Delivered Via E-Mail

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Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

August 30, 2024

Re: **Post-Hearing Submission of UVM Medical Center, Central Vermont Medical Center, and Porter Hospital**

Dear Chair and Members of the Green Mountain Care Board:

Thank you for the opportunity to present to the Green Mountain Care Board ("Board") the FY 2025 budgets for the University of Vermont Medical Center ("UVMMC"), Central Vermont Medical Center ("CVMC") and Porter Hospital ("Porter"). We will be working to address the Board's follow-up questions as quickly as possible. In the meantime, we want to address two of the more significant topics of discussion during the budget hearings: (a) the timing of UVMMC's decision to seek Sole Community Hospital status; and (b) the University of Vermont Health Network's ("UVM Health Network") choice of benchmarks regarding administrative and clinical efficiency, cost, and price. Please accept this letter on behalf of all three of the UVM Health Network's hospitals.

UVMMC's Sole Community Hospital Status

During the hearing, we discussed the fact that UVMMC sought and received Sole Community Hospital ("SCH") status from CMS, retroactively effective to December 1, 2022. This payment status has allowed UVMMC to receive better Medicare reimbursement rates, which relieves rate pressure on commercial payers. We emphatically agree that Vermont's hospitals and state government leaders should continue to do all they can, as soon as they can, to permissibly enhance public funding for health care, thereby reducing inflationary pressure on commercial payers, as well our budget as Vermont's largest private employer. Through its questions and

commentary, the Board suggested, while conceding that it did not know the facts, that UVMMC could have and should have sought SCH status earlier than it did, and it may have "left tens of millions of dollars on the table" as a result. As promised, we have examined this important issue and can assure the Board that UVMMC sought SCH status as soon as it was both available and financially beneficial for Vermonters.

UVMMC analyzed its potential eligibility for SCH status, as well as the financial pros and cons of that status, on multiple occasions since 2009. In 2009, it was determined that UVMMC's Medicare payment under the Boston Wage Index was more financially advantageous than a rural SCH designation. In the decade after UVMMC was no longer reimbursed under the Boston Wage Index, our analysis consistently demonstrated that UVMMC did not meet the SCH criteria of 42 CFR 412.92, because Northwestern Medical Center was within 35 miles using state roads and continued to meet the CMS definition of a "like" hospital. PRM-1, §2810(A)(2)(d).

In 2022, UVMMC first determined that it met the criteria for SCH designation and that it would be likely to maintain that designation once obtained. Northwestern Medical Center's Medicare cost reports, which become available five months after the close of the year, showed that its patient day volume fell below the CMS threshold of 8% of UVMMC's patient day volume in FY19 to FY20. The FY20 data, however, was significantly affected by both the COVID-19 pandemic that impacted both hospitals to different degrees and the cyberattack that significantly affected UVMMC's volume.[1] It was Northwestern's FY21 Medicare cost report, available in the late spring of 2022, that first made clear that Northwestern's patient day volume was, and would likely remain, below the CMS threshold of 8% of UVMMC's patient day volume, and Northwestern was therefore no longer considered a "like" hospital under CMS regulations.

After confirming the data on Northwestern's FY21 Medicare cost report, UVMMC applied and was approved by CMS to reclassify to the Rural Vermont core-based statistical area ("CBSA") effective September 30, 2022. UVMMC also applied and was approved by CMS for Rural Referral Center status effective October 1, 2022. After the rural designations were granted, UVMMC applied and was approved by CMS for Rural SCH designation effective retroactive to December 1, 2022. In short, UVMMC is doing all it responsibly can, as quickly as it can, to reduce the burden on Vermont's commercial ratepayers by seeking enhanced governmental reimbursement.

Finally, while we are confident that in this instance UVMMC improved its CMS payment status at the earliest advantageous date, all UVM Health Network hospitals are constantly seeking to improve their efficiency, their reimbursement from governmental payers, and other factors that beneficially impact commercial rates for Vermonters. It is our hope that we will continue to make meaningful progress in all of these areas in the coming years, often in partnership with the State of Vermont. And when we do, we also hope the Board will recognize those improvements as positive developments.

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[1] SCH status is lost as soon as a hospital no longer meets the criteria, which puts the hospital at significant risk of paying back any benefit it might have briefly received. As a result, responsible hospitals only consider changing status when they can reasonably be assured that it will "stick."

Applicable Benchmarks

We spent much of our hospital budget hearings discussing and debating "benchmarks" – meaning metrics of hospital performance with respect to clinical efficiency, administrative efficiency, productivity, cost and price; hospital comparator groups; the data sets and sources from which information about hospital performance should be obtained; and the level of performance hospitals should demonstrate with respect to each metric.[2] We wholeheartedly agree with the sentiment expressed by several of the Board members during the hearings: The budget process and the Board's decisions should be based on reliable and expert data, and both the Board and Vermont's hospitals need to clearly identify and understand the benchmarks against which hospital performance and budgets will be judged. While we may not be able to agree perfectly on which benchmarks are the most applicable, or the weight any single benchmark should receive in the Board's decision, we should at least have a discrete set of benchmarks that is designated in advance of budget formation and is commonly understood by both the regulator and the regulated. Put differently, the hospital budget hearings should not be the venue where the appropriate benchmarks are debated, but instead should be the time for a conversation about whether the hospitals' performance and proposed budgets meet the appropriate benchmarks, and if not, why not.

Unfortunately, the Board did not adopt clear benchmarks prior to the deadline for budget submission or the budget hearings. That meant that our budget hearings this year were partially consumed by conversations about which benchmarks we should collectively be using. Those discussions did not serve anyone well.

