STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re: North Country Hospital Fiscal Year 2025	)))	Docket No. 24-008-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.

North Country Hospital (NCH) requested a 1.6% increase in NPR over its FY24 approved budget and a 4.7% increase in commercial rate over its FY24 approved commercial rate. NCH's senior leadership presented its proposed budget to the Board at a public hearing held on August 12, 2024. NCH 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 NCH's FY25 budget with modifications to its proposal, setting FY25 NPR growth at not more than 1.6% 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. NCH is a critical access hospital with its primary location in Newport, Vermont.

2. In its FY25 budget submission NCH requested 1.6% growth in NPR from its FY24 budgeted NPR, for a total of $105,626,414. *See* NCH Submission, Income Statement, 2. This proposed increase meets the 3.5% growth benchmark.

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

4. NCH's proposed budget anticipates an operating margin of approximately $2.2 million or 2.0%, which meets the benchmark for a positive operating margin. 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. NCH assumes that for FY25 the Medicare reimbursement rate will increase by approximately 2.0% and the Medicaid reimbursement rate will increase by 0%. *See* NCH 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. NCH anticipates a 2.3% increase in NPR due to increased utilization. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 150.

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). NCH's submitted documentation, shown in full below, does not include sufficient detail for the GMCB to evaluate whether its methodology is reasonable. *See* Net Revenue and Public Payor Reimbursement Analysis.

> *North Country only has an increase to Medicare outpatient net revenue reflected in the budget or government payers.*
>
> *This amount is $646,523..*
>
> *The reimbursement structure of Medicaid inpatient and outpatient and Medicare Inpatient does not increase reimbursement with increased charges.*
>
> *There was no reduction to bad debt or charity care in the budget.*

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. NCH has consistently underbudgeted NPR from Medicare; NCH's commercial NPR has been consistently overbudgeted, except for FY21; and NCH's total NPR from all payers has been overbudgeted each year except for FY21. Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 137.

	FY18 Δ		FY19 Δ		FY20 Δ		FY21 Δ		FY22 Δ		FY23 Δ	
Commercial	(10.20)	-23.9%	(1.61)	-4.1%	(6.17)	-15.5%	4.19	10.1%	(7.86)	-19.3%	(1.38)	-3.0%
Medicaid	0.74	6.5%	(0.78)	-6.0%	(0.90)	-7.1%	2.64	20.6%	2.66	20.5%	(5.71)	-31.0%
Medicare	6.70	27.2%	1.50	5.3%	0.32	1.0%	3.72	13.4%	2.34	7.0%	3.50	10.6%
DSH	0.12	29.4%	0.01	0.8%	(0.06)	-6.1%	(0.23)	-25.8%	0.68	99.3%	(0.03)	-4.2%
	(2.65)	-3.35%	(0.89)	-1.09%	(6.81)	-8.15%	10.32	12.47%	(2.18)	-2.48%	(3.63)	-3.67%

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. NCH has overestimated operating revenues and underestimated operating expenses in recent years, although FY24 projections are closer to budget. *Id.* at 141.

