

STATE OF VERMONT  
GREEN MOUNTAIN CARE BOARD

**FY2025 HOSPITAL BUDGET DECISION AND ORDER**

In re: Southwestern Vermont Medical Center ) Docket No. 24-013-H  
Fiscal Year 2025 )  
\_\_\_\_\_ )

**INTRODUCTION**

Vermont is confronting a health care affordability crisis. Our state’s marketplace plans are among the most expensive in the country.<sup>1</sup> Qualified Health Plan (QHP) premiums have grown more than in any other state.<sup>2</sup> Employer-based insurance premiums are growing faster than the national average.<sup>3,4</sup> According to the 2021 Vermont Household Health Insurance Survey, the cost of health insurance is the most common reason for a gap in coverage.<sup>5</sup> 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.<sup>6</sup> 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.<sup>7</sup>

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.<sup>8</sup> 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.<sup>9</sup> 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).<sup>10</sup> 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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<sup>1</sup> KFF Average Marketplace Premiums by Metal Tier, 2018-2024. <https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier>.

<sup>2</sup> *Id.*

<sup>3</sup> See GMCB Staff Presentation, Overview of FY25 Budget Requests (Aug. 6, 2024), 9.

<sup>4</sup> 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](https://gmcboard.vermont.gov/hospital-budget-review). Board presentations are available at [gmcboard.vermont.gov/2024-meetings](https://gmcboard.vermont.gov/2024-meetings). Recordings of GMCB hearings and deliberations are available at [www.orcamedia.net/](http://www.orcamedia.net/) and [www.youtube.com/@GreenMountainCareBoard](https://www.youtube.com/@GreenMountainCareBoard).

<sup>5</sup> 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>.

<sup>6</sup> *Id.*

<sup>7</sup> See GMCB Staff Presentation, Impact of FY25 Budget Requests (Sept. 4, 2024), 3-10.

<sup>8</sup> Press Release: GMCB Sets Premium Adjustments for BCBS and MVP. <https://gmcboard.vermont.gov/board/news>.

<sup>9</sup> *Id.*

<sup>10</sup> 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.<sup>11</sup>

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.<sup>12</sup> In FY24, spending at Vermont hospitals is expected to be \$3.6 billion.<sup>13</sup> Collectively, hospitals' budget submissions reflect a 48% increase over pre-pandemic actuals, an increase of \$1.6 billion since FY19.<sup>14</sup> 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.<sup>15</sup> Specialist utilization has shown signs of decreasing and, despite the state's reform efforts, PCP utilization has not shown meaningful signs of improvement.<sup>16</sup> This year, the GMCB collected clinical productivity data from each hospital, finding that approximately 70% of reported hospital departments are performing below the 50<sup>th</sup> percentile of their respective benchmark.<sup>17</sup> 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.<sup>18, 19</sup>

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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<sup>11</sup> *See* 16 V.S.A. §§ 4025(a)(1), 4025(b).

<sup>12</sup> Peterson-KFF Health System Tracker. <https://www.healthsystemtracker.org/indicator/spending/drivers-health-spending-growth>

<sup>13</sup> *See* Impact of FY25 Budget Requests, GMCB Staff Presentation (Sept. 4, 2024), 16.

<sup>14</sup> *Id.*, at 29.

<sup>15</sup> *See* Health Services Wait Times Report, AHS, GMCB, and DFR (Feb. 16, 2022), 24.

<sup>16</sup> *Id.*, at 25.

<sup>17</sup> *See* Impact of FY25 Budget Requests, GMCB Staff Presentation (Sept. 4, 2024), 30.

<sup>18</sup> *Id.*, at 33.

<sup>19</sup> *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<sup>20</sup> growth benchmarked at 3.5% over FY24 systemwide approved budgets; (2) commercial rate growth<sup>21</sup> 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.

Southwestern Vermont Medical Center (SVMC) requested a 3.5% increase in NPR over its FY24 approved budget and a 3.5% increase in commercial rate over its FY24 approved commercial rate. SVMC's senior leadership presented its proposed budget to the Board at a public hearing held on August 7, 2024. SVMC also submitted pre-hearing and post-hearing responses to questions asked by GMCB staff.<sup>22</sup> On September 11, 2024, following GMCB staff presentations and Board deliberations, and for the reasons set forth below, the Board established SVMC's FY25 budget with modifications to its proposal, setting FY25 NPR growth at not more than 3.5% over its FY24 approved budget, with commercial rate growth at not more than 3.4% over its FY24 approved commercial rate.

