STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re: Central Vermont Medical Center Fiscal Year 2025	)))	Docket No. 24-002-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.

Central Vermont Medical Center (CVMC) requested an 11.9% increase in NPR over its FY24 approved budget and a 5.5% increase in commercial rate over its FY24 approved commercial rate. CVMC's senior leadership presented its proposed budget to the Board at a public hearing held on August 30, 2024. CVMC 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 CVMC's FY25 budget with modifications to its proposal, setting FY25 NPR growth at not more than 6% 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. CVMC is a prospective payment system hospital with its primary location in Berlin, Vermont. It is one of three Vermont hospitals within the University of Vermont Health Network (UVMHN).

2. In its FY25 budget submission CVMC requested 11.9% growth in NPR from its FY24 budgeted NPR, for a total of $307,672,329. *See* CVMC Submission, Income Statement, 2. This proposed increase exceeds the 3.5% growth benchmark.

3. CVMC requested commercial negotiated rate growth of 5.5% over its FY24 approved rate. *See* CVMC Workbook, Rate Decomposition Sheet. This proposed increase exceeds the 3.4% commercial negotiated rate growth benchmark.

4. CVMC's proposed budget anticipates an operating margin of $115,483, or 0.04%, 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. CVMC assumes that for FY25 the Medicare reimbursement rate will increase by approximately 0.4% and the Medicaid reimbursement rate will increase by 0.4%. *See* CVMC Workbook, Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 145.

6. CVMC's assumption of a 0.4% increase in Medicare rates appears low. On August 1, 2024, CMS issued its updated "market basket," the index used to adjust payment rates annually for prospective payment system hospitals. *See* CMS Newsroom, FY25 Hospital IPPS and LTCH PPS Final Rule;[23] CMS Newsroom, FY25 Hospital OPPS and ASC Payment System Proposed Rule.[24] For inpatient services the FY25 market basket increase is 3.4%, reduced to 2.9% for a productivity adjustment; for outpatient services the FY25 market basket increase is 3.0%, reduced to 2.6% for a productivity adjustment. *Id.* While there are factors that could cause such deviation between these prospective payment system increases and CVMC's budgeted 0.4% increase in Medicare rate, the hospital has not sufficiently demonstrated that this deviation is likely to occur.

7. CVMC's assumption of a 0.4% increase in Medicaid rates is generally consistent with the fact that the Department of Vermont Health Access (DVHA) will not increase Medicaid rates for FY25, however CVMC may realize increased rates from neighboring state Medicaid programs.

8. 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. Of its budgeted 11.9% increase in NPR, CVMC anticipates that 8.5% will come from increased utilization. *See*

[23] https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0
[24] https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center

Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 146. This projected increase in utilization is quite high. In support of this projected increase CVMC points to increased volumes to Medical Group services, imaging, lab services, and pharmaceutical services, as well as increased volumes for endoscopy and some surgical procedures. *See* CVMC Budget Narrative, 3, 9. CVMC projects that Medicare Advantage and commercial payers will represent its highest increases in volume, at 9.9% and 9.6% respectively. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 146.

9. A hospital's net revenue and public payer reimbursement analysis is a method of showing that the revenue it needs from non-Medicaid payers incorporates any anticipated increases in Medicaid or public payer revenues. Hospitals are required to provide this analysis each year, along with an analysis showing reductions in bad debt or charity care due to an increase in the number of insured lives. *See* FY25 Hospital Budget Guidance & Reporting Requirements, Section VI, Part 11; *see also* 18 V.S.A. § 9456(b)(9). CVMC submitted the following account of its methodology, which deducts projected public payer rate increases from its commercial negotiated rate request. *See* CVMC Pre-Hearing Follow-Up Responses (Aug. 16, 2024), 11. While this methodology is reasonable, the Medicare revenue increase below is representative of CVMC's assumption of a 0.4% increase in Medicare rate, described above.

