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August 30th, 2024

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

Re: Office of the Health Care Advocate FY2025 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 regulating Vermont's hospitals. Our comments aim to provide the Board with actionable recommendations that we believe will improve patient affordability and access while preserving hospital sustainability.

As we did last year, the HCA contracted with Dr. Nancy Kane to review and analyze the financial positions of University of Vermont Health Network (UVMHN) hospitals from 2019-2023. Dr. Kane is Professor Emerita of Health Policy and Management at the Harvard T.H. Chan School of Public Health and a national health finance and policy expert. Her findings are appended to the end of this comment on pages 18-24.

Our recommendations are as follows:

1. Establish a price ceiling for all inpatient and outpatient services at the 6th decile nationally of RAND standardized price.

2. If the Board chooses not to apply a price ceiling this year, the Board should take enforcement action to reduce the commercial rate increase requests of Northeastern Vermont Medical Center, Rutland Regional Medical Center and Porter Hospital by the amounts that they exceeded their FY23 budget. The Board should reduce UVMMC's commercial rate request by at least the amount of its FY23 overage and strongly consider reducing it further by the total amount of its subsidization of New York hospitals.

3. If the Board chooses not to apply a price ceiling this year, the Board should approve NPR and commercial rate increases of no more than the guidance caps of 3.5% and 3.4% for all other hospitals.

4. As a part of each budget order, require that hospitals achieve a minimum of 1.5:1 ratio of bad debt to free care for FY25; notice that the Board will exercise enforcement authority to correct variances between budgeted and actual performance on bad debt and free care; and order hospitals to fully comply with Act 119.

1. **Establish a price ceiling for all inpatient and outpatient services at the 6th decile nationally of RAND standardized price.**

The HCA has not seen any credible evidence to explain why Vermont should be one of most expensive states in the most expensive country for healthcare.[1] Historically, common arguments hospitals offer to explain our high costs range from blaming Vermont's demographics to allegedly inadequate public payer reimbursement rates. These arguments are at best insufficient and inconclusive.[2] They are also far less convincing when compared with the extensive research showing that high prices are the driving force behind higher health care costs statewide, nationally, and internationally.[3]

A powerful tool that the Board has used and should continue to use to address Vermont's price issue is the RAND price transparency data.[4] While no dataset or method is perfect—as any honest researcher or data scientist will tell you—perfection is not, and should not, be the goal. A dataset can be imperfect, yet also accurate, meaningful, and useful for regulation. When it comes to comparative hospital price data, RAND is currently the best available dataset.

RAND utilizes two different price points—relative and standardized—to account for differences in hospital characteristics. While both price points have merit, standardized prices are particularly valuable because they incorporate public monies from Medicare for Graduate Medical

[1] Wager, E, et.al. How does health spending in the U.S. compare to other countries? 2024. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202022%20(U.S.%20dollars,%20PPP%20adjusted.

[2] Green Mountain Care Board. "Hospital Budget Review: Overview of FY25 Budget Requests". August 6, 2024. Slides 8 and 17. https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY25%20Hospital%20Budget%20Review%20-%20AUG%20-%20Staff%20Overview.pdf.

[3] Green Mountain Care Board. "GMCB Staff Presentation". August 6, 2024; Papanicolas, I, Woskie, LR, and Jha, AK. Health Care Spending in the United States and Other High-Income Countries. JAMA. 2018 13;319(10):1024-1039. https://pubmed.ncbi.nlm.nih.gov/29536101/.

[4] Green Mountain Care Board. "OSC Statement of Decision – Redacted". https://gmcboard.vermont.gov/sites/gmcb/files/documents/20240729_OSC_Statement_of_Decision_Redacted.pdf.

Education and Sole Community Hospital status. Both prices are case mix–adjusted and account for differences in procedure composition between hospitals.[5]

Not all VT hospitals are overpriced, particularly with respect to inpatient prices. Only two Vermont hospitals are above the 6th decile nationally for inpatient standardized price. **However, eight hospitals are above the 6th decile nationally for outpatient standardized price.** There is no credible explanation for why Vermonters and Vermont's insurers should be paying prices that are in the top 40% nationally. A cap must be implemented for both inpatient and outpatient because hospitals could simply raise inpatient prices if only outpatient prices were capped and vice versa.

The HCA knows such a recommendation may be seen as controversial. However, the Board should compare the potential risks of making this decision to the likely catastrophic future costs of not making it. To prevent an impending financial disaster for Vermonters and Vermont families, small businesses, the insurance market, and the state budget, the Board must go further than reducing commercial rate and NPR increases. A health care system that is already one of the most expensive in the country - if not the most expensive - will remain that way if hospital prices are not capped. The legislature gave the Board the authority to set a price ceiling for a reason. There is no clearer time than now to exercise that authority.

[5] Whaley, C, et. al. Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2024. https://www.rand.org/pubs/research_reports/RRA1144-2.html.

