# HSF QUESTIONS FOR HOSPITALS

# HOSPITAL 14: UNIVERSITY OF VERMONT MEDICAL CENTER (UVMMC)

**Follow-Up Questions and Requests Related to Your Budget Submission**

**On your executive summary:**

**1. Can you provide more detail on how you've struggled to accommodate a larger than expected demand for inpatient care? In what service areas did you struggle most to meet patient demands? Do you expect this issue to persist in the future?**

The demand for inpatient care has created a multitude of issues:
Capacity – space and personnel.
We have had capacity issues in our IP units with very high average daily census. This has created pressure on staffing levels to meet those patient care needs. The staffing affected goes beyond nurses and incorporates the need for additional therapists, radiology and lab technicians, phlebotomy, housekeeping staff, food delivery system and staff as well as security and staff who respond to codes. To try to manage the space constraints, we have had to open additional beds for the non-acute patients who have little to no alternative placement options due to lack of post acute placement options.

During the period of May 6, 2023 to August 7, 2024 the hospital has been at red census level – meaning the hospital is at or over capacity – 250 times. That's more than 50% of the duration. In the last year we've had to stand up at least one modified incident command to coordinate delivery of services in the face of overly high census.

More generally, as indicated by our own projections as well as Oliver Wyman's, it is apparent that Vermont's population will be growing and aging in the coming years, which will continue to drive increased census pressure and needs for additional staffing and space. This also will place increased pressure on post acute services that are already not able to meet current needs.

**2. Can you quantify how much you've expanded access to surgical services, primary care, or other services (akin to how you've done with radiology and GI/Endoscopy)?**

UVMMC focused on improving access across both the Main and Fanny Allen campuses. In FY23, UVM Medical Center performed 21,204 surgeries and procedures, which was 2,161 cases more than FY22 or pre-COVID year FY19 by 3,972. During FY23, UVM Medical Center ran a "Sprint Room" – one OR's worth of capacity dedicated to working down patient backlogs on a daily basis. Over the course of FY23, the Sprint Room was allocated to Cardiac Surgery, Orthopedics, ENT, Neuro Surgery, General Surgery, Urology, and Gynecology.

To further aid in opening access, in the FY24 budget UVM Medical Center planned to open the 5th OR at the Fanny Allen campus, a small OR with inherent limitations that had been closed since COVID. In this OR, UVMMC planned to serve 600 incremental patients and therefore targeted an overall budget of 21,804 patient cases in FY24 (600 cases above FY23 actual). FY24 October through July inclusive, UVM Medical Center is 216 cases above pace to achieve the FY24 budget target. In FY24, OR access has been prioritized to work down backlogs in Cardiac Surgery, Plastic Surgery, General Surgery, Gynecology, Orthopedics, Dental Surgery, and ECT. Also during FY24, UVM Medical Center brought on line its second DaVinci surgical robot, which has been highly utilized by Urology, Gynecology, General Surgery, and Thoracic Surgery groups to provide minimally invasive surgical care for patients.

In FY25, UVM Medical Center is targeting 22,130 patient cases in its ORs, an increase of 326 patients served compared to the FY24 budget. This would be yet another tremendous accomplishment for increasing patient access in the UVM Medical Center ORs and would push prime time room utilization well beyond 80%. These increases put significant strain on our staff, space and processes – the FY25 budget does reflect associated expenditures.

In December 2023, UVMMC had no adult primary care practices open to accepting new patients. Through a combination of our template redesign work finalized in early 2024 and our risk adjusted panel size efforts that have gone into effect as of July 1, 2024, today we have 35 primary care providers open and accepting new patients across our UVMMC adult primary care sites. As of 8/12/2024, we have the capacity to add a minimum of 3,537 more patients in our UVMMC adult medical homes. As our primary care providers adapt to our new risk adjusted panel size approach, that number will likely grow as individual providers choose to grow their Observed to Expected panel size beyond 100% to our maximum of 125%.

In addition, we implemented Fast Pass (a digital tool which allows patients who wish to be seen sooner than their originally scheduled appointment to be added to a wait list and alerted either by a phone call or a MyChart message when a sooner appointment is available). We have seen improvements in days ranging from a low of 11 days improvement at South Burlington Adult Primary Care to a high of 65 days improvement at Burlington Adult Primary Care for patients who have accepted a Fast Pass offering. Fast Pass ensures we do our best to fill all available capacity within our schedules.

