Translational Sciences (NCATS) of the National Institutes of Health (NIH), and in part, by the National Institute of Aging, under award number U01 AG046830.

Figure 12:



Source: Dartmouth Atlas of Health Care

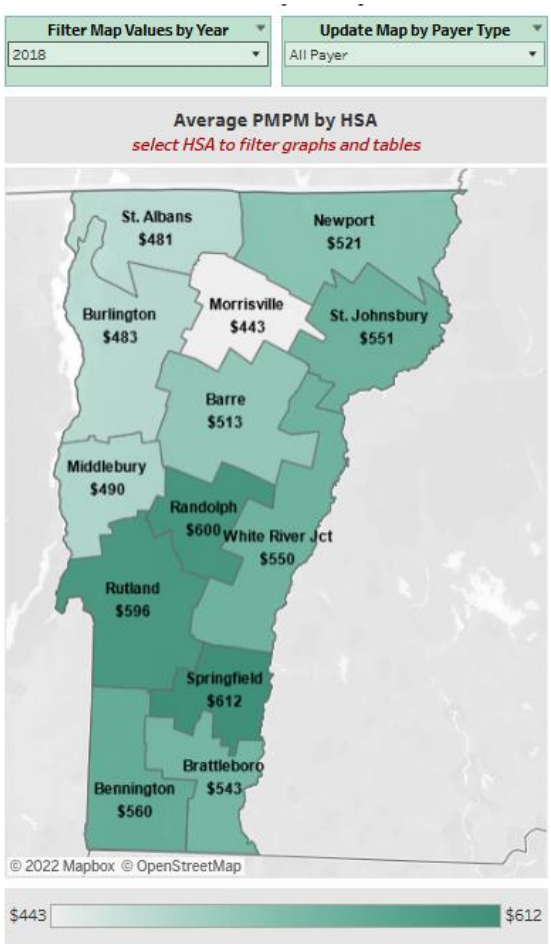
Figure 13:



Source: Dartmouth Atlas of Health Care

The Board's own data reinforce our assessment that the areas of the state we serve are relatively low cost, as shown in the map below.

Figure 14:



[All-Payer Total Cost of Care | Green Mountain Care Board (vermont.gov)]

Population and per capita cost growth in our service area

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 on a per-capita basis as required by law.

In prior submissions we have highlighted that the 3.5% cost cap the Board uses as its primary regulatory guide is inadequate in two ways:

- It is applied to hospital revenue, rather than total per-capita costs of care, as was the intent of the All-Payer Model.
- It is not anchored to a denominator, such as covered lives or total population. This is the only true way to measure cost growth from a per-capita perspective.

Last year in our FY22 budget submission, we presented a model, as an example, that showed how this measurement could be done. We have updated that model for our FY23 submission this year. We used actual Vermont population data through 2021, and created a projection for FY22 and FY23 using the recent trend. These data have been adjusted to reflect the UVM Health Network (combined UVM Medical Center, Central Vermont Medical Center, and Porter Hospital) market share by county. The data are then broken into three age categories – under 45, 45 to 64, and over 65. Weights are applied to these categories to reflect the difference in utilization of health care services between those age groups 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. This is used as a proxy for building patient acuity into the model, which is factored into every total cost of care (TCOC) model.

In this model, after removing revenue generated by UVM Medical Center, CVMC, and Porter Hospital from serving New York residents (so that we are only comparing Vermont-based net patient revenue with Vermont population), the UVM Health Network hospitals from FY17 through FY22 have been below the 3.5% per capita growth guidance used by the Board, with the average rate increase being 1.3%.

This very small rate of growth was caused by approved rate increases, up through FY21, that were below the increase in cost inflation. The growth in the FY23 budget is a combination of capturing delayed care caused by the pandemic, and the higher-than-normal rate increase required to cover extraordinary cost inflation.

If our FY23 budget is approved as submitted, we will be slightly over the 3.5% growth guidance (at 4.3%), when properly adjusted for the population we serve. However, we believe the 3.5% limit is no longer realistic for the period of extraordinary cost inflation that we are in, especially given that our historical costs grew at a rate well below that level for several preceding years.

The TCOC model we have described above is admittedly not perfect, but it is an example of how the Board could more appropriately apply a per capita cost limit to hospital costs. We have hired a research team, led by Steve Kappel of Policy Integrity, which is working to develop options for a more sophisticated approach to patient attribution and calculation of total costs of care by hospital. We look forward to sharing the results of that research with the Board in the hope that such a method could be employed in the budget process in the future for more accurate cost calculations and better alignment with the All-Payer Model.

Figure 15:

	Utilization Adjustment	FY17	FY18	FY19	FY20	FY21	FY22	FY22 Budget	FY23 Budget
Primary Market Population									
Chittenden		162,372	164,572	163,774	168,323	168,865	169,409	168,865	169,954
Franklin		49,025	49,421	49,402	49,946	50,325	50,707	50,325	51,092
Grand Isle		6,998	7,090	7,235	7,293	7,421	7,551	7,421	7,684
Lamoille		25,337	25,300	25,362	25,945	26,126	26,308	26,126	26,492
Washington		58,290	58,140	58,409	59,807	59,969	60,131	59,969	60,294
Addison		36,776	36,973	36,777	37,363	37,260	37,157	37,260	37,055
Subtotal		338,798	341,496	340,959	348,677	349,966	351,264	349,966	352,571
Rest of Vermont		284,859	284,803	283,030	294,400	295,604	296,813	295,604	298,027
Total Vermont		623,657	626,299	623,989	643,077	645,570	648,077	645,570	650,597
UVMHN Population (market share adj)									
Under 45		173,776	176,855	177,026	181,750	178,348	174,298	178,348	171,248
45 - 64		88,167	87,683	86,704	90,608	94,068	97,547	94,068	102,081
65 +		53,038	55,701	58,033	60,283	62,117	64,524	62,117	66,941
Total		314,981	320,239	321,763	332,642	334,533	336,369	334,533	340,270
Utilization Adjusted UVMHN Population									
Under 45	X 1.00	173,776	176,855	177,026	181,750	178,348	174,298	178,348	171,248
45 - 64	X 2.52	222,041	220,821	218,357	228,189	236,902	245,664	236,902	257,082
65 +	X 4.45	235,949	247,799	258,173	268,181	276,339	287,050	276,339	297,798
Total		631,766	645,474	653,556	678,120	691,589	707,011	691,589	726,128
UVMHN NPR		$ 1,494,225,412	$ 1,538,581,738	$ 1,587,997,998	$ 1,481,191,345	$ 1,636,173,812	$ 1,786,160,265	$ 1,863,812,924	$ 2,043,709,666
Less: NY NPR		$ 181,667,846	$ 194,375,659	$ 195,355,597	$ 185,957,876	$ 204,003,732	$ 223,946,237	$ 236,835,517	$ 262,162,842
UVMHN VT NPR		$ 1,312,557,566	$ 1,344,206,079	$ 1,392,642,401	$ 1,295,233,469	$ 1,432,170,080	$ 1,562,214,028	$ 1,626,977,407	$ 1,781,546,824
VT NPR per UVMHN VT Population		$ 4,167	$ 4,198	$ 4,328	$ 3,894	$ 4,281	$ 4,644	$ 4,863	$ 5,236
VT NPR per UVMHN VT Population (Age Adj)		$ 2,078	$ 2,083	$ 2,131	$ 1,910	$ 2,071	$ 2,210	$ 2,353	$ 2,453
Percent Change		2.6%	0.2%	2.3%	-10.4%	8.4%	6.7%		4.3%
FY17 to FY22 per Year Average							1.3%		

B. YEAR-OVER-YEAR CHANGES

i. NPR/FPP: Overview

a. Referencing the data submitted in Appendix 1 of Part B below, explain each component of the budgeted FY23 NPR/FPP change over the approved FY22 budget, referencing relevant FY23 budget-to-projection variances.

i. Discuss changes in NPR/FPP expected from Medicare, Medicaid, and Commercial; and other reimbursements from government payers.

UVMMC: Please refer to Appendix 1, Table 1 on page 3 in the appendices.
FY23 Medicare payment rate changes – 3.4% which include an assumed pickup in Medicare ACO shared savings of $8.5M.
FY23 Medicaid payment rate changes – 0.0% change for hospital.
FY23 Commercial payment rate changes – 19.9%; please refer to page 9 in the budget narrative for justification of the commercial rate request.
Table 1 in Appendix 1 fairly highlights the various items driving the NPR/FPP change budget-to-budget.

CVMC: Please refer to Appendix 1, Table 1 on page 11 in the appendices.
FY23 Medicare payment rate changes – 4.4% which include an assumed pickup in Medicare ACO shared savings of $3.0M.
FY23 Medicaid payment rate changes – 0.0% change for hospital, 10% for SNF.
FY23 Commercial payment rate changes – 14.52%; please refer to page 9 in the budget narrative for justification of the commercial rate request.
Table 1 in Appendix 1 fairly highlights the various items driving the NPR/FPP change budget-to-budget.

Porter Hospital: Please refer to Appendix 1, Table 1 on page 19 in the appendices.
FY23 Medicare payment rate changes – 2.8%.
FY23 Medicaid payment rate changes – 0.0% change for hospital.
FY23 Commercial payment rate changes – 11.45%; please refer to page 10 in the budget narrative for justification of the commercial rate request.
Table 1 in Appendix 1 fairly highlights the various items driving the NPR/FPP change budget-to-budget.

ii. Also include any significant changes to revenue assumptions from FY22 (e.g.,Centers for Medicare and Medicaid Services (CMS) and Department of Vermont Health Access (DVHA) reimbursement policies, reimbursement adjustments, settlement adjustments, reclassifications, other accounting adjustments, rate changes, utilization, and/or changes in services).

Table 1 in Appendix 1 fairly highlights the various items driving the NPR/FPP change budget-to-budget.

1. 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 baddebt 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/charges from all payers. For the most part, the percentage of bad debt and free care is measured as a percentage of total gross revenue/charges.

Bad debt and free care as a percentage of total gross revenue:

	FY22 Budget	FY23 Budget
UVMMC	1.78%	1.79%
CVMC	2.00%	1.50%
PMC	3.68%	3.19%

ii. NPR/FPP: Utilization

a. Describe any significant variances from the FY22 budget and projection (includingchanges in reimbursements and utilization).

UVMMC: Please refer to Appendix 1, Tables 1 and 3 on pages 3 and 4 in the appendices.
CVMC: Please refer to Appendix 1, Tables 1 and 3 on pages 11 and 12 in the appendices.
Porter Hospital: Please refer to Appendix 1, Tables 1 and 3 on pages 19 and 20 in the appendices.

b. Please provide your occupancy rate per licensed and staffed bed, occupancy rate, and average daily census for FY23 versus FY22 and FY21.

This information is not available to provide, as we do not budget using these conventions.

c. Referencing the data submitted in Appendix 3 of Part B below, explain changes in your utilization assumptions to support your NPR/FPP variances.

UVMMC: Please refer to Appendix 3, page 6 in the appendices.
CVMC: Please refer to Appendix 3, page 14 in the appendices.
Porter Hospital: Please refer to Appendix 3, page 22 in the appendices.

iii. Charge Request

a. Referencing the data submitted in Appendix 2 of Part B below, explain the hospital's overall charge request on the charge master in Table 1.