2. **If the Board chooses to not apply a price ceiling this year, then the Board must at a minimum take enforcement action to reduce the commercial rate increase requests of Northeastern Vermont Medical Center, Rutland Regional Medical Center, and Porter Hospital by the amounts that they exceeded their FY23 budgets.[6] The Board should reduce UVMMC's commercial rate request by at least the amount of its FY23 overage (at least 3%) and strongly consider reducing it further by the total amount of its subsidization of New York hospitals.**

At a high level, the Board's authority to set budgets is of little value if hospitals are permitted to exceed allowed budgets without consequence. Vermont cannot afford excess costs in one year, let alone allow them to be carried into future years through rebased budgets. The HCA does not dispute that increased revenue received by hospitals was largely to provide care to Vermonters. However, this does not change the fact that revenue is still just the product of price and utilization. If a hospital received more revenue than was allowed, then its commercial rate request should be reduced.

Five arguments inform the HCA's specific recommendation to reduce UVMMC's commercial rate increase by at least 3%. First, UVMMC has not presented sufficient credible evidence to justify its commercial rate or its NPR increases, both of which are more than double the increases outlined in the Board's hospital budget guidance (Guidance). Second, there is credible evidence that shows that UVMMC is overpriced. Third, there is credible evidence that shows that UVMMC is inefficient. Fourth, UVMMC's assertion that its commercial charge and NPR increases are justified by public payer under-reimbursement is neither persuasive nor supported by reliable evidence. Lastly, UVMMC is in a robust financial position, particularly considering that its position would be even stronger if it did not choose to subsidize its New York affiliates.

[6] The HCA recognizes that if the Board sets a cap on inpatient and outpatient prices, this will have a significant effect on the budgets of some but not all hospitals, as several are below the 6th decile for both outpatient and inpatient standardized price. However, such a price cap would impact UVMMC and Northeastern Vermont Medical Center. If a price cap was applied, then it would reduce their charges significantly more than if just the budget overage amount was utilized, thus negating the need for enforcement action.

a. UVMMC failed to justify its commercial rate or NPR increases.

UVMMC's 7.91% commercial rate increase request and 8.6% NPR increase request, both more than double the Guidance, must be justified by "credible and sufficient supporting evidence that the excessive growth reflects an improvement in access or quality of care."[7] UVMMC attempts to justify its increases by asserting that they improve access. However, UVMMC conflates utilization with access. Utilization is only a metric of *realized* access. Many Vermonters, even before the requested price increases, are priced out of even going to the hospital when they need to.

Given that utilization lowers access for some, increased utilization, assuming it is appropriate, must be balanced against the fact that increased utilization leads to health insurance rate increases. Higher insurance rates make the already substantial cost barrier that Vermonters face when accessing services even larger. This fact is summed up by two comments submitted during the rate review process:

> My 'affordable' health care is currently close to $800/month with a deductible of almost $10000. This increase would be detrimental to me continuing to get this health care as it's already a stretch and I make decent money. I am a solo business owner with already extremely high small business taxes and not to mention astronomical housing costs. This increase would be devastating to my continuing [effort] to recover health… and also continue [to] pay for housing, food, and other basic needs. With the thought of a family in the future, I cannot even think of how I would be able to afford health care for my family without going broke.[8]

> As a small business owner I pay for my own health insurance and a significant proportion of our employees['] health insurance. Health insurance rates have been increasing at an unsustainable rate for far too long. Insurance keeps getting more expensive at a faster rate than anything else, it takes up a larger and larger portion of my personal budget and our businesses. This means we either need to go without insurance, literally gamble with our lives, or forgo other basic needs. From a business perspective health insurance costs prevent us from hiring more employees and make it harder to grow. Additionally as a business we are forced to make health care decisions for our employees, if we offer health plans like we do some employees [lose] out on the subsidies from the exchange, if we don't offer health insurance then other

[7] Green Mountain Care Board. "FY25 Hospital Budget Guidance". https://gmcboard.vermont.gov/document/fy25-hospital-budget-guidance-updated.
[8] Green Mountain Care Board. "2025 Vermont Induvial and Small Group Rate Filing Comment". Pub. Comment 219. https://ratereview.vermont.gov/sites/dfr/files/documents/Combined_Redacted.pdf.

> employees [lose] out on our subsidies for health insurance. No business should have to decide which of its employees gets better health care and which don't.[9]

UVMMC compounds this access issue by requesting that the Board disregard it actual-to-budget NPR overage. UVMMC offers various arguments for this request, the most prominent being that increased utilization drove revenues higher than expected. UVMMC implies that the increased utilization caused their expenses to increase at essentially same rate as the NPR overage, e.g., that nearly all expenses were "variable." This argument is not convincing because it assumes a variable cost accounting method that is far outside what is seen as standard in the hospital industry, which is closer to 40-60%.[10]

UVMMC's also asserts that it needed the additional revenues to "recover" cash to "pre-pandemic" levels, even though in 2021 their days cash on hand (DCOH) of 201 was relatively high—well above their own "178 benchmark" and the 172 DCOH they had in 2019. Regarding the 88-day days cash on hand reduction in 2022 from 2021, such a reduction requires context. There are several alternative explanations for a substantial amount of this reduction: unrealized losses on their investment portfolio in 2022 (23 days); transfers to affiliates (6 days); and changes in working capital, reduction in accounts payable/accrued expenses, and other current liabilities, including, but not limited to repaying Medicare and Social Security for COVID related advances (33 days cash on hand). The lack of a separate unconsolidated cash flow statement from UVMMC for 2022 makes further analysis of other potential causes of reduction in DCOH impossible to evaluate. UVMMC has provided no evidence to rule out such alternative explanations.

