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August 25, 2023

Owen Foster, Chair
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Office of the Health Care Advocate FY2024 Hospital Budget Review Comments

Dear Chair Foster and Members of the Green Mountain Care Board:

The Office of the Health Care Advocate (HCA) thanks the Green Mountain Care Board (Board) and its Hospital Budget team for their diligent work to regulate Vermont's health care system. As the Board is aware, the state is at a critical tipping point regarding affordability and access. Between back-to-back years of commercial health insurance rate increases, a period of historic inflation and volatility, ongoing recovery from a global pandemic, and now recovery from devastating flooding, more and more Vermonters are being priced out of the care that they need. Our comments aim to provide the Board with actionable and evidence-informed recommendations to help guide its FY24 hospital budgets decisions. These recommendations are summarized below on pages 2-3 and described in further detail on pages 3-12.

This year, the HCA contracted with Dr. Nancy Kane to analyze the finances of the University of Vermont Health Network (UVMHN). We made the decision to focus on UVMHN due to its outsized influence on and importance to Vermont's health care system. Dr. Kane is Professor Emerita at the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health and a national health policy expert with specific expertise in hospital and health systems finance. She previously served on the Medicare Payment Advisory Commission (MedPAC), an agency advising the U.S. Congress on issues affecting the Medicare Program, and as a member of the Massachusetts Special Commission on Health Care Cost Containment. Dr. Kane analyzed the audited financial materials of the University of Vermont Medical Center

(UVMMC), the UVMHN Obligated Group, and UVMHN from 2019-2022 as well as their FY24 hospital budget submission. Her findings informed our recommendations and a summary of her findings and analyses are attached at the end of these comments beginning on page 13.

Below we provide our summary recommendations regarding FY24 hospital budget decisions. We provide evidence to support these recommendations in the body of these comments.

Summary Recommendations

1. In the interest of affordability and accountability, the Board should reduce all hospital budget increase requests that materially exceeded the two-year Net Patient Revenue/Fixed Prospective Payment (NPR/FPP) guidance to 2.8%, which is equivalent to Vermont's real GDP growth.[1] Implementing this recommendation would reduce the proposed charge increase of UVMMC, Central Vermont Medical Center, Porter Medical Center, North Country Hospital, Grace Cottage Hospital, Northeastern Vermont Regional Hospital, Springfield Hospital, Copley Hospital, Brattleboro Memorial Hospital, and Mt. Ascutney Hospital and Health Center.

2. The Board should approve the proposed FY24 budgets of Rutland Regional Medical Center, Gifford Medical Center, Southwestern Vermont Medical Center, and Northwestern Medical Center because they materially conform to the Board's two-year NPR/FPP guidance.

3. The HCA recommends that the Board exercise its enforcement authority under GMCB Rule 3.400 to conduct an independent review of UVMHN due to its demonstrated inability to control cost growth or conform to budget guidance in most years. Specifically, the Board should work with UVMHN to establish a performance improvement plan with the goal of cutting costs and aligning UVMHN's year-over-year growth with Vermont's real GDP growth over a two-year period. There is a clear

[1] United States Bureau of Econ. Analysis, Dep't of Com., GDP by State (last updated June 30, 2023), https://www.bea.gov/data/gdp/gdp-state (follow "Tables Only" hyperlink, see Table 1).

precedent for this approach: it is currently being done successfully by Massachusetts regulators with Mass General Brigham.[2]

4. The Board should build on the evidence-based guidance process launched this year by expanding its benchmarks to include hard caps on NPR/FPP, commercial charge, operating and administrative expense growth in accordance with established national benchmarks. The HCA also recommends that the Board consider site neutral billing rules and provider rate setting to reduce system costs, support independent practices, and improve access. Lastly, the HCA also recommends codifying clear metrics to evaluate meaningful progress on health equity, affordability, patient financial assistance, and community benefit in the FY25 budget guidance.

Introduction

The literature and on-the-ground evidence is clear that affordability negatively impacts a community's ability to get the right care at the right time.[3] The Vermont Household Health Insurance Survey – the highest quality representative survey available to quantify Vermonters actual experience with our health care system – shows that the rate of underinsurance among Vermont's privately insured residents alone has increased substantially from 27.3% to 44% from 2014 to 2021 (the most recent survey was conducted in 2021).[4] As costs increase, more and more Vermonters are likely to become uninsured, shift to low-quality plans with high out-of-pocket cost exposure (i.e., be underinsured), or forced into collections after receiving care because the cost of care and coverage are not affordable. As we know from the annual insurance rate review process, hospital charge increases drive the majority of the increases in premiums for commercial insurance coverage. It is also a truism that insurance carriers simply

[2] Mass. Health Pol'y Comm'n, Performance Improvement Plan – Mass General Brigham, https://www.mass.gov/info-details/performance-improvement-plan-mass-general-brigham.
[3] E.g., Shameek Rakshit et al., How Does Cost Affect Access to Healthcare? (January 30, 2023), https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care; Vt. Off. of the Health Care Advoc., Medical Debt in Vermont: Real People – Real Stories, https://www.vtmedicaldebt.org/.
[4] Vt. Dep't of Health, 2021 Vermont Household Information Survey at 45 (March 2022), https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR-VHHIS-2021-Report.pdf

pass the bulk of such price increases on to subscribers.[5] The evidence is clear that this is particularly true in highly concentrated markets[6] like Vermont.

