STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re:	Northwestern Medical Center Fiscal Year 2025	)))	Docket No. 24-010-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

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[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

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[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.

Northwestern Medical Center (NMC) requested a 6.8% increase in NPR over its FY24 approved budget and a 6.4% increase in commercial rate over its FY24 approved commercial rate. NMC's senior leadership presented its proposed budget to the Board at a public hearing held on August 14, 2024. NMC also submitted pre-hearing and post-hearing responses to questions asked by GMCB staff.[22] On September 13, 2024, following GMCB staff presentations and Board deliberations, and for the reasons set forth below, the Board established NMC's FY25 budget with modifications to its proposal, setting FY25 NPR growth at not more than 6.8% over its FY24 approved budget, with commercial rate growth at not more than 3.4% 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. NMC is a prospective payment system hospital with its primary location in St. Albans, Vermont.

2. In its FY25 budget submission NMC requested 6.8% growth in NPR from its FY24 budgeted NPR, for a total of $134,725,507. *See* NMC Submission, Income Statement, 2. This proposed increase exceeds the 3.5% growth benchmark.

3. NMC requested commercial negotiated rate growth of 6.4% over its FY24 approved rate. *See* NMC Workbook, Rate Decomposition Sheet. This proposed increase exceeds the 3.4% commercial negotiated rate growth benchmark.

4. NMC's proposed budget anticipates an operating margin of approximately $1.4 million, or 1.0%, 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. NMC assumes that for FY25 the Medicare reimbursement rate will increase by approximately 0.0% and the Medicaid reimbursement rate will increase by 0.0%. *See* NMC Workbook, Rate Decomposition Sheet; *but see* Narrative, 10 (stating NMC assumes it will realize a 1.7% Medicare rate increase from an anticipated market basket increase of 2.6% for inpatient and outpatient services).

6. NMC's assumption of either a 0% Medicare rate increase (Rate Decomposition Sheet) or 1.7% Medicare rate increase (Budget Narrative) is low. On August 1, 2024, CMS issued its updated "market basket," the index used to adjust payment rates annually for prospective payment system hospitals. *See* CMS Newsroom, FY25 Hospital IPPS and LTCH PPS Final Rule;[23] CMS Newsroom, FY25 Hospital OPPS and ASC Payment System Proposed Rule.[24] For inpatient services the FY25 market basket increase is 3.4%, reduced to 2.9% for a productivity adjustment; for outpatient services the FY25 market basket increase is 3.0%, reduced to 2.6% for a productivity adjustment. *Id.*

7. NMC's assumption of 0.0% increase in Medicaid rates is generally consistent with the fact that the Department of Vermont Health Access (DVHA) will not increase Medicaid rates for FY25.

8. A hospital's budgeted assumptions about utilization can similarly help delineate the accuracy of its projected revenues and the reasonability of its commercial rate request. NMC anticipates a 9.0% increase in NPR due to increased utilization. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 25. This assumption is credible. NMC has increased provider resources in nearly every specialty (cardiology, ENT,

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[23] https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0

[24] https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center

orthopedics, pulmonology, urology, and ophthalmology) and is planning to increase operating room hours by 40% over its FY24 budget. *See* Narrative, 4, 8.

9. A hospital's net revenue and public payer reimbursement analysis is a method of showing that the revenue it needs from commercial payers incorporates 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). NMC 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.

11. Net Revenue and Public Payor Reimbursement Analysis

1% increase in Medicare reimbursement equates to 0.72% change in charge
1% increase in Medicaid reimbursement equate to 0.23% change in charge
1% increase in insured population equates to .040% change in charge

10. 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. NMC has had a pattern of overestimating commercial and Medicaid revenues but its overall actuals came in closer to budget in FY22 and FY23. *See* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 12.

