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# Hospital Budget Review: Overview of FY25 Budget Requests

AUGUST 6TH, 2024

# Agenda

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1. Background
2. Statute, Rule, and FY25 Hospital Budget Guidance
3. Summary of FY25 Hospital Budget Requests
4. Next Steps

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# BACKGROUND

# State Health Spending per Capita Decile Ranks Over Time

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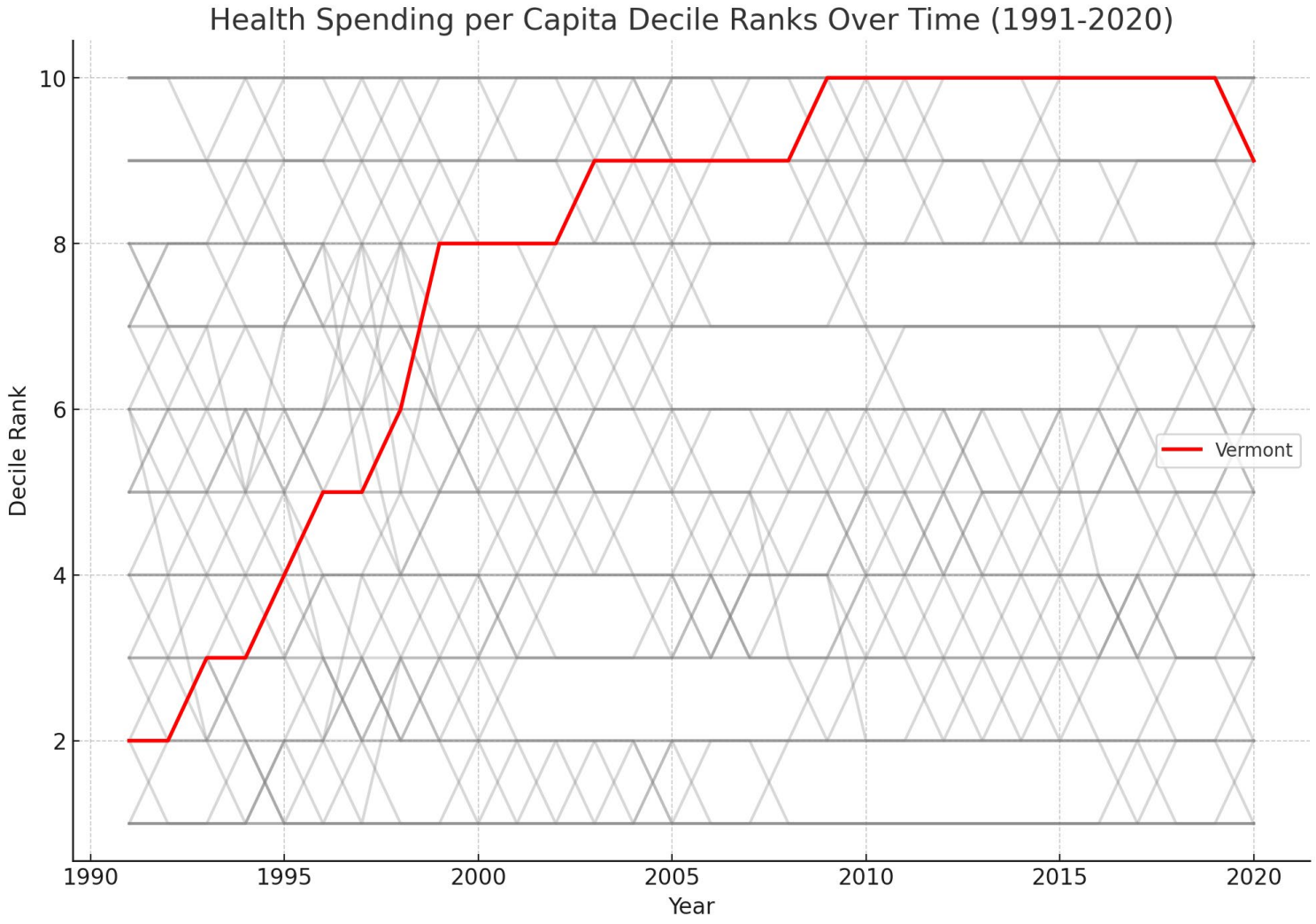


Vermont was among the states with the lowest per capita health care spending in the 1990s, and since 2010 is consistently among the highest.

# Vermont Per Capita Health Care Spending vs. New England States

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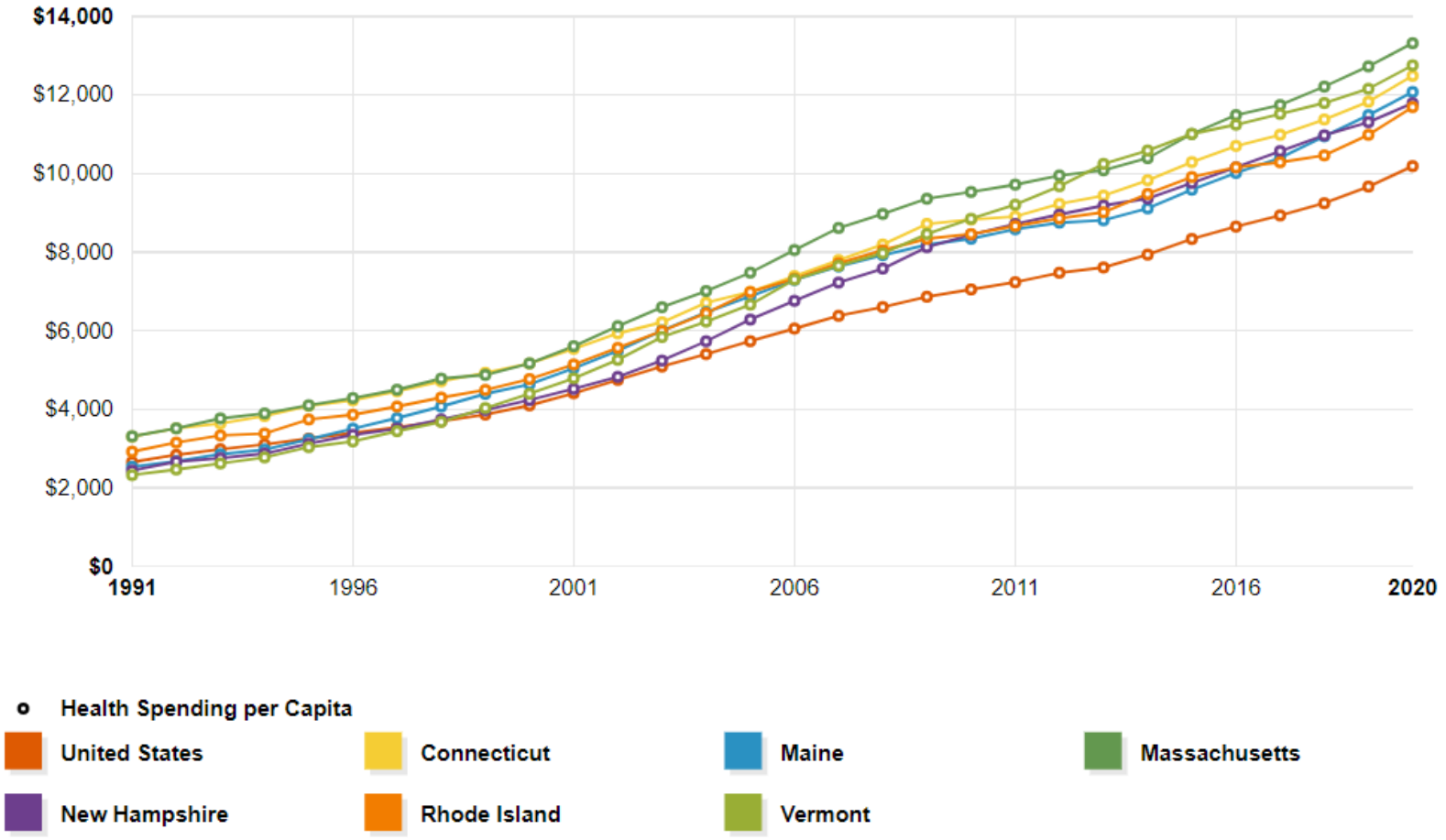


Vermont remains among the states with the highest per capita spending compared to other New England states.

# Marketplace Premium Averages

## Vermont is Higher than National Average

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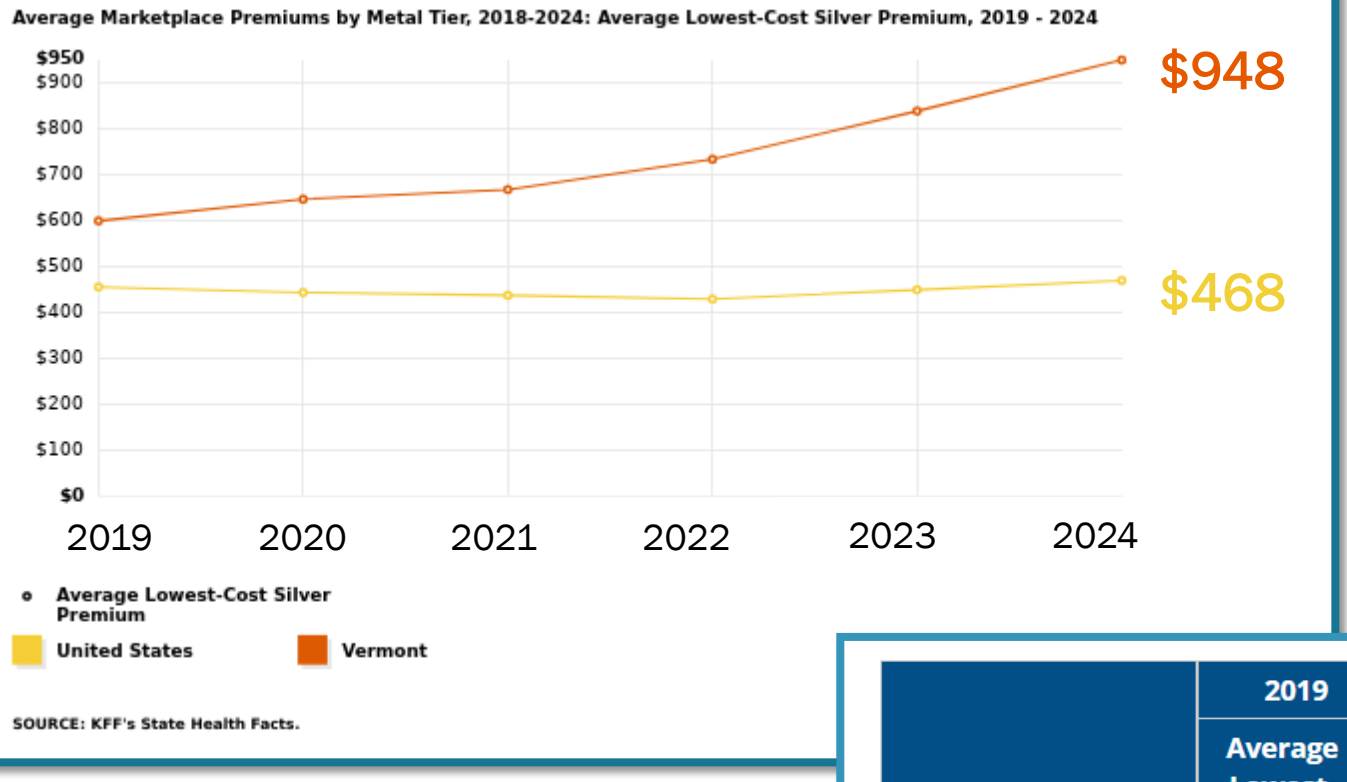


| Location | 2019 Average Lowest-Cost Silver Premium | 2020 Average Lowest-Cost Silver Premium | 2021 Average Lowest-Cost Silver Premium | 2022 Average Lowest-Cost Silver Premium | 2023 Average Lowest-Cost Silver Premium | 2024 Average Lowest-Cost Silver Premium |
|---|---|---|---|---|---|---|
| United States | $454 | $442 | $436 | $428 | $448 | $468 |
| Vermont | $598 | $645 | $470 | $732 | $837 | $948 |

Source: KFF Average Marketplace Premiums by Metal Tier, 2018-2024

# Premium Growth: VT vs. NEW ENGLAND QHP

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## Premium Growth 2019 to 2024

- VT: 58.5%
- CT: 44.6%
- MA: 22.9%
- RI: 20.6%
- US: 3.0%
- ME: -2.2%
- NH: -13.1

| Location | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|
| | Average Lowest-Cost Silver Premium | Average Lowest-Cost Silver Premium | Average Lowest-Cost Silver Premium | Average Lowest-Cost Silver Premium | Average Lowest-Cost Silver Premium | Average Lowest-Cost Silver Premium |
| 1. Vermont | $598 | $645 | $470 | $732 | $837 | $948 |
| 2. Connecticut | $448 | $547 | $523 | $540 | $592 | $648 |
| 3. Maine | $525 | $506 | $342 | $420 | $449 | $513 |
| **United States** | **$454** | **$442** | **$436** | **$428** | **$448** | **$468** |
| 4. Massachusetts | $323 | $324 | $340 | $374 | $407 | $397 |
| 5. Rhode Island | $315 | $314 | $469 | $341 | $364 | $380 |
| 6. New Hampshire | $373 | $390 | $388 | $305 | $317 | $324 |

# Premium Growth: Age does not explain VT vs. New England trends

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ME: 45 (1)

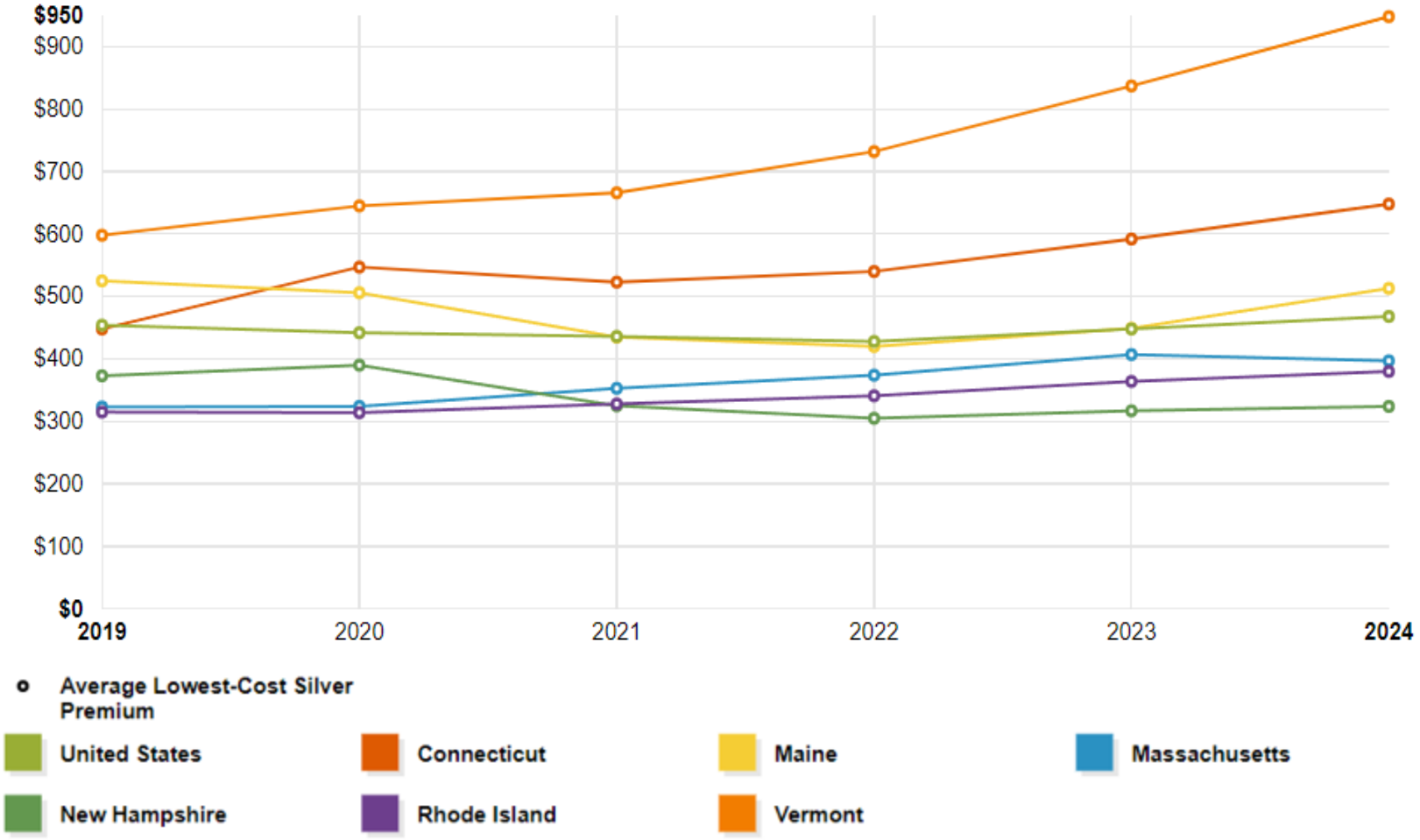
NH: 43.1 (2)

VT: 43 (3)

CT: 41.2 (7)

RI: 40.3 (9)

MA: 39.7 (17)



