STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re: Rutland Regional Medical Center Fiscal Year 2025	)))	Docket No. 24-012-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.

Rutland Regional Medical Center (RRMC) requested a 6.1% increase in NPR over its FY24 approved budget and a 2.8% increase in commercial rate over its FY24 approved commercial rate. RRMC's senior leadership presented its proposed budget to the Board at a public hearing held on August 7, 2024. RRMC 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 RRMC's FY25 budget with modifications to its proposal, setting FY25 NPR growth at not more than 5.0% over its FY24 approved budget, with commercial rate growth at not more than 2.8% 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. RRMC is a prospective payment system hospital with its primary location in Rutland, Vermont.

2. In its FY25 budget submission RRMC requested 6.1% growth in NPR from its FY24 budgeted NPR, for a total of $348,766,196. *See* RRMC Submission, Income Statement, 2. This proposed increase exceeds the 3.5% growth benchmark.

3. RRMC requested commercial negotiated rate growth of 2.8%. *See* RRMC Workbook, Rate Decomposition Sheet. This proposed increase meets the 3.4% commercial negotiated rate growth benchmark.

4. RRMC's proposed budget anticipates an operating margin of approximately $9.2 million, or 2.5%, 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. RRMC assumes that for FY25 the Medicare reimbursement rate will increase by approximately 1.0% and the Medicaid reimbursement rate will increase by 0%. *See* RRMC Narrative, 12; RRMC Workbook, Rate Decomposition Sheet.

6. RRMC's assumption of a 1.0% increase in Medicare rates appears low. On August 1, 2024, CMS issued its updated "market basket," the index used to adjust payment rates annually for prospective payment system hospitals. *See* CMS Newsroom, FY25 Hospital IPPS and LTCH PPS Final Rule;[23] CMS Newsroom, FY25 Hospital OPPS and ASC Payment System Proposed Rule.[24] For inpatient services the FY25 market basket increase is 3.4%, reduced to 2.9% for a productivity adjustment; for outpatient services the FY25 market basket increase is 3.0%, reduced to 2.6% for a productivity adjustment. *Id.* RRMC explains that it applied the "anticipated inflationary market basket increase of 2.6% to both inpatient and outpatient services [resulting in] an aggregated improvement of 0.97% in the Medicare rate, budget-to-budget." *See* Narrative, 12. While there are factors that could cause such deviation between these prospective payment system increases and RRMC's budgeted increase in the Medicare rate, the hospital has not sufficiently demonstrated that this deviation is likely to occur.

7. RRMC's assumption of a 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. RRMC

[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

anticipates a 4.6% increase in NPR due to increased utilization. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 83.

9. A hospital's net revenue and public payer reimbursement analysis is a method of showing that the revenue it needs from non-Medicaid payers incorporates any anticipated increases in Medicaid or public payer revenues. Hospitals are required to provide this analysis each year. *See* FY25 Hospital Budget Guidance & Reporting Requirements, Section VI, Part 11; *see also* 18 V.S.A. § 9456(b)(9). Except for its Medicare rate assumption described above, which is low, RRMC provided analysis with a reasonable methodology. *See* RRMC Narrative, 34.

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. Except for FY20, RRMC has consistently underestimated Medicare NPR in prior years. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 70.

Revenue Trends: Actual vs. Budgeted NPR
Rutland Regional Medical Center

VERMONT
GREEN MOUNTAIN CARE BOARD

	FY18 Δ		FY19 Δ		FY20 Δ		FY21 Δ		FY22 Δ		FY23 Δ	
Commercial	(6.20)	-4.8%	1.14	0.9%	(22.10)	-15.8%	3.44	2.7%	20.99	16.7%	(7.30)	-4.3%
Medicaid	(3.46)	-14.0%	(6.69)	-25.4%	(2.75)	-11.2%	9.42	39.3%	1.81	5.9%	(6.75)	-20.3%
Medicare	13.17	14.3%	3.25	3.2%	(3.76)	-3.7%	15.68	17.0%	8.77	7.9%	26.58	25.1%
DSH	(0.24)	-6.0%	(0.02)	-0.6%	0.07	2.3%	(0.02)	-0.7%	3.44	100.1%	(0.11)	-3.4%
	3.27	1.30%	(2.32)	-0.90%	(28.53)	-10.65%	28.52	11.52%	35.01	12.95%	12.42	3.97%