[9] Green Mountain Care Board. "2025 Vermont Induvial and Small Group Rate Filing Comment". Pub. Comment 99. https://ratereview.vermont.gov/sites/dfr/files/documents/Combined_Redacted.pdf.
[10] Roberts, RR, et. al. Distribution of variable vs fixed costs of hospital care. JAMA. 1999 Feb 17;281(7):644-9. doi: 10.1001/jama.281.7.644. PMID: 10029127.

Lastly, recall that **just six years ago UVMHN asked the Board to grant UVMMC a 0% commercial rate change because of revenue overages due to increased utilization**.[11] Back then, UVMHN stated:

> 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 and Porter Hospital propose commercial rate increases no greater than 2.8%, the average rate of medical inflation.[12]

UVMMC does not address why their 2023 overage should be treated any differently than how they themselves requested it be treated back in 2019. Instead, its response letter to the FY2023 variance simply asserts the excess revenues should be kept by itself, which would only increase commercial insurance rates for Vermonters.

While the HCA is encouraged by improvements in some measures of access that were documented in UVMHN's recent response, it is disappointing and misleading that UVMHN is now arguing that these improvements are somehow *dependent* on obtaining revenue significantly beyond what was approved in the budget order. It is also critical to note that despite earning excess revenue in FY23, UVMMC is not asking for a 0% commercial increase, as it did under similar circumstances in the past—it is requesting a commercial increase that is more than double the Guidance. **The Board must reject UVMMC's argument that improving access requires approving excess NPR.**

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[11] Green Mountain Care Board. "Hospital Budget Enforcement: FY2017 UVMHN Enforcement Action". https://gmcboard.vermont.gov/Hospital-Budget-Enforcement.
[12] UVMHN. "FY 2017 Actual-to-Budget Narrative at 1". Jan. 31, 2018. https://gmcboard.vermont.gov/sites/gmcb/files/A17N99%20NARR.pdf.

b. UVMMC is overpriced.

The Board should focus on the impact that UVMMC's high prices on both Vermonters and the Vermont health care system. **RAND data makes clear that UVMMC is expensive both nationally and relative to other hospitals in the Guidance peer group whether using relative or standardized price.** UVMMC is the highest priced hospital in the Guidance peer group regarding relative price for outpatient services and standardized price for outpatient services. UVMMC is also in the highest deciles nationally in relative price and standardized price for outpatient services. Outpatient prices are of particular importance given that outpatient care revenue accounts for 68% of UVMMC's budgeted revenue for FY2025B (over $3.4 billion dollars in FY2025).[13] On the other hand, UVMMC is close to the middle of the peer group in terms of relative price and standardized price for inpatient services and is in the 6th decile nationally in terms of relative price.

UVMMC's submission seeks to cast doubt on the accuracy and validity of the RAND data by suggesting that it is incomplete and therefore inaccurate. UVMMC arguement conflates whether a data source is "incomplete"—as is inevitable with any pricing data in the United States—with it being inaccurate. Representativeness and validity are far more important and meaningful measures of data quality than completeness. RAND's study leveraged data from the Vermont All-Payer claims database (VT-APCD) and incorporated roughly one-third of total commercial spending in the final sample, which is more than sufficient to make valid statistical comparisons. Most neighboring states (New Hampshire, Rhode Island, Maine, and Connecticut), which include many of the hospitals in the guidance peer group, also submitted all-payer claims data. It is dubious to assume—without evidence—that the data excluded from the VT-APCD or the supposed unique mix of services offered could have caused the pricing data to be significantly inflated or inaccurate.

[13] UVMMC. "Income Statement". https://gmcboard.vermont.gov/document/uvmmc-income-statement-fy25-0.

UVMMC's own price analysis, which is presumably offered to counter RAND, is flawed. UVMMC writes that: "the standardization of cases used in the RAND analysis is not fully capturing the differences between patients, and that part of the pricing is determined by patient complexity in a way that has not been fully captured" and presents data with its own additional case mix adjustment. However, this results in an adjustment to both sides of the equation. Analysis with this type of methodological error is not reliable. Put simply, there is no credible evidence in the record to dispute the finding that UVMMC is expensive relative to comparable peers and nationally.

UVMMC also argues that it is low-cost by overgeneralizing and misinterpreting conclusions from outdated published research. For instance, it writes of the work of Zack Cooper from the Yale Price Transparency Project: "Cooper published two papers showing this spending, the first in 2015 and the second in 2022. The 2015 paper shows that the Burlington, VT HRR, which is the area in which UVMMC is the primary provider of tertiary hospital care and in which all 6 UVMHN hospitals are located, is in the second spending quintile nationally (2nd least expensive). While this area was one of the least expensive Medicare regions, it was also among the lower cost commercial areas." What is not mentioned is that the Burlington, VT HRR region includes seven *non*-UVMHN hospitals: Rutland, Copley, and Northwestern in Vermont, and Potsdam, Massena, Saranac Lake, and Ticonderoga in New York. It is therefore misleading for UVMMC to claim credit for its HRR being comparatively lower cost, because UVMHN and non-UVMHN hospitals are grouped together. It could just as well be that non-UVMHN hospitals helped explain why the HRR was lower cost comparatively in that period. There is no way to answer that question without conducting a type of adjusted regression to isolate the individual price/cost effects of non-UVMHN vs. UVMHN hospitals in the HRR. The study cited, though methodologically valid, was not designed or intended to examine hospital-specific prices.

c. UVMMC is inefficient.

