STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re: Gifford Medical Center Fiscal Year 2025	)))	Docket No. 24-005-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.

Gifford Medical Center (Gifford) requested an 8.2% increase in NPR over its FY24 approved budget and a 6.8% increase in commercial rate over its FY24 approved commercial rate. Gifford's senior leadership presented its proposed budget to the Board at a public hearing held on August 12, 2024. Gifford 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 Gifford's FY25 budget with modifications to its proposal, setting FY25 NPR growth at not more than 3.5% 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. Gifford is a critical access hospital with its primary location in Randolph, Vermont.

2. In its FY25 budget submission Gifford requested 8.2% growth in NPR from its FY24 budgeted NPR, for a total of $69,746,472. *See* Gifford Submission, Income Statement, 2. This proposed increase exceeds the 3.5% growth benchmark.

3. Gifford requested commercial negotiated rate growth of 6.8% over its FY24 approved rate. *See* Gifford Workbook, Rate Decomposition Sheet. This proposed increase exceeds the 3.4% commercial negotiated rate growth benchmark.

4. Gifford's proposed budget anticipates an operating margin of approximately $3.1 million, or 4.4%, 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. Gifford assumes that for FY25 the Medicare reimbursement rate will increase by approximately 0% and the Medicaid reimbursement rate will increase by 0%. *See* Gifford Workbook, Rate Decomposition Sheet. This Medicaid assumption is consistent with the fact that the Department of Vermont Health Access will not be increasing Medicaid rates for FY25. As a critical access hospital, Gifford should expect an increase in Medicare rates in proportion to increased cost growth. These increases are not reflected in its workbook. *See* Workbook, Rate Decomposition Sheet. In its Budget Narrative, Gifford writes that Medicare reimbursement estimates for the FY25 budget "have considered an increase in outpatient activity as well as the correlative increase in costs associated with the mix of services budgeted; therefore, the net revenue assumptions have been adjusted accordingly." *See* Narrative, 6. This explanation does not sufficiently describe the methodology used to predict the hospital's rate increase for Medicare.

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. Gifford anticipates a 5.3% decrease in NPR due to a total utilization decrease. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 129. While Gifford anticipates a modest increase in commercial volume at 0.4%, it projects decreased utilization for all public payers, including a 16.9% decrease in Traditional Medicare and 6.5% decrease in Medicare Advantage. *Id.*

7. 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. *See* FY25 Hospital Budget Guidance & Reporting Requirements, Section VI, Part 11; *see also* 18 V.S.A. § 9456(b)(9). Gifford provided an analysis with a reasonable methodology, stating that its projected 0% increase in public payer rates does not reduce its commercial negotiated rate request. *See* Gifford, Net Payer Revenue Submission.

8. The accuracy of a hospital's past assumptions about commercial NPR and public payer NPR can verify that its current budget assumptions are reasonable. Gifford has a consistent trend of overestimating its commercial NPR, as shown below. *See* Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 116. The result of this trend is that Gifford has consistently received less in commercial NPR than predicted since FY18.

Revenue Trends: Actual vs. Budgeted NPR
Gifford Medical Center

VERMONT
GREEN MOUNTAIN CARE BOARD

	FY18 Δ		FY19 Δ		FY20 Δ		FY21 Δ		FY22 Δ		FY23 Δ	
Commercial	(6.31)	-19.1%	(3.95)	-12.5%	(4.16)	-14.9%	(3.31)	-11.5%	(3.89)	-14.0%	(3.24)	-12.8%
Medicaid	(1.59)	-32.7%	(0.60)	-14.5%	0.87	17.1%	2.06	48.1%	(0.74)	-10.3%	0.57	13.1%
Medicare	(2.77)	-13.2%	(1.30)	-6.6%	(1.87)	-9.9%	8.24	44.7%	9.30	49.4%	(0.62)	-2.2%
DSH	(0.00)	0.0%	(0.00)	0.0%	0.00	0.3%	(0.02)	-2.9%	(0.22)	-41.6%	0.09	26.3%
	(10.67)	-17.93%	(5.84)	-10.45%	(5.15)	-9.83%	6.98	13.40%	4.46	8.22%	(3.20)	-5.51%

Note: Negative values reflect over-budgeted revenues (actuals less than budget), positive values, under-budgeted.