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

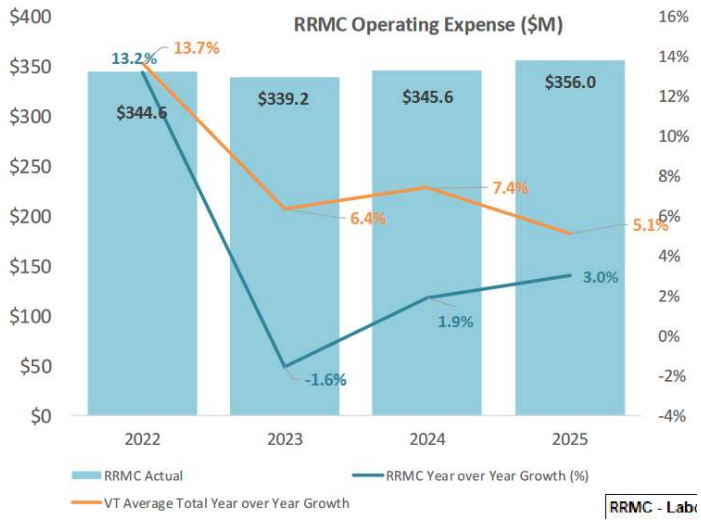
11. The accuracy of a hospital's previous assumptions about its operating revenues and expenses can speak to the reasonableness of its projected operating margin. If a hospital underestimates revenues, it may see a higher margin than budgeted. If a hospital underestimates its expenses, it may see less margin than budgeted. RRMC's recent budgets have underestimated both operating revenues and operating expenses. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 74. In FY23 and FY24 there has been a proportional underestimation of operating revenues and expenses, as shown below. *Id*.

	2022	2023	2024
RRMC Operating Revenue	$332,091,819	$346,573,334	$352,732,684
RRMC Operating Expense:	$344,575,357	$339,150,667	$345,558,192
RRMC Margin:	-$12,483,538	$7,422,666	$7,174,492
RRMC Operating Revenue: (Actual - Budget)	$40,984,715	$13,261,505	$5,894,655
RRMC Operating Revenue: % Difference in Actual vs. Budget	14.1%	4.0%	1.7%
RRMC Operating Expense: (Actual - Budget)	$53,589,616	$13,088,195	$6,612,516
RRMC Operating Expense: % Difference in Actual vs. Budget	18.4%	4.0%	2.0%
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. In FY23 RRMC's actual operating margin (2.1%) was very close to its budgeted operating margin (2.2%). RRMC's FY24 operating margin is projected to also be close to its budgeted operating margin (2.0% vs. 2.3%). *Id*, at 75.

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	0.0%	-3.8%	2.2%	2.1%	2.3%	2.0%	2.5%
Total Margin	2.2%	-13.6%	2.3%	-0.3%	4.4%	6.3%	5.3%
EBIDA	5.0%	0.5%	6.3%	6.3%	6.4%	6.2%	6.6%

13. The trajectory of a hospital's operating expense growth is one method of examining operating efficiency. RRMC's operating expenses have grown at a slower rate than the Vermont average in recent years, as shown. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 72.



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, RRMC has a ratio of 20.2%, lower than comparators, although the ratio has varied year to year and at different times has been notably higher and lower than comparators. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 86.

15. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, RRMC budgets 61% clinical FTEs and 39% non-clinical FTEs. Its distribution of newly budgeted FTEs is 77% clinical and 23% non-clinical. *See* Workbook Submission; *see also* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 73.