It is well-established that Medicare prices are designed to provide modest profit margins for efficient hospitals.[14] However, recent work by Board consultants Bartholomew & Nash show that the six largest Vermont hospitals are dramatically underperforming with respect to managing to Medicare, with UVMMC identified as the worst performer in terms of its Medicare Payment-to-Cost ratio (72%).[15] While the HCA acknowledges that UVMMC disputes both the interpretative value and accuracy of this finding, it is difficult to credibly argue that the data itself is invalid, because hospitals themselves are the source of Medicare cost report data. It is also not methodologically valid to simply adjust UVMMC's costs downward using a non-transparent method and not fully explain why other hospitals that are being compared to UVMMC are largely left unadjusted. Even if the calculations that Bartholomew & Nash generated were the result of an analysis of incomplete data, UVMMC does not explain why there has been a negative trend in how this ratio has eroded over time (94% in 2011 to 72% in 2024).[16] Further, even if one is to assume, for the sake of argument, that the calculations were substantially off—say by 10-15%, a significant error—UVMMC would still be inefficient as defined by MedPAC. Such inefficiencies are important to identify because they directly translate to prices borne by Vermonters.

d. Public payer reimbursement is not the cause of UVMMC's high commercial rate increases.

A primary argument that UVMMC advances in support of needing a 7.91% increase in commercial rates is the cost shift. That theory, which argues low public payer reimbursement rates

[14] Medicare Payment Advisory Commission (MedPAC). "2022 Report to Congress". https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_v3_SEC.pdf.
[15] Presentation by Bartholomew, J, and Nash, T to the Green Mountain Care Board. "Financial Analysis - Vermont Hospitals Presentation to GMCB". July 15, 2024. https://gmcboard.vermont.gov/sites/gmcb/files/documents/Bartholomew%20and%20Nash%20presentations%20-%2008.06.2024.pdf.
[16] Green Mountain Care Board. "UVMMC FY25 Budget Presentation". https://gmcboard.vermont.gov/sites/gmcb/files/documents/UVMMC%20FY25%20budget%20presentation%208.28.24%20final.pdf.

cause the need for high commercial prices, has been thoroughly debunked by academic research, policy reviews, and case studies at the state level.[17] UVMMC's citation of a blog post written by a hospital industry CEO to justify its continued use of the shift to justify its high commercial charge is not credible.

According to Kaiser Family Foundation, Vermont has one of the highest Medicaid reimbursement rates in the country, the highest in New England,[18] and the highest of all states in which Guidance peer group hospitals are located. This data source is the most current available for statewide comparisons, likely due to the logistical challenge of contacting each state's Medicaid agency and collating relative reimbursement from states with significantly different reimbursement approaches and methodologies.

State	2019 Relative Reimbursement Rate
Vermont	0.86
Massachusetts	0.78
Connecticut	0.75
Pennsylvania	0.68
Maine	0.66
New York	0.57
New Hampshire	0.57
Rhode Island	0.37

[17] Colo. Dep't of Health Care Pol'y and Fin. Colorado Cost Shift Analysis. 2023. https://hcpf.colorado.gov/colorado-cost-shift-analysis; Presentation by Zack Cooper to the Green Mountain Care Board. "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 to the Green Mountain Care Board. "Cost shift or revenue shifting?" March 22, 2023, https://gmcboard.vermont.gov/sites/gmcb/files/documents/Green%20Mountain%20Board%20Cost%20Shift%202023.pdf; Blavin, F. 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.

[18] Kaiser Family Foundation. Medicaid-to-Medicare Fee Index. 2019. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D .

Using the 2019 reimbursement rate and 2019 Medicaid cost report data, the HCA conducted a comparative analysis of UVMMC to other Guidance peer group hospitals. We looked at the relationship between unreimbursed Medicaid costs as a percentage of operating expenses and relative Medicaid reimbursement rate, as well as between unreimbursed Medicaid costs as a percentage of operating expenses and payer mix—two relationships that would have to be correlated if the cost shift were true. We found a very weak to nonexistent relationship between these variable pairs (p = -0.11 and 0.03, respectively). These Vermont-specific findings are consistent with previously cited real-world and academic research showing the nonexistence of the cost shift at the state and national level. In sum, UVMMC argues that the amount of unreimbursed Medicaid costs means that costs must be shifted to the prices they charge commercial payers. Behind this contention, are two assumptions—that Vermont reimburses Medicaid claims less than other states and/or that Vermont hospitals provide more services to patients with Medicaid (payer mix). One or both assumptions needs to be true for the cost shift claims to be plausible. Neither assumption is supported by the evidence.

e. <u>UVMMC is in a strong financial position.</u>

UVMMC is in a strong financial position (see pages 17-19), but UVMHN has consistently weakened its financial position by choosing to transfer monies to the New York hospitals, local affiliates that are a part of UVMHN, and the UVM medical school. Operating margins before net payments to the UVM medical school were over 4% in three of the past five years—above median operating margins of Fitch-rated hospitals and systems through 2022. Net payments to the UVM medical school—89 million net of Medicaid Graduate Medical Education (GME) payments—took between 1 and 2 percentage points off UVMMC's operating margin each year. UVMMC has also transferred over $93 million to other affiliates over the period 2019-2023. The HCA has not heard a credible explanation for why Vermonters should be subsidizing the UVM medical school or

UVMHN's New York hospitals in part through higher commercial rates. A complete analysis of the audited financials of UVMMC, UVMHN, CVMC, and Porter Hospital is available on pages 17-22.

