STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re: Brattleboro Memorial Hospital Fiscal Year 2025	)))	Docket No. 24-001-H

INTRODUCTION

Vermont is confronting a health care affordability crisis. Our state's marketplace plans are among the most expensive in the country.[1] Qualified Health Plan (QHP) premiums have grown more than in any other state.[2] Employer-based insurance premiums are growing faster than the national average.[3, 4] According to the 2021 Vermont Household Health Insurance Survey, the cost of health insurance is the most common reason for a gap in coverage.[5] Forty-four percent of privately insured Vermonters under the age of 65 are underinsured, meaning they have insufficient incomes to cover deductibles and out-of-pocket expenses.[6] Simply put, the commercial market in Vermont cannot afford the current cost of care. This year Vermonters submitted public comments to the Board identifying the harmful impacts of these costs on their businesses, their budgets, and their ability to pay for care.[7]

Nonetheless, in August, the Green Mountain Care Board (GMCB or Board) approved individual rate increases averaging 14.2% for MVP and 19.8% for Blue Cross Blue Shield of Vermont (Blue Cross). The Board also approved small group rate increases averaging 11.1% for MVP and 22.8% for Blue Cross.[8] This difficult decision responded to these insurers' history of losses and serious concerns expressed by the Department of Financial Regulation about Blue Cross' continued solvency.[9] Effective July 1, 2024, the Department of Financial Regulation approved premium increases of 15.7% to 16.7% for the Vermont Education Health Initiative (VEHI).[10] These high commercial increases will make it more difficult for many Vermonters to afford care. For the small group market, many of these increases will be borne by small employers

[1] KFF Average Marketplace Premiums by Metal Tier, 2018-2024. https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier.
[2] *Id.*
[3] *See* GMCB Staff Presentation, Overview of FY25 Budget Requests (Aug. 6, 2024), 9.
[4] Hospital FY25 budget materials, including GMCB guidance documents, hospital budget submissions, professional reports, and GMCB staff analyses are available on the GMCB website at gmcboard.vermont.gov/hospital-budget-review. Board presentations are available at gmcboard.vermont.gov/2024-meetings. Recordings of GMCB hearings and deliberations are available at www.orcamedia.net/ and www.youtube.com/@GreenMountainCareBoard.
[5] *See* Vermont Department of Health, 2021 Vermont Household Health Insurance Survey (March 2022), 44-45, 118, available at: https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR-VHHIS-2021-Report.pdf.
[6] *Id*.
[7] *See* GMCB Staff Presentation, Impact of FY25 Budget Requests (Sept. 4, 2024), 3-10.
[8] Press Release: GMCB Sets Premium Adjustments for BCBS and MVP. https://gmcboard.vermont.gov/board/news.
[9] *Id.*
[10] Vermont Education Health Initiative (VEHI), VEHI FY 25 Health Rates Approved for Website.pdf.

or their employees. VEHI rate increases will impact homeowners in the form of property tax increases across the state.[11]

For commercial rate increases to slow, our statewide health system needs to curb spending. While hospitals make up one-third of total health care spend nationally, Vermont hospitals account for almost half of the state's total health care expenditures.[12] In FY24, spending at Vermont hospitals is expected to be $3.6 billion.[13] Collectively, hospitals' budget submissions reflect a 48% increase over pre-pandemic actuals, an increase of $1.6 billion since FY19.[14] Nonetheless, health care access is unacceptably low. Vermont has had longer wait times than peer states, with half of statewide specialist appointments not scheduled within two months.[15] Specialist utilization has shown signs of decreasing and, despite the state's reform efforts, PCP utilization has not shown meaningful signs of improvement.[16] This year, the GMCB collected clinical productivity data from each hospital, finding that approximately 70% of reported hospital departments are performing below the 50th percentile of their respective benchmark.[17] Despite recent GMCB orders approving high commercial rate increases, 9 out of 14 hospitals in Vermont had negative operating margins in each of the last two years.[18, 19]

In July 2024 the Board began its review of the FY25 budgets proposed by Vermont's 14 general community hospitals. Following public meetings, presentations by hospitals, presentations by GMCB staff, and a special public comment period, the Board established each hospital's budget in conformity with the framework set out in statute. In total, FY25 systemwide hospital net patient revenue and fixed prospective payments ("NPR/FPP" or "NPR") is capped at $3.7 billion, an increase of 4.1% ($146 million) over FY24 budgeted NPR. FY25 systemwide hospital increases to commercial NPR are capped at $1.9 billion, an increase of 3.3% ($58.7 million) over FY24. This is a 43% reduction in total commercial NPR growth proposed by hospitals, representing a modification of $43.5 million.

LEGAL FRAMEWORK

Review of proposed hospital budgets is one of the Board's core regulatory duties. 18 V.S.A. §§ 9375(b)(7), 9456. Hospitals bear the burden of persuasion in justifying their proposed budgets. GMCB Rule 3.000, § 3.306(a). The Board must establish a hospital's annual budget no later than September 15 and issue a written decision by October 1. 18 V.S.A. § 9456(d)(1).