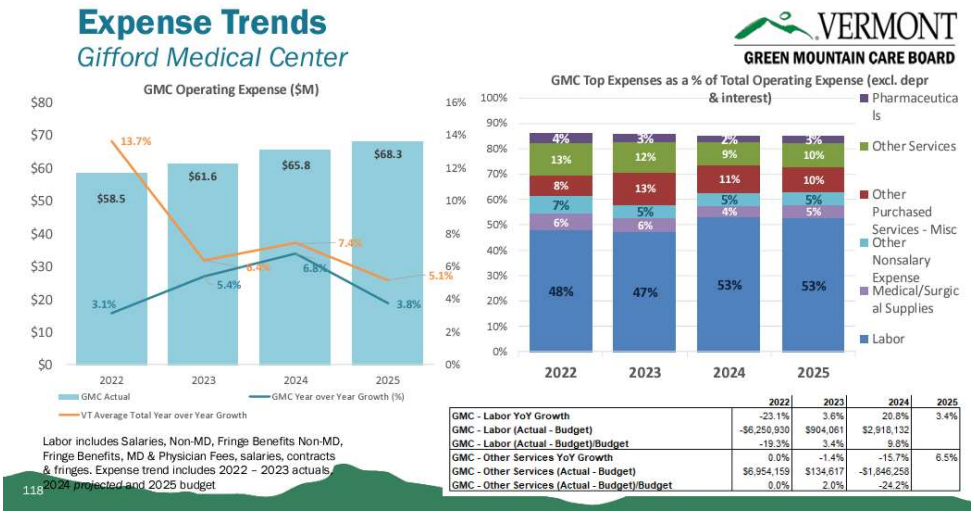
9. The accuracy of a hospital's previous assumptions about its operating revenues and expenses can speak to the reasonableness of its projected operating margin. If a hospital underestimates revenues, it may see a higher margin than budgeted. If a hospital underestimates its expenses, it may see less margin than budgeted. Gifford's recent assumptions for both operating revenues and operating expenses have been inconsistent with actuals and FY24 projected. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 120. In FY23 and FY24 Gifford overestimated its operating revenue. *Id*. This variance is the result of significant issues with its new electronic health record (EHR), which had a difficult rollout that delayed implementation from July 2023 to October 2024. *See* Budget Narrative, 3. These difficulties caused revenues for FY23 and FY24 to decrease. *Id.* In these same years, Gifford underestimated operating expenses by a considerable margin, with FY23 actuals 16.8% above budget and FY24 actuals projected to be 8.1% above budget. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 120.

	2022	2023	2024
GMC Operating Revenue	$62,855,580	$56,895,993	$63,100,782
GMC Operating Expense:	$58,474,915	$61,629,925	$65,825,042
GMC Margin:	$4,380,666	-$4,733,932	-$2,724,260
GMC Operating Revenue: (Actual - Budget)	$6,358,173	-$2,627,735	-$3,343,608
GMC Operating Revenue: % Difference in Actual vs. Budget	11.3%	-4.4%	-5.0%
GMC Operating Expense: (Actual - Budget)	$5,302,122	$8,864,331	$4,953,790
GMC Operating Expense: % Difference in Actual vs. Budget	10.0%	16.8%	8.1%
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%

10. Comparing prior year budgeted margins to actual margins can help test the reasonableness of a proposed budget. In FY23 Gifford's actual operating margin was 19.7% less than budgeted at negative 8.3%. *Id*. at 121. Its total margin was 15.9% less than budgeted at negative 2.8%. *Id.* Its EBIDA was 19.7% less than budgeted at negative 1.2%. *Id.* While FY24 projected total margin and EBIDA are not in the negative, the deviation is still substantial. *Id.* As discussed above, these figures in part represent Gifford's challenging EHR rollout. *See* Budget Narrative, 3.