3. **If the Board chooses not to apply a price ceiling this year, the Board should approve NPR and commercial rate increases of no more than the guidance caps of 3.5% and 3.4% for all other hospitals.**

Following the approval of double-digit rate increases for Vermont's individual and small group markets for the second consecutive year, coupled with consistent data of hospital prices and early data from the hospitals predicting a rise in uninsured/self-pay patients, there is no need to belabor the point that Vermont is in a downward spiral with respect to affordability. Indeed, the Board's adoption of a commercial rate and NPR cap in guidance reflects an acknowledgment of the critical importance of Vermonter's ability—often inability—to pay for medical care. The Board should do more in the future to explicitly establish an affordability standard within the hospital budget and rate review processes. This year, the Board should use PCE price index plus 1% standard as of January 2024. Also, the Board should consistently require Vermont's hospitals to operate within the financial means of the populations they serve.

4. **As a part of each budget order, require that hospitals achieve a minimum of 1.5:1 ratio of bad debt to free care for FY25; notice that the Board will exercise enforcement authority to correct variances between budgeted and actual performance on bad debt and free care; and order hospitals to fully comply with Act 119.**

The HCA is encouraged that most hospitals are close to Act 119 compliance. The HCA began contacting every hospital over a year ago reminding them of how to comply with the law and provided each hospital with template a plain language summary, a template financial assistance policy, and other resources for how to construct their asset tests and document requirements. We performed this role because it is critical that low- and middle-income Vermonters receive the benefits afforded to them by Act 119.

We have concerns about the commitment of some hospitals to comply with Act 119. Most policy changes and updates came in the last month during the hospital budget review process, not

before the July 1st date when the law became effective. Hospitals also tended to implement changes that focused on ensuring theoretical access rather than making substantive changes to the mechanics of demonstrating financial assistance eligibility, such as revising application documentation or adjusting how assets and household income are measured per Act 119 requirements. Some hospitals, for example, required applicants to report income and submit documents related to Veterans' benefits, housing vouchers, food stamps, worker's compensation, and child support even though Act 119 explicitly excludes those items from being counted as income. Further, while most hospitals describe "presumptive eligibility" in their full financial assistance policy, not a single hospital updated their application or other public-facing materials to inform patients about it. Under such policies, if the patient receives certain types of public assistance benefits, the hospital can deem them "presumptively eligible" for financial assistance without the patient needing to apply.

We agree with hospitals that some patients do not complete the documentation that hospitals require them to provide. However, we do not believe that low application completion rates are somehow reflective of patients' unwillingness to cooperate. Rather, patient "non-compliance" is more likely due to the excessive and onerous eligibility documentation requirements of the past that are now prohibited under Act 119. Additionally, it is plausible that many patients are not even aware that financial assistance exists or that they might qualify.

Hospitals gave various excuses for their poor bad debt to free care ratios and their non-compliance with Act 119 requirements during the hearings. These excuses ranged from blaming the patient to pointing out the brief timeframe for Act 119 compliance. We do not find either of these arguments' persuasive. It is a basic fact that the more barriers one establishes to successfully receive aid, the fewer people will apply and receive support. Furthermore, Act 119 had a two-year implementation window. As discussed above, hospitals were given templates that would have, if used, brought them into compliance with the law and were offered technical assistance repeatedly by

the HCA over the past year. That some hospitals chose to put off legal compliance until or after the last minute is concerning.

Switching topics slightly, as raised on multiple occasions in the hearings, hospitals consistently overbudget free care and underbudget bad debt. The difference between budgeted and actual free care and bad debt is often substantial and actuals tend to show that hospitals write off more bad debt than budgeted while providing less free care than budgeted. Given this discrepancy and the fact that patient financial assistance too often is an afterthought, we recommend that the Board actively define an acceptable baseline ratio for the provision of free care.

A mandated minimum of free care to bad debt ratio of 1.5:1 is reasonable in the first year of Act 119, with a goal of moving all hospitals to a minimum of 1:1 ratio by FY2026. Further, the budgeted ratio should be "trued up" with actual results, and hospitals whose budgeted ratio varies significantly from its actual ratio should be required to submit concrete corrective action plans on programs and practices that will be implemented to better align budget to actuals.

Eight of fourteen hospitals are already at or close to the 1.5:1 ratio in their budgeted submissions to the Board, so the HCA does not believe this recommendation to be onerous. While such budgeted variance might be viewed as a rounding error for some hospitals or a niche concern of the HCA, we are adamant that increasing Vermonter's ability to apply for and receive patient financial assistance, if eligible, directly improves affordability and access. While a $1,000 or even a $100 hospital bill might appear trivial in the context of multi-million or multi-billion-dollar budgets, such amounts can be devastating for Vermonters. Receiving patient financial assistance can make the difference between Vermonters going into debt or avoiding getting the care they need.