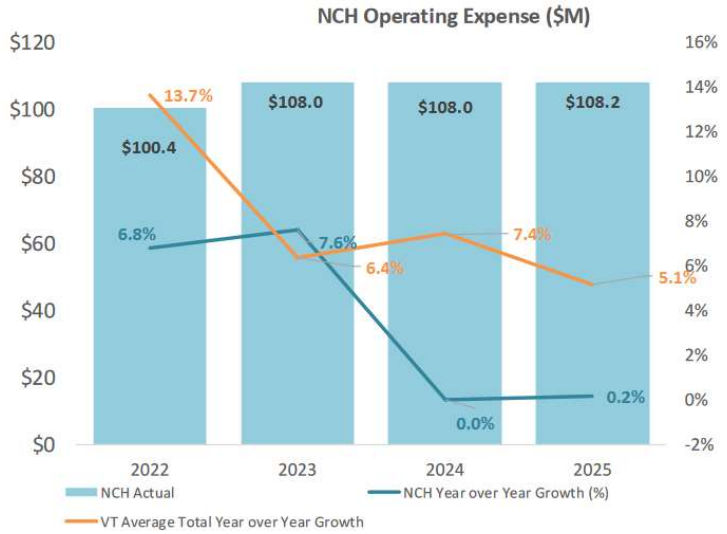
	2022	2023	2024
NCH Operating Revenue	$91,013,640	$99,222,055	$107,590,732
NCH Operating Expense:	$100,396,862	$108,010,132	$107,987,646
NCH Margin:	-$9,383,222	-$8,788,077	-$396,914
NCH Operating Revenue: (Actual - Budget)	-$3,373,994	-$5,626,895	-$998,480
NCH Operating Revenue: % Difference in Actual vs. Budget	-3.6%	-5.4%	-0.9%
NCH Operating Expense: (Actual - Budget)	$6,989,809	$5,256,406	-$601,569
NCH Operating Expense: % Difference in Actual vs. Budget	7.5%	5.1%	-0.6%
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. In FY23 NCH's actual operating margin (-8.9%) was significantly lower than its budgeted operating margin (2.0%). For FY24, NCH is projecting an operating margin that is closer to budget (-0.4% vs. 0.0%). Although NCH's projected FY24 operating margin is negative, its total margin is projected to be positive (3.9%).

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	1.0%	-10.3%	2.0%	-8.9%	0.0%	-0.4%	2.0%
Total Margin	1.9%	-5.3%	2.0%	-10.9%	0.0%	3.9%	2.0%
EBIDA	5.0%	-5.9%	6.1%	-4.6%	4.0%	3.4%	6.2%

11. NCH asserts that "the very poor implementation of Cerner Community Works EMR and the limitation of the product itself is the main reason for our negative financial performance over the last two years." Narrative, 2. NCH is pursuing legal remedies. *Id.*; *see also* Testimony of Thomas Frank, Hearing Tr. (Aug. 12, 2024), 174:16-24, 181:2-11. NCH is looking at the possibility of switching to another EMR system, but not sooner than FY26. *See* Testimony of Thomas Frank, Hearing Tr. (Aug. 12, 2024), 239:12-21, 240:6-12.

12. The trajectory of a hospital's operating expense growth is one method of examining operating efficiency. NCH's operating expense growth, while above the average of Vermont hospitals in from FY22 to FY23, is projected to be flat FY23 to FY24. For FY25, NCH is budgeting much lower growth than the Vermont average. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 139.



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, NCH has a ratio of 15.4%, which is below the ratio of its comparators. *Id.* at 153.

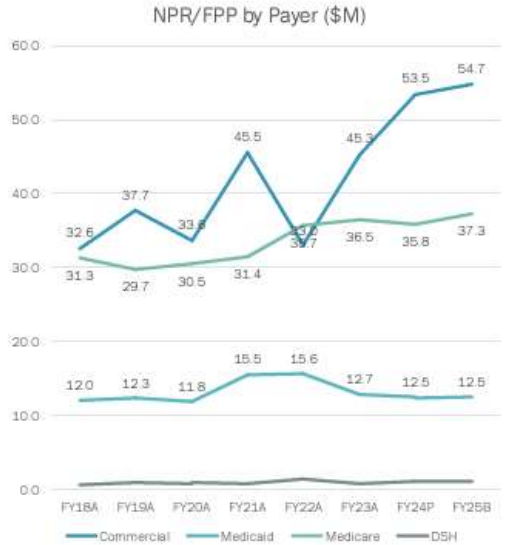
14. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, NCH budgets 58% clinical FTEs and 41% non-clinical FTEs. Its distribution of newly budgeted FTEs is 67% clinical and 33% non-clinical. *See* Workbook Submission; *see also* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 140.