UVMMC: Please refer to Appendix 2, page 5 in the appendices. For change-in-charge request, there was a mostly consistent approach applied to service areas.
CVMC: Please refer to Appendix 2, page 13 in the appendices. For change-in-charge request, there was a fairly consistent approach applied to service areas, with slightly higher weighting towards inpatient over professional and outpatient.

Porter Hospital: Please refer to Appendix 2, page 21 in the appendices. For change-in-charge request, there was a consistent approach applied to service areas.

b. 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 Tables2-3. Describe how the charge request affects the areas of service (specifically, inpatient,outpatient, professional services, etc.) in gross revenues, NPR and FPP by payer. Explain the underlying assumptions and methodology used to make that allocation.

Please note that a change-in-charge is defined as the increase applied to the charge master, which applies to all payers. Change-in-charge **is not** to be conflated with, and is **not the same,** as a Change-in-Payer-Rates, which is defined as the overall rate increase to payers through increased fixed fee terms and discount of charge percentages.

For Change-in-Payer-Rates, please refer to the response for NPR/FPP: Overview on page 24 of the narrative.

c. Please indicate the dollar value of 1% NPR/FPP FY23 in Table 3 of Appendix 2 of PartB below, overall change-in-charge.

Please note that a change-in-charge is defined as the increase applied to the charge master, which applies to all payers. Change-in-charge **is not** to be conflated with, and is **not the same,** as a Change-in-Payer-Rates, which is defined as the overall rate increase to payers through increased fixed fee terms and discount of charge percentages.

Please note that the 1% values in Appendix 2, Table 4 are a per 1% of change in payer rate value, not a change-in-charge.

UVMMC: Please refer to Appendix 2, Table 4 on page 5 in the appendices.
CVMC: Please refer to Appendix 2, Table 4 on page 13 in the appendices.
Porter Hospital: Please refer to Appendix 2, Table 4 on page 21 in the appendices.

d. Please provide the following updates from the hospital's GMCB <u>approved</u> change-in-charge for FY22:

UVMMC: Please refer to Appendix 2, Table 1 on page 5 in the appendices.
CVMC: Please refer to Appendix 2, Table 1 on page 13 in the appendices.
Porter Hospital: Please refer to Appendix 2, Table 1 on page 21 in the appendices.

Please note that a change-in-charge is defined as the increase applied to the charge master, which

applies to all payers. Change-in-charge **is not** to be conflated with, and is **not the same,** as a Change-in-Payer-Rates, which is defined as the overall rate increase to payers through increased fixed fee terms and discount of charge percentages.

i. Did the hospital receive the full amount of its approved FY22 rate increase fromthe commercial payers?

Please note that a change-in-charge is defined as the increase applied to the charge master, which applies to all payers. Change-in-charge **is not** to be conflated with, and is **not the same,** as a Change-in-Payer-Rates, which is defined as the overall rate increase to payers through increased fixed fee terms and discount of charge percentages.

Yes, UVMMC received the 6.05% commercial rate increase approved by the Board in the October 1, 2021 FY22 Budget Order. The FY22 Mid-Year Budget Adjustment Order on April 15, 2022, allowing for a 2.5% commercial rate increase for UVMMC above the hospital approved FY22 budget is still subject to implementation across payers due to contractual language limitations. For any commercial payers that did not implement the mid-year adjustment change in commercial rate effective 6/1/22, it is the expectation and modeled within our FY23 budget submission that the increase, subject to compounded impact, will be added to the FY23 Board-approved commercial rate effective 1/1/23.

Yes, CVMC received the 6.00% commercial rate increase approved by the Board in the October 1, 2021 FY22 Budget Order. The FY22 Mid-Year Budget Adjustment Order on April 15, 2022, allowing for a 2.7% commercial rate increase for CVMC above the hospital approved FY22 budget is still subject to implementation across payers due to contractual language limitations. For any commercial payers that did not implement the mid-year adjustment change in commercial rate effective 6/1/22, it is the expectation and modeled within our FY23 budget submission that the increase, subject to compounded impact, will be added to the FY23 Board-approved commercial rate effective 1/1/23.

Yes, Porter Hospital received the 4.00% commercial rate increase approved by the Board in the October 1, 2021 FY22 Budget Order.

ii. Did the hospital increase its charges to the full approved amount for FY22, if not, why not and by how much did the hospital increase those rates?

Please note that a change-in-charge is defined as the increase applied to the charge master, which applies to all payers. Change-in-charge **is not** to be conflated with, and is **not the same,** as a Change-in-Payer-Rates, which is defined as the overall rate increase to payers through increased fixed fee terms and discount of charge percentages.

UVMMC, CMVC and Porter Hospital implemented charge master changes for the full change in charge in the FY22 Budget Orders, October 1, 2021. Subsequently UVMMC and CVMC received a FY22 Mid-Year Budget Adjustment Order, April 15, 2022, which the charge masters were updated by an additional 2.5% for UVMMC and 2.7% for CVMC.

iii. How did the resulting increase impact areas of service (specifically, inpatient, outpatient, professional services, etc.)?

Changes-in-charge related to FY22 budget and FY22 mid-year budget adjustment approvals were mostly spread evenly across respective hospital service areas of inpatient, outpatient and professional for UVMMC, CVMC and Porter Hospital.

iv. Adjustments (physician transfers and accounting adjustments):
a. Account for operational or financial changes, including provider transfers and/or accounting changes.

There have been no major operational or financial changes that have material impact on financial projections or budgeting at any of our three Vermont hospitals.

v. Other Operating and Non-Operating Revenue:
a. *Explain the budgeted FY23 other operating revenue and non-operating revenue changes over the approved FY22 budget, as well as relevant FY22 budget-to-projection variances.*
b. Please denote the COVID-19 advances, relief funds, and other grants received in Appendix 6 of Part B below, and the respective treatment of each funding source as of September 30, 2021, projected as of September 30, 2022, and budgeted as of September 30, 2023.
c. 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.
d. 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.

UVMMC:
Other operating revenue: Increasing by $88.6M, or 41.5%, from FY22 budget to FY23 budget.

- $80.7M growth in outpatient pharmacy business (increased specialty pharmacy volumes offset by 340B reductions, due to continued impacts of drug manufacturer restrictions)
- $7.1M higher other revenue related to PHSO and FEMA funding
- $5.5M higher payer incentive premium revenue
- ($3.2M) lower client lab revenue due to less COVID-19 testing
- ($1.4M) lower cafeteria revenue (closing of two cafeterias)

The two primary components of other operating revenue from pharmacy are retail pharmacy revenue, principally from specialty pharmacy, and 340B contract pharmacy. Our budget for FY23 projects that retail pharmacy revenue will continue to grow. This growth is primarily in specialty pharmacy, and tracks with our recent historical results of strong year-over-year growth in this segment. In contrast, contract pharmacy revenue is projected to continue to decrease. The cause of the decrease is nation-wide actions by pharmaceutical manufacturers to withdraw access to 340B pricing at contract pharmacies. Litigation between drug companies and the federal government recently resulted in a ruling against the federal government, but it is too early to tell whether that will result additional revenue to any of our hospitals.

FY23 budget-to-projection is heavily impacted by the HHS funding for COVID-19 relief and the cyberattack insurance payment.

Non-operating revenue: We budgeted for increased liability related to the post-retirement medical plan. The increase in the FY23 budget over FY22 projection is due to negative market performance YTD in FY22.

b. Please denote the COVID-19 advances, relief funds, and other grants received in Appendix 6 of Part B below, and the respective treatment of each funding source as of September 30, 2021, projected as of September 30, 2022, and budgeted as of September 30, 2023.

Please refer to page 9 in the appendices.

At the time of this budget submission, the only COVID-19 relief funds that have been identified for UVM Medical Center is $5M for projects submitted. The estimated time frame is 12 to 18 months. The UVM Health Network will continue to review all opportunities on an ongoing basis.

d. 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.

Other operating revenue: Both outpatient pharmacy sources of revenue have been unstable in recent budget years, for several reasons. As mentioned above, the manufacturer actions around 340B have been unpredictable and have had very significantly detrimental effects on financial performance. In the same timeframe, we have pursued continued expansion of our specialty pharmacy patient care services. This effort, in addition to the industry-wide growth in utilization of specialty drug products, has led to annual revenue growth in excess of 40% in several recent years. The future for 340B revenue is hard to predict, but we anticipate strong growth in specialty pharmacy for at least the next two budget years, in line with what we have recently experienced.

Non-operating revenue: The unrealized gain/(loss) on investments is the most unpredictable portion of non-operating revenue because it is entirely dependent on how the capital markets perform. This is a non-cash revenue item, as the value in this line flows through to the balance

sheet as a change to the total market value of investments shown. There is no actual cash impact to the P&L for unrealized gains and losses.

To balance the unpredictable nature of investments, the organization employs a fairly conservative investment strategy to help minimize losses when the capital markets become volatile and/or perform poorly. Roughly 60% of the organization's investment balance is in equities or other growth oriented investments. The remaining 40% is held in fixed income, where predictable income streams occur, and principal losses are generally less severe than with equities and other growth assets. That investment mix is intended to smooth out the ups and downs of the market that occur over time.

CVMC:

a. Explain the budgeted FY23 other operating revenue and non-operating revenue changes over the approved FY22 budget, as well as relevant FY22 budget-to-projection variances.

FY23 budget excludes any operating income pertaining to stimulus monies compared to FY22 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. Other operating revenues are dependent on 340B program stability. CVMC is working with the UVM Health Network to expand a retail pharmacy program, which includes the Health Assistance Program housed at UVMMC and a specialty pharmacy program designed to improve access to those who need this service. This program has been launched with two pharmacists to be shared in the Hematology-Oncology, Dermatology and Rheumatology clinics.

There is a budget to budget increase of $1M due to anticipated increase in value-based programs, and the remainder of increase for client services revenue (mainly lab). The unfavorable difference in projections is mainly due to COVID-19 HHS funding received in FY22; at the time of FY23 budget submission, that funding is not anticipated to continue.

b. Please denote the COVID-19 advances, relief funds, and other grants received in Appendix 6 of Part B below, and the respective treatment of each funding source as of September 30, 2021, projected as of September 30, 2022, and budgeted as of September 30, 2023.

As outlined on page 17 in the appendices, CVMC received COVID-19 relief funds in FY21 and FY22. For grant funds that were awarded to support expenditures, funds were expended in alignment with the grant programs' allowed purposes. Expenses included COVID-19 testing expenses, personnel and fringe expenses associated with COVID-19, facility and equipment expenses, as well as other miscellaneous expenses allowable under each grant program.

At the time of budget submission, CVMC has a FEMA application in progress, to be submitted prior to the 9/30/22 deadline (total dollar amount unknown at this time); the State of Vermont premium pay grant has been completed and submitted (total dollar amount unknown at this time). The estimated time frame is 12 to 18 months. CVMC works with the UVM Health Network to continue to review all opportunities on an ongoing basis.

d. 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.

Non-operating revenue: The unrealized gain/(loss) on investments is the most unpredictable portion of non-operating revenue because it is entirely dependent on how the capital markets perform. This is a non-cash revenue item, as the value in this line flows through to the balance sheet as a change to the total market value of investments show. There is no actual cash impact to the P&L for unrealized gains and losses.

As part of the UVM Health Network, CVMC is part of the conservative investment strategy to help minimize losses when the capital markets become volatile and/or perform poorly. Roughly 60% of the organization's investment balance is in equities or other growth-oriented investments. The remaining 40% is held in fixed income, where predictable income streams occur, and principal losses are generally less severe than with equities and other growth assets. That investment mix is intended to smooth out the ups and downs of the market that occur over time.

