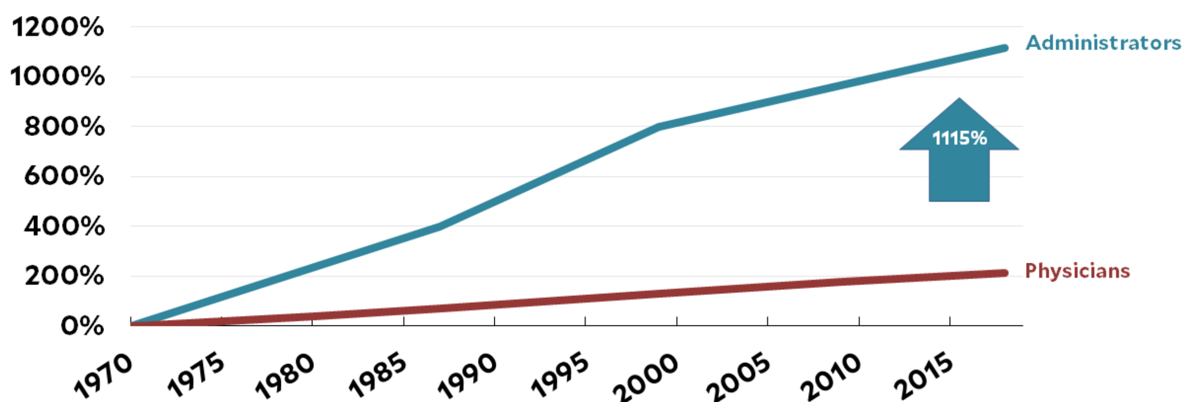

No evaluation of hospital budget "expenses" can be complete without stratifying the hospitals' administrative to provider ratio. As has become abundantly clear to researchers, more profound than runaway pharma prices is the growth of administrative burden and its contribution to rising costs in our health care system.

I recall visiting UVMMC's campus upon starting my brief tenure there. Upon landing in its atrium, I remarked I hadn't seen such ceiling heights since I lived on Central Park South across from the AOL Time Warner building and would enter its similarly grand atrium there. When arriving at the OneCare VT Water Tower campus in Colchester, I was struck by the AAA+ office space greeting me with sweeping, panoramic views of the ADK's to the west and Mount Mansfield and Camel's Hump to the east. Offices here reminded me of my own previous corner office overlooking Times Square.

When I left UVMHN for Lamoille Health Partners in Morrisville, VT I somehow found ease with the modest but adequate space provided us there to serve the mostly rural poor. I did not find the personal secretary I had at UVMHN was missed, adequate was my ability to make my own phone calls and photocopies. Gone too was the aspiring finance and consultant lingo so pervasive at UVMHN. Truncated words and phrases like "spend, ask, value add, high-level, granular, agnostic, exogenous, etc" and a literal handbook of acronyms were no longer burdening down every redundant and superfluous calendar invite I was forced to accept.

As Dr.'s Stensland and Walsh underscored well, "cost" is a function of the supply of health care dollars – money supply (M2) in any given system. With nearly 2/3's of health care M2 controlled by UVMHN, the fact that it is regulated makes the matter even more perilous. As competitors are lobbied out of Certificate of Need submissions, insurers are foreclosed from operating in VT due to onerous regulations, leaving those remaining at the mercy of the UVMHN monopoly promulgating its own competing MA payer, and a seemingly acquiescent DVHA run Medicaid and QHP portfolio – UVMHN routinely backs into its annual budget after already arbitrarily exercising its growing capital budget.

Dr. Stensland accurately described, the incentive lies with the foregoing administrative class's growing control over the providers it manages. CEO compensation orthodoxy has always been that they command roughly .1% of annual revenue – we see this reflected in both Dr. Brumsted's historical and now Dr. Eappen's current compensation. Not only is this an awe-inspiring incentive for such CEO's to grow their monopoly's revenue, but moreover, it compels them to insulate their executive board room with well-paid executive fealty and pay McKinsey consultant of questionable value.

Surveying the Director level and above titles and compensation of UVMHN, one will find myriad roles of questionable value to the average Vermonter – SVP's of PR/Comms, VP's of Data Management Offices, COO's who previously ran fish stands, and a whole cadre of former state appointees and BCBS VT execs meant to grease the wheels of monopolistic ambition. And beneath this ivory tower on the hill, remains all the humble front-line providers across the state like Lamoille Health Partners who struggle to barely make ends meet, with no less than 12 independent practices closing in just the last five years.

GMCB must flex its regulatory power. No examination of "expenses" will be complete without the following:

1. Meaningful examination of the value of administrative personnel at Director level and above, inclusive of their compensation contrasted with relevant median salaries.
2. Immediate and decisive employment and promulgation of site-neutral billing that does not reward monopolies for lavish spending on facilities so that the same or worse level care can be provided miles away from non-UVMHN practices teetering on the verge of failure.
3. Substantial re-examination of the CON process, its spirit and intent particularly as UVMHN currently submits for the state of VT to build surgical, ambulatory care denied to other non-UVMHN practices in just the last several years. Those denied must be brought back to the table and their CON proposals must be considered extant and competitive.

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