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<sup>20</sup> 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.

<sup>21</sup> 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).

<sup>22</sup> *See* Additional FY25 Hospital Budget Information. <https://gmcboard.vermont.gov/node/11866>

## FINDINGS

1. SVMC is a prospective payment system hospital with its primary location in Bennington, Vermont. The hospital became a member of the Dartmouth Health (DH) system in July 2023. *See SVMC Budget Presentation (Aug. 7, 2024), 8.*
2. In its FY25 budget submission SVMC requested 3.5% growth in NPR from its FY24 budgeted NPR, for a total of \$210,580,798. *See SVMC Submission, Income Statement, 2.* This proposed increase meets the 3.5% growth benchmark.
3. SVMC requested commercial negotiated rate growth of 3.5% over its FY24 approved rate. *See SVMC Workbook, Rate Decomposition Sheet.* This proposed increase exceeds the 3.4% commercial negotiated rate growth benchmark.
4. SVMC's proposed budget anticipates an operating margin of approximately \$3.6 million, or 1.6%, 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. SVMC's Rate Decomposition Sheet assumes an FY25 Medicare rate increase of approximately 0.7% and the Medicaid rate increase of 0%. *See SVMC Workbook, Rate Decomposition Sheet.* In its budget narrative SVMC writes that it expects Medicare rates to increase by 2.5% for inpatient services effective October 1, 2024, and 1.0% for outpatient services effective January 1, 2025, with a 0.05% Wage Index decrease and \$200,000 decrease due to Add-on Population loss. *See Updated Narrative (July 24, 2024), 9.*
6. SVMC's assumption of a 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.
7. 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;*<sup>23</sup> *CMS Newsroom, FY25 Hospital OPSS and ASC Payment System Proposed Rule.*<sup>24</sup> 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.* SVMC budgeted a lower Medicare rate increase because CMS had not yet issued its full market basket increases at the time SVMC completed its budget. *See SVMC Net Payer Revenue and Public Reimbursement Analysis.* Taking these published increases into consideration, SVMC's Medicare rate increase assumptions are low.

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<sup>23</sup> <https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipp-and-long-term-care-hospital-prospective-0>

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

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. SVMC anticipates a 1.7% increase in NPR due to increased utilization. *See Rate Decomposition Sheet; see also Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 41.*
  
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).* SVMC provided an analysis with a reasonable methodology. *See SVMC Net Payer Revenue and Public Reimbursement Analysis.*
  
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. *See Hospital Budget Review, GMCB Staff Presentation (Sept. 6, 2024), 28.* Since FY21 SVMC has had relatively stable assumptions on commercial NPR, but it has consistently underestimated its Medicaid NPR. *Id.*

	FY18 Δ		FY19 Δ		FY20 Δ		FY21 Δ		FY22 Δ		FY23 Δ	
<b>Commercial</b>	(3.58)	-4.4%	(4.58)	-5.5%	(10.34)	-11.9%	3.55	4.2%	(0.91)	-1.0%	(3.58)	-3.6%
<b>Medicaid</b>	1.31	7.4%	0.20	1.1%	(0.54)	-2.9%	3.22	17.9%	3.51	19.2%	2.08	11.3%
<b>Medicare</b>	3.90	6.6%	3.17	5.1%	(7.34)	-11.1%	2.56	4.0%	5.51	8.3%	(2.74)	-3.9%
<b>DSH</b>	(0.01)	-0.5%	(0.05)	-4.4%	0.00	0.2%	(0.08)	-9.4%	1.03	140.1%	0.08	10.4%
	1.62	1.01%	(1.25)	-0.76%	(18.22)	-10.57%	9.25	5.54%	9.13	5.14%	(4.17)	-2.21%

*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. Projected operating revenues and expenses for FY24 are close to budget. *See Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 32.* In FY23 SVMC underestimated operating expenses by 4.1% for a difference of approximately \$8 million. *Id.*