CVMC	FY2025 Cost Inflation
Total Cost Inflation	$9,973,896
Less Retail Pharmacy	$0
Net Cost Inflation for Commercial Rate Calc	**$9,973,896**
Less:	
FY2025 - Medicare Rate Increase	$90,212
FY2025 - Medicare ACO Rate Increase	
FY2025 - Medicaid Rate Increase	$205,437
FY2025 - Other Payer Changes	$372,201
APM Shared Savings	$2,405,203
LOS Reduction & Placement Impacts	$754,666
GME/IGT Change	$0
UM/UR Change	$260,855
PHSO	$314,612
Legislative Changes - Bad Debt/Charity/Denials	$264,108
Rate Impact on Bad Debt/Charity/Denials Calculation	($972,650)
Sub-Total	**$3,694,644**
Required Funding from Commercial Rate	**$6,279,253**
Per 1 % Impact of Commercial Rate:	
Budget Year (9 months: Jan-Sept)	$960,130
Commercial Rate Increase in FY2025 Budget	**6.54%**

10. 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. CVMC budgeted for a positive operating margin in FY23 but experienced significant negative operating margin due to higher operating expenses and lower revenue than projected. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 137. Projected FY24 results indicate that CVMC has underestimated both its operating revenue and its operating expense. *Id*. In FY24 CVMC budgeted for a negative margin. *Id*. While

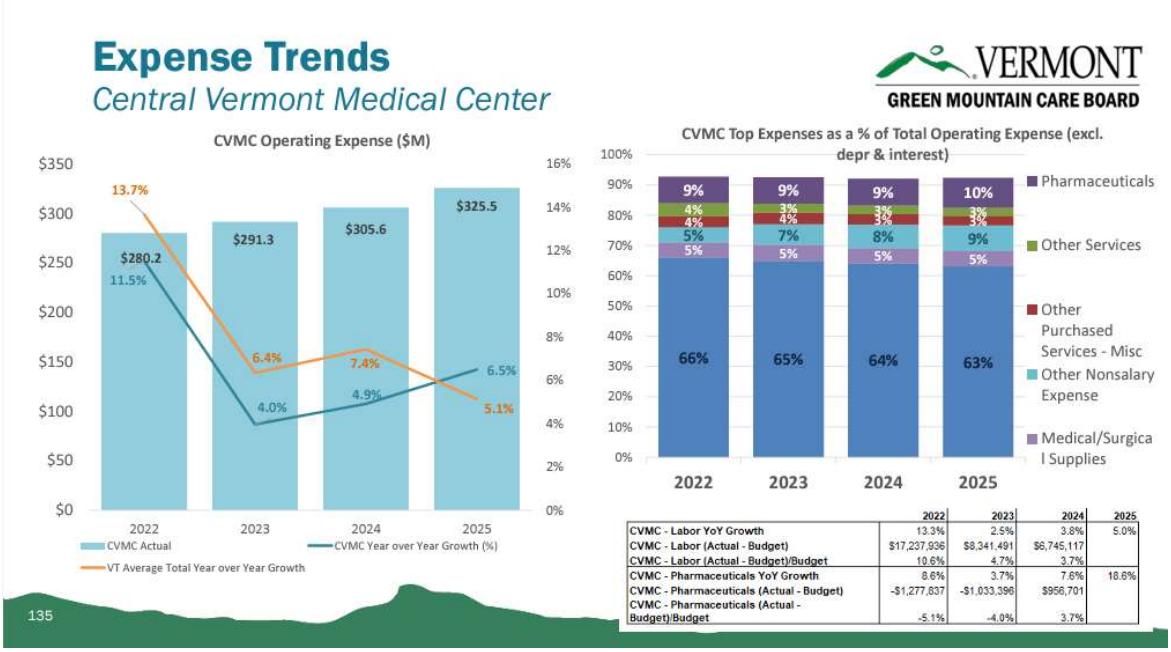
expenses have thus far been higher than projected, CVMC is poised to obtain a positive margin due to even higher than anticipated revenue. *Id.* Taken together, this indicates a recent trend for CVMC of experiencing actuals that substantially vary from its budget.