CONCLUSION

All parties agree that we need a sustainable health care system that is high quality and affordable. Implementing hospital rate setting and establishing a clear affordability standard coupled with rigorous enforcement standards around NPR, commercial rate and bad debt/free care will help realize a better Vermont healthcare system. As the Board's enabling statute states: "Systemic barriers, such as cost, must not prevent people from accessing necessary health care" yet "Overall health care costs must be contained, and the growth in health care spending must balance the health care needs of the population with the ability to pay for such care."[19]

Thank you for your consideration.

Sincerely,

s\ Mike Fisher, Chief Health Care Advocate

s\ Sam Peisch, Health Policy Analyst

s\ Emma Zavez, Consumer Research & Health Policy Analyst

s\ Eric Schultheis, Staff Attorney

s\ Charles Becker, Staff Attorney

[19] 18 V.S.A. § 9371.

Review of UVMMC & UVMHN Audited Financials: 2019-2023

By Dr. Nancy Kane

UVM Medical Center Financial Performance

UVMMC is financially healthier than the System in terms of profitability and solvency. The consolidating schedules of the audited financials did not provide the data needed to calculate the adequacy of capital spending (capital expenditures, accumulated depreciation). Operating margins before net payments to the Medical School were over 4% in 3 of the five years – above median operating margins of Fitch-rated hospitals and systems through 2022. Operating margins before med school payments were much lower in 2020 and 2022, which were tough years across the industry. Net payments to the medical school took between 1 and 2 percentage points off the operating margin each year.

Total margins excluding unrealized gains and losses were below operating margins in three of the five years, mostly because of negative adjustments to the value of pension investments in 2021 and realized losses on investments in 2022. When unrealized gains and losses were included, the total margin is quite a bit more volatile, but generally higher than without the unrealized results except in 2022.

Liquidity at UVMMC was like the System as a whole, since over half the System's cash and investments were held by UVMMC. UVMMC transferred over $93 million to affiliates over the period 2019-2023, which lowered the level of cash and investments held by the Med Center (unless they are transferring out other types of assets, which is possible but not disclosed).

Liquidity:	**2023**	**2022**	**2021**	**2020**	2019
Current Ratio	2.61	1.97	1.92	1.72	2.02
Days Cash on Hand All Srcs	115	113	200	194	172
Days cash before transfers	118	121	200	208	175
Days in Patient Accounts Receivable	44	44	52	49	45
Cash and Investments, all sources, $000	622879	561438	826265	743299	639915

In terms of solvency, UVMMC on its own is carrying relatively less long-term debt than the System as a whole. Even when including its pension and operating lease obligations, its "adjusted debt" to total capitalization is below the Fitch medians for just long-term debt/total capitalization. Debt service coverage and cash to long-term debt ratios are within healthy limits for the industry.

Solvency:	**2023**	**2022**	**2021**	**2020**	**2019**
Longterm debt/total capitalization	0.28	0.31	0.28	0.32	0.32
Adj Debt/ Total capitalization	0.29	0.32	0.29	0.33	0.32
Debt Service Coverage	4.01	1.44	1.65	2.07	6.80
Cash and Investments/LTD only	1.61	1.42	1.98	1.69	1.41

Review of UVMHN Audited Financials: 2019-2023

Summary: Overall, the System's financial position shows a number of red flags, from poor operating profitability to inadequate capital investment. Liquidity is marginally adequate, but solvency ratios (debt levels and the ability to repay) suggest that the System will not be able to add significant new debt in the near term, despite aging facilities.

UVM Medical Center continues to be the primary source of financial strength for the System, with stronger operating and total margins as well as greater capacity to increase debt than the System as a whole. It continues to transfer payments to other entities in the system and to subsidize the medical school.

System Profitability: UVMHN is unprofitable on operations over the five years 2019- 2023: operating losses totaled $93 million. A significant non-patient-care driver of these losses was the UVMHN subsidies to the Medical School, which totaled $89 million net of Medicaid GME payments. Without these subsidies, UVMHN would have had cumulative operating losses of roughly $4 M.

Excess revenue over expense, which included nonoperating revenues (excluding unrealized gains and losses on their investment portfolio) generated only $26.8 million over the period. For the four years following 2019, total margins hovered near breakeven. Unrealized gains and losses made the total margin much more volatile, higher in most years but much lower in 2022, a bad year for capital markets.

Overall, UVMHN profitability is inadequate to sustain a viable health system over the long term, particularly if they continue to provide substantial subsidies (over $20 million/year after GME payments) to UVM.

Standard Ratios:	UVMHN	UVMHN	UVMHN	UVMHN	UVMHN
Profitability:	**2023**	**2022**	**2021**	**2020**	**2019**
Total Margin	(0.000)	(0.016)	(0.000)	0.011	0.020
Total Margin excluding Net Med School Payments*	0.007	0.008	0.012	0.012	0.013
Total Margin including Unrealized Gains/losses	0.029	(0.097)	0.034	0.017	0.025
Operating Margin	(0.002)	(0.037)	0.009	(0.009)	0.005
Operating Margin Excl Net Med School Payment*	0.01	-0.03	0.02	0.00	0.02
EBITDA Margin	0.04	0.03	0.08	0.06	0.07
Markup	2.34	2.22	2.26	2.04	2.17

System Liquidity: UVMHN liquidity was adequate but not generous; at 129 days in 2023, they retained enough resiliency to survive a bad year. In 2022, their most challenging year over the period of analysis, days cash dropped by about 80 days. But relatively little of the drop was due to operating losses; most of the reduction was due to unrealized losses (changes in the market value of their investment portfolio) and the need to repay Covid-related Medicare advances and Social Security tax deferrals. Their 2022 ending days cash on hand remained above investment grade from a credit rating perspective, and the current ratio (ability to pay their bills) well above 1. 2023 saw improvements in days cash and the current ratio.