As we head into FY25, we are working to implement Ticket Scheduling and Direct Scheduling, both designed to give control to our patients on when they are scheduled to see their primary care provider. In addition, we are working together with our Population Health Services Organization (PHSO) to bring new centralized resources online to allow our PCPs to focus on delivering direct patient care. We believe all these improvements will help with access for our current patients and our community seeking to establishing care with us.

**On regional collaborations:**

**3. Are you able to quantify the impact of your hospital's training and expertise-sharing with out-of-network area hospitals?**

We offered obstetrical emergency training to EMS and Emergency Medicine teams in New York's Franklin and St. Lawrence Counties where we identified a need for support.

We are currently organizing additional obstetrical and neonatal training opportunities to out-of-network emergency departments in Vermont.

Our physicians, nurses and other experts are organizing and presenting in approximately 20 in-state conferences and continuing medical education opportunities which are open to Vermont practitioners and beyond on topics such as: respiratory therapy, wilderness medicine, emergency medicine, dermatology, nursing and family medicine.

We also run weekly Grand Rounds which have an open invitation for every provider in the state.

**On substantive variations from last budget:**

**4. It appears almost 36% of your new staff/FTEs included in this budget are for non-clinical positions (see Staff/FTE sheet in adaptive). In particular, it looks like there have been 47 new positions added in your administrative department, and another 16.5 in fiscal services serving in non-clinical roles. Can you please explain this resource allocation decision and how these positions are expected to drive value for Vermonters? Please provide the estimated costs associated with these positions (compensation and benefits).**

Fiscal services new positions are related to IT, Patient Financial Services, Registration, Customer Service, Corporate Accounting, Revenue Finance & Reimbursement departments with a reduction to budgeted vacancies within Finance.

Administrative department adds are related to Pharmacy, Credentialing & Enrollment, Network Nursing, Early Hearing Detection as well as several UVMHN miscellaneous adds across many departments.

These positions are important to our direct clinical operations and are vital to the structure in the health care delivery model. All positions go through a position review process prior to posting for hire. This process includes the assessment of the necessity of the position.

Using an overall average salary for all UVMMC staff, the total compensation and benefits related to these adds would be approximately $7M.

**5. What proportion of your labor expense growth is for new positions versus increases to compensation & benefits for existing positions?**

The proportion of total labor expense growth that is related to all new positions is 30.55% and includes a total of 26.53 additional physicians.

**From the May 7th meeting:**

**6. You launched a project using Epic data and Vizient to improve operating room efficiency. Can you provide an update on this project?**

As submitted to the Green Mountain Care Board as part of the Outpatient Surgery Center CON application, 75% utilization is a utilization benchmark beyond which organizations should look to increase capacity. This benchmark was recommended by Vizient and Halsa Advisors. Top 10% of Epic organizations are reporting 64% prime time room utilization and top 10% of Epic Academic Medical Center users are reporting 68% prime time room utilization.

In FY25, UVM Medical Center is targeting 22,130 patient cases in its ORs, an increase of 326 patients served compared to the FY24 budget. This would be yet another record year for patient access in the UVM Medical Center ORs since FY15 and would push prime time room utilization well beyond 80%.

**7. We previously asked you if UVMHN used a service to benchmark wait times against other hospitals. At the time, you responded that you were not sure. Could you now clarify your answer with a yes or no?**

UVMMC uses wait times as one of the measures to understand patient and community needs for access to health care services. There is not yet a nationally standardized measure or benchmark for wait times by patient population, specialty and service, given the variability of definitions, scheduling systems, tracking processes, and risk-adjustment, among others. We have included in the UVMMC FY25 budget resources to reduce patient backlogs and wait times for procedures, specialty consultations, and primary care visits.

We also have budgeted resources to expand tools such as eConsults and enhanced referrals to reduce the time it takes for patients to navigate multiple providers.

**On utilization:**

**8. Can you provide a more specific assessment of where volume has increased above FY2024 budgeted expectations. How have you recalibrated your expectations as to not underpredict your NPR for FY2025?**

When budgeting for utilization (i.e. Volumes), we start with volume levels from the October to January period, and from there we add or subtract volume for new providers, departures, new equipment, access initiatives, and seasonal factors that we know are not present in the October to January base period. As February and March data becomes available, we do adjust accordingly, if there is reason. The below chart shows where we are running for some of our key areas compared to the FY24 Budget. Several of these areas are now expected to exceed the FY24 Budget and have already exceeded the FY25 Budget.