All the compelling data in the world on the lack of affordability is of little value to Vermonters and Vermont families if it does not inspire meaningful action from policymakers and regulators. The Board must turn the page and move beyond its history of approving more than 99% of what hospitals have requested for their budgets.[7] Oddly, despite a regulatory history that is incontrovertibly favorable to Vermont hospitals, the bulk of the Vermont hospital industry still argues that the Board is somehow insufficiently supporting hospitals every hospital budget cycle. This year was no different. During the FY24 hospital budget guidance process, the Vermont Association for Hospitals and Health Systems argued that complying with the Board's previously established growth targets would cause hospitals to "risk either defaulting on their debt covenants and downgraded bond ratings or quickly cutting services to the community."[8]

Despite this threat of imminent default, UVMHN has an "A" debt rating from Fitch, with a "good payor mix and … a leading market share position with limited competition as a provider of high-end services" in its large service area.[9] To improve its rating (which was recently downgraded from a very healthy A+ rating to an also very healthy A rating), it has already executed a a margin improvement plan that is targeting hundreds of millions of dollars in expense savings (along with revenue enhancements which are largely already reflected in payer

[5] Cong. Budget Office, Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services (Sept. 2022), https://www.cbo.gov/publication/58541.
[6] E.g., Andrew Boozary et al., The Association Between Hospital Concentration and Insurance Premiums in ACA Marketplaces 38 Health Affairs 668 (2019); Nancy Beaulieu et al., Organization and Performance of U.S. Health Systems, 329(4) JAMA 325 (2003).
[7] Presentation by Owen Foster, Chair of the Green Mtn Care Bd. at 18 (Jan. 27, 2023), https://legislature.vermont.gov/Documents/2024/WorkGroups/Senate%20Health%20and%20Welfare/Green%20Mountain%20Care%20Board/W~Owen%20Foster~Introduction%20to%20Green%20Mountain%20Care%20Board~1-27-2023.pdf.
[8] Letter from Michael Del Treco, President and CEO, Vt. Ass'n of Hosps and Health Sys., to Owen Foster, Chair of the Green Mtn Care Bd. (May 3, 2023), https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB%20Letter%20on%20FY24%20Hospital%20Budget%20Guidance%20Reconsideration%205%203%2023.pdf.
[9] Fitch Ratings, Fitch Downgrades University of Vermont Medical Center Revenue Bonds to 'A'; Outlook Stable (June 30, 2023), https://www.fitchratings.com/research/us-public-finance/fitch-downgrades-university-of-vermont-medical-center-revenue-bonds-to-a-outlook-stable-30-06-2023.

contracts).[10] The Fitch ratings report outlines how much of this projected revenue has already been secured through contracts: "A major component of the plan is an increase in both commercial rates and supplemental payments with a target of $174 million, with $150 million already in finalized contracts, effective Jan.1, 2023, that is expected to generate $58 million revenue enhancement in FY23. However, the full value of the rate increases will only be realized in the next fiscal year." The rating agency suggests an operating EBITDA at or above 7% to maintain its rating – which UVMMC appears to have already achieved in its projected 2023 performance.[11] The obligated group, which includes UVMMC, ECH, and CVPH, may have a lower performance, at least in part because of the inclusion of one New York hospital that lost $30 million in 2022 (compared to a loss of $22 million for UVMMC alone), and which has been losing millions on operations in recent years.[12]

What the above-described dynamic makes clear is that the Board must impose significant constraints on hospital cost growth to fulfill its important regulatory duty to address consumer affordability. Many hospitals have demonstrated, year after year, that they are simply unwilling or unable to reduce costs themselves – particularly the University of Vermont Health Network. Given this fact and the convincing evidence that the current status quo ensures health care is neither affordable nor accessible, effective regulation is the best option available. The HCA is aware that adopting a stronger approach will not be easy – but there is simply no other choice. Failure to reduce cost growth will destroy Vermont's system of care to the detriment of patients. Vermonters deserve a high-quality, affordable health care system – and the Board has a duty to exert its authority to move the state closer to achieving that goal. Considering these facts, the HCA makes the recommendations listed below regarding FY24 hospital budgets.

[10] Id.
[11] Green Mtn Care Bd., FY24 Hospital Budget Review Tool (last updated August 15, 2023), https://public.tableau.com/app/profile/state.of.vermont/viz/hospitalbudgetreviewtool/OVERVIEW.
[12] Id.