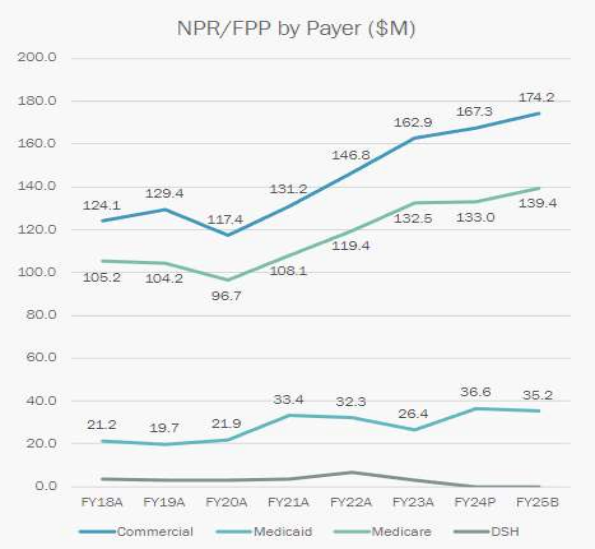
16. The Medicare payment to cost ratio is an indicator of a hospital's relative cost efficiency. This ratio measures a hospital's revenues obtained from Medicare and Medicare's estimate of the cost to the hospital for providing that care. Medicare payments are adjusted to reflect individual hospital 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, GMCB Presentation (Aug. 6, 2024). RRMC's 2022 Medicare payment to cost ratio was 73%, which was less than its peer median of 93%. *Id*. at 16. This indicates that cost inefficiencies may exist at RRMC which, if successfully managed, could decrease expenses and lead to greater margin.

17. A hospital's wait times are also an indicator of system efficiencies. RRMC reports that 37% of new patients are seen within 14 days. *See* Workbook, Referral Lags and Visit Lags. 22% of new patients are seen within 15-30 days, 25% of new patients are seen within 31-90 days, and 14% of new patients are seen within 91-180 days. *Id.* Overall, these wait times are average compared to other Vermont hospitals, with the percentage of patients (14%) waiting 91-180 days being higher than the state average. *See* GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times.[25] However, Vermont experiences longer wait times than peer states. *See* Health Services Wait Times Report, AHS, GMCB & DFR, (Feb. 16, 2022), 24.

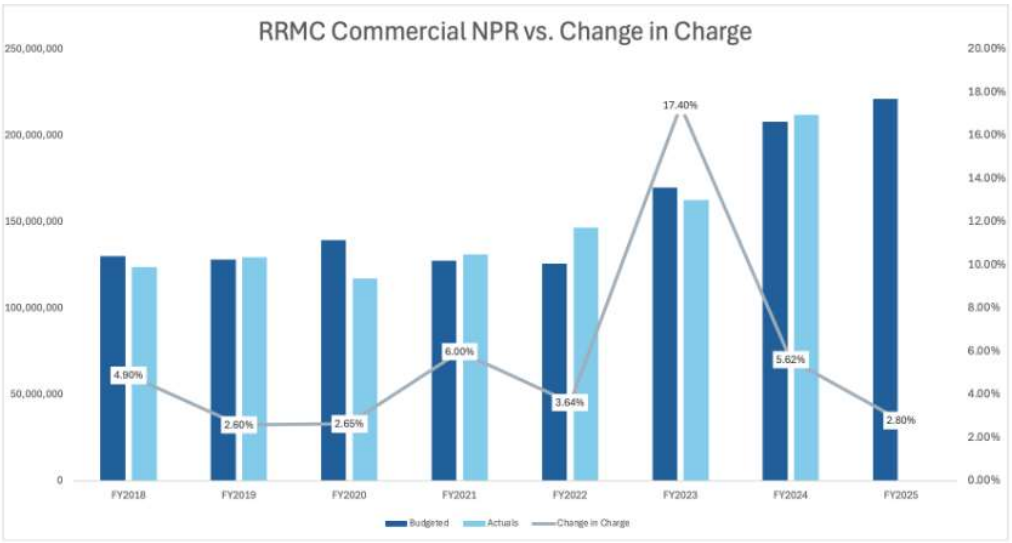
18. A hospital's investment in workforce development is an important aspect of its budget. *See* 18 V.S.A. § 9456(b)(12). Progress in this area can improve access to services and can reduce costs at a time when statewide locum traveler expenses are still high. RRMC's investments include a nurse residency program, an LNA program launched in 2024, and a program that incentivizes nurses to mentor and onboard new hires. *See* Narrative, 22.

