THE
University of Vermont
HEALTH NETWORK

March 27, 2023

Green Mountain Care Board
c/o The Honorable Owen Foster, Chair
144 State Street
Montpelier, VT 05602

Dear Chair Foster:

As we have over the last several years, in our oral presentations and written submissions, the University of Vermont Health Network team has urged the Green Mountain Care Board to establish externally-derived benchmarks and objective criteria drawn from credible national and regional health care data sources by which hospital budgets will be judged. In our letter to the Board on February 3, we proposed a set of objective benchmarks that should govern your review of Vermont's FY 2024 hospital budgets – criteria that would produce budgets that best meet the needs of Vermonters and the hospitals that care for them.

Our team appreciated the work of Sarah Lindberg and the GMCB hospital finance staff in their effort to update the hospital budget guidance approach, focusing on expense growth thresholds based on publicly-available data. After reviewing Sarah's presentation to the Board on March 15, our Network team was beginning to assess the proposed staff framework and appreciated the direction of the GMCB staff approach, even if the extent of the impact of their recommendation was not fully knowable.

After listening to discussion during the Board's March 22 meeting, it became apparent that Board members likely would reverse the staff recommendation and ultimately decide to stay with a Net Patient Revenue (NPR) cap in this year's hospital budget guidance. Draft FY 2024 budget guidance with these changes included was posted on Friday afternoon – just three days before the deadline for public comment, and just five days before the Board will formally approve and adopt budget guidance. Considering these time constraints on what should be an inclusive process, it is challenging to provide meaningful input to the Board or have real insight of the Board's regulatory approach.

Please find below comments from the Network regarding specific sections of the draft guidance and our initial thoughts regarding the proposal currently before the Board.

Net Patient Revenue

In adopting FY 2023 hospital budget guidance in March 2022, the Board established NPR growth guidance of up to 8.6% for FY 2023 and FY 2024 combined – 4.3% for each budget year. The Board has often used 4.3% as an allowable NPR growth target for a given budget year, as it has been commonly used to equate the overall acceptable yearly growth of total health care costs (not hospital costs) in our All-Payer Model. Our Network has asserted many times over that an annual NPR increase of 4.3% is simply not representative of the reality we experience delivering health care, and it does not fully address the record-setting cost inflation and expense challenges hospitals are currently facing.

If the Board continues approval of the 8.6% NPR cap (for FY 2023 and FY 2024 combined) in this year's budget guidance, we know UVM Medical Center will automatically exceed the limit. Simply limiting NPR growth without consideration of the access and revenue implications or the overall financial health of hospitals risks destabilizing our health system. We believe it is essential to establish appropriate targets for hospital financial margins as part of your process, as well as to recognize cost inflation that we cannot control.

Ultimately, we continue to believe that our regulatory framework must move toward population-based budgeting, with Total Cost of Care targets adjusted for patient acuity and cost inflation. In fact, the Board's enabling statute[1] directs it to focus on a per-capita measurement of cost – we again ask that the Board focus its regulatory energy on advancing a structure grounded in value-based care as opposed to continuing down this path of measurement grounded in a fee-for-service system.

Comparisons and Benchmarks

Throughout the draft budget guidance, the Board has contemplated comparing or benchmarking various aspects of hospital budget growth against external sources. While this would seem to meet the stated request of the Network as it relates to our year-over-year feedback on the Board's budget review process, we are left with many questions. For instance, how seemingly differing or competing benchmarks will be evaluated remains unknown.

Specific areas of concern include:

Section A. Labor Expenses
On March 24, the Vermont Department of Labor released news that the Vermont unemployment rate decreased yet again[2]. We are not in a healthy labor environment, and the Board assessing per FTE growth in salary and benefits using a metric not based on our experience in Vermont does not take into account the real experience of hospitals as they work to hire desperately needed staff.

Section C. Pharmaceutical Expenses
We can support providing more information on pharmaceutical expenses, which is one of the

[1] https://legislature.vermont.gov/statutes/chapter/18/220
[2] https://labor.vermont.gov/press-release/press-release-vermonts-unemployment-rate-decreased-28-percent-february

fastest growing portions of our budgets, but need to be clear that our ability to impact the purchasing costs of drugs is severely limited. While the Network has an outstanding supply chain and pharmacy team, our ability to negotiate pales in comparison to the pharmaceutical manufacturers.

Section D. Cost Inflation
Included on page 8 of the draft budget guidance is a peer group chart. UVM Medical Center is the only academic medical center in the state – what hospitals will you compare it to? How will it be treated as both an academic medical center and as a community medical center, and what are the sources for these benchmarks?

Section F. Financial Indicators
The draft budget guidance reads: "Financial health may be assessed at the hospital and consolidated levels." If the Board were to choose to do so, how would they define our consolidated system? And if we are to be evaluated as a system, what benchmarks would be used in performing that evaluation?

Varied Data Sources

The draft budget guidance contains mention of many varied data sources:

- RAND relative pricing project
- Yale Health Care Pricing Project
- GMCB reimbursement variation report
- KaufmanHall National Flash Reports
- Cecil G. Sheps Center for Health Services Research at the University of North Carolina indicators
- Dartmouth Atlas of Health Care
- All-Payer Model Total Cost of Care
- Mathematica Policy Research's Rural Health PAU Dashboard

We ask the Board to define clearly in the budget guidance how these sources will be used in the hospital budget process. These data sources contain multitudes of information (some of which draw competing conclusions). It will be important to understand how they will be used to judge hospital budgets – what are the metrics that will be used in the process? How will those sources of data be applied? What specific measures will be drawn from these data sources, and what are the allowable ranges or expected thresholds associated with those measures?

Facility Fees

The request to report "facility fees" is confusing based on the Board's definition, which is not aligned with industry standards. It is unclear as to what the Board is asking as it relates to a facility that is "out of network." Does that mean out of a payer network or a hospital network system? Within hospital billing and revenue a "facility fee" generally means any separate charge or billing by a provider-based clinic. This is done by reducing the professional fee for physicians' services and creating a facility bill for the difference, which is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

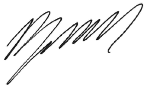
Medicare and most Medicare Advantage payers incorporate “facility fees” into the reimbursement of services in order to support services moved from hospitals into clinic settings covering overhead and additional costs of providing care. Commercial payers have varied in this policy with most moving away from such a billing model, which creates barriers at times when moving services into a provider setting. Given the long term practice of provider-based billing, which allows for facility fees, reporting of distinct “facility fees” would not materially impact the GMCB review of a hospital’s proposed budget as the revenue, which is permitted per Medicare and payer billing policies, is incorporated in a hospital’s overall revenue model.

Administrative Costs

We are concerned that some information you are requesting in this section of the guidance may be proprietary in nature. Additionally, the Board’s intended use of this data is unknown – what would be your intention for using this information? What value does it bring to the Board’s deliberative process?

In conclusion, we are at a critical juncture in our state’s health care system history, where queries lacking in specificity may have negative unintended consequences and further destabilize the system. We generally support the use of external benchmarks, but hope to be able to work with you to more clearly specify how they will be used. We do not support the NPR cap as proposed and hope you will consider a cost limit that relates more directly to our financial health and cost inflation. That said, as we have every year, the UVM Health Network will continue to justify why we require the budget we submit.

Sincerely,



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