August 17, 2023

Green Mountain Care Board
c/o The Honorable Owen Foster, Chair
144 State Street
Montpelier, VT 05602

Dear Chair Foster:

Our team at the University of Vermont Health Network looks forward to engaging with the Board during our budget hearing for the University of Vermont Medical Center, Central Vermont Medical Center and Porter Hospital on August 23. Based on our understanding of the hospital budgets that have already been reviewed this month, we understand that the GMCB FY24 budget review tool will be covered during our hearing.

Members of our Network team met with Director Sarah Lindberg on August 11 to discuss the hospital budget review tool and the figures graphed for our three Vermont hospitals. We sincerely appreciate the time Director Lindberg spent with our staff discussing the components displayed in the tool. This letter memorializes our conversation.

Utilization:

The budget review tool shows that UVMMC, CVMC and Porter's utilization growth exceeds the benchmark. The term "utilization" as it is being used to describe this growth is not completely accurate for our organizations. A portion of that growth is true utilization, coming primarily from the aging population (people over 65) and our work to improve patient access, but the other component is the population growth in the counties served by the Network. We highlighted these components in our narrative. Approximately 50% of the growth attributed in this category is true utilization growth, and the other 50% is population growth.

Pharmaceutical expenses:

At UVMMC, retail pharmacy expense – not a component of net patient revenue – is driving the 30.7% total pharmacy expense growth. Pharmaceutical expense – which is part of NPR – is growing at a rate of 11.3%. This is broken out in the table below.

	FY2022 Act	FY2023 Bud	FY2023 Proj	FY2024 Bud	Change to FY2024 Budget		
					FY22 Act	FY23 Bud	FY23 Proj
Retail Pharmacy Expense	114,058,752	139,643,143	146,505,459	170,067,669	49.1%	21.8%	16.1%
Pharmaceuticals	108,095,687	111,514,163	114,653,511	120,314,488	11.3%	7.9%	4.9%
Total Pharmacy Expense	**222,154,438**	**251,157,306**	**261,158,970**	**290,382,157**	**30.7%**	**15.6%**	**11.2%**

Cost report:

Ratio of administrative and general salaries to clinical salaries:

The GMCB budget review tool uses Worksheet A, column 1 on the FY22 Medicare cost report to calculate percentages of administrative and general salaries to clinical salaries. This results in a misleading ratio, as it includes all UVMHN shared services salaries that run through the UVMMC General Ledger in the administrative and general category. The Medicare cost report appropriately reclasses and adjusts off the UVMHN home office salaries and expenses (among many other required reclassifications and adjustments) on Worksheets A-6, A-8, A-8-1 and A-8-2, which flow to columns 4 and 6 on Worksheet A. In addition, Worksheet A, column 1 does not include contracted labor salaries, which are on Worksheet S-3, Part III and are a significant clinical labor factor.

We manually completed a reconciliation of the cost report Worksheet A, column 1 to incorporate the FY22 cost report reclassifications and adjustments for the salary portion of the UVMHN home office expense, as well as including the clinical contract labor salary expense. After these adjustments, the accurate reflection of the UVMMC ratio of administrative and general salaries to clinical salaries is 24.4%, which is in the benchmark range.

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

Syntellis Functional Area Metric Comparisons

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

CMI and CMI adjusted cost per adjusted discharge:

As highlighted on the Medicare CMI chart in the budget tool, both UVMMC and CVMC are on the lower end of the benchmark. We have known for some time through external assessments and comparisons to benchmarks that we are not accurately capturing the acuity of our patients. We have tried to tackle the issue through staff and provider education and process improvements, but have had little impact on CMI. Most other organizations have a more robust system for capturing CMI opportunities without relying on a human combing through multiple components of the electronic health record (EHR). That system for us is called Iodine, which went live for our Network on August 14. Iodine is an AI enabled data mining tool that highlights CMI opportunities by correlating multiple pieces of data in our EHR (lab test, x-rays, notes, etc.). Iodine combined with other CDI related initiatives will finally generate a CMI that accurately reflects the acuity of our patients, which we project will be in the 2.3 range for UVMMC and 1.6 for CVMC.