| | FY24 Anlzd | FY24 | FY24 Bud to YTD Jul Anlzd | | FY25 |
|---|---|---|---|---|---|
| **HOSPITAL (Key Volume Metrics)** | **YTD Jul** | **Budget** | **Variance** | **% Variance** | **Budget** |
| Inpatient Discharges | 23,340 | 23,017 | 323 | 1.4% | 24,290 |
| *ALOS - Discharge Days* | *6.16* | *6.35* | *0.19* | *2.9%* | *6.10* |
| Inpatient Patient Days | 150,581 | 146,159 | 4,422 | 3.0% | 148,170 |
| Total ED Visits | 69,028 | 67,476 | 1,552 | 2.3% | 69,415 |
| MG Professional Worked RVUs (including Anes) | 3,537,439 | 3,561,574 | (24,134) | -0.7% | 3,686,830 |
| Total OR Cases | 21,962 | 21,804 | 159 | 0.7% | 22,130 |
| Total GI/Endoscopy | 10,729 | 11,730 | (1,001) | -8.5% | 16,593 |
| Total MRI | 25,660 | 24,260 | 1,400 | 5.8% | 25,761 |
| Total CT Scan | 76,513 | 71,065 | 5,448 | 7.7% | 74,763 |
| Total Mammography | 66,158 | 64,554 | 1,604 | 2.5% | 69,891 |

As called out in the Rate Decomposition file, utilization changes from the FY24 budget NPR to FY25 Budget NPR account for $93.7 million. FY24 actual run-rates account for the majority of the increase. If you were to annualize YTD June actual, it would account for approximately 70% of the increase and we're estimating additional access and unique patient counts will continue to increase through FY25 for the remainder. Unique Treated Patients have increase from 231,825 in FY23 (October-June) to 238,207 in FY24 (October-June).

Please keep in mind there is no perfect math for calculations such as this. The NPR amounts are calculated based on changes in gross revenues which should serve to provide a fair perspective for the areas increasing utilization & access. While there are some +/- here, below are the primary areas driving the change:

| | |
|---|---|
| Nursing Services | 17% |
| pharmacy | 26% |
| Periop | 12% |
| Radiology Services | 14% |
| Rehab & Respiratory Services | 13% |
| MG | 18% |

**On pharmaceuticals:**

**9. You've written that a higher NPR is necessary in part because of rising pharmaceutical expenses. Can you explain why you predict pharmaceutical expenses to increase by 18% compared to the FY2024 budget? It seems that pharmaceutical cost inflation is limited (only budgeted = 4%) and pharmaceutical utilization is actually expected to *decrease* (page 21). So why do you predict such a large increase in expenses?**

| | FY24 Budget | FY24 YTD Jul Anlzd | FY25 Budget | Bud to Bud % Change | Bud to Anlzd % Change |
|---|---|---|---|---|---|
| Retail Pharmacy Expense | $ 170,067,669 | $ 194,497,284 | $ 202,361,678 | 19.0% | 4.0% |
| IP Pharmaceutical Expense | $ 121,421,596 | $ 142,590,287 | $ 142,202,920 | 17.1% | -0.3% |
| Total Pharmacy Expense | $ 291,489,265 | $ 337,087,571 | $ 344,564,598 | 18.2% | 2.2% |
| | | | | | |
| Retail Pharmacy as a % of Total Pharmacy Expense | 58.3% | 57.7% | 58.7% | | |

When looking at Pharmaceuticals, you need to separate IP Pharmacy from Retail Pharmacy. Retail Pharmacy is not part of NPR.

Although total pharmacy expenses are increasing budget to budget by 18.2%, the portion of pharmaceutical expense related to NPR is only the IP pharmaceutical expense section and is increasing by 17.1% budget to budget primarily due to utilization of higher cost drugs in patient care in the current fiscal year. We are not reflecting a further cost increase in FY25 as the increase is already in the FY24 actual expenses.

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

See response under question #11 below.

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

Response below addresses both questions #10 and #11.

UVM Medical Center participates in the 340B program as a cost-avoidance program that is funded by participating pharmaceutical manufacturers and not by taxpayers.

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

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

Not every non-profit hospital qualifies for the 340B program.  The University of Vermont Medical Center qualifies as a disproportionate share hospital (DSH > 11.75%), Central Vermont Medical Center qualifies as a sole community hospital (DSH > 8%), and Porter Medical Center qualifies through their status as a critical access hospital.  Unlike the University of Vermont Medical Center, Central Vermont Medical Center and Porter Medical Center are excluded from 340B pricing for orphan status medications.