Recommendation #1: In the interest of affordability and accountability, the Board should reduce all hospital budget increase requests that materially exceed the two-year Net Patient Revenue/Fixed Prospective Payment (NPR/FPP) guidance to Vermont's real GDP growth, which currently stands at 2.8%.

Budget guidance is of little value if regulated entities are permitted to continually ignore it without consequence. It is simply wrong to ask Vermonters to pay the price for the fact that most Vermont hospitals decided to ask for budget increases at or exceeding the budget guidance in the first year of a two-year period (increases that they received). The Board did not require or encourage any hospital to structure their budgets this way. Hospitals have significant autonomy to make a broad range of strategic decisions that impact the finances of their own organizations without requiring Board approval. Pursuant to GMCB Rule 3.305, the Board "may adjust the proposed budgets of hospitals that do not meet established benchmarks" which includes "(2) the hospital's ability to limit services to meet its budget, consistent with its obligations to provide appropriate care for all patients."[13] As outlined by the Board, the approved budget guidance aligned with the upper limit growth goal of 4.3% of the All-Payer Model Agreement.[14] The Board has the power to grant no budget increase to hospitals that exceeded the guidance. However, in the hope that Vermont hospitals continue to improve in their ability to recruit and retain permanent rather than increase or maintain reliance on traveling staff, expand and improve patient financial assistance, and meaningfully invest in evaluable health equity efforts, the HCA is supportive of a granting a small increase that aligns with Vermont real GDP growth.[15]

[13] GMCB Rule 3.305.
[14] Green Mtn Care Bd., About Vermont's All-Payer Model, https://gmcboard.vermont.gov/content/APM/AboutTheAPM.
[15] United States Bureau of Econ. Analysis, Dep't of Com., supra note 1.

Recommendation #2: The Board should approve the NPR/FPP increase requests for Rutland, Gifford, Southwestern Vermont Medical Center (SVMC), and Northwestern given that they materially conform to the Board's two-year NPR/FPP guidance.

While the HCA recognizes that all hospitals have room to improve with respect to expanding awareness, access, and patient financial assistance, we believe that the budget increase requests from Rutland Regional Medical Center, Gifford Medical Center, Southwestern Vermont Regional Hospital, and Northwestern Medical Center provide sufficient evidence to be approved given that they materially conform to the Board's budget guidance.

Recommendation #3: The Board should exercise its enforcement authority under GMCB Rule 3.400 to conduct an independent review of UVMHN due to its continued inability to control cost growth or align with Board budget guidance. Further, the Board should direct UVMHN leadership to work with them to establish a performance improvement plan that aligns cost growth with Vermont real GDP growth over a two-year period.

The HCA has significant concerns about the budget submission from the UVMHN, which asks for a substantial budget increase far exceeding the budget guidance approved by the Board.[16] GMCB Rule 3.306 clearly establishes that the hospitals bear the burden of persuasion to justify their proposed budgets. Further, Board rules clearly specify actions that the Board can take to modify a proposed budget – the "Board may adjust the proposed budgets of hospitals that do not meet the established benchmarks outlined in Section 3.202."[17] UVMHN's budget submission fails to meet the burden of persuasion and it does not meet the applicable guidance. It is essential that Vermonters have access to the only tertiary academic medical center in the state, which is staffed by some of the best nurses, technicians, and doctors in the world who deliver excellent care. Yet such a network is of no value if people cannot afford to receive care there. UVMHN's budget increase request – if not substantially reduced – will further price more and more Vermonters out of the care that they need.

[16] Green Mtn Care Bd., FY24 Hospital Budget Review Tool (last updated August 15, 2023), https://public.tableau.com/app/profile/state.of.vermont/viz/hospitalbudgetreviewtool/OVERVIEW.
[17] GMCB Rule 3.305.

UVMHN's budget submission shows that it has overperformed in several key dimensions from a revenue perspective relative to its approved budget.[18] In 2023, UVMMC is projecting to grow NPR by 15.5%, but the Board approved budget was along for 10.7% growth.[19] Contributing to the revenue in excess of budget was a Medicaid Graduate Medical Education payment projected to be $72 million, but only $41 million was in the budget. In 2023, the impact of the increased revenue over budget is projected to result in an increase in operating income of $26.8 million ($66 million instead of the budgeted $39 million). The 2023 budget also underestimated the proceeds from the Sale of Investments – the budget was $16 million but is projected to be $61 million. Taken together on the revenue side alone, UVMMC is projecting they will finish FY2023 with at least $100 million dollars more than what was approved by the Board. Despite this, they are still requesting an NPR/FPP increase that would be nearly three times more than the approved two-year guidance.