# Employer-Based Insurance Premiums
## Vermont is Higher Than National Average

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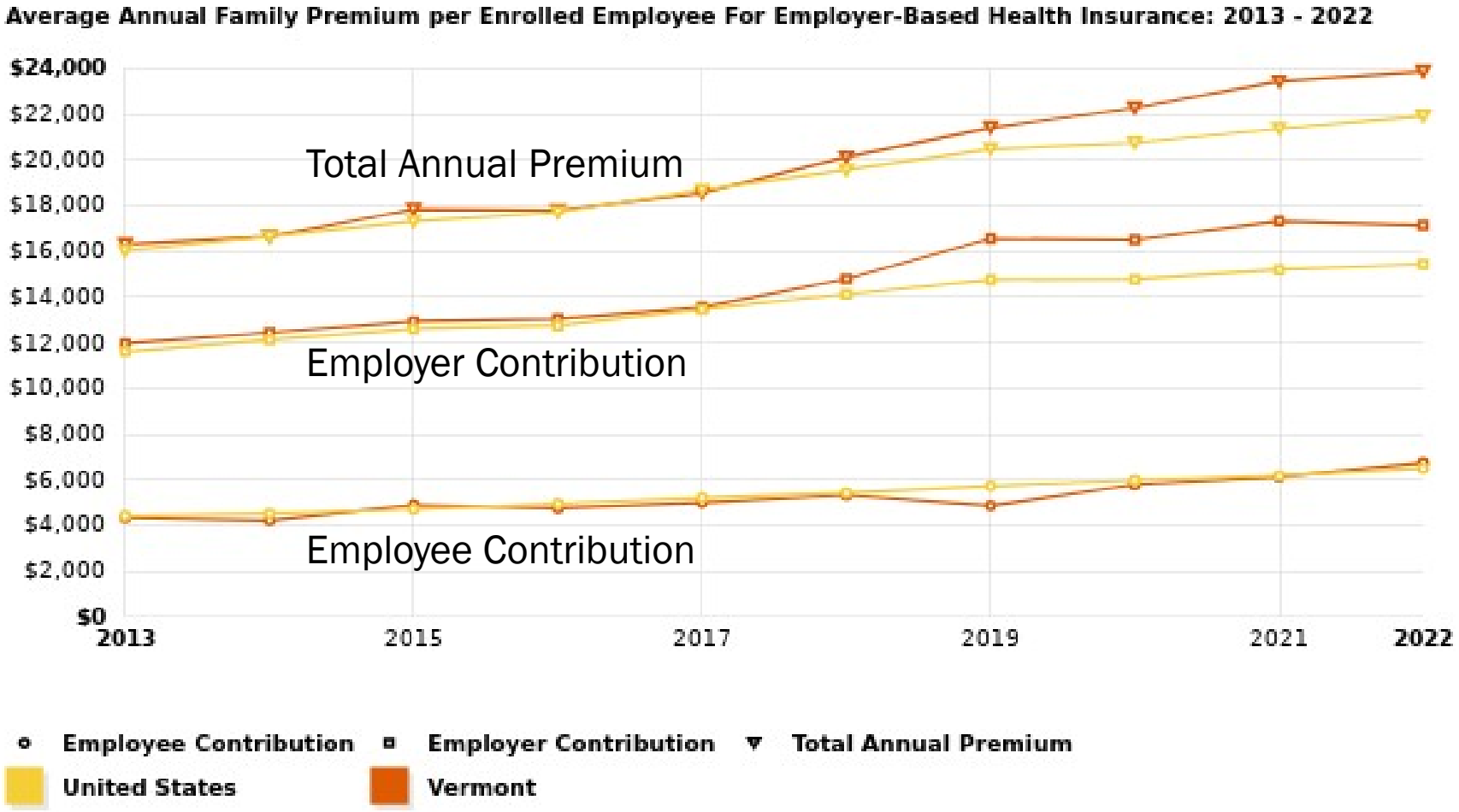


***Employee contributions*** *are growing with the national average, but* ***Employer contributions*** *are growing faster than the national average.*

Source: https://www.kff.org/health-costs/state-indicator/

# Cumulative Average Change to QHP Rates

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| Cumulative Average Change to Rate (2018 base year) | | | | |
|---|---|---|---|---|
| | MVP - I | MVP - SG | BCBS - I | BCBS - SG |
| 2019 | 6.6% | | 5.8% | |
| 2020 | 17.4% | | 18.9% | |
| 2021 | 20.5% | | 23.9% | |
| 2022 | 35.8% | 21.5% | 29.7% | 15.6% |
| 2023 | 61.9% | 60.6% | 44.5% | 29.1% |
| 2024 | 80.4% | 60.2% | 64.6% | 46.2% |
| 2025 | TBD | TBD | TBD | TBD |

QHP = Qualified Health Plan
I = Individual
SG = Small Group

# Hospitals: one third of total health care spending in the US

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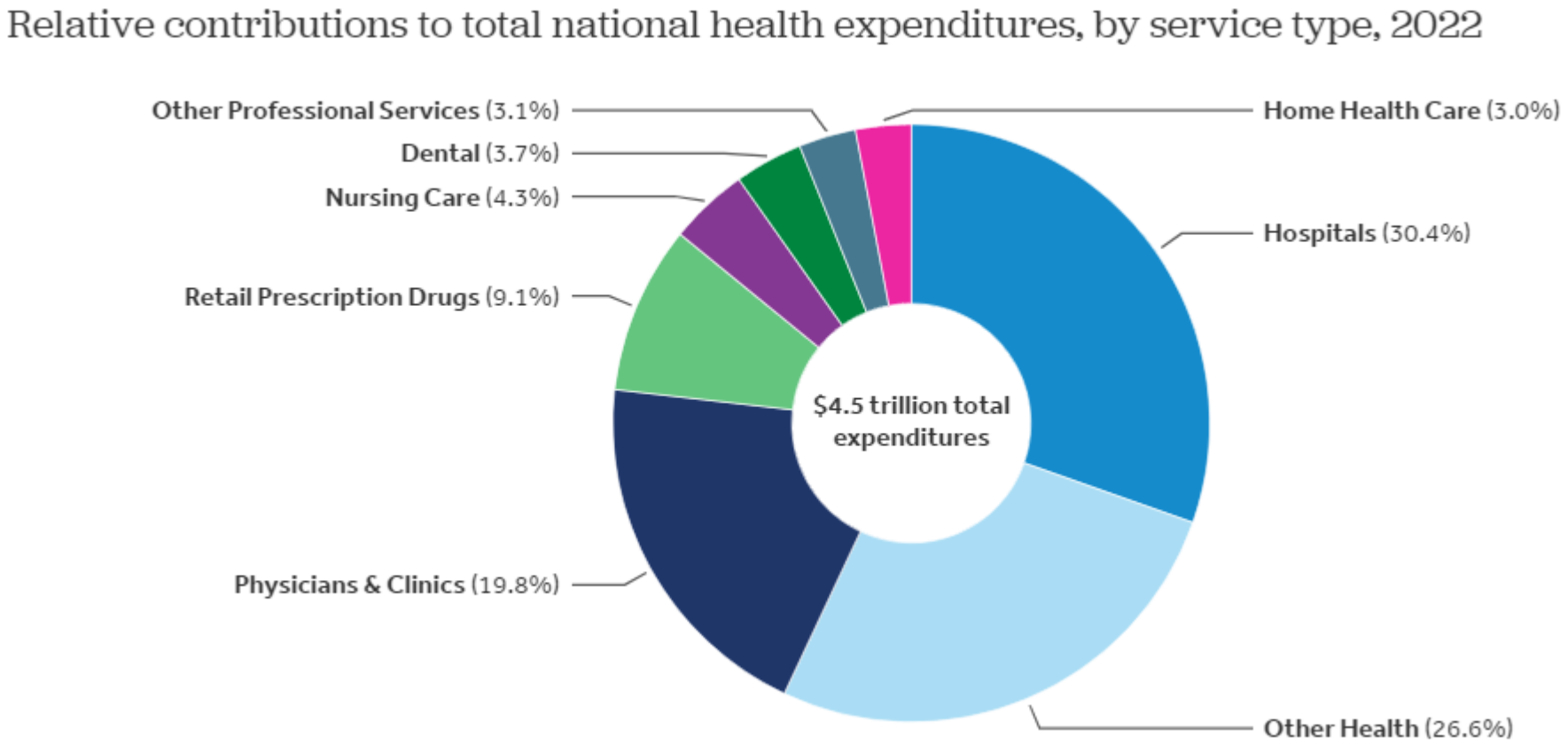


Source: https://www.healthsystemtracker.org/indicator/spending/drivers-health-spending-growth

# Hospitals Make Up Almost Half of Health Care Dollars Spent in Vermont

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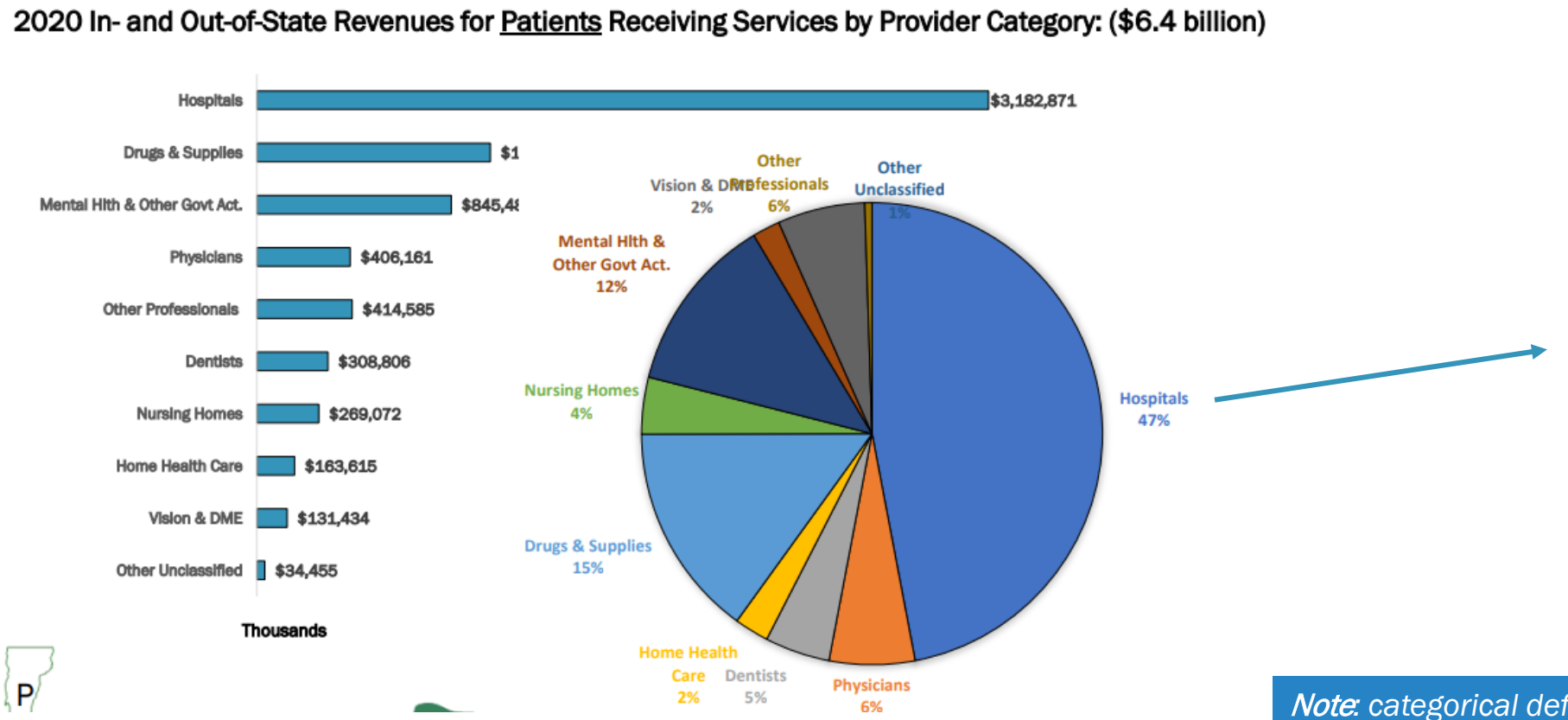


47%

of health care dollars spend in Vermont go to hospitals

*Note*: categorical definitions here are not equivalent to those on the previous slides and cannot currently be directly compared

Source: 2020 Vermont Health Care Expenditure Analysis
https://gmcboard.vermont.gov/sites/gmcb/files/documents/2020_VT_Health_Care_Expenditure_Analysis_Final_May_9_2022.pdf

# Vermont is a low-volume state

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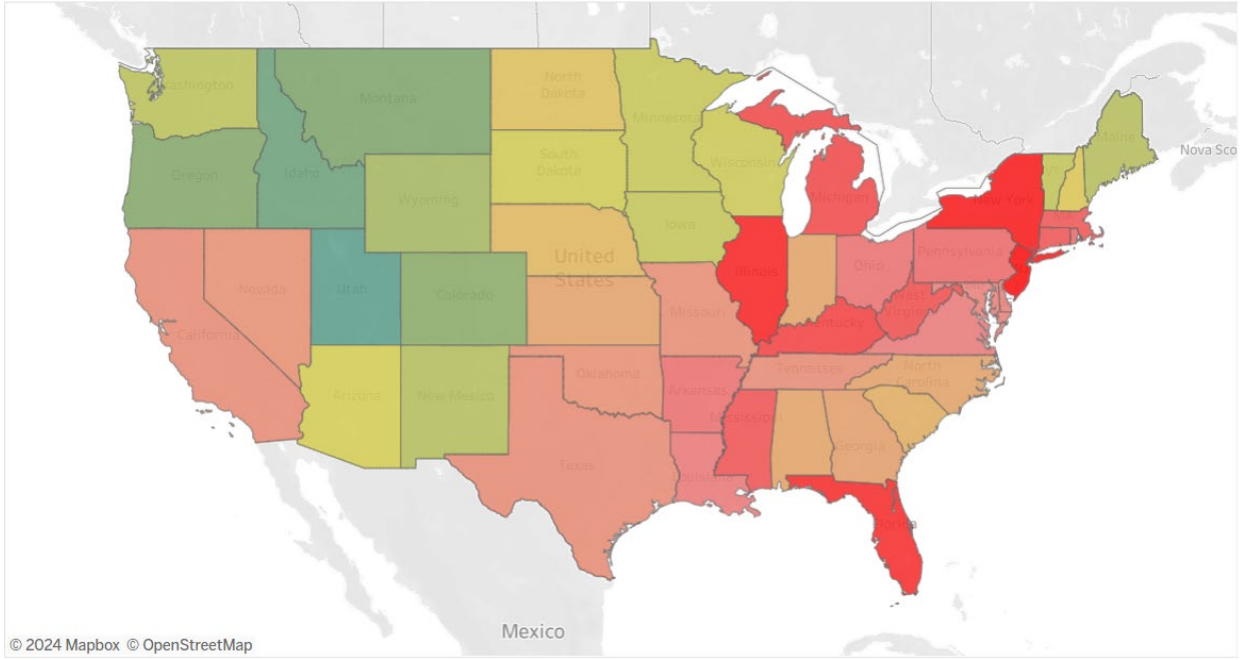
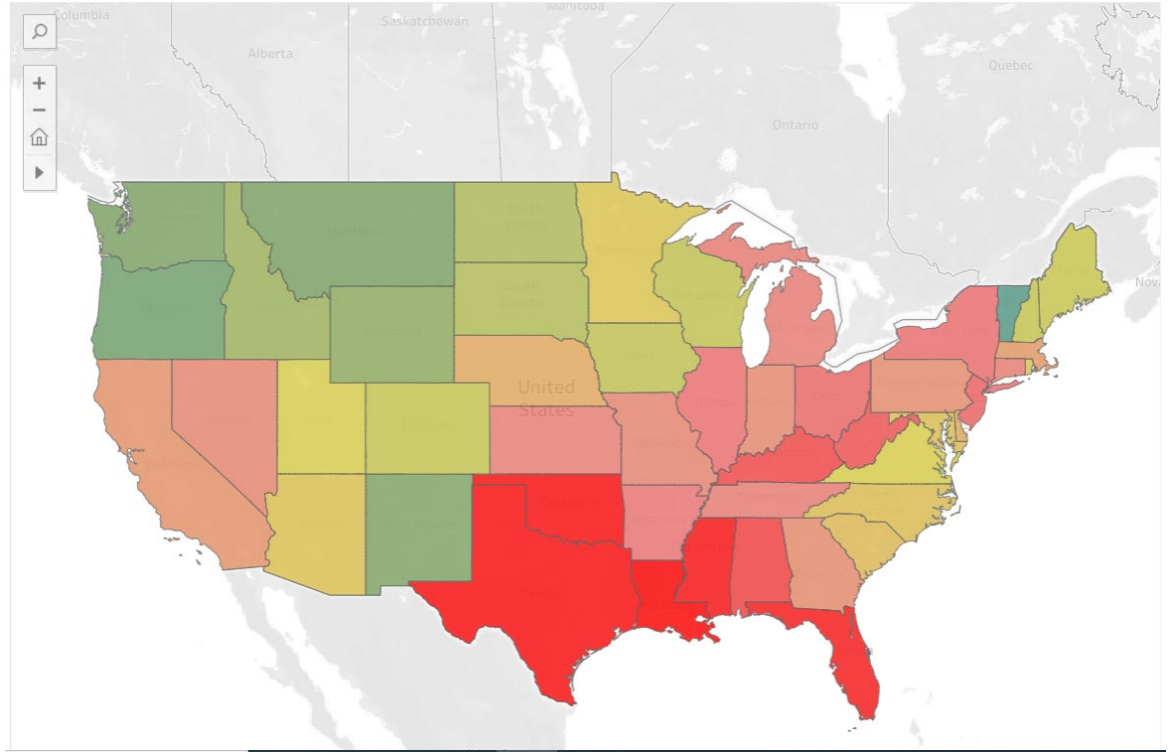
Map: Hospital Admissions per Decedent during the Last Six Months of Life, by State (2017)




Map: Price-Adjusted Total Medicare Reimbursements per Enrollee (Parts A and B), by State (2019)
(Price, Age, Sex, and Race adjusted)



Source: Dartmouth Atlas

# Vermont vs. New England: Inpatient & Outpatient Volume

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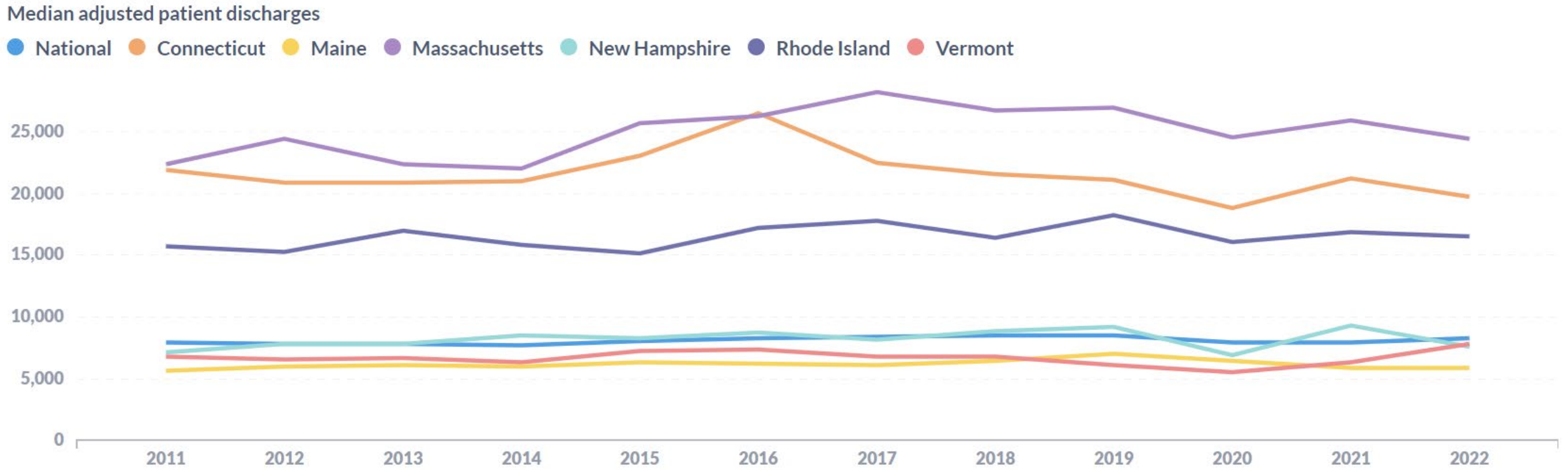
## Adjusted Patient Discharges

The calculated inpatient and outpatient patient discharges indicating the hospital's total patient volume for the reported period. Using the adjusted patient discharges to standardize hospital-level metrics allows comparison of hospitals of various sizes.