When reviewing a hospital's budget, the Board is guided by its statutory purpose (18 V.S.A. § 9372), its duty to regulate consistent with the principles of health care reform (18 V.S.A. § 9371; *see also* 18 V.S.A. § 9375(a)), its obligation to establish budgets with the considerations

[11] *See* 16 V.S.A. §§ 4025(a)(1), 4025(b).
[12] Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/indicator/spending/drivers-health-spending-growth
[13] *See* Impact of FY25 Budget Requests, GMCB Staff Presentation (Sept. 4, 2024), 16.
[14] *Id.*, at 29.
[15] *See* Health Services Wait Times Report, AHS, GMCB, and DFR (Feb. 16, 2022), 24.
[16] *Id.*, at 25.
[17] *See* Impact of FY25 Budget Requests, GMCB Staff Presentation (Sept. 4, 2024), 30.
[18] *Id.*, at 33.
[19] *See* FY23 Vermont Hospital Reporting: Year-End Actuals, GMCB Staff Presentation (Mar. 13, 2024), 9.

for hospital budget review specifically set forth in statute (18 V.S.A. § 9456), and the benchmarks established annually against which proposed budgets are evaluated (18 V.S.A. § 9456(e); GMCB Rule 3.000, §§ 3.202, 3.305).

First, the Legislature's purpose in establishing the Board was 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. § 9372.

Second, the Board must execute its duties consistent with the principles of health care reform set forth in 18 V.S.A. § 9371. These principles include, but are not limited to, the following:

(1) "The State of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care." 18 V.S.A. § 9371(1).

(2) "Overall health care costs must be contained, and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care." 18 V.S.A. § 9371(2).

(3) "Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities." 18 V.S.A. § 9371(4).

(4) "Vermont's health delivery system must seek continuous improvement in health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment." 18 V.S.A. § 9371(9).

(5) "Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth." 18 V.S.A. § 9371(10).

Third, in conjunction with budget reviews, the Board considers numerous factors including but not limited to (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) the salaries for hospital leadership, hospital salary spread, and a comparison of median salaries to the medians of northern New England states; (6) reimbursement changes for public health care programs, and 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; and (11) any other information

this Board deems relevant. 18 V.S.A. § 9456(b); GMCB Rule 3.000, § 3.306(b). Each approved budget must, among other requirements, be consistent with state and community health care needs; promote the hospital's efficient and economic operations; reflect the hospital's budget performance for prior years; and take into consideration national, regional, or in-state peer group norms according to indicators, ratios, and statistics established by the Board. 18 V.S.A. § 9456(c).

Fourth, this Board adopts annual benchmarks by March 31 of each year, which hospitals use in the development and preparation of proposed budgets. GMCB Rule 3.000, § 3.202. The Board meets with Vermont hospitals, the Vermont Association of Hospitals and Health Systems (VAHHS), and any other interested persons to obtain input prior to establishing benchmarks. GMCB Rule 3.000, § 3.202(a). Benchmarks for FY25 consist of the following: (1) NPR[20] growth benchmarked at 3.5% over FY24 systemwide approved budgets; (2) commercial rate growth[21] benchmarked at 3.4% over FY24 approved commercial rates; and (3) an operating margin greater than 0%. FY2025 Hospital Budget Guidance & Reporting Requirements (Mar. 29, 2024; updated Apr. 18, 2024), 8-9 (FY25 Guidance). These benchmarks assist the Board in determining the extent to which adjustment of a proposed budget is necessary to carry out the statutory criteria described above.

FY25 REVIEW PROCESS

The Board and its staff began developing the FY25 Guidance in December 2023. During this process, Board staff met with representatives of hospitals, the Vermont Association of Hospitals and Health Systems (VAHHS), and the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers. The Board adopted FY25 Guidance ("FY25 Guidance" or "Guidance") on March 31, 2024. A minor update was made to the Guidance on April 17, which changed the report period for referral and visit lags. *See* Guidance, 3. Section I of the FY25 Guidance includes the benchmarks described above.

Brattleboro Memorial Hospital (BMH) requested a 2.5% increase in NPR over its FY24 approved budget and a 4.7% increase in commercial rate over its FY24 approved commercial rate. BMH's senior leadership presented its proposed budget to the Board at a public hearing held on August 14, 2024. BMH also submitted pre-hearing and post-hearing responses to questions asked by GMCB staff.[22] On September 11, 2024, following GMCB staff presentations and Board deliberations, and for the reasons set forth below, the Board established BMH's FY25 budget with modifications, approving FY25 NPR growth at not more than 2.5% over its FY24 approved budget, with commercial rate growth at not more than 3.4% over its FY24 approved commercial rate.

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[20] NPR is defined as the net revenue a hospital receives for the patient services it provides. NPR includes two forms of revenue: fee-for-service (FFS), which are payments made for individual services, and fixed prospective payments (FPP), which are advance payments made for specific services rendered to a set group of patients.