Importantly, recall that in 2018, the Board took enforcement action regarding a surplus for UVMMC's overperformance in FY2017.[20] This was in response to a letter from UVMHN that stated, in part:

> The University of Vermont Health Network was called upon to care for many more patients than anticipated in FY 2017. While that unexpected increase in patient volume affected Network hospitals to different degrees, it caused all the Network's Vermont affiliates to receive more revenue for patient care services than they had budgeted. The Network's Vermont hospitals also incurred significant additional expenses to treat those patients, and they collectively had a net margin that was 0.9% above budget.
>
> In order to ensure that the FY 2017 unbudgeted patient revenue is appropriately returned to Vermont's commercially insured patients, the UVM Medical Center proposes that the GMCB mandate a 0.0% change in the Medical Center's Vermont commercial rates in FY 2019, and both Central Vermont Medical Center

[18] See, infra, p. 15 (Table 1).
[19] Univ. of Vt. Med. Ctr., Report 1 Profit & Loss Statement, https://gmcboard.vermont.gov/sites/gmcb/files/documents/UVMMC%20FY24%20Summary_Income_Statement.pdf.
[20] Green Mtn Care Bd., Hospital Budget Enforcement: FY2017 UVMHN Enforcement Action, https://gmcboard.vermont.gov/Hospital-Budget-Enforcement.

> and Porter Hospital propose commercial rate increases no greater than 2.8%, the average rate of medical inflation.[21]

The HCA believes this is an appropriate precedent for reducing UVMHN's FY24 budget increase requests.

Shifting to the cost side, several key metrics demonstrate that UVMHN is not controlling costs effectively. To provide a few key examples: UVMMC's administrative to clinical ratio is more than double the national median for similar hospitals.[22] Its prices for inpatient and outpatient services are in the 8th and 9th highest decile nationally.[23] Porter Hospital's operating expense growth (17.8%) is more than double the benchmark (8.6%). UVMMC's pharmaceutical cost growth (30.7%) far outpaces the upper limit of the Board's benchmark (12.0%).[24] UVMHN's proposal to invest over $13 million dollars in their population health services organization (PHSO)[25] merits a similar level of scrutiny from the Board as it has recently applied to OneCare Vermont. Over the next 1-2 years, we recommend that the Board evaluate whether the PHSO is able to provide objective evidence that it is achieving a causal impact on the problems it is purportedly designed to address.

As is customary, a primary argument that UVMHN advances in support of its budget submission is the cost shift – a theory that has been thoroughly debunked by numerous academic and

[21] Univ. of Vt. Health Network, FY 2017 Actual-to-Budget Narrative at 1 (Jan. 31, 2018) https://gmcboard.vermont.gov/sites/gmcb/files/A17N99%20NARR.pdf
[22] Green Mtn Care Bd., supra note 15.
[23] Christopher M. Whaley et al., Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative (2022), https://www.rand.org/pubs/research_reports/RRA1144-1.html.
[24] Green Mtn Care Bd., supra note 15.
[25] Univ. of Vt. Health Network, Fiscal Year 2024 Hospital Budget Submissions to the Green Mountain Care Board at 45 (June 30, 2023), https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY_2024_UVMHN_budget_narrative_6.30.23_final_1.pdf.

policy analyses[26] as well as representative real-world case studies at the state level.[27] Yet even if one was to accept that the cost shift justification logic advanced by UVMHN was sound – and set aside the fact that doing so requires believing in the unsupported inherent rationality of the hospital chargemaster and the convenient legitimacy of all hospital-defined costs – where would this leave the role of regulator? Following the logic of the cost shift to its logical conclusion results clearly implies that the regulator should simply approve whatever costs the hospital submits. This would inevitably both further incentivize and legitimize spiraling cost increases into the future. Such cost increases – if approved – would inevitably be passed on to Vermonters and deplete public payer funds. The role of regulation is not to apply incentives for cost overruns but to establish reasonable constraints that encourage efficiency, improve access and quality without compromising the financial health of Vermont's hospital system.

It is also critical for the Board to recognize that hospitals have tremendous flexibility to modify their own budgets and how they operate. Many revenue and expense numbers are the result of strategic decisions fully within their control, not dictated by the Board. For example, the Board does not require UVMHN to subsidize its medical school[28] or its New York hospitals[29] as much as it does yearly. The HCA is not suggesting that the NY hospitals and the medical schools should not be supported. Rather, we question whether VT ratepayers should be the ones subsidizing it.

Given the substantial number of concerns detailed above, the HCA recommends that the Board develop a performance improvement plan with the UVMHN to reduce costs to align with

[26] E.g., Presentation by Zack Cooper before the Green Mtn Care Bd., Hospital Prices in the US: Why Do We Care, Why Do They Vary, and Why Do they Grow? (April 5, 2023), https://gmcboard.vermont.gov/sites/gmcb/files/documents/Zack%20Cooper%20GMCB%20-%2004.05.2023.pdf; Presentation by Jeff Stensland before the Green Mtn Care Bd., Cost shift or revenue shifting? (March 22, 2023), https://gmcboard.vermont.gov/sites/gmcb/files/documents/Green%20Mountain%20Board%20Cost%20Shift%202023.pdf; Frederic Blavin, Association of Commercial-to-Medicare Relative Prices with Health System Performance (2023), 4(2) JAMA Health Forum, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2801226; Office of the Health Care Advoc., Fact or Fiction? Evaluating the Evidence on the "Cost Shift" (June 2022), https://www.vtlegalaid.org/sites/vtlegalaid/files/publications/HCA-Policy-Paper-Cost-Shift-%28limited-accessibility%29.pdf.