# Hospital Volume by State: Adjusted Discharges by State

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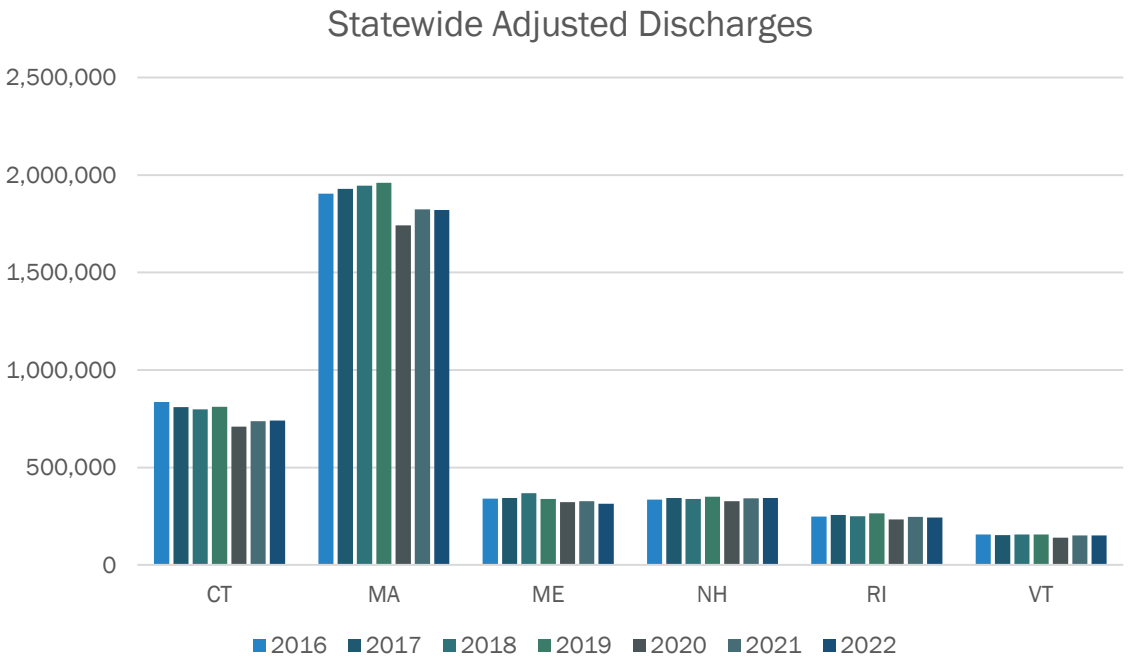


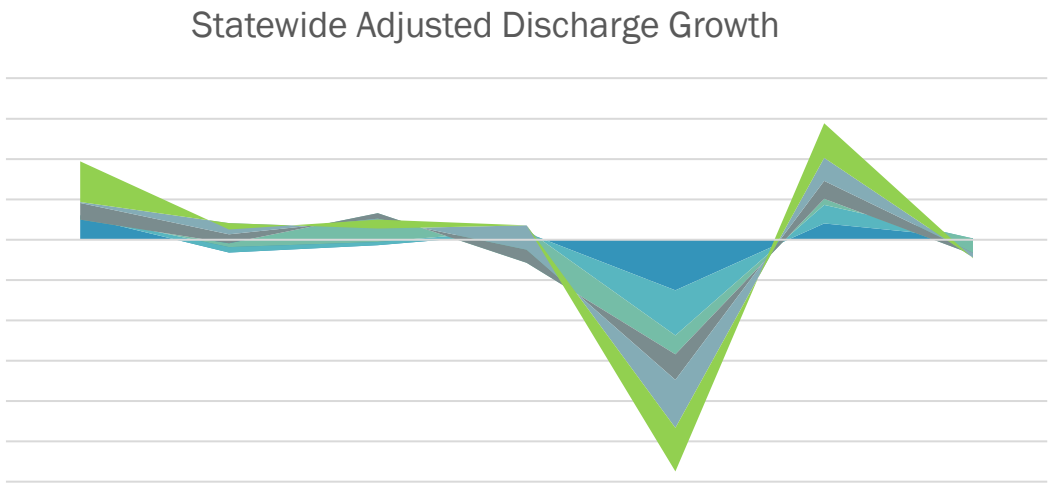


| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|
| VT | 10.0% | -1.5% | 2.2% | 0.0% | -10.8% | 8.6% | -0.2% |
| RI | 0.3% | 2.8% | -2.5% | 6.0% | -11.9% | 5.7% | -1.2% |
| NH | 4.1% | 2.2% | -1.4% | 3.3% | -6.3% | 4.4% | 0.3% |
| ME | -1.0% | 0.9% | 7.2% | -8.3% | -4.7% | 1.5% | -3.9% |
| MA | 0.2% | 1.3% | 0.8% | 0.8% | -11.1% | 4.7% | -0.1% |
| CT | 5.7% | -3.2% | -1.4% | 1.7% | -12.6% | 4.0% | 0.4% |

| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|
| New England Total | 2.0% | 0.4% | 0.5% | 0.6% | -10.5% | 4.4% | -0.4% |

Source: NASHP Cost Tool Hospital Data

# Hospital Admissions per 1,000 Population: New England States

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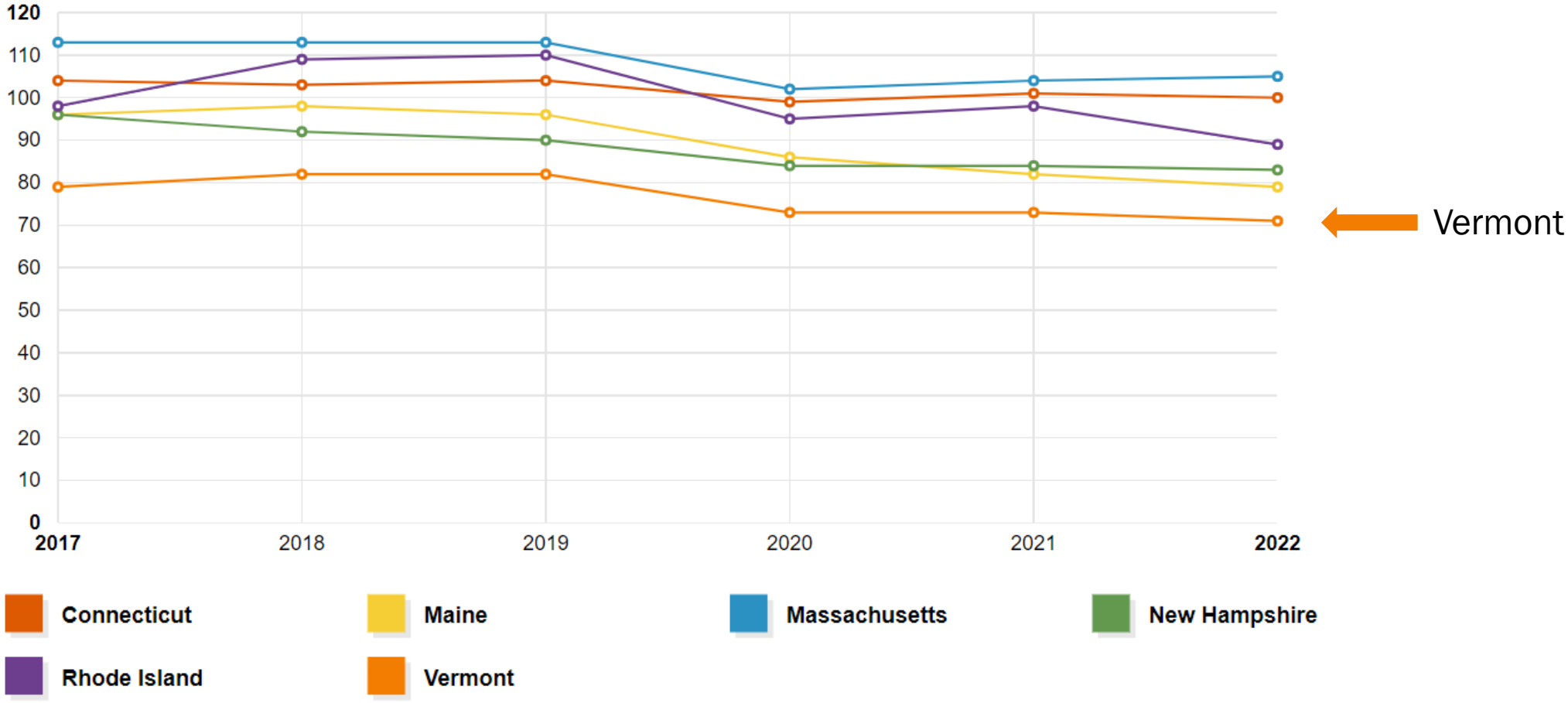


Source: KFF

# Vermont Hospital System Volume Trends (VUHDDS)

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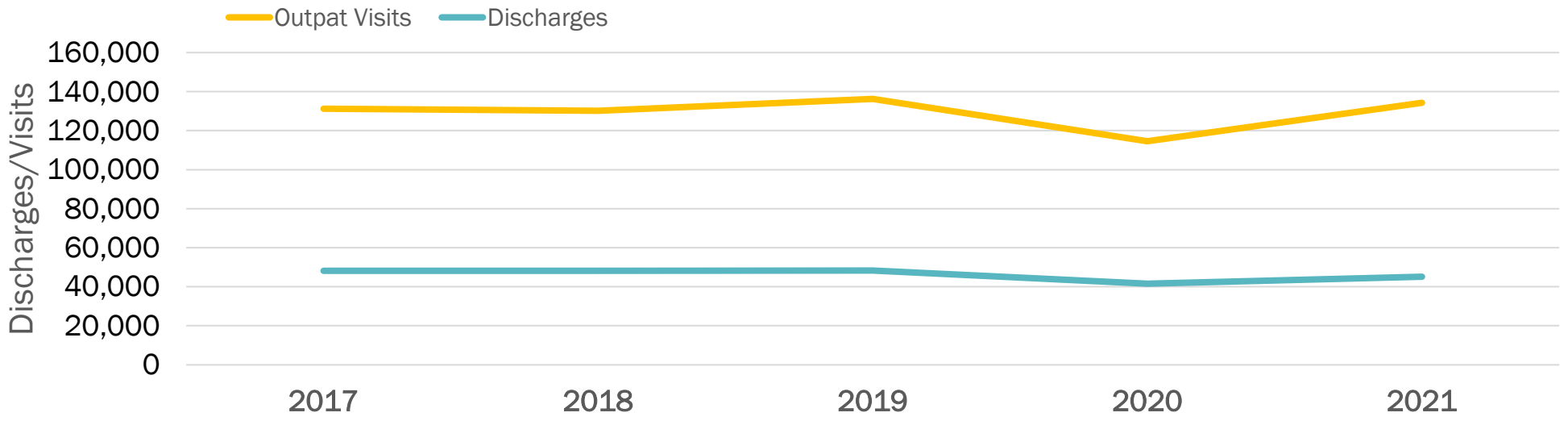


| Year-Over-Year Δ | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|
| Outpatient Visits | -0.8% | 4.6% | -15.9% | 17.2% |
| Discharges | 0.2% | 0.1% | -13.9% | 8.6% |
| Patient Days | 2.1% | 2.7% | -9.8% | 10.0% |
| Ave LOS | 2.0% | 2.0% | 3.9% | 1.9% |

*With the exception of COVID, inpatient & outpatient utilization is relatively stable, but these data are only currently available through **2021**.*

# Vermont vs. New England States: OpEx Growth per Adj Discharge

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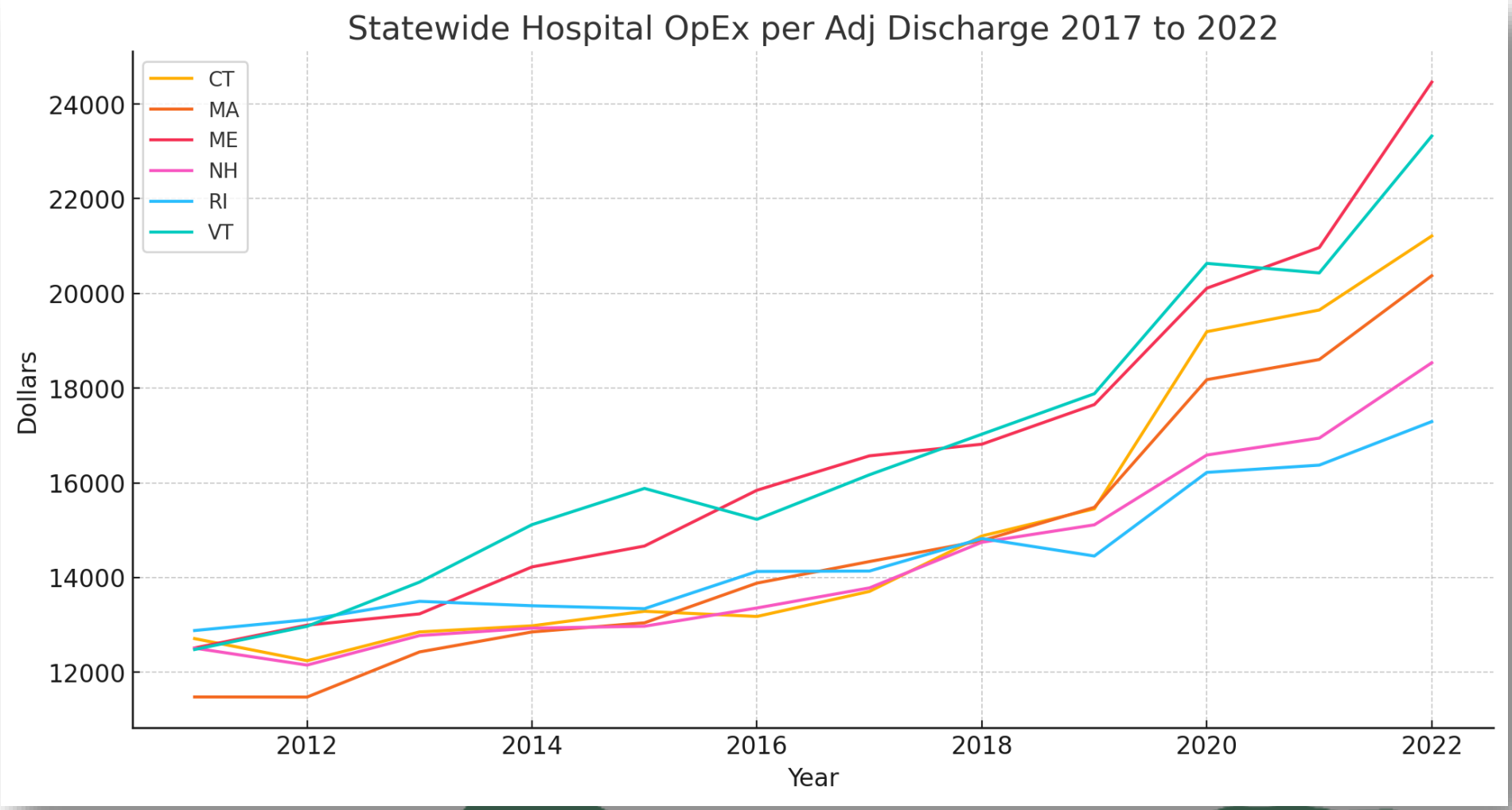


Vermont



Source: NASHP hospital cost tool data

# Vermont's hospital prices are higher compared to most states

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**Selected State Ranking in the U.S. for Total Facility Plus Physician as a Percent of Medicare**