At the UVM Health Network, we use our 340B savings to:

- Fund patient assistance programs that provide access to medications to thousands of patients with financial need.
- In FY23, 8.3% of patients served by the UVMHN pharmacy qualified for the health assistance program (under- and un-insured) and received co-pay assistance.  This encompassed 18.4% of all prescriptions filled.
- Lessen the gap between the cost of care and reimbursement from government payers.
- Help keep our hospitals solvent to ensure patients in our region have local/In-State access to specialty, comprehensive, and high-quality care services, without which patients would have to travel out of Vermont to receive - likely at higher cost.

Yes, however, we cannot provide a payer mix for revenues from 340B. We estimate approximately 80% to 90% drug supply replenishment cost for hospital outpatient provided pharmaceuticals for qualifying sites of service are eligible for the 340B drug pricing program. For retail pharmacy, which includes retail, mail order and specialty pharmacy combined, based on inventory supply order units, approximately 50% of our prescriptions run through our 340B program, and the other 50% run through other higher cost (non-340B eligible) wholesale acquisition cost (WAC) accounts.  In FY23, the UVMHN outpatient pharmacy generated $68.8M in gross margin.

Regardless of access to the UVMHN outpatient pharmacy, prescriptions likely would have been filled and dispensed to eligible patients.  The UVMHN outpatient pharmacy allows those health care dollars to stay in our system and be reinvested into the care of patients throughout the UVMHN.

UVMHN participates in contract pharmacy arrangements, which allows 340B cost-avoidance / cost-savings to be captured through prescription fills and refills at contracted non-UVMHN pharmacies.  In FY23, UVMHN received $34.8M in margin from the contract pharmacy arrangements [UVMMC $24.6M, CVMC $9.0M, and PMC $1.2M].

Reference:


1. Health Resources and Services Administration. https://www.hrsa.gov/ops Accessed August 12, 2024.
   Health Resources and Services Administration. https://www.hrsa.gov/opa/program-requirements/orphan-drug-exclusion Accessed August 12, 2024.

**On rate changes:**

**12. Regarding rate changes by payer, please describe any assumptions you have made across payers and across settings of care.**

Rate Increases:
Medicare: 3.26% inpatient, -1.4% outpatient, 1.5% professional
Medicaid: 0%
Commercial: 7.91% inpatient, 7.91% outpatient, 7.91% professional

There were other initiatives and assumptions which were utilized to offset cost inflation prior to the rate calculation.
These assumptions may or may not have impacted all payers equally.

| | |
|---|---|
| APM Shared Savings | $5,975,837 |
| LOS Reduction & Placement Impacts | $14,250,827 |
| GME/IGT Change | $7,259,044 |
| UM/UR Change | $2,217,597 |
| PHSO | $1,089,673 |
| Legislative Changes - Bad Debt/Charity/Denials | $2,706,261 |

**On contingency plan:**

**13. Why do you cite the same contingency plan for UVMMC that you cite for Porter Medical Center?**

We assume this is referencing question C.h on pages 28 and 29 of our budget narrative. If so, our approach to addressing a reduced NPR would be similar regardless of the size of the hospital.

**On investments in mental health, SUD, LTC, and primary care:**

**14. You've attributed a large increase in expenses to free care related to SUD patients and wound care. At the moment, do you undertake any proactive efforts to prevent SUD-related wounds/infections within your community? Since your hospital has already hired two FTEs to handle the patient influx, do you think such upstream programs might be cost-efficient?**

The increase in extremely complex wounds that we are currently seeing is the result of xylazine usage, not injection site infections, so upstream programs have a more limited impact on what we're addressing, but are still very much needed. To that end, we are partnering with community-based organizations to provide SUD care in the community and also reconfigured our SUD treatment services into a new Addiction Treatment Center, which uses community outreach, treatment, and support strategies to provide rapid access to prospective patients, expanding touch-points and referral options for the community at-large, and ensuring that ATC's treatment and support programs incorporate the most up-to-date best practices. This is another service that we are able to provide due in-part to our robust partnership with Larner College of Medicine.

