Fiscal Year 2026 Hospital Budget Submission to the Green Mountain Care Board

On behalf of University of Vermont Medical Center

July 1, 2025

University of Vermont Health Network

The health care organizations that comprise University of Vermont Health Network have worked together for more than 100 years. Each has built local trust by responding to the needs of its community through high-quality care delivered by dedicated staff who are also community members, neighbors and friends of the people we serve. Our purpose is deeply rooted in our role as nonprofit health care providers, which means that individually and together, we are driven by improving the health of our patients and our communities above all else. Working together as a health system, we share our resources and expertise to offer life-saving and preventative care to communities across our region that would otherwise not be available.

These budget submissions come at an inflection point – a moment of crisis and opportunity for rural health care across the country. The status quo of health care in our state is unaffordable for the Vermonters who rely on us. To survive and ensure we are here for the future generations who will need health care, we must think differently and act with more determination than ever before. We recognize that we have not yet fully realized the benefits of our rural academic health system – we know we must deliver more value to our communities.

As the sole integrated health system based in Vermont, we share common goals and resources to work smarter and deliver high-quality care to communities throughout our region that is more affordable and responsive to their needs. That means finding the right combination of care, ranging from care in the community and at home, critical access and community hospitals, as well as our anchor academic medical center. Our work begins and ends with a focus on our patients – a commitment reflected in our Fiscal Year 2026 (FY26) budgets to be a stronger partner and neighbor in the years ahead.

Our FY26 budgets reflect our work to adapt, innovate and lead to improve the value and sustainability of the rural academic health care we provide. Our budgets support the advancement of three overarching goals:

- Provide high-quality care to our patients to drive outcomes toward top quartile performance.
- Accelerate our efforts to address the rising cost of health care in our region.
- Invest in maintaining or improving access to care, focusing on outpatient care and telehealth.

These budgets are submitted to be in compliance with the Green Mountain Care Board's (GMCB) FY26 budget guidance. The current state of health care in Vermont and across the United States means Vermont's hospitals must find new ways to control health care costs, while working to limit the impact on clinical services. Our budgets reflect the difficult decisions required to get to this point.

UVM Health Network's FY26 budget submissions to GMCB:

	NPR growth	**Commercial rate growth**	**Operating expense growth**
UVM Medical Center	2.2%	-7.9%	3.2%*
Central Vermont Medical Center	3.5%	-3.3%	2.8%
Porter Hospital	3.5%	3.0%	2.6%

**This is 0.2 higher than GMCB budget guidance. The overage is due to Vermont provider tax, which is allowed as an exemption per GMCB budget guidance.*

We challenged ourselves and our teams to find new opportunities to reduce costs while protecting clinical services. This means that the burden of cost reduction will primarily impact non-clinical areas of our organization, which are nonetheless vital to running our hospitals and supporting the care they provide. As a consequence, reductions to our non-clinical areas may be felt by providers and patients across the state.

We do not take these decisions lightly, but there is no alternative if we are to remain sustainable and serve future generations of Vermonters and meaningfully do our part to address health care affordability in our state. We are committed to navigating these challenges with transparency, accountability and a continued focus on delivering safe, high-quality care to every patient.

About UVM Health Network

UVM Health Network is a rural academic health system serving more than one million people living in rural communities across Vermont and northern New York. Our health system employs 15,000 people in our region and is comprised of six partner hospitals, a children's hospital, a home health and hospice agency, 154 outpatient care sites, three skilled nursing facilities, a multispecialty medical group with over 1,000 employed physicians, approximately 500 advanced practice providers and a population health services organization.

Each of our partner organizations is deeply connected to its local community, providing compassionate, personal care shaped by the latest medical advances and delivered by highly skilled experts. Meanwhile, our essential academic partnerships with local colleges and universities in Vermont help us train the next generation of caregivers and bring leading-edge research to the bedside. These partnerships include the University of Vermont Larner College of Medicine and College of Nursing and Health Sciences, Community College of Vermont, Norwich University and Vermont State University. Our three Vermont hospitals are subject to GMCB budget approval under 18 V.S.A. § 9375(b)(7).

As a nonprofit health system, every dollar that comes into UVM Health Network stays within our health system to support the care we provide. Across all our health care partner organizations, we are working hard each day to make the most of these resources and enhance the experience of our patients and caregivers: making it easier to access care physically and financially, strengthening our workforce and responsibly investing in the critical resources we need to deliver the high-quality care our patients deserve, now and in the future.

University of Vermont Medical Center

A. Executive Summary

Provide a high-level overview of key considerations for the proposed budget. Include discussion of variations from the current year approved budget, including any assumptions about current year projections relative to the approved budget. Indicate areas where the proposed budget deviates from parameters specified in this Guidance, providing justifications for such deviations, including credible and substantive evidence to support those justifications. For hospitals that are part of a network, affiliation, or have a financial arrangement with another legal entity (e.g. nursing home), explain any differences in what is happening at the hospital versus the network level, and quantify any financial impact on the hospital budget as a result of the relationship with any non-hospital entities.

High-Level Overview: University of Vermont Medical Center's proposed budget represents a commercial rate decrease while prioritizing patient and staff needs, access, quality and regulatory requirements. By necessity, it achieves significant expense reductions to not just adhere to budget guidance but also work towards achieving affordable and sustainable health care for all Vermonters. Key strategies and considerations include reducing administrative services and operating expenses, eliminating service duplication and, wherever possible, keeping care in local communities. Our budget prioritizes affordability while preserving quality, safety and service.

Variations from Current Year Approved Budget: Compared to the current year's approved budget, the proposed budget includes several notable changes:

Account Description	FY25 Budget*	FY25 GMCB Proj	FY26 Budget**
TOTAL NPSR + FPP + OCV REVENUE	1,903,520,112	1,973,192,311	1,986,591,292
Total Other Revenue	420,358,186	438,107,958	433,336,189
TOTAL UNRESTRICTED REVENUE & OTHER	2,323,878,298	2,411,300,269	2,419,927,481
Total Salaries	1,022,148,936	1,035,316,990	1,063,507,384
Payroll Tax & Fringe	226,429,362	255,238,189	274,385,506
Salaries, Payroll Taxes, and Fringe Benefits	1,248,578,298	1,290,555,179	1,337,892,891
Total Non-Salary Expense	1,005,983,969	1,055,038,735	1,009,987,945
TOTAL EXPENSES	2,254,562,267	2,345,593,914	2,347,880,836

*FY25 Total NPSR + FPP + OCV above does not include revenue from transfer of CVHO patients or FY24 Budget order variance of $19.8M

**FY26 Total NPSR + FPP + OCV in compliance with budget order when above note is included. FY26 Total Expenses includes expenses related to the transfer of CVHO patients.

1. **Net Patient Revenue – FY25 Budget to FY26 Budget:** Please refer to the Appendix.
2. **Expense Reductions:** Significant expense reductions were made to the following areas:
    - Traveler expense reduced by $19.7M
    - Purchased services reduced by $9.5M
    - Software and IT maintenance reduced by $4.5M
    - Administrative expenses reduced by $23.9M

- $29.9M in savings from other expenses related to reducing cost of care, as follows:
    - Supply chain management related to surgical tools, implantable devices and other clinical materials
    - Length of stay initiatives
    - Adding Emergency Department (ED) observation to better manage ED patient volume and short-stay inpatient populations
    - Quality initiatives yielding expense reductions

3. **Service Transfers:** Incorporation of an existing external oncology practice, including infusion services, to preserve this essential care in the state. This was previously submitted on Schedule A.

4. **Service Location:** Systemwide efforts to keep care as local as possible includes providing more care in community hospitals in Vermont and New York, such as imaging, testing and surgery. Keeping care closer to home is good for patients and families and increases capacity at UVM Medical Center for necessary tertiary-level care that cannot be delivered elsewhere in the state. While these efforts aim to enhance care close to home, UVM Medical Center also serves as the community hospital for its local community and serves the acute care needs of Vermont and parts of New York.

Deviations from Guidance Parameters: The proposed budget for UVM Medical Center does not deviate from budget guidance parameters. Provider tax is excluded from the operating expense threshold per budget guidance.

Integration within UVM Health Network: UVM Medical Center's integration in UVM Health Network enhances patient care and operational efficiency through shared administrative services and regional coordination. In 2025, this collaboration allowed us to streamline non-acute patient transfers to community hospitals, home health, hospice, skilled nursing facilities and rehabilitation centers—freeing up clinical staff time, reducing hospital length of stay and lowering overall costs. Coordination within our system played a large part in reducing UVM Medical Center's subacute population from a high of 80 patients per day to a more manageable 20 per day and reduced length of stay without impacting readmissions. In short, by leveraging our system's infrastructure, UVM Medical Center can deliver more coordinated, cost-effective care across the region.

B. Background

a) Explain any changes that occurred to your corporate structure within the last year.

There have been no changes to UVM Medical Center's corporate structure within the last year.

b) Explain your approach to considering and participating in any corporate affiliations in which you or the other organization may have a financial stake.

UVM Medical Center is not currently considering any corporate affiliations. When we do consider participating in corporate affiliations, the primary consideration is whether the affiliation will allow us to better serve our patients' health care needs.

c) Explain and quantify any service-line closures, transfers, reductions, or additions since the prior year budget review.

Service	Status	Patients Per Year	Description
Transplant	Transferred to Dartmouth Health	17 per year average	Transplant surgeries have been transferred to Dartmouth Health. We continue to support transplant patients pre- and post- operation. Surgical transplant services at UVM Medical Center ended on March 1, 2025, due to low volume and high cost.
Genomic Medicine	Genomics lab at UVM Medical Center closed, and all genomic medicine testing will be sent to out-of-state labs	200	Due to the high cost of providing next generation sequencing as well as rapid developments in the field, we have outsourced genomic medicine laboratory testing to external labs. To mitigate the impact on our patients, we intend to continue to employ genomic medicine physicians to guide diagnostics and treatment.
Champlain Valley Hematology Oncology (CVHO) service	Transfer to UVM Medical Center	7,400 infusions and 9,300 evaluation and management visits annually	This is a critical service provided within the community that was closing. UVM Medical Center integrated the existing services to preserve access.

C. Budget Questions

a) Concisely describe substantive variations from current year approved budget to current year projected, and to the proposed budget, in terms of service line changes (differentiate between new or divested services, and volume changes that necessitate changes in staffing), physician transfers, accounting adjustments, etc.

Divested Services
Our FY25 budget anticipated a partnership with Dartmouth for transplant services. This partnership began in May 2025, and therefore, the operational expenses and associated revenue historically budgeted by UVM Medical Center have not been budgeted for FY26.

We began outsourcing our genomic medicine laboratory testing on May 31, 2025. As a result, the associated operations previously managed by UVM Medical Center are not included in the FY26 budget.

Provider transfer / Practice closure / CVHO:

- FY25 budget - $0 Revenue / $0 Expense
- FY25 projection - $0 Revenue / $0 Expense
- FY25 estimated impact per Schedule A - $7M NPR / $5.3M Expense
- FY26 budget - $20.2M NPR / $19.4M Expense per Schedule A (submitted on May 22, 2025)

Note: Schedule A estimates are prior to H.266.

There are no substantive changes in the proposed budget relative to the current year's approved budget in terms of service volumes or service lines. We are not introducing major new services or divesting existing ones. There are no significant physician transfers or staffing changes anticipated outside the previously submitted Schedule A. Additionally, the only accounting change is related to denials. Denials previously were allocated to Other in the NPR bridges table; due to system refinement, it is now allocated by payer.

b) Explain the charge master increase, if necessary, to support your submitted commercial reimbursement rate increase. This should match the value provided in the rate decomposition sheet - "Chargemaster Increase Required for reimbursement increase requested."

