STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re:	Grace Cottage Hospital Fiscal Year 2025	)))	Docket No. 24-006-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.

Grace Cottage Hospital (GCH) requested a 12.0% increase in NPR over its FY24 approved budget and a 2.5% increase in commercial rate over its FY24 approved commercial rate. GCH's senior leadership presented its proposed budget to the Board at a public hearing held on August 12, 2024. GCH 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 GCH's FY25 budget with modifications to its proposal, setting FY25 NPR growth at not more than 6.0% over its FY24 approved budget, with commercial rate growth at not more than 2.5% over its FY24 approved commercial rate.

---

[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. Grace Cottage Hospital (GCH) is a critical access hospital with its primary location in Townshend, Vermont.

2. In its FY25 budget submission GCH requested 12% growth in NPR from its FY24 budgeted NPR, for a total of $30,886,387. *See* GCH Submission, Income Statement, 2. This proposed increase exceeds the 3.5% growth benchmark.

3. GCH requested commercial negotiated rate growth of 2.5% over its FY24 approved rate. *See* GCH Workbook, Rate Decomposition Sheet. This proposed increase meets the 3.4% commercial negotiated rate growth benchmark.

4. GCH's proposed budget anticipates an operating margin of approximately -$753,000 or -2.3%, which does not meet 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. GCH assumes that for FY25 the Medicare reimbursement rate will increase by approximately 5% and the Medicaid reimbursement rate will increase by 0%. *See* GCH Workbook, Rate Decomposition Sheet. This Medicaid assumption is consistent with the fact that the Department of Vermont Health Access (DVHA) will not be increasing Medicaid rates for FY25.

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. GCH anticipates a 6% increase in NPR due to increased utilization. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 107.

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). GCH's analysis shows total budgeted cost inflation, budgeted growth of public payer revenues, and the additional commercial revenue necessary to net out budgeted cost inflation. *See* Grace Cottage Net Payer Revenue and Public Reimbursement Analysis.

8. A hospital's previous assumptions about the NPR it will realize from its commercial and public payers can speak to the reasonableness of its assumptions in its current budget. Since FY21 GCH's commercial and Medicaid revenues have been consistently over budget. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 94.

	FY18 Δ		FY19 Δ		FY20 Δ		FY21 Δ		FY22 Δ		FY23 Δ	
Commercial	0.29	5.9%	(0.44)	-7.8%	0.15	2.7%	0.26	3.7%	1.82	25.4%	1.24	13.4%
Medicaid	(0.20)	-12.7%	(0.12)	-8.2%	(0.29)	-18.1%	0.19	13.1%	0.41	27.1%	0.24	12.8%
Medicare	(0.55)	-4.6%	(0.00)	0.0%	(0.40)	-3.1%	(0.53)	-4.3%	(0.62)	-4.6%	(2.00)	-14.1%
DSH	-		-		-		-		-		-	
	(0.46)	-2.44%	(0.56)	-2.89%	(0.54)	-2.72%	(0.08)	-0.39%	1.61	7.31%	(0.52)	-2.04%

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

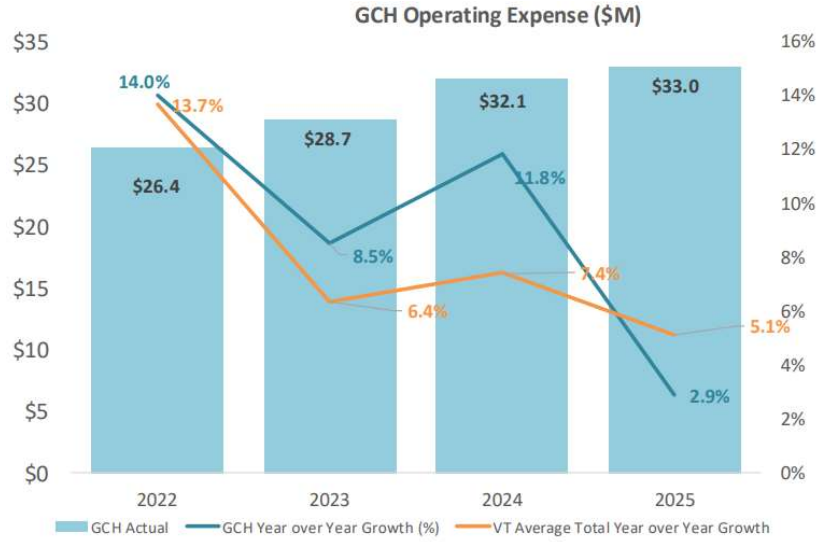
9. The accuracy of a hospital's previous assumptions about its operating revenues and expenses can speak to the reasonableness of its projected operating margin. If a hospital underestimates revenues, it may see a higher margin than budgeted. If a hospital underestimates its expenses, it may see less margin than budgeted. GCH underestimated operating expenses in FY23 and FY24, resulting in total operating expense overages of approximately $3 million. *Id.* at 98. The hospital underestimated operating revenue in FY24 by 3.3%, which is approximately half of underestimated operating expenses for FY24. *Id.*