**Performance improvement plan (systemwide-cost reduction plan):**

**15. "In your analysis you reference $21.1M of non-patient administrative services revenue to be generated in FY 2024, with $3.1M through administrative services and another $16.1M through PHSO**

**services. Please provide the Board with an itemize accounting of how these are being generated.**

| | | |
|---|---|---|
| Admin Service | ROI on Housing Investment | 3.1 |
| PHSO | OneCare Analytical Support | 4.3 |
| PHSO | Blue Print Funding | 3.6 |
| PHSO | Various Grants | 0.8 |
| PHSO | MVP collaborations/Analytic work | 2.7 |
| PHSO | VT Medicaid MAT program | 2.2 |
| PHSO | Other collaborations | 2.5 |

**16. Please provide data on the costs of your HR department, IT department, and Revenue Cycle services.**

| | HR | Revenue Cyle | IT |
|---|---|---|---|
| Salary & Fringe | 18,730,718 | 73,668,166 | 66,712,571 |
| Non-Salary Expense | 8,168,829 | 5,526,823 | 80,904,538 |
| Total Expense | 26,899,546 | 79,194,989 | 147,617,109 |

**On network-shared services:**

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

There are 123 physicians with budgeted effort at UVMMC and at least one other hospital in UVM Health Network. These partnerships are accounted for within our FY25 budget. Volumes, professional revenue, and personnel costs are reflected in the respective partner hospital budget based on the planned effort at each partner hospital.

**18. Please quantify transfers from UVMHN to NY hospitals (3-year actuals, 2024 projected, 2025 budgeted?). Please also quantify your projected rate increases for NY hospitals in 2025.**

For the first part of the question, please refer to the NY/VT Funds Flow document that was uploaded as part of the budget submission, specifically the tab titled “Analysis of UVMHN & UVMMC Reinvestment of NY Funds back to NY.”

FY25 commercial rate increases for the NY hospitals: CVPH ranged between 5.8%-6.0%, for the Critical Access Hospitals AHMC & ECH it is 4.5%.

**On last year’s deliberations:**

**19. Last year, some board members expressed skepticism that UVMMC has not pursued all revenue streams at its disposal, including increased FPP payments and increased utilization at outpatient clinics. Do you believe there is room for revenue growth? Can you provide evidence that would**

**address the Board's concerns?**

We monitor our FPP revenue with OneCare Vermont to ensure adjustments are made year over year and when necessary taking into account expected utilization changes and any increase in Medicaid rates. Additionally, as described in our clinical effectiveness reference, we are looking to move patients to outpatient from inpatient as resources are available maximizing our performance fixed payments. As we enhance population health services we will maximize revenue from payers through delegation of services and accountability based agreement.

**On your workbook submission:**

**20. In Table 1 of the workbook, it seems that, with the exception of the pain management clinic, many services take more than 3 days to process a referral. Can you explain the reasons for these delays? Do you have an estimate of how much longer these patients are waiting to receive care?**

There are several reasons for delays in processing referrals including increases in number of referrals due to loss of specialty capacity in surrounding areas, support staff vacancies, prior authorization requirements for some services, and clinical review of referrals for appropriateness by the receiving specialty office. Of our 79 UVMMC clinics, 25% get all their new patients in within 90 days of scheduling the appointment. At the 180-day mark, 92% of clinics have been able to get most new patients in, leaving six clinical areas where provider capacity is the rate limiting factor (Pedi GI, Pedi Genetics, Rheumatology, Urology, Memory, and Neuromuscular).

**21. In Table 7 of the workbook, your RVUs vary widely, though notably there are many that fall far below the 50$^{th}$ percentile. Why do you believe this is the case? How do you plan to improve productivity in the future?**

Provider productivity below the 50th percentile of the benchmarks can be related to a number of factors such as new providers needing time to "ramp up" as they transition from training to actual clinical practice (ramp up time varies by specialty from one to two years before a provider can be expected to achieve benchmark productivity), inadequate support staff to enable the provider working to the top of their license, challenges with 'schedule filling' around late cancellations and patient no shows, and administrative burden for providers related to documentation/prior authorization requirements/billing/care coordination. To address these issues, we are revising our provider scheduling templates (we started with adult primary care and are currently working with Cardiology & Endocrinology) to ensure a standardized approach to scheduling, alignment between provider effort and capacity on the schedules, and ensuring our scheduling templates allow us to fully utilize the digital tools available in Epic. The digital tools include Fast Pass, which allows patients who wish to be seen sooner to be placed on a wait list and receive either a phone call or an autogenerated offer via MyChart of a sooner appointment that has become available. Ticket scheduling and patient direct scheduling are the other two digital tools we have begun to implement within adult primary care and will spread to our specialty areas as we complete the provider template revisions. We are working diligently to recruit staff to support our providers with a care team that can optimize efficiency.