	2022	2023	2024
CVMC Operating Revenue	$263,067,664	$273,474,553	$307,720,295
CVMC Operating Expense:	$280,204,325	$291,318,581	$305,635,372
CVMC Margin:	-$17,136,661	-$17,844,028	$2,084,923
CVMC Operating Revenue: (Actual - Budget)	-$5,308,013	-$14,361,696	$16,510,286
CVMC Operating Revenue: % Difference in Actual vs. Budget	-2.0%	-5.0%	5.7%
CVMC Operating Expense: (Actual - Budget)	$15,888,152	$6,356,302	$11,602,430
CVMC Operating Expense: % Difference in Actual vs. Budget	6.0%	2.2%	3.9%
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%

11. Comparing prior year budgeted margins to actual margins can help test the reasonableness of a proposed budget. In FY23 CVMC's actual operating margin was 7.5% lower than budgeted, with a total margin 11.1% lower than budgeted at -8.3%. *Id.*, at 138. For FY24 CVMC is trending in a better direction and closer to budgeted predictions. *Id.*

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	1.5%	-6.5%	1.0%	-6.5%	-1.0%	0.7%	0.0%
Total Margin	4.4%	-11.1%	2.8%	-8.3%	0.5%	2.9%	0.9%
EBIDA	5.0%	-3.5%	3.9%	-3.9%	1.5%	2.9%	2.2%

12. The trajectory of a hospital's operating expense growth is one method of examining operating efficiency. CVMC's operating expense growth was below the Vermont average for FY22 and FY23 and is projected to also be below the average for FY24, as shown. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 135. CVMC's FY25 budget would put its expense growth above the Vermont average, increasing from 4.9% in FY24 to 6.5% in FY25. *Id.*



13. 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, CVMC has a ratio of 20.8%, which is nearly identical to the Vermont median and below the Vermont prospective payment system hospital median. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 149.

14. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, CVMC budgets 65% clinical FTEs and 35% non-clinical FTEs. Its distribution of newly budgeted FTEs is 1% clinical and 99% non-clinical. *See* Workbook Submission; *see also* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 136.

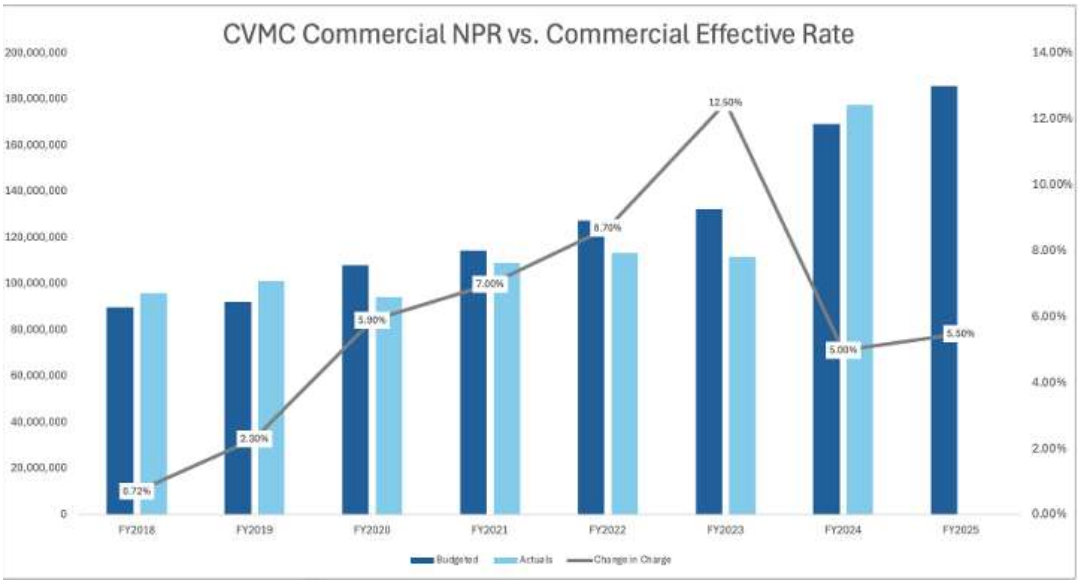
15. The Medicare payment to cost ratio is an indicator of a hospital's relative cost efficiency. This ratio measures a hospital's revenues obtained from Medicare and Medicare's estimate of the cost to the hospital for providing that care. Medicare payments are adjusted to reflect individual hospital 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). CVMC's 2022 Medicare payment to cost ratio was 77%, which was less than its peer median of 89%. *Id*., at 16. This indicates that some cost inefficiencies may exist at CVMC which, if successfully managed, would decrease expenses and lead to greater margins.