UVM Medical Center is not submitting a request for a commercial reimbursement rate increase for FY26. However, we have built a 3% chargemaster increase into the budget for FY26, which is reflected in the rate decomposition sheet.

A chargemaster increase does not necessarily result in a commercial reimbursement rate increase. The amount a commercial payer spends for a service is not necessarily correlated with the hospital's charge for the service.

Specifically, if a service is paid according to a commercial payer's fee schedule or DRG rate, the hospital's charge for that service is not relevant. For UVM Medical Center's major commercial payers, most services are paid according to some fixed fee, like a DRG or fee schedule. This means that an increase in the hospital's charges will not result in an increase in the payer's reimbursement rates.

There are reasons to not have a chargemaster change match a commercial reimbursement change. Decreasing charges to match commercial reimbursement decreases could have the following unintended consequences:

- A government payer like Medicare might pay for a service at the lesser of a hospital's charge or a specified rate, so if the hospital's charge is less than the government payer's specified rate, the hospital leaves money on the table by charging less than the specified rate.
- CMS uses the hospital's charges to calculate the hospital's cost-to-charge ratio; thus, decreasing the charges could adversely impact this calculation on the Medicare cost report. This, in turn, could result in lesser Medicare reimbursement.

c) For each of the Section I benchmarks not met in the budget submission, explain and justify the deviation using credible and sufficient evidence.

UVM Medical Center has submitted a budget in full compliance with NPR growth, commercial rate growth and expense benchmarks. Vermont provider tax slightly raises operating expense growth beyond

the benchmark, but the GMCB budget guidance exempts provider tax from this measure. To ensure compliance, we met with GMCB staff to review FY24 revenue base, and it was agreed that the FY24 GMCB budget order would be the basis for NPR instead of Adaptive. In addition, Schedule A related to the service transfer for CVHO patients was submitted and reviewed with GMCB staff and determined not be viewed as a deviation. CVHO patients increase the NPR and expense structure for UVM Medical Center, but this does not negatively impact Vermont's health care delivery system overall, because these patients were already being treated within the system. These patients will be subject to newly enacted H.266 in January, which will significantly reduce anticipated NPR.

d) Explain the assumptions embedded in your proposed budget for each of the bulleted points a-i below, providing evidence to support your assumption(s), as well as any substantive variations from FY25 (budget & projected). For applicable sections, fill out the accompanying table in the supplemental budget workbook.

a. Labor expenses. Please complete the supplemental table "Labor Expense" in the workbook for projected 2025 & budgeted 2026. Differentiate between the use of employed versus contracted labor, separating nursing from other clinical and nonclinical staff. In your narrative response, highlight any trends that are specific to particular clinical domains. Explain where these costs are reflected on the income statement.

Trends Supporting Expense Management
A key positive trend is the continued reduction in traveler FTEs and short-term contracts, which have decreased from 370 in FY24 to 240 YTD. This has been driven by a combination of factors, including our strategic efforts to reduce the number of non-acute patients, maintain census levels within budgeted targets across all units as well as the evolving national market for contract labor. Additionally, thanks to a significant body of work across our system, we are realizing lower-than-average staff turnover and resultant decreasing vacancy rates. By retaining experienced staff, we have minimized the need for costly temporary replacements and preserved institutional knowledge, particularly in nursing units.

Finally, reductions in special pay – such as urgent, scheduled special pay and incentive bonuses – have also contributed to lower overall labor costs.

Challenges to Expense Management
Current multi-year contracts for employees covered by collective bargaining units, which include significant pay escalations exceed the newly introduced expense growth cap. This reduces financial flexibility and introduces fixed costs that are difficult to adjust in response to changing operational needs and regulatory requirements.

Methodology for Labor Expense Budgeting

Start With Current Usage: The first step in developing our labor expense budget at UVM Medical Center is to project FTEs (staff and physicians). We use the FTEs we have at the end of January of the current year as the starting point (October to January period serves as the base for the entire budget).

Adjust Based on Anticipated Changes: From there, we adjust the FTEs for vacant positions that must be filled, known volume changes, planned recruitments, changes in service offerings, department consolidations, cost reduction targets and position eliminations. Current salary rates, shift differentials and on call payments are then applied to the FTEs (mid-point of the salary range is used for vacant positions) to generate a total salary cost. That salary cost is then adjusted for known or planned salary increases to occur in the current year that are not reflected in the October to January base period.

Add Benefits and Inflation: We develop our benefits budget line by line (health, dental, life, vacation, retirement, etc.) based on the number of FTEs in the budget, plus projected household members who will also be covered by UVM Health Network benefits. Applying inflation factors is the last step in developing the labor expense budget.

The inflation factors consist of known position-specific increases, such as negotiated union contract increases and market surveys that require salary adjustments and a general merit/cost of living increase for all other positions. For the FY26 budget, the staff labor expense inflation factor for UVM Medical Center is 4.5% (driving the higher than benchmark increases at UVM Medical Center are existing and expected union contracts). Contracted labor pay rate increases of 5% account for almost $21M of increased expense and required offsets in other expense areas to remain within the budget guidance expense cap of 3%.

		FY26 Budget		
Union Category	**Contracted Incr for FY26**	**FTEs**	**Salary Expense**	**FTEs as % of Total**
VFNHP Nurses	5.0%	1,712.40	$ 209,171,064	22.4%
VFNHP Technical	5.0%	827.80	$ 70,132,697	10.8%
AFTVT Support	5.0%	1,882.50	$ 120,013,889	24.7%
CIR SEIU	5.0%	373.30	$ 31,145,123	4.9%
Subtotal - Union	5.0%	4,796.00	$ 430,462,773	62.8%
Other Non-Union*	5.0%	2,839.70	$ 350,736,775	37.2%
Total		**7,635.70**	**$ 781,199,548**	**100.0%**
*Not contracted				

We are budgeting a reduction from FY25 budget in traveler FTEs of (117) and cost reduction of $19.7M.

Traveler Type	FY24 Actual	FY25 Budget	FY25 YTD May	FY26 Budget
Staff Nurse	260.5	197.4	150.2	83.9
Tech	59.6	47.0	57.9	48.9
Respiratory Therapist	12.7	9.0	14.0	9.0
Other (LNA, Phlebotomy, PT)	37.3	8.5	17.6	3.0
Total	**370.2**	**261.9**	**239.6**	**144.8**

DIVISION	TRAVELERS AS % of TOTAL FTES			TRAVELERS AS % of TOTAL STAFF SALARIES		
	FY25 Budget	FY25 YTD Apr Act	FY26 Budget	FY25 Budget	FY25 YTD Apr Act	FY26 Budget
Perioperative Services	14.7%	15.5%	12.9%	25.0%	27.8%	21.7%
HS Emergency Med	19.4%	15.0%	11.9%	34.8%	29.2%	24.4%
Nursing - Med Surg and Specialties	10.2%	6.7%	2.9%	17.2%	13.6%	6.2%
HS Radiology	4.3%	8.8%	4.4%	8.3%	18.3%	9.9%
Respiratory Therapy	11.9%	19.0%	12.1%	19.4%	31.9%	20.8%
Renal Services	8.1%	7.5%	7.5%	13.8%	12.9%	11.9%
Nursing - Critical Care	9.0%	4.7%	2.9%	15.2%	8.6%	5.3%
MG Anesthesiology Dept	0.0%	3.9%	5.0%	0.0%	12.2%	14.6%
Cardiology	2.0%	3.0%	2.0%	3.8%	6.5%	3.5%
Endoscopy	10.5%	10.1%	5.3%	16.8%	15.0%	8.1%
Nursing - IV Therapy	19.3%	10.7%	8.7%	20.1%	15.0%	12.6%
Nursing - IP Mental Health	9.7%	6.7%	1.1%	15.6%	12.4%	2.3%

		Appendix U1: FTEs FY25 Budget To FY26 Budget							
		FTES				SALARIES			
		FY25 Bud Total	FY26 Bud Total	Variance Amount	Variance %	FY25 Bud Total	FY26 Bud Total	Variance Amount	Variance %
TOTAL SALARIES / FTES		**8,277**	**8,348**	**(71.1)**	**-0.9%**	**1,022,148,936**	**1,063,507,384**	**(41,358,449)**	**-4.0%**
TOTAL PHYSICIAN	**Clinical**	**713.9**	**712.3**	**1.6**	**0.2%**	**240,027,116**	**252,108,174**	**(12,081,058)**	**-5.0%**
Physicians	**Clinical**	711.7	706.4	5.3	0.7%	236,467,541	249,769,549	(13,302,008)	-5.6%
Locums	**Clinical**	2.1	5.9	(3.7)	######	3,559,575	2,338,625	1,220,950	34.3%
TOTAL STAFF		**7,563.0**	**7,635.7**	**(72.7)**	**-1.0%**	**752,192,549**	**781,199,548**	**(29,006,999)**	**-3.9%**
Resident	**Clinical**	369.8	374.3	(4.4)	-1.2%	29,675,192	31,230,240	(1,555,048)	-5.2%
APP	**Clinical**	313.7	306.5	7.3	2.3%	46,672,010	49,609,583	(2,937,574)	-6.3%
Traveler	**Clinical**	261.9	147.8	114.1	43.6%	49,844,192	31,971,096	17,873,095	35.9%
RN	**Clinical**	1,476.7	1,586.6	(109.9)	-7.4%	175,459,922	190,808,800	(15,348,878)	-8.7%
LPN	**Clinical**	67.3	58.8	8.6	12.7%	5,682,546	5,253,237	429,310	7.6%
Tech	**Clinical**	613.5	607.0	6.5	1.1%	54,300,481	55,781,896	(1,481,415)	-2.7%
Other Clinical	**Clinical**	1,625.2	1,661.3	(36.1)	-2.2%	127,126,212	135,938,398	(8,812,186)	-6.9%
Management	Non-Clinical**	619.0	617.3	1.8	0.3%	97,591,195	101,629,664	(4,038,469)	-4.1%
Staff Other	Non-Clinical**	2,215.7	2,276.3	(60.5)	-2.7%	165,840,800	178,976,633	(13,135,833)	-7.9%
TOTAL STAFF OTHER	Non-Clinical**	-	-	-	**0.0%**	**9,709,278**	**6,031,021**	**3,678,257**	**37.9%**
TOTAL PHYSICIAN OTHER	Non-Clinical**	-	-	-	**0.0%**	**20,219,993**	**24,168,641**	**(3,948,648)**	**-19.5%**
Clinical FTEs *		5,442	5,454	(12)	-0.2%	728,787,670	752,701,425	(23,913,755)	-0.0328
Clinical %		65.75%	65.34%	0.41%	0.6%	71.30%	70.78%	0.52%	0.7%

** Clinical FTEs incl total paid FTEs for job classifications Resident, APP, Traveler, RN, LPN, Tech, Other Clinical, & Phys. This total incl non-productive and admin time.*

*** While classified as Non-clinical, some may have clinical duties.*

	Appendix U1: FTEs FY25 Budget To FY26 Budget							
	FTES				SALARIES			
	FY25 Bud	FY26 Bud	Variance		FY25 Bud	FY26 Bud	Variance	
	Total	Total	Amount	%	Total	Total	Amount	%
Management	**619.0**	**617.3**	**1.8**	**0.3%**	**97,591,195**	**101,629,664**	**(4,038,469)**	**-4.1%**
Senior Leader	17.0	16.0	1.0	5.9%	9,246,402	9,615,937	(369,535)	-4.0%
VP	38.5	39.4	(0.9)	-2.3%	12,185,479	13,017,603	(832,124)	-6.8%
AVP	11.0	9.0	2.0	18.2%	2,433,115	2,081,263	351,852	14.5%
Director	127.0	126.7	0.3	0.2%	23,197,229	23,760,393	(563,164)	-2.4%
Manager	188.1	185.8	2.2	1.2%	25,541,876	26,276,796	(734,920)	-2.9%
Supervisor	237.5	240.4	(2.8)	-1.2%	24,987,093	26,877,672	(1,890,578)	-7.6%

b. Utilization. Explain and quantify any anticipated changes in utilization across care settings (e.g. inpatient/outpatient), or any other expected deviations from historical trends. Indicate the method(s) used to derive utilization changes in proposed budgets. If utilization assumptions include increases associated with hiring additional staff or other capacity changes, provide evidence to support estimated impact on utilization. Any referenced impact to net revenue should tie to the submitted Rate Decomposition worksheet.