[21] Commercial rate growth is defined as the total increase in negotiated rate (or price) that a hospital receives from commercial health insurers. For the purposes of this Order, the terms "rate," "negotiated rate," and "price" are used interchangeably. These terms are distinct from "commercial revenue," which is comprised of two variables: price (what the hospital is paid for its services) and volume (the quantity of services the hospital provides). Commercial health insurance is defined as any health insurance provided by a private company (i.e. not Medicaid or traditional Medicare).

[22] *See* Additional FY25 Hospital Budget Information. https://gmcboard.vermont.gov/node/11866

FINDINGS

1. BMH is a prospective payment system hospital with its primary location in Brattleboro, Vermont.

2. In its FY25 budget submission BMH requested 2.5% growth in NPR from its FY24 budgeted NPR, for a total of $113,921,241. *See* BMH Submission, Income Statement, 2. This proposed increase meets the 3.5% growth benchmark.

3. BMH requested commercial negotiated rate growth of 4.7% over its FY24 approved rate. *See* BMH Workbook, Rate Decomposition Sheet. This proposed increase exceeds the 3.4% commercial negotiated rate growth benchmark.

4. BMH's proposed budget anticipates an operating margin of approximately $550,500, or 0.5%, which meets the benchmark for a positive operating margin. *See* Income Statement, 2.

5. A hospital's budgeted assumptions about its public payer rate increases can help delineate both the accuracy of its projected revenues and the reasonability of the commercial rate increase it submits with its budget. BMH assumes that for FY25 the Medicare reimbursement rate will increase by approximately 2.3% and Medicaid reimbursement will increase by 0%. *See* Rate Decomposition Sheet. BMH adhered to the Medicare IPPS rate of 2.26% for traditional Medicare to make this prediction. It relied upon notice on June 5, 2024, that the Department of Vermont Health Access (DVHA) would not be increasing Medicaid rates for FY25. *See* BMH Narrative, 3.

6. A hospital's budgeted assumptions about utilization can similarly help delineate the accuracy of its projected revenues and the reasonability of its commercial rate request. BMH anticipates a 3.3% increase in NPR due to increased utilization, which is higher than the 2.5% NPR growth rate submitted by BMH. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 48. While the exact cause of this discrepancy is not clear, BMH made multiple submissions and appears to use gross revenue instead of net revenue in its calculations. *See* Rate Decomposition Sheet. BMH anticipates modest growth spread equally across public and commercial payers, at 4.5%. *Id*. However, the accuracy of its utilization expectations on net patient revenue cannot be reasonably determined.

7. An analysis of net revenue and public payer reimbursements can estimate the revenue needed from private payers. BMH was nonresponsive to the GMCB's requests for this analysis and did not submit a net payer revenue analysis. *See* FY25 Hospital Budget Guidance & Reporting Requirements, Section VI, Part 11. As such, it is not possible to determine whether the methodology employed by BMH is reasonable.

8. The accuracy of a hospital's previous assumptions about its operating revenues and expenses can speak to the reasonableness of its projected operating margin. If a hospital underestimates revenues, it may see a higher margin than budgeted. If a hospital underestimates its expenses, it may see less margin than budgeted. BMH's recent assumptions for both operating revenues and expenses have trended toward underbudgeting. BMH underestimated operating revenues

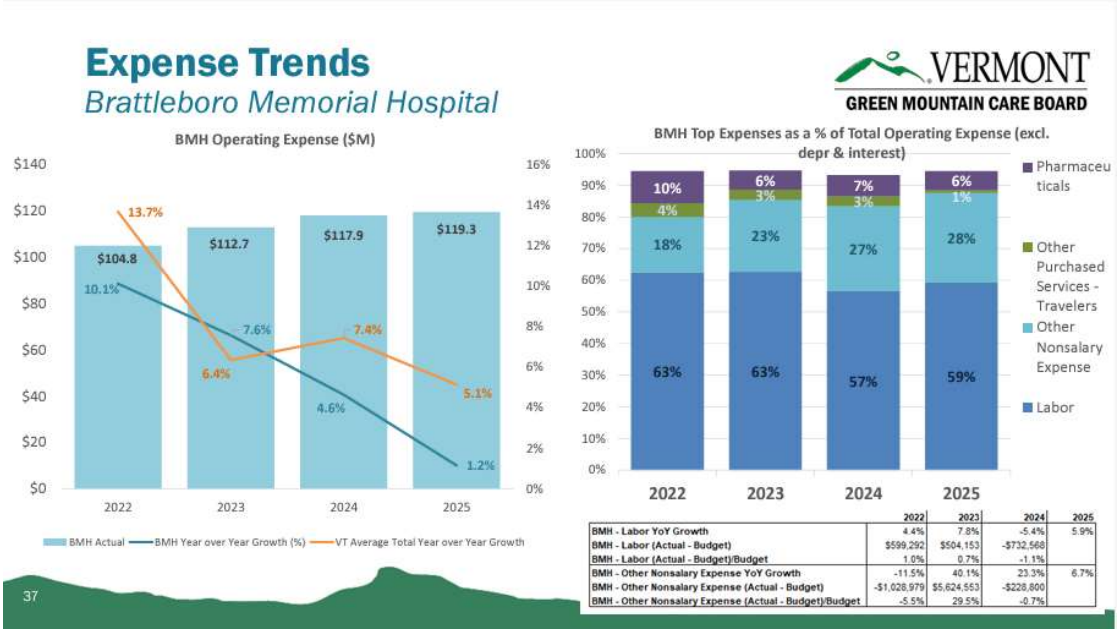
in FY22 and FY23 and is projected to have underbudgeted operating revenues again in FY24 by 2.4%. BMH has also underestimated operating expenses by a wider margin in FY22 and FY23, however projected revenues trend toward closer alignment, as shown below. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 39.