19. Commercial revenue is the highest contributor to RRMC's overall NPR, with an increase of approximately 48% since FY20. *See* Hospital Revenue Trends by Payer, Staff Analysis, 7.[26]

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

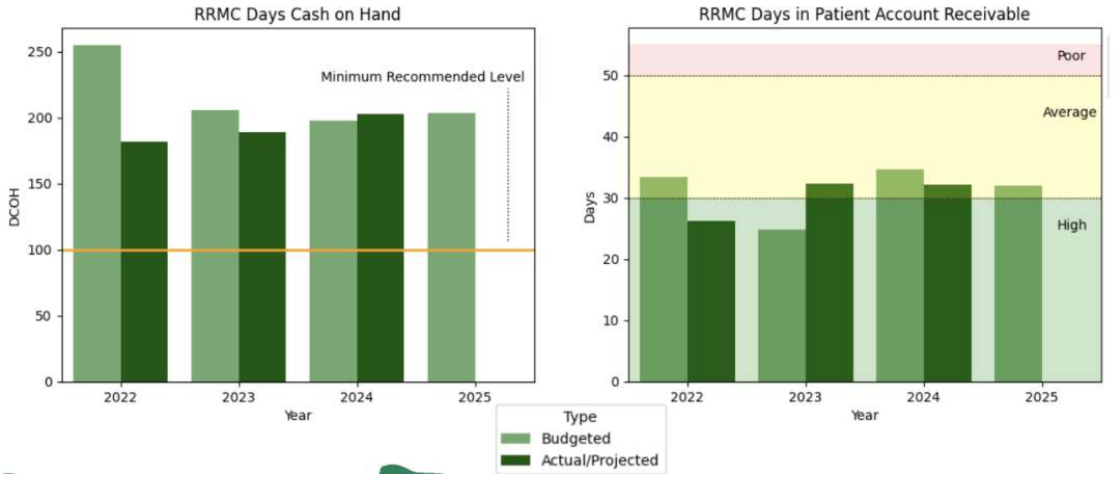


20. RRMC has previously been approved for commercial charge increases as shown below. *Id.* at 71. These increases, which include a substantial increase of 17.4% in FY23 and a 5.6% increase in FY24, have contributed to the commercial NPR increase shown both above and below.



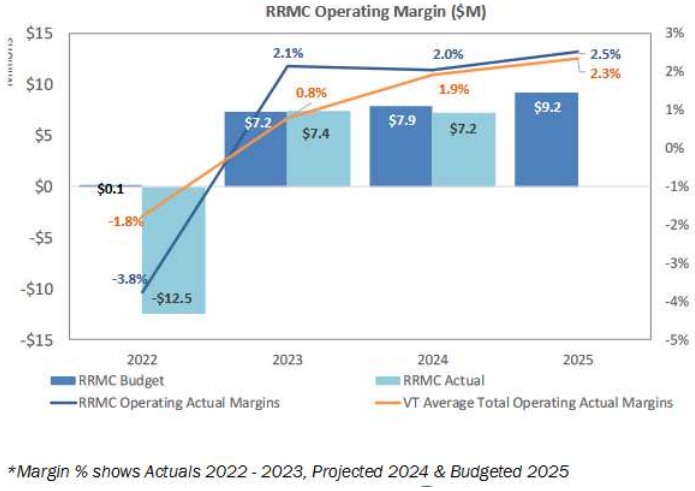
21. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a relative price by comparing a hospital's commercial prices to the Medicare payment system as a benchmark. RAND then calculates the standardized price by 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. The most current RAND report uses prices from 2020-2022. *See* RAND Hospital Price Transparency Project, GMCB Presentation (Aug. 6, 2024), 7-9. RRMC's commercial standardized prices are close to the median for hospitals nationally, with outpatient facility prices lower than the median at the 3rd decile. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 81. However, this price data does not reflect the 17.4% commercial increase RRMC received in FY23 or the 5.6% commercial increase it received in FY24.