15. Hospitals also monitor clinical productivity. When assessed at the hospital level, as done here, this measure is an indicator of potential inefficiencies. NCH's productivity data, as submitted, demonstrates that, of 13.95 physician FTEs, none work in departments performing under the 25th percentile and 49.1% work in clinical departments performing under the 50th percentile. *See* Workbook Submission, Clinical Productivity Tab; *see also* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 153.

16. 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 relatively low clinical productivity suggests the existence of untapped revenue that would not only increase patient access but also mitigate the need for higher prices to generate margin. NCH reports that 56% of appointments are scheduled within three business days of referral and, of NCH's new patients, 43% are scheduled to be seen within 14 days, 23% within 15-30 days; 29% within 31-90 days; and 4% within 91-180 days. *See* Workbook Submission, Referral Lags and Visit Lags. These wait times are generally average compared to hospitals statewide. See GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times.[23]

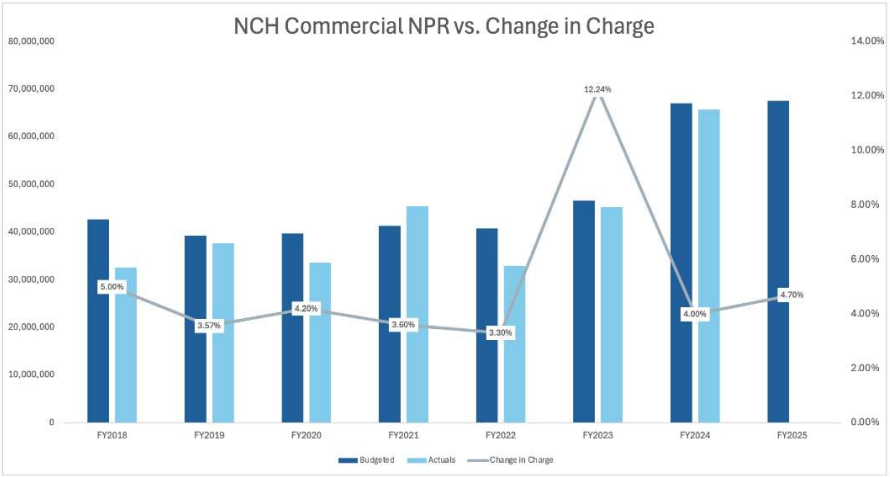
17. A hospital's investment in workforce development is an important aspect of its budget. *See* 18 V.S.A. § 9456(b)(12). Progress in this area can both improve access to services and reduce costs at a time when statewide locum traveler expenses are still high. Recognizing that recruitment to the Northeast Kingdom is a challenge, NCH describes several workforce development partnerships and activities. *See* NCH Narrative, 9-10.

18. Except for FY22, commercial revenue has been the highest contributor to NCH's overall NPR. While public payer revenues have seen relatively small changes, commercial NPR has increased substantially since FY22. *See* Hospital Revenue Trends by Payer, GMCB staff analysis.



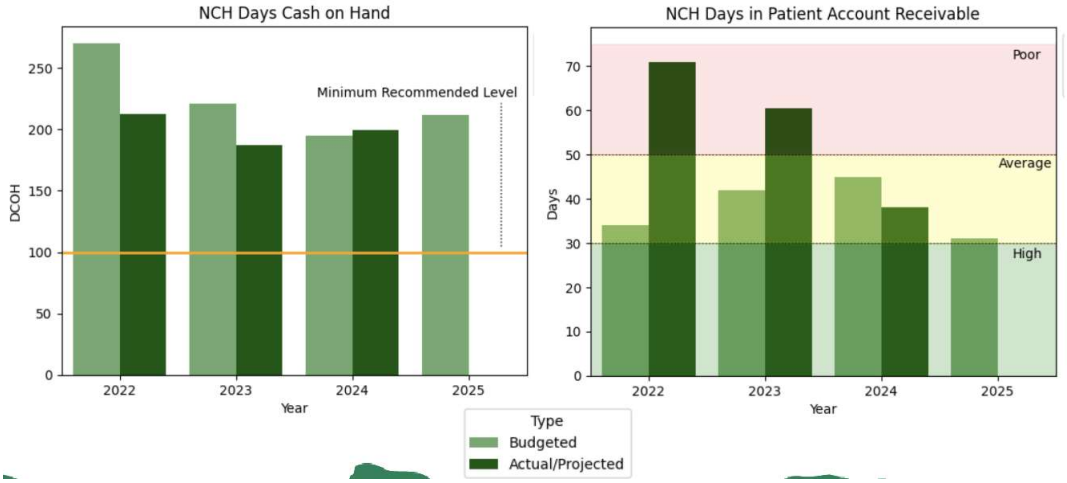
[23] https://gmcboard.vermont.gov/document/fy25-hospital-aggregated-wait-times