	2022	2023	2024
BMH Operating Revenue	$100,930,930	$110,801,802	$117,763,464
BMH Operating Expense:	$104,777,540	$112,706,339	$117,935,458
BMH Margin:	-$3,846,610	-$1,904,537	-$171,994
BMH Operating Revenue: (Actual - Budget)	$3,401,116	$1,594,413	$2,777,221
BMH Operating Revenue: % Difference in Actual vs. Budget	3.5%	1.5%	2.4%
BMH Operating Expense: (Actual - Budget)	$7,917,054	$4,225,950	$3,794,318
BMH Operating Expense: % Difference in Actual vs. Budget	8.2%	3.9%	3.3%
VT Operating Revenue: % Difference in Actual vs. Budget	5.7%	3.1%	3.0%
VT Operating Expenses: % Difference in Actual vs. Budget	10.4%	4.3%	3.3%

9. Comparing prior year budgeted margins to actual margins can help test the reasonableness of a proposed budget. In FY23 BMH's actual operating margin was less than budgeted. For FY24 BMH is trending in the same direction, which indicates BMH may see less margin than budgeted if it cannot decrease its expenses or increase its revenues. *Id*. at 40.

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	0.7%	-3.8%	0.7%	-1.7%	0.7%	-0.1%	0.5%
Total Margin	1.2%	-8.0%	0.7%	1.7%	0.7%	-0.1%	0.5%
EBIDA	6.0%	0.2%	4.8%	2.2%	4.5%	3.6%	4.2%

10. The trajectory of a hospital's operating expense growth is one method of examining efficiency. BMH's operating expenses have consistently grown at a slower rate than the Vermont average and have demonstrated a downward growth trend, as shown. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 37.



	2022	2023	2024	2025
BMH - Labor YoY Growth	4.4%	7.8%	-5.4%	5.9%
BMH - Labor (Actual - Budget)	$599,292	$504,153	-$732,568	
BMH - Labor (Actual - Budget)/Budget	1.0%	0.7%	-1.1%	
BMH - Other Nonsalary Expense YoY Growth	-11.5%	40.1%	23.3%	6.7%
BMH - Other Nonsalary Expense (Actual - Budget)	-$1,028,979	$5,624,553	-$228,800	
BMH - Other Nonsalary Expense (Actual - Budget)/Budget	-5.5%	29.5%	-0.7%	

11. A hospital's ratio of administrative and general salaries to clinical salaries is another method of gauging efficiency. A lower number indicates a smaller percent of non-clinical salaries in the hospital. Using the most recent FY22 data, BMH has a ratio of 19.6%, which is lower than its comparator hospitals. *Id.,* at 51.

12. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, BMH budgets 63% clinical staff and 37% non-clinical staff. Its distribution of newly budgeted FTEs is 90% clinical and 10% non-clinical. *See* Workbook Submission; *see also* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 38.

13. The Medicare payment to cost ratio is an indicator of a hospital's relative cost efficiency. This ratio measures a hospital's revenues obtained from Medicare and Medicare's estimate of the cost to the hospital for providing that care. Medicare payments are adjusted to reflect individual hospital characteristics, so this measure shows how well a hospital manages its expenses. A lower ratio indicates inefficient expense management, while a higher ratio indicates greater efficiency. *See* Financial Analysis for Vermont Hospitals, Bartholomew & Nash, GMCB Presentation (Aug. 6, 2024). BMH's 2022 Medicare-payment-to-cost ratio was 58%, which was considerably less than its peer median of 88%. *Id.* at 16. This suggests BMH could decrease its expenses, which would lead to a greater margin.