22. Days cash on hand (DCOH) is a measure of a hospital's financial health. RRMC's days cash on hand rose from around 182 in FY22 to around 189 in FY23 and is projected to be around 203 for FY24. *Id.* at 76; Impact of FY25 Budget Requests & Summary of Staff Recommendations, Staff Presentation (Sept. 4, 2024), 20.



23. 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, RRMC's days in patient accounts receivable shows average to high performance, as shown above. Hospital Budget Review, Staff Presentation (Sept. 6, 2024), at 76.

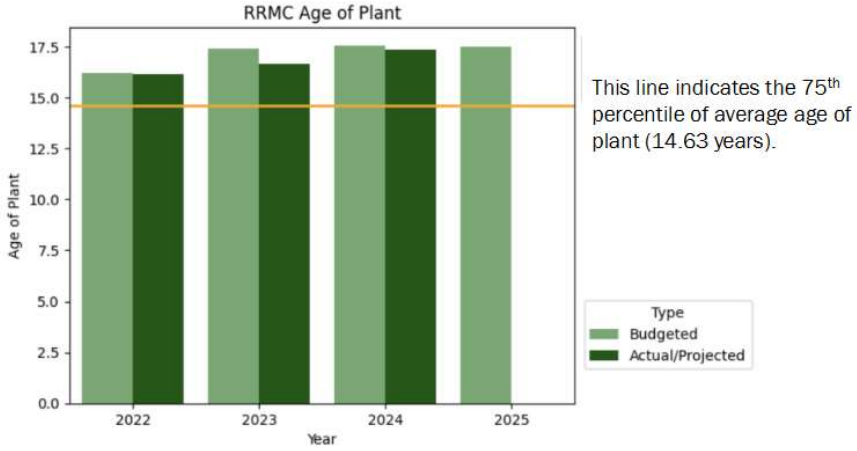
24. A hospital's operating margin is another evaluation of its financial health. Operating margins demonstrate a hospital's ability to cover expenses with revenues, but do not demonstrate that a hospital is efficiently delivering care or being adequately reimbursed. RRMC's operating margin was below budget and below the Vermont average in FY22 and above budget and above the Vermont average in FY23. In FY24, RRMC is projecting an operating margin of approximately $700K below its budget and consistent with the Vermont average. *Id.* at 74.



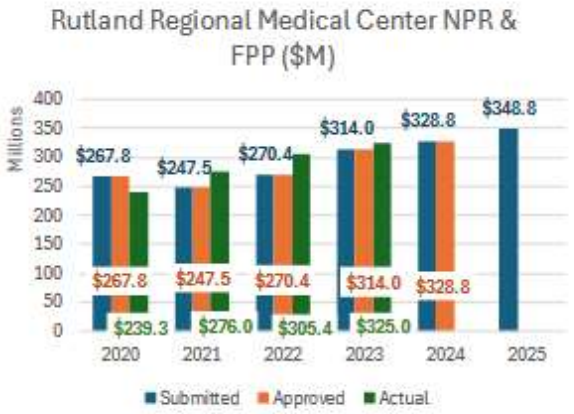
**Margin % shows Actuals 2022 - 2023, Projected 2024 & Budgeted 2025*