	FY18 Δ		FY19 Δ		FY20 Δ		FY21 Δ		FY22 Δ		FY23 Δ	
Commercial	(5.57)	-10.1%	(2.03)	-3.7%	(9.97)	-17.2%	3.42	5.7%	(1.95)	-3.0%	(5.38)	-7.3%
Medicaid	1.23	6.9%	(2.86)	-14.4%	(3.40)	-16.6%	(1.00)	-5.0%	(0.30)	-2.0%	(0.36)	-2.3%
Medicare	1.62	5.1%	(1.35)	-3.6%	(5.03)	-13.4%	3.88	12.4%	0.70	2.1%	2.12	6.9%
DSH	(0.08)	-6.5%	(0.00)	-0.2%	0.02	2.5%	0.28	37.2%	1.22	116.7%	0.06	5.0%
	(2.81)	-2.65%	(6.24)	-5.54%	(18.37)	-15.71%	6.57	5.87%	(0.34)	-0.29%	(3.56)	-2.94%

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

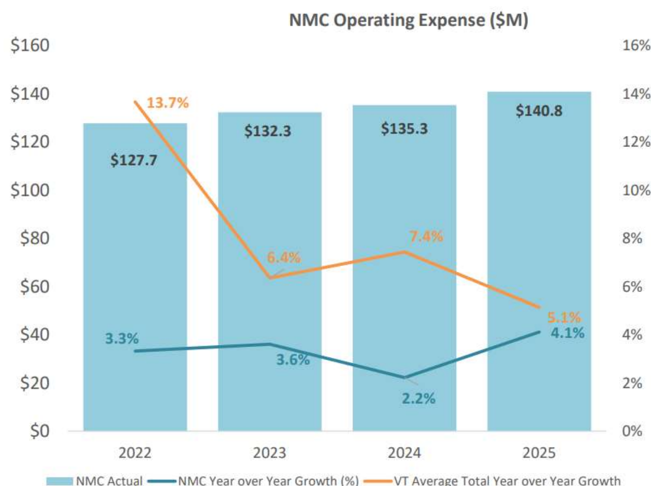
11. The accuracy of a hospital's previous assumptions about its operating revenues and expenses can speak to the reasonableness of its projected operating margin. If a hospital underestimates revenues, it may see a higher margin than budgeted. If a hospital underestimates its expenses, it may see less margin than budgeted. Given the difficulty of budgeting during the pandemic, it is reasonable to expect greater variance between budgeted and actuals in FY21 and FY22 but starting FY23 this trend should diminish. In FY23 NMC overestimated operating revenue and underestimated its operating expense, leading to a negative operating margin. Projections for FY24 are closer, but operating expenses are still higher than budgeted. *Id.* at 16.

	2022	2023	2024
NMC Operating Revenue	$122,501,257	$124,101,425	$134,223,302
NMC Operating Expense:	$127,717,820	$132,328,875	$135,270,258
NMC Margin:	-$5,216,563	-$8,227,450	-$1,046,956
NMC Operating Revenue: (Actual - Budget)	$885,431	-$2,827,921	$1,506,600
NMC Operating Revenue: % Difference in Actual vs. Budget	0.7%	-2.2%	1.1%
NMC Operating Expense: (Actual - Budget)	$8,554,042	$6,658,452	$3,871,349
NMC Operating Expense: % Difference in Actual vs. Budget	7.2%	5.3%	2.9%
VT Operating Revenue: % Difference in Actual vs. Budget	5.7%	3.1%	3.0%
VT Operating Expenses: % Difference in Actual vs. Budget	10.4%	4.3%	3.3%

12. Comparing prior year budgeted margins to actual margins can help test the reasonableness of a proposed budget. Given the difficulty of budgeting during the pandemic, it is reasonable to expect greater variance between budgeted and actual margins in FY21 and FY22 but starting FY23 this trend should diminish. In FY23 NMC's actual operating margin was negative and 7.6% below its budgeted 1.0% operating margin. NMC's FY24 operating margin is projected to be negative and under budget by 1.8%, which is largely due to underestimated operating expenses as shown above. *Id.* at 17.

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	2.0%	-4.3%	1.0%	-6.6%	1.0%	-0.8%	1.0%
Total Margin	3.2%	-10.1%	2.2%	1.2%	2.8%	6.4%	2.6%
EBIDA	7.0%	1.4%	6.3%	-1.3%	6.3%	4.6%	6.6%

13. The trajectory of a hospital's operating expense growth is one method of examining operating efficiency. NMC's operating expenses have grown less than the Vermont average, at approximately 3.3% per year, as shown. *Id.* at 14.