<u>Porter Hospital:</u>
Other operating revenue is decreasing by $1.8M, or 28.4%, from FY22 budget to FY23 budget. Reduction is due to outpatient pharmacy revenues primarily pursuant to changes with 340B manufacturers limiting the distribution of certain 340B drugs through community pharmacies. Non-operating revenues are budgeted based on current market trends for investments.

b. Please denote the COVID-19 advances, relief funds, and other grants received in Appendix 6 of Part B below, and the respective treatment of each funding source as of September 30, 2021, projected as of September 30, 2022, and budgeted as of September 30, 2023.

Please refer to page 25 in the appendices.

Porter Hospital received COVID-19 relief funds in FY21 and FY22. For grant funds that were awarded to support expenditures, funds were expended in alignment with the grant programs' allowed purposes. Expenses included COVID-19 testing expenses, personnel and fringe expenses associated with COVID-19, facility and equipment expenses, as well as other miscellaneous expenses allowable under each grant program.

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

d. 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.

Other operating revenue: The stability of the pharmacy revenue, specifically 340B, continues to

demonstrate volatility as a result of the manufactures' breadth or lack thereof to participate expansively in this program. Porter Hospital is working with the manufacturers (along with the UVM Health Network) to establish a mutually agreeable program that benefits all the parties with the main focus being the patients in need of the prescriptions. Additionally, philanthropic contributions are budgeted as other revenue and are not fully within Porter's control.

Non-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.

vi. Operating Expenses:

a. Explain changes in budgeted FY23 operating expenses over the approved FY22 budget.

Current year and next year cost inflation are the primary drivers for increased expense from FY23 operating expenses over FY22 approved budget, primarily in workforce, supplies and services.

UVMMC:

Expenses from FY22 budget to FY23 budget increase by approximately $258M.
The key components are:

$ 66.1M FY22 cost inflation above FY22 budget
$ 93.8M FY23 cost inflation
$ 57.3M drugs
$217.2M total or 84% of total increase

We have limited influence over this $217M, as these factors relate to current local and national workforce challenges and cost inflation.

Of the remainder, this is mostly comprised of salaries, travelers and locums totaling $38.8M, which is primarily related to additional volumes.
While the table shows an increase in equipment / software / other maintenance of $21.4M, this is partially offset by expenses that previously went through purchased services and other expenses. With the completion of the Epic implementation, expenses have been consolidated through equipment / software / other maintenance.

CVMC:

Expenses from FY22 budget to FY23 budget increase by approximately $20.6M.
The key components are:

$ 6.8M FY22 cost inflation above FY22 budget
$12.4M FY23 cost inflation
$19.2M total or 93% of total increase

The increase is related to cost inflation and workforce. Many of the other categories are offsetting each other.

Porter Hospital:

Expenses from FY22 budget to FY23 budget increase by approximately $7.5M. If you total FY23 cost inflation and travelers, it amounts to $7.7M – they are the same drivers.

b. Describe any significant variances between your FY23 budget and FY22 projections (variances in costs of labor, supplies, utilization, capital projects) and how those variances affected the hospital's FY23 budget.

Changes from FY22 projections to FY23 budget are the same factors driving the changes budget to budget.

c. Referencing the information and data submitted in Appendices 1 and 4 of Part B below and relevant portions of the FY23 budget submission, please discuss the categories of inflation and their relevance to the hospital's budget and operations.

Appendix 4 captures the driving categories of inflation. Please note that Appendix 4 does not capture FY22 cost inflation above the FY22 budget, which is carried forward in the FY23 budget. Appendix 1, Table 2 identifies the FY22 cost inflation carried forward in FY23 for UVMMC and CVMC.

For more specific detail, please refer to figures 5 through 7.

d. Describe any cost saving initiatives proposed in FY23 and their impact on the budget.

UVMMC:

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 continued expansion in this area in FY23. We are assuming in our FY23 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 Axiom (budgeting and financial reporting), 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. With the increased cost of food and labor, we plan to continue in FY23 the closure of two cafeterias.

CVMC:

CVMC has contracted to receive 13 international RN travelers with anticipated start date March 2023 at significantly reduced rates. The contracts for these RNs are three years.

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. Pre-pandemic workforce shortages were further 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 FY21, we launched a second LPN cohort. Those LPNs and RNs have completed the program and graduated in June 2022. In addition to these programs, CVMC has launched a Medical Assistant program and received approval from the State Board of Nursing to run its own LNA program; both programs are well underway. These "earn while you learn" programs provide a unique opportunity for staff from our organization to enter professional health care careers.

In addition to cost containment efforts, CVMC, as part of the Network margin improvement work streams, is focusing on the following revenue enhancements: Revenue cycle optimization $977K, value-based contract incentives $411K, length of stay improvement initiative $1.2M, Medicaid to commercial insurance shift $2.5M.

Porter Hospital:
During the past few years, Porter Hospital retained traveling registered nurses (RNs) and licensed practical nurses (LPNs) to ensure adequate professionals were present to perform the work needed to keep Porter Hospital operational. Though the traveler RNs and LPNs provided Porter Hospital with the stop gap during the staff shortage, in FY23 Porter Hospital is focusing on programs and initiatives to reduce the use of traveling RNs and LPNs. The goal is to hire and retain RN and LPNs that are Porter Hospital employees. This initiative is anticipated to reduce traveler staffing by 43%, resulting in a net salary and fringe savings of $2.4M. In addition, the systems implementation of Epic software is anticipated to be fully integrated in FY22, thus reducing the software and IT maintenance fees for FY23 by $500,000.

e. Describe the impact operating expenses have on requested NPR/FPP.

Expenses related to additional patient care volume and cost inflation impacts on NPR/FPP are individual line items in Appendix 1, Table 1.

vii. Operating Margin and Total Margin:
a. Discuss the hospital's assumptions in establishing its FY23 operating and total margins. Explain how the hospital's FY23 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 FY22 budget-to-projection variances.

Please refer to the objective financial metrics section in the budget narrative, beginning on page 15.

b. 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 marginto transfer

surplus to a subsidiary. If so, please provide the name of the subsidiary, the budgeted amount of the subsidy that will be required as part of the hospital's budget request and the financial impact of that subsidy on the subsidiary.

All of our Vermont hospitals support activities and entities outside the physical hospital. The UVM Health Network's hospitals are part of an integrated health care delivery system and are therefore committed to addressing the health needs of our communities through partnerships with organizations both within and outside of the UVM Health Network. It would be impossible to accurately quantify here all of the effects those partnerships have on any one hospital's operating margin, either in terms of costs incurred or avoided.

C. EQUITY

What is your hospital doing to recognize and correct inequities in your community, and prepare for the development of health equity measures? RAND defines a health equity measurement approach as "an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients."

At the UVM Health Network, we are invested in the ongoing work of fostering a culture of belonging for our patients and families, our people and our communities. This means providing thoughtful, compassionate and equitable care for all of our patients and embedding diversity, equity and inclusion in all aspects of our operations. This work is being carried out under the direction of the Network's first Senior Vice President, Chief Diversity and Inclusion Officer, Dr. Jackie Hunter, who joined us in October 2021.

Providing equitable care means taking into consideration the multiple disparities that have affected individuals and groups – especially those who are part of marginalized groups, such as BIPOC, LGBTQIA+ and those who have a disability – and addressing the inequitable systems that have fueled that cycle. Our approach to this work is illustrated in the graphic below.

Figure 16:

UVM Health Network DEI Strategy

The UVM Health Network is committed to creating a culture that is diverse, equitable and inclusive for our employees, patients and communities we serve. This will be embedded in all strategies and tactics and will ultimately be a part of who we are as an organization.

Our Patients and Families

We will work to create a more equitable and inclusive care environment throughout the health system, in order to provide high-quality health care to our diverse and evolving communities.

Our strategic priorities include:

- Identifying and establishing processes to address disparities in health outcomes, and to advance health equity.
- Improving timely, appropriate access to critical health care services.
- Fostering cultural awareness and humility among providers and staff.
- Developing and reviewing external policies and practices related to equity and inclusion of patients, families and visitors.

Our People

We will work to create a more equitable and inclusive environment for providers and staff, in order to foster a culture of belonging and attract and retain a talented and committed workforce.

Our strategic priorities include:

- Identifying and addressing areas of opportunity to better support our diverse workforce.
- Embedding diversity, equity and inclusion in all aspects of recruitment and retention.
- Identifying and reviewing internal policies through a DEI lens, with process standardization across the Network.
- Providing diversity, equity and inclusion education for all employees Network-wide.

Our Communities

We will work collaboratively to create more inclusive and sustainable local economies; to help address systemic barriers to health; and to foster health and well-being in our communities.

Our strategic priorities include:

- Engaging in a population health/ high value care approach to address structural determinants of health, advance equity and keep our communities as healthy as possible.
- Leveraging local hiring, purchasing and investment to create equitable economic impact.
- Focusing our local boards on community needs and population health.
- Fostering community partnerships to identify and address areas of opportunity, and communicating transparently about our work.
- Acknowledging historical inequities in health care and working to build trust.

Some of the strategies we have pursued or are pursuing include:

- Completed a Network-wide gap analysis
- Created a strategy roadmap to improve health equity across all of our spaces where we serve patients, staff and communities
- Ongoing compilation of data stratifying race, ethnicity and language (REAL) and sexual orientation and gender identity (SOGI) data, including payer and social determinants of health (SDOH)
- Placing DEI at the forefront by making it part of the Network strategy and goals for FY23 and beyond

Specific steps we have taken to implement these strategies include:

- Updated our Cloud-based software, Workday, to capture REAL and SOGI data of our staff if they choose to disclose
    - Pronouns will be able to be made public via employee profile if they choose
    - Data will allow us to review trends/gaps within certain diversity dimensions, such as race and age, within management and job groups (i.e. racial, gender, and age diversity within senior executive leadership and VP and above). We will be able to track turnover, as well.
- Population health: Stratifying patient data in REAL and SOGI to create implementation plans to improve by certain percentages and make an impact. For example, colorectal

cancer screening, depression screening and breast cancer screening will be stratified by dimensions of DEI

- Forming community partnerships focused on underserved communities; this includes the work of the UVMMC Community Health Improvement team and their focus in the 2022 Community Health Needs Assessment (CHNA) to include implementation and going beyond the mandatory exercise of completion
- Restructuring language access to address gaps and implementing improvement opportunities across the Network
- Updating Network policies that address violence to health care workers, biases, micro aggressions and incivility

D. WAIT TIMES

To be submitted to the Board by August 5, 2022.

E. RISKS AND OPPORTUNITIES

i. Please discuss the hospital's risks and opportunities in FY23. Recognizing the risks and opportunities in the current environment, please explain how the FY23 budget proposal supports strategies for addressing these issues.

Risks to achieving our budget

There are many assumptions underpinning our budget submissions. We strive to make the most realistic assessment possible of our ability to reduce costs and realize planned revenue, but there is risk involved in each assumption. Below we outline some of the most significant risks.

Revenue risks

Patient revenue: We are again submitting a budget this year that includes only the net patient revenue and commercial rate increases necessary to cover cost inflation. If the revenue we are requesting is reduced by the Board, by any amount, we are not going to be able to cover the shortfall through other sources.