As noted in our monthly submissions to GMCB staff, we continue to see increased demand for services, specifically in Interventional Radiology, Mammography, Ultrasound, Cath Lab, Electrophysiology and Radiation Oncology. This necessitates contracted staffing to meet patients' needs and ensure access to critical diagnostic services. Below is the total NPR related to utilization. The larger NPR table contains more detail by payer.

NPR	Total
FY2025/FY2026 Utilization	
All Payers	$ 76,101,037
Denials	$ (1,859,271)
Bad Debt	$ (2,602,412)
Charity	$ (2,049,205)
Provider Transfer (offset by rate reduction of $21.8M)	$ 42,055,570
Other Initiatives	$ -
Total FY2025/FY2026 Utilization Impact	**$ 111,645,720**

Note: The NPR in chart above only demonstrates NPR related to utilization – it is further reduced by rate and is reflected in the full NPR chart.

Method: As we do for all components of the budget, for utilization (i.e. volume), we start with volume levels from the October to January period, and from there we add or subtract volume for new recruits, departures, new equipment, access initiatives and seasonal factors that we know are not present in the October to January base. The key volume metrics we budget for individually that drive the gross revenue budget (revenue before deductions are applied) are inpatient admissions and discharges, ED visits, inpatient days, OR cases, professional work RVUs, radiology exams (MRI, CT, nuclear medicine, mammography, ultrasound, diagnostic), catheterization lab procedures, electrophysiology lab procedures, endoscopy procedures, radiation oncology procedures, lab tests and pharmaceuticals.

Volume Metric	FY24 Actual	FY25 Budget	FY25 Anlzd YTD Apr	FY26 Budget	% Chng Bud to Bud
Total ED Visits	69,772	69,415	69,790	70,487	1.5%
MG Professional Worked RVUs (including Anes)	3,552,793	3,673,563	3,637,996	3,870,597	5.4%
Total OR Cases	21,908	21,804	21,816	21,558	-1.1%
Total Cath Lab	5,437	5,502	5,758	5,671	3.1%
Total EP	2,440	2,311	2,391	2,458	6.4%
Total GI/Endoscopy	10,685	14,593	12,650	12,084	-17.2%
Total MRI	25,854	24,818	26,222	26,303	6.0%
Total CT Scan	76,837	73,328	75,314	75,493	3.0%
Total Ultrasound	36,319	35,228	38,122	37,524	6.5%
Total Mammography	66,562	68,891	70,860	68,891	0.0%
Total Pharmacy Doses	3,303,461	3,157,447	3,091,668	3,257,907	3.2%

c. Pharmaceutical expenses. Explain assumptions regarding growth due to price from volume, or product mix. Please estimate reimbursements received in excess of the cost of pharmaceuticals (FY24 actuals, FY25 budget and projection, and FY26 proposed budget), noting how you arrived at those estimates.

Growth Assumptions

We use October to January as the base, and from there we adjust for known volume changes and planned introduction of new drugs. Adjustments for new drugs that typically have a material impact on the budget are for chemotherapy treatments. From this FY26 base amount, we then apply inflation factors. In the FY26 budget, the inflation factor for pharmaceuticals is 5%. As shown in the charts below, drug costs continue to increase at a faster pace than volumes, driven by drug mix and unit costs.

Reimbursement vs. Expense Outpatient

In the hospital outpatient setting, we do not budget for gross margin, just Gross Patient Service Revenue (GPSR) based on volume and drug mix. We report the expense for these drugs as part of hospital operating expenses, but these are not split out at the level of detail being requested here. Similarly, we do not split out drug revenue from other lines of revenue, in part because drug revenue often comes from multiple sources. Because of the integrated nature of reporting revenue for drugs delivered in the outpatient setting, it is not possible, based on how this information is reported in budget information today, to determine a precise "margin" for these drugs specifically. We do, however, have a tool that captures reimbursement from our remittance files and associates a drug purchase with the charge. Please see the table below. Please note that this information is imprecise and incomplete – for example, "drug cost" does not include any expenses related to the administration of the drug, such as labor, or supply costs.

	FY24		
	Reimbursement	Drug Cost	Reimbursement Less Drug Cost
UVMMC	$ 166,557,016	$ 103,501,917	$ 63,055,099

Reimbursement vs. Expense Inpatient
The cost of drugs administered in the inpatient setting depends on the terms of the contract with the source of the medication. Reimbursement for drugs administered in the inpatient setting is driven by the terms of a patient's medical benefits and the terms of our participation agreements with payers. Most of UVM Medical Center's major commercial payers reimburse for inpatient services on a case rate/DRG basis, meaning that we do not typically receive a line-item reimbursement for drugs administered in this setting. As such, it is not possible, based on how this information is reported in the budget today, to determine a "margin" for these drugs specifically. That said, we are willing to work with the GMCB to create an agreed-upon approach moving forward to get to the information the GMCB is seeking.

Retail and Contract Pharmacy
Retail pharmacy is reported separately as "other revenue," and the expense is reported as cost of goods sold under "retail pharmacy expense." Revenue, price paid to the pharmacy, is determined by the Pharmacy Services Administration Organization contracted terms with Pharmacy Benefit Managers (PBMs), which is largely the industry standard. Pharmacies are frequently underpaid by PBMs for the medications they dispense, and that is the primary reason why even some of the large retail pharmacy stores (e.g. Rite Aid) are going out of business in Vermont. UVM Health Network pharmacies are gaining patients from the stores that are closing in the Burlington health service area, and our pharmacies are staying solvent due to participation in the 340B prescription drug pricing program. Our outpatient pharmacy allows those health care dollars to stay in our system and be reinvested into the care of our patients.

Pricing for retail pharmacy medications are not included in the hospital pharmacy chargemaster. Claims for retail prescriptions are adjudicated through the PBM using the pharmacy information system, McKesson EnterpriseRx. The price paid by the patient is determined by the PBM and plan sponsor. The patient out of pocket expense should be the same irrespective of the dispensing pharmacy (e.g. co-pay or co-insurance) if the pharmacy is included in the PBM network.

UVMMC	FY24 Actual	FY25 Budget	FY25 Anlzd YTD May	FY26 Budget
Retail Pharmacy Expense				
Non 340B COGS	87,080,299	93,612,295	103,881,223	100,049,957
340B COGS	109,309,603	122,065,982	130,510,172	128,529,521
Total	**196,389,902**	**215,678,278**	**234,391,395**	**228,579,478**
Pharmaceuticals				
IP Non Chemo Pharmaceuticals	87,151,532	79,154,077	93,566,788	97,678,275
IP Chemo Drugs	57,272,619	55,309,118	62,107,531	62,755,769
Total	**144,424,150**	**134,463,196**	**155,674,319**	**160,434,044**

UVMMC	FY24 Actual	FY25 Budget	FY25 Anlzd YTD May	FY26 Budget
Pharmacy Volumes				
Total Pharmacy Doses	3,303,461	3,157,447	3,093,807	3,257,907
Total Pharmacy Prescriptions	494,868	484,803	554,112	537,929

For more information related to the 340B program and pricing, please refer to the 340B Supplement section of the budget narrative.

d. Case Mix Index (CMI). Explain any expected substantive changes in CMI by Payer, providing evidence to justify anticipated changes. i. Quantify any impacts on your budget by payer.

As we have partnered with post-acute services such as home health, skilled nursing facilities and hospice to find appropriate discharge options for non-acute patients starting at the end of FY24 and throughout FY25, we have seen our CMI increase. This is due to the prior CMI dilution from the low acuity of those patients. We only track CMI by Medicare separately.

UVMMC	FY25 Budget	FY25 Anlzd YTD Jan	FY25 Anlzd YTD Apr	FY26 Budget
CMI - All payers	1.89	1.91	1.92	1.92
CMI - Medicare Only	2.15	2.16	2.18	2.18

e. Rate Changes by Payer. Explain any assumptions related to rate changes for Medicare, Medicare Advantage, Medicaid (e.g. In State/Out of State), and Commercial Payers overall and by setting of care (inpatient, outpatient, professional services). This should align with the rate decomposition worksheet.

Medicare/Medicare Advantage assumptions were based on the latest proposed IPPS rule published in late April. The wage index change was the biggest driver for IP/OP. No assumed Medicaid changes (in or out of state). The commercial increase was determined by the 3% guidance for the F26 budget slightly offsetting the H.266 impact.

	Inpatient	Outpatient	Professional
Medicare	5.79%	5.90%	1.30%
Medicare Advantage	5.79%	5.90%	1.30%
Medicaid	0.00%	0.00%	0.00%
Major Commercial*	0.40%	-12.60%	-3.50%

**Major Commercial total (7.9%) includes Bad Debt/Free Care, as reflected in the rate decomposition sheet.*

f. Financial indicators. Explain any changes (key drivers) to your Operating Margin, Days Cash on Hand, and Debt Service Coverage Ratio relative to your FY25 projections, as well as any other key financial indicators that are important to consider in relation to your budget request.

While these represent the calculated financial indicators for UVM Medical Center, it is important to note that for bond agency rating assessments and annual bank and debt covenant testing thresholds, these financial indicators are calculated at the system level, rather than individual hospitals.

UVM Medical Center

	FY25 Budget	FY25 Projection	FY26 Budget
Operating Margin	2.98%	2.72%	2.98%
Days Cash on Hand	123.9	127.8	134.4
Debt Service Coverage Ratio	5.2	4.5	4.6

g. Uncompensated care. Differentiate any assumptions/changes as they relate to exogenous trends (e.g. patient needs) or internal practices (e.g. changes in accounting or business processes) related to bad debt and free care. Please include a description of collection processes. Report your budgeted bad debt to free care ratio and how you derived your estimates for bad debt and free care.

Any changes in trends are related to previous actual experiences. We use previous actual experiences to model future impacts for current services provided. As actual experiences fluctuate, the model is updated to reflect changes in previous actual experiences to estimate future impacts. Bad debt and free care are tracked, monitored and estimated as a percentage of gross revenue.

UVM Medical Center has updated its financial assistance policy to align with Vermont's Act 119 requirements. This includes expanding income eligibility, making more patients eligible for help. As a result, the percentage of free care provided – measured against Gross Revenue – has increased.