14. 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, NMC has a ratio of 26.5%, with a higher ratio than its comparators for all years except FY20. *Id.* at 28.

15. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, NMC budgets 60% clinical FTEs and 40% non-clinical FTEs. Its distribution of newly budgeted FTEs is 116% clinical and -16% non-clinical. *See* Workbook Submission; *see also* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 15.

16. The Medicare payment to cost ratio is an indicator of a hospital's relative cost efficiency. This ratio measures a hospital's revenues obtained from Medicare and Medicare's estimate of the cost to the hospital for providing that care. Medicare payments are adjusted to reflect individual hospital characteristics, so this measure shows how well a hospital manages its expenses. A lower ratio indicates inefficient expense management, while a higher ratio indicates greater efficiency. *See* Financial Analysis for Vermont Hospitals, Bartholomew & Nash (Jul. 15, 2024). NMC's 2022 Medicare payment to cost ratio was 72%, which was less than its peer median of 85%. *Id*. at 16. This indicates that cost inefficiencies may exist at NMC which, if successfully managed, could decrease expenses and lead to greater margin.

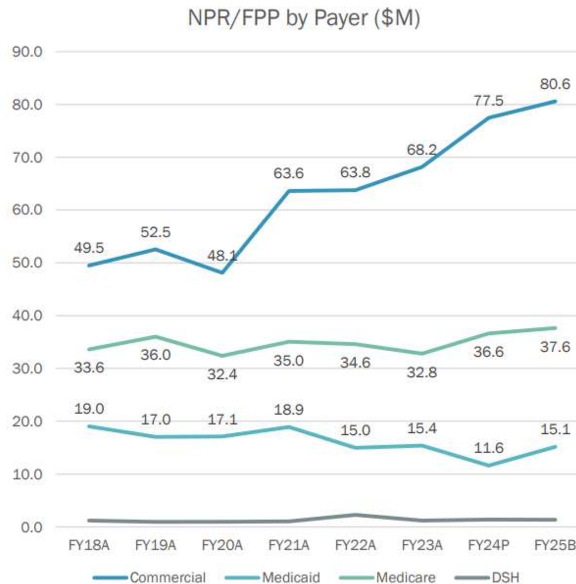
17. Hospitals also monitor clinical productivity. When assessed at the hospital level, as done here, this measure is an indicator of potential inefficiencies. NMC's clinical productivity data, as submitted, shows that 43% of its physician FTEs are in specialty areas performing below the 25th percentile, 51% of physician FTEs are in specialty areas performing between the 25th and 75th percentiles, and 6% of physician FTEs are in specialty areas performing above the 75th percentile. *See* Workbook Submission, Clinical Productivity Tab; *see also* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 28. NMC's productivity data segmented by clinical practice area shows 54% of practices below the 25th percentile, 38% of practices between the 25th and 75th percentiles, and 8% of practices above the 75th percentile. *Id*. NMC also utilizes separate department productivity reports, which compare departments' staffing levels per unit of service to a national benchmark provided by a third party. *See* NMC Hearing Presentation, 22; *see also* Public Comment of Peter Wright, Deliberations Tr. (Sept. 9, 2024), 44:6-45:26. NMC describes this metric as "very similar to a worked RVUs per clinical FTE metric." Narrative, 5. Departments set targets relative to these benchmarks at either the 50th or 75th percentile, with approximately 65% of NMC departments meeting or exceeding targets. *See id*.

18. 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. NMC did not provide wait times for referrals. However, NMC reported that 22% of new patients are scheduled to be seen within 14 days, 16% of new patients are scheduled to be seen within 15-30 days, 30% of new patients are scheduled to be seen within 31-90 days, 19% of new patients are scheduled to be seen within 91-180 days, and 13% of new patients are not scheduled within 180 days.

See Workbook Submission, Referral Lags and Visit Lags. While these wait times are generally average compared to hospitals statewide, Vermont experiences longer wait times than its peers. *See* GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times;[25] *see also* Health Services Wait Times Report, AHS, GMCB & DFR, (Feb. 16, 2022), 24.