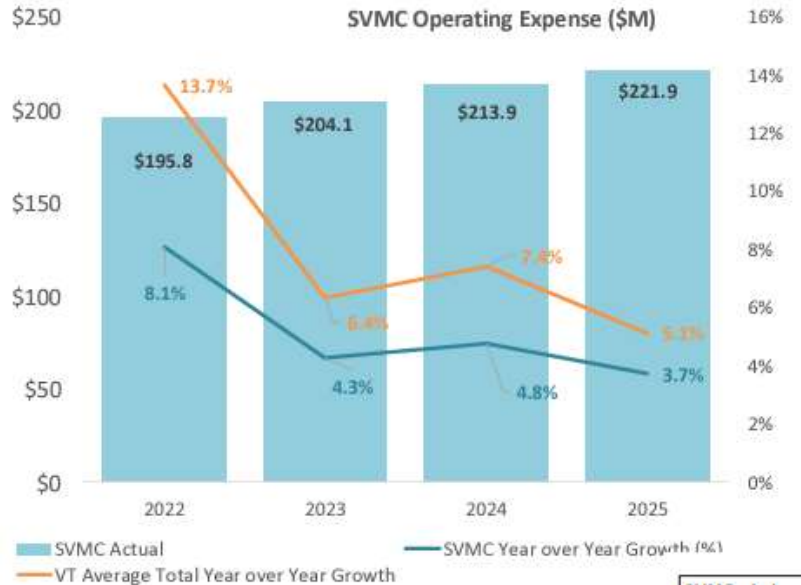


	2022	2023	2024
SVMC Operating Revenue	\$195,437,613	\$196,737,153	\$216,314,408
SVMC Operating Expense:	\$195,777,045	\$204,148,854	\$213,938,841
SVMC Margin:	-\$339,432	-\$7,411,702	\$2,375,567
SVMC Operating Revenue: (Actual - Budget)	\$11,048,846	-\$284,513	\$2,663,595
SVMC Operating Revenue: % Difference in Actual vs. Budget	6.0%	-0.1%	1.2%
SVMC Operating Expense: (Actual - Budget)	\$15,016,803	\$8,031,716	\$2,347,353
SVMC Operating Expense: % Difference in Actual vs. Budget	8.3%	4.1%	1.1%
VT Operating Revenue: % Difference in Actual vs. Budget	5.7%	3.1%	3.0%
VT Operating Expenses: % Difference in Actual vs. Budget	10.4%	4.3%	3.3%

12. Comparing prior year budgeted margins to actual margins can help test the reasonableness of a proposed budget. SVMC’s actual operating margin in FY23 was negative and considerably less than budgeted, consistent with its operating expense overage described above. *Id.* at 33. FY24 projected operating margin is close to budget. *Id.*

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	2.0%	-0.2%	0.5%	-3.8%	1.0%	1.1%	1.6%
Total Margin	-33.7%	3.8%	0.8%	-0.7%	5.8%	4.2%	3.0%
EBIDA	6%	3.4%	4.0%	0.0%	5.5%	5.0%	5.8%

13. The trajectory of a hospital’s operating expense growth is one method of examining operating efficiency. SVMC’s operating expenses have consistently grown under the Vermont average, as shown. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 30. Operating expense growth is projected to be 2.6% under Vermont average in FY24. *Id.* SVMC attributes its slower operating expense growth to its focus on cutting administrative expenses. Narrative, 5; *see also* SVMC FY25 Budget Presentation (Aug. 7, 2024), 24.



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, SVMC has a ratio of 36%. *See Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 44.* This ratio is higher than that of its comparator hospitals but does not factor in the administrative expense reductions that SVMC describes in its narrative. *Id.*; *see also* Narrative, 5.
15. A hospital’s ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, SVMC budgets 75% clinical FTEs and 25% non-clinical FTEs. Its distribution of newly budgeted FTEs is 79% clinical and 21% non-clinical. *See Workbook Submission; see also Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 31.*
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).* SVMC’s 2022 Medicare payment to cost ratio was 84%, which was less than its peer median of 107%. *Id.* at 16. This indicates that cost inefficiencies may exist at SVMC 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. SVMC’s productivity data, as submitted, demonstrates that 28.5% of its physician FTEs work in clinical departments that are performing under the 25<sup>th</sup> percentile, with 66.4% of physician FTEs working in departments that are performing below the 50<sup>th</sup> percentile. *See Workbook Submission, Clinical Productivity Tab; see also Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 44.*