[27] Colo. Dep't of Health Care Pol'y and Fin., Colorado Cost Shift Analysis (2023), https://hcpf.colorado.gov/colorado-cost-shift-analysis.

[28] See, infra, p.16 (Table 2) p. 18 (Table 3); p. 21 (Table 6).

[29] See, infra, p. 19 (Table 4).

Vermont's real GDP over a two-year period. We recommend consulting with the Massachusetts Health Policy Commission which recently led successful negotiations with Mass General Brigham, after the commission identified a pattern of unsustainable cost overruns for reasons not dissimilar to those currently present at UVMHN.[30] The performance improvement plan – jointly brokered by Mass General Brigham and approved by the Massachusetts Health Policy Commission – is slated to result in over $127.8 million in savings, the bulk of which ($90 million) will be from commercial pricing actions.[31] As was done in Massachusetts, the Board need not micromanage hospital costs on a granular level – but it can work with the hospital to find agreement on cost centers to target. Although we recommend a collaborative approach, the Board must be prepared to act if UVMHN is unwilling to cooperate.

Recommendation #4: Build on the strong evidence-based guidance and hospital budget process launched this year.

The HCA looks forward to continuing to work with the Board as part of the hospital budget guidance process as it evolves. We recommend that the Board consider expanding its benchmark metrics in the FY25 Budget Guidance to include hard caps on Net Patient Revenue tied to real state GDP[32], provider rate setting[33], as well as clear benchmarks by which to measure health equity,[34] affordability,[35] and community benefit.[36] As outlined in our previous comments, we continue to advocate that hospitals both continue to shift more of their uncompensated care from bad debt to free care, improve engagement with community

[30]Mass. Health Pol'y Comm'n, HPC Board Meeting (Jan. 25, 2022), https://www.mass.gov/doc/presentation-board-meeting-january-25-2022/download.
[31] Mass. Health Pol'y Comm'n, HPC Board Meeting (Sept. 27, 2022), https://www.mass.gov/doc/presentation-board-meeting-september-27-2022/download.
[32] Id.
[33] Nat'l Assoc. of State Health Plans, Overview of State Hospitals' Referenced Based Pricing to Medicare Initiatives (Feb. 7, 2023), https://nashp.org/overview-of-states-hospital-reference-based-pricing-to-medicare-initiatives/.
[34] E.g., Sahil Sandhu et al., Hospitals and Health Equity — Translating Measurement into Action (2022) 387(26) New Eng. J. Med. 2395, https://www.nejm.org/doi/full/10.1056/NEJMp2211648.
[35] E.g., Ezekiel Emanuel et al., Measuring the Burden of Health Care Costs on U.S. Families: The Affordability Index (2017), 318(19) JAMA 1863, https://jamanetwork.com/journals/jama/fullarticle/2661699; Office of the Health Care Advoc., The Cost of Health Insurance: Quantifying the Vermont Affordability Crisis (2018), https://www.vtlegalaid.org/sites/vtlegalaid/files/publications/HCA-The-Cost-of-Health-Insurance-Quantifying-the-Vermont-Affordability-Crisis_V3.pdf.
[36] E.g., Nat'l Acad. for State Health Pol'y, State Reporting Templates for Tax Exempt Hospitals: Community Benefit Expenditures and Program Outcomes, https://www.nashp.org/wp-content/uploads/2020/03/hosp-cmmty-benefit-reporting-template-3-13-2020.pdf.

members to ensure awareness and access to patient financial assistance is as straightforward as possible for all parties, and consider hiring community health liaisons to engage with patients where they are rather than continue spending money on contracts with debt collectors. The HCA continues to remain concerned that hospitals are both measuring and reporting bad debt and free care in an inconsistent and unpredictable manner across the Vermont hospital system. We believe that improving Vermonter's access to patient financial assistance would benefit from clear direction and action from the Board.

Conclusion

The HCA remains committed to working with Vermont's hospitals and the Board to improve access to care and affordability for Vermonters. We believe all parties agree that we need a sustainable health care system that is high quality and affordable. However, we must remember that these goals are not mutually exclusive. Both are not only possible, but essential to protect and maintain. Please do not hesitate to contact the HCA Policy Team with any questions regarding our recommendations. Thank you for your consideration.