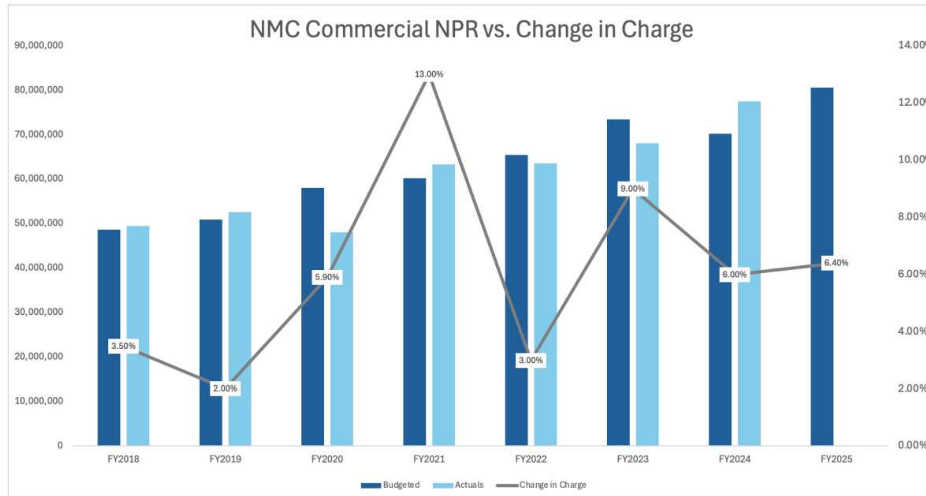
19. A hospital's investment in workforce development is an important aspect of its budget. *See* 18 V.S.A. § 9456(b)(12). Progress in this area can both improve access to services and reduce costs at a time when statewide locum traveler expenses are still high. Among others, NMC's investments in workforce development include subsidizing the Vermont State University School of Nursing, partnering with other hospitals and the Vermont Agency of Human Services to develop a nursing apprenticeship and pipeline program, establishing scholarships for RN programs with post-graduate work requirements, and operating an LPN bridge program and LNA program that allow students to pursue their advanced degrees while maintaining full-time employment. *See* Narrative, 17.

20. Commercial revenue has been the highest contributor to NMC's overall NPR. While public payer revenues have seen relatively small changes, commercial revenues have grown almost 63% since FY18. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 11.



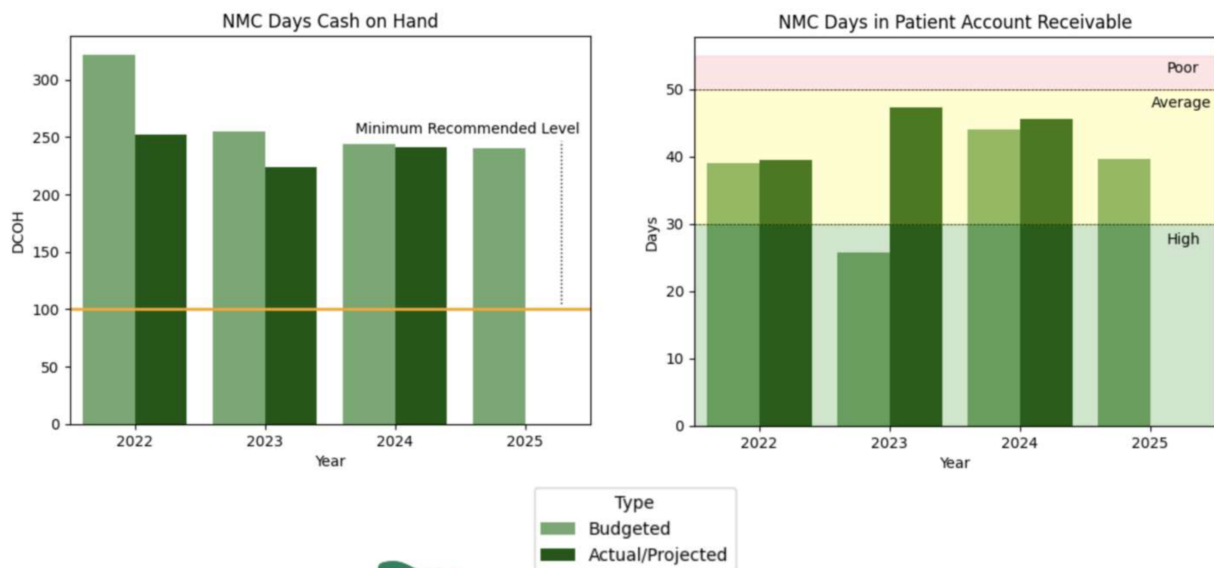
21. NMC has previously been approved for commercial charge increases as shown below, which include a 9.0% commercial increase in FY23 and a 6.0% commercial increase in FY24. *Id*. at 13. These increases have contributed to the commercial NPR increase shown above.