19. NCH has previously been approved for commercial charge increases as shown below, which include a 12.24% increase in FY23. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 138. These increases have contributed to the commercial NPR increase shown above and below, with a significant increase in commercial NPR from FY23 to FY24.



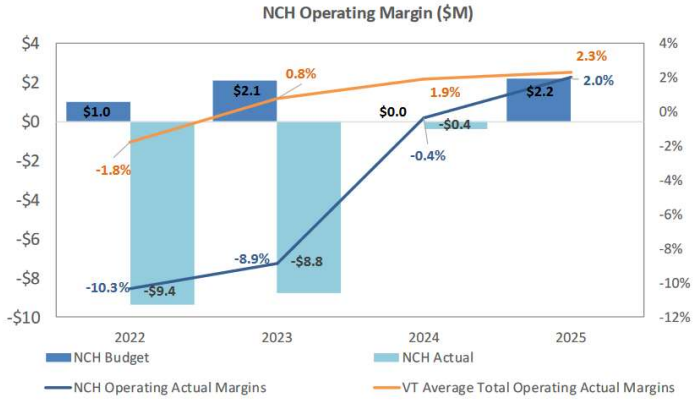
20. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a relative price by comparing a hospital's commercial prices to the Medicare payment system as a benchmark. RAND then calculates the standardized price by adjusting the benchmark using Medicare's case mix grouping and relative weights. For standardized price, a higher decile indicates that commercial prices appear to be higher than the national median, while a lower decile indicates that commercial prices appear to be lower than the national median. *See* RAND Hospital Price Transparency Project, GMCB Presentation (Aug. 6, 2024), 7-9. NCH's commercial standardized prices in 2022 are high compared to hospitals nationally. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 148. Commercial outpatient prices are in the 10th decile and commercial inpatient prices are in the 8th decile. *Id.* These prices do not incorporate the 12.24% charge increase NCH received in FY23.

21. Days cash on hand (DCOH) is a measure of a hospital's financial health. NCH's days cash on hand is approximately twice the minimum recommended level. *Id.* at 143.



22. 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, NCH's days in patient accounts receivable has improved from FY22 to FY24 and is currently average, as shown above. *Id.* at 143.

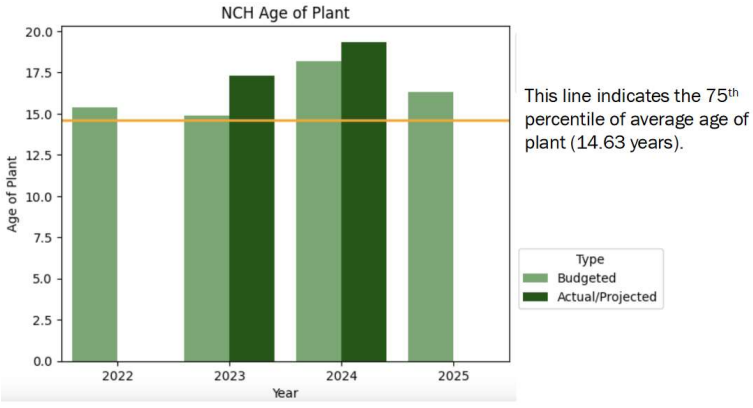
23. A hospital's operating margin is another evaluation of its financial health. Operating margins demonstrate a hospital's ability to cover expenses with revenues, but do not demonstrate that a hospital is efficiently delivering care or being adequately reimbursed. NCH's operating margin was very low in both FY22 (-10.3%) and FY23 (-8.9%), far below the statewide average, but is projected to improve significantly in FY24 (to -0.4%) and come closer to the statewide average of 1.9%. *Id.* at 141.