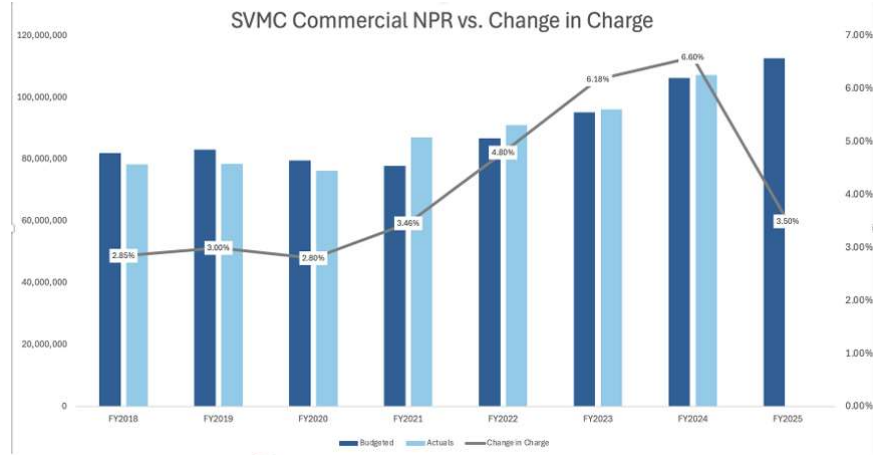


18. A hospital's wait times are also an indicator of system efficiencies. SVMC reports that 68% of appointments are scheduled within three business days of referral. *See* Workbook, Referral Lags and Visit Lags. 48% of new patients are seen within 14 days, 17% of new patients are seen within 15-30 days, 26% of new patients are seen within 31-90 days, 5% of new patients are seen within 91-180 days, and 4% of new patients are not seen within 180 days. *Id.* Overall, these wait times are better than many Vermont hospitals, with the percentage of patients (48%) seen within 14 days among the best. *See* GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times.<sup>25</sup> However, the Vermont average must be considered against the fact that Vermont experiences longer wait times than peer states. *See* 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 improve access to services and can reduce costs at a time when statewide locum traveler expenses are still high. SVMC participates in nursing pipeline and training efforts, as well as other education and recognition strategies, to retain and recruit its nursing workforce. *See* Narrative, 16-17.
20. Commercial revenue is the highest contributor to SVMC's overall NPR. *See* Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 25. While Medicare NPR has seen relatively small changes, increasing from \$58.6 million in FY20 to \$74.3 million in FY24 (an increase of 27%), commercial NPR has increased from \$76.4 million in FY20 to \$107.4 million in FY24 (an increase of 41%). *Id.*



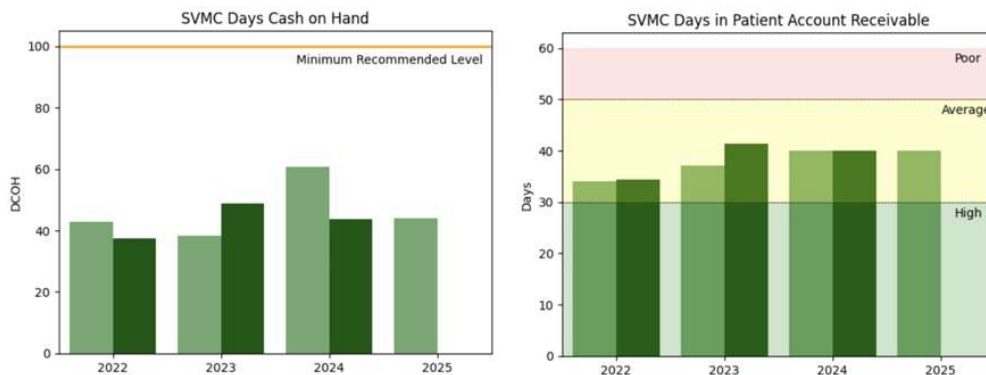
<sup>25</sup> <https://gmcboard.vermont.gov/document/fy25-hospital-aggregated-wait-times>

21. SVMC has previously been approved for commercial charge increases as shown below. See GMCB Staff Analysis, Change in Charge: Adjusting FY25 Requested Values, 6. These include a 6.18% increase in FY23 and a 6.6% increase in FY24. *Id.* These increases have contributed to the commercial NPR increase shown in the finding above.