Outpatient pharmacy revenue: As we have highlighted the last few years, the pharmaceutical industry has been attacking the 340B program, and they have been successful in their pursuits this past year. Many pharmaceutical companies have impacted our ability to provide drugs to our patients at 340B prices that utilize local pharmacies, known as contract pharmacy arrangements. There is a risk that more will do the same this coming year. We are projecting that we will lose more than $40M in margin from these actions, but that number could grow.

Market performance: Currently both the equity and bond markets are down by a significant amount. The only other times both markets dropped simultaneously were in 1976 and 1994. Our unrestricted reserves are invested in a properly diversified asset allocation across those two markets, but when both are down, it has a significant negative impact on our days cash on

hand. If we don't start to generate an adequate amount of cash from operations (operating EBIDA margin in 7% to 9% range), and need to further utilize our reserves to support operations, the liquidation of those assets might occur at point that would generate investment losses, further deteriorating our finances.

Medicaid redeterminations: The Federal Emergency Order that has delayed Medicaid eligibility redeterminations is slated to sunset. This will allow for the usual and customary work done by the Medicaid program to determine whether individuals enrolled in the program remain eligible for coverage. These redeterminations undoubtedly will result in some shift from Medicaid to commercial insurance, and from Medicaid to uninsured status. For our budget, we created a model to determine the amount of migration from Medicaid to both commercially insured populations and bad debt and free care. An extension of the federal emergency order will delay this and could undermine our assumptions.

Availability of Skilled Nursing Facility beds: Currently we are seeing a significant backlog of patients lingering in acute inpatient beds despite being ready for post-acute care due to the lack of skilled nursing facility (SNF) bed availability, as well as patients awaiting an inpatient psychiatric bed. This impacts our inpatient flow and results in a revenue reduction because we cannot fill those beds with acute care patients. We are not getting paid, in many cases, by Medicare when a patient stays beyond the normal time assumed in a DRG payment. Our budgets assume a stabilization of the long-term care and skilled nursing facility system. If that does not materialize, it will materially impact our budget performance**.**

Expense risks

Workforce: We have spent a tremendous amount of time and resources to improve recruitment and retention of staff and providers. We have assumed in our budgeting that these efforts will reduce our utilization of contract labor, and our Network initiatives to consolidate contract labor contracts has resulted in reduced rates for this labor. If these efforts do not continue to show returns, we will incur more cost than is built into our budgets. This is a significant risk, as we will not be able to wait another full budget cycle to address the issue if we continue to incur temporary labor costs at current levels. Further, additional vacancies due to staff burnout and unpredictable outcomes of labor negotiations are potential expense risks.

Supply chain disruptions: The ongoing shortage of supplies to deliver care, on top of the workforce crisis, is an ongoing risk to the health care delivery system. Due to the imbalance between supply and demand, these situations increase the cost of the item or service, and in some instances where the supply is drastically impacted, as was the case recently with radiology contrast media, the supply disruption can impact access to care.

Rating downgrade: Over the last few years, our rating agencies have been clear – and we have communicated this information – that if we do not start generating an operating EBIDA margin of 7% to 9%, and begin to rebuild our cash reserves, we will receive a rating downgrade. During the two years of the pandemic, the rating agencies have given the entire health care industry somewhat of a pass, but that is likely not going to be the case in calendar year 2023. If we are not on track by the time we meet with the rating agencies in early March 2023, we are almost certain to receive a downgrade, which will limit our ability to access capital, and the capital we do

access will be at a much higher rate. This would occur at the worst possible time, as we have many investments we need to make to repair, upgrade or install or build equipment and facilities to meet the growing needs of our region.

Other risks

Another COVID-19 surge: As we have seen throughout the pandemic, each new wave of the pandemic has had a negative impact on our workforce, access to services and our finances. If we experience another significant surge in FY23, given our already precarious financial position, we will not be able to absorb those impacts without relief funds of some kind.

COVID-19 impacts on community health: We have seen increased disease incidence and patient demand, particularly in the areas of mental health and substance use disorders, and we cannot predict whether these phenomena will increase or decrease in the near term.

Opportunities to outperform our budget

Outpatient pharmacy revenue: As highlighted above, this area is a risk, but it also presents a potential opportunity. First, the restrictions the pharmaceutical companies have placed on our ability to provide drugs to our patients that utilize local pharmacies have faced many legal challenges. Those legal challenges are at different stages both at the federal and state levels. If successful challenges remove the ability of pharmaceutical companies to limit our contract pharmacy arrangements, we could see the projected $40M margin impact come back into our organizations. Second, the Supreme Court recently ruled that the outpatient drug reimbursement rate cuts applied in 2018 to 340B eligible hospitals was unlawful, and returned the case to the lower court to determine the remedy. If the remedy includes making retroactive payments back to 2018 to 340B-eligible hospitals, that would bring back revenue into the Network.

Value-based reimbursement: One of our core strategies is to continue to move from fee-for-service to value-based reimbursement. This year, we have made a sizeable investment in the development of our Population Health Services Organization (PHSO), aimed at improving our performance and ability to capture available dollars under these arrangements. In the FY23 budget we have essentially assumed a break-even return on that investment, but there is the potential to do better if we’re successful at integrating the capture of these opportunities into our daily clinical and revenue cycle workflows.

Margin improvement work streams: Our 12 work streams summarized on pages 14 and 15 and listed in greater detail below, comprise the internal plan guiding our path back to financial stability. Each work stream has a responsible senior leader and a team supporting that leader to achieve the projected results. For some work streams, we are also enlisting outside experts who will accelerate realization of those opportunities. We have made assumptions in our budget tied to these work streams. There is the potential to achieve results that would exceed the budget assumptions we have made. It is important to point out that one of those work streams is generating a rate increase that will offset the uncovered cost inflation we incurred in FY22 that was not fully offset by our mid-year rate increase. The Board plays the key role in the Network achieving that result. The work streams are:

- Pharmacy optimization

- Traveler reduction
- Dialysis service optimization
- Network post-acute management
- Network bed management
- Network perioperative optimization
- Capturing pent up demand
- Epic optimization
- Future of work (balancing remote, hybrid and on-site work)
- Patient revenue rate increase
- Shared service efficiency
- Revenue cycle optimization

Government payers recognizing cost inflation: Given the cost inflation the country has experienced this past year, the FY23 rate increases provided by Medicare and Medicaid were disappointing. They certainly do not reflect the extraordinary inflationary times we are living in. Our hope is that government payers will realize that they need to do more to support the health care industry and not allow its continued financial deterioration, either through provider payment increases or supplemental payments, reducing the need for revenue from commercial payers and other sources.

ii. 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.

The impact of COVID-19 on our communities and on our Network has been immense. Our communities are experiencing increased mental health incidents, and the pandemic delayed care for many, complicating access and heightening our need to triage patients presenting with more acute symptoms.

Pandemic impacts on the Network increased during the Omicron wave:

- Volumes for higher margin services decreased due to inpatient capacity and outpatient surgery constraints
- Average length of stay increased
- Traveler FTEs and cost per FTE grew substantially
- Unprecedented cost inflation

As the COVID-19 pandemic took hold, we rapidly accelerated our efforts to provide care to most of our adult and pediatric patients through video and phone visits. This meant providing more than 1,500 of our providers with the needed equipment and educating thousands of patients on a different way to receive care. In the span of one month, we moved from 10 video visits a week to roughly 7,000 by the end of April 2020.

Although poor internet service across our region limits digital options for some patients, those without this limitation have responded positively to this approach. Patient surveys have shown

high satisfaction with video visits in particular, with the majority of patients giving high marks when asked to rate their overall experience with this type of visit.

We have continued patient and visitor COVID-19 screening.

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

At the UVM Health Network, we took an "all hands on deck" approach and 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
- Expanding inpatient and Emergency Department capacity
- Creating skilled nursing facility and temporary inpatient psychiatry capacity
- Expanding telehealth access
- Launching mass vaccination clinics in each of our three Hospital Service Areas (HSAs)

As we continue to move through different phases of the pandemic, the Network has continued patient and visitor screening for the safety of our patients and staff.

iv. Please discuss the workforce challenges of the hospital as it relates to the following:
a. Vacancy rate by Primary Care MD, Specialty MD, RN, Nursing Support and All Other.

Figure 17:

Specialty	Employed Physicians	Turnover #	Turnover Rate	Vacant Positions
Anesthesia	76	8	11%	12
Childrens	77	2	3%	6
Emergency Med	51	2	4%	7
Family Medicine	100	9	9%	18
Hospital Medicine	71	4	6%	13
Medicine	158	15	9%	21
Neurology	39	3	8%	8
Ortho	44	5	11%	4
Pathology	49	3	6%	3
Primary Care	39	5	13%	6
Psychiatry	49	15	31%	16
Radiation Oncology	10	0	0%	2
Radiology	46	3	7%	8
Surgery	102	7	7%	10
Womens	40	4	10%	1

Notes:

- Employed Physicians as of 6/29/2022
- Terms last rolling 12 months
- Vacancies per Approved Business Plan Tracker

Figure 18:

VT Hospitals: Vacancy Rate

ORG	Job Category	Vacancy %
UVMMC	RN	19.3%
	Nursing Support	34.2%
	All Other	14.2%
CVMC	RN	22.9%
	Nursing Support	37.6%
	All Other	18.4%
Porter	RN	27.1%
	Nursing Support	22.2%
	All Other	17%

NOTES:
-Vacancy rate as % of budgeted open roles versus total # employed in Job Category
-Vacancy rates for 'Nursing Support' & 'All Other' are informed estimates based on available data

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b. Provide your average turnover rates by Primary Care MD, Specialty MD, RN, Nursing Support and All Other for FY18-FY21.

Please refer to figure 17.

Figure 19:

VT Hospitals: Voluntary Turnover

ORG	Job Category	2019*	2020	2021	2022**
UVMMC	RN	9%	10.1%	12.8%	16.1%
	Nursing Support	19.8%	17.9%	27.9%	28.5%
	All Other	12.4%	13.6%	17.1%	16.1%
CVMC	RN	9.4%	14.9%	23.2%	16.1%
	Nursing Support	13.4%	20.8%	29.4%	21.7%
	All Other	11%	16.1%	22%	21.6%
Porter	RN	4.4%	21.5%	19.6%	23.7%
	Nursing Support	12.6%	17.7%	36.6%	19.4%
	All Other	15%	19.1%	21.3%	20%

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NOTES:
-Numbers include all affiliate employed FTEs
-Voluntary turnover does not include exits where employment was ended by org
-Accurate data begins mid FY 2019 based on Workday implementation:
*12 month trend on last 2 quarters data available for FY 2019
**12 month trend based on 3 available quarter average for FY 2022
-# of employees per Job Category (from large to small): All other, RN, Nursing Support

c. Report on initiatives and funding sources to reduce workforce pressures through recruitment and retention.

<u>Physicians:</u>
UVMHN Medical Group put forth a physician loan repayment benefit for new recruits, utilizing operating funds. The benefit is $60,000 over four years:

- $10,000 Year 1
- $10,000 Year 2
- $10,000 Year 3
- $30,000 Year 4

After utilizing this benefit over four years, eligible Vermont physicians will also be able to apply for an AHEC grant. UVMHN Medical Group is actively discussing putting forth a physician loan repayment benefit for current physicians. If this occurs, non-operating funds would be required.

UVMHN Medical Group is partnering with Navigate, LLC, beginning in summer 2022. Navigate, LLC is a firm providing expert advice regarding student loan debt. Providers will be able to set up on-on-one sessions with experts to learn consolidation and payoff options for their student loan debt. This is being done as a one year trial and may be extended depending on provider feedback. It is funded via operating funds.