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

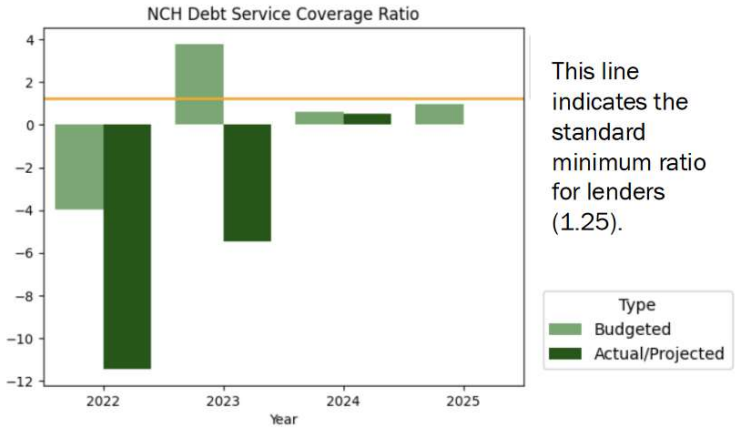
24. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. NCH's current ratio of assets to liabilities, including funded depreciation, is above breakeven and is above the US median. Its current ratio of assets to liabilities without funded depreciation is below the breakeven and below the US median. *Id.* at 141.

25. Average age of plant, a ratio that measures the age of a hospital's fixed assets, is another assessment of a hospital's financial health. It indicates how much capital spending may be required in the near term. As such, an older average age of plant indicates a greater immediate need for capital resources. NCH's average age of plant is above the 75th percentile, as shown below. *Id.* at 145.

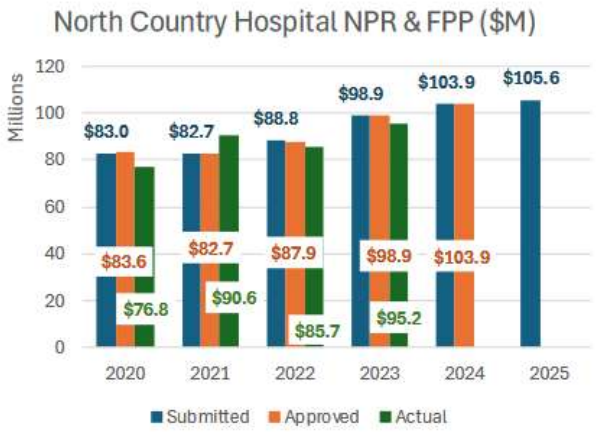


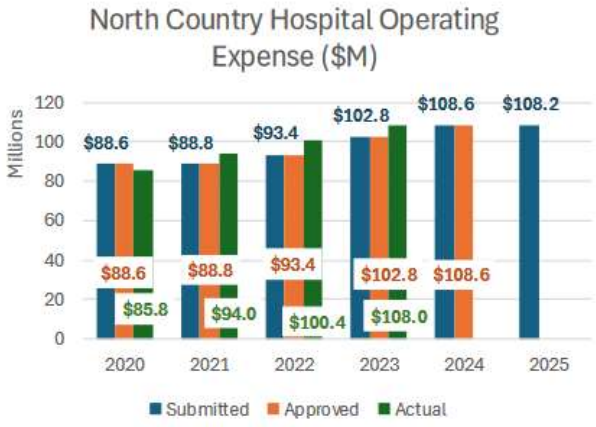
26. NCH has been on a capital expenditure freeze for the last three years. *See* NCH Narrative, 6. As a result, NCH states that it has a higher-than-normal capital budget for 2025 and needs its budgeted margin to generate cash to fund its capital budget. Testimony of Tracey Paul, Hearing Tr. (Aug 12, 2024), 211:3-16.