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	5.9%	7.0%	11.4%	-8.3%	8.4%	-4.3%	4.4%
Total Margin	7.4%	-0.3%	13.1%	-2.8%	8.4%	0.0%	4.8%
EBIDA	13.0%	13.0%	18.5%	-1.2%	14.3%	2.1%	10.0%

11. The trajectory of a hospital's operating expense growth is one method of examining operating efficiency. Gifford's operating expense growth has consistently been lower than the Vermont average, as shown, with operating expense growth budgeted to decrease from a projected 6.8% in FY24 to 3.8% in FY25. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 118.



	2022	2023	2024	2025
GMC - Labor YoY Growth	-23.1%	3.6%	20.8%	3.4%
GMC - Labor (Actual - Budget)	-$6,250,930	$904,061	$2,918,132	
GMC - Labor (Actual - Budget)/Budget	-19.3%	3.4%	9.8%	
GMC - Other Services YoY Growth	0.0%	-1.4%	-15.7%	6.5%
GMC - Other Services (Actual - Budget)	$6,954,159	$134,617	-$1,846,258	
GMC - Other Services (Actual - Budget)/Budget	0.0%	2.0%	-24.2%	

12. 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. Gifford's ratio was relatively stable at approximately 16.6% until FY22, when it increased to 23%. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 132.

13. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, Gifford budgets 85% clinical FTEs and 15% non-clinical FTEs. *See*

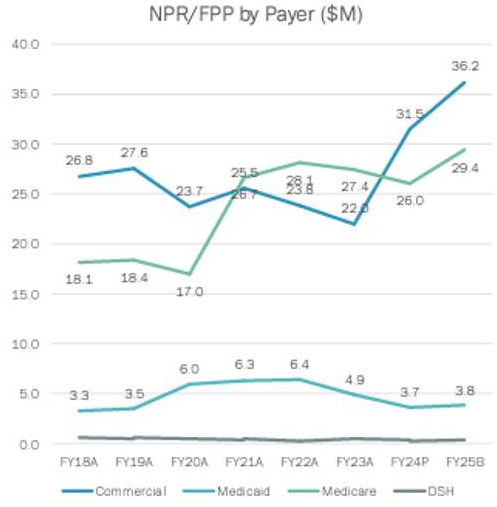
Workbook Submission; *see also* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 119. Its distribution of newly budgeted FTEs is 93% clinical and 7% non-clinical. *Id.*

14. Hospitals also monitor clinical productivity. When assessed at the hospital level, as done here, this measure is an indicator of potential systemic inefficiencies. Gifford's productivity data, as submitted, demonstrates that 10% of physician FTEs are in specialty areas performing below the 25th percentile, with 30% of physician FTEs in specialty areas performing below the 50th percentile. *See* Workbook Submission, Clinical Productivity Tab; *see also* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 132. 15% of Gifford's clinical departments are performing below the 25th percentile, with 46% of clinical departments performing below the 50th percentile. *Id.*

15. A hospital's wait times are also an indicator of system efficiencies. While longer wait times can occur for numerous reasons, longer wait times paired with lower physician efficiency data demonstrate inefficiencies that cause higher than necessary expenses. Gifford reports that 51% of new patients are seen within 14 days. *See* Workbook Submission, Referral Lags and Visit Lags. 21% of new patients are seen within 15-30 days. *Id.* 26% of new patients are seen within 31-90 days. *Id.* 3% of new patients are scheduled to be seen within 91-180 days. *Id.* Overall, these wait time figures are some of the lowest in the state. *See* GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times.[23]