Standard collection process: Guarantors are billed monthly on a 28-day cycle for all self-pay balances deemed to be their responsibility. Guarantors receive a total of six statements over 180 days. Patients are provided with options for financial assistance, payment plans and any other applicable resources. If payment is not received after 180 days, accounts are referred to a third-party collection agency for follow

up, but per our longstanding practice, these accounts are not shared with credit reporting agencies.

Below are the trends used to inform the FY26 budget. Our FY26 budget does not take into account potential changes at the federal or state levels regarding Medicaid.

UVMMC	FY24 Actual	FY25 Budget	FY25 Anlzd YTD May	FY26 Budget
Bad Debt as a % of Gross Revenue	0.99%	1.03%	0.76%	0.77%
Free Care as a % of Gross Revenue	0.66%	0.80%	0.90%	0.97%
Total Bad Debt + Free Care as a % of Gross Revenue	1.65%	1.82%	1.65%	1.74%

h. Community Benefit. Differentiate between the various drivers of community benefit.

	FY23 Net community benefit expense	Prior Year Net community benefit Expense
Financial Assistance at cost	12,039,460	13,232,387
Medicaid	213,720,229	175,687,994
Cost of other means-tested government programs		
Total Financial Assistance and Means-Tested Government Programs	**225,759,689**	**188,920,381**
Community health improvement services and community benefit operations	4,609,095	3,803,098
Health professions education	9,899,531	26,388,518
Subsidized health services	50,387,562	57,375,512
Research	250,000	
Cash and in-kind contributions for community benefit	2,530,157	2,645,594
Total Other Benefits	**67,676,345**	**90,212,722**
Total	**293,436,034**	**279,133,103**

Note: We are providing FY23 numbers, as this information is tabulated for our 990 submission which is still in progress.

The largest drivers of net community benefit expense are: Medicaid, subsidized health services and financial assistance.

Community health improvement services and discretionary community benefit expenses are focused on areas identified in our Community Health Needs Assessment, developed in partnership with our community. They include:

- Mental health and wellbeing
- Housing
- Cultural humility and health care

Work on these priorities is performed in partnership with nonprofit organizations and residents within our catchment areas.

i. List any other factors not included above that may be material to your budget along with supporting material. This includes any assumptions that are uncertain but could have a potential budgetary impact. For such assumptions that are not reflected in your budget, quantify the range of potential impact.

Please see below for the list of uncertain assumptions that could potentially impact our budget.

e) Briefly summarize known risks in the budget as submitted, including the potential impact of and any known timelines associated with the risk, as well as any risk mitigation efforts, and their cost or potential benefit.

Below are the uncertain items that could impact our budget. We are not able to quantify the impact these might have. If any of these items negatively impact our finances, we would seek ways to offset them with additional cost reductions to maintain the margin we have budgeted. We need those resources to reinvest in our rapidly aging facilities and equipment, or we will need to further restrict our planned capital spend, as our already low days cash on hand (DCOH) cannot absorb any further deterioration.

In light of the federal government's current deliberations on the *One Big Beautiful Bill Act*, we recognize the potential for significant impacts on the people we serve – chiefly lower-income, vulnerable populations – as well as health care funding streams that support our operations, either directly or indirectly. While our submitted budget reflects current funding levels, several key areas present notable risks:

- **Medicaid funding:** Potential changes to Medicaid reimbursement rates or eligibility criteria could materially impact our revenue. Even small changes to this program could result in a substantial impact on our budget. We are closely monitoring state and federal policy developments and engaging in advocacy efforts to mitigate this risk.
    - Medicaid work requirements and increased redeterminations resulting in increased self-pay / bad debt expense
    - Medicaid rate cuts
    - Reduction in FMAP and Directed Payments

- **Other risks:**
    - Expiration of Premium Tax Credits would lead to a significant reduction in commercially insured patients
    - Cuts to 340B program
    - Additional commercial rate cuts
- **Graduate Medical Education (GME) funding:** GME support remains a critical component of our academic mission and the care we provide. Any federal adjustments to GME allocations could affect our ability to sustain current residency and fellowship programs. As the program that administers medical residents and fellows, the GME program is an important part of our care delivery and supports more affordable care.
- **Potential tariffs and other unknown inflation factors:** May have a post-budget impact unknown at the time of submission.

We will continue to monitor these risks closely and adjust our mitigation strategies as more information becomes available.

f) Administrative vs. Clinical Expenses: using the Medicare Cost Report definition of administrative, clinical, and mixed expenses in Wang & Bai (2023)1, also defined in the Uniform Reporting Manual, please comment on the relative trends in each of these expense categories over time.

Due to the legal structure of UVM Health Network, most shared services salaries and expenses are initially recorded on UVM Medical Center's hospital Medicare cost report, before being removed via cost report adjustments in accordance with the Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Hospital & Hospital Health Care (Form CMS 2552-10).

UVM Medical Center's administrative and clinical labor expenses per adjusted discharge (after removing the shared services expense allocated to other partners within our system) based on Medicare cost report data are trending as follows over the last three years:

	FY22	FY23	FY24
Direct Patient Care Labor Costs	$ 10,021	$ 10,068	$ 10,002
Non-Patient Labor Costs	$ 4,861	$ 4,085	$ 4,611
Management & Administrative Labor Costs	$ 2,382	$ 1,462	$ 1,640

g) Does your budget increase request consider consumer affordability, and if so, how?

We recognize that the status quo of health care is unaffordable for the Vermonters who rely on us. We hear from our patients how the rising cost of living, including health care costs and the shortage of affordable housing and childcare options, are making it more difficult to live in our state.

We know we must think differently about how we operate as a unified health system and act with more determination than ever before to make health care more affordable. To be clear, we have not yet fully realized the benefits of our rural academic health system. We know that by sharing common goals and resources, we can work smarter and deliver high-quality medicine that is more affordable and responsive

to our patients' needs.

Our FY26 budgets reflect our work to adapt, innovate and lead to improve the value of health care we provide. Our budgets support the advancement of three overarching goals:

- Provide high-quality care to our patients to drive outcomes toward top quartile performance.
- Accelerate our efforts to address the rising cost of health care in our region.
- Invest in maintaining or improving access to care, focusing on outpatient care and telehealth.

Further, as part of UVM Medical Center's April 2025 settlement agreement with the GMCB to submit compliant budgets, we undertook further comprehensive reviews of our operational and administrative expenses. We challenged ourselves and our teams to find new opportunities to reduce costs while protecting clinical services. We do not take these decisions lightly, but there is no alternative if we are to remain sustainable and serve future generations of Vermonters and meaningfully do our part to address health care affordability in our state.

h) Describe planned fundraising efforts and anticipated donations for FY26.

At UVM Medical Center, we estimate that in FY26 we will receive donations totaling $6M. Priority areas include workforce development, patient and family support funds, programs within the UVM Children's Hospital and UVM Cancer Center and enhancements to our aging facilities and equipment. Should the Outpatient Surgery Center move forward, it will be a priority fundraising effort for FY26, which will increase our estimated donations.

i) Has your hospital experienced a reduction in payment from any payer based on quality performance in the last two years? If so, please explain the nature of the penalty, the revenue impact, and steps taken to remediate the situation.

2024	
Adjustment Category	**Amount**
Readmission	$(152,391.23)
VBP	$(133,134.76)
HAC	$(1,475,132.59)
Total	**$(1,760,658.58)**

Hospital Acquired Conditions
In 2024, UVM Medical Center received a penalty for Hospital Acquired Conditions (HACs) for the first time. This penalty was based on performance during calendar year 2022 (data from 2021 was not used in this calculation due to ongoing stress on hospitals emerging from the pandemic). While it is not straightforward to predict whether UVM Medical Center will have a penalty in any given year since the threshold changes based on cohort performance, UVM Medical Center had already identified the issue and initiated performance improvement work well before being informed of this penalty.

Interventions:

- Leveraging our relationship with the medical school, reference librarians were used to validate that our current protocols followed evidence-based best practice.
- Working collaboratively with unit staff to identify barriers to implementing current protocols to reduce HACs (Lean methodology).
- Iteratively reinforcing best practice strategies via protocols, policy, education and training.
- Re-organizing committee structures to better align work across accountable team members by refocusing on data driven analysis to create more timely response to performance changes.
- Introducing leader sweeps, where unit leaders evaluate quality control daily by identifying at-risk patients to validate that care delivery is compliant with best practice and complete real-time recovery when gaps in care are identified.
- Implementing senior leader rounds and sweeps in a way that increases visibility and allows bedside clinical staff to feel both supported and accountable to delivering high quality and safe patient care.

Through this work, we are seeing improved outcomes with an overall decrease in HACs compared to 2022 and 2023 outcomes data, which moves us toward our goal of achieving and sustaining performance in the best quartile of comparable academic medical centers. There is a two-to-three-year lag between performance and penalty, therefore data from current improvement work will likely not mitigate the penalty until 2028; the penalty will likely be enforced for the next two years regardless of our quality improvement efforts.

Readmission Reduction
While UVM Medical Center has traditionally had a low readmission rate compared to our peers, there are certain diagnoses that have a higher than target readmission rate, most notably patients with congestive heart failure. The Population Health Services Organization (PHSO) within UVM Health Network is currently working on care pathways for congestive heart failure and other higher risk diagnoses that lead to higher-than-expected rates of readmissions. The goal is to ensure these patients have adequate follow-up after their hospitalization and that patients are able to comply with their care plan. These pathways will also allow us to detect any unexpected worsening of the patient's condition and intervene before they require readmission. In addition, we will use our data management office to analyze the readmission data in greater detail and direct further improvements in care pathways, both while in the hospital and after discharge.

j) Describe the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors, residency programs, and any other workforce development initiatives in which you are participating. Include a description of the program and where the accounting entries show up in your proposed budget (income statement and balance sheet).

UVM Health Network and UVM Medical Center continue to generate innovative solutions to train community members and our workforce for in-demand positions across our system. This includes internal training programs and partnerships with colleges in Vermont and nationally. These initiatives are key to harmonizing existing programs and creating scalable, sustainable workforce solutions across the health system, while preparing for projected national staffing shortages. By doing so, we immediately reduce our dependence on costly temporary labor, improve patient access and care and benefit Vermont's broader health care system.

Program Name	Program Description	Annual UVMMC Participation	Budget Line Item
Nursing			
LPN to RN Pathway	Paid study time and tuition to become RNs in partnership with Vermont State University.	43	Benefits for Tuition and Salaries for paid study time
Accelerated Bachelor of Nursing (ABSN) Pathway	18-month accelerated RN degree in partnership with AHS and Norwich University.	8	Tuition flows through Benefits category
Master of Science in Nursing Pathway	MSN for nurses, in exchange for service as faculty in partnership with AHS, Vermont State University and Norwich University.	22	Tuition flows through Benefits category
RN to BSN Program	100% BSN tuition benefit. Increasing the number of baccalaureate prepared nurses improves quality of care and patient outcomes, which reduces the cost of care.		Tuition flows through Benefits category
Nurse Assistant Training	LNA training	120	Purchased Services – Professional
New-Grad Nurse Residency	12-month residency; 96 hour dedicated training time	120-150	Purchased Services – Professional Salaries Other expenses
Student Nurse Preceptor Incentive	Hourly pay for teaching students	Varies	Salaries
Technologists			
Phlebotomy Apprenticeship	Phlebotomy apprenticeship program	22	Purchased Services – Professional
Dialysis Tech Training	12-week dialysis tech training	10	Salaries
Additional Initiatives			

Pathfinder Program	Prepays prerequisites for health care degrees	20	Purchased Services – Professional
English Language Learning	English as a second language classes for staff	32	Purchased Service – Other
Project SEARCH	Internships for youth with disabilities	7	Salaries
	TOTALS	**434**	

k) Please describe the hospital's investments in workforce retention such as housing, day care, and other employee benefits. Include a description of the program and where the associated accounting entries show up in your proposed budget (income statement and balance sheet).