Liquidity:	2023	2022	2021	2020	2019
Current Ratio	2.37	1.73	1.83	1.99	1.94
Days Cash on Hand, Short Term Sources	61	42	69	87	32
Days Cash on Hand including Board-designated and unc	129	121	199	192	142
Days operating cash excl AAPP and PayTaxDef	129	117	182	174	142
Days in Patient Accounts Receivable	45	48	52	48	45
Cash and Investments, all sources, $000	1,149,852	1,012,063	1,416,099	1,272,609	942,103

System Solvency: UVMMC has trended toward higher leverage ratios, not because of new long-term debt but because net assets (equity) were reduced by the losses sustained in 2022. The ability to make timely debt service payments is adequate, and the System's unrestricted cash and investments are greater than their long-term debt. But the System as a whole may be constrained in their ability to raise new debt due to their limited EBITDA margin which reflects the cash they can generate annually from operating and nonoperating activities.

Solvency:	2023	2022	2021	2020	2019
Longterm debt/total capitalization	0.361	0.349	0.316	0.355	0.317
Pension-adjusted LTD/Capitalization	0.367	0.355	0.323	0.379	0.351
Pension and Lease-Adj Capitalization	0.382	0.371	0.339	0.395	
Adj Debt/Adj Ebitda	5.224	7.335	3.549	4.796	
Debt Service Coverage	1.64	1.38	1.45	2.40	
Cash and Investments/LTD only	1.59	1.58	2.09	1.79	1.65
Funded Status of DB Pension (% funded)	**0.92**	0.94	0.93		

Adequacy of Capital Spending: The System has not been investing in capital at a rate adequate to replace what is "used up" (depreciation expense being an approximation of the "using up" of capital assets). The average age of plant is creeping up over time, although roughly at the 2022 median for fitch-rated systems. However capital expenditures over the five-year period are well below what creditors would consider "healthy."

Adequacy of Capital Spending	2023	2022	2021	2020	2019
Average Age of Plant	12.28	11.53	12.10	10.49	11.02
Capital expenditure / depreciation expense	0.67	0.71	0.69	0.88	1.80
Cumulative Capex/depreciation	0.794				

System Cumulative Sources and Uses of Cash, 2019-2023

STATEMENT OF CASH FLOWS	source	%	use	
Excess Revenue	26824	5%		
Noncash Adjustments	391044	70%		
Working Capital			-19708	4%
Increase cash and Investments			-34497	6%
Purchase PP&E			-455548	82%
Net increase in LTD	137778	25%		
Other Financing Activiites			-45893	8%
Sum	555646		-555646	
Breakdown of Excess Revenue:				
Operating Income	-93323			
Nonoperating Revenue	120147			

Overview of Porter Medical Center Audited Financials: 2019-2023

This review is of the total Porter Medical Center, which includes the hospital, nursing home and other entities.

Summary: Overall, Porter Medical Center is in a strong financial position, despite carrying significant *operating* losses from their nursing home operation. Their combined operating margins were strong most years, and they do not have to rely on nonoperating sources (investment income) to make debt service payments or other capital obligations. They are also adequately liquid although cash on hand has declined in the last two years. They have plenty of debt capacity and are in a good position to expand that if they need to invest in capital improvements.

Profitability: Porter Medical Center was solidly profitable on operations with margins of 2 – 5% every year except 2022. The hospital alone was profitable every year, while the nursing home reported operating losses every year. The real estate entity was also profitable every year, so the combined entity remained profitable on operations throughout a difficult period for the industry. Even though the consolidated medical center was profitable and liquid, it was the net recipient of 1.5 million in equity transfers from affiliates.

Total margins excluding unrealized gains and losses were slightly above operating margins, adding up to 1% to the bottom line.

Profitability:	**2023**	**2022**	**2021**	**2020**	**2019**	
Total Margin excluding unrealized investment income	0.03	-0.01	0.05	0.04	0.03	
Total Margin incl Unrealized Investment Inc	0.05	-0.06	0.06	0.04	0.03	
Operating Margin	0.02	-0.02	0.05	0.03	0.03	
EBITDA Margin Excl unrealized gains/losses	0.05	0.02	0.09	0.07	0.07	
	2023	**2022**	**2021**	**2020**	**2019**	**Sum**
Transfers from (to) other affiliates	1268	-300	-28	300	341	1581
Net Operating Income	2979	-1835	5510	3183	2555	12392
Hospital operating income	9055	3229	7672	3672	4706	28334
Nursing Home operating losses	**-6544**	**-5521**	**-2568**	**-781**	**-2445**	-17859
Other entity (real estate)	**468**	**456**	**467**	**330**	**294**	2015
Excess Revenue	3608	-1263	5895	3566	3338	15144

Liquidity: Porter Med Center had ample ability to pay its bills on time. It was not dependent on affiliate loans to do so. Days cash on hand, excluding amounts owed back to Medicare and Social Security (covid-related advances) remained above 100 days during the period, although the trend declined after peaking in 2021. Unrestricted cash balances in 2023 were higher than in the pre-Covid year of 2019.