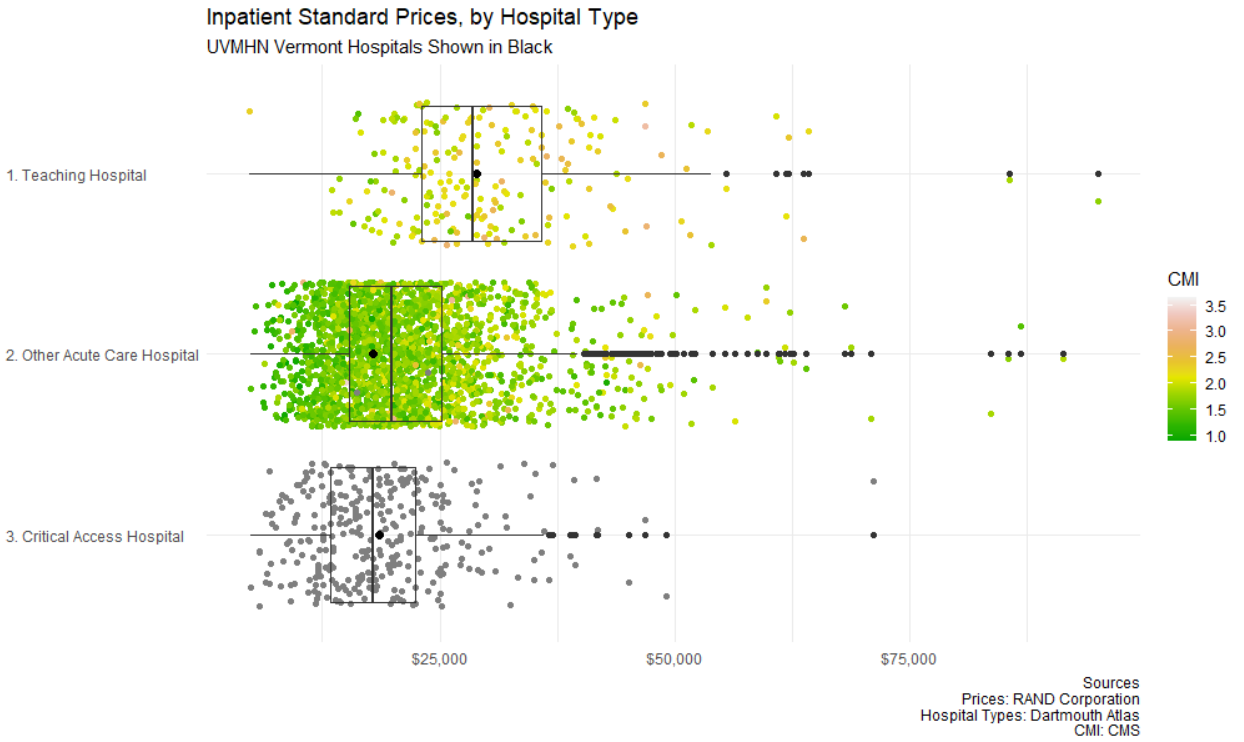
Once we have a more accurate CMI, CMI adjusted cost metrics will also be impacted, like the one included in the budget tool. If we had a more accurate CMI for UVMMC, the CMI adjusted cost per adjusted discharge in the tool would be $12,813, and for CVMC $11,046. Both of these figures would be within the benchmark range. We see this same dynamic in the Association of American Medical Colleges' (AAMC) Council of Teaching Hospitals and Health Systems (COTH) benchmark data that we use for UVMMC. We are near the 25th percentile for CMI and expense per adjusted patient day, but CMI adjusted expense per adjusted day is near the median.