RAND 2022

VERMONT at #13
CONNECTICUT at #23
MAINE at #29
NEW HAMPSHIRE at #43
RHODE ISLAND at #45

**Highest Total Facility Plus Physician Price as a Percent of Medicare in the U.S.**

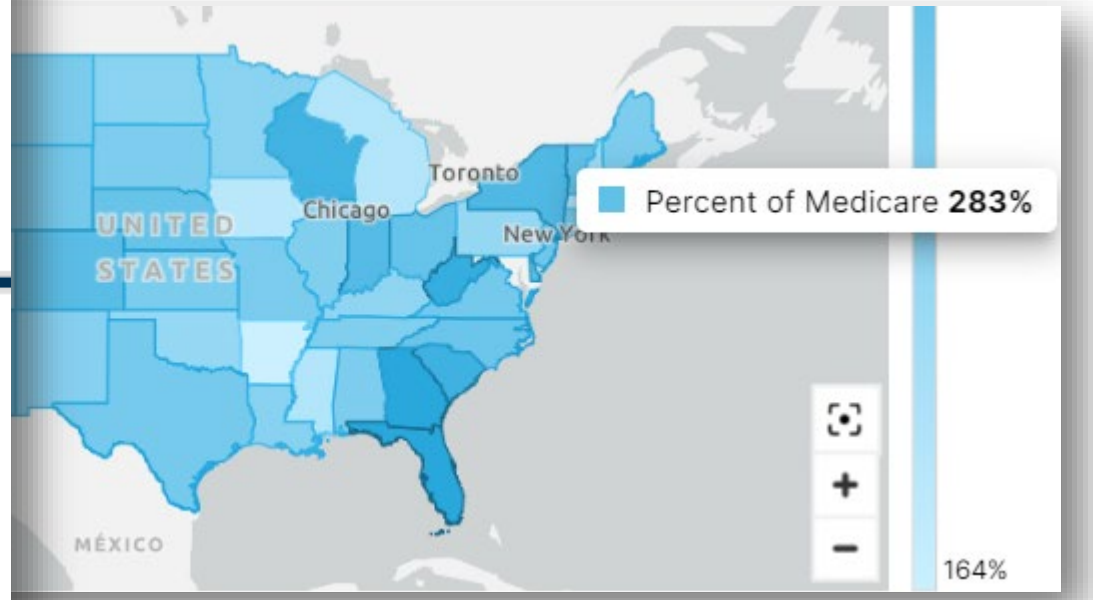
RAND 2022

GEORGIA with 345%
FLORIDA with 345%
WEST VIRGINIA with 330%

**Lowest Total Facility Plus Physician Price as a Percent of Medicare in the U.S.**

RAND 2022

ARKANSAS with 164%
IOWA with 185%
MICHIGAN with 192%




Source: Sage Transparency https://employerptp.org/sage-transparency/

*More on this during this afternoon's Board meeting…*

# Vermont Hospital Prices: Inpatient Services *Relative & Standardized Prices*

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| Hospitals | 2020 | | 2021 | | 2022 | |
|---|---|---|---|---|---|---|
| All Vermont Hospitals | 200% | $25,480 | 209% | $27,678 | 227% | $30,260 |
| Dartmouth-Hitchcock | 144% | $21,970 | 147% | $22,058 | 159% | $25,871 |
| Independent (CAH) | 143% | $18,417 | 142% | $19,731 | 164% | $22,685 |
| Rutland Regional Health Services | 193% | $22,487 | 202% | $24,546 | 211% | $27,690 |
| Southwestern VT Health Care | 220% | $22,412 | 231% | $24,016 | 227% | $23,017 |
| UVM Health Network | 216% | $27,839 | 229% | $30,454 | 248% | $32,729 |

Source: RAND https://www.rand.org/health-care/key-topics/paying-for-care.html

# Vermont Hospital Prices: Outpatient Services *Relative & Standardized Prices*

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| Hospitals | 2020 | | 2021 | | 2022 | |
|---|---|---|---|---|---|---|
| All Vermont Hospitals | 296% | $442.35 | 308% | $462.84 | 316% | $484.22 |
| Dartmouth-Hitchcock | 246% | $496.52 | 252% | $489.69 | 253% | $504.30 |
| Independent (CAH) | 205% | $423.38 | 204% | $408.66 | 195% | $434.60 |
| Rutland Regional Health Services | 325% | $378.42 | 323% | $391.34 | 349% | $427.67 |
| Southwestern VT Health Care | 315% | $435.88 | 301% | $418.58 | 332% | $461.51 |
| UVM Health Network | 347% | $480.91 | 370% | $515.28 | 383% | $537.38 |

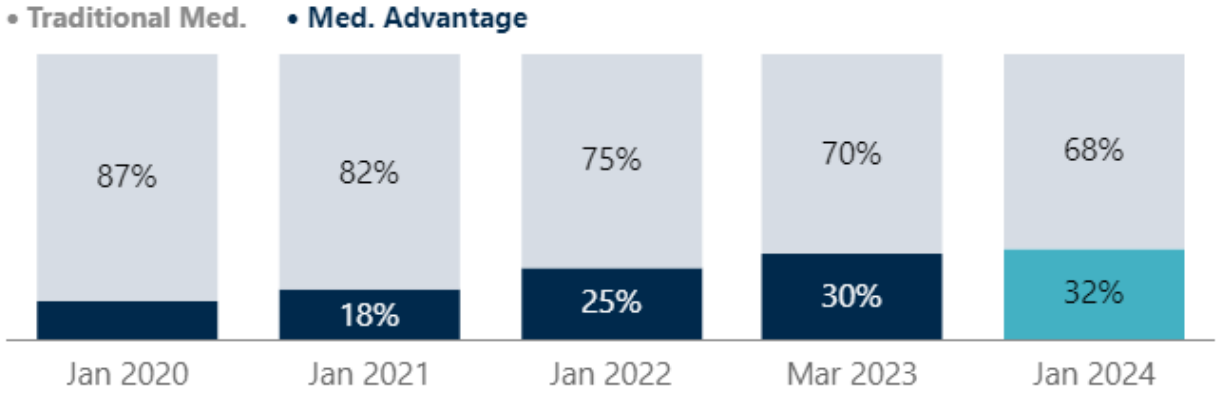
Source: RAND https://www.rand.org/health-care/key-topics/paying-for-care.html

## What is my state's MA adoption trend?

Your state lags the national percent of Medicare-eligible population that chooses MA, which is at 50%. Fewer individuals rely on MA for their coverage.

**32%**

↑ +1.7%pt in 2024 vs. prior year

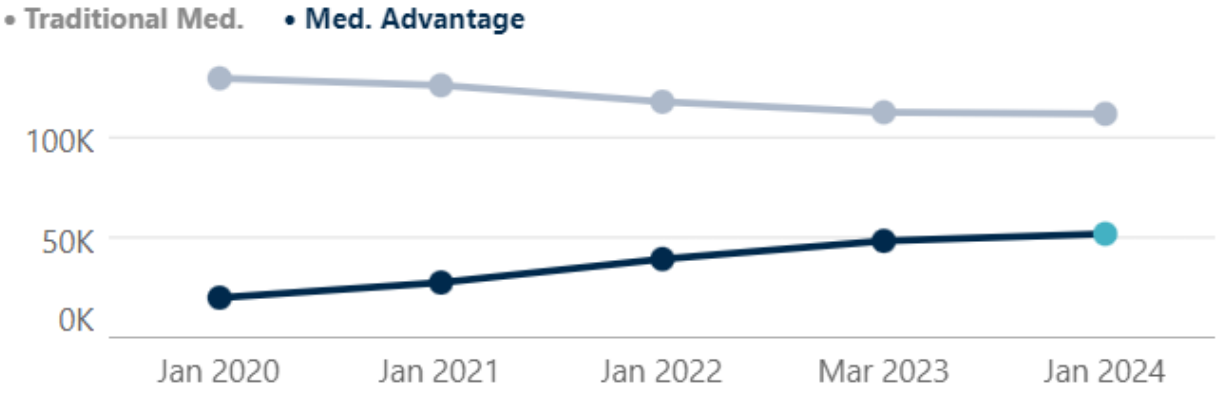



## How has MA enrollment grown in my state?

Nationally, the number of MA enrollees grew 5% from 2023 to 2024. Your state grew 7%, which is down from 24% growth the year before.

**51K**

↑ +4K (7%) in 2024 vs. prior year




# Medicare Advantage Continues to Expand in Vermont…

# Public Payer Rates: Less than Inflation

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## Medicare

- IPPS/OPPS for FY25 reflects a 2.9% rate increase over FY24
- Critical Access Hospitals continue to receive “cost +1%”

## Medicaid

- VT will have a 0% rate increase over FY24
- NY increased Medicaid investments to hospitals for FY25 (*question to hospitals on est. budgetary impact*)

Source: VT Medicaid, NY Dept of Health, CMS Rule

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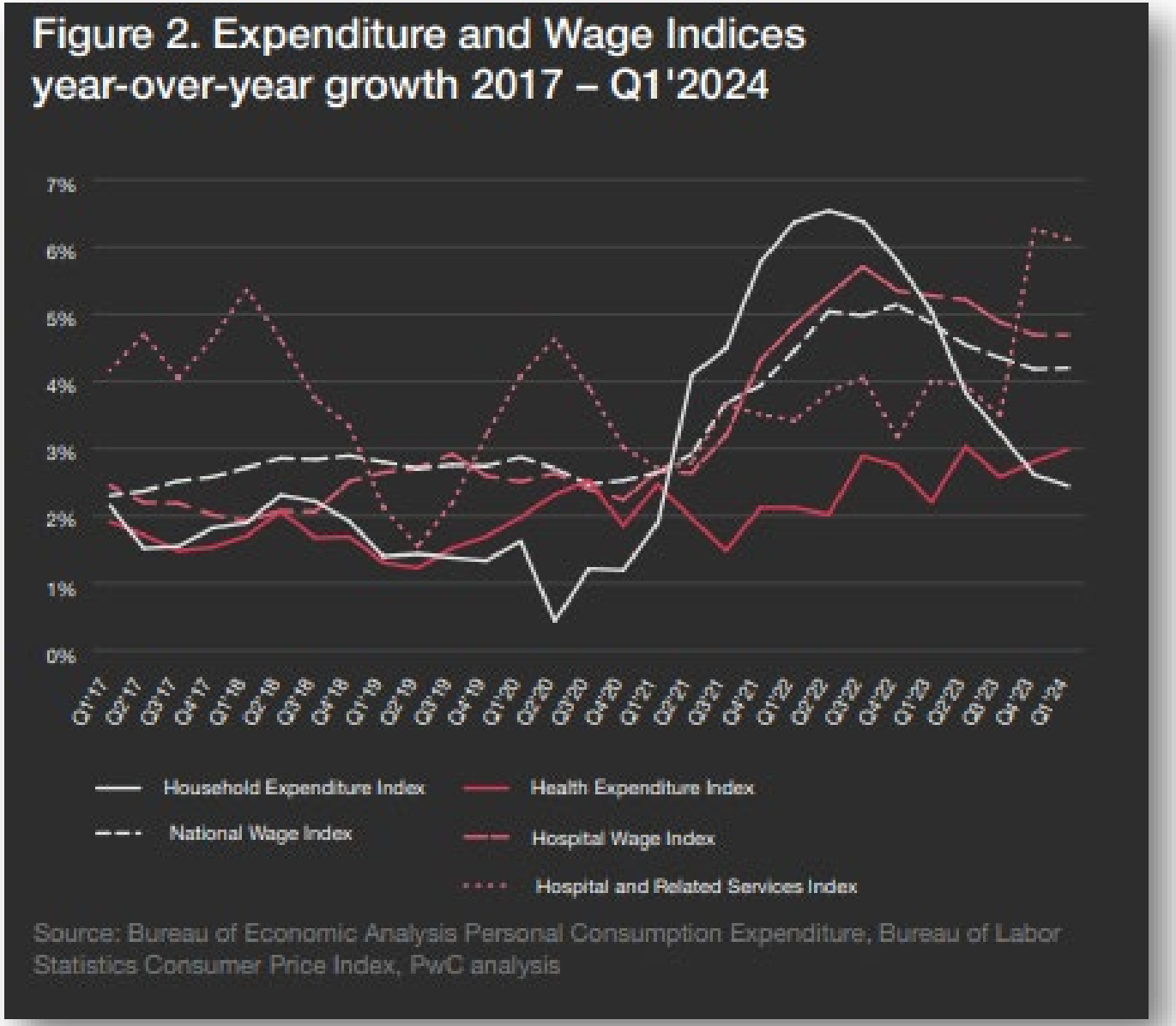


Cost of Health Care Labor Continues to Rise

Source: https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

# Pharmaceutical Spending

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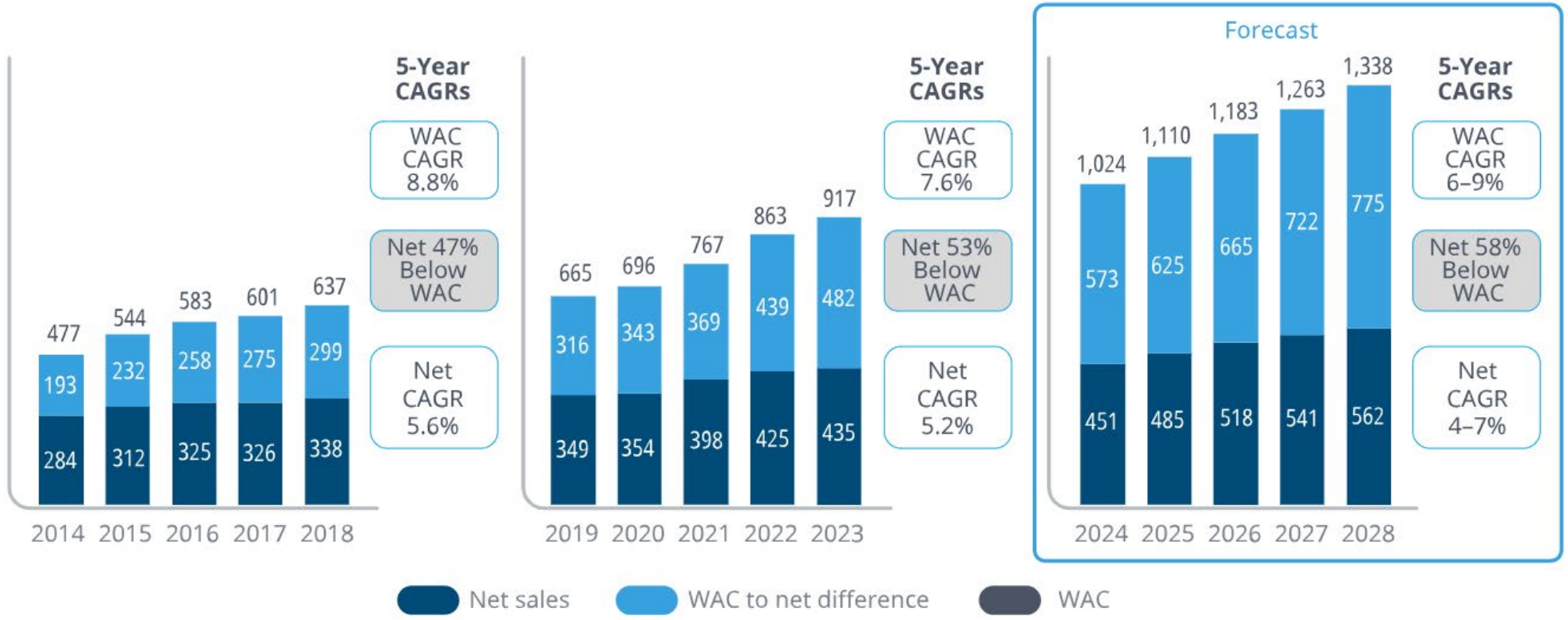
**U.S. medicines spending is forecast to grow 4 to 7% through 2028 lifted by novel drugs and offset by expiries and price cuts**




Source: IQVIA

# Pharmaceutical Prices

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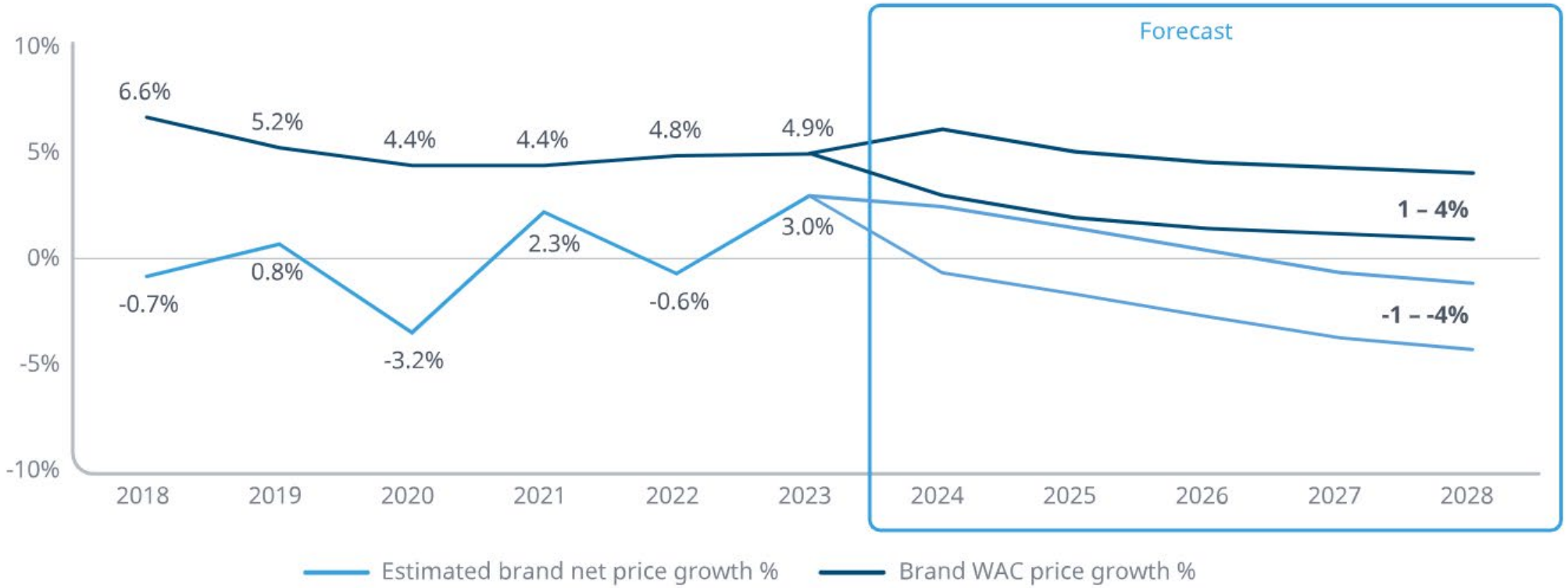
**Net prices for protected brands are forecast to decline -1 to -4%, while list prices will grow 1 to 4% including impact of price cuts**




Source: IQVIA

# Adopting and scaling of AI continues…

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Increased use of AI in provider settings related to clinical decision support tools, and diagnostics and treatment recommendations…

# Hospital Financials: National Trends June 2024

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## Key Takeaways

1. **June operating margins showed continued signs of stabilization.** Examination of the data shows median growth month-over-month, while the median change declined. This further points to a growing divide between higher performing and lower performing hospitals.
2. **Payments resulting from the 340B settlement are bolstering performance.**
3. **All regions except for the Great Plains demonstrated improvement compared to last year.** Hospitals in this region tend to be smaller hospitals that may be facing challenges related to size and access to capital.