27. NCH's debt service coverage ratio has improved significantly since FY22 but is still below the minimum ratio for lenders. Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 146.

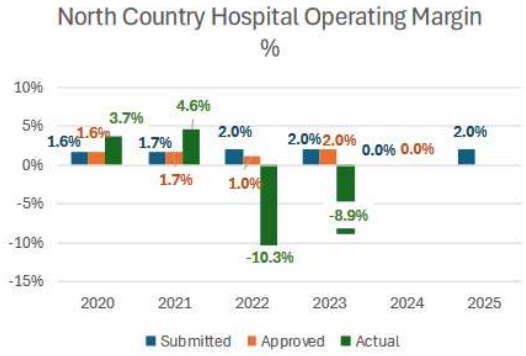


28. NCH's prior years' submitted NPR, approved NPR, and actual NPR and operating expenses are shown below. *Id.* at 152.





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



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

CONCLUSIONS

While NCH met the GMCB's benchmarks for NPR growth and operating margin, its proposed budget includes commercial negotiated rate growth of 4.7%, exceeding the benchmark of 3.4%. *See* Findings, ¶¶ 2-4. As such, we review NCH's budget for possible modification based on the factors set out in FY25 Guidance, in GMCB Rule 3.000, and in statute, considering that NCH bears the burden of persuasion in justifying its budget as submitted. GMCB Rule 3.000, § 3.306(a).

NCH explains that 4.7% commercial negotiated rate growth is necessary to obtain a margin of 2.0%, which in turn is necessary for NCH to make certain capital investments following a lengthy capital spending freeze. *See* Narrative, 2-3, 6. NCH's high average age of plant suggests that it does indeed need to invest in capital improvements. *See* Findings, ¶ 25. Although NCH has relatively strong DCOH, its negative operating margins in FY22 and FY23 and its debt service coverage ratio are of concern. *See* Findings, ¶¶ 21, 23, 27, 29. NCH's financial performance in recent years has been strongly affected by problems with its electronic medical record and NCH is taking legal action against the EMR vendor and exploring its options for alternative systems. *See* Findings, ¶ 11.

We recognize NCH's financial need. However, we are tasked with establishing a budget that promotes "efficient and economic operation of the hospital" and we must strive 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), 9456(c)(3). We do not find that commercial rate growth of 4.7% supports these obligations.

Even before receiving a 12.2% charge increase in FY23, NCH's prices were high compared to hospitals nationally. *See* Findings, ¶ 20. This 12.2% increase in FY23 appears to have contributed to a sharp increase in commercial NPR from FY22 to FY23 and into FY24. *See* Findings, ¶ 19. While NCH has managed to keep its expense growth almost flat from FY23, it

appears to have room to improve clinical productivity, which could allow it to generate revenue without significantly increasing costs. *See* Findings, ¶¶ 12, 15. Given the statutory factors we must consider, we believe this strategy to be most appropriate at this time.

For the reasons set forth above, we find that NCH has not met its burden of justifying its 4.7% commercial negotiated rate growth and we therefore approve NCH's budget with 3.4% commercial negotiated rate growth. NCH'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, NCH's budget is approved for FY25 subject to the following terms and conditions:

A. NCH's FY25 NPR/FPP ("NPR") budget is approved at a growth rate of not more than 1.6% over its FY24 budget, with a total NPR of not more than $105,626,414 for FY25.

B. NCH'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 NCH and commercial insurers. NCH 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. NCH's expected commercial NPR, based on its budget as adjusted in this Order, is $51,271,663. NCH 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. NCH 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. NCH 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, NCH 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, NCH 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. NCH 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. NCH 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. NCH 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, NCH 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. NCH 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) NCH 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. NCH shall participate in the Board's work, including the community engagement process, pursuant to Act 167.

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

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

R. NCH 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.