- David Taft today will share his story about his missed cancer diagnosis in 2019 and his current unpaid medical bills he's paying UVMMC after they degraded his credit score, while trying to pay to rectify what they missed and how he will live rest of his years hoping his treatments keep the previous stage 4 cancer from spreading further. There are many more like him who have reached out to me, too afraid to speak. My hope is David's courage has inspired them to make their voices heard as well.
- The type of diagnosis and treatment David needed in 2019 is the fundamental medicine that requires sufficient staffing. Since 2018, UVMHN has coordinated the redirection of hundreds of millions of dollars that would otherwise have been available to direct patient care to the sexier work of population and IT execs paid at 15x the median income of VTers funding their salaries, IT projects at 3x national average, some of the most costly/sf vanity building projects in the country, concurrent to expanding its revenue and balance sheet as Dr. Eappen's predecessor went on a more than decade long spending spree and acquisition endeavor. Dr. Eappen's predecessor was a profligate spender.
- The state of hospitals at present reminds me of the state of retail before I left it for health care
 - Massive consolidation transpired from the late 90's through the Great Financial Recession
 - Enormous sums were spent on expensive but low margin acquisitions and handsome executive salaries.
 - And then the business model broke post-GFR when tremendous *deflationary* pressures with the entrance of online retailing
 - Shareholders raced to justify every line item of expense, returning conglomerates to fundamentals that eventually either went bankrupt or were chopped up into what was valuable.
- Similarly, hospitals post-Covid face tremendous *inflationary* pressures which have broken their business model. Vermonters are UVMHN's shareholders, and GMCB is VTers board of directors. As with retail after the GFR, GMCB in the state of VT must examine every line of cost for its ROI. Chair Foster has repeatedly asked academics and hospital executives how to balance controlling costs and not reducing access to care. There are four main areas where "non-profit" hospitals plow profits executive compensation, vanity building projects, excessive IT spending and unproven population level endeavors with poor outcomes.
 - The four top executives Seated before us today shared an aggregate of \$4mm in C-suite compensation averaging to \$1mm per executive or 33x Vermonters median income paying their salaries. Many more were on this call today:
 - Dr. Eappen's predecessor went on an unbridled spending spree on executive recruitment, snatching up:
 - a former regulator at a cost of \$800k annually
 - another former regulator VT AHS presumably at 15x median VT wages
 - A former US Atty on this call today at \$600k+ at 20x VT median wages
 - A former BCBS VT exec
 - On and on and on
 - There are members of this GMCB regulating these executives, equally qualified to perform some of their roles and yet you work for many multiples less.

- UVMHN even accounting for their proposed change in math for admin to clinical compensation is at the high whisker mark or more than 71% above the national median, demonstrating economies of scale As Member Walsh pointed out haven't been realized and as I will enumerate further momentarily, this is a top-heavy organization. Reducing UVMHN from 24% to the median of 14% would yield some of the savings necessary for the hundreds of front-line staff who have cried out to GMCB this week. It's the type of move shareholders would demand after leadership abandoned management fundamentals for a decade.
- UVMHN proposes an OSC that on a cost/sf basis is the most expensive proposed build in the nation at 3-5x cost of similar builds. No less than 3 hospitals and a nurse's union have petitioned for Interested Party Status to protest the ill-conceived nature of this proposed \$150mm investment to be made by VT tax and premium payers.
- Such profligate spending results in facility fees and outsized consumption of scarce health care dollars in the system which every year risks to put our higher value, lower cost community providers out of business forever, exacerbating the current well documented access to care crisis VT faces. And while UVMHN may claim it necessary to recruit top talent, ask VT's highest paid physician in Rutland, Dr. Mel Boynton if he's stayed for RRMC's lavish atrium.
- UVMHN has spent hundreds of millions on IT infrastructure since 2019, but has never told Vermonter's what ROI they've received for it
 - In 2024 alone UVMHN proposes to spend \$150mm on IT 3x the national average of 3% of operating expense – on this line alone \$100mm in 2024 exceeds the national average spend for same
 - Top heavy management include:
 - An SVP of Network IT at \$655k annually or 20x VT Median income
 - Network VP Health Informatics \$450k 15x VT Median income
 - Chief Medical Informatics again \$450k and 15x
 - A VP of Enterprise Info Mgmt & Analytics, presumably at similar comp
- UVMHN has led this state's health reform efforts. Since 2018, hundreds of millions of scarce health care dollars have poured into this ACO and now UVMHN proposes to spend another \$23mm on a duplicative Population Health Services Organization and provides only very high level, aspirational language around its aims and accomplishments over the last 21 months. This is eerily reminiscent of the same language its ACO used for years before former AHS Commissioner Mike Smith said it needed to move on from being aspirational to being operationalized.
 - Top heavy management includes:
 - \$2mm spent on ACO executives.
 - \$590k on SVP of High Value Care.
 - \$510k on SVP & Chief Population Health & Quality.
 - Assistant General Counsel of Population Health (whatever that is).
 - VP Managed Care contracting.
 - I cautioned UVMHN's wholly owned ACO in 2018 it could not achieve its aims with the analytics it possessed, they were not actionable or reliable, despite

continuing to represent otherwise to GMCB, DVHA, the Legislature and the public. For that I was terminated by my supervisor.

- That supervisor is now a UVMHN VP over analytics mentioned a moment ago.
- Four years later BCBS VT would cite lack of actionable data and consequent interventions as part of its reason for withdrawing and even the NORC report assesses providers find the analytics similarly insufficient or irrelevant.
- Since 2018, UVMHN's leadership of health care reform has seen its 3 most important clinical quality measures – hypertension, depression screening and SUD screening underperform, as hypertension scores bounced between the 60th and 70th percentile and Depression and SUD weren't benchmarked and rates of uptake in screening showed little improvement.
 - From 2018 to 2021, what CDC data tragically shows us is that hypertension, suicide, and SUD related deaths grew far in excess of national averages for age-adjusted mortality and likely resulted in over 500 additional age-adjusted deaths beyond national averages over the same period.
- It's time to get back to the fundamentals of medicine. Every line item matters, the time for pie in the sky is over.
- The public would make the following requests accordingly:
 - First and foremost, compel UVMHN to examine the case of David Taft:
 - Immediately clear his credit history
 - Reimburse him for all he's paid to treat stage 4 cancer that metastasized because of their missed prostate cancer Dx in 2019.
 - Immediately pay for him to receive a second opinion on his current treatment course and reassure him the prostate that wasn't surgically intervened in addition to the cancer found in his ribs will remain in remission with UVMHN's chosen course of Tx.
 - Provide him free care for all remaining course of treatment
 - Deny the current CON until and if:
 - Its projected costs are brought in line with national cost/sf averages.
 - It can be shown that UVMHN will provide the better quality and cost of care than current care in the region or by those who were and continue to be denied specialties offering higher value, lower cost care.
 - Reduce the 2024 budget by an amount equal to the excess of 3% of operating expenses for their IT investments – currently \$100mm
 - Demand an ROI accounting for all Epic investments made to date
 - Demand UVMHN perform a thorough evaluation of all executive leadership, their value – including their total compensation as compared to national median comp for same at VP level and above.
 - The 71% greater than national median ratio of admin to provider total compensation must be reduced to national average for same a top heavy organization's ranks need to be thinned during times of crisis

The monopoly business model has broken post-Covid. This moment is a sea change. Monopolies can either take a line-item approach on behalf of its shareholders who are the Vermont tax and premium payers funding it and you the GMCB – Vermonter's Board of Directors, or like past industries who refused to change, they can face the risks of loans being called and further financial deterioration.