# What other states are doing about hospital spending…

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An increasing number of states are implementing initiatives similar to Vermont's, including hospital spending growth targets, hospital rate-setting boards, CON programs, value-based payment methodologies, and more.

- For example, states with hospital growth targets now include California, Connecticut, Delaware, Mass., Nevada, New Jersey, Oregon, Rhode Island, and Washington.

Maryland and Pennsylvania have both implemented global budget methodologies for select hospitals (Maryland for its acute-care hospitals and Pennsylvania for its rural hospitals).

- Maryland is currently the only state to establish hospital *prices* at fixed levels for all payers.

# Rural Hospital Closures

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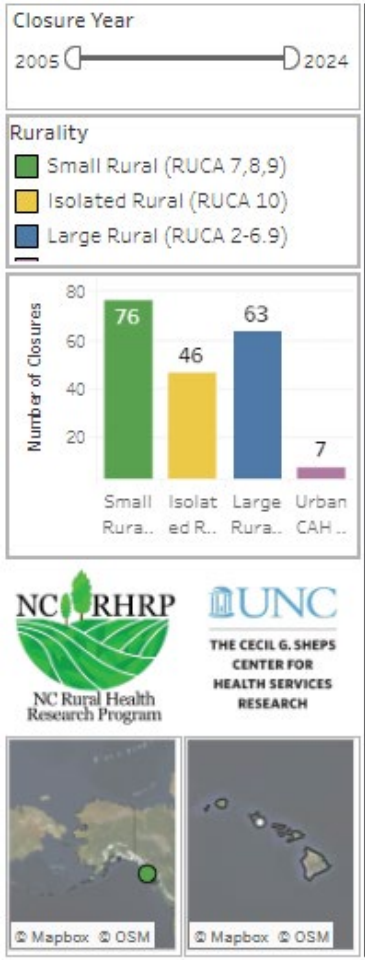
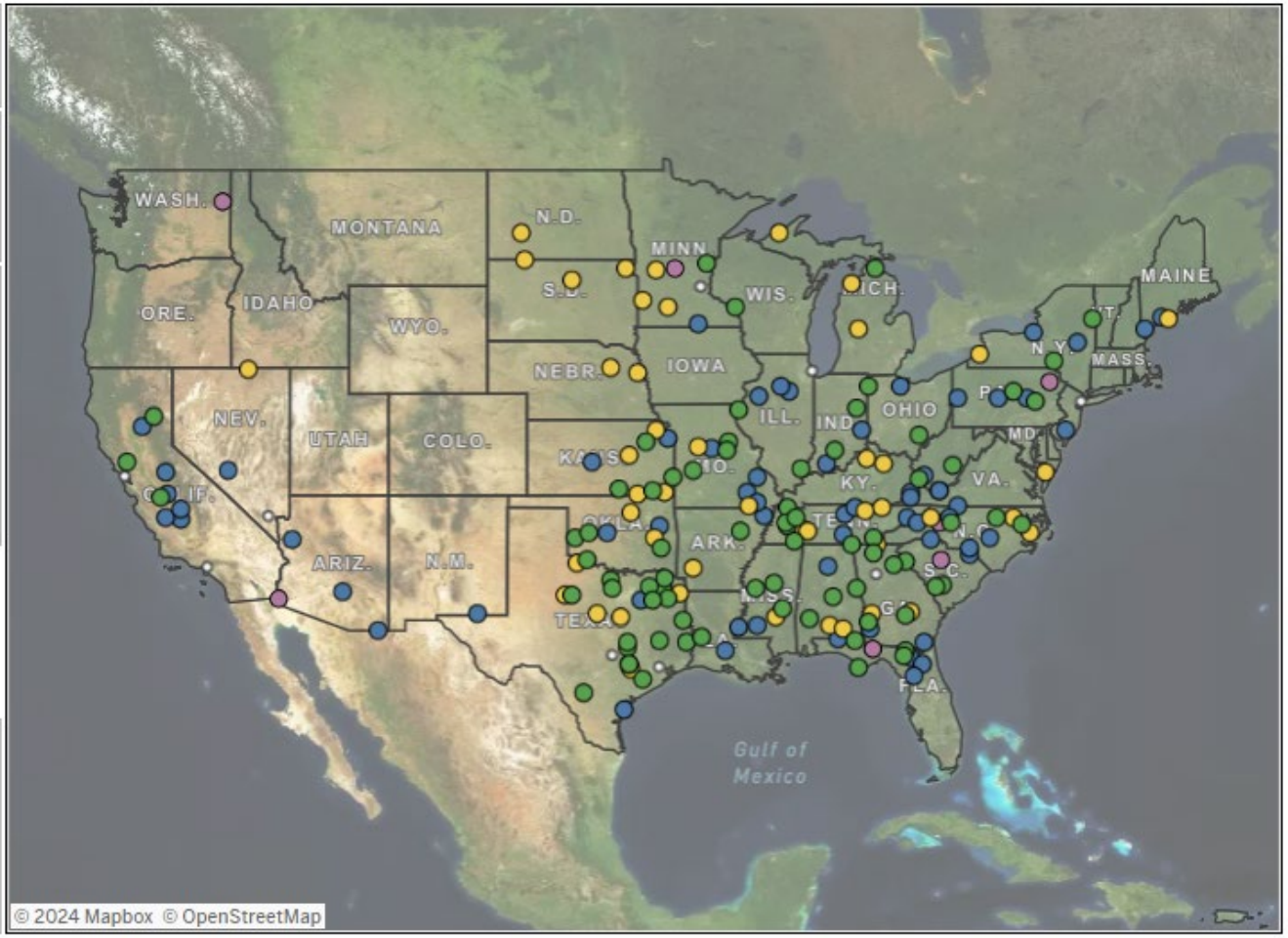
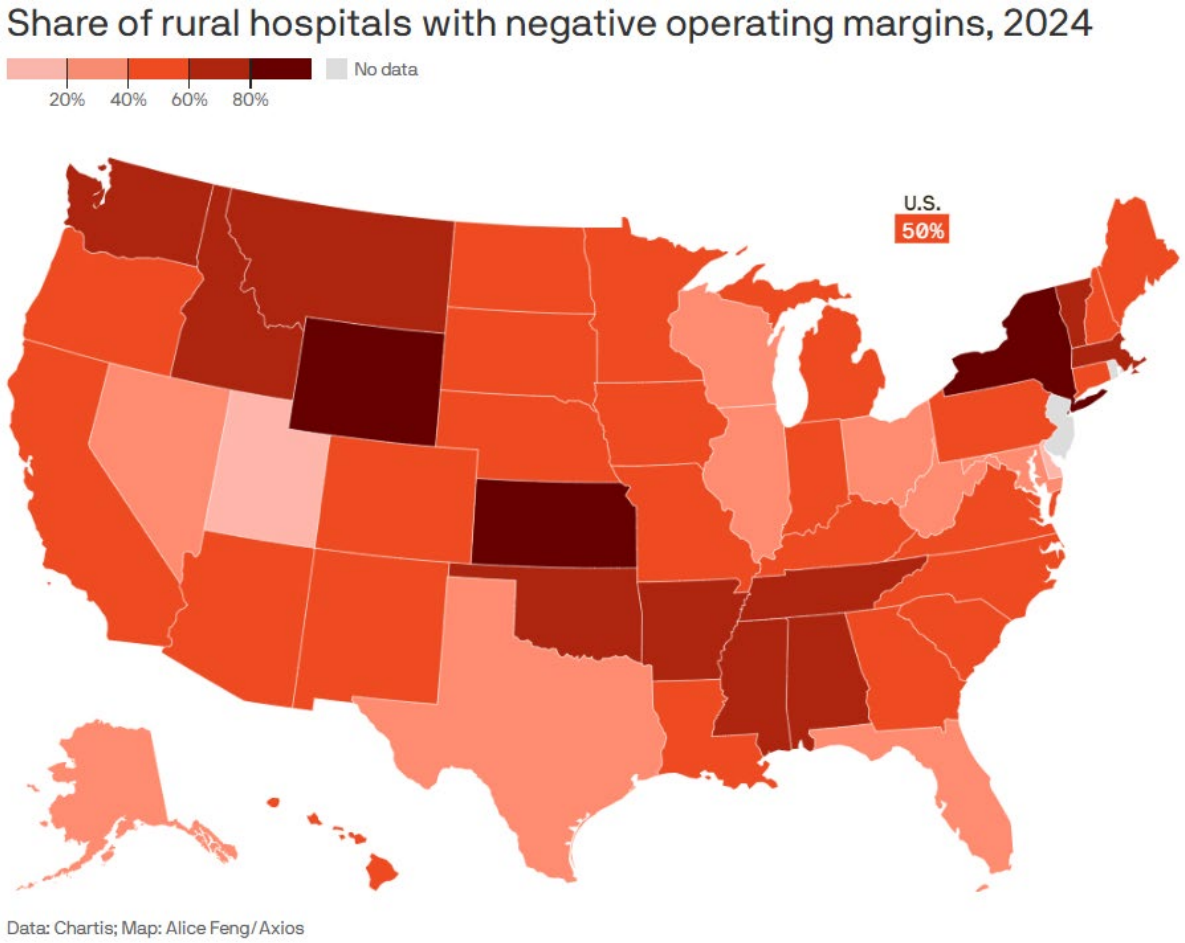



192 Rural Hospital Closures since 2005.

# More than half of US rural hospitals are at risk of closure...



# If Vermont is spending so much on hospital care, why are our hospitals struggling financially?

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- Declining patient volume & higher costs associated with maintaining access to low volume services
- Inefficient operations and low provider productivity
- Administrative cost growth
- Fixed costs are too high given variability in patient volume
- (unreimbursed) boarders and transfers better served in non-hospital settings
- Insufficient Medicaid reimbursement (for efficiently delivered services)
- Provider by-pass (local residents choosing to drive further for care, including out of state)
- Rural health care workforce shortages and recruitment challenges leading to a higher cost of labor

# ACT 167 Community Engagement

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## SCOPE, GOALS, AND APPROACH: IMPROVING THE VERMONT HEALTHCARE DELIVERY SYSTEM REQUIRES INPUT FROM ACROSS THE COMMUNITY IT SERVES

Act 167 (of 2022) requires GMCB, in collaboration with the Agency of Human Services, to develop and conduct a data-informed, patient-focused, community-inclusive engagement process for Vermont's hospitals to **reduce inefficiencies, lower costs, improve population health outcomes, reduce health inequities, and increase access to essential services**

GMCB tasked Oliver Wyman with engaging diverse healthcare stakeholders to ascertain **their 1) interactions with the health system and 2) perceived needs** to improve equitable healthcare access and outcomes

**Community and provider engagement process** *(see detailed Gantt in Deep Dive)*

### *Aug-Sept 2023*

**Step 1. Finalize engagement plan and interview scheduling**

Identify and schedule interviews with key stakeholders in the following groups:

- Hospital leaders
- Provider organizations
- Community leaders and members
- Diverse populations
- State of Vermont partners and Legislators
- Health related organizations

### *Sept-Nov 2023*

**Step 2. Develop current state understanding through 1st round of interviews**

Obtain community perspective on:

- Hospital Service Area (HSA) characteristics
- Hospital & healthcare delivery system performance
- Community needs
- Desired health system future state

### *March – May 2024*

**Step 3. Develop solution options and vet with community through 2nd round of interviews**

- Develop solutions to address current needs and reach the desired future state while considering Act 167 goals
  - *In conjunction with analytics contractor*
- Obtain stakeholder perspective on the impact of recommendations on hospital performance and healthcare delivery

### *May – June 2024*

**Step 4. Develop and deliver final report to GMCB**

- Document and socialize confirmed current state understanding, designed future state, and recommended steps to achieve future state (including pros and cons)
- Obtain stakeholder alignment on recommendations

# Why Regulate Hospitals?

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Higher hospital spending is a major contributor to **unaffordable health insurance premiums** and **out-of-pocket costs.**

Higher spending in one sector (e.g. Hospital Spending) **limits resources** that could otherwise be **allocated to other parts of the delivery system** (e.g. primary care, mental health, preventative services, social determinants of health etc.) or to other parts of the economy.

Vermont's health care system is highly concentrated. Regulation is essential to contain costs in **monopoly markets.** This is particularly salient in **rural settings** where there is less opportunity for efficient competition.

# Vermont's Regulation of Hospital Budgets: A Brief History

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**1983**

Vermont establishes Hospital Budget Review

18. V.S.A. § 9456

**1992**

### Vermont Health Care Authority Established

Merges Health Policy Council, Health Data Council and Certificate of Need Review Board

**1995**

### Banking, Insurance, Securities, and Health Care Administration (BISHCA)

Established authority to limit hospital budgets

**2011**

### Green Mountain Care Board

Transfers some authorities previously at BISHCA to GMCB renaming BISHCA to Dept. of Financial Regulation (DFR)

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# STATUTE & RULE

# Background

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- The GMCB must establish a budget for each hospital by September 15, with a written decision by October 1. 18 V.S.A. § 9456(d)(1).
- When establishing a budget, the GMCB must rely on its statutory charge and the state's regulatory objectives.
- Hospitals bear the burden of persuasion in justifying their budgets as submitted. GMCB Rule 3.000, § 3.306(a).
- If a hospital does not meet its burden, the GMCB must adjust the budget such that it aligns with the state's regulatory objectives.

# Background

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- When reviewing a hospital's budget, the Board is guided by:
  - The Board's statutory purpose and charge. 18 V.S.A. § 9372.
  - Its duty to regulate consistent with the principles for health care reform. 18 V.S.A. § 9371; 18 V.S.A. § 9375(a).
  - Its obligation to establish budgets using statutory considerations set forth for hospital budget review. 18 V.S.A. § 9456; GMCB Rule 3.000, § 3.306.
  - The annual benchmarks established by the Board, against which proposed budgets are evaluated. 18 V.S.A. § 9456(e); GMCB Rule 3.000, §§ 3.202, 3.305.

# 18 V.S.A. § 9372

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"It is the intent of the General Assembly to create an independent board to promote the general good of the State by:

1. improving the health of the population;
2. reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
3. enhancing the patient and health care professional experience of care;
4. recruiting and retaining high-quality health care professionals; and
5. achieving administrative simplification in health care financing and delivery."

# 18 V.S.A. § 9371

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The GMCB must execute its charge consistent with the principles of health care reform. These principles include, in part:

1. Universal access to high-quality, medically necessary health services. Systemic barriers, such as cost, must not prevent people from accessing necessary care.
2. Health costs must be contained. Growth in spending must balance the needs of the population with the ability to pay for it.
3. Primary care must be preserved and enhanced.
4. The system must be evaluated to improve quality, safety, access, and cost containment, including efforts to promote healthy lifestyles.
5. Unnecessary expenditures must be eliminated. This includes admin costs that do not contribute to efficient, high-quality services or improve health outcomes.

# 18 V.S.A. § 9456

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Specific to hospital budgets the GMCB considers, in part:

1. Vermont's critical health needs and resources.
2. Actual hospital performance with respect to past budgets.
3. Utilization information.
4. Hospital administrative costs.
5. Salaries for hospital leadership, hospital salary spread, and a comparison of median salaries in NE.
6. The extent to which undercompensated costs are charged to the commercial market.
7. Hospitals' investments in workforce development.
8. Reports from professional review organizations.
9. Public comment on all aspects of hospital costs and use, and on individual hospital budgets.
10. The benchmarks established by this Board.

# Annual Benchmarks

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- The Board may establish a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks. 18 V.S.A. § 9456(e).
- The Board establishes benchmarks for hospital use in developing and preparing budgets. GMCB Rule 3.000, § 3.202(a).
  - GMCB meets with VAHHS & HCA to obtain input.
  - Benchmarks provided to hospitals by March 31.
- Benchmarks help the Board consider whether budget adjustment is necessary. GMCB Rule 3.000, § 3.202(b).

# Simplified Overview

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- The Board is tasked with establishing hospital budgets that meet the state's objectives as described in statute.
- These regulatory objectives consistently tie back to increasing access, improving quality, and containing costs.
- Each year the Board establishes benchmarks to focus its analysis and to aid discussion with hospitals.
- The Board establishes budgets using the objectives described in statute. The benchmarks are useful tools.
- Each hospital bears the burden of persuading the Board that its proposed budget aligns with the state's regulatory objectives.