UVMHN Medical Group has put forth a RFP to work with a firm to assess our entire physician benefit package. This work will allow us to understand how competitive we are in the national marketplace. The engagement will be funded via non-operating funds. Should the physician benefit package need to be further enhanced to be market competitive, funding for additional benefits would come through operating funds, most likely beginning in FY24.

Non-physicians:
The national workforce shortage is impacting health care organizations across the country, and our region is no exception. Today, there are simply not enough health care providers, technicians and professional staff to fill all of the available positions here and elsewhere. To develop, nurture and retain talent in, we are working toward:

- Partnering to provide educational and training initiatives and financial support to people in our community interested in training for available work.
- Filling vacancies and working to increase employee satisfaction by creating new opportunities for growth and development, as our financial position allows.
- Analyzing compensation for positions across the Network and negotiating wage increases so they are competitive in the labor market. Additionally, we are offering sign-on bonuses for certain hard-to-fill shifts.

We strive to create an inclusive, welcoming workplace that fosters a sense of belonging and drives employee satisfaction. We support this effort by:

- Hiring our first Chief Diversity and Inclusion Officer for the UVM Health Network.
- Putting into place a more flexible approach for some roles to move into hybrid and remote work.
- Developed a strategic partnership to create housing for our employees.
- Assessing our opportunity to increase our investment in childcare.
- Understanding our employee needs through an upcoming organizational health and engagement survey.
- Focusing on the development of our people.

We are not immune from the national workforce shortage. There simply aren't enough people to fill our available positions. Both the volume of open roles and our hiring results have increased 250% during the pandemic. That spike has increased recruiter open role volume to 100+ open positions, more than double the norm. To meet this challenge, we have evaluated recruitment programs to innovate and strengthen these efforts:

- Network-wide recruitment team – We have redesigned our recruiting model for greater efficiency and effectiveness. Leveraging technology, adding resources where necessary and deploying innovative best practice processes and tools.

- Recruitment experts and HR specialists – We've also established a specialist Network-wide recruitment model to build expertise and market specific knowledge for hard-to-recruit-for roles. Specifically, we continue to develop and further build out our team of physician and nurse recruitment experts.
- Convert temporary staff to employees – We are working to recruit traveling nurses as employees. So far, we have successfully recruited 25 traveling nurses into permanent employee roles.

We know we can't recruit our way out of this workforce challenge. Our training and retaining initiatives are being designed to make it easier for current and prospective employees to move into jobs that are in high demand. Wherever we can, we are exploring strategies to reduce or eliminate the financial and logistical obstacles that can stand in the way of people looking for jobs in health care. We are reaching into our communities and training people for open positions, as well as providing growth and development opportunities for employees to advance their careers:

- Nurse residency program – This program at UVMMC supports approximately 120 new nurses each year and helps recently graduated nurses transition from academic training to work in a clinical setting.
- Licensed Practical Nurse (LPN) pathways program – This program allows full-time employees at CVMC to gain their LPN degree.
- Pharmacy technician apprenticeship program – Trainees can learn the profession while working toward certification in much-needed positions.
- Training program for careers in phlebotomy – An innovative training initiative that prepares graduates to become certified phlebotomists and guarantees them a job at UVMMC following graduation.

d. Please comment on and quantify the impact of nursing and MD travelers on your budget request.

<u>Physicians:</u>

- UVMMC: $2,590,877 physician locums, the bulk of which is budgeted in Anesthesiology and Gastroenterology to support current vacancies and patient access. In addition, there is $457,580 budgeted for certified registered nurse anesthetists (CRNAs) locums in Anesthesiology, again to support current vacancies and patient access.
- CVMC: $1,047,768 physician locums, which is budgeted in Neurology and Family Psychiatry to support current vacancies and patient access. There are not any advanced practice provider (APP) locums budgeted.
- PMC: $0 budgeted in physician and APP locums.

Figure 20:

Division	Department	MD TOTAL Dollars 2023 Budget	APP TOTAL Dollars 2023 Budget	**MD & APP TOTAL Dollars 2023 Budget**
1611 Anesthesia	Anesthesiology Services	$1,092,702	$457,580	**$1,550,282**
1612 Pathology	Pathology Physicians	$127,971		**$127,971**
1612 Pathology	Pathology Clinical	$58,153		**$58,153**
1614 Medicine	Gastroenterology & Hepatology	$1,062,500		**$1,062,500**
1618 Childrens	UVMCH Childrens Specialty Ctr	$8,000		**$8,000**
1618 Childrens	UVMCH Cardiology	$5,343		**$5,343**
1624 MG Radiation Oncology	Radiation Oncology Physicians	$236,208		**$236,208**
Grand Total		**$2,590,877**	**$457,580**	**$3,048,457**

Division	Department	MD TOTAL Dollars 2023 Budget	APP TOTAL Dollars 2023 Budget	**MD & APP TOTAL Dollars 2023 Budget**
CVMC	Neurology	$297,766		**$297,766**
CVMC	Family Psychiatry	$750,002		**$750,002**
Grand Total		**$1,047,768**	**$0**	**$1,047,768**

<u>Non-physicians:</u>
The FY23 budget includes a $52M increase in nursing travelers for UVMMC, CVMC and Porter from the FY22 budget. The FY23 budgeted figure is an $86M decrease from FY22 projected.

e. Provide salaries per FTE, FTEs per adjusted occupied bed, and salaries expense to NPR.

Figure 21:

	FY2023 Budget
UVMMC	
Staff Salaries Per FTE	91,046
CVMC	
Staff Salaries Per FTE	80,551
Porter Hospital	
Staff Salaries Per FTE	82,833

Figure 22:

	FY2023 Budget
UVMMC	
FTEs Per Occupied Bed	5.87
CVMC	
FTEs Per Occupied Bed	4.06
Porter Hospital	
FTEs Per Occupied Bed	3.03

Figure 23:

	FY 2023 Budget
UVMMC	
Total Salaries Per NPR	40.4%
CVMC	
Total Salaries Per NPR	41.2%
Porter Hospital	
Total Salaries Per NPR	37.4%

F. VALUE-BASED CARE PARTICIPATION

i. Referencing the data submitted in Appendix 5, if there are any value-based care programs that the hospital is not participating in for CY23, please explain why and describe any barriers that exist. What changes, if any, to each of these programs would need to be made in order to facilitate your participation?

Participation in value-based care programs generally

UVM Medical Center, Central Vermont Medical Center, and Porter Hospital are planning to participate in OneCare Vermont's (OCV's) Medicaid, Medicare, commercial, and self-insured programs in CY23. Participation is part of our core strategy to move more of our payment portfolio to value-based programs.

That said, we are seeking several improvements to how the All-Payer Model (APM) is structured and administered through OCV. Examples of critical areas that require change include:

- The Board should allow the full rate increase permitted under the APM. This would bring more Medicare funds into the state and help ease the burden on commercial health insurance ratepayers to cover provider expense inflation.
- The Medicare program should move to an unreconciled fixed prospective payment, like OCV receives from the Medicaid program.
- Medicare must change the way 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), diminishing provider incentives to participate in or perform well in the program.
- Quality incentives should reward rather than penalize providers, and should come from a funding source other than OCV-participating hospitals.
- With risk shifting from payers to providers, providers should be able to build risk reserves, like the payers do.
- Value-based programs should move away from establishing targets based on prior year fee-for-service equivalents and instead create a fixed starting point, to which annual trend and other factors would then be applied. With spending targets based on prior year fee-for-service equivalents, 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.

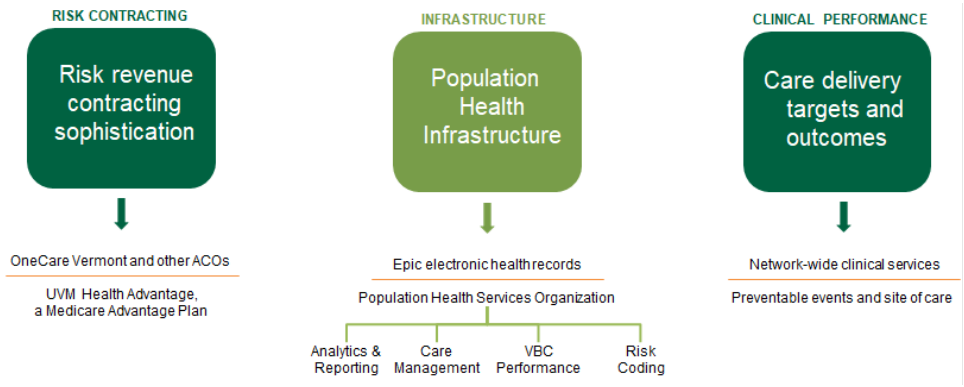
ii. Understanding that the pandemic has just started to recede, what changes in each of the hospital's cost centers that relate to value-based care initiatives (e.g. population health management, care coordination, chronic condition management, etc.) have been made as a result of participating in the ACO? Be specific in describing each cost center and how it haschanged since joining the ACO. Additionally, speak to how the fixed payments or other ACO payments from OCV are or are not advancing value-based care at your hospital.

Participation in and coordination with OneCare Vermont

The UVM Health Network has made a concerted effort to invest in and implement key strategic initiatives in alignment with participation in OCV and the All-Payer Model, prompted in part by the State's All-Payer Model Improvement Plan. The investments and programs we have implemented focus on aligning our data analytics and care management with OCV and lay the necessary groundwork for further participation in risk agreements across all payers through OCV. The population health improvement work across the Network, which supports OCV's success, has taken a significant leap forward over the last year despite the pandemic and other acute crises.

Several of these initiatives will be described in further detail below, including the Network's establishment of a Population Health Services Organization (PHSO) and our clinical redesign efforts across UVMHN primary care. These initiatives more closely align with, and support, the Network's goals of performance in High Value Care (HVC) agreements and Population Health Management. Core functions and initiatives ensuring success in these domains include:

Figure 24:



Population Health Services Organization (PHSO)

As part of our High Value Care model, the UVM Health Network has established a single Network-wide PHSO. A PHSO is a unit within our Network that will provide the most appropriate constellation of services to our affiliates to support improved clinical and financial outcomes. The graphic below highlights those services:

Figure 25:

PHSO Service	Service Overview
Population Health Analytics	Provide strategic and operational HVC analytics for UVMHN and OCV: • Implement Analytics platform supporting UVMHN HVC Analytics Needs across multiple payers • Transition OneCare PHM Analytics to PHSO (reducing duplication and maximizing economy of scale
Care Management	Provide access to equitable, data-driven Care Management for UVMHN Primary Care attributed lives: • Align OCV and Blueprint funding for CM to improve efficiency and economy of scale • Leverage existing and new CM resources ensuring consistent CM teams and services across UVMHN Primary Care • Standardize CM model of care ensuring evidence-based practice is provided across UVMHN • Use analytics to proactively identify and engage high- and rising-risk patients • Achieve NCQA accreditation for Case Management-enabling delegation agreements with payers
Risk Coding Performance Management	Establish a prospective and retrospective Risk Coding Performance program across UVMHN Primary Care Sites ensuring: • Risk-adjusted panels that are linked to reimbursement • Investment in resources to match care intensity with patient's clinical and social needs • Accurate reimbursement rate for Medicare & Medicare Advantage lives in a full-risk or shared-risk payment model
Value-based Contracting	Align VBC and PHSO strategies to increase likelihood of success in risk, based on quality-based arrangements: • Centralize payer relationships regarding VBCs via PHSO and Contracting • Align PHSO and VBC roadmaps to increase likelihood of success • Build network VBC performance reporting
Quality Performance Management	Actively manage existing value-based contract performance: • Build scalable processes to manage VBC performance • Monitor performance of existing VBCs in real-time • Close care gaps via centralized PHSO processes to ensure VBC credit for completed work • Provide chase-lists of vetted opportunities to practices ensuring care needs of patients are met – particularly for preventative care
PHSO Administration	• Work across PHSO Services and with other strategic initiatives ensuring strategic and operational alignment

The PHSO will ensure equitable access across the Network to key tools, technologies and resources known to improve performance in value-based care and will enable alignment of our payment models with our clinical and quality strategy in harmony with OCV and its attributed patients.

