THE University of Vermont HEALTH NETWORK

Delivered Electronically

August 24, 2022

Jessica Holmes, PhD
Acting Chair
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Dear Acting Chair Holmes:

My team and I respect the right of anyone to express their opinion about the budget requests the University of Vermont Health Network (UVMHN) have submitted to the Green Mountain Care Board (GMCB) for Fiscal Year 2023, and we welcome public involvement in this process. The budget increases we seek are significant, and their causes and impacts should be fully understood by the public. For that reason, we have done more than ever this year to explain and be transparent about our requests, including sharing multiple explanations with community leaders, meeting face-to-face with business leaders, briefing the media and creating a website (www.uvmhealthimpact.org) that includes a section devoted to our financial challenges and the factors driving our unprecedented budget increases.

That said, we found it alarming and disappointing that Blue Cross Blue Shield of Vermont (BCBSVT) would file official testimony with the Board containing multiple false or misleading claims, and we feel it necessary to refute them, lest the public take their testimony as truth. Before addressing the specific falsehoods and misinterpretations included in BCBSVT's letter, I want to first address their conclusion: that Vermont might not need an in-state academic medical center. This proposition is particularly disturbing, and suggests a detachment from the reality of what their members – our patients – need.

Because Vermont has an academic medical center, the University of Vermont Medical Center (UVMMC), Vermonters are able to receive specialized care without traveling hundreds of miles to out-of-state hospitals, and we are able to train health care professionals who are so desperately needed right now.

Below we address a few key points that demand a response, in the order presented by BCBSVT.

Bond Ratings

Contrary to BCBSVT's claim, concern about our bond rating is not a justification we are using for the budget increase we seek. Our bond rating is a measure of our financial health, derived from

other measures (operating margin, operating EBIDA margin, days cash on hand, etc.) that indicate our financial stability and our riskiness as a borrower. Financial stability is needed to meet the needs of our region, including by investing in doctors, nurses, equipment and facilities, and to make these investments, we need to be financially stable and viewed as a reliable borrower.

We have not requested a budget increase based on losses from investments. Rather, we have requested a budget increase based on unprecedented cost inflation, primarily in our labor costs.

Performance Benchmarks

We believe financial, operational and quality benchmarks should be the backbone of a consistent, predictable and fair regulatory process. When BCBSVT asks for a rate increase, regulators look at the actuarial trends underpinning their cost assumptions and whether they have adequate reserves. Each year, we urge the GMCB to employ similar, standard benchmarks in their assessment of our requested budgets and our financial performance. We have suggested six measures we believe are legitimate, and provided the ranges related to those measures, which four rating agencies consider to be good indicators of financial stability. UVMHN's performance thresholds are a combination of all four benchmark sources, as all four sources reflect the greatest sample size from which to measure the financial stability of an organization. It would not be appropriate to only use the S&P system benchmark to determine financial stability, as Fitch and Moody's do not have a separate system benchmark, yet they too rate our organization and the data in their benchmarks also highlight what a financially stable organization looks like.

Hospital Inefficiencies

During our budget presentation, we cited several reputable and well-established national data sources for assessing our costs and quality as a health system. These include:

- The Dartmouth Atlas of Health Care (for Medicare only)
- The Council of Teaching Hospitals
- The National Academy for State Health Policy
- The Lown Institute
- CMS "Star Ratings"

All of these organizations are transparent about their data sources and methodologies. The only data source cited by BCBSVT, the American Hospital Directory (https://www.ahd.com/), is not one we have ever heard of. We do not know if it is valid, but we do see some striking discrepancies between the data cited and that which we produce ourselves or obtain through

reputable, well-vetted sources, and in looking at their website we cannot ascertain their methods[1]. Discrepancies we see include:

- The number of employees across the organizations listed are not apples-to-apples comparisons, as they vary depending on the structure of the organization and use of contracted labor. For example, the 3,912 employee figure listed for Dartmouth does not include their physicians, or their centralized network shared admin service staff (HR, IT, Revenue Cycle, etc.), whereas the UVMMC employee figure does.
- The investment income number shown for UVMMC is incorrect.
- Cash on hand versus general investment is very difficult to compare from one organization to another without knowing the organization's cash management policy, i.e. how much they keep liquid versus investing. That is why the only valid metric to benchmark is days cash on hand, as it combines the two and normalizes the data to the size of the organization. In addition, there appear to be issues with the data itself, as it is very unlikely that Maine Medical Center only has $2.6M days cash on hand and $6.9M in their general investment account.
- The personnel expense ratios cited in these data vary wildly and suggest that data are not an apples-to-apples comparison. Such comparisons are tricky across institutions when the source of the data has not been standardized to reflect differences in hospitals that employ the physicians, those that utilize more contract services than employing staff, and other related differences.