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# FY25 HOSPITAL BUDGET GUIDANCE

# Hospital Budget Review Process

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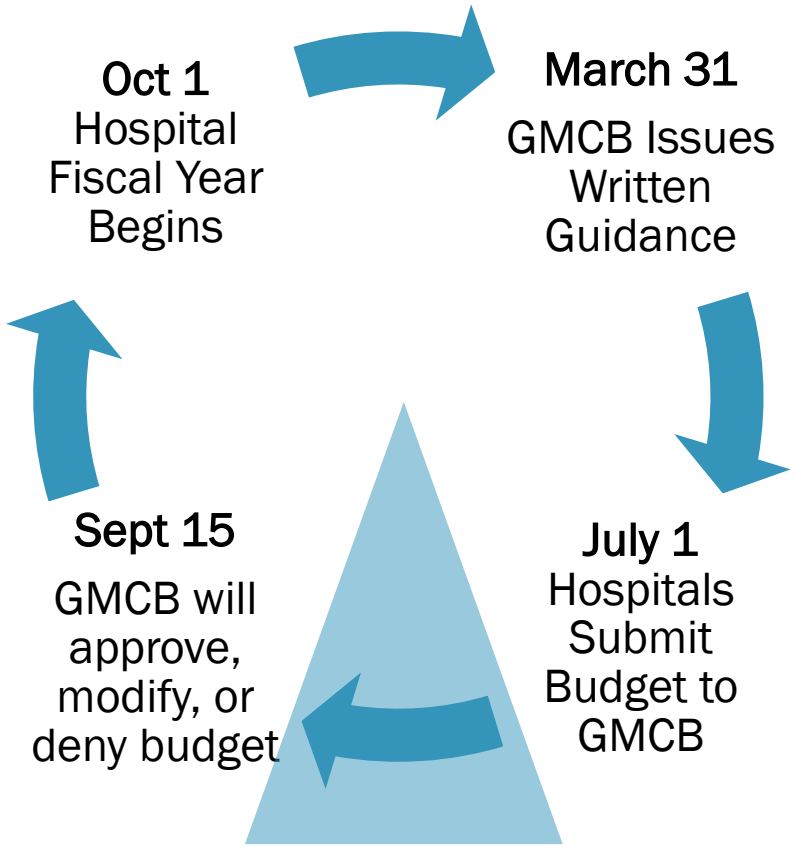
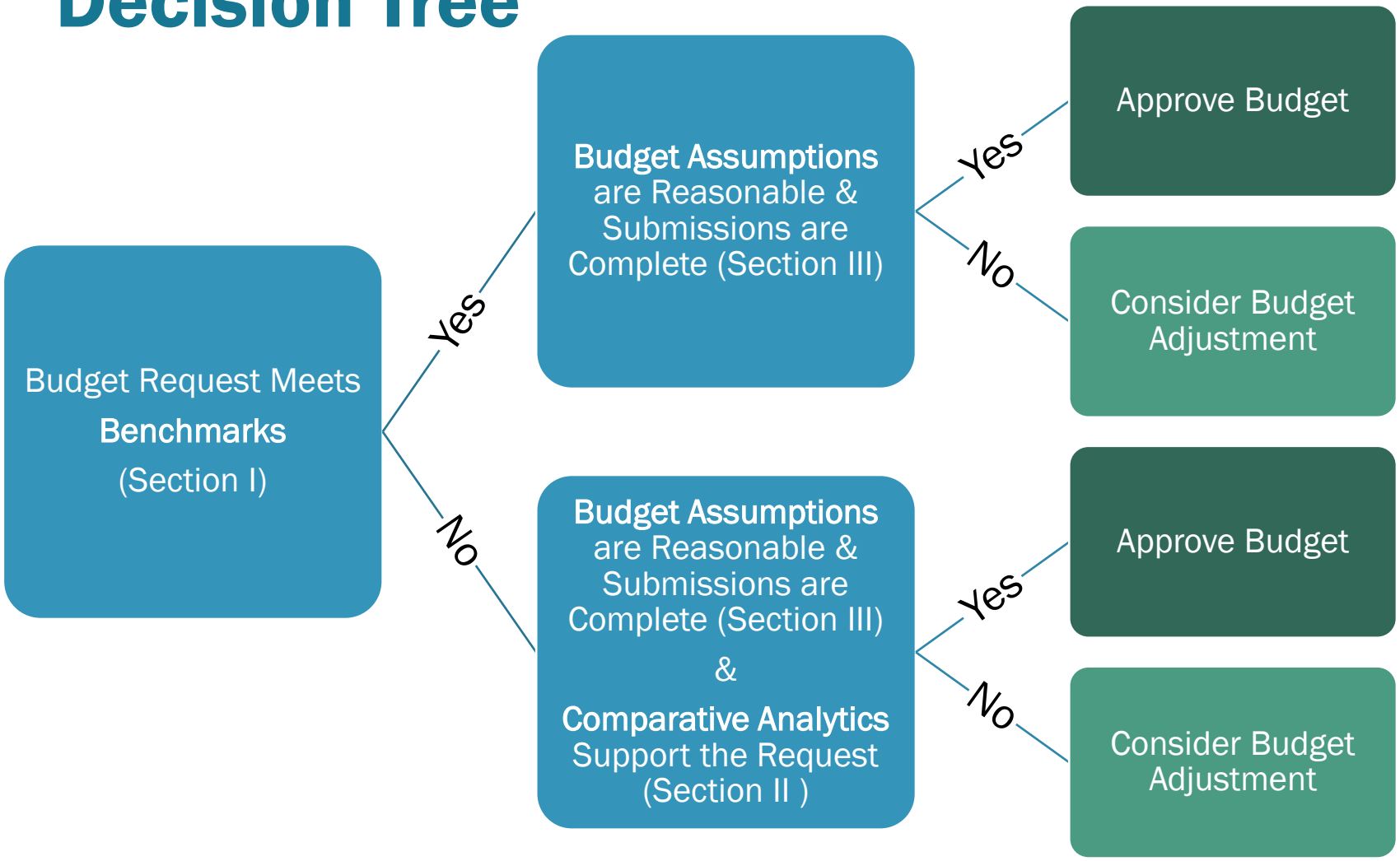



- ✓ **November**: staff meet with hospital CFOs to debrief FY24.
- ✓ **January-March**: staff meet with VAHHS and HCA to solicit input on benchmarks and other aspects of the process.
- ✓ **February**: open special public comment (Today).
- ✓ **February/March**: Staff continue collecting input on guidance from interested parties.
- ✓ **March**: Board issues hospitals written guidance for FY25.
- ✓ **April-July**: Hospital continue to develop FY25 budgets.
- ❑ **July**: GMCB receives budgets (due 7/1), staff begins review.
- ❑ **August**: Hospital Budget hearings.
- ❑ **September**: Board publicly deliberates to approve, modify, or deny budgets by 9/15.
- ❑ **October**: Budget orders delivered to hospitals by 10/1 (start of hospital fiscal year).

# FY25 HBR Guidance: Decision Tree

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*Regardless of budget approval or adjustment, insights gained from data in any of the sections of this guidance may be used to facilitate conversations around improvement opportunities and may lead to general or hospital-specific budget order conditions.*

# FY25 HBR Guidance: Section I Benchmarks

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1. **Net Patient Revenue** is capped at no more than 3.5% above prior year budget, in line with the Vermont All Payer Model Agreement.

2. **Commercial rate growth** overall and for each payer shall be no more than the **PCE Price Index +1%** (January 2024 release), over FY24 approved budget, which amounts to 3.4% for FY25.

3. **Operating margin** shall be greater than 0%.

*Hospitals exceeding these benchmarks are required to justify with evidence.*

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# SUMMARY OF HOSPITAL BUDGET REQUESTS FY25

# Compliance: Were submitted budget materials ***complete*** and ***timely***?

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Two hospitals made major updates to their budget post-deadline:

1. In mid-July, SVMMC notified us that they needed to request a higher rate due to an inability to negotiate a higher Medicare reimbursement rate. They resubmitted their budget on July 24, 2024.
2. On July 22, UVMMC notified us that they needed a higher rate due to higher-than-expected costs associated with bargaining. They began resubmitting their budget documents August 2nd, with documents coming in as late as August 5th (**yesterday**). Staff made their best effort to incorporate the latest data into this presentation but have not had time to reassess all materials.

# Compliance: Were submitted budget materials ***complete*** and ***timely***?

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Though hospitals have now submitted all required documents, none had a complete submission by the extended deadline of July 8th (from July 1st).

We're currently waiting for edits and/or resubmissions from the following hospitals:

- 1-2 items: Brattleboro, North Country, Gifford, and Springfield.
- 3+ items: CVMC, Porter, and UVMMC.

***Staff are exploring process improvements for FY2026 including June office hours, templates for budget assumptions (and certainty), proposing to level fund budgets that are not timely nor complete.***

# FY25 Hospital Budget Requests vs. Section I Benchmarks

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| Hospital | Comm. Rate* | Benchmark (< 3.4%) | NPR | Benchmark (< 3.5%) | Operating Margin | Benchmark (> 0%) | All Section I Benchmarks |
|---|---|---|---|---|---|---|---|
| Brattleboro Memorial Hospital | 4.70% | No | 2.5% | Yes | 0.5% | Yes | **No** |
| Central Vermont Medical Center | 5.54% | No | 11.9% | No | 0.0% | Yes | **No** |
| Copley Hospital | 10.50% | No | 11.8% | No | 2.8% | Yes | **No** |
| Gifford Medical Center | 6.80% | No | 8.2% | No | 4.4% | Yes | **No** |
| Grace Cottage Hospital | 2.50% | Yes | 12.0% | No | -2.3% | No | **No** |
| Mt. Ascutney Hospital & Health Ctr | 2.20% | Yes | 4.4% | No | 0.7% | Yes | **No** |
| North Country Hospital | 4.70% | No | 1.6% | Yes | 2.0% | Yes | **No** |
| Northeastern VT Regional Hospital | 4.50% | No | 3.9% | No | 0.7% | Yes | **No** |
| Northwestern Medical Center | 6.40% | No | 6.8% | No | 1.0% | Yes | **No** |
| Porter Medical Center | 2.50% | Yes | 4.2% | No | 4.7% | Yes | **No** |
| Rutland Regional Medical Center | 2.80% | Yes | 6.1% | No | 2.5% | Yes | **No** |
| Southwestern VT Medical Center | 3.80% | No | 3.5% | Yes | 1.6% | Yes | **No** |
| Springfield Hospital | 2.20% | Yes | 12.0% | No | 1.4% | Yes | **No** |
| The University of Vermont Medical Center | 5.70% | No | 9.3% | No | 2.9% | Yes | **No** |

*Commercial rate (price growth) is found in the rate decomposition workbook. NPR growth is also in the workbook and is expected to tie to Adaptive.

# Price vs. Non-Price Components of FY25 Hospital NPR Growth

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| *FY2025 Year Over Year Growth* | | | | | | | | | % of NPR Growth | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Hospital** | **NPR** | **Comm Price** | **Util** | **Public Price** | **Payer Mix** | **Service Mix** | **Other** | **Non-Price** | **Comm Price** | **Non-Price** |
| BMH | +2.5% | -2.5% | +1.1% | -91.1% | -9.5% | -6.3% | +110.7% | +5.0% | -1.0% | 1.9% |
| NVRH | +3.9% | +1.8% | - | +2.3% | +0.4% | -0.5% | -0.0% | +2.1% | 0.8% | 0.9% |
| RRMC | +6.1% | +1.4% | - | +4.3% | +0.3% | +0.2% | -0.0% | +4.7% | 1.6% | 5.5% |
| CVMC | +11.9% | +2.2% | +8.4% | +1.3% | +1.0% | - | -1.1% | +9.6% | 2.2% | 9.4% |
| PH | +4.2% | +0.9% | +6.1% | +2.0% | +0.8% | - | -5.5% | +3.3% | 0.4% | 1.5% |
| UVMMC | +9.3% | +3.3% | +5.1% | +1.6% | -0.4% | - | -0.3% | +6.0% | 21.4% | 38.9% |
| Copley | +11.8% | +8.2% | -0.2% | +3.9% | +3.0% | - | -3.2% | +3.6% | 3.1% | 1.3% |
| GMC | +8.2% | +3.5% | -5.5% | - | +3.6% | - | +6.5% | +4.7% | 0.8% | 1.1% |
| GCH | +12.0% | +1.0% | +6.2% | +0.6% | -0.1% | - | +4.3% | +11.0% | 0.1% | 1.1% |
| MAHHC | +4.3% | +0.9% | +1.8% | +1.1% | +0.0% | - | +0.5% | +3.4% | 0.2% | 0.8% |
| NCH | -0.5% | +2.1% | +2.3% | +1.1% | +0.5% | - | -6.5% | -2.6% | 0.7% | -0.9% |
| NMC | +6.8% | +3.9% | +8.6% | - | +0.7% | - | -6.3% | +2.9% | 1.7% | 1.3% |
| SVMC | +3.5% | +1.6% | +1.8% | +0.2% | -0.1% | - | +0.0% | +1.9% | 1.1% | 1.4% |
| SH | +13.0% | +1.0% | +11.5% | +1.8% | -1.9% | - | +0.6% | +12.0% | 0.2% | 2.6% |
| | | | | | | | | | | |
| **System YOY %** | **+8.0%** | **+2.7%** | **+4.2%** | **-1.2%** | **-0.2%** | **-0.2%** | **+2.7%** | **+5.3%** | **33.3%** | **66.7%** |
| **System YOY** *$ (millions)* | *$283* | *$94* | *$149* | *($41)* | *($7)* | *($7)* | *$95* | *$189* | *$94.18* | *$188.76* |

*Note: Summary of Rate Decomposition Data Submitted by Hospitals as of 08/05/2024.*

# Price vs. Non-Price Components of FY25 Commercial NPR Growth

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| *FY2025 Year Over Year Growth* | | | | | | | | | | % of Comm NPR Growth | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hospital** | **Comm NPR** | | **Comm Price** | | **Util** | **Public Price** | **Payer Mix** | **Service Mix** | **Other** | **Non-Price** | **Comm Price** | **Non-Price** |
| UVMMC | +10.8% | | +6.8% | | +5.7% | - | -1.1% | - | -0.5% | +4.1% | 34.3% | 20.5% |
| CVMC | +15.4% | | +5.5% | | +9.6% | - | +3.2% | - | -2.9% | +9.9% | 3.6% | 6.4% |
| Copley | +12.3% | | +10.5% | | +0.2% | - | -0.1% | - | +1.7% | +1.8% | 3.3% | 0.6% |
| NMC | +14.3% | | +6.4% | | +13.8% | - | +1.0% | - | -6.9% | +8.0% | 2.7% | 3.4% |
| RRMC | +5.9% | | +2.8% | | - | +2.9% | - | +0.2% | -0.0% | +3.1% | 2.7% | 2.9% |
| BMH | +7.0% | | +4.7% | | +4.0% | -100.0% | +0.2% | +0.5% | +97.6% | +2.3% | 2.5% | 1.2% |
| SVMC | +5.7% | | +3.5% | | +3.7% | - | -1.5% | - | +0.0% | +2.2% | 2.3% | 1.4% |
| NVRH | +3.9% | | +4.5% | | - | +2.5% | - | -3.1% | - | -0.6% | 1.4% | -0.2% |
| GMC | +3.9% | | +6.8% | | +0.4% | - | -2.4% | - | -0.9% | -2.9% | 1.3% | -0.5% |
| NCH | -0.5% | | +2.1% | | +2.3% | +1.1% | +0.5% | - | -6.5% | -2.6% | 1.1% | -1.4% |
| PH | +16.0% | | +2.5% | | +5.9% | - | +1.4% | - | +6.2% | +13.5% | 0.7% | 3.6% |
| MAHHC | +6.6% | | +2.2% | | +0.8% | - | +3.6% | - | +0.0% | +4.4% | 0.3% | 0.7% |
| SH | +13.0% | | +1.0% | | +11.5% | +1.8% | -1.9% | - | +0.6% | +12.0% | 0.3% | 4.0% |
| GCH | +15.3% | | +2.5% | | +8.0% | - | - | - | +4.8% | +12.8% | 0.2% | 0.9% |
| | | | | | | | | | | | | |
| **System YOY %** | **+9.6%** | | **+5.4%** | | **+5.1%** | **-4.7%** | **-0.4%** | **-0.0%** | **+4.2%** | **+4.2%** | **57%** | **43%** |
| **System YOY** $ (millions) | *$180* | | *$102* | | *$95* | *($89)* | *($7)* | *($1)* | *$80* | *$78* | *$102* | *$78* |

*Note: Summary of Rate Decomposition Data Submitted by Hospitals as of 08/05/2024.*

# NPR Growth vs. APM Target

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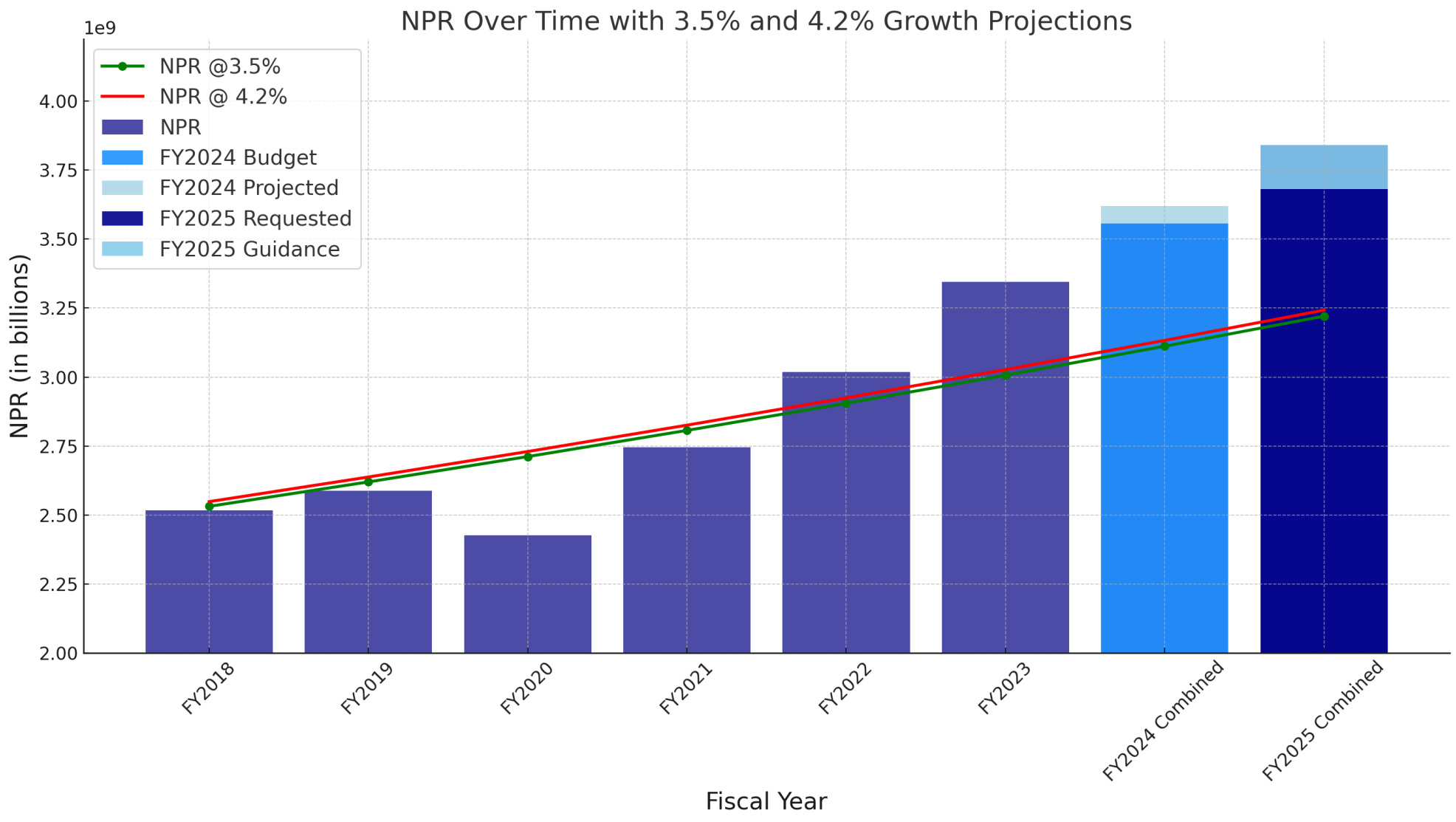


Compound annual NPR growth since 2017 has been approx. **6%**.