Housing
In alignment with strategies across UVM Health Network, UVM Medical Center has made investments in three residential apartment buildings with a total of 227 apartments in South Burlington City Center. Two buildings are fully leased, and the third is currently under construction. UVM Medical Center holds a lease for the entire property, which is offset by rent paid by employees (with the exception of rental subsidies furnished by the organization). This cost allows us to recruit and retain employees, which reduces our reliance on higher cost contract labor. Accounting entry is through our fringe benefits category.

Childcare
UVM Medical Center has continued our partnership with the YMCA for subsidized childcare, and we provide the facility for the delivery of that care. We have also developed a new relationship with Chittenden County nonprofit One Arts for an additional subsidized childcare facility within South Burlington City Center, which opened its doors in June 2025. Accounting entry is through our fringe benefits category.

UVM Medical Center continues to absorb the employee share of the Child Care Contribution that was enacted in July 2024 for FY26. Accounting entry is through our fringe benefits category.

Education and Workforce Development
We provide tuition reimbursement for all eligible staff based on years of service. Accounting entry is through our fringe benefits category.

While Workforce Development is mentioned above, it is important to note that it provides career pathways to existing employees and directly contributes to retention of those employees.

Wellness Program and Human Resource Programs
UVM Medical Center offers extensive wellness programming for physical and mental wellbeing. Using philanthropic funds, we are piloting a staff pet therapy program and have opened a dedicated staff wellness space on the main campus.

We also offer in-person and online EFAP options for our team.

These expenses are reflected in the UVM Medical Center areas of fringe expenses, lease and rental expense, facility and equipment maintenance and repairs and utilities. Any revenue will be seen in Other Revenue.

Other highlights include:

- A milestone recognition program for employees at five-year increments.
- The philanthropically funded LeRoyer fund that provides small interest free loans and grants to employees.
- Our Working Bridges partnership with the United Way, which provides extensive social supports for our employees.

The housing and childcare initiatives in Chittenden County, made possible through partnerships between UVM Health Network and locally based organizations, are available to all system employees.

l) For what drivers of expense growth do you feel hospitals should be "held harmless" and why? For any identified drivers reference the amount and account code in adaptive where those expenses are allocated.

Not applicable. UVM Medical Center has submitted a compliant budget for FY26.

D. Hospital & Health System Improvement

a) Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, please share any investments you are making and/or the steps you are taking to improve access in each of those areas, with specific ties to your budget, where appropriate.

1. Primary and Ambulatory Care Access

UVM Medical Center continues to empanel additional patients in primary care, expand electronic consults, build enhanced referrals and make sure all clinics schedules are available for a minimum of 13 months. Additionally, there has been significant work performed in the FY26 budget process to improve the accounting of clinical FTE as it relates to a physician or APP's effort. Below are a few highlights:

Primary Care

Our primary care providers have completed the transition away from tracking "productivity" via wRVUs and instead work within a "risk-adjusted panel size model." This, coupled with operational improvements, such as standardized schedules, has allowed UVM Medical Center to create more access to primary care providers. At the end of May 2025, UVM Medical Center has added 1,758 patients to primary care over FY25.

Specialty Care

- **e-Consults:** As of the end of May, UVM Medical Center clinicians have performed 2,451 electronic consults in FY25. This is an increase of 10.3% as compared to the same time last year.

- **Schedule standardization:** UVM Medical Center will continue this work over FY26, leading to the implementation of digital tools, many of which may improve access to care. An example is the opportunity for a patient to cancel and reschedule their own appointments via the patient portal.

Population Health Services Organization

UVM Health Network continues to invest in the PHSO to support access and equity across our health system. Examples include diabetes management support, nurse-led Medicare Annual Wellness Visits and centralized post-discharge follow-up to ensure timely and appropriate care. The care management team handles 700–1,000 unique referrals monthly.

Blueprint for Health

This helps to integrate mental health and substance use services into primary care and funds community health workers.

2. Mental Health Access

- **Chittenden County Mental Health Urgent Care**: Operated by Howard Center and financially supported by our system; opened October 28, 2024.
- **Suicide Care Clinic**: Expected opening fall/winter 2025 with philanthropic support already in place.
- **Primary Care Mental Health Integration (PCMHI)**: Continued implementation and optimization across Vermont and New York clinics, with plans to share best practices with non-UVM Health Network practices. We have seen ED usage decrease due to this work.
- **Emergency Psychiatry Services**: Enhanced coverage at UVM Medical Center from 8am–8pm, 7 days/week.
- **Telehealth ED Consultations**: In development to expand access.
- **Neuromodulation Services**: Planning for ECT, TMS and ketamine/esketamine treatments.
- **Continuum of Care Staffing**: Sustained staffing for inpatient psychiatry, ED psychiatry (UVM Medical Center and Central Vermont Medical Center) and outpatient programs (Seneca, PHP, Mood and Anxiety).

3. Substance Use Disorder Access

- **Addiction Treatment Center**: Consolidation of services (Addiction Treatment Program and Day One) to streamline referrals and reduce barriers.
    - Open referral process (self, family, provider, community)
    - Single intake screening
    - Minimal wait times (typically within one week for clinician, one to two weeks for MD)
- **STAR Program**: ED-initiated rapid access to medications for opioid use disorder (MOUD) with next-business-day clinician and MD visits.

- **Contingency Management**: Now offered for stimulant use disorder, supported by full-time RN staffing.
- **Low-Barrier Services**: Maintained at the Addiction Treatment Program.

4. Long Term Care

- **SNF agreement**: A long-term investment in a local nursing home to support the ability of the Skilled Nursing Center operator to take patients whose care needs require resources above and beyond that which is typical for a long-term care client.
- **Longitudinal Care Program**: A community-based program operated by UVM Health Network Home Health & Hospice that supports people with complex medical needs, a high degree of health-related social needs and who lack family or informal social support systems to enable them to remain independent in their homes. UVM Medical Center provides funding toward the operation of this program that serves more than 35 people on average.
- **McClure Miller Respite House**: Vermont's only Medicare certified inpatient hospice home receives funding from UVM Medical Center to offset losses associated with patients who are transferred to McClure Miller Respite House from the hospital for hospice care.
- **Harbor Place**: UVM Medical Center provides funding to support the availability of beds that are used for patients who are discharged from the hospital but do not have a safe or suitable location to go to recover from their injury, illness or chronic conditions.

b) Describe how you work with other providers in your community, including the FQHC, designated agencies, other community-based services etc., being sure to include opportunities and obstacles to ensuring smooth transitions of care along the care continuum.

Centralized Blueprint Team
UVM Health Network partners with Blueprint for Health to administer programs across the three Vermont health service areas (HSAs) we serve – Burlington, Barre, and Middlebury. In each HSA, our system leverages Blueprint resources to support community collaboratives, offer community health team services and facilitate Patient-Centered Medical Home (PCMH) accreditation. Each area is also supported by a dedicated Blueprint-funded UVM Health Network quality improvement facilitator who brings expertise in PCMH care and guides continuous improvement efforts for both UVM Health Network and independent primary care practices.

In 2024, UVM Health Network established a centralized team within its PHSO to enhance coordination with independent primary care practices, designated agencies, Federally Qualified Health Centers (FQHCs) and other community-based services through our partnership with Blueprint for Health. This centralized structure enables operational efficiencies, promotes shared learning and ensures fiscal and programmatic alignment across HSAs. Additionally, it allows UVM Health Network to create robust relationships with partners in independent primary care. The PHSO also provides the infrastructure to support data-informed decision-making within local community collaboratives such as CACH in Burlington, THRIVE in Barre and CHAT in Middlebury. Through this model, UVM Health Network strengthens community partnerships, supports PCMH accreditation, and deploys community health team members to ensure patients receive coordinated, person-centered care and timely access to community resources.

Additionally, UVM Health Network facilitates access for community providers to EpicCare Link. This provides a much-needed care coordination tool for independent practices and enables timely access to critical information about the care of their attributed patients. In lieu of a statewide, or contracted, Admission, Discharge and Transfer (ADT) alert system, EpicCare Link has become the primary tool for enabling community providers to engage their patients in timely post-discharge follow-up care. This is a key function of improving acute care utilization patterns and reducing readmissions.

WRAP

With the expansion of the Working to Reduce Admissions Program (WRAP) Network Program to UVM Medical Center, Central Vermont Medical Center and Porter, our care managers have tackled some of the region's most complex patient scenarios. Reducing unnecessary utilization and readmissions is crucial, and our primary focus is connecting patients to longitudinal support in real-time. To achieve this, we have strengthened partnerships with designated mental health agencies, FQHCs, shelters, drop-in clinics and centers for Medications for Opioid Use Disorder (MOUD) treatment. Our strategy to enhance care transitions involves increasing WRAP care management visibility, leading to better treatment coordination and reduced duplication.

Recent efforts include weekly WRAP nurse care manager presence at COTS Day Station facilitating meetings with the Burlington Police Department and Howard Center Street Outreach and holding structured meetings with FQHCs, like Plainfield Health Center. Challenges include the lack of a centralized electronic medical record among community agencies, which hampers communication and can lead to duplication. To address this, we rely on recurring meetings to discuss mutual patients, create care plans and assign responsibilities. Additionally, our collaboration with Blueprint for Health has been vital in reducing duplication and addressing patient needs efficiently.

Mental Health and Housing

Our community partnerships with Howard Center, Community Health Centers and Pathways are vital in ensuring smooth transitions of care along the continuum. Through UVM Medical Center’s Mental Health & Housing Investment Committee, we support critical services for our most vulnerable patients, addressing housing instability and mental health needs. This includes contracts with local motels for medical respite, assistance with temporary housing through organizations like Champlain Housing Trust and partnerships with designated agencies for mental health outreach. We also collaborate with local primary care groups, invest in patient transport vendors and fund necessary home modifications to facilitate safe discharges.

However, we face obstacles such as limited access to medical records for patients managed by designated agencies, which delays planning and discharge. The availability of transitional and therapeutic housing options is also limited, and crisis stabilization services are scarce. Additionally, collaboration and communication with designated agencies can be slow, and financial approvals for long-term Medicaid often take time, even when information is provided promptly.

Peer Recovery Coaching

Launched in 2018, this initiative embeds Peer Recovery Coaches – individuals with lived experience in long-term recovery – directly in the ED to support patients struggling with substance use. These coaches provide immediate, compassionate support during moments of crisis, helping patients navigate treatment options, connect with community resources and begin their recovery journey. Their role extends beyond the hospital visit, offering ongoing encouragement through daily follow-ups and personalized guidance tailored to each individual's needs.

This partnership has proven to be highly effective. 83% of patients who engage with a Peer Recovery

Coach in the ED choose to continue services with the Turning Point Center after discharge.

The coaches serve as trusted allies, offering emotional support, advocacy and practical assistance with challenges such as housing, employment and mental health care. By bridging the gap between emergency care and long-term recovery, the program not only enhances patient outcomes but also strengthens the broader community response to addiction. It exemplifies how collaboration between health care institutions and peer-led organizations can create meaningful, lasting change in the lives of those affected by substance use disorders.