**22. Please review the rate decomposition details you submitted as well as the "summary" tab and explain the following (where available, show supporting calculations):**

a. **How did you arrive at the assumed rates of growth for price, volume, and payer mix shifts by payer?**
b. **For non-zero values in the "other" column, how did you derive these estimates?**

NPR Crosswalk from FY24 Budget to FY25 Budget:

| | A | B | C | D | E=A+B+C+D | F | H=E+F |
|---|---|---|---|---|---|---|---|
| | FY24 Budget | FY24 Actual to Budget Rate Experience | Payer Mix Shift Impacts | Utilization Changes | FY25 Base NPR Prior to FY25 Rates | FY25 Rate Assumptions | FY25 NPR Budget |
| **UVMMC** | | | | | | | |
| **Total NPR** | **1,833,658,419** | **(6,016,614)** | **(6,960,789)** | **93,709,667** | **1,914,390,683** | **89,784,108** | **2,004,174,791** |
| Medicaid | 198,616,008 | (10,727,800) | (1,717,804) | 6,633,712 | **192,804,115** | 8,857,295 | 201,661,410 |
| Medicare | 553,395,695 | 10,099,335 | (3,929,523) | 26,818,475 | **586,383,983** | 20,311,001 | 606,694,984 |
| Major Commercial | 912,131,127 | (4,794,282) | (9,935,650) | 51,717,051 | **949,118,247** | 61,949,827 | 1,011,068,074 |
| All Other | 203,824,120 | 31,571,064 | 13,624,169 | 11,604,778 | **260,624,132** | 4,255,545 | 264,879,677 |
| Bad Debt | (32,361,190) | (9,704,071) | (4,155,018) | (2,110,934) | **(48,331,212)** | (3,148,061) | (51,479,274) |
| Free Care | (17,098,253) | (18,592,260) | (846,963) | (953,417) | **(37,490,893)** | (2,441,499) | (39,932,391) |
| DSH | 15,150,911 | (3,868,600) | - | - | **11,282,311** | - | 11,282,311 |
| | | | | | | | |
| Total NPR % Change | | B/A | C/A | D/A | (E-A)/A | F/A | (H-A)/A |
| From FY24 Budget | | -0.30% | -0.40% | 5.10% | 4.40% | 4.90% | 9.30% |
| | | | | | | | |
| | | | | | | F/E | |
| FY25 Rate/Price on FY25 Base | | | | | | 4.70% | |
| | | | | | | | |
| **GMCB Rate Decomp File: Data Column Reference** | | | | | | | |
| | C | R | Q | M | | K+O | E |

Column B reflects what is represented in the "other" column in the Rate Decomposition file.
This difference is FY24 Budget to Actual collection experience. The calculation is based upon the GPSR change from FY24 budget to FY25 Base (prior to any rate changes) multiplied by the collection rate difference from the FY24 Budget to FY24 Actual experience.

Column C reflects payer mix difference from FY24 Budget to FY24 actual experience.
The calculation is based on taking the difference in FY24 Budgeted payer mix to current actual experience. Then restating what FY24 Budget GPSR would have been by payer if based on current actual payer. Then take the difference in GPSR by payer and multiply by FY24 Budgeted collection rate for that payer.

Column D reflections utilization/Access improvements.
The calculation is based on GPSR change by payer from the FY24 budget to FY25 Base (prior to any rate changes) +/- any payer mix changes then multiply that difference by FY24 Budgeted collection rates by payer.

Column F reflects the rate changes necessary to cover cost inflation.
As spoken to in question #12, we take rate assumptions for the non-commercial payer first, apply any initiatives and assumptions which were utilized to offset cost inflation prior to the rate calculation, the remainder is then used to calculate the commercial rate increase necessary to fund cost inflation. The calculation is below.