# Hospital Financial Health: Operating & Total Margin

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| | Operating Margin | | | EBIDA % | | | Total Margin | | |
|---|---|---|---|---|---|---|---|---|---|
| Hospitals | FY23 Actuals | FY24 Projected | FY25 Submitted Budget | FY23 Actuals | FY24 Projected | FY25 Submitted Budget | FY23 Actuals | FY24 Projected | FY25 Submitted Budget |
| Brattleboro Memorial Hospital | -1.7% | 0.7% | 0.7% | 2.2% | 4.5% | 4.2% | 1.7% | 0.7% | 0.5% |
| Central Vermont Medical Center | -6.5% | 0.7% | 0.0% | -3.9% | 2.9% | 2.2% | -8.3% | 2.9% | 0.9% |
| Copley Hospital | -1.8% | 0.0% | 2.8% | 1.6% | 2.9% | 6.4% | -1.4% | 0.2% | 3.2% |
| Gifford Medical Center | -8.3% | -4.3% | 4.4% | -1.2% | 2.1% | 10.0% | -2.8% | 0.0% | 4.8% |
| Grace Cottage Hospital | -8.9% | -6.7% | -2.3% | -5.2% | -3.0% | 1.2% | -0.2% | 0.5% | 12.4% |
| Mt. Ascutney Health & Hospital Center | 2.0% | 0.1% | 0.7% | 6.0% | 4.3% | 4.8% | 7.5% | 5.0% | 4.8% |
| North Country Hospital | -8.9% | -0.4% | 2.0% | -4.6% | 3.4% | 6.2% | -10.9% | 3.9% | 2.0% |
| Northeastern VT Regional Hospital | 0.5% | -0.7% | 0.7% | 4.5% | 3.4% | 3.9% | 1.4% | 1.5% | 0.6% |
| Northwestern Medical Center | -6.6% | -0.8% | 1.0% | -1.3% | 4.6% | 6.6% | 1.2% | 6.4% | 2.6% |
| Porter Medical Center | 7.6% | 4.0% | 4.7% | 9.9% | 6.1% | 6.6% | 11.4% | 4.7% | 6.0% |
| Rutland Regional Medical Center | 2.1% | 2.0% | 2.5% | 6.3% | 6.2% | 6.6% | -0.3% | 6.3% | 5.3% |
| Southwestern VT Medical Center | -3.8% | 1.1% | 1.6% | 0.0% | 5.0% | 5.8% | -0.7% | 4.2% | 3.0% |
| Springfield Hospital | -0.9% | 0.1% | 1.4% | 1.2% | 2.3% | 3.8% | -0.7% | 0.7% | 1.3% |
| The University of Vermont Medical Center | 3.1% | 3.0% | 2.9% | 7.3% | 6.8% | 6.5% | 5.6% | 5.2% | 3.7% |

Operating Margin = Net Operating Income / Total Operating Revenue
EBIDA % = (Net Operating Income + Interest (Short Term) + Interest (Long Term) + Depreciation Amortization) / Total Operating Revenue
Tota Margin = (Excess of Revenue Over Expense) / (Net Patient Revenue + Other Operating Revenue + Non-Operating Revenue)

# Hospital Financial Health: Days Cash on Hand

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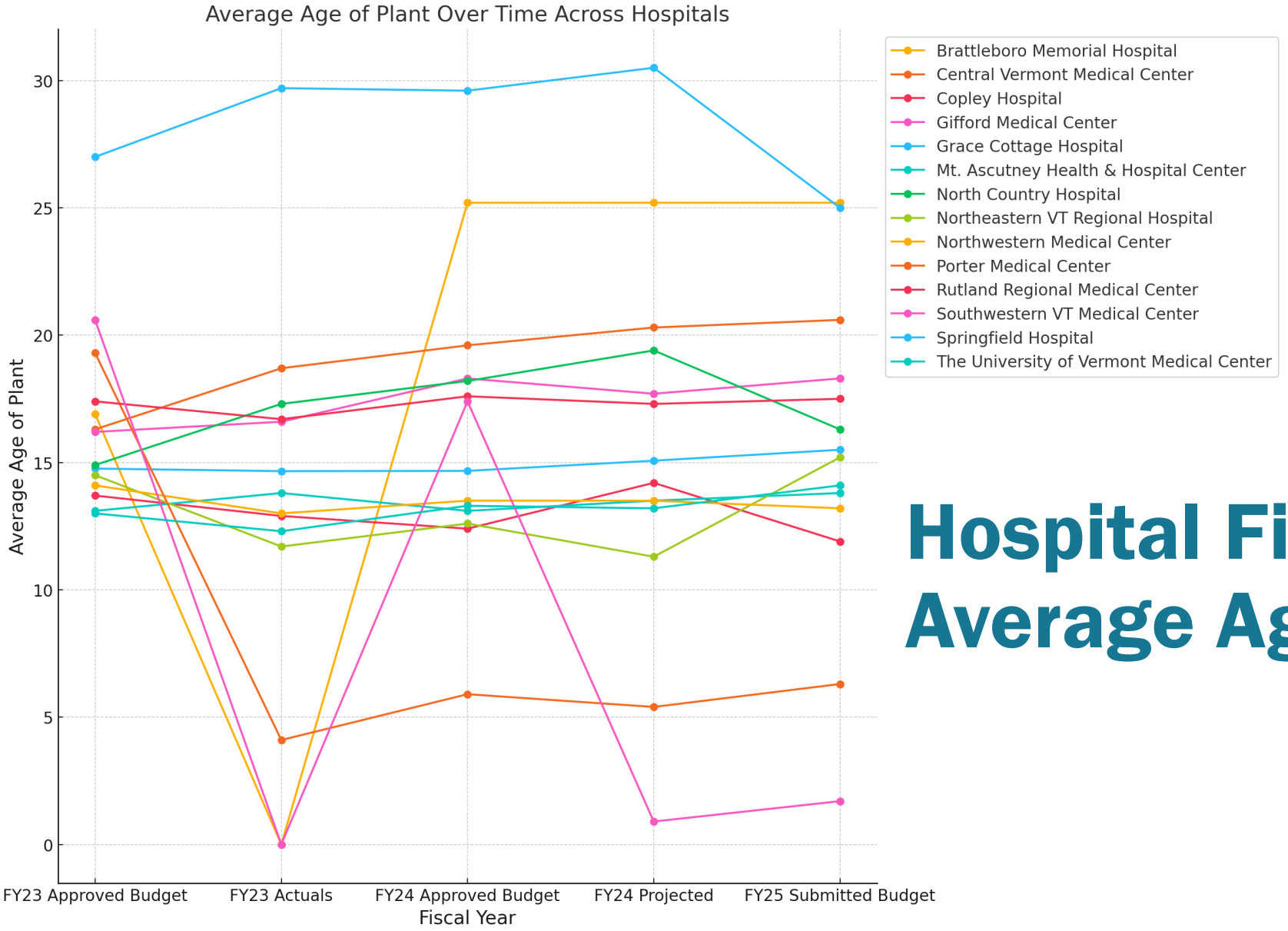
| | Days Cash on Hand | | | | |
|---|---|---|---|---|---|
| Hospitals | FY21 Actuals | FY22 Actuals | FY23 Actuals | FY24 Projected | FY25 Submitted Budget |
| Brattleboro Memorial Hospital | 213.6 | 131.7 | 108.4 | 119.2 | 99.7 |
| Central Vermont Medical Center | 114.1 | 68.7 | 78.5 | 72.6 | 69.4 |
| Copley Hospital | 125.7 | 65.8 | 42.5 | 57.9 | 69.4 |
| Gifford Medical Center | 326.4 | 203.5 | 146.4 | 101.1 | 108.9 |
| Grace Cottage Hospital | 249.0 | 99.1 | 87.9 | 85.0 | 87.9 |
| Mt. Ascutney Health & Hospital Center | 246.1 | 207.5 | 220.0 | 224.5 | 229.0 |
| North Country Hospital | 315.3 | 212.6 | 186.9 | 199.8 | 212.1 |
| Northeastern VT Regional Hospital | 189.2 | 105.7 | 98.2 | 97.4 | 86.2 |
| Northwestern Medical Center | 297.9 | 251.9 | 223.9 | 241.5 | 240.4 |
| Porter Medical Center | 173.9 | 120.0 | 98.2 | 111.7 | 93.2 |
| Rutland Regional Medical Center | 274.3 | 181.9 | 188.7 | 202.6 | 203.6 |
| Southwestern VT Medical Center | 52.5 | 37.5 | 48.8 | 43.7 | 43.9 |
| Springfield Hospital | 42.2 | 70.4 | 71.0 | 50.1 | 55.7 |
| The University of Vermont Medical Center | 198.8 | 112.5 | 115.4 | 117.7 | 119.7 |

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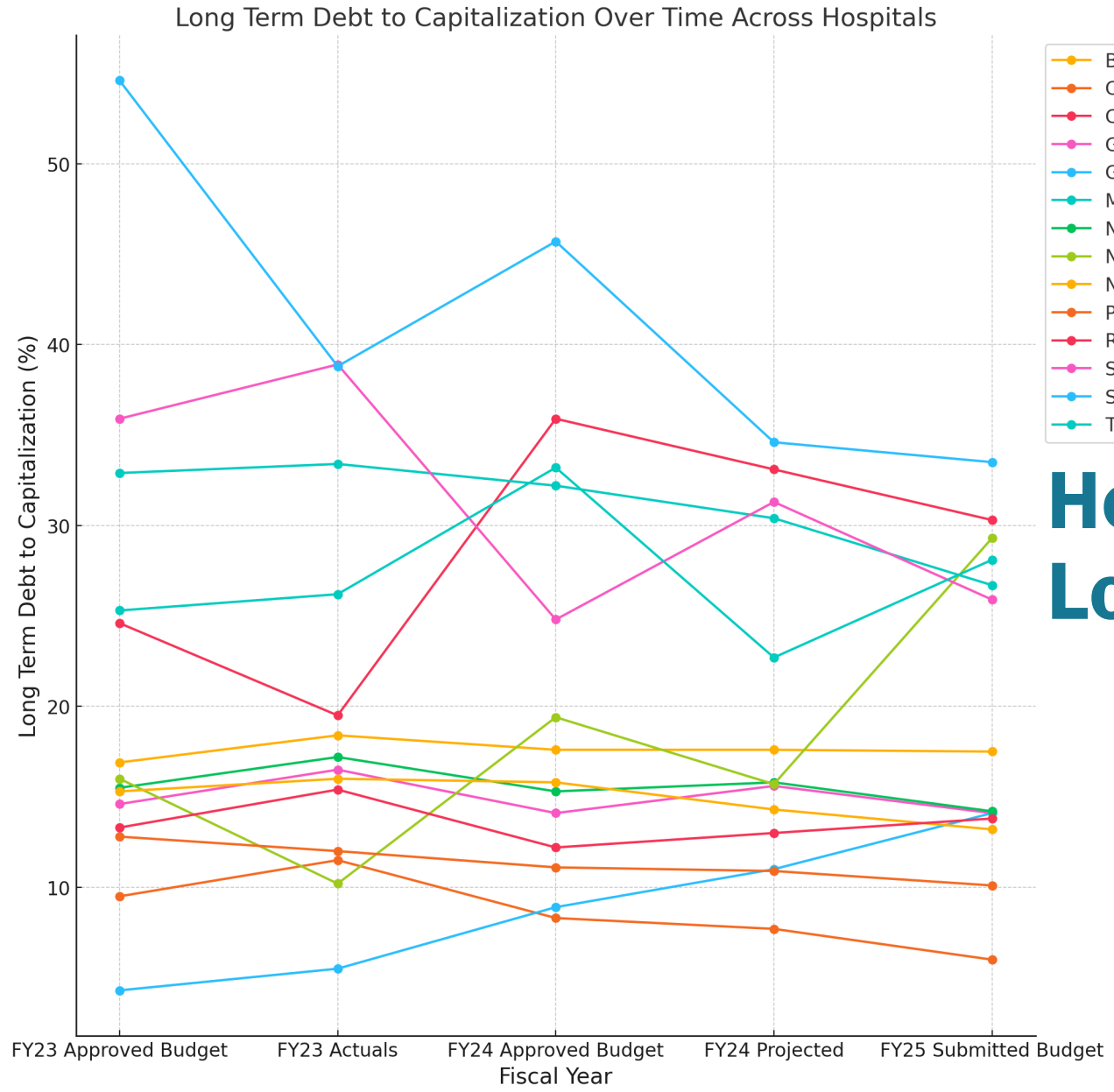
# Hospital Financial Health: Average Age of Plant

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# Hospital Financial Health: Long term debt to capitalization

# Operating Expense Growth: Cumulative 2020 to 2025 Requested

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# Labor Expense Growth

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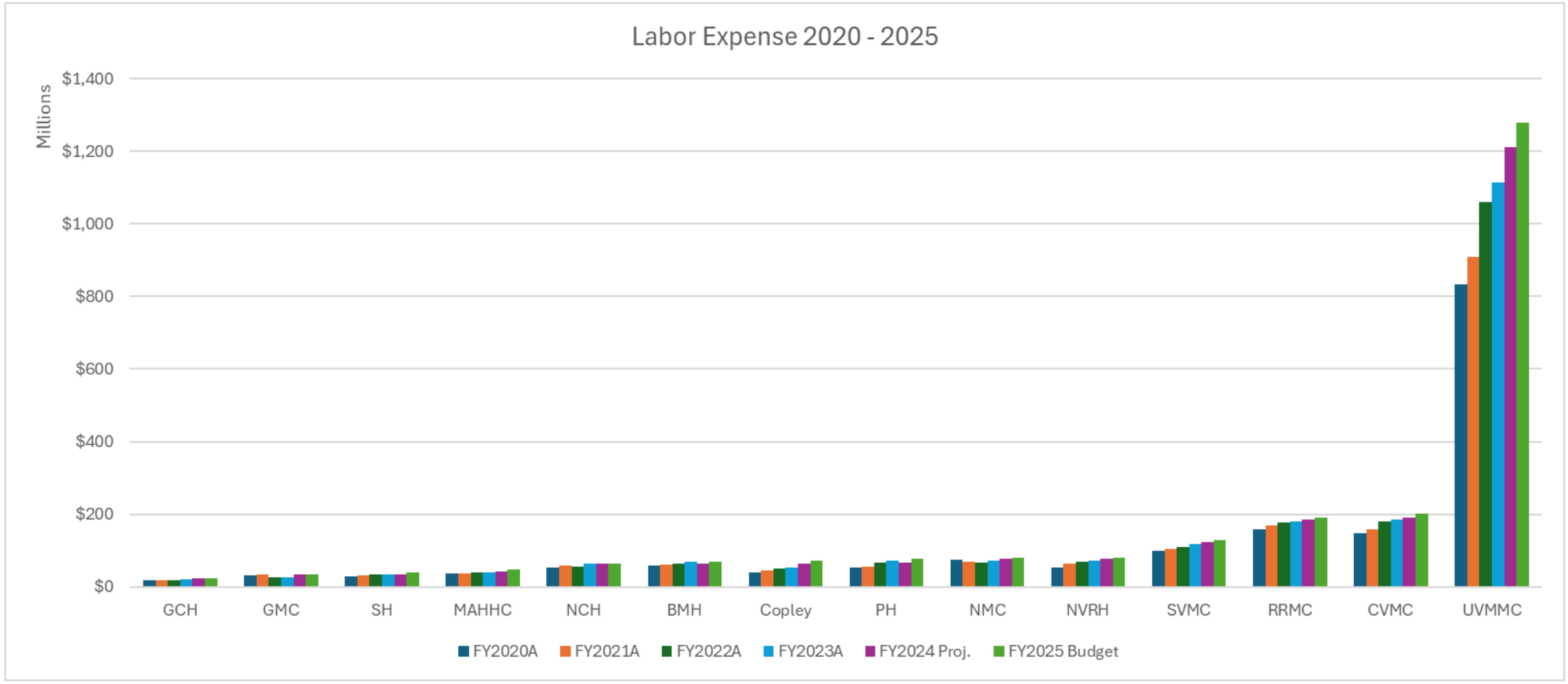