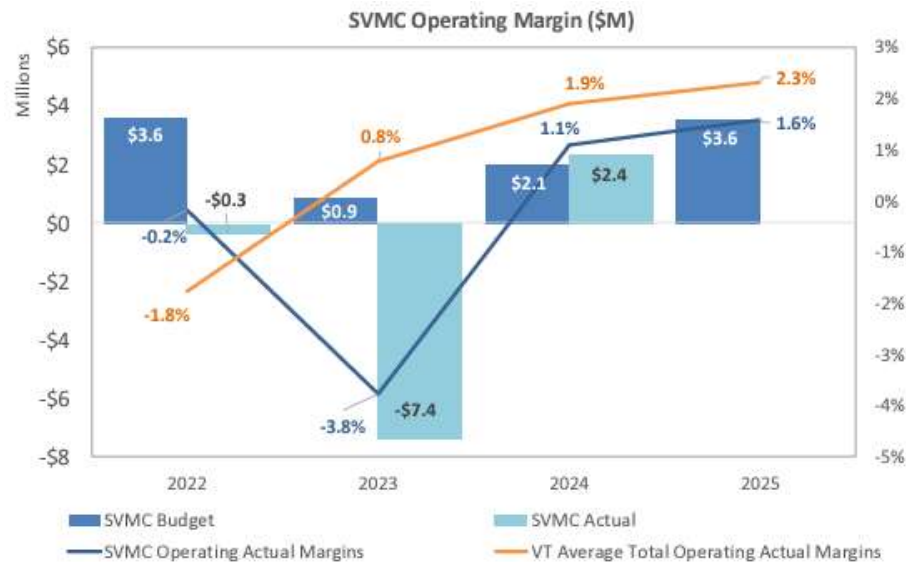


22. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a relative price by comparing a hospital’s commercial prices to the Medicare payment system as a benchmark. RAND then calculates the standardized price by 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. SVMC’s commercial standardized outpatient prices are at the 8<sup>th</sup> decile (5<sup>th</sup> decile for outpatient facility). See Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 39. Its inpatient prices are at the 6<sup>th</sup> decile (5<sup>th</sup> decile for inpatient facility). *Id.*

23. Days cash on hand (DCOH) is a measure of a hospital’s financial health. SVMC’s days cash on hand is low, hovering at approximately 40 days since FY22. *Id.* at 34. However, this figure does not include DCOH held at SVMC’s parent organization, Southwestern Vermont Health Center (SVHC), which holds approximately 170 DCOH. SVMC FY25 Budget Presentation (Aug. 7, 2024), 33.

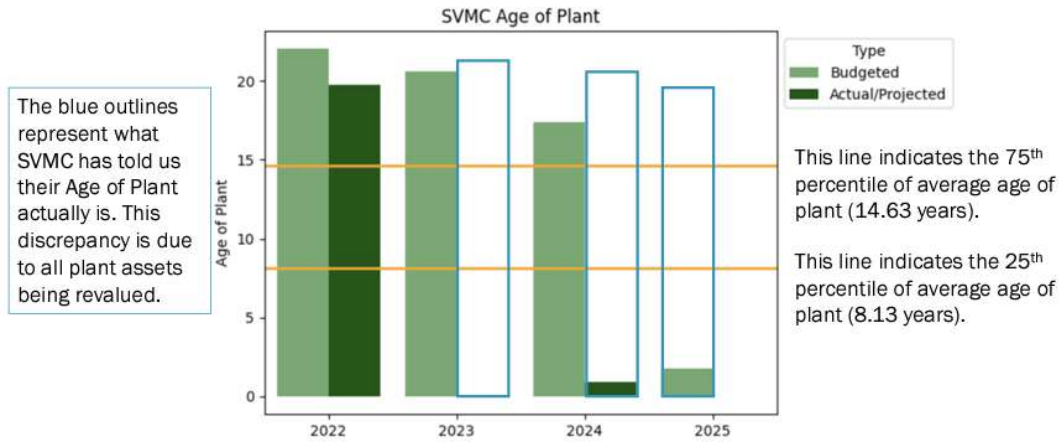


24. Days in patient accounts receivable, which reflects the average time it takes for a hospital to collect revenues for patient services rendered, is an important input to analyze a hospital's financial health. Using the industry standard, SVMC's days in patient accounts receivable is approximately 40, which indicates average performance. *See Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 34.*
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 being adequately reimbursed. SVMC budgeted for a positive operating margin in FY22 and FY23 but in both years performed under budget and in the negative (-\$0.3 million in FY22 and -\$7.4 million in FY23). *Id.* at 32. Operating margin for FY24 is projected at \$2.4 million, which is slightly above budget. *Id.* Still, its operating margin is below the FY24 average for Vermont hospitals. *Id.*