	2022	2023	2024
GCH Operating Revenue	$24,750,893	$26,357,862	$30,075,634
GCH Operating Expense:	$26,440,217	$28,696,865	$32,085,830
GCH Margin:	-$1,689,324	-$2,339,003	-$2,010,196
GCH Operating Revenue: (Actual - Budget)	$1,403,532	-$100,059	$957,934
GCH Operating Revenue: % Difference in Actual vs. Budget	6.0%	-0.4%	3.3%
GCH Operating Expense: (Actual - Budget)	$1,921,332	$1,252,618	$1,989,775
GCH Operating Expense: % Difference in Actual vs. Budget	7.8%	4.6%	6.6%
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. GCH has experienced a steady trend of negative operating margins and operating and total margins that have been less than budgeted. *Id.* at 99. These margins are partially the result of underestimated operating expenses, as shown in the finding above. *Id.*

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	-5.0%	-6.8%	-3.7%	-8.9%	-3.4%	-6.7%	-2.3%
Total Margin	-1.0%	-7.6%	0.7%	-0.2%	12.9%	0.5%	12.4%
EBIDA	-0.7%	-3.0%	0.4%	-5.2%	0.3%	-3.0%	1.2%

11. The trajectory of a hospital's operating expense growth is one method of examining operating efficiency. GCH's operating expense growth has consistently been above the Vermont average, as shown, except for FY25 in which operating expense growth is budgeted under the average at 2.9%. *Id.* at 96.



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. Using the most recent FY22 data, GCH has a ratio of 23.3%, which is notably higher than both the Vermont hospital median and the median for other Vermont critical access hospitals. *Id*. at 111.

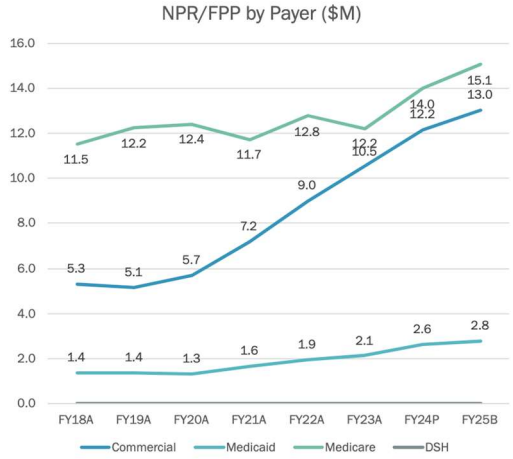
13. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, GCH budgets 57% clinical FTEs and 43% non-clinical FTEs. Its distribution of newly budgeted FTEs is 31% clinical and 69% non-clinical. *See* Workbook Submission; *see also* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 97.

14. A hospital's wait times are also an indicator of system efficiencies. GCH reported that 40% of new patients are scheduled to be seen within 14 days, 12.5% of new patients are scheduled to be seen within 15-30 days, 45% of new patients are scheduled to be seen within 31-90 days, and 2.5% of new patients are scheduled to be seen within 91-180 days. *See* FY25 Referral and Visit Lags. These wait times are above average compared to Vermont hospitals. *See* GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times.[23]

15. 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 can reduce costs at a time when statewide locum traveler expenses are still high. GCH offers opportunities for community college nursing student rotations and is a participant in the Nursing Needs Assessment for the Vermont Talent Pipeline. *See* GCH Narrative, 5.