Sincerely,

s\ Mike Fisher, Chief Health Care Advocate

s\ Sam Peisch, Health Policy Analyst

Financial Analysis of University of Vermont Health Network

Dr. Nancy Kane in Collaboration with the VT Office of the Health Care Advocate (HCA)

Dr. Nancy Kane is a Professor of Management Emerita in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health. Dr. Kane consults with a wide range of federal and state agencies involved in health system design, oversight, and payment. She served two terms as a member of the Medicare Payment Advisory Commission (MedPAC), an agency advising the U.S. Congress on issues affecting the Medicare Program and as a member of the Massachusetts Special Commission on Health Care Cost Containment. She won the 1997 Taplin Award for Translation of Ideas into Public Benefit for her work on creating financial transparency of nonprofit hospitals and their community benefit activities. Dr. Kane's research expertise is in financial and strategic performance of health care organizations. Dr. Kane earned her Master's and Doctoral Degrees in Business Administration from Harvard Business School.

Executive Summary

- UVMHN is on solid financial footing from a traditional financial metrics standpoint.
- UVMHN must consider the financial impact of subsidizing underperforming New York (NY) hospitals – particularly Champlain Valley Physicians Hospital (CVPH).
- UVMHN and the Board must consider the long-term sustainability and value of subsidizing its medical school to the tune of 20 – 30 million dollars per year net of Medicaid GME payments.
- The Board should consider reducing UVMHN's commercial rate increase request by the sum of its overperformance in NPR and the projected improvement in sale of investments from 2023B to 2023P.
- The Board should consider implementing a similar benchmark target (per capita health expenditure growth cap tied to state growth in GDP per capita) and performance improvement plan process as the Massachusetts Health Policy Commission.

Introduction

Enclosed below is an analysis of financial findings from standardizing the audited financials of University of Vermont Health Network (UVMHN or System) going from 2022 back to 2019. UVMHN is operating around break-even from operations, except for 2022 when they reported a 3.7% operating loss, which would have been much worse (-6%) without Cares Act grants. The Medical School support payments are a huge drain on their ability to generate an operating profit. At the system level, it represents between 1 and 2% of total operating expenses, which directly reduces operating profits, EBITDA, by that amount. I recommend that the Board evaluate whether the state medical school subsidy should be this large a burden on the clinical system, given that it is financed by patients and insurers. The liquidity of UVMHN is adequate despite the drop in market value of their portfolio in 2022 (which has been recovering in 2023). The system has enough cash to more than cover their long-term debt, so they are in no danger of a solvency crisis. The System has a reasonable long-term debt – on the high end of "reasonable" from a rating agency perspective; but their relatively low operating cash flow limits their ability to add much more debt. They made it through 2022 with adequate coverage of 1.38, despite the heavy draw of the medical school, but generally rating agencies like to see higher coverage ratios. Any plans for additional debt (beyond refinancing) will heighten the pressure on them to improve operating cash flow.

Most of the System's financial strength comes from the University of Vermont Medical Center (UVMMC), which, besides making over $110 million in subsidies to the medical school over the last four years (taken out of operating expense), has also transferred another $90.9 million out ("below the line" – not affecting income) to affiliates, especially to the UVMHN "Parent" organization, which redistributes resources back out to the various members of the System (see Table 3). UVMHC also seems to be where roughly half the cash and investments in the System are "pooled," and the investment income earned by the pool resides at the Parent. The Parent's primary mission is to "develop a highly coordinated health care delivery system…;" and it undertakes a lot of shared service activities. The cost structure is in flux; in 2020 it reported close to $5 million in operating expenses, which have whittled down to $0 in 2022. It remains unclear where this expense went and what activities these expenses supported. Economic

transactions within UVMMC are not broken out in the audited financials; only transfers among the top and second line "boxes" in the org chart could be identified. The Medical School, the biggest recipient, is an "expense" within UVMMC's financials.

Table 1. Comparison of UVMHN Projected Budget to Approved Budgeted

Here is what the net revenue history looks like from the audited financials (AFS) and the rate filing for UVMMC alone:

	2024 Budget	**2023 Projected**	**2022 Rate Filing**	**AFS: 2022**	**AFS: 2021**	**AFS: 2020**	**AFS: 2019**
Regulated NPR	1640986	1512845	1309050	1309050	1133578	1033439	1141749
Annual Growth	1.084702002	1.155682		1.154795	1.096899	0.905137	
	2023 Budget:	1449920					
	2023 B over 2022 Actual	1.107612					
	2023 Proj over 2023 Budgeted	1.043399					

Key Takeaways

- UVMHN grew NPR by 15.5%, but the budget was for a 10.7% growth. This suggests that UVMHN's budgets may be on the conservative side (e.g., understating revenues).
- In 2023, the impact of the increased revenue over budget is an increase in operating income of 26.8M (66M instead of the budgeted 39M).