Care redesign

In addition to building out our PHSO, we have accelerated our care redesign effort with an emphasis on primary care and performance in Population Health Management/High Value Care. We will enhance our care teams' ability to proactively engage at-risk patients, add resources to provide longitudinal care coordination, streamline specialty access through direct scheduling and leveraging asynchronous eConsults, and improve documentation and coding to accurately capture clinical and social determinants of health (SDOH) status.

Furthermore, we will add rigor to our performance monitoring, ensuring impact on key process and outcome measures that are indicative of improved quality, access, patient and care team experience and right-sized cost of care.

Our care redesign is guided by these key principles:

Figure 26:

Principles of this Work

Identify and Engage High Risk Patients
- Leverage data to identify patients with rising risk and existing health needs
- Engage patients with higher needs more often in primary care
- Ensure access for patients to their care team based on a proactive care plan

Resource Our Care Teams
- Resource care teams within the medical homes according to panel needs
- Provide longitudinal care coordination and direct patient support via integrated Care Management (a resource pool for our medical homes)

Streamline Interactions with Specialties
- Streamline direct scheduling from primary care into specialty care
- Leverage eConsults to support asynchronous support to primary care
- Incorporate access metrics, HVC metrics and best practices into existing specialty QA/QI processes

Support Complete Documentation
- Accurately capture patient clinical and SDOH status
- Inform resource allocation to clinics and care teams
- Ensure appropriate reimbursement in VBC and FFS models, support reinvestment
- Provide data that enables our QA/QI initiatives

A highlight of some of the specific care redesign strategies being activated across the Network are outlined below:

Figure 27:

Performance in High Value Care through care delivery

Value Drivers	Care Delivery	HVC Strategies
Quality	Team-based care	Patient care planned by level of clinical and social needs (VBC Pathways) More patient touchpoints: proactive and preventative care visits Right-sized panels to care team resources Analytics-based notification of patient needs Integrated Care Management
	Proactive Care Management	
	Care Gap Closure	
Satisfaction	Patient Experience	Improved access to primary care team Enhanced referrals for Specialty care Coordination of patient care via weekly care coordination meetings Expanded care management resources to support patients' needs Improved efficiency of patient visit with comprehensive pre visit planning
	Care Team Satisfaction	
Cost	Optimized Site of Care	Analytics-supported identification of patient risks & trends Optimizing access through proactive, integrated care Shifting care from high-cost to lower-cost settings *(ie. ED → Primary Care; SNF → Home Health)* Analytics-supported identification of out-of-network utilization patterns
	Reduced Complications	
	Reduced Preventable Exacerbations	

OCV's Value Based Incentive Fund (VBIF) incentivizes and rewards participants for achieving high-quality performance results. By creating transparency into value-based care performance data and aligning our Network-wide initiatives with our contracts with OCV, we will continue to improve clinical and financial performance in FY23.

The consistency and predictability of fixed payments makes it easier for the Network to engage in redesign efforts that allow us to utilize all available sites of care to their highest value and best use (e.g., filling open capacity, improving scheduling, reducing no show rates, leveraging telehealth, etc.) without jeopardizing our overall financial stability. Increasing alignment between UVMHN's population health efforts and OCV (and other payer quality incentive programs), enables UVMHN to invest in the tools, technologies, and behaviors required to succeed in managing total cost of care and impacting broader risk-based payment models. One challenge, however, is that fixed prospective payment currently is limited to Medicaid contracts. As a result, the full value of the UVMHN population health efforts is not captured through value-based programs.

iii. As the pandemic recedes, what specific population health priorities are emerging for the hospital? How will each of these priorities be conveyed to providers to in order to impact care delivery? How will success be measured for each of these initiatives?

We continue to transform the way we deliver care to provide consistent high-quality, affordable health care across the Network and timely, appropriate access to the kind of care we know will help our patients and communities achieve their best health. Further, we are committed to ongoing, careful and meaningful action in the effort to create a culture that is equitable, diverse and inclusive for our employees, patients and the communities we serve.

To get a better understanding of disparities in health care, we will analyze health outcome data for patients who identify as BIPOC and along other dimensions of diversity. As part of this effort, we are reorganizing how we approach Community Health Needs Assessments (CHNAs) across the Network. We have restructured our governance so that the Boards of Directors of each of our affiliate organizations will be the locus for CHNA activity, coordinated and supported across the Network by our Chief DEI Officer. We believe this will result in more robust assessments in each community, standardization and improvement of our outputs from the CHNA process and a more effective linking of our assessments and resulting investments and interventions with our agenda to promote health equity.

We also are committed to increasing collaboration between primary and specialty care, leveraging data to inform clinical decision-making, proactively managing at-risk and rising-risk patients and aligning our payment models to support our care delivery system. Increased collaboration between primary and specialty care will help us manage patients in lower acuity settings and increase specialty efficiency.

The UVMHN PHSO and UVMHN Medical Group are in the process of implementing changes that will leverage data and analytics to proactively identify high- and rising-risk patients and

ensure every primary care site across the Network has the access to the right embedded and centralized resources required to match patient needs. A Network-wide implementation plan has been developed to engage care team members and provide robust education and training on key components of the model including:

- Care management
- Pre-visit planning
- Chronic disease management
- Risk coding
- Risk-adjusted panels
- Closure of gaps in care

Success of these measures will be monitored iteratively via a set of "High Value Care Key Performance Indicators." These KPIs include process and outcome measures aligned with value-based contracts, National Committee for Quality Assurance (NCQA) quality measures, and industry standard measures of population health performance (access, utilization, cost of care, quality, clinical outcomes, etc.).

iv. As of CY22, OCV is providing each HSA with quarterly quality reports. How are the results of these reports being communicated to providers in a way that will impact care delivery and quality outcomes?

While there is summary level value in the quarterly HSA data that OCV provides, the UVMHN has been engaged directly with OCV to align our analytics strategy to ensure both UVMHN and OCV networks have access to higher quality, industry leading analytics that provide actionable intelligence, in real-time for our affiliates. For UVMHN, it is imperative that we have these same insights across all of our payers including, but not limited to, OCV. As a result, the UVMHN will leverage its PHSO to support population health analytics in partnership with OCV:

- The UVMHN PHSO will serve as the centralized point of communication with Network providers and will pair the information provided in the quarterly quality reports with actionable intelligence for each Network affiliate.
- By aligning our analytics platform with OCV in FY23, we will further improve our ability to link and operationalize analytics with our care delivery and quality outcomes.
- The UVMHN PHSO has begun analyzing OCV quality reports along with similar reports from other payers to ensure consistent, payer agnostic, analysis of performance improvement opportunities.
- The High Value Care KPIs described above align with standard measures monitored by OCV (and other payers). These measures will be aligned with our Epic dashboards to ensure point of care analytics and decision-making tools align with population health and value-based contracting performance.

v. Regarding the CY20 settlement information for the hospital (separate tables will be provided by Board), what are the planned investments of those dollars in furthering the

hospital's health care reform goals? If no investments in health care reform were made withthese dollars, how were they invested? If the hospital experienced a net shared loss during this time period, how is the hospital using that information to inform change to the delivery system?

One of the goals of the APM and the ACO programs was to support successful implementation and program sustainability of UVMHN's reform goals via predictable payments and the creation of a predictable revenue stream that would provide inflation-adjusted TCOC payments. This would help reduce the burden commercial payers bear on needing to cover more than their fair share of this inflation (i.e., the cost shift). As a result, when we generate shared savings, a portion of that is helping to reduce this burden. It was not expected that all of the potential positive impact from ACO programs would be used to build more population health infrastructure.

That said, the Network continues to invest in infrastructure to further our High Value Care mission, including a PHSO that includes a centralized Population Health Management analytics platform, establishing a single Care Management program across all affiliates and redesigning our care model to improve access to primary and specialty care.

G. CAPITAL INVESTMENT CYCLE

In accordance with 18 V.S.A. § 9435(f), describe the investment cycle and how it relates to the hospital's overall strategic plan. Discuss how the hospital's capital investment cycle has continued to evolve as a result of COVID-19. Please mention certain items and the resulting status as a result of COVID-19 (i.e. cancelled, postponed, rescheduled, etc.). If any of the hospital's anticipated capital investments are required improvements (e.g., regulatory or accreditation requirements), please identify and explain.

The UVM Health Network annually develops an enterprise-level capital budget, and our FY23 – FY27 capital budget submission reflects a continued commitment to this approach. The 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;
- Align with the UVM Health Network's financial sustainability goals;
- 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. adjusting capital spending 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 emphasizes our ability to restrict capital as needed and

where clinically safe, while allowing our budget to be enhanced (release more capital dollars) if and when financial targets are met.

Our current five year capital framework has been revised to reflect a reduction in projected margin. As our work to recover from financial challenges of the COVID-19 pandemic continues, new challenges related to increased supply chain and human resource costs have emerged, effectively reducing 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 done annually.

As the Network continues to be challenged with these substantial financial pressures, our capital investment process has been frozen. While in a capital freeze, all break-fix capital requests, regardless of cost, are approved individually by executive leadership. Many strategic-level projects, and the planning associated with those projects, have been postponed, re-prioritized, or cancelled. To date, the UVM Health Network has committed approximately 40% of FY22 budgeted capital through 70% of the fiscal year, again, keeping capital purchase to strictly break-fix and margin-improving investments. This follows FY21, where we committed 70% of budgeted capital as a Network.

Additionally, projects are being evaluated by not only their justification in providing high-quality, advanced health care in our region to meet the increased need for health care services, but also by their ability to provide a return on investment. Perhaps most notably, plans for a 40-bed inpatient psychiatric facility on the CVMC campus were put indefinitely on hold as the costs to build and operate the facility could not be offset by adequate net patient revenue. Additional high priority projects have been evaluated extensively to ensure their cost can be adequately offset by net patient service revenue.

For FY23, the UVM Health Network's Vermont hospitals are proposing a capital budget not to exceed $151.9M with modest projected carry forward capital from FY22. Full details on FY22 carry forward will be provided as the fiscal year comes to a close. The below table represents additional detail regarding the forecasted capital allocation by expense type.

Figure 28:

	46.1	*105.8*	*151.9*
Entity	Routine Capital	Major Capital	TOTAL
UVMMC	37.7	96.7	134.4
CVMC	5.9	5.1	11.0
PMC	2.5	4.0	6.5
			151.9

In FY23 we plan to submit CON applications for various equipment replacements, along with some net new devices, to accommodate growing demand in our region, ensure our ability to attract and retain highly qualified clinicians, and stay current with advancements in health care delivery modalities and standards of care.

H. SUPPLEMENTAL DATA MONITORING

To be submitted to the Board by August 5, 2022.