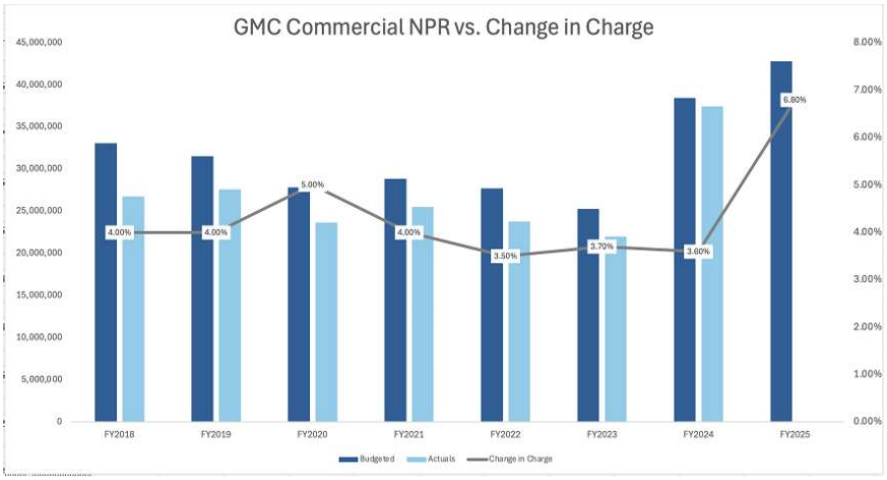
16. A hospital's investment in workforce development is an important aspect of its budget. *See* 18 V.S.A. § 9456(b)(12). Progress in this area can both improve access to services and reduce costs at a time when statewide locum traveler expenses are still high. Gifford has invested in efforts to expand nursing care, including a pathway program that assists LNAs to obtain the education and experience needed to become LPNs or RNs. *See* Budget Narrative, 12.

17. Commercial NPR has grown rapidly, from approximately $22 million in FY23 to a budgeted $36 million in FY25. *See* Hospital Revenue Trends by Payer, Staff Analysis, 9.[24]



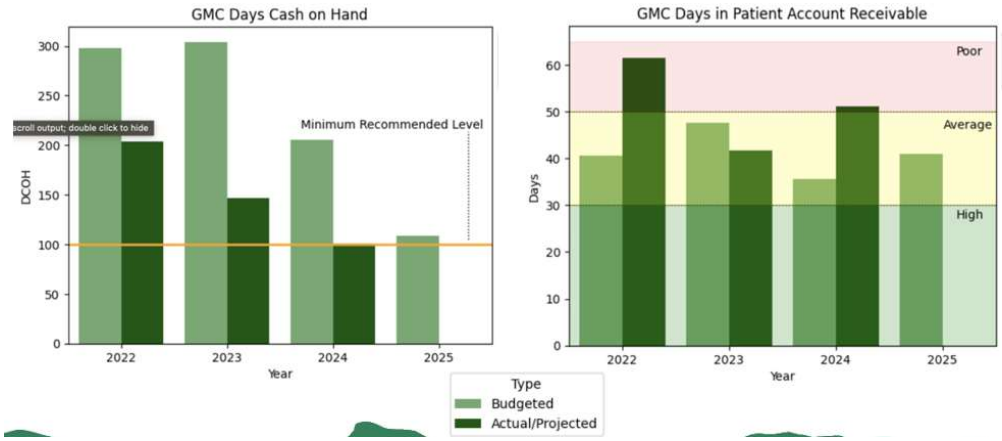
[23] https://gmcboard.vermont.gov/document/fy25-hospital-aggregated-wait-times
[24] https://gmcboard.vermont.gov/hospital-budget-review/FY25-Professional-Staff-Analyses

18. Gifford has previously been approved for commercial charge increases as shown below. *See* GMCB Staff Analysis, Change in Charge: Adjusting FY25 Requested Values, 4. These increases have contributed to the commercial NPR increase shown below. *Id*.