Table 2. Key Financial Metrics for UVMHN

Profitability:	2022	2021	2020	2019	Fitch Rating Median 2022	
					A	A-
Total Margin	(0.016)	(0.000)	0.011	0.020	.032	.01
Total Margin excluding Net Med School Payments	.008	0.012	0.012	0.013		
Total Margin including Unrealized Gains/losses	(0.097)	0.034	0.017	0.025		
Operating Margin	(0.037)	0.009	(0.009)	0.005	.011	-.013
Op Marg excluding Net Medical School Payments	-0.003	0.02	0.00	0.02		
EBITDA Margin	0.027	0.076	0.063	0.067	.086	.06
Markup	2.22	2.26	2.04	2.17		
Liquidity:						
Days Cash on Hand including Board-designated and undesignated investments	121	199	192	142	222	187
Days in Patient Accounts Receivable	48	52	48	45	47	49
Solvency:						
Long term debt/total capitalization	0.349	0.316	0.355	0.317	.38	.42
Pension-adjusted LTD/Capitalization	0.355	0.323	0.379	0.351		
Total Debt to EBITDA	16.1	7.2	9.4	6.7	3.8	6.3
Debt Service Coverage	1.38	1.45	2.40		3.5	2.6
Cash and Investments/LTD only	1.58	2.09	1.79	1.65	1.18	1.11
Funded Status of DB Pension (% funded)	0.94	0.93				
Other:	2022	2021	2020	2019		
Average Age of Plant	11.53	12.10	10.49	11.02	13.5	12
Capital expenditure / depreciation expense	0.71	0.69	0.88	1.80	1.03	.92
Cumulative Capex/depreciation 2019-2022	1.000					
Free care/Total Operating Expense	0.005	0.004	0.006	0.006		

Key Takeaways

- Profitability is roughly break-even and made slightly negative with medical school payments net of the Medicaid GME subsidy, and the performance of 2 of their 3 hospitals in NY (see Table 4)

- 2022 was their worst year in terms of operating margin; industry trends in premium labor and longer ALOS were probably the main contributors, and these are mitigating in 2023 (as one can see in their projected 2023 operating margin for UVMMC from Rate Filing). Included in these operating losses are substantial losses incurred in two of their New York hospitals (see table 3 below)

- Pre-2022 EBITDA margins are roughly where Fitch has suggested they should be.

- Liquidity is adequate, negatively impacted by losses and by a very large loss in market value due to stock market swings (which have been swinging back in 2023).

- Plant age is well within the rating category.

Notes on Medical School Subsidization from UVMHN 2022 Audited Financial Statements[37]

Appended from Footnote 16 of AFS

- "UVM Medical Center's Affiliation Agreement with UVM was renewed as of September 1, 2022 and extends through August 31, 2032. The Affiliation Agreement expresses the shared goals of UVM and UVM Medical Center for teaching, clinical care and research, documents the many points of close collaboration between the two organizations, provides the underpinnings for UVM Medical Center's status as an academic medical center, and obligates UVM Medical Center to provide substantial, annual financial support to UVM. The current Affiliation Agreement provides for three components of financial support to UVM: (1) payments by UVM Medical Center, known as the "commitment," to fund two costs: (a) a portion of the salary, benefits and related expenses paid through UVM to physician-faculty who are jointly employed by both UVM and UVMHN Medical Group and, (b) a portion of the cost of UVM facilities, utilities and other campus operating expenses that are not paid or reimbursed by any form of federal funding; (2) an academic support payment paid by UVM Medical Center, and (3) a Dean's Tax paid by UVM Medical Group. The amounts of the commitment approximated $59,639,000 and $45,157,000 in the years ended September 30, 2022 and 2021, respectively. In addition, UVM Medical Center reimburses UVM for equipment rental, research, and certain other administrative expenses through the commitment."

- "UVM Medical Center made academic support payments to UVM in monthly installments. The annual amount of the academic support payment was $8,848,000 and $8,543,000 in the years ended September 30, 2022 and 2021, respectively. Under the current affiliation agreement, the base amount for academic support payments increased for $9,806,000 in fiscal year 2023, with an inflationary increase in the years thereafter."

- "Under the Affiliation Agreement, the Dean's Tax is paid to UVM by UVM Medical Center in an amount equal to 2.3% of the Medical Group's net patient service revenues exclusive of all Medicaid revenues for that fiscal year. The amount of the Dean's Tax approximated $4,836,000 and $4,826,000 in the years ended September 30, 2022 and 2021, respectively. Additionally, a guaranteed payment of $1,000,000 in Dean's Taxes on UVM Medical Group patient service revenues of community-based physicians was recorded in the years ended September 30, 2022 and 2021."

[37] Ernst & Young, Consolidated Financial Statements and Supplemental Information: The University of Vermont Health Network Inc. and Subsidiaries Years Ended September 30,2022 and 2021 With Report of Independent Auditors, Footnote 16, Pages 60-61. January 26, 2023. https://gmcboard.vermont.gov/sites/gmcb/files/documents/UVMHN%20and_Subsidiaries_22-21_VFINAL_%28Unsecured%29.pdf

Table 3. UVMHN Intra-System Transfers

$ in thousands

Intra-UVMHN Transfers	2022	2021	2020	2019	Four-year sum
UVMMC	-30666	-610	-50859	-8754	-90889
CVMC	500	56	1468	7631	9655
CVPH	-491	-573	-5	4537	3468
ECH	0	925	73	21	1019
UVMHN	73950	-870	-27798	-42189	3093
Obligated Group Eliminations	-14033	372	76087	48249	110675
PMC	-300	-28	300	341	313
Alice Hyde	-425	0	106	480	161
Home and Hospice	500	500	800	860	2660
Other entities	8349	14698	13253	-3131	33169
Eliminations	-37506	-14985	-4846	-8044	-65381
Sum of "transfers & other"	-122	-516	8579	-21	7920

Key Takeaways

- UVMHN's is making several significant transfers from UVMMC, its flagship academic medical center, to support the community hospitals and other affiliates in both Vermont and New York.