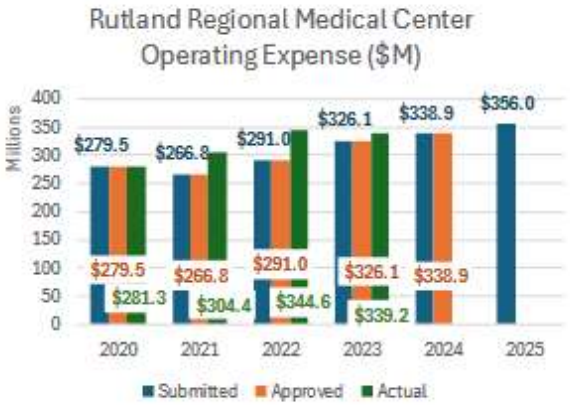
25. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. RRMC's current ratio of assets to liabilities, including funded depreciation, is above breakeven and is above the US median. Its current ratio of assets to liabilities without funded depreciation is above the breakeven and below the US median. *Id.* at 77.

26. 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. RRMC's average age of plant is above the 75th percentile, as shown below. *Id.* at 78.

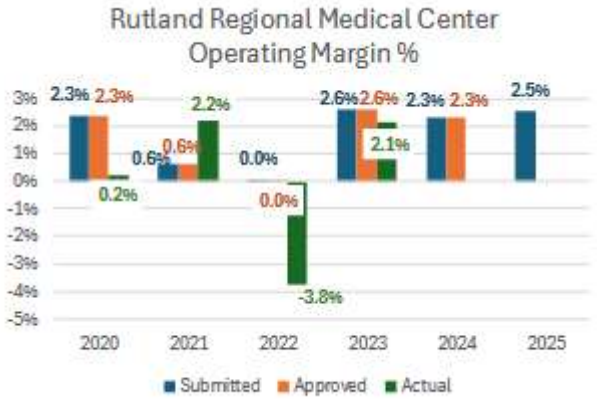


27. RRMC's prior years' submitted NPR, approved NPR, and actual NPR and operating expenses are shown below. *Id.* at 85.





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



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

CONCLUSIONS

While RRMC met the GMCB's benchmarks for commercial negotiated rate and operating margin, its proposed budget includes NPR growth of 6.1%, which exceeds the benchmark of 3.5%. *See* Findings, ¶¶ 2-4. As such, we review RRMC'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).

RRMC represents that the 6.1% increase in NPR is attributable to increased utilization and reduced wait times for some services. *See* Narrative, 6, 9. The hospital argues that this NPR growth is necessary to maintain a budgeted 2.5% margin for FY25. *Id.* at 2; *see also* Findings, ¶ 4. We recognize and appreciate RRMC's efforts at increasing access to patients who otherwise may not have had timely access to care. To that effect, we must consider whether RRMC's proposed budget promotes the efficient and economic operation of the hospital. 18 V.S.A. § 9456(c)(3). However, we must also act 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), 9371(2).

We conclude that 5.0% NPR growth, which is 1.5% higher than the benchmark established in FY25 Guidance, will promote efficient and economic operation of the hospital while supporting the health care reform principles described above. RRMC shows indicators of strong financial health compared to other Vermont hospitals. Operating expense growth has been lower than the Vermont average. *See* Findings, ¶ 13. Days cash on hand and patient accounts receivable are strong. *See* Findings, ¶¶ 22-23. RRMC has a high average age of plant but its ratio of assets to liabilities is above breakeven. *See* Findings, ¶¶ 25-26. While RRMC contends that a higher NPR increase is necessary to obtain a stable margin, its Medicare payment to cost ratio is a full twenty points behind peers, indicating that despite operating expense growth that is lower than the state average, RRMC has capacity to reduce its operating expenses. *See* Findings, ¶ 16. This strategy is consistent with our observation that RRMC's operating expenses have been over budget since

FY21. *See* Findings, ¶ 27. Although we appreciate RRMC's effort to expand access and increase utilization, a 5.0% growth in NPR will encourage it to make every possible effort to shift care that does not need to be at the hospital to lower-cost clinically appropriate settings. Shifting services where appropriate to other area providers strikes the appropriate balance of ensuring that population health care needs are met while restricting the overall price of care.