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



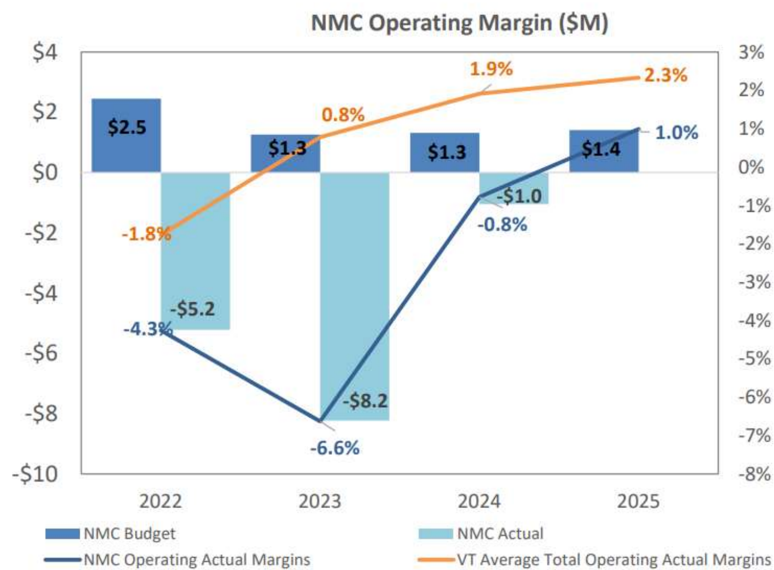
22. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a relative price by comparing a hospital's commercial prices to Medicare payments. RAND then calculates the standardized price by adjusting for case mix and other relative weights. For standardized price, a higher decile indicates that commercial prices appear to be higher than the national median, while a lower decile indicates that commercial prices appear to be lower than the national median. The most current RAND report uses prices from 2020 - 2022. *See* RAND Hospital Price Transparency Project, GMCB Presentation (Aug. 6, 2024), 7-9. NMC's commercial standardized prices are median or below median compared to hospitals nationally. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 23. However, this price data does not incorporate the 9% increase NMC received in FY23 or the 6% increase it received in FY24.

23. Days cash on hand (DCOH) is a measure of a hospital's financial health. NMC's days cash on hand has been well above the minimum recommended level of 100 days, consistently hovering around 250 days. *Id.* at 18.



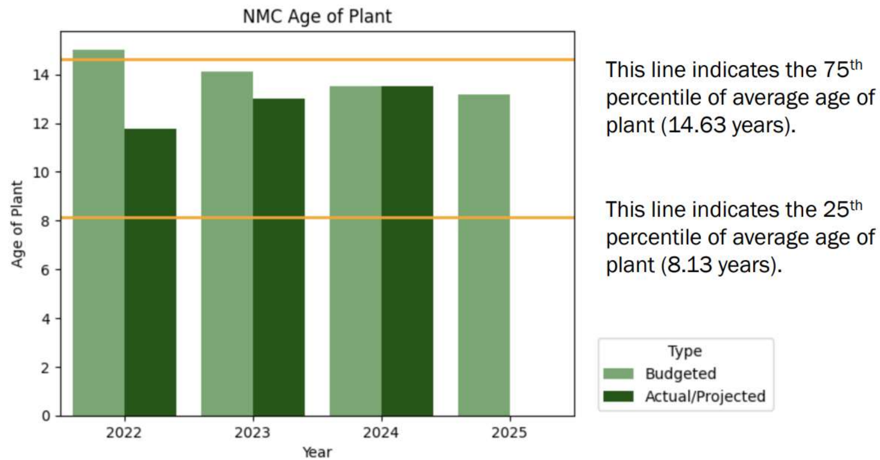
24. Days in patient accounts receivable, which reflects the average time it takes for a hospital to collect revenues for patient services rendered, is an important input to analyze a hospital's financial health. Using the industry standard, NMC's days in patient accounts receivable have been operating at an average level since FY22 as shown above. *Id.* at 18.