Table 4. Performance of New York Hospitals

	Operating Income		
	ECH	**AHMC**	**CVPH**
2022	2,677,000	-12,033,000	-30,950,000
2021	3,048,000	-2,287	-7,921,000
2020	2,237,000	2000	-8,406,000
2019	1,523,000	213,000	-8,039,000
System Subsidy 2019-2022	1,018,000	163,000	3,466,000*
2022 Long-term debt plus current portion **(13.5% total long-term debt of system in 2022)**	13,200,000	29,100,000	50,733,000

*Most of CVPH subsidy was provided in 2019 (4.5M); since then, CVPH has been transferring back a total of about 1M.

** It appears CVPH owes "related parties" (current liability) $29M as of 2022; AHMC owes "related party" $3.5M current and 2.2M long term. ECH owes only about $122K (current). This raises questions as to whether short-term loans will be enough and how UVMHN plans to address these New York hospital system losses going forward.

Key Takeaways

- CVPH and AHMC are a significant negative draw on UVMHN's finances.

Table 5. Financial Impact of CVPH on Key Bond Rating Metrics

	OG-CVPH	Obligated Group
Profitability:	2022	2022
Total Margin excluding investment income	0.007195	-0.00484
Operating Margin	-0.01728	-0.02664
EBITDA Margin Excl Unrealized gains/losses	0.051089	0.038305
Op EBITDA margin	0.027699	0.017438
Current Ratio	2.249447	1.827476
Days Cash on Hand All Sources	141.3345	123.9503
Long-term debt/total capitalization	0.329287	0.337703
LTD/EBITDA	5.032934	6.077693
Debt Service Coverage	2.004041	1.990794
Cash and Investments/LTD only	1.440687	1.4136

Key Takeaways

- CVPH negatively impacts UVMHN's bond rating due to being a part of the obligated group.

Table 6. UVM Medical Center (UVMMC) Key Financial Metrics

$000 in thousands

Profitability:	**2022**	**2021**	**2020**	**2019**		
Total Margin	-0.018	-0.012	-0.006	0.023		
Total Margin before Med School Payments	0.015	0.017	0.025	0.055		
Total Margin including Unrealized Gains/losses	-0.081	0.047	0.024	0.045		
Operating Margin	-0.012	0.023	-0.003	0.022		
Operating Margin before Med School Payments	0.02	0.051	0.028	0.054		
EBITDA Margin	0.028	0.038	0.051	0.07		
EBITDA Margin before med school payments	**0.067**	**0.103**	**0.086**	**0.101**		**Totals**
Transfers to other affiliates	-30666	-610	-50859	-8756		-90891
Net Operating Income	-22727	36523	-4005	31406		41197
Excess Revenue	-32632	-18461	-9275	33107		-27261
Medical school payments	-59639	-45157	-45512	-46198		-196506
Current Ratio	1.94					
Days Cash on Hand including Board-designated and undesignated investments	112					
Days cash if no transfers	132					
Days in Patient Accounts Receivable	44					
Cash and Investments, all sources, $000	554,000					
Cash and Investments if kept transfers 2019-2022	644,891					
Long term debt/total capitalization	0.308					
Long term debt/total capitalization X transfers 2019-2022	0.288					
Debt Service Coverage	1.44					
Debt service coverage before med school payment	3.1					
Cash and Investments/LTD only	1.4					
Cash and Investments before transfers/LTD 2019-2022	1.63					

Key Takeaways

- Transfers to the medical school from UVMHN have a negative impact on EBITDA, total margin, and operating margin.

Notes from Review of Audited Financials

UVMHN (Network): Primary assets as of 2022 were cash and investments. The only source of revenue was investment income, both realized and unrealized. No reported expenses in the 2022 AFS, but did report expenses in 2020 of about $4.7 million, then only $894K in 2021, then 0 in 2022. These expenses are mostly managerial salaries.

Primary activities per IRS 990 from 2020 (latest available): Provide services designed to develop a highly coordinated health care delivery network to improve quality, increase efficiency, and lower the cost of health care in the regions it service. Shared services at network level include credentialing, enrollment, contracting, management of budgeting and reporting tools, marketing and communication, IT services, auditing fees and investment fees. The network appears to primarily be a conduit for the allocation of pooled investment returns.