I. QUESTIONS FROM THE OFFICE OF THE HEALTH CARE ADVOCATE

Hospital Financial Assistance and Bad Debt during COVID-19

Please provide the following updates since last year's hospital budget process:
How have you changed your official or unofficial patient financial assistance policies and/or procedures? How has your handling of patient collections changed?
Please estimate the most recent quarter when you reviewed whether your free care policy documents (full policy, plain language summary, application, etc.) align.

Collecting on patient debt:
If a patient is overcharged, please explain your ability to correct a bill once the collection process has begun.
Do you inform patients when patient balances owed are written off as bad debt?
How many patients had bills that you sent to a third party to collect the debt during the following timespans: (1) Q4 FY2020 and Q1-Q3 FY2021 and (2) Q4 FY2021 and Q1-Q3 FY2022?
What is the total dollar amount of bills sent to collections during the following timespans: (1) Q4 FY2020 and Q1-Q3 FY2021 and (2) Q4 FY2021 and Q1-Q3 FY2022?

Please provide the FY2021 actual and FY2022 projected bad debt by whether the patient who accrued the debt was insured or uninsured. Please split the insured category by whether the patient's primary insurance is Medicaid, Medicare, or a commercial plan.

<u>UVMMC:</u>
We have not made official changes to our patient financial assistance policies, however, the financial assistance policy is in the final approval stages of updates; these include clear language for the coverage of undocumented patients as well as an expanded exclusion list for non-medically necessary services.

There has been no material change with how patient collections are handled.

The most recent review of our free care policy documents was completed in Q2 and Q3 of FY22. We have reviewed and are in the process of updating our documents and will ensure all aspects align upon completion, which is anticipated in Q4 of FY22.

If we are notified or identify that we have incorrectly billed for a service, then we would recall the account from the outside collection agency and make the required corrections. If there was a remaining balance assigned to self-pay once corrections were made and any insurance had re-processed the claim, we would refer the self-pay balance back to the agency. We have dedicated staff who work with our collection agencies to facilitate the resolution of any disputes.

Each of the four statements that a patient receives prior to an account being referred for collection contains multiple messages informing the patient that their account needs to be resolved to avoid further collection activity and ways to contact us. Once an account is placed, the agency sends the patient a letter.

How many patients had bills that you sent to a third party to collect the debt during the following timespans: (1) Q4 FY20 and Q1-Q3 FY21 and (2) Q4 FY21 and Q1-Q3 FY22?

Qtr	GE BAR	GE HPA	Epic	Total
Q4 FY20	3,674	2,384	50	6,108
Q1-Q3 FY21	384	742	33,090	34,216
Q4 FY21	164	128	10,550	10,842
Q1-Q3 FY22	24	91	26,529	26,644
Total	4,246	3,345	70,219	77,810

What is the total dollar amount of bills sent to collections during the following timespans: (1) Q4 FY20 and Q1-Q3 FY21 and (2) Q4 FY21 and Q1-Q3 FY22?

Qtr	GE BAR	GE HPA	Epic	Total
Q4 FY20	$1,203,230	$3,149,553	$110,111	$4,462,894
Q1-Q3 FY21	$246,986	$1,143,632	$26,123,628	$27,514,246
Q4 FY21	$122,368	$282,513	$7,641,726	$8,046,607
Q1-Q3 FY22	$33,621	$191,227	$19,560,031	$19,784,879
Total	$1,606,205	$4,766,925	$53,435,496	$59,808,626

<u>CVMC:</u>
There have been no changes made to the CVMC official or unofficial patient financial assistance policies and/or procedures. CVMC ceased collections activities during the COVID-19 emergency and resumed collections activity on July 1, 2020.

We last reviewed our free care policy documents in May 2022.

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 we are notified or identify that we have incorrectly billed for a service, then we would recall the account from the outside collection agency and make the required corrections. If there was a remaining balance assigned to self-pay once corrections were made and any insurance had

reprocessed the claim, we would refer the self-pay balance back to the agency. We have dedicated staff who work with our collection agencies to facilitate the resolution of any disputes.

How many patients had bills that you sent to a third party to collect the debt during the following timespans: (1) Q4 FY20 and Q1-Q3 FY21 and (2) Q4 FY21 and Q1-Q3 FY22?

Quarter	Patients
Q4 FY20	2,925
Q1 - Q3 FY21	23,926
Q4 FY21	6,334
Q1 FY22 - 6/16/22	18,206
Total	51,391

What is the total dollar amount of bills sent to collections during the following timespans: (1) Q4 FY20 and Q1-Q3 FY21 and (2) Q4 FY21 and Q1-Q3 FY22?

Quarter	Dollars
Q4 FY20	$1,341,033
Q1 - Q3 FY21	$3,304,016
Q4 FY21	$1,774,271
Q1 FY22 - 6/16/22	$5,972,623
Total	$12,391,943

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 a third party to collect the debt during the following timespans: (1) Q4 FY20 and Q1-Q3 FY21 and (2) Q4 FY21 and Q1-Q3 FY22?

Quarter	Patients
Q4 FY20	1,203
Q1-Q3 FY21	2,485
Q4 FY21	1,681
Q1-Q3 FY22	1,887

*The patient count for the Q1-Q3 FY21 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 collections during the following timespans: (1) Q4 FY20 and Q1-Q3 FY21 and (2) Q4 FY21 and Q1-Q3 FY22?

Quarter	Dollars
Q4 FY20	$932,958
Q1-Q3 FY21	$2,667,693
Q4 FY21	$880,825
Q1-Q3 FY22	$830,902

Medicaid Screening Processes

Emergency Medicaid
If your organization has written policies regarding screening for emergency Medicaid under HBEE Rule 1702(d) please provide them.
For Q1-Q3 of FY 2022, please provide the number of facility patients screened for emergency Medicaid and the number of facility patients who received emergency Medicaid.
For Q1-Q3 of FY 2022, please provide the number of labor and delivery patients screened for emergency Medicaid and the number of labor and delivery patients who were covered by emergency Medicaid.
If your organization has outreach materials on the application process and eligibility criteria for Emergency Medicaid, please provide them. Please explain how your patients can access these materials and list the languages into which the materials have been translated.

<u>UVMMC:</u>
We do not have written policies regarding screening for emergency Medicaid, however, we do screen and assist in the application process for uninsured inpatients, newborns and outpatient hospital procedures as well as underinsured patients who have Medicare only coverage.

We are unable to calculate the number of facility patients screened nor the number of labor and delivery patients screened, as we do not track these values. We typically pursue traditional Medicaid versus emergency Medicaid, completing full applications and submission in tandem

with the patient, and our teams track the application through notice of decision and then bill to Medicaid.

At this time, no outreach materials exist. 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 (HAP), in addition to our Registration Department, screens (and will enroll as qualified) every patient who is referred for being uninsured for emergency Medicaid (called Presumptive Eligibility) or regular Medicaid or any health insurance.

We advertise that we assist with connecting patients but do not provide specific materials that spell out the process or criteria. We were the first program to pilot it in 2018, and we got only two patients during the 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 HAP rack card. These new rack cards have been printed and distributed in: pharmacy, primary care offices, specialty care, and the Emergency Department. Social workers and other community organizations know we offer this service and connect patients to us; data show that we do not receive many emergency Medicaid enrollments. Enrollment occurs at Registration more often when patients need to set up an appointment. Our current version of the prescription assistance program rack card is available and translated into Arabic, Bosnian, Cantonese, French, Mandarin, Nepali, Somali, Spanish, Swahili, and Vietnamese.

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

CVMC:
CVMC does not currently have written policies regarding screening for emergency Medicaid, however, we do screen and assist in the application process for uninsured patients, newborns and outpatient hospital procedures, as well as underinsured patients who have Medicare only coverage.

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 FY22, 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 FY22	84	80
Q2 FY22	47	45
Q3 FY22 - 6/16	52	42

For Q1-Q3 of FY 2022, please provide the number of labor and delivery patients screened for emergency Medicaid and the number of labor and delivery patients who were covered by emergency Medicaid.

No statistics have been kept on this patient population.

Porter Hospital:
No written policy or procedures around emergency Medicaid are currently in place, and we do not track patients screened for emergency Medicaid. No outreach materials currently exist or are managed by registration.

Deemed Newborns
If your organization has written policies regarding screening newborns for Medicaid in line with HBEE rule 9.03(b), please provide them.
For Q1-Q3 of FY 2022, please provide the number of newborns screened for Medicaid without an application and the number of those newborns who received Medicaid.
Since the passage of "H. 430/Act No. 48 An act relating to eligibility for Dr. Dynasaur-like coverage for all income-eligible children and pregnant individuals regardless of immigration status," what steps have you taken to prepare for the implementation? Do you have outreach materials, and if so, what languages are they translated into? If you have such materials, please provide them.

UVMMC:
We do not have an official policy for screening newborns for Medicaid. 100% of newborns are managed with UVMMC actively applying the newborn for coverage (in collaboration with the parent) and for the patient with commercial insurance, we work with parents to ensure they are aware of responsibilities to notify the employer or insurance company; further we follow these accounts until coverage is secured and subsequently bill to the insurance carrier.

We do not track the number of newborns screened for Medicaid, as our newborn information is blended across payers. We will work to begin tracking this data for the next reporting year.

We are eagerly anticipating the new Act 48 implementation on July 1. We are actively meeting

with our outreach teams, and we are ready to transfer these patients from the grant to the new program. We are still awaiting complete guidance from the state on the program, but we do not anticipate any delays on our end with the technical implementation, even if we need to hold claims for a period of time awaiting the state implementation. We are holding off creating outreach materials until we have the enrollment forms from the state.

CVMC:
CVMC does not have an official policy for screening newborns for Medicaid. One hundred percent of newborns are managed with CVMC actively applying for coverage, in collaboration with the parents. For the patient with commercial insurance, we work with parents to ensure they are aware of the responsibility to notify the employer or insurance company. Further, we follow these accounts until coverage is secured and subsequently bill to the insurance carrier.

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 FY22, 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 FY22	15	15
Q2 FY22	22	22
Q3 FY22	19	19

Like UVMMC, CVMC is eagerly anticipating the new Act 48 implementation on July 1. As part of the UVM Health Network, we are actively meeting with our outreach teams, and are ready to transfer these patients from the grant to the new program. We are still awaiting complete guidance from the state on the program, but we do not anticipate any delays on our end with the technical implementation, even if we need to hold claims for a period of time awaiting the state implementation. We are holding off creating outreach materials until we have the enrollment forms from the state. CVMC will be participating in the training that is being offered by AHS and DVHA on June 29.

Porter Hospital:
As noted above, there is no written policy regarding screening patients or newborns for Medicaid enrollment. No statistics have been kept on this patient population.

Porter Hospital, in collaboration with UVM Health Network, reviewed and implemented Act 48. Implementation at Porter Hospital was comprised of providing information regarding the

existence of this program in an easy-to-use format to any provider who needed to complete attestation forms. The Open Door Clinic, Women's Health and Pediatric clinics were all informed of this program. In addition, UVM Health Network provided a point person for this program to answer questions. Our Patient Financial Advocate reviewed all financial assistance applications for qualifying patients. Porter does not currently have outreach materials.

Health Equity

a. Please provide examples of any policies, procedures, and initiatives that your hospital has undertaken, or plans to undertake, to address systemic racism within your institution and community.