25. 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 that it is adequately reimbursed. NMC's operating margin has been consistently below the state average and has been negative for the last several years. NMC projects a -$1.0 operating margin in FY24 and is budgeting for a $1.4 million operating margin in FY25. *Id.* at 16.

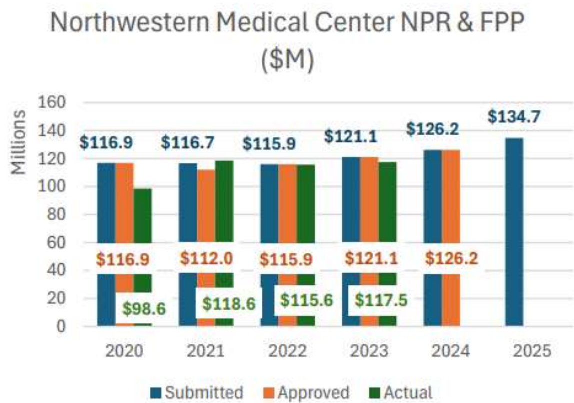


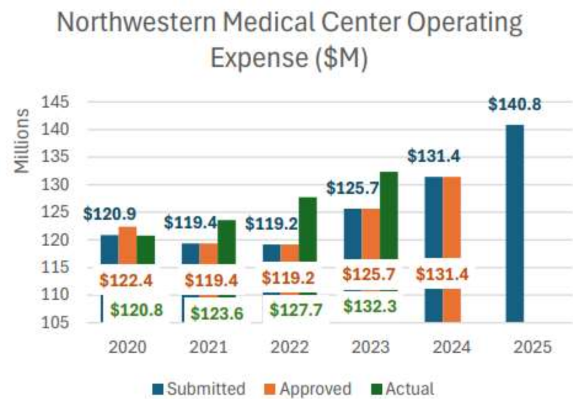
26. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. NMC's current ratio of assets to liabilities, with and without funded depreciation, is well above both breakeven and the US median (nearly five-times breakeven, and more than 3 times US median). *Id.* at 19.

27. 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. NMC's average age of plant is below the 75th percentile and above the 25th percentile as shown below. *Id.* at 20.

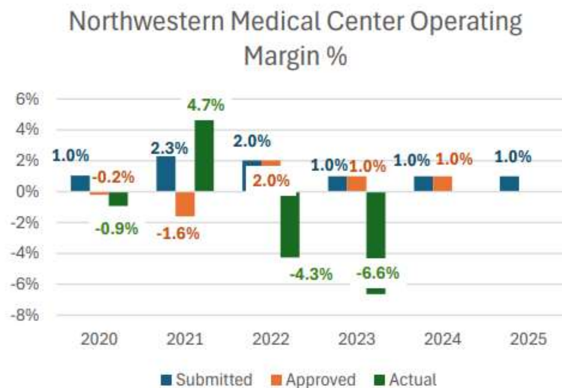


28. NMC prior years' submitted NPR, approved NPR, and actual NPR and operating expenses are shown below. While the hospital's actual NPR has been relatively consistent with its approved budget since FY21, its operating expenses have significantly exceeded approved amounts. *Id.* at 27.





29. NMC'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 NMC, through a special comment period during the GMCB's hospital hearings and deliberations.