City Partnership

We also partner with the City of Burlington on many initiatives. Most recently, we assisted the Burlington Fire Department in launching the PREVENT Initiative, a pioneering program designed to reduce barriers to opioid addiction treatment by empowering first responders to administer buprenorphine – an FDA-approved medication for opioid use disorder – directly at the scene of an overdose. This initiative, the first of its kind in the nation to include both paramedics and advanced emergency medical technicians, allows approximately 80 Burlington EMS personnel to offer immediate treatment to individuals in crisis. By initiating care in the field, the program seeks to bridge the critical gap between overdose reversal and long-term recovery, especially as more individuals decline transport to EDs after being revived with naloxone.

c) Please describe your incoming & outgoing referral process in regards to providers outside of the hospital system. For an incoming referral from an outside provider - what is the process for continued treatment and care, once the patient has received referral care? For an outgoing referral, are there any methodologies in place to refer care outside of the hospital system to a private practice provider, particularly if there are wait times or more affordable options possibly available to the patient?

The community provider-to-UVM Health Network provider referral process is a structured communication and coordination pathway, ensuring patients receive specialized care when needed. Below is a step-by-step breakdown of how our referral process typically works from our community providers:

1. **Referral Initiation:** The referring physician sends a referral request form to the needed specialty department.

2. **Authorization:** Designated staff monitor the outgoing work queue to manage authorizations. Each order should be acted upon within three business days of receiving the order.

3. **Specialist Review and Scheduling**
   - The receiving specialist's office reviews the referral request, supporting clinical documentation and determines priority status.
   - The receiving specialist's office contacts the patient to schedule an appointment.
     a. The specialty office makes up to three attempts to reach the patient over a 10-day business period.

4. **Specialist Consultation or Procedure/Imaging/Test**
   - The patient sees the specialist, who evaluates the condition and may order further tests or begin treatment.
   - If for procedure, imaging, test, results routed to referring provider for review and additional evaluation determination.

5. Feedback to Referring Physician/Post-Appointment Follow-up

- The specialist sends a consultation note or summary back to the referring physician, detailing: diagnosis, treatment plan and follow-up recommendations.
    a. Clinical documentation is reviewed, and appropriate actions are taken as directed by the referring provider. The referral status is updated to "Specialty Report Received," closing the referral loop and removing it from the work queues. The expectation is to close the loop and send above within five business days to the referring provider's office.

When a UVM Health Network provider refers a patient to a non-UVM Health Network provider:

1. Placing the Order

- When a provider places an order for services to be performed at an outside organization, the class is marked as "External" in the Electronic Medical Record.
- Checkout staff review the order to determine if all external referrals have a "to provider" identified. If not, staff will ask the patient where they plan to go for the referral and enter the "to provider" information.

2. Managing the External Work Queue

- Designated staff track referrals for external providers, ensuring critical referrals are followed up. Staff contact the community provider/organization to request the date, provider, location and any additional comments about the appointment.
- Staff manually enter the external appointment details into the scheduling section of the referral and make multiple attempts to reach the patient or external provider to confirm the appointment. If unable to contact, the referral status is updated to "Unable to Contact," and the ordering provider is notified.

3. Follow up

- Staff follow up with the community provider's office to obtain the specialty report. If the report is received, the referral status is updated to "Specialty Report Received," completing the referral process.
- If no information is received from the community provider's office after multiple attempts, the supervisor will be notified for further action.
    - UVM Health Network staff will make up to three attempts to reach the community provider office over a 10-day period to obtain the notes.
        - If no information is received from the community provider office, a referral message to the ordering provider notifies them of our attempts.

Addressing Wait Times and Affordability

Providers are always welcome to refer a patient anywhere, external or internal to the hospital system. If there are shorter wait times or more affordable options available to our patient, staff may refer care outside of our system to a private practice provider. This involves identifying alternative providers who can offer timely and cost-effective care, which is not automated and can be a labor-intensive and inconsistent process.

Staff will communicate with the patient about these options and assist in coordinating the referral to ensure the patient's needs are met efficiently.

These processes are in place to ensure referrals, both incoming and outgoing, are managed efficiently, maintaining continuity of care and addressing patient needs promptly.

SECTION VI: HOSPITAL REPORTING REQUIREMENTS

1. FY2024 Medicare Cost Report (completed 4/1/25)
Submit a pdf of your full FY24 Medicare Cost Report as submitted to the Centers for Medicare and Medicaid Services (CMS).

2. Verification under Oath
Attestation to truth of filing on which the hospital Board, CEO and CFO, swears and affirms that the information provided is true and accurate to the best of their knowledge. The hospital should submit an individual document for each of these Executives.

3. Budget Narrative
For each hospital, submit a budget narrative (see Section V for specific requirements and questions to be answered).

4. FY2026 Budget Request
Each hospital must submit details of its budget request in the Adaptive database using the following Sheets. Projections for FY25 should also be provided in those same sheets. These Adaptive sheets are listed below in the most efficient order of completion since some accounts populate accounts in other sheets. More detailed definitions and requirements can be found in the Uniform Reporting Manual and Adaptive User Guide.

Hospital and Physician Revenue
The Hospital and Physician Revenue Sheet collects units of service and Net Patient Revenues and Fixed Prospective Payments, Reserves and Other Payments at the Department level.

Payer Revenue
The Payer Revenue sheet records Gross Patient Revenues and Deductions by Payer, where payer is broken by Medicaid, Traditional Medicare, and Commercial; and Commercial is broken out by Traditional Commercial, Medicare Advantage, Workers Comp, Self-Pay, Commercial FPP, and Other. The Net Patient Revenue by Payer calculated from these submitted values should tie to the totals reflected in the Rate Increase Decomposition sheet.

Other Revenue
The Other Revenue sheet includes both Other Operating Revenues (for example, grant income, 340B pharmacy, etc.) and Non-Operating Revenues.

Staff/FTE
The Staff/FTE (Full Time Equivalent) sheet collects all budgeted FTEs for each Hospital by department and service area by clinical and non-clinical FTEs per the Uniform Reporting Manual.

CON Sheets (Non-CON Detail, CON Detail, Capital Summary)
The CON sheets provide information on hospitals' planned capital expenses. The Non-CON Detail sheet includes information on projects costing more than $500K but not triggering a Certificate of

Need reviews, while the CON Detail sheet includes all CON projects. The Capital Summary sheet combines the Non-CON and CON detail sheets, and also allows entry of the aggregated cost of non-CON projects less than $500K each.

Balance Sheet
If your budget is entered in the order above, several accounts in the Adaptive Balance sheet will be populated by entries made on other sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions.

Income Statement
Like the Balance Sheet, several accounts will be automatically populated if your entries are made in the order above. Where accounts are not linked, please ensure that all figures reported on your income statement tie to the relevant figures on the Other Revenue and Payer Revenue sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions. Income statement will be driven by entries on the payer revenue sheet and other revenue.

Network Shared Services Financials
Adaptive sheets will be used to collect financial details associated with network-level shared services, including Network Administration, Revenue Cycle, Other Fiscal Services, Human Resources, Information Technology, Supply Chain, Marketing & Advertising, Quality, Population Health Services, and other.

Utilization
The utilization sheets collect Beds, Admissions, and Patient Days by various departments, as well as outpatient visits.

5. Supplemental Workbook
While the data requested below are not viewed as being wholly reflective of a hospital's operating performance, it will be considered in the broader context of administrative data and other types of data noted in other sections of this guidance.

340B Supplement
Each hospital must submit certain financial information on drugs purchased through the 340B program and dispensed to patients during the fiscal year. Financial information includes total revenues from the sale of 340B drugs, the estimated subset of revenues from patient cost sharing, and total expenditures associated with purchasing and distributing 340B drugs. GMCB has refrained from requesting any 340B data that does not have immediate relevance to the Hospital Budget Review.

Health Resources & Services Administration (HRSA) states the intent of the 340B program is to "enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." HRSA's 340B prescription drug discount program is critically important to our rural providers, as it is a vital lifeline for safety net health care organizations providing a high level of services to low-income individuals or serving isolated rural communities. Significantly more 340B hospitals provide vital, yet money-losing, health services than non-340B hospitals – services like mental health and substance use disorder treatment, trauma centers, and neonatal intensive care units.

UVM Medical Center procures medications from wholesale distributors, 503B compounders, and directly from manufacturers at 340B, group purchasing organization (GPO) and/or wholesale acquisition cost (WAC) price points. The 340B prescription drug pricing program is only available for medications used

in the outpatient setting based on qualifying patient visits. The 340B drug pricing program lessens the gap between the cost of care and reimbursement from governmental payers. The 340B program is a cost-avoidance program that is funded by pharmaceutical manufacturers and not by taxpayers. Without the federal 340B prescription drug pricing program, our pharmaceutical expenses and cost of goods sold would be significantly higher.

Retail and Contract Pharmacy

Retail pharmacy is reported separately as "other revenue," and the expense is reported as cost of goods sold under "retail pharmacy expense." Revenue, price paid to the pharmacy, is determined by the Pharmacy Services Administration Organization contracted terms with Pharmacy Benefit Managers (PBMs), which is largely the industry standard. Pharmacies are frequently underpaid by PBMs for the medications they dispense, and that is the primary reason why even some of the large retail pharmacy stores (e.g. Rite Aid) are going out of business in Vermont. UVM Health Network pharmacies are gaining patients from the stores that are closing in the Burlington health service area, and our pharmacies are staying solvent due to participation in the 340B prescription drug pricing program. The UVM Health Network outpatient pharmacy allows those health care dollars to stay in our system and be reinvested into the care of our patients.

Pricing for retail pharmacy medications are not included in the hospital pharmacy chargemaster. Claims for retail prescriptions are adjudicated through the PBM using the pharmacy information system, McKesson EnterpriseRx. The price paid by the patient is determined by the PBM and plan sponsor. The patient out of pocket expense should be the same irrespective of the dispensing pharmacy (e.g. co-pay or co-insurance) if the pharmacy is included in the PBM network. Regardless of access to UVM Health Network outpatient pharmacies, prescriptions likely would have been filled and dispensed elsewhere to eligible patients. Some of the financial and access benefits of UVM Health Network pharmacies over traditional retail pharmacies include:

- Lower Patient Out of Pocket Expense
    - Health Assistance Program – covers some/all of the patient out of pocket expense based on federal poverty level limits
    - Patient and Family Services – cover the costs of prescriptions during the discharge process, if needed
    - Free mail order including USPS, UPS, FedEx and a local courier service to ensure prescription access
    - Provide a bridge to care for patients utilizing free clinics while they are waiting for Medicaid or other primary insurance coverage
    - Accept cash pricing discount card for patients paying with cash
    - Help with foundation support and financial assistance for high-price specialty medications

- Access to Medications and Clinical Services
    - Stock high price, hard to find medications and will dispense partial quantities, which is not done in other retail pharmacy settings
    - UVM Health Network pharmacies are open 365 days per year
    - Medsafe is available in all locations for patients to safely dispose of medications
    - Benefit check and prior authorization assistance is offered regardless of if we can fill the prescription or have to send it to another preferred network pharmacy
    - Pharmacists in primary care and specialty clinics to help manage medication therapy for chronic diseases (e.g. diabetes, high lipids, obesity, and high blood pressure control)
    - Immunization services - routine and travel

The retail pharmacy cost of goods sold is approximately a 50%/50% mixture of WAC and 340B purchases. The retail pharmacy is not eligible for GPO acquisition cost (HRSA GPO exclusion). We budget annually on anticipated prescription volume and drug mix. However, new FDA drug approvals, new biosimilars, PBM formulary changes and other market dynamics outside our control make our budgetary predictions highly variable.