	UVMMC	CVMC
FY2022		
Total Medicare Discharges	7,058	1,880
Avg Cost per Discharge	$29,469	$17,674
CMI	2.0640	1.4648
CMI Adjusted Avg. Cost	$14,278	$12,066
Revised CMI	2.3000	1.6000
Revised CM Adjusted Avg. Cost	$12,813	$11,046

RAND:

When looking at the standardized price per inpatient stay at UVMMC, it is important to note that the RAND study data does not differentiate between Academic Medical Centers (AMC) and all other acute care hospitals; there is a separate breakout for Critical Access Hospitals (CAH). UVMMC falls at the more expensive side of the distribution for all non-CAHs, but is well within the normal range for a teaching hospital. The graph and table below show the following:

- The pricing for teaching hospitals is systematically higher than the pricing for other acute care hospitals.
- The acuity for teaching hospitals is systematically higher than the acuity for other acute care hospitals. The lower-priced teaching hospitals tend to have patient acuity that is more similar to other acute care hospitals than to other teaching hospitals.
- There are far more general acute care hospitals than teaching hospitals, so comparing UVMMC to the general group of non-CAHs will primarily compare it to hospitals treating lower acuity patients.

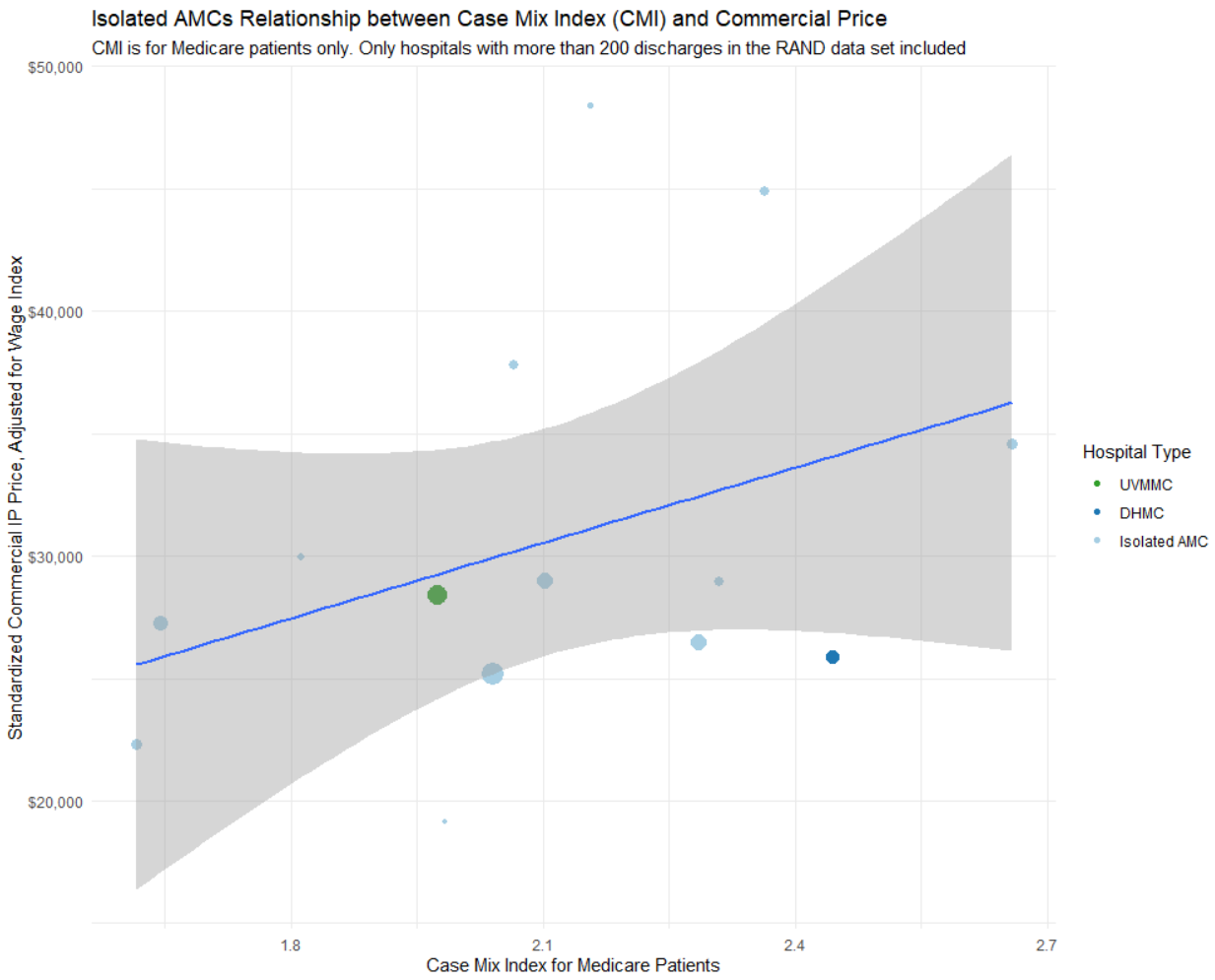


UVMHN Vermont Hospitals Compared to Comparable Hospitals in RAND Study

RAND Comparison	1. Teaching Hospital	2. Other Acute Care Hospital	3. Critical Access Hospital
25th Percentile	$ 23,079	$ 15,346	$ 13,391
Median	$ 28,495	$ 19,880	$ 17,910
75th Percentile	$ 36,056	$ 25,243	$ 22,556
Mean	$ 31,838	$ 21,764	$ 19,240
UVMHN	$ 28,896	$ 17,892	$ 18,609

UVMMC serves both as a community hospital and as an integrated AMC because there is no other community hospital in the Burlington area. To fairly compare pricing at UVMMC to other hospitals nationwide, we identified a group of AMCs that may similarly also serve as community hospitals in some capacity. These are identified as AMCs which are also the only acute care hospital in either their hospital service area or county or have no other significantly smaller hospital nearby.