CONCLUSIONS

While NMC met the GMCB's benchmark for operating margin, its proposed budget includes NPR growth of 6.8%, exceeding the benchmark of 3.5%, as well as commercial negotiated rate growth of 6.4%, exceeding the benchmark of 3.4%. *See* Findings, ¶¶ 2-4. As such, we review NMC's budget submission consistent with the factors set out in FY25 Guidance, GMCB Rule 3.000, and in statute. NMC bears the burden of persuasion in justifying its budget as submitted. GMCB Rule 3.000, § 3.306(a).

NMC has not adequately justified its proposed commercial negotiated rate growth. NMC's operating expenses have been over budget in each of the past few years, contributing to lower than anticipated operating margins in FY22 and FY23. *See* Findings, ¶¶ 25, 28-29. The rate of NMC's expense growth has been lower than the Vermont average in the past few years but is budgeted to rise from FY24 to FY25. *See* Findings, ¶ 13. At the same time, NMC's Medicare payment to cost ratio is lower than its peer median, suggesting that cost inefficiencies exist at NMC which, if successfully managed, could decrease its expenses and increase operating margins. *See* Findings, ¶ 16. NMC's ratio of administrative to clinical salaries is also higher than that of comparators. *See* Findings, ¶ 14. NMC's wait times show room for improvement. *See* Findings, ¶ 18. Its clinical productivity is low, measured in worked RVUs per clinical FTE. *See* Findings, ¶ 17. While NMC has presented an alternative productivity measure for us to consider that measures departmental staffing levels or hours worked per unit of service, which NMC uses internally and which shows comparatively better results, we conclude that NMC has not sufficiently demonstrated a reason for us to deviate from the measure of productivity we have used for other hospitals. *Id*. To the extent we entertain this alternative productivity benchmark, we note that 35% of NMC's departments are not meeting their selected targets, with an undisclosed deviation between these targets and current actual performance. *Id*. Finally, NMC has not provided sufficient justification that the low rate increase it has budgeted for Medicare is reasonable. *See* Findings, ¶¶ 5-6. If NMC receives a higher Medicare rate increase than budgeted, its requested commercial rate will risk higher than budgeted NPR growth.

Rather than approving commercial rate growth above the benchmark, we conclude that improving productivity and reducing expense growth will more effectively promote efficient and economic operation of the hospital, consistent with 18 V.S.A. § 9456(c)(3). This approach is also more consistent with our charge to ensure that all Vermonters "receive affordable and appropriate health care at the appropriate time in the appropriate setting" and 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(1)-(2), 9375(a), 9456(c)(3).

NMC has adequately justified its requested NPR growth. NMC has hired new physicians and plans to significantly increase its operating room hours. *See* Findings, ¶ 8. As noted above, NMC also has an opportunity to increase access and decrease wait times with clinical productivity improvements. *See* Findings, ¶ 17, 18. Given NMC's lower commercial prices compared to UVM

Medical Center, approving its NPR growth as submitted, with appropriate pressure on productivity increases, encourages more access at a hospital that is lower cost. *See* Findings, ¶ 22.

For the reasons set forth above, we find that NMC has not met its burden of justifying its budget as submitted. We conclude that a 6.8% increase in NPR and a 3.4% increase to commercial negotiated rate is appropriate. NMC's expected commercial NPR, provided in Condition E, below, incorporates NMC's current 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, NMC's budget is approved for FY25 subject to the following terms and conditions:

A. NMC's FY25 NPR/FPP ("NPR") budget is approved at a growth rate of not more than 6.8% over its FY24 budget, with a total NPR of not more than $134,725,507 for FY25.

B. NMC'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 NMC and commercial insurers. NMC 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. NMC's expected commercial NPR, based on its budget as adjusted in this Order, is $84,906,213. NMC 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. NMC 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. NMC 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, NMC 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, NMC 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. NMC 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. NMC 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. NMC 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, NMC 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. NMC 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) NMC 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. NMC shall participate in the Board's work, including the community engagement process, pursuant to Act 167.

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

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

R. NMC 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/ Thom Walsh)

Board Member Murman, dissenting.

I dissent from the majority's decision to establish NMC's FY25 budget with NPR growth at 6.8% and a 3.4% increase to its overall change in charge and commercial negotiated rate.

Filed: October 1, 2024

Attest: *<u>/s/ Jean Stetter</u>*
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.