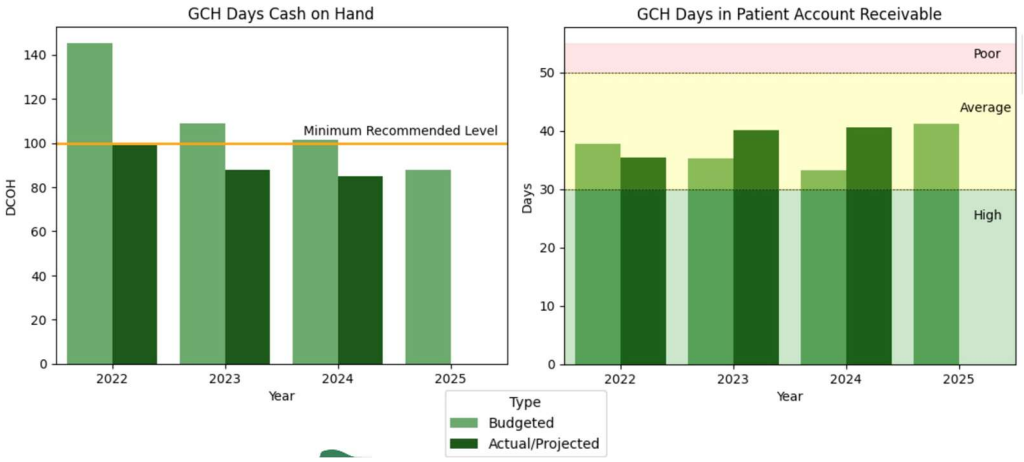
[23] https://gmcboard.vermont.gov/document/fy25-hospital-aggregated-wait-times

16. Medicare revenue is the highest contributor to GCH's overall NPR. While Medicare NPR has increased by 22% since FY20, commercial NPR has increased by 128%, an almost sixfold increase over that of Medicare. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 93.



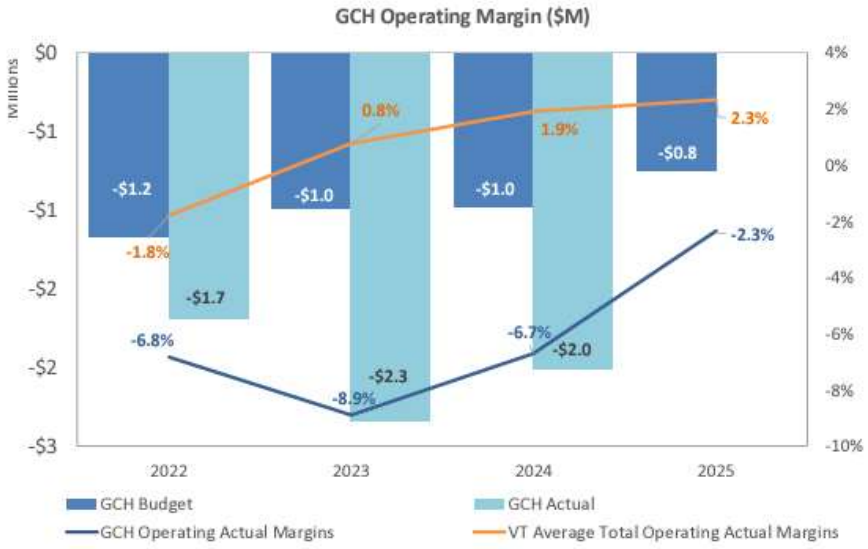
17. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a relative price by comparing a hospital's commercial prices to the Medicare payment system as a benchmark. RAND then calculates the standardized price by 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. GCH performs too few inpatient services for their inpatient numbers to be included in the RAND study, so there are only outpatient values for GCH. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 105. Its outpatient facility prices are at the 7th decile and its outpatient services prices are at the 9th decile. *Id*.

18. Days cash on hand (DCOH) is a measure of a hospital's financial health. GCH's days cash on hand has declined since FY22, from approximately 99 days in FY22 to a projected 85 days in FY24. *Id.* at 100.