| UVMMC | FY2025 Cost Inflation |
|---|---|
| | Revised Budget |
| | |
| Total Cost Inflation | $98,656,926 |
| Less Retail Pharmacy | ($7,783,141) |
| **Net Cost Inflation for Commercial Rate Calc** | **$90,873,784** |
| | |
| **Less:** | |
| FY2025 - Medicare Rate Increase | $7,277,283 |
| FY2025 - Medicare ACO Rate Increase | $0 |
| FY2025 - Medicaid Rate Increase | $8,508 |
| FY2025 - Other Payer Changes | $2,016,053 |
| APM Shared Savings | $5,975,837 |
| LOS Reduction & Placement Impacts | $14,250,827 |
| GME/IGT Change | $7,259,044 |
| UM/UR Change | $2,217,597 |
| PHSO | $1,089,673 |
| Legislative Changes - Bad Debt/Charity/Denials | $2,706,261 |
| Rate Impact on Bad Debt/Charity/Denials Calculation | ($8,142,746) |
| **Sub-Total** | **$34,658,337** |
| | |
| **Required Funding from Commercial Rate** | **$56,215,447** |
| | |
| Per 1 % Impact of Commercial Rate: | |
| Budget Year ( 9 months: Jan-Sept) | $7,104,757 |
| | |
| **Commercial Rate Increase in FY2025 Budget** | **7.91%** |

**Other:**

**23. In your narrative discussion of your operating expense trends overtime (beginning on page 13), can you describe how you picked your peer group against which you benchmarked yourself, and why you chose not to use the peer groups established in the FY25 guidance?**

We used the AAMC Council of Teaching Hospitals survey in our narrative because we've used it for years to measure how we're doing on operating costs. The survey includes all AMCs in the country and represents actual reported costs, not costs derived from Medicare cost reports. We view it is a credible source.

We used the Syntellis benchmark survey because we use it in setting administrative shared service targets each year to ensure we're continuing to improve our administrative efficiency. The Syntellis benchmark peer group utilized for this purpose is Academic Medical Center systems greater than 500 beds, of which Syntellis data set represents 57 hospitals in this category. We view it as a credible source.

We're still learning how the data in the NASHP survey is compiled, since it is derived from Medicare cost reports, but felt important to incorporate that source and show how we compare to New England AMCs since it is a source used by the GMCB.

**24. According to your audited financial statements, you are funding the University of Vermont Medical School at approximately $80M/year. Net of Medicaid subsidies, this is still a substantial sum that is passed on to commercial rate payers. Why should Vermont commercial rate payers fund these activities? What other sources of funding have you explored?**

The affiliation and funds flow between the UVM Medical Center and the University of Vermont Larner College of Medicine, which has been in place for many decades, is crucial to the success of the Larner College of Medicine, which is in turn necessary to the UVM Medical Center's identity as Vermont's only Academic Medical Center. The benefits to Vermonters of having an academic medical center are many, and include:

- Training – having an Academic Medical Center allows us to train the next generation of doctors and nurses. Many choose to remain here after their training, easing recruitment pressures to the benefit of commercial and non-commercial ratepayers.
- Recruitment – many of the doctors who choose to practice at UVM Medical Center do so because they are also able to engage in academic activities in parallel to caring for patients. We would be unable to attract those physicians without a healthy Larner College of Medicine.
- Staffing – medical students, residents and fellows provide varying levels of care as part of their education and training. Patients are not charged for this care.
- Quality – our doctors are able to continuously advance their skills and knowledge through their participation in the college.
- Elevated care throughout the UVM Health Network. Our academic chairs now have oversight over their departments Network-wide, meaning patients at Porter can anticipate a level of care derived from that academic affiliation.
- Patient access to clinical trials and advanced care. Our patients are able to access advanced therapies close to home due to our affiliation with Larner College of Medicine. We've citied several of the specialized programs that flow through this affiliation. A non-exhaustive list includes:
    - UVM Children's Hospital and Neonatal Intensive Care Unit
    - UVM Cancer Center and advanced therapies such as CAR-T gene therapy
    - Addiction Treatment Center
    - Dementia Caregiver Center
    - Osher Center for Integrative Health and its award-winning Comprehensive Pain Program
    - The newly-accredited Pulmonary Hypertension Care Center
    - Our Thrombosis & Hemostasis Program
    - An infectious disease department, that recently brought the Lyme Disease vaccine clinical trial to Vermont
    - Our lab, which serves as a reference laboratory throughout New England and functioned as a testing backbone during the COVID-19 pandemic

Every Academic Medical Center in the United States is a partnership between a health care delivery system and an educational system. In some states, those systems are fully integrated into a single entity; in others, like Vermont, they are separate but affiliated entities. But in virtually every instance, the health care delivery component flows funds to the educational component in order to support the education, workforce development, and research upon which patients depend. The funds that flow from UVMMC to UVM are consistent, both in type and size, with how medical education is funded everywhere in the United States.

All of UVM Medical Center's patient revenue – including Medicare, Medicaid, and commercial insurers – are used, in part, to support the decades-long affiliation agreement between UVM and UVMMC. Of course, the University of Vermont funds the Larner College of Medicine from a variety of other sources, but UVM Medical Center does not have other sources of available funding for medical education.