16. Hospitals also monitor clinical productivity. When assessed at the hospital level, as done here, this measure is an indicator of potential inefficiencies. CVMC's clinical productivity data, as submitted, shows that 47.7% of its physician FTEs are in specialty areas performing below the 25th percentile, with 69.7% of physician FTEs in specialty areas performing below the 50th percentile. *See* Workbook Submission, Clinical Productivity Tab. CVMC's productivity data

segmented by clinical practice area shows 62.3% of specialties below the 25th percentile and 82.0% of specialties below the 50th percentile. *Id*. CVMC targets the national median salary for clinical MDs and nurses but states that it is becoming more difficult to recruit at the median. *See* Testimony of Anna Noonan, Hearing Tr. (Aug. 30, 2024), 70:6-13, 70:14-24. To the degree that providers are paid rates that are at or above national medians, there is opportunity to lower salary expenses to match benchmarked clinical productivity and/or raise clinical productivity to match benchmarked compensation. Either way, CVMC has the potential to increase revenue and improve operating margin without relying on increases to commercial prices.

17. 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. CVMC reports that 39% of appointments are scheduled within three business days of referral. *See* Workbook Submission, Referral Lags and Visit Lags. 28% of new patients are scheduled to be seen within 14 days, 17% of new patients are seen within 15-30 days, 31% of new patients are seen within 31-90 days, and 21% of new patients are seen within 91-180 days. *Id*. These wait times are generally average compared to hospitals statewide, except for the percent of patients seen within 91-180 days, which is the second highest in Vermont. *See* GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times.[25] Vermont experiences longer wait times than peer states. *See* Health Services Wait Times Report, AHS, GMCB & DFR (Feb. 16, 2022), 24.

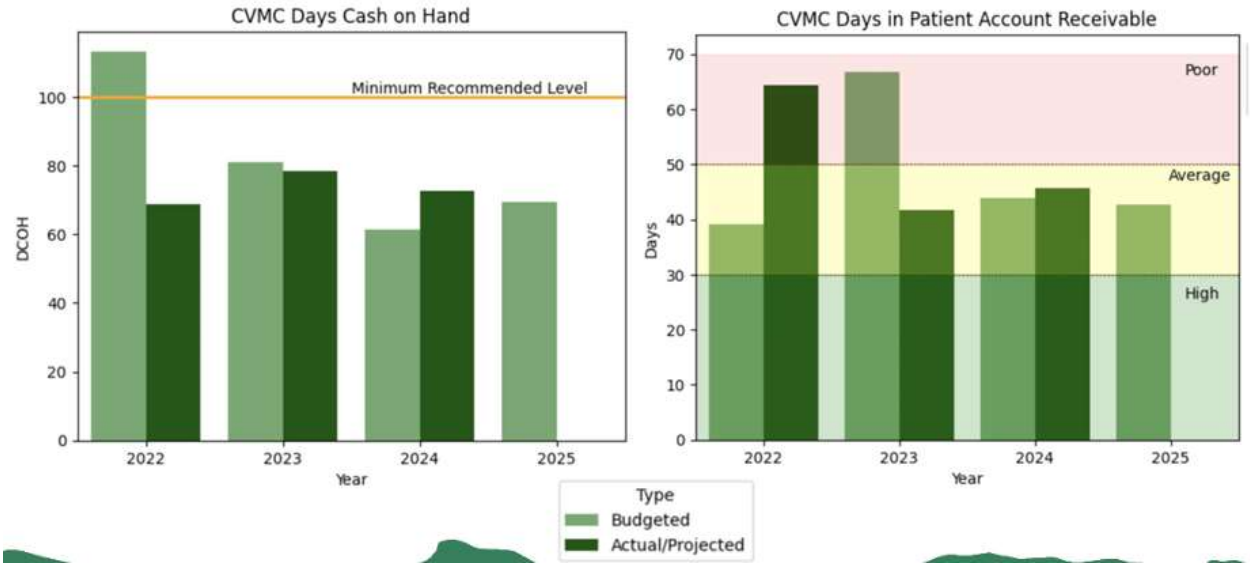
18. CVMC has previously been approved for commercial charge increases as shown below. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 134. In recent years CVMC has received high commercial rate increases, including a 7.0% increase for FY21, an 8.7% increase for FY22, and a 12.5% increase for FY23. *Id*. CVMC received a 5.0% increase for FY24. These increases have contributed to growth in commercial NPR, also shown below, with commercial NPR for FY24 projected to exceed budget. *Id*.