We conclude that RRMC's commercial negotiated rate request of 2.8%, inclusive of the conditions set forth below, is reasonable. This request, which is below the 3.4% benchmark, adequately accounts for higher commercial negotiated rates in FY23 and FY24 for a hospital that in FY22 had average standardized prices. *See* Findings, ¶¶ 20-21. We note that RRMC has objected to Condition B, which caps the change in charge and commercial negotiated rate increases at 2.8%, with no overall negotiated rate increase for any payer to exceed that amount, arguing that "[t]his blanket cap overlooks the nuances of specific payer agreements, leading to misalignment between the budget order and RRMC's submitted budget." *See* RRMC Objection (Sept. 10, 2024), 4. While this cap may not align with RRMC's chosen method of calculating its commercial rate request, the language in Condition B is consistent with RRMC's FY24 Budget Order, which was identical in form, and plainly consistent with FY25 Guidance, which provided that "[t]he GMCB anticipates establishing a cap on any commercial rate increase for each hospital, which will also apply as a cap on the increase that the hospital may receive from any individual commercial payer." *See* FY24 Budget Decision and Order for RRMC, Condition B at 9; *see also* FY25 Guidance at 8. We are similarly unpersuaded by RRMC's argument that this approach "directly results in a $312,817 loss and contradicts the [GMCB] staff's own projections." *See* RRMC Objection (Sept. 13, 2024), 2. As communicated in FY25 Guidance and as set forth below, the approved commercial rate increase of 2.8% is a cap, not a guarantee. *See* FY25 Guidance, 8-9. RRMC is not guaranteed to get any of the rates it seeks from commercial payers.

For the reasons set forth above, we find that RRMC has not met its burden of justifying its budget as submitted. We modify its budget as submitted to approve 5.0% growth in NPR and a 2.8% increase to commercial negotiated rate, as limited below. Given the evidence before us, this modification advances our statutory obligations described above. RRMC'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, RRMC's budget is approved for FY25 subject to the following terms and conditions:

A. RRMC's FY25 NPR/FPP ("NPR") budget is approved at a growth rate of not more than 5.0% over its FY24 budget, with a total NPR of not more than $345,262,783 for FY25 and a commensurate reduction in operating expenses

B. RRMC's overall change in charge and commercial negotiated rate increase are approved at not more than 2.8% over current approved levels, with no commercial negotiated rate increase for any payer at more than 2.8% over current approved levels. The commercial

negotiated rate increase overall or with respect to any payer may be less than 2.8% as negotiated between the hospital and payer.[27]

C. The commercial rate increase cap in Paragraph B is a maximum and is subject to negotiation between RRMC and commercial insurers. RRMC 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. RRMC's expected commercial NPR, based on its budget as adjusted in this Order, is $180,122,210. RRMC 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. RRMC 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. RRMC 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, RRMC 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, RRMC 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. RRMC 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.

[27] RRMC's 2.8% overall change in charge and commercial negotiated rate increase are further reduced by 1.6% due to Board enforcement of the hospital's FY23 budget overage. *See* Hospital Budget Review, GMCB Staff Presentation (Sept. 13, 2024), 1-9, 14-15. Accordingly, RRMC's overall FY25 change in charge and commercial negotiated rate increase are approved at no more than 1.2% over current approved levels, with no commercial negotiated rate for any payer at more than 1.2% over current approved levels, as explained in this Board's forthcoming Budget Enforcement Order for RRMC.

K. RRMC 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. RRMC 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, RRMC 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. RRMC 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) RRMC 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. RRMC shall participate in the Board's work, including the community engagement process, pursuant to Act 167.

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

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

R. RRMC 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.