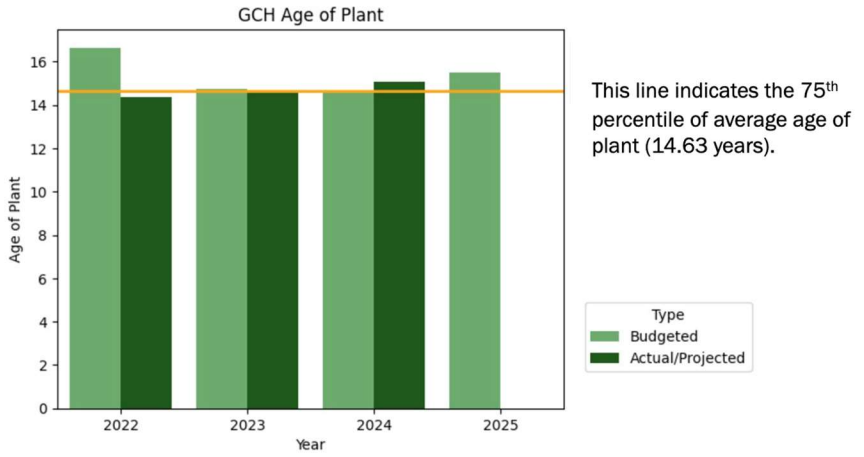
19. Days in patient accounts receivable, which reflects the average time it takes for a hospital to collect revenues for patient services rendered, is an important input to analyze a hospital's financial health. Using the industry standard, GCH's days in patient accounts receivable shows average performance, as shown above. *Id.* at 100.

20. 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. GCH's operating margin has been consistently below both its budget and the Vermont average since FY22. In FY24 GCH is projecting an operating margin of approximately $1 million below its budget, far below the Vermont average. *Id.* at 98.

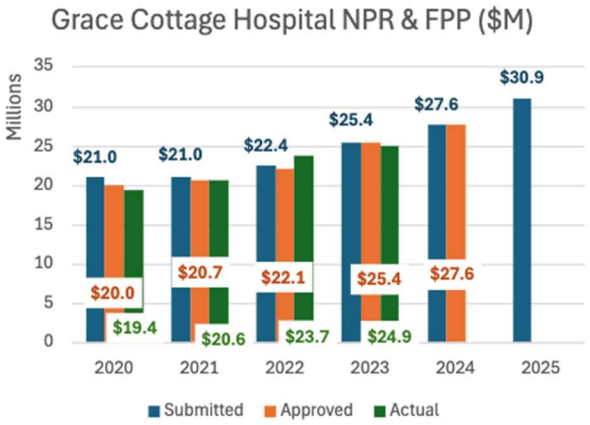


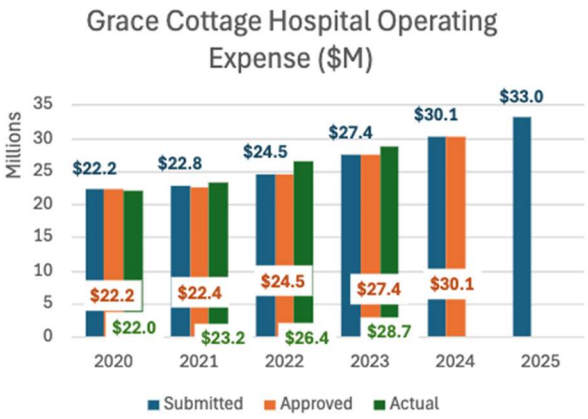
21. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. GCH's current ratio of assets to liabilities, without funded depreciation, is above breakeven and is below the US median. GCH does not have any funded depreciation. *Id.* at 101.

22. 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. GCH's average age of plant is just above the 75th percentile, shown below. *Id.* at 102.