Liquidity:	**2023**	**2022**	**2021**	**2020**	**2019**
Current Ratio	2.68	1.85	3.19	2.95	3.05
Current Ratio Excl DTA	3.09	2.09	3.57	3.11	3.27
Days Cash on Hand All Sources	102	119	171	163	127
Days Cash excl Days in MAAPP, SS tx	102	119	164	144	127
Days in Patient Accounts Receivable	59	43	50	57	51
Cash and Investments, all sources, $000	37,323	39,588	48,996	43,848	34,702

Solvency: Porter Medical Center reported a low level of long-term debt and other long-term liabilities, especially once they had fully funded their pension (2023). Long-term operating lease obligations did not add significant liability to their balance sheet.
Porter was more than able to make required debt service every year, plus they had a very strong cash cushion of 3 – 4 times the level of long-term debt.

Solvency:	**2023**	**2022**	**2021**	**2020**	**2019**
Long-term debt/total capitalization	0.153	0.187	0.179	0.222	0.253
Adj Debt/ Total capitalization	0.157	0.220	0.218	0.308	0.338
Debt Service Coverage	6.61	2.25	9.06	6.70	
Cash and Investments/LTD only	3.85	3.79	4.37	3.69	2.76

Overview of Central Vermont Medical Center Audited Financials: 2019-2023

This review is of the Central Vermont Medical Center, which includes physician group and Rehab/SNF facility.

Summary: CVMC would be in "distressed" financial status, unable to pay its bills and long-term obligations, if it were not for loans and equity transfers from affiliated entities within UVMHN. Operating losses have grown significantly since 2021, severely eroding their liquidity and solvency positions.

Profitability: CVMC reported negative operating margins every year, with a dramatic increase in losses in 2022 and 2023. Investment income was not enough to fully offset the losses in three of the five years. They were the beneficiaries of over $8 million in equity transfers and over $30 million in affiliate loans over the period 2019-2023, which allowed them to maintain their financial viability.

Profitability:	**2023**	**2022**	**2021**	**2020**	**2019**	
Total Margin excluding unrealized investment income	-0.06	-0.04	0.02	0.01	-0.01	
Total Margin incl Unrealized Investment Gains/Losses	-0.04	-0.10	0.05	0.02	-0.01	
Operating Margin	-0.07	-0.07	-0.01	-0.01	-0.02	
EBITDA Margin Excl unrealized gains/losses	-0.04	-0.01	0.05	0.05	0.03	
EBITDA Margin (incl unrealized gains)	**-0.01**	**-0.07**	**0.08**	**0.06**	**0.03**	
						SUM:
Transfers From (To) affiliates	-1268	500	56	1466	7631	8385
Net Operating Income	-17845	-17136	-2540	-1320	-4679	-43520
Excess Revenue	-17405	-10726	4306	3478	-2637	-22984

In terms of liquidity, CVMC's current ratio is below one in every year except 2020. In 2022 and 2023, "due to affiliates" increased significantly (from 4 – 10 M to 20 – 30M). Without the affiliate loans, their current ratio would have been above 1 in every year except 2021, indicating that they were able to pay outside vendor/creditor bills but did not have the liquidity to repay affiliate loans. Days cash were highest in 2020 and 2021, in part because of covid-related advances and deferrals (see Days Cash in MAAPP, SS Tx). Days cash on hand on 2022 and 2023 was at a level that would be considered below investment grade if they were a stand-alone entity.

Liquidity:	**2023**	**2022**	**2021**	**2020**	**2019**
Current Ratio	0.83	0.73	0.92	1.01	0.85
Current Ratio Excl DTA	1.54	1.13	0.99	1.11	1.10
Days Cash on Hand All Srcs	75	69	109	132	96
Days in Patient Accounts Receivable	32	50	56	42	39

Cash and Investments, all sources, $000	61,206	54,386	76,131	82,123	57,613
Days cash in MAAPP, SS Tx	0	0	10	15	0

From a solvency perspective, CVMC does not have a lot of long-term debt, but it did have capitalized operating leases and pension liabilities that, combined, were greater than their long-term debt (see "adj debt total capitalization). Pension liability was on and off their balance sheet over time, reflecting changes in the value of funded assets relative to the actuarial value of their pension obligations. The pension liabilities were highest in 2019 and 2020.

Weak cash flow from operations in 2022 and 2023 meant that debt service coverage was well below 1, meaning they could not meet debt payments with operating cash flow. While they had enough cash and investments to cover debt payments as of 2023, that is not a viable long-term financing option.

Solvency:	**2023**	**2022**	**2021**	**2020**	**2019**
long-term debt/total capitalization	0.128	0.123	0.121	0.189	0.114
Adj Debt/ Total capitalization	0.275	0.178	0.171	0.365	0.349
Debt Service Coverage	(1.45)	(0.37)	2.34	1.75	
Cash and Investments/LTD only	6.76	4.64	4.94	4.16	6.06