In addition, the University of Vermont makes an intergovernmental transfer to Department of Vermont Health Access, which the State then uses to draw down additional federal funding to support graduate medical student education by UVMMC. That additional federal reimbursement supplements UVMMC's government reimbursement and reduces the cost-shift, thus benefitting commercial payers and their insureds. This year as we highlighted on our commercial rate calculation, the request from commercial insurance would have been $4M higher had it not been for the increase in additional federal matching funds.

Finally, many of the programs and services we've described above are funded through grants that UVM receives and the only means to leverage those grants is by having an academic medical center.

**25. Your hospital had planned to build a mental health facility but redirected those funds towards other ends. What is the current plan for these funds?**

On May 31, 2023, the UVM Health Network, in cooperation with the Vermont Department of Mental Health, submitted our proposal in compliance with the Green Mountain Care Board's order dated March 22, 2023, which mandates the investment of the remaining funds ($18 million) set aside in accordance with the Board's order dated April 18, 2018. In the GMCB's June 28, 2023, meeting, Susan Barrett noted in her Executive Director report that the Board and staff had reviewed the submission and were in the process of developing a monitoring plan. In addition, the Vermont Psychiatric Survivors and the Vermont Chapter of NAMI (National Alliance of Mental Illness) provided letters of support for the UVMHN mental health plan. These letters and associated materials on the mental health plan are located on the GMCB website under the hospital budgets and enforcement actions tab.

Our shared goal is to address some of the state's most pressing needs by increasing capacity for mental health services, with a particular emphasis on services that will reduce the need for inpatient care. UVM Health Network and the Department of Mental Health continue to believe these investments will reduce the frequency of hospitalization and length of stay for adults, adolescents, and children experiencing a mental health episode.

UVM Health Network will submit a Year 1 Interim Report of the projects at the end of the hospital fiscal year. As noted in our May 31st, 2023, letter, we anticipated the possibility of delays to the three-year plan for the expenditure of these funds due to emerging priorities limiting staff resources or implementation postponements as the proposals moved from original ideation towards implementation. The planning phases have extended as the projects received further vetting and minor modifications, but all are still on track for execution, some just not on the original timelines. While actual spending may not fall into the proposed fiscal year, we plan to spend the entire $18 million on improvements to the mental health system of care in our region.

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

Medicaid is underfunding the care we are delivering to patients. Medicaid reimbursement does not keep pace with annual cost inflation.

It is important to note that NPR does not always cover all the cost of services. There are services which lose money, meaning NPR does not cover the full cost of providing care. It's important to recognize that other revenues are utilized to help support services which could otherwise be at risk of being providing locally if not for the proceeds from other revenue activities. Pharmacy activities are a significant generator of other revenues, as referenced in the responses to questions #10 and #11 and help "lessen the gap between the cost of care and reimbursement from government payers."

Calculation: Based FY23 P&L and using an RCC cost allocation methodology, Medicaid covered about 77% of the total cost of care with a funding shortfall estimated at $60 million.

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

Medicare is underfunding the care we are delivering to patients. Medicare reimbursement does not keep pace with annual cost inflation.

Please be mindful that NPR does not always cover all the cost of services.

There are services which lose money, meaning NPR does not cover the full cost of providing care.

It's important to recognize that other revenues are utilized to help support services which could otherwise be at risk of being providing locally if not for the proceeds from other revenue activities. Pharmacy activities are a significant generator of other revenues, as referenced in the responses to questions #10 and #11 and help "lessen the gap between the cost of care and reimbursement from government payers."

Calculation: Based FY23 P&L and using an RCC cost allocation methodology, Medicare covered about 65% of total cost of care with a funding shortfall estimated at $268 million.

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

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

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

**Narrative Questions That Still Need to Be Answered:**

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

If a patient has an unpaid balance, they may resolve their balance, either by paying in full, setting up a payment plan, applying for financial assistance or making other arrangements with our Patient Financial Services Department. Once a patient has received 4 statements over a 120 day time period and no arrangements have been made for payment, the account is referred to a third party collection agency. Our collection agencies have the depth to reach out on large volumes of accounts with high levels of efficiency. They use a series of letters and make telephonic, text and voice mail attempts to reach the patient. Once contact is made, the agencies work with the patient on repayment terms that best fit their financial needs. Agencies also discuss financial assistance and advise how they can apply.