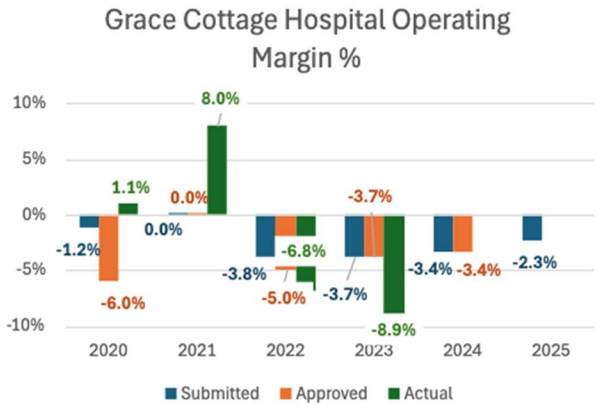


23. GCH prior years' submitted NPR, approved NPR, and actual NPR and operating expenses are shown below. *Id.* at 109.





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



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

CONCLUSIONS

Although GCH met the GMCB's benchmarks for commercial rate, its proposed budget includes NPR growth of 12%, which exceeds the benchmark of 3.5%, and a negative operating margin, which does not meet the operating margin benchmark. *See* Findings, ¶¶ 2-5. As such, we review GCH'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).

We conclude that GCH's proposed commercial rate growth of 2.5% is reasonable. GCH is a hospital that had high commercial outpatient prices in 2022. *See* Findings, ¶ 17. It received price increases of 5.0% in FY23 and 4.0% in FY24, which contributed to the significant rise ~~it has had~~ in commercial NPR. *See* Findings, ¶ 16. The hospital's commercial NPR has exceeded its budget since FY20, with a 25.4% overage in FY22 and a 13.4% overage in FY23. *See* Findings, ¶ 8. We conclude that 2.5% commercial rate growth is appropriate given our duty to ensure that growth in health care spending "balance the health care needs of the population with the ability to pay for such care." 18 V.S.A. § 9371(2).

We conclude that GCH has not met its burden to justify NPR growth at 12%. GCH states that this request is built upon a 6% increase in NPR due to increased utilization, which is generally consistent with its historical utilization trends. *See* Findings, ¶ 6; *see also* Narrative, 1-2. While we commend GCH's efforts to increase access at its rural health clinic, we conclude that such a high increase in NPR risks disincentivizing GCH from making every possible effort to shift care that does not need to be at the hospital to lower-cost clinically appropriate settings, consistent with our goal of ensuring that all Vermonters "receive affordable and appropriate health care at the appropriate time in the appropriate setting." 18 V.S.A. § 9371(1).

We conclude that establishing NPR at the requested 12% would also risk disincentivizing GCH in closely examining its expenses. GCH has regularly underestimated operating expenses, which have consistently been higher than average. *See* Findings, ¶¶ 9, 11. These high operating expenses have resulted in negative margins, for which excessive NPR growth is not the appropriate cure. *See* Findings, ¶ 10, 24. GCH has a high ratio of administrative to clinical salaries and a high ratio of new non-clinical to clinical FTEs budgeted for FY25. *See* Findings, ¶¶ 12-13. Although a significant increase in revenue might result in better margins, we conclude that an NPR lower than GCH's request will put appropriate pressure on expense management to promote efficient hospital operations. *See* 18 V.S.A. §§ 9456(c)(3).

For the reasons set forth above, we find that GCH has not met its burden of justifying its budget as submitted. We conclude that NPR growth at 6% and commercial rate growth at 2.5%, as limited below, are appropriate. GCH'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, GCH's budget is approved for FY25 subject to the following terms and conditions:

A. GCH'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 $29,222,187 for FY25, and a commensurate reduction in operating expenses.

B. GCH's overall change in charge and commercial negotiated rate increase are approved at not more than 2.5% over current approved levels, with no commercial negotiated rate increase for any payer at more than 2.5% over current approved levels. The commercial negotiated rate increase overall or with respect to any payer may be less than 2.5% 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 GCH and commercial insurers. GCH 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. GCH's expected commercial NPR, based on its budget as adjusted in this Order, is $14,621,255. GCH 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. GCH 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. GCH 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, GCH 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, GCH 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. GCH 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. GCH 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. GCH 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, GCH 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. GCH 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) GCH 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. GCH shall participate in the Board's work, including the community engagement process, pursuant to Act 167.

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

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

R. GCH 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.