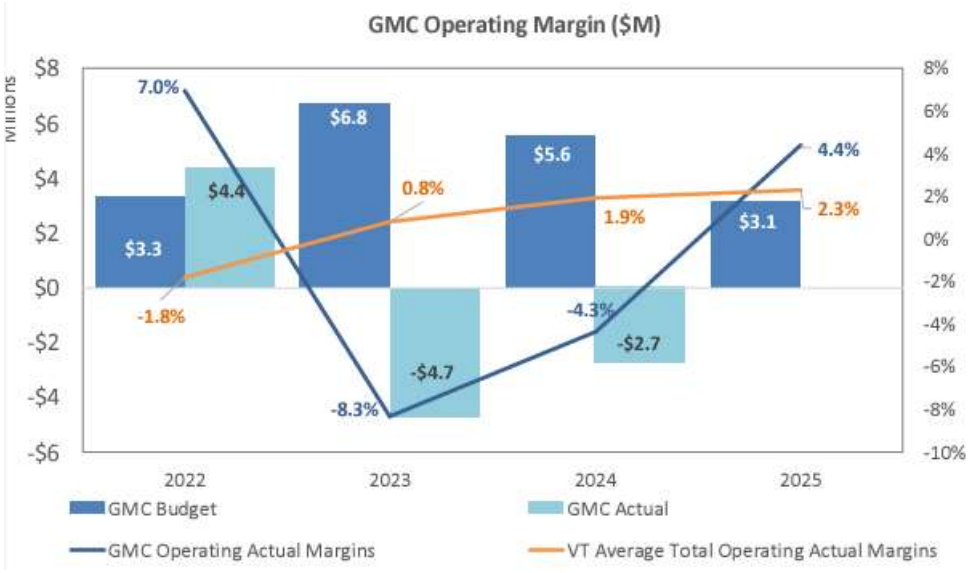
19. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a "relative price" by comparing a hospital's commercial prices to the Medicare payment system as a benchmark. RAND then calculates the standardized price 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. *See* RAND Hospital Price Transparency Project, GMCB Presentation (Aug. 6, 2024), 7-9. Gifford's commercial standardized prices for inpatient services are close to the national median. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 127. However, its standardized outpatient prices are high, with outpatient service and facility prices in the 9th decile. *Id.*

20. Days cash on hand (DCOH) is a measure of a hospital's financial health. Gifford's FY25 projected days cash on hand sits at the minimum recommended level, which represents approximately half of its DCOH in FY24. *Id.*, at 122.



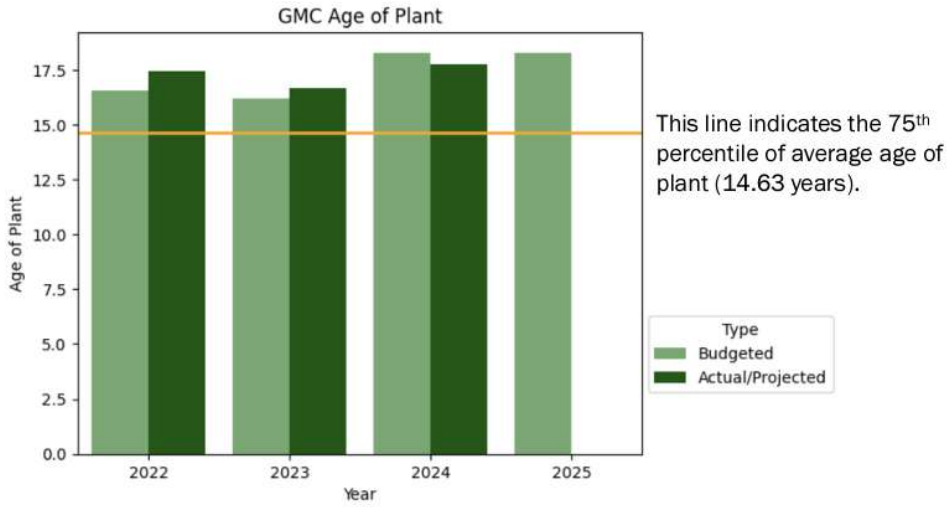
21. Days in patient accounts receivable, which reflects the average time it takes for a hospital to collect revenues for patient services rendered, is an important input to analyze a hospital's financial health. Using the industry standard, Gifford's days in patient accounts receivable has improved since FY22, as shown above, and is projected to be approximately 40 days for FY25. *Id*.

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. Gifford budgeted for strong positive margins in FY23 and FY24 but experienced a negative margin of $4.7 million in FY23 and is expected to realize a negative margin of $2.7 in FY24. *Id.* at 120. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 120.