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

19. 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 Medicare payments. RAND then calculates the standardized price by adjusting for case mix and other 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. CVMC's commercial standardized prices in 2022 appear close to the national median, with core service lines in the 4th and 7th deciles. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 144. However, this price data does not incorporate the 12.5% commercial increase that CVMC received in FY23 or the 5% increase it received in FY24.

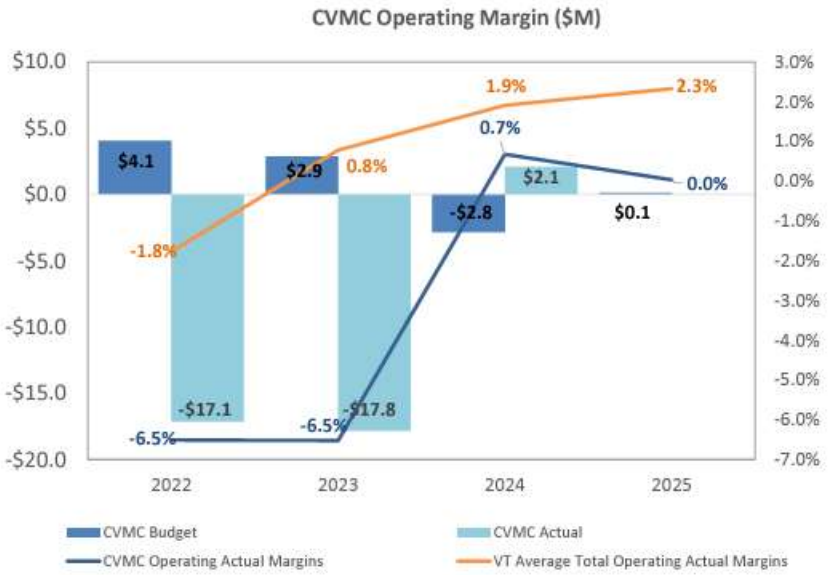
20. Days cash on hand (DCOH) is a measure of a hospital's financial health. CVMC's days cash on hand is low and has not been above 100 since FY22. *Id.* at 139. While DCOH is an important indicator of a hospital's financial health, it must be considered in conjunction with the hospital's network status (i.e., CVMC's status as a member of UVMHN).



21. Days in patient accounts receivable, which reflects the average time it takes for a hospital to collect revenues for patient services rendered, is an important input to analyze a hospital's financial health. Using the industry standard, CVMC's days in patient accounts receivable has improved from poor to average since FY22, as shown above. *Id*. An improvement in this metric is typically accompanied by an improvement in DCOH. This has not occurred with CVMC, perhaps due to its network affiliation.

22. 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. For FY22 and FY23

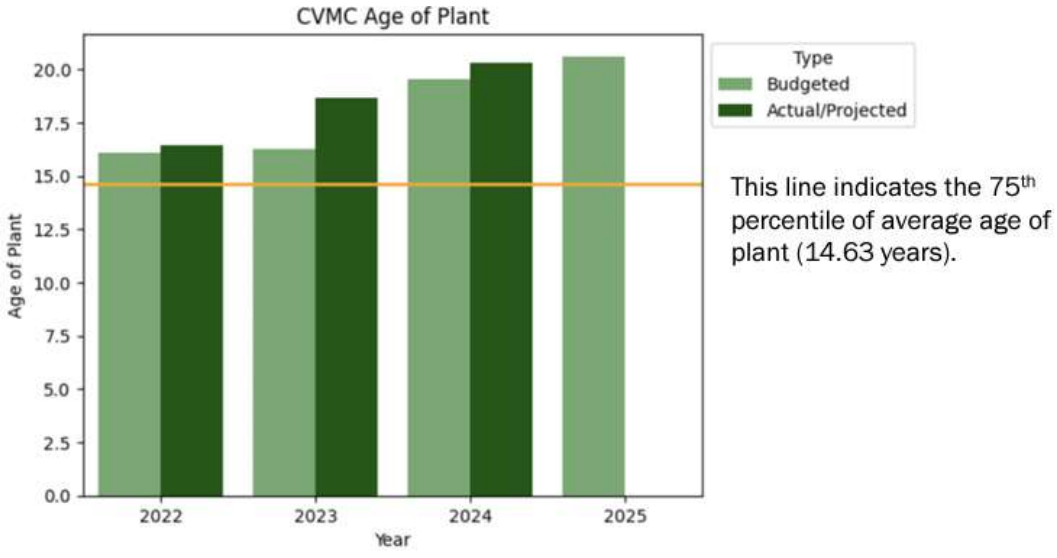
CVMC had negative operating margins. *Id.* at 137. There is evidence of improvement for FY24 but CVMC's operating margin is still below the Vermont average. *Id*.