The graph below shows UVMMC's prices relative to the other hospitals in this group. Because standardized price is correlated with acuity in the RAND data for both AMCs and community hospitals, we also show the average acuity for Medicare patients as well as the relationship between price and acuity. This shows that, even as we account for UVMMC's role as a community hospital as well as an AMC, the pricing still falls well within the normal range.



Conclusion:

As you know, over the last several years our Network has been asking the Board to establish externally-derived benchmarks and objective criteria drawn from credible national and regional health care data sources by which hospital budgets would be judged, and to publish those benchmarks and criteria in the Board's hospital budget guidance. The Network submitted public comment letters to this effect regarding the FY24 hospital budget guidance process on January 10, February 3 and March 27.

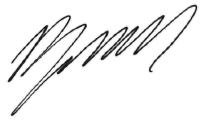
The GMCB FY24 hospital budget review tool was developed and published outside of this spring's budget guidance period, after FY24 budget guidance was adopted at the end of March, and after hospital budgets were submitted to the Board at the end of June. The budget review tool was sent to hospital CFOs and finance staff on August 1. We therefore expect that, whatever use the Board makes of the tool, it will not use it as justification for making downward adjustments to hospital budgets.

We nonetheless see this year's hospital budget review tool as a step in the right direction, and we are eager to work with the Board and staff on validating the data in the tool and ensuring its

applicability for future budget years, after it has been adopted as part of the annual budget guidance process and may therefore be used as a legitimate decision-making tool. We look forward to working with you to improve the budget review tool for future years.

Thank you for your careful consideration. We look forward to discussing these topics with you during our Network's budget hearing on August 23.

Sincerely,



Rick Vincent
Executive Vice President and Chief Financial Officer
The University of Vermont Health Network