At the UVM Health Network, we are invested in the ongoing work of fostering a culture of belonging for our patients and families, our people and our communities. This means providing thoughtful, compassionate and equitable care for all of our patients and embedding diversity, equity and inclusion in all aspects of our operations. This work is being carried out under the direction of the Network's first Senior Vice President, Chief Diversity and Inclusion Officer, Dr. Jackie Hunter, who joined us in October 2021.

Providing equitable care means taking into consideration the multiple disparities that have affected individuals and groups – especially those who are part of marginalized groups, such as BIPOC, LGBTQIA+ and those who have a disability – and addressing the inequitable systems that have fueled that cycle. Our approach to this work is illustrated in the graphic below.

Figure 29:

UVM Health Network DEI Strategy

The UVM Health Network is committed to creating a culture that is diverse, equitable and inclusive for our employees, patients and communities we serve. This will be embedded in all strategies and tactics and will ultimately be a part of who we are as an organization.

Our Patients and Families

We will work to create a more equitable and inclusive care environment throughout the health system, in order to provide high-quality health care to our diverse and evolving communities.

Our strategic priorities include:

- Identifying and establishing processes to address disparities in health outcomes, and to advance health equity.
- Improving timely, appropriate access to critical health care services.
- Fostering cultural awareness and humility among providers and staff.
- Developing and reviewing external policies and practices related to equity and inclusion of patients, families and visitors.

Our People

We will work to create a more equitable and inclusive environment for providers and staff, in order to foster a culture of belonging and attract and retain a talented and committed workforce.

Our strategic priorities include:

- Identifying and addressing areas of opportunity to better support our diverse workforce.
- Embedding diversity, equity and inclusion in all aspects of recruitment and retention.
- Identifying and reviewing internal policies through a DEI lens, with process standardization across the Network.
- Providing diversity, equity and inclusion education for all employees Network-wide.

Our Communities

We will work collaboratively to create more inclusive and sustainable local economies; to help address systemic barriers to health; and to foster health and well-being in our communities.

Our strategic priorities include:

- Engaging in a population health/ high value care approach to address structural determinants of health, advance equity and keep our communities as healthy as possible.
- Leveraging local hiring, purchasing and investment to create equitable economic impact.
- Focusing our local boards on community needs and population health.
- Fostering community partnerships to identify and address areas of opportunity, and communicating transparently about our work.
- Acknowledging historical inequities in health care and working to build trust.

Some of the strategies we have pursued or are pursuing include:

- Completed a Network-wide gap analysis
- Created a strategy roadmap to improve health equity across all of our spaces where we serve patients, staff and communities
- Ongoing compilation of data stratifying race, ethnicity and language (REAL) and sexual orientation and gender identity (SOGI) data, including payer and social determinants of health (SDOH)
- Placing DEI at the forefront by making it part of the Network strategy and goals for FY23 and beyond

Specific steps we have taken to implement these strategies include:

- Updated our Cloud-based software, Workday, to capture REAL and SOGI data of our staff if they choose to disclose
    - Pronouns will be able to be made public via employee profile if they choose
    - Data will allow us to review trends/gaps within certain diversity dimensions, such as race and age, within management and job groups (i.e. racial, gender, and age diversity within senior executive leadership and VP and above). We will be able to track turnover, as well.

- Population health: Stratifying patient data in REAL and SOGI to create implementation plans to improve by certain percentages and make an impact. For example, colorectal cancer screening, depression screening and breast cancer screening will be stratified by dimensions of DEI
- Forming community partnerships focused on underserved communities; this includes the work of the UVMMC Community Health Improvement team and their focus in the 2022 Community Health Needs Assessment (CHNA) to include implementation and going beyond the mandatory exercise of completion
- Restructuring language access to address gaps and implementing improvement opportunities across the Network
- Updating Network policies that address violence to health care workers, biases, micro aggressions and incivility

We are working on assuring that our policies, such as the code of conduct, violence against health care workers, and provider/staff preference, include language that encompasses DEI measures.

We have held listening sessions for staff across our Vermont hospitals from 2020 to present, and we also plan to partner with the community and hold listening sessions, as well.

b. If you have a funded DEI/Racial Equity position or DEI committee at the hospital, what are their primary roles and responsibilities? How is this position empowered and supported within the hospital? If you do not have this type of position, are you planning to create one? What obstacles are preventing you from creating this type of position?

There are three total staff who focus on DEI at our Vermont hospital affiliates. As noted previously, our Senior Vice President, Chief Diversity and Inclusion Officer, Dr. Jackie Hunter, joined the Network in October 2021. Dr. Hunter reports directly to the CEO of the Network, and is supported by having seat at the table and direct influence across a variety of key stakeholders. At UVMMC, Dr. Marissa Coleman serves as the Vice President of DEI. Guadelupe Martinez, Network Diversity and Inclusion Director, joined the Network in March 2022 and helps cover CVMC, Porter Hospital and Home Health & Hospice, who do not have a dedicated DEI staff member yet.

The primary roles and responsibilities for these three positions are to create a more equitable and inclusive care environment throughout the health system, in order to provide high-quality health care to our diverse and evolving communities.

Our strategic priorities include:

- Identifying and establishing processes to address disparities in health outcomes, and to advance health equity;
- Improving timely, appropriate access to critical health care services;
- Fostering cultural awareness and humility among providers and staff; and

- Developing and reviewing external policies and practices related to equity and inclusion of patients, families and visitors.

Each of our three Vermont hospitals has a DEI committee; each committee is there to be a voice and a local space to understand what's happening at each particular hospital and bring forth opportunities for change.

c. Please describe the process for how your hospital handles patient complaints related to discrimination.

All patient complaints related to patient experience or quality of care are directed to Patient Advocacy. Patients are able to communicate with Patient Advocacy by whatever means is easiest (phone, in person, mail, e-mail) to ensure access to this service. Any complaints or concerns received by the organization through this function are received by our Patient Advocate. This individual will be responsible for information gathering, and subsequent review of the event with the service area leader. If there are any concerns that describe discriminatory practices or behaviors, Human Resources is contacted in addition to the supervisor or leader of the employee or service area. These types of events are also reviewed weekly through our Safety Adjudication Committee (SAC), which is a peer protected committee comprised of organizational leaders. Events that are considered severe often will prompt a huddle with appropriate senior leadership members. DEI leadership is consulted as requested and applicable.

d. How much funding in your current and future budgets has been allocated to DEI and/or racial equity focused projects, trainings, or collaborations?

Across the UVM Health Network, funding allocated to DEI amounts to $4.6M.

e. What percentage of staff and administrative leadership have received training in language access needs, implicit bias, and cultural competency? Does this vary significantly by job category?

The percentage of staff and administrative leadership who have received training in language access needs, implicit bias, and cultural competency varies by job category.

- Implicit bias – All leadership have undergone implicit bias training:
    - UVMMC 43%
    - CVMC 87% - all leaders
    - Porter 100% - senior leadership team, but not all leadership
    - UVM Health Network Home Health & Hospice 80% - senior leadership team
- Language access – All staff have a language access module in Cornerstone, our yearly training curriculum. This is a mandatory learning module for the Joint Commission.
- Cultural competency – There is a mandatory learning module for cultural competency to be completed yearly in Cornerstone.

- Unconscious bias – We are also adding this year an unconscious bias module that will incorporate weight bias for our bariatric clinic. This will go live this year.

f. Are patient satisfaction surveys given in languages other than English? In what languages is the survey available? Is race/ethnicity data collected as a part of these surveys?

At our Network hospitals in Vermont, we are in the process of streamlining patient satisfaction surveys and having all affiliates use Press Ganey. Currently, only UVMMC has been using Press Ganey, and the survey is available in Spanish as well as English. In the future, we will have our three Vermont hospitals use Press Ganey consistently, and we hope to stratify results by race, ethnicity and gender.

g. 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:

- *Patients whose primary language is not English*
- *BIPOC patients*
- *Patients with no or intermittent broadband and/or cellular telephone service*
- *Patients who are not U.S. citizens*

The UVM Health Network established a Population Health and Quality Dashboard. All population health measures (including access and care efficacy) will include demographic data such as race, ethnicity, age, gender and language. This will allow us to analyze health disparities amongst different patients including BIPOC, non-English speaking, etc.

DEI measures will be stratified (on the inpatient side and on the ambulatory side) by ethnicity, gender, race, age, language, payer and social determinants of health. This is a new population health dashboard that can stratify this data, and it will go live at the end of June 2022. This will track 30-day readmissions and hospital length of stay (both on the inpatient side). We are not currently tracking broadband and/or cellular telephone service, nor citizenship status. We plan to track satisfaction among vulnerable populations in the future, using our Press Ganey survey capabilities.

A CHNA is completed every three years to understand current health trends and regional needs. While it is not a complete analysis of any one issue, the data help identify priorities, facilitate community discussion and guide the creation of health- and health care-related goals. The 2022 CHNA at UVMMC — conducted over an 11-month period beginning in May 2021 — collected and analyzed data from interviews with more than 30 community leaders, more than 70 population-level health and wellbeing indicators drawn from existing secondary data, focus group discussions with five specific groups facing unique challenges related to health and wellbeing, a community survey with more than 3,700 residents, and community health priority sessions that included 140 participants, as well as 57 organizations and agencies. It was the first CHNA to be offered in multiple languages – a step that allowed the assessment to capture responses from a broader range of community members regarding what matters to them when it

comes to their health and wellbeing. Members of the assessment's 37-member steering committee also noted that the survey received more than double the number of responses as the 2019 CHNA.

CVMC is currently in the process of working through their CHNA, and Porter is slated for 2023.

h. Discuss how you utilize health disparities data to inform hospital policies and procedures.

We are currently at our baseline regarding how we will utilize health disparities data to inform hospital policies and procedures. We are currently stratifying data based on those different elements. In our future state, our goal is to get an executive summary from our Network's Data Management Office; based on that summary, DMO staff will connect with DEI staff to convert the data to action. If we see trends, we will work with clinical and non-clinical teams to bring awareness. If we see disparities, we will focus on a couple issue areas each year, and decide from that collected data how we can best partner with people in our communities. We will engage in strategic partnerships to best impact our most vulnerable populations. Regarding policies, we collaborate with compliance to review polices for inclusive language, such as our patient responsibilities, code of conduct, language access and workplace violence policies, to name a few.

Contingency Planning

Please provide a high-level contingency plan detailing how your hospital would amend its business strategy if the Board reduced or denied your charge request.

If the Board denies all or a portion of our budget request, we will be faced with a challenge unlike any we have seen before. We already are in an unprecedented financial crisis: Our projected FY22 year-end operating EBIDA margin has been reduced to 1.4% and our days cash on hand is projected at 148, well below minimum industry standards of 7.0% and 175 days. Now the aftermath of the pandemic and the cost of labor and other inputs is pushing us to reduce expenses and increase budget requests to a degree that we could not have imagined a few years ago.

We have provided the Board with what we believe is a fair and realistic approach to keeping our Network solvent. We have reduced expenses below projected levels by more than $70M for FY23. We are already a low-cost provider network – lowest in the country for Medicare costs. This is because our patients and providers use fewer services than *anywhere else in the nation*. This is largely due to years of focus on the development of clinical pathways and implementation of best practice, resulting in the appropriate utilization of care. If the Board cuts our budget, we will need to assess the services we are currently providing. If we are forced to make reductions, we will look at service lines that are low volume, or do not cover their costs, but we will not reduce or eliminate a service without a clear plan for where our patients can go to get the care they need.