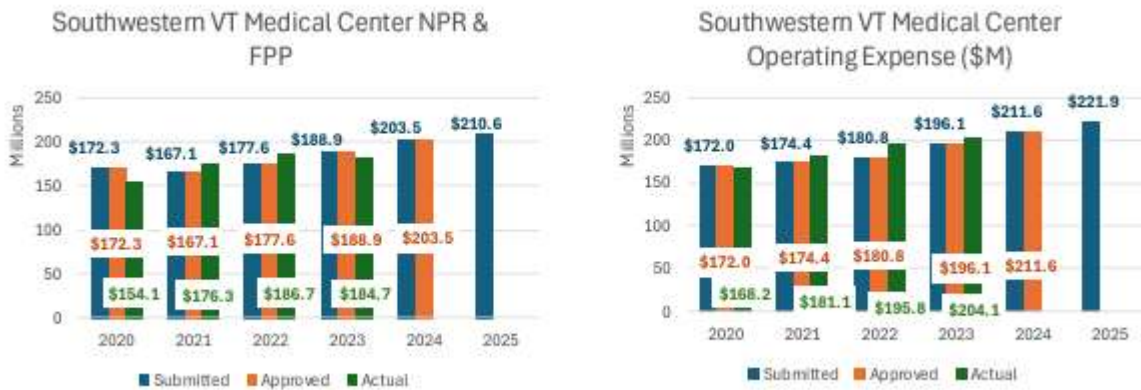


26. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. SVMC's current ratio of assets to liabilities, including funded depreciation, is projected to be below breakeven and below the US median for FY24, although it was above the breakeven in FY23. *Id.* at 35. Its current ratio of assets to liabilities without funded depreciation has been below the breakeven and significantly below the US median since FY22. *Id.*
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. SVMC's average age of plant is above the 75<sup>th</sup> percentile in FY22, but then drops dramatically in FY23, shown in green below, due to a revaluation of SVMC's plant assets as part of its affiliation with Dartmouth Health. *Id.* at 36; *see also* SVMC Follow-Up Responses, Response to #12, 6. SVMC's plant assets without this revaluation remain above

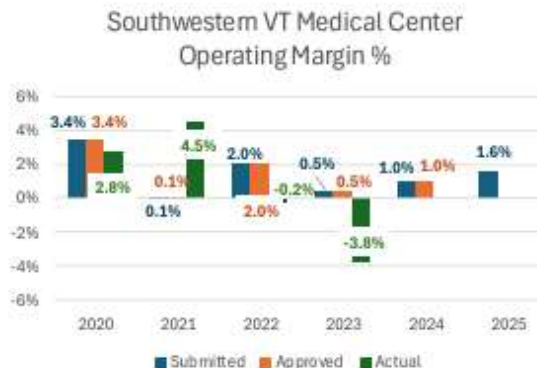
the 75<sup>th</sup> percentile, shown in blue below. See Hospital Budget Review, Staff Presentation (Sept. 6, 2024), 36.



28. SVMC prior years’ submitted NPR, approved NPR, and actual NPR and operating expenses are shown below. *Id.* at 43. SVMC’s operating expenses have been higher than budgeted since FY21. *Id.*



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

### CONCLUSIONS

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

SVMC explains that its 3.5% commercial rate growth is necessary because it is a low-cost provider, which makes it difficult to cut expenses and maintain a high level of care. *See Narrative, 5.* SVMC also points to administrative expense reductions it has already made in its FY25 budget of 1.6%. *Id.* It is accurate that SVMC's operating expense growth has declined from 4.3% in FY23 and 4.8% in FY24 to 3.7% budgeted for FY25. *See Findings, ¶ 13.* SVMC also has close to median commercial facility prices. *See Findings, ¶ 22.* However, upon review of the record, we cannot find sufficient support to justify SVMC's explanation for a 3.5% increase to commercial rate.