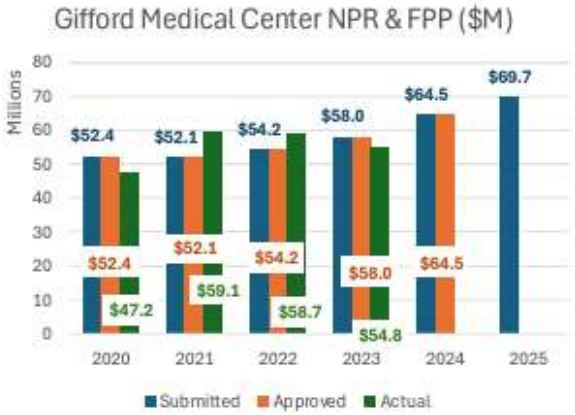
23. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. Gifford's current ratio of assets to liabilities, including funded depreciation, is above breakeven and is above the US median. Its current ratio of assets to liabilities without funded depreciation is above the breakeven but below the US median. *Id.* at 123.

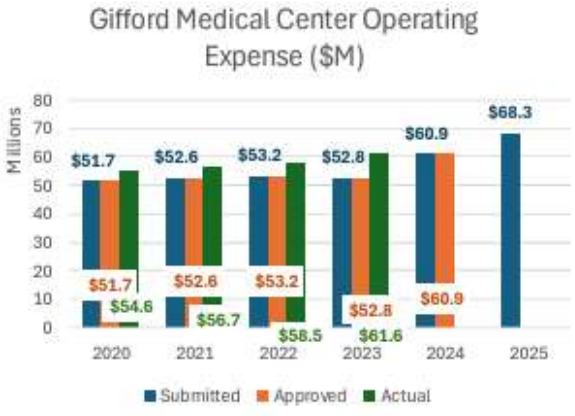
24. Average age of plant, a ratio that measures the age of a hospital's fixed assets, is another assessment of a hospital's financial health. It indicates how much capital spending may be required in the near term. As such, an older average age of plant indicates a greater immediate need for capital resources. Gifford's average age of plant is high, above the 75th percentile, as shown below. *Id.* at 124. It has been high since FY22. *Id*.



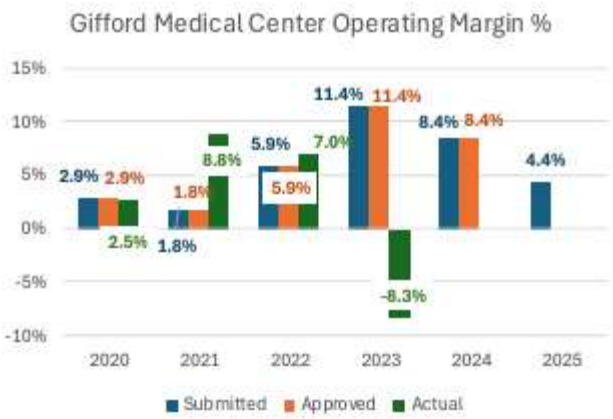
25. Debt service coverage ratio (DSCR) measures a hospital's current cash flow to pay its current debts. A DSCR of 1.25 is the standard minimum ratio for lenders. This figure indicates that a hospital's net operating income can cover current debts by 125%. Gifford's DSCR has been a significant concern. *Id*. at 125. It was negative in FY23. *Id.* It is projected to be less than 1.25 for FY24. *Id.*

26. Gifford prior years' submitted NPR, approved NPR, and actual NPR and operating expenses are shown below. *Id.* at 131. Gifford's NPR and operating expenses have been approved each year as submitted, except in FY22. *Id.* While actual NPR has oscillated above and below the approved amount, actual operating expenses have been over budget each year. *Id*.





27. Gifford's prior year submitted operating margins, approved operating margins, 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 Gifford, through a special comment period during the GMCB's hospital hearings and deliberations.

CONCLUSIONS

Gifford met the GMCB's benchmark for positive operating margin, but its proposed budget includes NPR growth of 8.2%, exceeding the benchmark of 3.5%, and a commercial negotiated rate increase of 6.8%, exceeding the benchmark of 3.4%. *See* Findings, ¶¶ 2-4. As such, we review Gifford's budget submission consistent with the factors set out in FY25 Guidance, in GMCB Rule 3.000, and in statute. Gifford bears the burden of persuasion in justifying its budget as submitted. GMCB Rule 3.000, § 3.306(a).