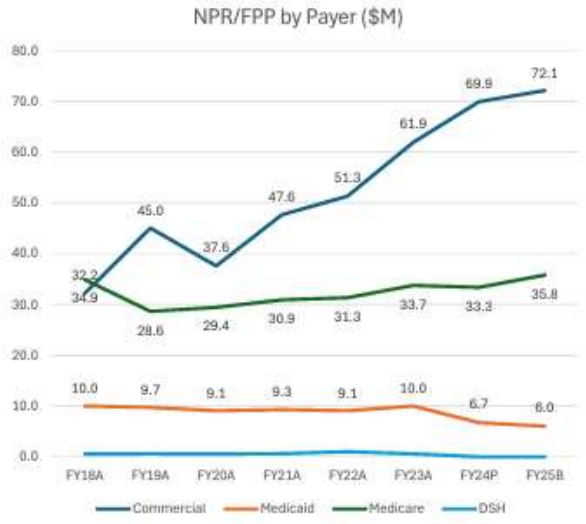
14. Hospitals also monitor clinical productivity. When assessed at the hospital level, as done here, this measure is an indicator of potential systemic inefficiencies. BMH's productivity data, as submitted, shows that 33% of its physician FTEs are in specialty areas performing below the 25th percentile, with 29% of its specialty departments performing below the 25th percentile. *See* Workbook Submission, Clinical Productivity; *see also* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 51.

15. A hospital's wait times are also an indicator of system efficiencies. While longer wait times can occur for many reasons, longer wait times paired with relatively low clinical productivity suggests the existence of untapped revenue that would increase patient access and mitigate the need for higher commercial price to generate margin. BMH reports that 31% of appointments are scheduled within three business days of referral. *See* Workbook Submission, Referral Lags and Visit Lags. 0% of new patients are scheduled to be seen within 14 days, 25% are scheduled to be seen within 15-30 days, 72% are scheduled to be seen within 31-90 days, and 3% of new patients are scheduled to be seen within 91-180 days. *Id.* These wait times trend higher than the statewide average. *See* GMCB Staff Analysis, FY25 Aggregated Hospital Wait Times.[23] Vermont experiences longer wait times than peer states. *See* Health Services Wait Times Report, AHS, GMCB & DFR, (Feb. 16, 2022), 24.

16. A hospital's investment in workforce development is an important aspect of its budget. *See* 18 V.S.A. § 9456(b)(12). Progress in this area can both improve access to services and reduce costs at a time when statewide locum traveler expenses are still high. BMH has developed a nurse residency program which recruits new graduates and provides on-the-job training. This program provides BMH new nursing staff and has helped reduce reliance on contract labor, reducing unnecessary labor expenses. *See* Narrative, 6.

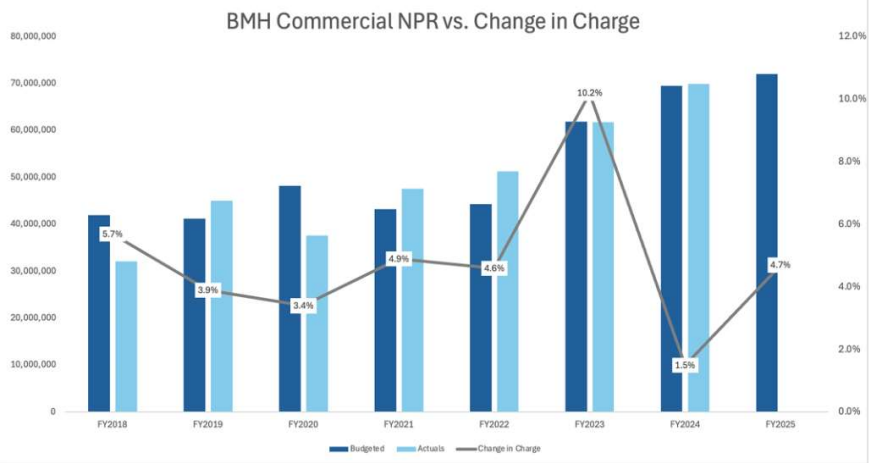
17. Looking ahead, BMH should see some cost savings through group purchasing endeavors with its recent participation in the New England Collaborative Health Network. BMH FY25 Budget Presentation (Aug. 14, 2024), 9.

18. Except for FY18, commercial revenue has been the highest contributor to BMH's overall NPR. While public payer revenues have seen relatively small changes, commercial revenues have substantially increased from $32.2 million in FY18 to a budgeted $72.1 million in FY25. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 34.



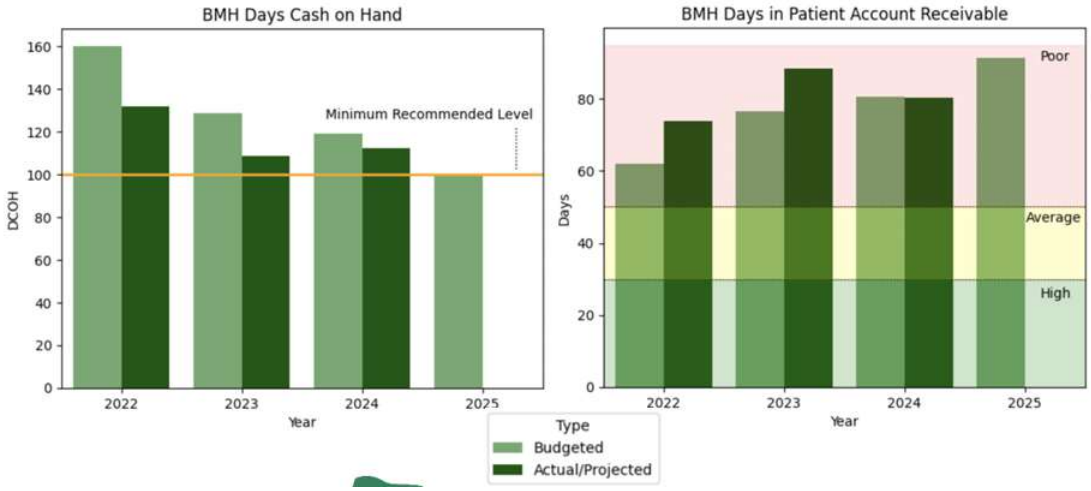
[23] https://gmcboard.vermont.gov/document/fy25-hospital-aggregated-wait-times