First, we do not agree that SVMC's commercial prices are low. SVMC's inpatient service prices are in the 6<sup>th</sup> decile and its outpatient service prices are in the 8<sup>th</sup> decile. *Id.* Second, while we commend SVMC on its budgeted 1.6% cut to administrative expenses, this reduction does not account for its high administrative to clinical salary ratio of 36% or low Medicare payment to cost ratio of 84% (compared to the peer median of 107%). *See Findings, ¶¶ 14, 16.* Third, while SVMC has better than average wait times compared to Vermont hospitals, its clinical productivity data demonstrates that the hospital has room to increase efficiency, which could result in a higher NPR. *See Findings, ¶¶ 17-18.* We therefore conclude that SVMC has sufficient opportunities to improve its margin by either decreasing expenses, increasing productivity, or both. While there are certainly circumstances in which a commercial rate increase over the benchmark would be appropriate, we conclude that such a financial strategy cannot be the first resort when there is evidence of other measures to increase revenue or reduce expenses. Such a financial strategy is consistent with our obligation to ensure that the established budget promotes "efficient and economic operation of the hospital." *See 18 V.S.A. § 9456(c)(3).* This strategy is also consistent with our duty to conform to the principle that the health care system is "efficient in operation, and accountable to the people it serves," and that it balances "the health care needs of the population with the ability to pay for such care." 18 V.S.A. §§ 9371(2)-(3).

This 0.1% reduction in SVMC's proposed commercial negotiated rate growth is consistent with its request for a 3.5% increase in NPR, which we find reasonable and approve. SVMC has not sufficiently justified its low Medicare rate assumption. *See Findings, ¶¶ 5, 7.* Assuming that the hospital's utilization and case mix assumptions are generally correct, this low assumption could cause higher than budgeted total NPR. SVMC has also historically underestimated its Medicaid NPR. *See Findings, ¶ 10.* Underestimating Medicaid NPR for FY25 could also cause a higher than

budgeted NPR. We therefore conclude that commercial rate growth at 3.4% is more appropriate to support SVMC's budgeted NPR growth at 3.5%.

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

- A. SVMC's FY25 NPR/FPP ("NPR") budget is approved at a growth rate of not more than 3.5% over its FY24 budget, with a total NPR of not more than \$210,580,798 for FY25.
- B. SVMC'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 SVMC and commercial insurers. SVMC 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. SVMC's expected commercial NPR, based on its budget as adjusted in this Order, is \$121,067,674. SVMC 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. SVMC 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. SVMC 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, SVMC 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, SVMC 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. SVMC 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. SVMC 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. SVMC 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, SVMC 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. SVMC 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) SVMC 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. SVMC shall participate in the Board’s work, including the community engagement process, pursuant to Act 167.
- P. SVMC shall timely file all forms and information required for practice acquisitions and/or transfers as determined by GMCB staff, if applicable.
- Q. SVMC shall file all requested data and other information in a timely and accurate manner.
- R. SVMC shall report on any changes it makes to the methods it uses to calculate information it reports to the GMCB. Any such report shall include a detailed explanation as to the reason for the change and the inclusion of a comparison report that shows the results using the hospital’s prior method of calculation.
- S. After notice and an opportunity to be heard, the GMCB may amend the provisions contained herein, and issue an amended order, consistent with its authority as set forth in 18 V.S.A. Chapter 220, Subchapter 1, 18 V.S.A. Chapter 221, Subchapter 7, and GMCB Rule 3.000.
- T. All materials required above shall be provided electronically, unless doing so is not practicable, as determined by the Director of Health Systems Finance.
- U. The findings and orders contained in this decision do not constrain the Board’s decisions in future hospital budget reviews, future certificate of need reviews, or any other future regulatory or policy decisions.

**So ordered.**

Dated: October 1, 2024  
 Montpelier, Vermont

s/ Owen Foster, Chair )  
 ) GREEN MOUNTAIN  
s/ Jessica Holmes ) CARE BOARD  
 ) OF VERMONT  
s/ Robin Lunge )  
 )  
s/ David Murman )  
 )  
s/ Thom Walsh )

Filed: October 1, 2024

Attest: /s/ Jean Stetter  
 Green Mountain Care Board  
 Administrative Services Director

*NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made.*