Other conclusions BCBSVT makes from these data are consistent with our own assessments and the testimony we have provided to the GMCB, including:

- Our case-mix index is low, and this is an area in which we need to improve our internal coding to more accurately reflect the risk profile of our patients.
- Our case-mix tends to be lower than Dartmouth's because we provide more services to patients with lower acuity as a community hospital.
- Our length of stay is above where we want it to be, and that has been exacerbated by the lack of post-acute and mental health placement options for our patients.

Utilization Calculation

As you know, total health care costs are a function of unit costs multiplied by the use of health care services. BCBSVT suggests that we should increase our utilization assumptions to reduce

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Please note this disclaimer on the American Hospital Directory website:
Disclaimer of Representations and Warranties
You agree and acknowledge that the information contained in this web site is intended to serve only as a guide and basis for general comparisons and evaluations, but not as the sole basis upon which any specific conduct will be recommended or taken.

our requested price increase. It would be nice to think that we could offset the price increases we have requested with increased volume of services provided, however:

- This flies in the face of our general approach to reducing overuse of care and everything we have been working to achieve as a state under the All-Payer Model (APM), and could be harmful to patients. We flatly reject the notion that we should "pump up the volume" of services to make our bottom line.
- We are at capacity across our hospitals, as are other hospitals across the state.
- The increase in revenue in our budget that is coming from additional services, given the extraordinary cost inflation we have incurred, will generate a loss, if the rate for that service is not increased. Each additional service we perform will generate even more loss, thus further deteriorating our financial stability. That is why the volume increase cannot be used, as BCBSVT suggests, to lower our rate increase.

As we hope we made clear in our presentation last week, we want to be held to overall cost of care and quality metrics, and do not want to simply play with utilization assumptions to prove our value.

340B and Pharmaceutical Drug Sales

It is true that hospitals across Vermont and across the country have become increasingly reliant on the 340B program to support their bottom line. Through this program, hospitals that serve significant numbers of Medicaid and uninsured patients can buy drugs at a discounted price through the federal government, sell them at the full price and use the difference to ensure access and overall sustainability of the organization. Reliance on this program as a major source of revenue has been incredibly challenging given its recent volatility, but it has in fact made the difference in being able to continue providing the access patients in our region have needed the last five years, as patient revenue rate increases have not kept pace with cost inflation. Most importantly, though, given the accusation, we want to clarify that UVMHN's participation in the 340B program in itself does not increase the cost of health care. In fact, just the opposite. Participation in the 340B program is simply moving revenue from the pharmaceutical industry to safety net health care providers, where that revenue is used to provide access to services.

Cost Shift from Public and For-Profit Payers

We have made clear in our testimony that we will apply any rate increases from Medicare and Medicaid that were not included in our budget submissions and that result in ongoing cost coverage to reduce our commercial rate request.

Affordability

BCBSVT displays a disappointing lack of awareness of the parameters of the All-Payer Model (APM) and how those parameters relate to your regulatory processes. We would like to be held to the APM targets for both costs and quality, and we are actively pursuing all opportunities to

engage in alternative payment models. BCBSVT, on the other hand, continues to resist meaningful participation in the APM.

Continual Hospital Growth

The BCBSVT testimony on this front is sadly out of touch with reality. We are not competing with Dartmouth. We are not competing with other community hospitals. We are trying to keep the doors open so we can preserve access and provide the services our communities need.

Taken together, BCBSVT's comments show a lack of understanding of hospital finances and financial health, a disregard for the health care needs of Vermonters and an irresponsible use of data sources. We trust you will weigh them accordingly.

Sincerely,

John R. Brumsted, MD
President & Chief Executive Officer
The University of Vermont Health Network

cc: GMCB members
Susan Barrett, GMCB Executive Director