19. BMH has previously been approved for commercial charge increases as shown below. *Id*., at 36. These increases have contributed to the commercial NPR increase shown above.



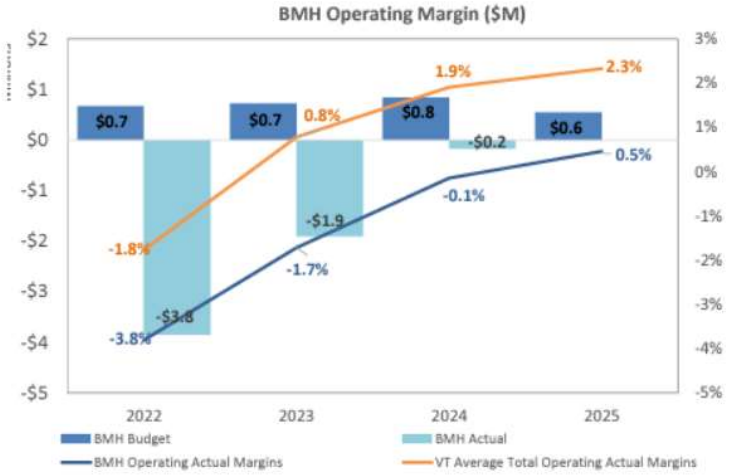
20. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a relative price by comparing a hospital's commercial prices to the Medicare payment system as a benchmark. RAND then calculates the standardized price by adjusting the benchmark using Medicare's case mix grouping and relative weights. For standardized price, a higher decile indicates that commercial prices appear to be higher than the national median, while a lower decile indicates that commercial prices appear to be lower than the national median. The most current RAND report uses prices from 2020 - 2022. *See* RAND Hospital Price Transparency Project, GMCB Presentation (Aug. 6, 2024), 7-9. Generally, BMH's commercial standardized prices are close to national median. While its outpatient services prices are high, in the 8th decile, its inpatient and facility prices are below median. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 46.

21. Days cash on hand (DCOH) is a measure of a hospital's financial health. BMH's DCOH has trended downward since FY22 and is budgeted at approximately 100 days for FY25. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 41.



22. Days in patient accounts receivable, which reflects the average time it takes for a hospital to collect revenues for patient services rendered, is another measure to understand a hospital's financial health. BMH's days in patient accounts receivable was greater than 60 days in FY22 and over 80 days in FY23. This figure is budgeted to approach 90 days in FY25, showing no expected improvement, as shown in the finding above. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 41. In FY24 BMH was affected by a national cyberattack, affecting its billing operations and decreasing its patient accounts receivable. BMH FY25 Budget Presentation (Aug. 14, 2024), 9.

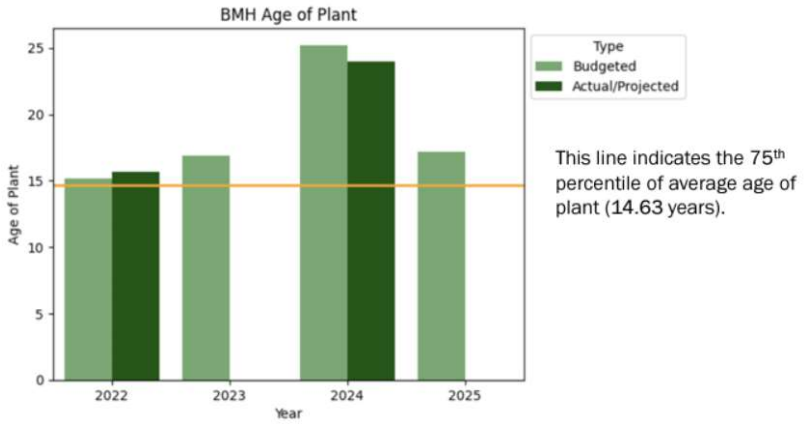
23. A hospital's operating margin is another evaluation of its financial health. Operating margins demonstrate a hospital's ability to cover expenses with revenues, but do not demonstrate that a hospital is efficiently delivering care or being adequately reimbursed. BMH shows operating margins that have been lower than the Vermont average since FY22, as shown below, with negative margins each year. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 39. It is noteworthy that for each of these years BMH had budgeted a positive margin. *Id*.