# Traveler Expense

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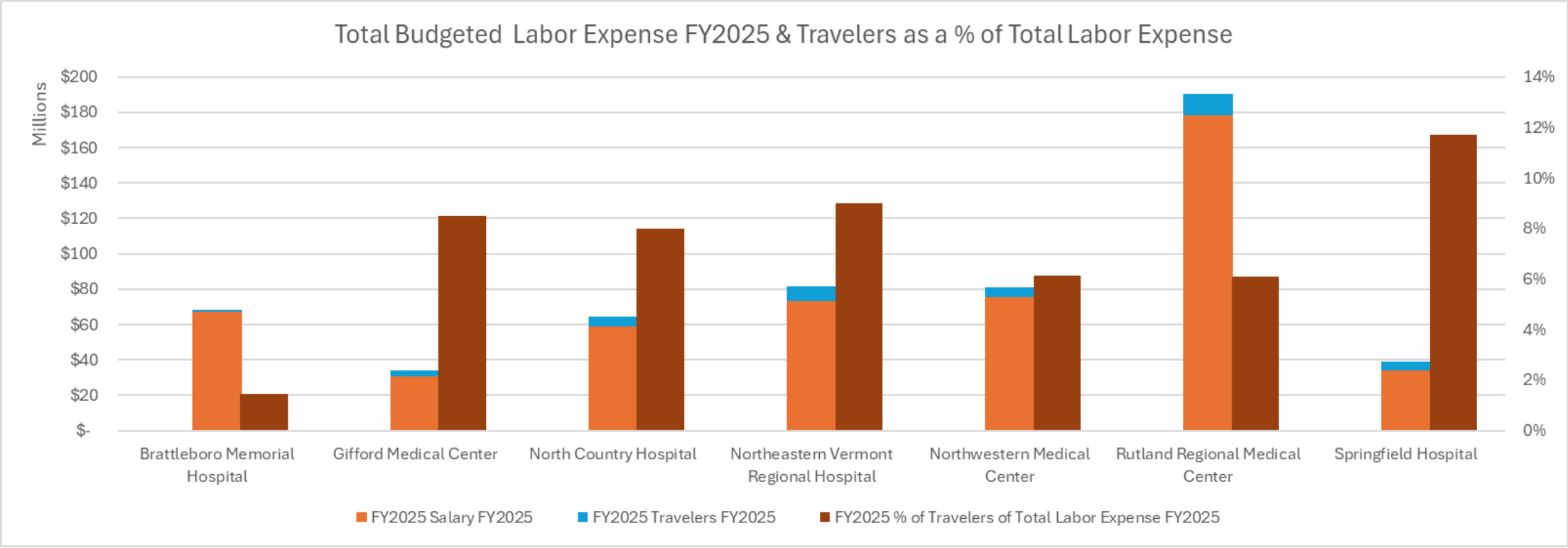


*Excludes Health Care Provider Tax
**Traveler data not provided by Copley, CVMC, GCH, MAHHC, PH, SVMC & UVMMC

# Capital Expenditures

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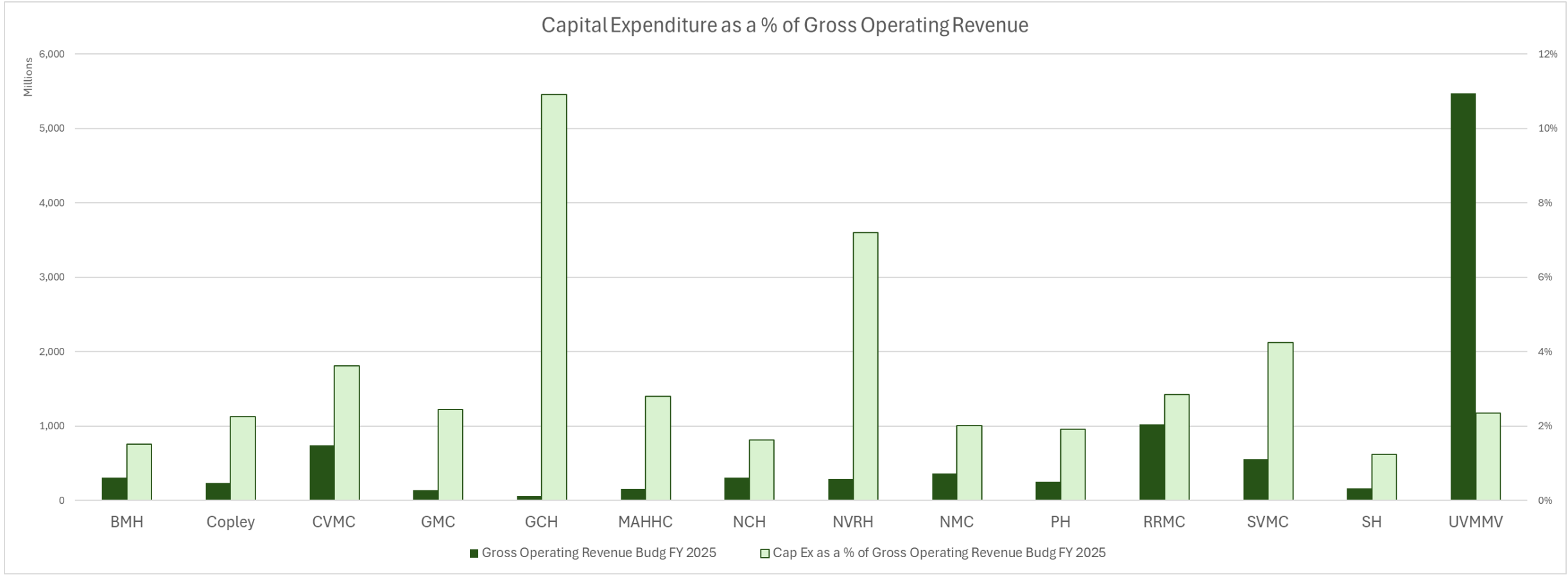

# Pharmaceutical Expenditure as a % of Gross Revenue

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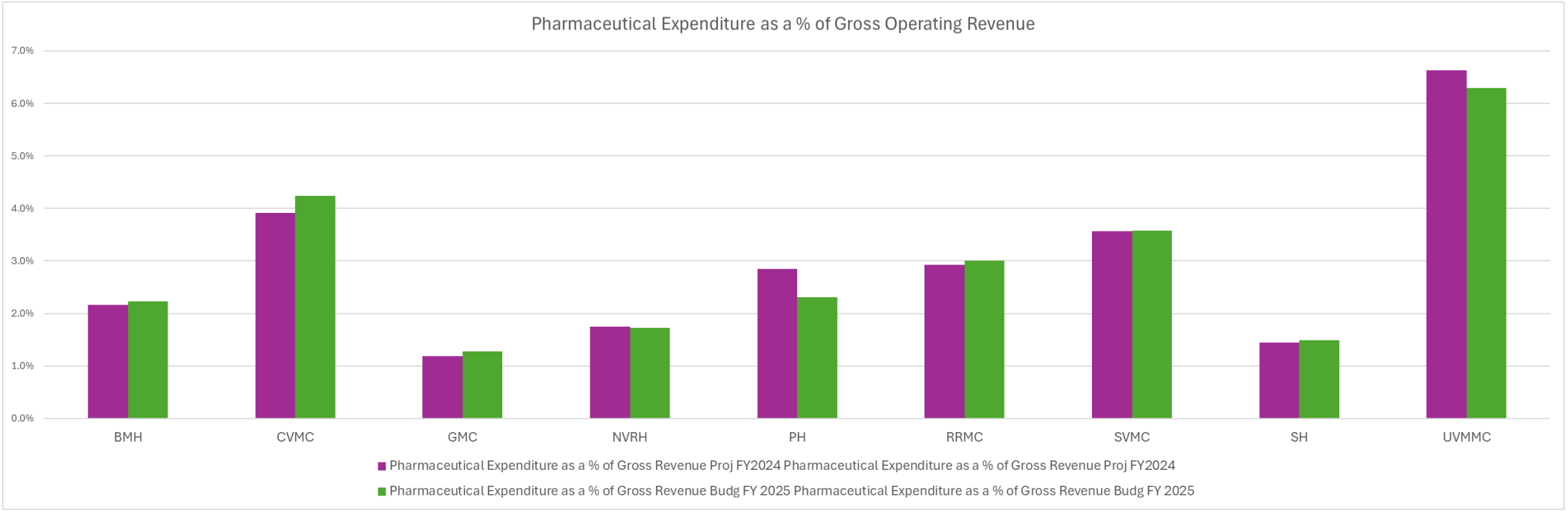


*Copley, GCH, MAHHC, NCH & NMC do not break out Pharmaceutical Expense as a separate line item on the I&E for 2025
**Gross Operating Revenue = Gross Patient Care Revenue + Other Operating Revenue

| | Hospital | BMH | CVMC | Copley | GMC | GCH | MAHHC | NCH | NVRH | NMC | PH | RRMC | SVMC | SH | UVMM |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CAH | yes | no | yes | yes | yes | yes | yes | yes | no | yes | no | no | yes | no |
| NPR | Overall Growth | 2.5% | 11.9% | 11.8% | 8.2% | 12.0% | 4.3% | -0.5% | 3.9% | 6.8% | 4.2% | 6.1% | 3.5% | 13.0% | 9.3% |
| | Medicaid | 2.1% | 8% | 50% | 373% | 35% | -13% | -60.7% | 7.8% | 1137.6% | -45.2% | -6.9% | 2.9% | 52.8% | -0.5% |
| | Medicare - FFS | 6.2% | -9.1% | 12.3% | 35.6% | 8.9% | 4.1% | -26.4% | 4.5% | 56.6% | -1.9% | 5.1% | 0.6% | -14.0% | -15.9% |
| | Medicare - MA | 22.6% | 21.5% | 12.3% | -50.9% | 0.0% | 0.0% | 43.5% | 13.2% | 31.8% | 16.3% | 23.4% | 2.2% | 43.1% | 28.5% |
| | Commercial | 7.0% | 15.4% | 12.3% | 3.9% | 15.3% | 6.6% | 20.2% | 3.9% | 14.3% | 16.0% | 5.9% | 5.7% | 24.9% | 10.8% |
| | FPP | 4.7% | 17.5% | -13.1% | -32.9% | 0.0% | -8.7% | 8.1% | -8.3% | -80.2% | 8.8% | -100.0% | 0.0% | 21.8% | 14.0% |
| Price | Overall Growth | 2.7% | 3.9% | 9.0% | 3.4% | 3.6% | 1.9% | 2.8% | 2.3% | 3.6% | 3.2% | 1.8% | 2.2% | 2.8% | 5.5% |
| | Medicaid | 0.0% | 0.4% | 0.0% | 0.0% | 0.0% | 0.9% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 1.0% | 6.6% |
| | Medicare - FFS | 2.3% | 0.4% | 9.0% | 0.0% | 5.0% | 1.9% | 2.0% | 0.7% | 0.0% | 3.7% | 1.0% | 0.7% | 1.9% | 2.1% |
| | Medicare - MA | 2.3% | 0.6% | 9.0% | 0.0% | 0.0% | 0.0% | 4.9% | 1.1% | 0.0% | 0.1% | 0.0% | 0.7% | 9.1% | 3.0% |
| | Commercial | 4.7% | 5.5% | 10.5% | 6.8% | 2.5% | 2.2% | 4.7% | 4.5% | 6.4% | 2.5% | 2.8% | 3.5% | 2.2% | 6.8% |
| | FPP | 2.4% | 4.6% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 6.5% | 0.0% | 0.0% | 1.0% | 4.3% |
| Volume | Overall Growth | 3.9% | 8.5% | 0.2% | -5.3% | 6.0% | 1.8% | 1.2% | 2.3% | 9.0% | 6.2% | 4.6% | 1.7% | 11.5% | 5.1% |
| | Medicaid | 4.0% | 2.1% | 0.0% | -2.1% | 25.8% | 3.8% | 2.0% | 2.5% | 8.5% | 1.4% | -6.2% | 3.9% | 12.2% | 2.0% |
| | Medicare - FFS | 4.0% | 6.8% | 0.2% | -16.9% | 1.3% | 2.4% | 0.1% | 2.5% | 3.3% | 3.9% | 4.1% | -2.5% | 8.0% | 4.4% |
| | Medicare - MA | 4.0% | 9.9% | 0.2% | -6.5% | 0.0% | 0.0% | 1.0% | 2.5% | 7.6% | 6.1% | 21.3% | -0.9% | 13.4% | 5.6% |
| | Commercial | 4.0% | 9.6% | 0.2% | 0.4% | 8.0% | 0.8% | 4.5% | 2.5% | 13.8% | 5.9% | 2.9% | 3.7% | 13.9% | 5.7% |
| | FPP | 1.5% | 8.6% | 0.0% | 0.0% | 0.0% | 0.0% | 1.5% | 0.0% | 0.2% | 8.7% | -100.0% | 0.0% | 12.2% | 4.9% |
| Payer Mix | Overall Growth | 0.1% | 1.8% | 3.0% | 3.5% | 0.0% | 0.1% | 1.0% | -0.2% | 0.8% | 0.8% | 0.2% | -0.1% | -1.9% | -0.9% |
| | Medicaid | 0.0% | -12.3% | 28.7% | 334.3% | 0.0% | -17.6% | 0.0% | 5.3% | 0.0% | -2.4% | -0.6% | -0.9% | 9.6% | -5.3% |
| | Medicare - FFS | 0.1% | -11.3% | 6.6% | 28.3% | 0.0% | -0.2% | 0.0% | 1.3% | 0.0% | -7.9% | 0.0% | 2.4% | -14.8% | -8.4% |
| | Medicare - MA | 0.0% | 17.1% | 6.6% | -60.0% | 0.0% | 0.0% | 0.0% | 9.6% | 0.0% | 5.0% | 1.1% | 2.4% | 15.0% | 14.2% |
| | Commercial | 0.2% | 3.2% | -0.1% | -2.4% | 0.0% | 3.6% | 1.0% | -3.1% | 1.0% | 1.4% | 0.2% | -1.5% | 4.1% | -1.1% |
| | FPP | 1.0% | 2.9% | -13.1% | 0.0% | 0.0% | 0.0% | 1.0% | -8.3% | 1.0% | 1.6% | 0.0% | 0.0% | 9.6% | -2.1% |

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# Reasonable Assumptions?

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# NEXT STEPS

# What's Next…

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Insights from outside experts (Today)

- RAND 5.0 – claims-based analysis of commercial prices
- Bartholomew & Nash – hospital financials using Medicare Cost reports
- Tom Rees – hospital financials using Medicare Cost reports
- Nancy Kane – audited financials

Hospital Budget Hearings

- Hospitals present budget requests & justifications

Staff Recommendations & Deliberations

- Staff review hospital budget requests and analyze justifications

Hospital Budget Decisions due September 15th

# Resources

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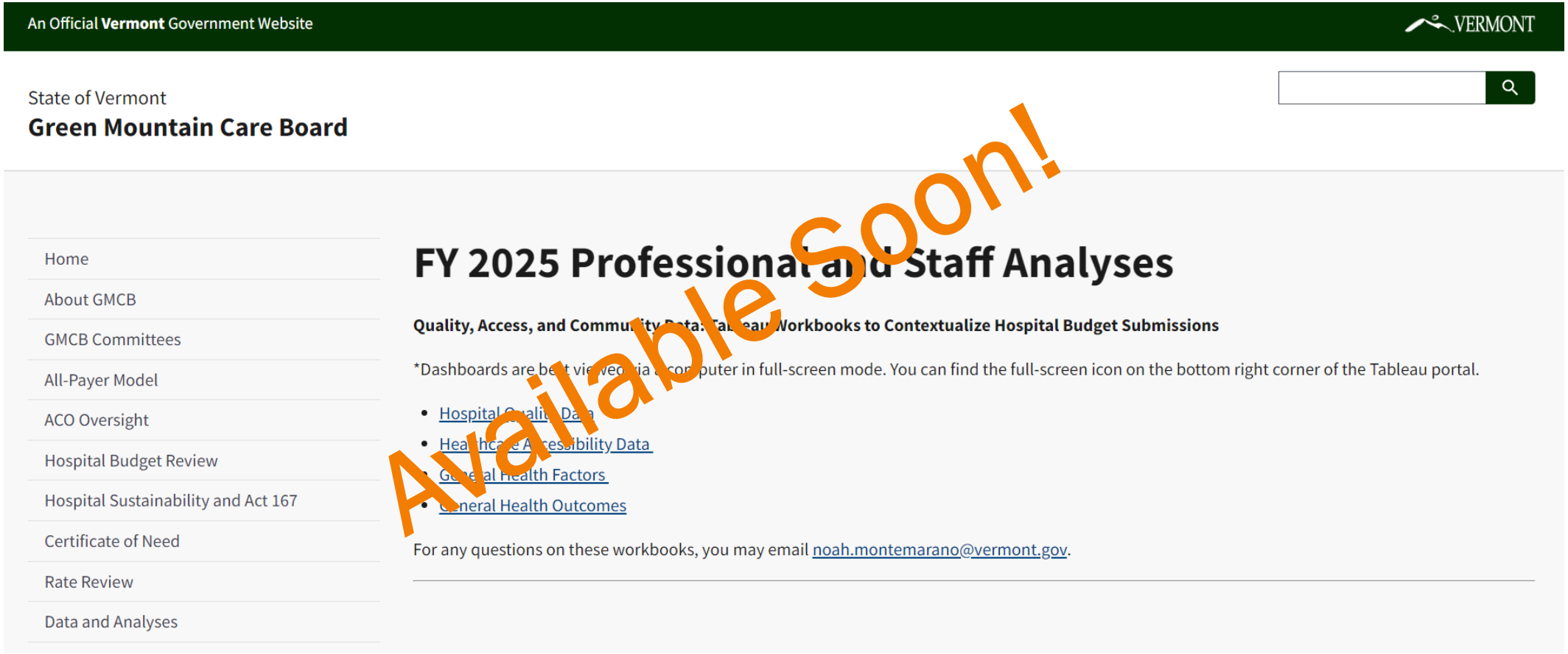


Source: FY 2025 Professional and Staff Analyses | Green Mountain Care Board (vermont.gov)