340B revenues, patient cost-sharing and total expenditures cannot be separated from the other lines of revenue and operating expenses. Contract pharmacy data, which is specific to 340B revenue and expense, retail pharmacy gross margin and hospital outpatient estimated 340B cost-avoidance are depicted in the table below.

UVMMC ($ in millions*)	FY23 Actual	FY24 Actual	FY25 Budget	FY25 YTD April Annualized	FY26 Budget
Contract 340B	24.7	21.4	22.9	28.7	34.7
Retail: Rx/Mail/Specialty	64.5	80.5	98.0	96.3	90.6
Total Gross Margin	89.1	101.9	120.9	125.0	125.3
Cost Avoidance					
Estimated 340B cost-avoidance on pharmaceuticals provided through hospital outpatient & physician office patient encounters**	59.1	67.8	0.0	79.3	0.0
Total With Estimated Cost-avoidance	148.2	169.7	120.9	204.3	125.3
Medicaid Share Back (Outpatient Pharmacy)	(24.1)	(23.4)	(23.3)	(23.8)	(24.3)
Medicaid Share Back (Inpatient Pharmacy)	(3.5)	(3.0)	(3.8)	(2.2)	(4.0)
Total With Medicaid Share Back	120.6	143.3	93.8	178.3	97.0

*Gross Margin = Other Revenue less Cost of Goods Sold. Does not include employee costs or GPSR.
**Cost-avoidance is difference between GPO cost and 340B cost or WAC cost and 340B cost.

Hospital Pharmacy

340B revenues, patient cost-sharing and total expenditures for hospital pharmacy cannot be separated from the other lines of revenue and operating expenses. We estimate approximately 80% to 90% of drug supply replenishment cost for hospital outpatient provided pharmaceuticals for qualifying sites of service are eligible for the 340B drug pricing program. UVM Medical Center pharmaceutical expenses are categorized into two major general ledger accounts: non-chemo pharmaceuticals and chemo drugs. The two accounts comprise most of the hospital pharmaceutical expenses.

UVM Medical Center strives to minimize and avoid cost by purchasing medications at 340B, GPO and WAC price points. The table below contains hospital pharmacy pharmaceutical expenses for FY25 YTD (April):

UVMMC	FY25 YTD April Expense ($)
General Ledger Account	--
Non-Chemo Pharmaceuticals	32.6 M
Chemo Drugs	35.3 M

UVM Medical Center does not have the ability to break out reimbursement for pharmaceuticals from the total reimbursement. The charges billed in the hospital inpatient and outpatient settings are generated through the hospital pharmacy chargemaster (except retail pharmacy and home infusion pharmacy). Revenue derived through the hospital inpatient and outpatient setting are included in NPR (except retail pharmacy).

Rate Decomposition

The Rate Decomposition sheet collects Net Patient Revenue due to reimbursement rate (i.e. charges less discounts) versus Net Patient Revenue due to non-reimbursement rate changes (i.e. utilization, payer mix, case mix, service, etc.), by core service line (inpatient, outpatient, and professional services) and payer, where payer is broken out by payer category and major commercial payers as defined in the uniform reporting manual.

Network Supplemental Financials

Networks that generate more than 50% of total network and member hospital revenue from Vermont hospitals are required to submit a supplemental financial workbook. This workbook is comprised of consolidating financial statements (balance sheet, income statement, change in net assets, cash flows) reflecting the network's submitted FY26 budget. Vermont hospitals must be broken out separately on these statements.

Referral and Visit Lags

Each hospital must submit data on referral and visit lags (see definitions below) for all referrals or appointments requested from April 1, 2025 - April 14, 2025. Please report such lags for each hospital-owned primary care practice, each hospital-owned specialty care practice, and the same imaging procedures as the hospital reported in FY25. If the five most frequent imaging procedures have changed, please add the new imaging procedures as well.

Referral lags: the percentage of appointments scheduled within 3 business days of referral (that is, the percentage of all referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place).

Visit lags: the percentage of new patient appointments scheduled for the patient to be seen within 14 days, 30 days, 90 days, and 180 days of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received.) This metric only concerns appointments for new patients. Please include all holidays and weekends in your calculation.

Margin on Services

Each hospital must submit their top 5 "highest margin" services & "lowest margin" services. For

each service, please include Revenue attributed to these services, (weighted) average historical margin, as well as (weighted) average commercial reimbursement (price?) over Medicare.

Clinical Productivity
Please report average work RVUs per clinical FTE by department – both the level and the associated percentile of national benchmarks, or similar, for the most recent year available. Report the number of clinical and budgeted FTEs (if different) that are included in the denominator. Hospitals must benchmark on year 2024.

Contingency Plan
A hospital which submits a budget that doesn't meet the benchmarks established in Section I must provide a comparison of gross revenue by department/service area for a compliant budget vs. their submitted budget.

Not applicable. UVM Medical Center's FY26 budget as submitted is in compliance with all FY26 GMCB budget guidance benchmarks.

Labor Expense
Each hospital must submit a detailed breakout of labor expenses, with a distinction between clinical and non-clinical staff.

Case Mix
Each hospital must complete a table providing historical and budgeted case mix index by payer.

Capital Expenses
Each hospital must provide a breakout of FY2026 planned Capital Expenditures at the summary level, as well as funding sources.

Regional Collaborations
Each hospital must complete a table detailing regional collaborations, including the partner organization(s), a description, and financial impact.

Cost Inflation
Each hospital must complete a table breaking out cost inflation, with a distinction between growth due to price and utilization.

6. Community Health Needs Assessment (CHNA) and Implementation Plan
Submit a complete copy of the hospital's most recent Community Health Needs Assessment (CHNA) and, if applicable, the most recent Implementation Strategy, as required by the Patient Protection and Affordable Care Act.

To view the most recent Community Health Needs Assessment and associated materials, please visit:
https://www.uvmhealth.org/health-wellness/uvm-health-network-community-benefit
https://www.uvmhealth.org/medcenter/about-uvm-medical-center/the-community/needs-assessment

7. Financial Assistance Policy & Reporting

In accordance with Act 119 of 2022, hospitals are required to submit a plain language summary of their financial assistance policy (FAP). In addition, please report the following:

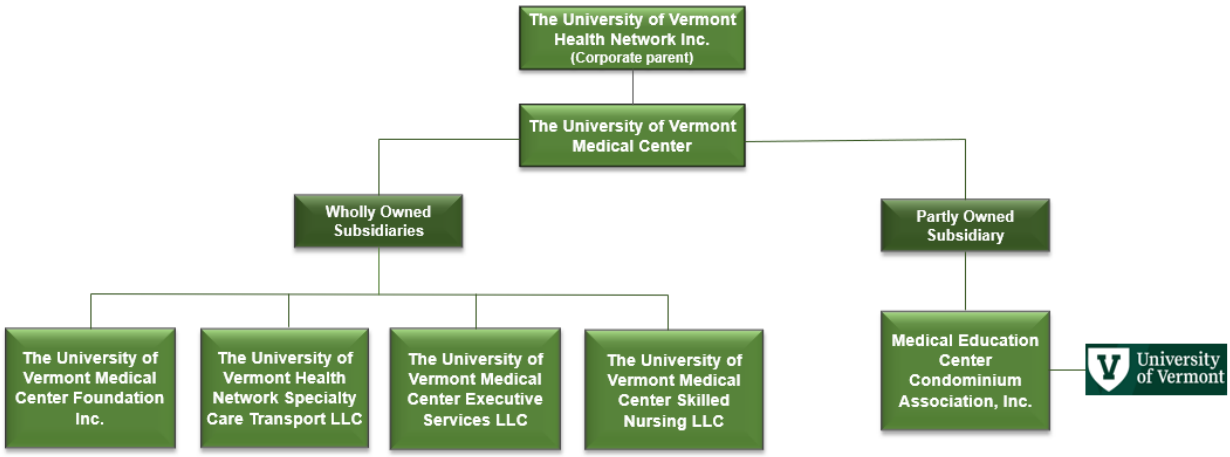
- **Total number of applicants granted any amount of FAP**
- **Number of applicants granted 100% FAP**
- **Number of applicants granted less than 100% FAP**
- **Total applicants denied FAP**
- **Breakdown of reason for denial (% or #)**

FY 2024	
University of Vermont Medical Center	**Volumes**
Total Applications	7,515
Total Household Members	8,770
Approved/Granted	
Free Care	3,589
Reduced Care	2,602
Total Approved	6,191
Denied	
Denied - No Eligible Charges	1
Denied - No Current/Scheduled Charges	0
Denied - Other Reason	14
Denied - Out of Service Area	3
Denied - Over Assets	105
Denied - Over Income	222
Denied - Over Income & Assets	18
Incomplete Application or Documentation	670
No Response from Patient	149
Qualified for Medicaid	73
Qualified for Other Assistance Programs	0
Total Denied	1,255

Please click here to view the current plain language summary (as of January 1, 2025) for UVM Medical Center's financial assistance policy.

8. Corporate Structure

Provide an up-to-date chart or graphic outlining the corporate structure associated with the Hospital.



9. Salary

Provide the FY25 and budgeted FY26 salaries, including any bonuses, variable payments, or incentive plans (potential or paid), for the hospital's executive and clinical leadership and the hospital's salary spread, so that the Board may consider that salary information and consider a comparison of median salaries to the medians of northern New England states in accordance with 18 V.S.A. § 9456(b)(13). Provide any benchmarks and/or bases on which such compensation was established, including the bases for any bonuses, variable payments, or inventive plans.

10. Net Revenue & Public Payer Reimbursement

File an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals as specified in 18 V.S.A. § 9456(b)(8) and (b)(9).