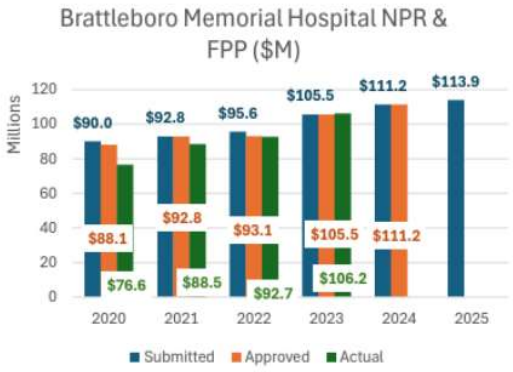
**Margin % shows Actuals 2022 - 2023, Projected 2024 & Budgeted 2025*

24. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. BMH's current ratio of assets to liabilities (including funded depreciation) is well above breakeven and is above the US median. Its current ratio of assets to liabilities (without funded depreciation) is above breakeven and appears to be increasing. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 42.

25. Average age of plant, a ratio that measures the age of a hospital's fixed assets, is another assessment of a hospital's financial health. It indicates how much capital spending may be required in the near term. As such, an older average age of plant indicates a greater immediate need for capital resources. BMH's average age of plant is high, above the 75th percentile, as shown below. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 43.



26. BMH prior years submitted net patient revenue (NPR), approved NPR, and actual NPR and operating expenses are shown below. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 50.



27. BMH's prior year submitted operating margin, approved operating margin, and its actuals for FY20 through FY23 are shown below. *Id.*

28. The GMCB solicited and considered public comment on all aspects of hospital costs and use, and on the budget proposed by BMH, through a special comment period during the GMCB's hospital hearings and deliberations.

CONCLUSIONS

While BMH met the GMCB's benchmarks for NPR growth and positive operating margin, its proposed budget includes a commercial negotiated rate request of 4.7%, which exceeds the benchmark of 3.4%. *See* Findings, ¶¶ 2-4. As such, we review BMH's budget submission consistent with the factors set out in FY25 Guidance, GMCB Rule 3.000, and pursuant to statute to determine whether it has satisfied its burden of persuasion in justifying its request. GMCB Rule 3.000, § 3.306(a).

We find that while BMH has made reasonable public payer assumptions, its projection for FY25 growth in utilization is concerning. *See* Findings, ¶¶ 5-6. If BMH experiences the utilization growth it appears to predict, it is poised to exceed its requested NPR with the commercial rate increase it has requested. *See* Findings, ¶¶ 2, 3, 6. BMH has underbudgeted its operating revenues in prior years. *See* Findings, ¶ 8. It has also underbudgeted expenses, which contributed to negative margins, though this trend is diminishing. *Id*. These trends cause us to question whether BMH needs the full commercial rate increase it has requested for FY25, as a higher commercial rate could again result in greater than budgeted revenues.

We see evidence of reasonable cost management in BMH's operational expense growth and its ratio of administrative and general costs. Findings, ¶¶10-12. However, BMH's low Medicare payment-to-cost ratio, its clinical productivity data, and its wait times indicate system inefficiencies that, if addressed, would allow BMH to meet its budgeted NPR without needing the requested commercial rate increase of 4.7%. Findings, ¶¶ 13-15. Therefore, modifying BMH's budget to reduce its commercial rate request is reasonable. This action is consistent with BMH's standardized prices, which were close to average compared to hospitals nationally before a large commercial rate increase in FY23. Findings, ¶¶18-20.

We also find the downward modification of BMH's commercial rate increase reasonable given its financial health, which is relatively good. Days cash on hand has been trending downward but should reverse with improvement in its patient accounts receivable. Findings, ¶¶ 21-22. Average age of plant is high, but BMH's ratio of assets to liabilities suggests an ability to manage immediate need. Findings, ¶¶ 24-254. BMH can also lower its expenses through its collaboration with the New England Collaborative Health Network. Findings, ¶ 17.

With these findings in mind, it is appropriate for the hospital to focus on managing expenses and reducing inefficiencies to obtain a positive margin rather than increasing its commercial rate. This strategy is appropriate to promote efficient and economic operation of the hospital. *See* 18 V.S.A. § 9456(c)(3).

We conclude that BMH has not met its burden of justifying the 4.7% commercial rate increase as requested. Given the evidence before us, this commercial negotiated rate increase does not advance our statutory obligation, which states that "[o]verall health care costs must be contained, and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care." 18 V.S.A. §9371(2). We therefore approve BMH's budget with its NPR growth as submitted but its commercial rate increase modified to 3.4% over the current approved level.

ORDER

Based on our findings and conclusions and the authority granted by Chapter 221, Subchapter 7 of Title 18, BMH's budget is approved for FY25 subject to the following terms and conditions:

A. BMH's FY25 NPR/FPP ("NPR") budget is approved at a growth rate of not more than 2.5% over its FY24 budget, with a total NPR of not more than $113,943,285 for FY25.