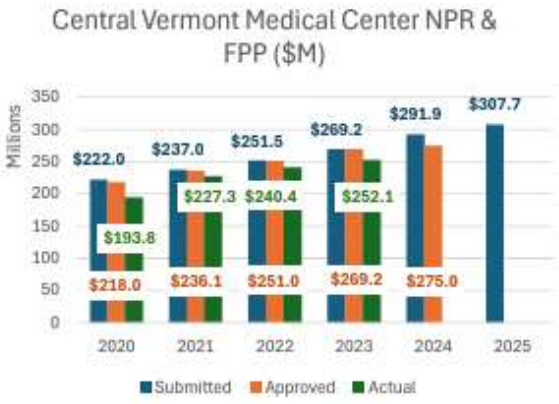
**Margin % shows Actuals 2022 - 2023, Projected 2024 & Budgeted 2025*

23. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. CVMC's current ratio of assets to liabilities, including funded depreciation, is above breakeven but below the US median. *Id.* at 140. Its current ratio of assets to liabilities without funded depreciation is below both the breakeven and US median. *Id*.

24. 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. CVMC's average age of plant is high, above the 75th percentile, as shown below. *Id.* at 141.



25. CVMC prior years' submitted NPR, approved NPR, and actual NPR and operating expenses are shown below. *Id.* at 148.



26. CVMC's prior year submitted operating margins, approved operating margins, and its actuals for FY20 through FY23 are shown below. *Id*.

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

CONCLUSIONS

While CVMC met the GMCB's benchmark for positive operating margin, its proposed budget includes NPR growth of 11.9%, which exceeds the benchmark of 3.5%, and a commercial negotiated rate increase of 5.5%, which exceeds the benchmark of 3.4%. *See* Findings, ¶¶ 2-4. As such, we review CVMC's budget submission consistent with the factors set out in FY25 Guidance,

GMCB Rule 3.000, and in statute to determine whether it has satisfied its burden of persuasion in justifying its request. GMCB Rule 3.000, § 3.306(a).

CVMC bases its requested commercial negotiated rate increase in part on its estimate of the rate increases expected from public payers; in other words, projected expense growth not covered by Medicaid and Medicare is shifted to the commercial population. *See* Findings, ¶ 9. However, we do not find credible CVMC's assumption that its Medicare rate will increase by only 0.4%. *See* Findings, ¶¶ 5, 6, 8. Given the recent trend of CVMC's actuals varying significantly from its budget, with FY24 commercial NPR projected to exceed budget, and its FY24 operating revenue projected to exceed budget by 5.7%, we are concerned that a high commercial rate increase based on a low Medicare rate assumption will lead to unnecessarily high commercial NPR growth. *See* Findings, ¶¶ 5, 6, 8, 10, 18.

CVMC argues that its requested 11.9% NPR growth and 5.5% commercial negotiated rate increase are necessary to offset significant expenses. *See, e.g.,* Budget Narrative, 6. Recent operating expenses have been higher than budgeted, with FY24 operating expenses projected to exceed CVMC's budget by 3.9%. *See* Findings, ¶ 10. Recent margins have also been poor, with FY23 actual total margin at -8.3%, and projected FY24 total margin at 0.5%. *See* Findings, ¶ 11. For FY25, CVMC projects that operating expenses will increase by approximately $20 million as compared to FY24. *See* Findings, ¶ 12. Setting aside, for the sake of argument, cashflows between CVMC and its hospital network, this could further reduce its already low days cash on hand. *See* Findings, ¶ 20.