Gifford explains that 6.8% commercial rate growth is necessary so it can obtain a margin sufficient to undertake deferred capital maintenance and so it can stabilize its financial performance. *See* Narrative, 1-2. We agree that Gifford's financial health is concerning. DSCR was negative in FY23 and, while it has improved, it is still less than the standard minimum ratio of 1.25. *See* Findings, ¶ 25. Gifford's days cash on hand are half of what they were in FY22, sitting now at the minimum recommended level. *See* Findings, ¶ 20. Gifford's days in patient accounts receivable, conversely, shows improvement since FY22, indicating that further improvement in this area might not make a meaningful impact on days cash on hand. *See* Findings, ¶ 21. With a high average age of plant, the hospital needs to invest in capital improvements. *See* Findings, ¶ 24. It must achieve sufficient financial health to do so. However, in FY23 and FY24, due in part to its difficult EHR rollout, Gifford had lower operating revenues than budgeted and negative operating margins. *See* Findings, ¶¶ 9, 10, 22. Although EHR implementation is improving, and the hospital expects improved charge capture, it may not see an immediate reversal in its operating margin. *See* Findings, ¶ 5; *see also* Narrative, 4.

While we recognize Gifford's financial need, we are tasked with establishing a budget that promotes "efficient and economic operation of the hospital." *See* 18 V.S.A. § 9456(c)(3). We must balance this need with our duty to ensure that the health care system is "efficient in operation, and accountable to the people it serves," balancing "the health care needs of the population with the ability to pay for such care." 18 V.S.A. §§ 9371(2), 9371(3).

We do not find that commercial rate growth of 6.8% supports these obligations. Gifford's outpatient prices were high in FY22, before increases to its commercial rate that contributed to nearly $10 million in commercial NPR growth from FY23 to FY24. *See* Findings, ¶¶ 17-19. There could be a scenario in which continued commercial rate growth would be justified. This is not one of them. Gifford is not a hospital with an established record of managing its expenses. Operating expenses have gone over budget each year since FY20, with a deviation of $5 million in FY22 and a deviation of $9 million in FY23. *See* Findings, ¶ 26. Gifford's underbudgeted operating revenues have exacerbated the harm to its margins and days cash on hand in the last two years, but this trend signals the need for a push toward efficiency and expense management, rather than a significant increase in commercial NPR. *See* Findings, ¶¶ 9-10.

For the same reasons we find that NPR growth at benchmark is appropriate and conforms to this lower than requested increase in commercial rate. We cannot verify Gifford's Medicare rate assumptions from the record, but as a critical access hospital Gifford should expect an increase in Medicare rate proportional to its cost growth. Gifford's projection that volume will decrease for Medicare and Medicaid but slightly increase for commercial payers leads us to conclude that this NPR growth at benchmark can be achieved. *See* Findings, ¶¶ 5-6. Gifford can still realize some NPR gains through improved charge capture and denials management, with appropriate pressure to control operating expenses.

For the reasons set forth above, we find that Gifford has not met its burden of justifying its budget as submitted. We conclude that NPR growth at 3.5% and commercial rate growth of 3.4%, as limited in Condition B below, are appropriate. Gifford's expected commercial NPR, provided in Condition E, incorporates its proposed 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, Gifford's budget is approved for FY25 subject to the following terms and conditions:

A. Gifford's FY25 NPR/FPP ("NPR") budget is approved at a growth rate of not more than 3.5% over its FY24 budget, with a total NPR of not more than $66,729,745 for FY25 and a commensurate reduction in operating expenses.

B. Gifford'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 Gifford and commercial insurers. Gifford 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. Gifford's expected commercial NPR, based on its budget as adjusted in this Order, is $37,672,810. Gifford 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. Gifford 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. Gifford 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, Gifford 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, Gifford 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. Gifford 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. Gifford 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. Gifford 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, Gifford 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. Gifford 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) Gifford 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. Gifford shall participate in the Board's work, including the community engagement process, pursuant to Act 167.

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

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

R. Gifford 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	)	
	)	
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.