B. BMH's overall change in charge and commercial negotiated rate increase are approved at not more than 3.4% over current approved levels, with no commercial negotiated rate increase for any payer at more than 3.4% over current approved levels. The commercial negotiated rate increase overall or with respect to any payer may be less than 3.4% as negotiated between the hospital and payer.

C. The commercial rate increase cap in Paragraph B is a maximum and is subject to negotiation between BMH and commercial insurers. BMH shall not represent the maximum commercial rate increase approved by the GMCB in Paragraph B or the expected commercial NPR based on that rate increase as the amounts set or guaranteed by the GMCB in the hospital's negotiations with insurers.

D. The commercial negotiated rate cap in Paragraph B shall not apply to Medicare Advantage plans.

E. BMH's expected commercial NPR, based on its budget as adjusted in this Order, is $102,740,686. BMH shall report its actual expected commercial NPR not later than March 15, 2025, or such later date as specified by the Director of Health Systems Finance and explain any variations from the expected commercial NPR.

F. BMH shall file an updated Rate Decomposition Sheet with the Board no more than 30 days after its FY25 contracts have been finalized with commercial payers.

G. BMH shall make any necessary changes to its methods of data collection such that it can report revenues segmented by the following payer types starting FY25: (1) Medicare, (2) Medicare Advantage, (3) Medicaid, (4) commercial health insurance, (5) Vermont-specific commercial payers, (6) non-Vermont commercial payers, and (7) all other payers (e.g. self-pay, workers' compensation, etc.), for which data collection and reporting may be

combined. The GMCB shall provide definitions for each payer type by October 1, 2024, so hospitals can uniformly implement this change.

H. Beginning on or before November 20, 2024, and every month thereafter, BMH shall file with the Board the actual year-to-date FY25 operating results as of the end of the prior month. The report shall be in a form and manner as prescribed by GMCB staff.

I. On or before January 31, 2025, BMH shall file with the Board, in a form and manner prescribed by GMCB staff, such information as the Board determines necessary to review the hospital's FY24 actual operating results.

J. BMH shall file with the Board one copy of its FY24 audited financial statements and associated management letter(s), as well as the parent organization's audited consolidated financial statements, if applicable, 15 days after the hospital receives its statements, or by January 31, 2025, whichever is earlier.

K. BMH shall file with the Board its actual year-to-date FY25 operating results on April 30, 2025 for October 1, 2024 through March 31, 2025. The report shall be in a form and manner as prescribed by GMCB staff.

L. BMH shall participate in check-ins to be scheduled at the discretion of the Director of Health Systems Finance based on the hospital's FY25 year-to-date operating performance.

M. Beginning on or before November 20, 2024, BMH shall include with each year-to-date monthly report a letter, if applicable, identifying any material changes to its FY25 budgeted revenues and expenses, or to the assumptions used in determining its budget, including: A. changes in Medicaid, Medicare, or commercial reimbursement; B. additions or reductions in programs or services to patients; and C. any other event that could materially change the approved NPR budget.

N. BMH shall develop and maintain a system to be able to measure and report to the GMCB the referral lag and the visit lag for each hospital-owned primary and specialty care practice as well as the top five most frequent imaging procedures. Referral lag means the percentage of appointments scheduled within 3 business days of referral (percentage of all referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place). Visit lag means the percentage of new patient appointments scheduled for the patient to be seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling date (the scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received or the date the patient will be seen).

    a) BMH shall report to the GMCB the referral lag and the visit lag for each hospital owned primary and specialty care practice as well as the top five most frequent imaging procedures on April 30, 2025, for February and March 2025, and as required by the GMCB's FY26 hospital budget guidance.

O. BMH shall participate in the Board's work, including the community engagement process, pursuant to Act 167.

P. BMH shall timely file all forms and information required for practice acquisitions and/or transfers as determined by GMCB staff, if applicable.

Q. BMH shall file all requested data and other information in a timely and accurate manner.

R. BMH shall report on any changes it makes to the methods it uses to calculate information it reports to the GMCB. Any such report shall include a detailed explanation as to the reason for the change and the inclusion of a comparison report that shows the results using the hospital's prior method of calculation.

S. After notice and an opportunity to be heard, the GMCB may amend the provisions contained herein, and issue an amended order, consistent with its authority as set forth in 18 V.S.A. Chapter 220, Subchapter 1, 18 V.S.A. Chapter 221, Subchapter 7, and GMCB Rule 3.000.

T. All materials required above shall be provided electronically, unless doing so is not practicable, as determined by the Director of Health Systems Finance.

U. The findings and orders contained in this decision do not constrain the Board's decisions in future hospital budget reviews, future certificate of need reviews, or any other future regulatory or policy decisions.

So ordered.

Dated: October 1, 2024
Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN CARE BOARD OF VERMONT
)
s/ Robin Lunge)
)
s/ David Murman)
)
s/ Thom Walsh)

Filed: October 1, 2024

Attest: */s/ Jean Stetter*
Green Mountain Care Board
Administrative Services Director

NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made.