We are not persuaded by CVMC's argument. While greater expenses can be offset by increased NPR and commercial price, they can also be reduced with effective cost containment. CVMC did not justify its above-benchmark commercial negotiated rate request with credible evidence of efficiency and maximized productivity of resources, as described in our guidance. *See* FY25 Guidance, Section I(A)(2), at 9. CVMC's clinical productivity is low. According to its own data, approximately half of its practice areas are performing below the 25th percentile. *See* Findings, ¶ 16. The hospital has long wait times, with approximately one-fifth of new patients waiting 91-180 days to be seen. *See* Findings, ¶ 17. With this unmet demand and room for improved productivity, CVMC can generate NPR without reliance on price increases above the established benchmark.

In addition to low productivity, CVMC's administrative expenses are high. Hospital systems frequently point to shared savings as a benefit of their consolidated status, and shared administrative support is often cited for cost savings across a network. We find no evidence of administrative savings at CVMC. According to its own data, CVMC's ratio of administrative to clinical salaries is similar to the Vermont State average. *See* Findings, ¶ 13. Its newly budgeted FTEs are 99% administrative. *See* Findings ¶ 14. CVMC has a Medicare to payment cost ratio that is 12% lower than its peers, indicating that expense reduction is a viable method of obtaining a positive margin. *See* Findings, ¶ 15.

Establishing a commercial negotiated rate increase lower than CVMC's request is also supported by CVMC's standardized price, which compared to national hospitals was average as of 2022, before its 12.5% commercial rate increase in FY23 and 5% increase in FY24. *See*

Findings, ¶¶ 18-19. Considering our obligation at 18 V.S.A. § 9456(c)(3) to promote efficient and economic operation of the hospital, we conclude that increasing commercial price at the rate CVMC proposes is not a sustainable budgetary solution. We further conclude that while CVMC may need more in NPR than the benchmark, it has not provided sufficient justification for high utilization projections that would necessitate NPR growth of 11.9%. *See* Findings, ¶ 8.

For the reasons set forth above, we find that CVMC has not met its burden of justifying its budget as submitted. We conclude that CVMC's appropriate budget incorporates a 6% increase to its NPR and a 3.4% increase to commercial negotiated rate. The hospital has a runway to obtain this NPR growth with effective cost reduction strategies and improvements to clinical productivity, which will help increase access and shorten long wait times. The hospital must also make every possible effort to shift care that does not need to be at the hospital to more clinically appropriate settings.

We conclude that these modifications to CVMC's budget promote efficient operations and balance its current financial needs with our obligation to ensure "universal access to and coverage for high-quality, medically necessary health services for all Vermonters." *See* 18 V.S.A. §9371(1). These modifications are also aligned with our duty to advance the statutory principle 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. *See* 18 V.S.A. § 9371(2). CVMC's expected commercial NPR, provided in Condition E, below, incorporates its payer mix and utilization assumptions and may not match the hospital's actual expected commercial NPR submitted on or before March 15, 2025.

ORDER

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

A. CVMC's FY25 NPR/FPP ("NPR") budget is approved at a growth rate of not more than 6% over its FY24 budget, with a total NPR of not more than $291,502,431 for FY25 and a commensurate reduction in operating expenses.

B. CVMC'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 CVMC and commercial insurers. CVMC 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. CVMC's expected commercial NPR, based on its budget as adjusted in this Order, is $132,241,679. CVMC 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. CVMC 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. CVMC 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, CVMC 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, CVMC 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. CVMC 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. CVMC 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. CVMC 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, CVMC 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. CVMC 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) CVMC 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. CVMC shall participate in the Board's work, including the community engagement process, pursuant to Act 167.

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

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

R. CVMC 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	)	
	)	GREEN MOUNTAIN
s/ Jessica Holmes	)	CARE BOARD
	)	OF VERMONT
s/ Robin Lunge	)	

Board Member Walsh, dissenting.

I dissent from the majority's decision to establish CVMC's FY25 budget with NPR growth at 6% and a 3.4% increase to its overall change in charge and commercial negotiated rate.

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.