We want to reiterate our commitment to working with you to establish a finite and commonly understood set of benchmarks to govern next year's budget process in the expectation that they will facilitate a more meaningful and productive exchange. We are particularly interested in finally defining benchmarks regarding the key element of the Board's statutory charge: "reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised." We firmly believe that such a conversation is a necessary foundation of a rational and orderly budget regulation process, and without it, we will continue to talk past one another.

The establishment, well in advance of the budget submission deadline, of the benchmarks the Board will use in setting hospital budgets is not merely a good idea. It is required by law. The Board's hospital budget review process is intended to provide a predictable regulatory framework for promoting the health of the population and patient experience, reducing costs, and promoting administrative simplification. The basic premise of the regulatory structure is straightforward:

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[2] We refer to these elements, taken together, as "benchmarks," because together they constitute a rational tool for budget regulation. Hospitals need to know which metrics the Board considers to be most important. They need to know the sources of information the Board considers credible with respect to those metrics, as well as the hospitals to which they will be compared on those metrics. And they then need to know what level of performance – e.g., the 50th percentile – the Board considers good or bad. Without any one of these basic pieces, the others cannot serve as a rational guide to decision-making.

- On an annual basis, "the Board…establish[es] benchmarks for any indicators for use in developing and preparing the upcoming fiscal year's hospital budgets." GMCB Rule 3.202.
- Hospitals then build their budgets and manage their operations with those benchmarks in mind.
- Once those budgets are built and approved by the hospital boards, hospitals submit their budgets to the Board, along with all of the other information they feel is necessary to explain why the budgets either meet the published benchmarks or depart from them in a way that does not require a budget adjustment. GMCB Rule 3.203 and 3.302.
- The Board is then required to approve or adjust the hospitals' budgets by reference to the benchmarks it established in advance. GMCB Rule 3.303 ("The benchmarks established under section 3.202 shall guide the Board's decisions whether or not to adjust a hospital's proposed budget.")

This type of framework, in which the rules are set in advance and not introduced or changed mid-game, is also required by due process. The Vermont Supreme Court has held in a different regulatory context that "a decision arrived at without reference to any standards or principles is arbitrary and capricious" and that "such ad hoc decision-making denies the applicant due process of law." *In re Handy*, 171 Vt. 336, 345, 764 A.2d 1226, 1235 (2000) (quoting *In re Miserocchi*, 170 Vt. 320, 325, 749 A.2d 607, 611 (2000)). While "a standard sufficient to save [a decision] can be general," one that provides "unlimited discretion" to the agency in performing its duties is not. *Id.* at 348-49, 764 A.2d at 1238. The subjects of a regulatory body must have "some ability . . . to predict how discretion will be exercised and to develop proposed [plans] accordingly. Flexibility cannot be a synonym for ad-hoc decision making that is essentially arbitrary." *Id.* at 349, 764 A.2d at 1238.

This year, the FY 2025 Hospital Budget Guidance section regarding "Comparative Analytics" explicitly states "[t]here are no specific performance benchmarks established for measures in this section as many of these measures must be considered collectively and may apply differently to different hospitals." FY 2025 Hospital Budget Guidance at 9. The Board's Hospital Budget Review Metrics contain dozens of metrics that the Board may consider, and even some data sources, but the level of performance hospitals are expected to attain is not defined. And the Guidance goes on to say that the Board may also review any "other publicly available data sets that are not listed in the Hospital Budget Review Metrics," without limitation. *Id.* at 11. If the Board gives itself the ability to consider any metrics and data it later chooses, it is the equivalent of selecting no metrics or data sets at all. The Board's hospital budget tool, which contains only limited comparative benchmarking data, was published more than a month after budget submissions, on the eve of hospital budget hearings. The Board was also still "adjusting" hospital peer groups as of the first week of August, a full month after hospital budgets were due.

In the absence of a defined set of benchmarks designated and published by the Board in advance of hospital budget submissions, UVM Health Network's Vermont hospitals proposed the benchmarks that we believe provide the best guidance for decision-making. In doing so, we intentionally drew on prior work presented to the Board at its request, such as RAND, NASHP,

and others. We also utilized the Board's designated FY24 peer group and data, in addition to the FY25 peer group and data that the Board only recently made available, which appears to have led to understandable but avoidable confusion.

In our follow-up written answers to the Board's hearing questions, we will take the opportunity to explain in more detail why we chose the benchmarks and peer groups that we chose, and why we continue to believe they should guide the Board's decision. But to the extent the Board does not consider those benchmarks to be applicable or helpful, it cannot permissibly hold that fact against the hospitals at this late date. Nor can it determine that the hospitals failed to satisfy their burden of proof with respect to those elements of their budgets—such as efficiency, cost, and price—that can only be determined by reference to objective benchmarks. The Vermont Supreme Court "has consistently affirmed the necessity of the clear application of applicable standards in . . . administrative decisions," and hospitals cannot lawfully be held responsible for failing to meet benchmarks the Board declined to establish and clearly disclose in advance of budget submission. *In re MVP Health Ins. Co.*, 2016 VT 111, ¶ 20, 203 Vt. 274, 155 A.3d 1207.

The UVM Health Network and its hospital partners remain committed to playing their part in developing a regulatory process that controls the cost of care in a rational and data-driven way. We look forward to continuing this discussion with you.

Sincerely,

Rick Vincent,
Executive Vice President and Chief Financial Officer

Eric Miller,
Senior Vice President and General Counsel

Cc: Office of the Health Care Advocate