APPENDIX

NPR Variance - FY25 BUDGET to FY26 BUDGET

	Ref Cells	A	B	C	D	E	F	G	H	I	J
		$ -									
NPR		**Total**	**Total Medicare**	**Total Medicaid**	**Total Major Comm**	**Other Commercial**	**Self-Pay**	**Public Agency/Workers Comp**	**Other**	**UVMMC Employee Self Funded Insurance Plan**	**DSH**
Gross revenue	1	$ 4,595,022,544	$ 2,180,384,347	$ 710,951,595	$ 1,166,278,499	$ 150,439,911	$ 58,090,778	$ 154,961,398	$ 19,975,513	$ 153,940,503	$ -
Deductions + denials	2	$ 2,607,694,370	$ 1,576,942,814	$ 512,941,723	$ 234,729,914	$ 36,343,044	$ 20,060,684	$ 100,927,509	$ 39,645,813	$ 97,385,180	$ (11,282,311)
FY25 BUDGET NPR By Payer excluding BD/Charity	3	**$ 1,987,328,174**	**$ 603,441,533**	**$ 198,009,872**	**$ 931,548,585**	**$ 114,096,867**	**$ 38,030,094**	**$ 54,033,889**	**$ (19,670,300)**	**$ 56,555,323**	**$ 11,282,311**
Bad Debt / Charity By Payer	4	$ (83,808,062)	$ (11,578,365)	$ (935,980)	$ (22,841,035)	$ (5,840,358)	$ (37,803,135)	$ (4,158,937)	$ (224,226)	$ (426,025)	$ -
FY25 BUDGET	5	$ 1,903,520,112	$ 591,863,168	$ 197,073,892	$ 908,707,550	$ 108,256,508	$ 226,959	$ 49,874,952	$ (19,894,526)	$ 56,129,298	$ 11,282,311
FY2025 Accounting Changes											
Denials	6	$ (0)	$ (9,691,902)	$ (13,514,766)	$ (7,960,661)	$ (972,695)	$ (392,753)	$ (2,533,914)	$ 35,368,119	$ (301,428)	$ -
Total FY2025 Accounting Changes Impact	7	**$ (0)**	**$ (9,691,902)**	**$ (13,514,766)**	**$ (7,960,661)**	**$ (972,695)**	**$ (392,753)**	**$ (2,533,914)**	**$ 35,368,119**	**$ (301,428)**	**$ -**
FY25 Budget After Accounting Changes	8	**$ 1,903,520,112**	**$ 582,171,265**	**$ 183,559,126**	**$ 900,746,889**	**$ 107,283,813**	**$ (165,794)**	**$ 47,341,038**	**$ 15,473,594**	**$ 55,827,870**	**$ 11,282,311**
Rate Decomposition Cell Reference	9	*I223*	*I193*	*I186*	*I201*	*Included in I211 Total*	*I215*	*Included in I218 Total*	*Included in I218 Total*	*Included in I211 Total*	*I199*
FY2026 Rate Changes											
All Payers	10	$ 54,444,174	$ 27,712,739	$ 145,554	$ 24,088,538	$ 2,303,773	$ 244,444	$ 88,472	$ (148,092)	$ 8,747	$ -
Denials	11	$ (1,648,502)	$ (259,578)	$ (346,177)	$ (754,746)	$ (109,946)	$ (233,126)	$ (89,987)	$ 155,275	$ (10,217)	$ -
Bad Debt	12	$ (1,125,845)	$ 49,058	$ 34,917	$ (366,599)	$ (130,823)	$ (663,572)	$ (60,006)	$ 22,641	$ (11,461)	$ -
Charity	13	$ (1,417,063)	$ (332,572)	$ (13,350)	$ (121,291)	$ (63,290)	$ (840,157)	$ (197)	$ (43,906)	$ (2,300)	$ -
LOS Reduction (IP - All Payers)	14	$ 1,860,000	$ 775,966	$ 135,370	$ 672,103	$ 114,196	$ 52,660	$ 56,677	$ 19,655	$ 33,372	$ -
Patient Acuity Shifts	15	$ 2,000,000	$ 834,372	$ 145,559	$ 722,691	$ 122,792	$ 56,624	$ 60,944	$ 21,135	$ 35,884	$ -
FY23 Rate Enforcement	16	$ (20,072,539)	$ -	$ -	$ (20,072,539)	$ -	$ -	$ -	$ -	$ -	$ -
H.266 pharmaceutical pricing reductions	17	$ (70,832,022)	$ -	$ -	$ (70,832,022)	$ -	$ -	$ -	$ -	$ -	$ -
FY25 mid-year rate decrease	18	$ (12,000,000)			$ (12,000,000)						
Other Initiatives	20	$ -									
Total FY2026 Rate Changes Impact	21	**$ (48,791,797)**	**$ 28,779,984**	**$ 101,872**	**$ (78,663,863)**	**$ 2,236,702**	**$ (1,383,127)**	**$ 55,902**	**$ 26,708**	**$ 54,026**	**$ -**
Rate Decomposition Cell Reference	22	*AE223*	*AE193*	*AE186*	*AE201*	*Included in AE211 Total*	*AE215*	*Included in AE218 Total*	*Included in AE218 Total*	*Included in AE211 Total*	*AE199*
FY2025 Budget to Actual Collection Rate											
All Payers	23	$ 8,264,414	$ (18,794,258)	$ 7,350,703	$ 7,935,301	$ 5,473,764	$ 5,480,989	$ (3,736,597)	$ 1,073,141	$ 3,481,370	$ -
GME Change	24	$ 0	$ -	$ 0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Disproportionate Share Payments (DSH)	25	$ (22,072)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (22,072)
Denials	26	$ (1,487,662)	$ 1,084,280	$ 1,625,600	$ (3,316,776)	$ (932,820)	$ (978,092)	$ 492,424	$ 417,076	$ 120,646	$ -
Bad Debt	27	$ 13,675,970	$ 6,128,832	$ 1,935,372	$ 6,358,317	$ 1,452,562	$ (5,002,343)	$ 2,111,055	$ 665,806	$ 26,370	$ -
Charity	28	$ (7,894,900)	$ (3,588,119)	$ (245,425)	$ 2,685,987	$ (1,269,188)	$ (4,115,478)	$ 29,901	$ (1,406,650)	$ 14,072	$ -
Revenue Cycle Improvement	29	$ 5,250,000	$ 1,548,477	$ 322,533	$ 2,616,225	$ 320,380	$ 114,722	$ 131,488	$ 21,773	$ 174,402	$ -
Total FY2025 Budget to Actual Collection Rate Impact	30	**$ 17,785,751**	**$ (13,620,787)**	**$ 10,988,782**	**$ 16,279,055**	**$ 5,044,697**	**$ (4,500,202)**	**$ (971,729)**	**$ 771,147**	**$ 3,816,859**	**$ (22,072)**
Rate Decomposition Cell Reference	31	*V223*	*V193*	*V186*	*V201*	*Included in V211 Total*	*V215*	*Included in V218 Total*	*Included in V218 Total*	*Included in V211 Total*	*V199*
FY2025/FY2026 Utilization											
All Payers	32	$ 76,101,037	$ 17,972,928	$ 2,023,404	$ 44,587,051	$ 4,986,319	$ 2,183,450	$ 1,856,590	$ (250,241)	$ 2,741,534	$ -
Denials	33	$ (1,859,271)	$ (489,496)	$ (536,650)	$ (624,901)	$ (67,161)	$ (34,944)	$ (79,358)	$ (3,715)	$ (23,046)	$ -
Bad Debt	34	$ (2,602,412)	$ (173,047)	$ (14,492)	$ (1,228,975)	$ (248,700)	$ (839,263)	$ (77,122)	$ 7,765	$ (28,579)	$ -
Charity	35	$ (2,049,205)	$ (312,730)	$ (8,250)	$ (384,025)	$ (6,138)	$ (1,329,936)	$ (1,656)	$ (1,356)	$ (5,114)	$ -
Provider Transfer	36	$ 42,055,570	$ 12,938,936	$ 4,079,658	$ 20,019,378	$ 2,384,416	$ (3,685)	$ 1,052,169	$ 343,905	$ 1,240,792	$ -
Other Initiatives	37	$ -									
Total FY2025/FY2026 Utilization Impact	38	**$ 111,645,720**	**$ 29,936,591**	**$ 5,543,670**	**$ 62,368,529**	**$ 7,048,737**	**$ (24,377)**	**$ 2,750,623**	**$ 96,360**	**$ 3,925,587**	**$ -**
Rate Decomposition Cell Reference	39	*P223*	*P193*	*P186*	*P201*	*Included in P211 Total*	*P215*	*Included in P218 Total*	*Included in P218 Total*	*Included in P211 Total*	*P199*
FY2025/FY2026 Payer Mix Changes											
All Payers	40	$ 4,343,295	$ 2,762,490	$ (12,596,389)	$ 20,787,926	$ 17,588	$ 1,184,800	$ (1,116,160)	$ (11,293,475)	$ 4,596,515	$ -
Denials	41	$ 146,834	$ (361,931)	$ 554,765	$ (190,298)	$ 15,821	$ (33,344)	$ 53,162	$ 133,999	$ (25,340)	$ -
Bad Debt	42	$ (1,463,886)	$ (206,132)	$ 11,730	$ (676,986)	$ (404,424)	$ (397,561)	$ 91,813	$ 146,747	$ (29,073)	$ -
Charity	43	$ (594,736)	$ 296,193	$ (17,521)	$ (167,519)	$ (153,834)	$ (651,733)	$ 1,695	$ 104,052	$ (6,068)	$ -
Total FY2025/FY2026 Payer Mix Changes Impact	44	**$ 2,431,507**	**$ 2,490,620**	**$ (12,047,415)**	**$ 19,753,124**	**$ (524,850)**	**$ 102,162**	**$ (969,490)**	**$ (10,908,677)**	**$ 4,536,034**	**$ -**
Rate Decomposition Cell Reference	45	*S223*	*S193*	*S186*	*S201*	*Included in S211 Total*	*S215*	*Included in S218 Total*	*Included in S218 Total*	*Included in S211 Total*	*S199*
Provider Acquisitions/Transfers	46	$ -									
Gross revenue	47	$ 5,025,510,834	$ 2,400,180,362	$ 728,402,741	$ 1,310,433,544	$ 165,792,945	$ 65,736,518	$ 164,120,155	$ 5,897,036	$ 184,947,533	$ -
Deductions + denials	48	$ 2,951,639,404	$ 1,760,705,806	$ 541,003,706	$ 373,207,686	$ 38,039,653	$ 20,064,677	$ 113,850,358	$ (291,222)	$ 116,318,980	$ (11,260,239)
FY26 BUDGET NPR By Payer excluding BD/Charity	49	*$ 2,073,871,430*	*$ 639,474,556*	*$ 187,399,035*	*$ 937,225,858*	*$ 127,753,293*	*$ 45,671,841*	*$ 50,269,798*	*$ 6,188,257*	*$ 68,628,553*	*$ 11,260,239*
Bad Debt / Charity By Payer	50	*$ (87,280,138)*	*$ (9,716,883)*	*$ 747,001*	*$ (16,742,125)*	*$ (6,664,194)*	*$ (51,643,178)*	*$ (2,063,454)*	*$ (729,126)*	*$ (468,177)*	*$ -*
FY26 BUDGET	51	$ 1,986,591,292	$ 629,757,673	$ 188,146,036	$ 920,483,733	$ 121,089,098	$ (5,971,337)	$ 48,206,343	$ 5,459,132	$ 68,160,376	$ 11,260,239
Rate Decomposition Cell Reference	52	*K223*	*K193*	*K186*	*K201*	*Included in K211 Total*	*K215*	*Included in K218 Total*	*Included in K218 Total*	*Included in K211 Total*	*K199*
$ Change from FY26 BUDGET Approved Budget	53	**$ 83,071,180**	**$ 47,586,407**	**$ 4,586,910**	**$ 19,736,844**	**$ 13,805,286**	**$ (5,805,543)**	**$ 865,306**	**$ (10,014,462)**	**$ 12,332,506**	**$ (22,072)**
Rate Decomposition Cell Reference	54	*M223*	*M193*	*M186*	*M201*	*Included in M211 Total*	*M215*	*Included in M218 Total*	*Included in M218 Total*	*Included in M211 Total*	*M199*
% Change from FY26 BUDGET Approved Budget	55	**4.4%**	**8.2%**	**2.5%**	**2.2%**	**12.9%**	**3501.7%**	**1.8%**	**-64.7%**	**22.1%**	**-0.2%**
Rate Decomposition Cell Reference	56	*AJ223*	*AJ193*	*AJ186*	*AJ201*	*Included in AJ211 Total*	*AJ215*	*Included in AJ218 Total*	*Included in AJ218 Total*	*Included in AJ211 Total*	*AJ199*
% Change from FY26 BUDGET Approved Budget: Total NPR (WAvg)	57	**4.4%**	**2.5%**	**0.2%**	**1.0%**	**0.7%**	**-0.3%**	**0.0%**	**-0.5%**	**0.6%**	**0.0%**
Rate Decomposition Cell Reference	58	*AK223*	*AK193*	*AK186*	*AK201*	*Included in AK211 Total*	*AK215*	*Included in AK218 Total*	*Included in AK218 Total*	*Included in AK211 Total*	*AK199*